12-2022

Factors Influencing Political Self-Efficacy And Political Astuteness in Undergraduate Nurse Educators

Mark William Longshore

UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

FACTORS INFLUENCING POLITICAL SELF-EFFICACY AND POLITICAL ASTUTENESS IN UNDERGRADUATE NURSE EDUCATORS

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

Mark William Longshore

College of Natural and Health Sciences
School of Nursing
Nursing Education

December, 2022

This Dissertation by: Mark William Longshore

Entitled: *Factors Influencing Political Self-Efficacy and Political Astuteness in Undergraduate Nurse Educators.*

Has been approved as meeting the requirements for the Degree of Doctor of Philosophy in the College of Natural and Health Sciences in the School of Nursing, Nursing Education program

Accepted by the Doctoral Committee

_____
Michael Aldridge, Ph.D., Research Advisor

_____
Melissa Henry, Ph.D., Committee Member

_____
Katrina Einhellig, Ph.D., Committee Member

_____
Michael Allen, Ph.D., Faculty Representative

Date of Dissertation Defense November 2, 2022

Accepted by the Graduate School

_____
Jeri-Anne Lyons, Ph.D.
Dean of the Graduate School
Associate Vice President for Research

ABSTRACT

Longshore, Mark William. *Factors influencing political self-efficacy and political astuteness in undergraduate nurse educators.* Published Doctor of Philosophy dissertation, University of Northern Colorado, 2022

The profession of nursing, 3.9 million strong, continues to lag in taking an active role in the development of health policy. Reasons for that include lack of time, a lack of knowledge, and perceived competence of political action. The factors of knowledge and the related perceived competence, or in the case of this study, self-efficacy, could be improved through education. To that end, it was important to identify if nurse educators had the political astuteness, or knowledge, and self-efficacy. If not, how would nurses learn the necessary skills and gain confidence to be more active politically? The purpose of this study was to describe the political astuteness and political self-efficacy in undergraduate nurse educators and explore the possible correlation between political astuteness and political self-efficacy in the nurse educator. Additionally, the possible correlation between demographic factors and political self-efficacy was explored. The political self-efficacy is an indirect measure of the nurse educator's ability to teach health policy to undergraduate nursing students.

This descriptive study measured the political self-efficacy and political astuteness of nurse educators using two instruments. The Teacher Political Self-Efficacy-Modified scale (TPSE-M) and the Political Astuteness Inventory (PAI). Demographic data were also collected. Bandura's (1997) self-efficacy theory framed the study.

A random sample of 149 nurse educators from across the United States participated in this study. Data were reviewed visually for errors and missing data. The data were then exported to SPSS,

with 132 participants included in the full analysis. The results of both the TPSE and the PAI showed low to mid-levels of astuteness and political self-efficacy. Having completed a health policy course in graduate school increased the educators' knowledge as measured by the PAI. The results also supported Bandura's theory (1997) with nurse educators belonging to professional organizations scoring higher in self-efficacy, likely through a degree of vicarious learning and encouragement from peers within those organizations. Additionally, there was a strong correlation of .739 between the results of the PAI and the TPSE in this population.

The main implication of this study was that many nurse educators do not have the knowledge or self-efficacy to be politically active and therefore are unlikely to be able to pass this knowledge and skill to new nurses. Nurse educators who teach this content have a responsibility to increase both their knowledge and self-efficacy. College leadership, including directors and deans, must evaluate their current faculty for the knowledge and skills of health policy and advocacy just as they would for the knowledge and skills of any other specialty. Steps toward increasing those health policy skills and self-efficacy could include providing time and compensation for classes in health policy in addition to encouraging political advocacy by their faculty as service, compensated through the faculty evaluation process. Improving the knowledge and skills of the faculty might also improve the PAI and self-efficacy related to health policy of new nursing graduates.

Key Words: Advocacy, teacher self-efficacy, political self-efficacy, nursing education, health policy

ACKNOWLEDGEMENTS

I start by thanking my research advisor, Dr. Michael Aldridge. He provided guidance and support while sharing his own expertise with the dissertation process. I also thank the other members of the research committee; Dr. Henry, Dr. Einhellig, and Dr. Allen for challenging me to make my study the best it could be and providing encouragement through the process.

A big thank you to the members of the 2018 Ph.D. cohort. Without the reassurance, sharing of ideas, and in some cases annual visits to the NEC, I may not have made it through.

Thanks to Jake with the UNC Research Consulting Lab for his patience and guidance in working through the statistics.

I also thank Dr. Modene, Dr. Primomo, and Dr. Hammon for their gracious permission to use their instruments. Additionally, they offered further support in my research if it was needed.

Finally, I thank my family, particularly my wife who gave me the “you can do this” when I thought I could not. She also listened to my ramblings as I talked things out while admitting she did not understand half of what I was talking about.

TABLE OF CONTENTS

CHAPTER I. INTRODUCTION....1

Nurses and Health Policy....2
New Expectations for Nurse Educators....11
Research Gap....16
Statement of the Problem....17
Statement of Purpose....17
Research Questions....18
Design and Methodology....19
Operational Definitions....20
Significance of the Study....20
Summary....21

CHAPTER II. LITERATURE REVIEW....22

Search Criteria....23
Social Cognitive Theory....23
Health Policy in Nursing....36
Political Astuteness....39
Summary....43

CHAPTER III. METHODOLOGY....45

Research Design....45
Research Participants....46
Methods of Data Collection....48
Data Analysis....52
Limitations and Delimitations....54
Summary....55

CHAPTER IV. RESULTS....56

Research Questions....56
Data Analysis....56
Sample Description....57
Research Question One....61
Research Question Two....63
Research Question Three....66

Research Question Four 67
Summary 70

CHAPTER V. DISCUSSION AND IMPLICATIONS 71

Summary of Research Data 72
Social Cognitive Theory 87
Implications 89
Significance to Nursing Education 94
Study Limitations 95
Recommendations for Future Research 97
Conclusion 97

REFERENCES 100

APPENDIX A. POSTINGS FOR SOCIAL MEDIA 117

APPENDIX B. CONSENT FOR PARTICIPATION 119

APPENDIX C. POLITICAL ASTUTENESS INVENTORY 12

APPENDIX D. TEACHER POLITICAL SELF-EFFICACY-MODIFIED SCALE 125

APPENDIX E. PERMISSION FROM DR. HAMMON TO USE TEACHER POLITICAL SELF-EFFICACY (ORIGINAL) INSTRUMENT 127

APPENDIX F. PERMISSION FROM DR. MODENE TO USE TEACHER POLITICAL SELF-EFFICACY-MODIFIED INSTRUMENT 129

APPENDIX G. PERMISSION FROM JANET PRIMOMO TO USE THE MODIFIED POLITICAL ASTUTENESS INVENTORY 131

APPENDIX H. PERMISSION FROM PEARSON TO USE CLARK'S POLITICAL ASTUTENESS INVENTORY 133

APPENDIX I. INSTITUTIONAL REVIEW BOARD APPROVAL 135

APPENDIX J. DEMOGRAPHIC QUESTIONS 138

LIST OF TABLES

Table

1. Personal Demographics of Nurse Educators.....59

2. Professional Demographics of Nurse Educators.....60

3. Teacher Political Self-Efficacy-Modified Mean Scores.....62

4. Political Astuteness Inventory Mean Scores.....65

5. Regression Analysis for Variables Predicting Mean Teacher Political Self-Efficacy Score.....68

6. Regression Analysis for Variables Predicting Total Political Astuteness Inventory Scores.....69

CHAPTER I

INTRODUCTION

Beth is finishing a 12-hour night shift when she is approached by the nursing supervisor who tells Beth she needs her to stay another four hours to care for patients after two nurses called in sick. Beth, tired after her 12 hours providing patient care on a unit chronically short-staffed, questions if she must stay and is concerned about her ability to provide safe care. What she does next depends on her knowledge of, and possibly participation in crafting, policies impacting nursing. That knowledge comes from nurse educators who have a responsibility to teach their students material relevant to the discipline of nursing. What is relevant has shifted over the past 50 years from an emphasis of the nurse as a direct caregiver, following orders without question, to broadly educated professionals who attain higher levels of education and function as part of the team (Akhtar & Ward, 2020). Nursing is consistently viewed as the most trusted profession in the healthcare team (American Nurses Association [ANA], 2022). With 3.9 million registered nurses, nursing is one of the largest professions in the United States and nurses make up the largest group of healthcare workers (American Association of Colleges of Nursing [AACN], 2019b; World Atlas, 2022). VandeWaa et al. (2019) stated these factors "produce a significant, but largely unused political power" (p. 628). In this chapter, I describe why nursing needs to take a greater role in health policy work and some barriers to that work. As lack of education on policy work is one barrier, this dissertation study focused on factors of the nurse educator that might lead to better prepared nurses.

Nurses and Health Policy

Nurses Don't Know the Law

The legal content influencing the daily work of nursing is so broad it is difficult to assess whether nursing programs are teaching what needs to be taught. That is in part due to the changing expectations of nursing education. For example, just over 20 years ago, Ely-Pierce (1999) described the "basic legal principals" all nurses must know" (p. 79) including malpractice, standards of care, the effect of protocols and policy manuals, and the requirements of informed consent. Similarly, Fulcher-Smith (1991) focused on malpractice, emphasizing topics such as battery, false imprisonment, and defamation. The study found even those arguably simple concepts were not well understood by nurses. Fulcher-Smith's conclusion was nurses should practice in a defensive manner. Many current educators received their undergraduate nursing education during the time these two researchers published their works. As such, the focus might still be largely that of protecting the nurse rather than advocating for change in health care. While it could be surmised that today's nurse educator has kept up on the expanding field of law and nursing, Fulcher-Smith found nurses had participated in legal programs during their career but the programs were apparently not covering the topics needed. While Fulcher-Smith stated political activity is higher in nurses with advanced degrees, nurses in the study at all levels of education identified the need to be taught more about political activity.

Most research focused on specific legal knowledge used in nursing practice. Several researchers explored nurses' knowledge and attitudes on advanced directives (Jezewski et al., 2005; Miller, 2018; Walerius et al., 2009). Jezewski et al. (2005) found 70% of oncology nurses had good knowledge of advanced directives in general. The other areas of study included questions specifically on the Patient Self-Determination Act (PDSA) and state law in the area of

advanced directives. The results showed knowledge scores of 51% and 53%, respectively. In that study, the participants recognized their own need for additional knowledge in this area. Each identified a knowledge deficit of advanced directives. Miller (2018) added that nurses with higher confidence did not always have accurate information.

Willmott et al. (2020) found similar results when exploring nurses' knowledge of law during end-of-life treatment. Nurses' concern about criminal charges related to providing pain relief that might hasten death was found to result in the patient not getting the care they need. The conclusion again was to provide education to increase nurses' knowledge of the law as it related to end-of-life care.

Knowledge of specific laws, however, was superficial compared to the greater responsibility of affecting change in those laws. The largest, most trusted healthcare discipline has a responsibility to advocate for their patients and their community. Doing so requires knowledge and skills of health policy, sometimes referred to as health policy advocacy or political advocacy, placing the focus on the recipient of care (Eaton et al., 2017).

What is Health Policy?

The breadth of health policy is considerable with a number of organizations using the "health in all policies" mantra (American Public Health Association, n.d.; Centers for Disease Control and Prevention [CDC], 2016). Health policies are issued by organizations as well as local, state, and federal governments to impact the quality and safety of healthcare practice as well as issues of access, equity, cost, and social justice within that practice (AACN, 2008; Duquesne University, 2020a).

At the state level, executive agencies such as the Board of Nursing and Department of Health establish licensing and operation policies for healthcare providers and organizations as

well as public health goals with a focus of health and safety. At the federal level, agencies such as the U.S. Department of Health and Human Services (n.d.) and the CDC (2022) published guidelines both on direct patient care—from the mask recommendation for COVID-19 outbreak to safe practice for the nurses such as the use of safety needles and needleless systems.

Statutes from state legislatures provided the nurse practice acts and nurse to patient ratios while federal legislation included the privacy provisions of the Health Insurance Portability and Accountability Act and the anti-dumping regulations of the Emergency Medical Treatment and Labor Act (Duquesne University, 2020b).

Further, non-governmental organizations such as the Joint Commission, the National League for Nursing, and the American Nurses Association regulate nursing both through publication of their own standards as well as through their lobbyists acting at the state and federal level. For example, the AACN (n.d.) focuses specifically on education related matters for nurses and setting standards to be covered in nursing education programs, leading to well educated, safe nurses.

Health Policy Changes by Nurses

Nursing has not been consistently involved in health policy over time. Reinhart (2020) described nurses and doctors as being trusted sources of information who were not seen as influential in policy development and health reform. Rather, government and insurance companies were each seen as health policy influencers at 75% and 56%, respectively, compared to only 14% for nurses. Ironically, only one nurse was on the committee to produce the Institute of Medicine's "Quality Through Collaboration: The Future of Rural Health Care" (Wakefield, 2005). Mason et al. (2018) found nurses were the source of only 2% quotes in the media with these quotes typically focused on nursing itself rather than the broader health policy. Nurses and

nursing were mentioned in only 13% of healthcare related articles (Mason et al., 2018). Mason et al.'s most recent findings demonstrated a drop in nurses' influence to the current 2% from 4% found in the Woodhull study 20 years ago. The majority of quotes in the media came from physicians in spite of the fact that nurses are the largest healthcare profession at 3.9 million compared to about one million physicians and provide a majority of the care in acute and long-term care centers (AACN, 2019b; American Association of Medical Colleges, 2021). It is difficult to quantify the impact of nurses in health policy when they are not identified as being part of the team developing policy. Still, there are areas where nurses have been successful independently or as part of larger organizations in effecting health policy change.

The American Nurses Association (ANA, n.d.) acknowledged nurses perform this advocacy role in their workplace and at a local level but need also to escalate to higher levels of political advocacy to improve nursing practice and patient care. The ANA represents all nurses in both state and national legislative environments (Walton, 2017). Advocating for nurses and the public, the ANA (2019) has studied the issue of safe patient ratios, providing data and guidance to state and federal legislatures.

There are examples of nurses affecting policy through state and national organizations. A group of healthcare workers in Washington are pushing for safe staffing at the state level (Washington State Nurses Association, 2021). A group of Colorado educators lobbied against a recommendation from a school system that might have resulted in lesser educated, unsafe nurses in practice. In the Colorado General Assembly (2018), HB18-1086 was passed through the efforts of nurse educators across the state working closely with the Colorado Community College System to allow community colleges to offer a Registered Nurse to Bachelor of Science in Nursing (RN-to-BSN) program for students who had graduated from or were currently

enrolled in associate degree programs. While this program might not have the promised impact on the nursing shortage, it does provide a cost-effective and familiar path for those students to continue their education. Were it not for the testimony by the nurse educators and nursing students, the bill would likely not have passed. The remarkable thing about this example was nurse educators, nursing students, and practicing nurses also testified against the bill. It was an example of nurses advocating for what they felt was important in meeting the needs of their community.

Nurses also made a difference independently. Mund (2012) reminded us nurses have the most consistent contact with patients. As such, nurses are in the best position to advocate for their patients on local, national, and international levels. Chafee et al. (2012) identified four areas of health policy impacted by nurses. The first was community in which nurses joined community planning boards or other organizations with a goal of improving health status. This could be the local health district or an affordable housing group such as Habitat for Humanity. The next, and possibly best known to nurses, were practice committees with their employer. These committees set policy for nursing care as well as broader policies in the institution such as fee setting. Next was the government policy area such as proposing and/or supporting legislation and administrative rules. Unfortunately, although a nurse might testify on a particular bill or provide information to their state or federal legislator, such activity was not widely known. Last was policy making within professional organizations (Chafee et al., 2012). It is important to recognize these many spheres of influence as not all nurses, even with the necessary education, would want to pursue legislative action but they could still significantly impact the healthcare environment through their employer or professional organization. The simple act of voting was also a form of health policy work (Primomo, 2007).

Although the move to increase health policy content in nursing education programs is fairly recent, we see examples in history of nurses affecting change in health policy. The nurse best known for health policy was Florence Nightingale who pushed for environmental changes at field hospitals during the Crimean War (Fee & Garofalo, 2010). Less than 50 years later, Lillian Wald worked to form partnerships between insurance companies, schools, the department of health, and other groups to transform public health in New York City and went on to start the National Organization of Public Health Nursing (D'Antonio et al., 2020). While one might dismiss the actions of one nurse and the coalition she formed to change policy in one town, the work performed by Lilian Wald continues to occur across the country as local groups seek partnerships to care for vulnerable populations (D'Antonio et al., 2020). That is health policy.

Political advocacy often takes place at the advanced practice level. Fuller (2016) gave the example of the Barbara Lumpkin Prescribing Act, which gave authority to nurse practitioners and physician assistants to prescribe controlled substances. Fuller pointed out this law was not passed in one year but rather in small steps over time with nurses working together. This prescriptive authority was not just for the benefit of the advanced practice nurse but also of their patients who are able to have their health needs met by one provider.

Nurses are the frontline of our healthcare system, yet are not equipped with knowledge and skills to make a significant impact on policy. Short (2008) suggested five steps nursing could take: (a) Meet with policymakers and share facts about healthcare, (b) build a relationship with politicians and others, (c) learn the interests of legislators, (d) build your own image as a reliable source of information, and (e) identify and share policy solutions by considering all sides. Nurses are seen by others and themselves as limited in their political power. Socialization into the profession, including professional responsibilities beyond bedside care, takes place during the

education process and could help ensure nurses recognize their political advocacy role (Benner et al., 2010; Gimbel et al., 2017; Short, 2008).

Increasing Nurses' Participation in Health Policy

One recommendation from the Institute of Medicine (IOM, 2011) was that nurses must become partners with other providers in redesigning the U.S. healthcare system. This included the necessity that "nurses must see policy as something they can shape rather than something that happens to them" (IOM, 2011, p. 32). The IOM cited a number of barriers to this goal including laws, professional resistance, a lack of foundational competence, and exclusion from boards.

With the few examples above of political activity and advocacy by nurses, the question remains of why nurses are not more heavily active in such work. Benton et al. (2017) performed an integrative review to answer this question. What they found was inconsistent or inconclusive results across numerous studies looking at nursing's policy pursuits and political competence. One suggestion was to look outside nursing to see what other professions are doing, which is described briefly below. The second suggestion was to explore the subject with larger participant sizes to identify actual barriers. Since nurse educators' lack of political self-efficacy was one potential barrier to nurses having this knowledge, this study further explored this factor. Researchers (Benton et al., 2017; Primomo & Björling, 2013) also highlighted the importance of increasing politics and policy education at the undergraduate level.

Lewinski and Simmons (2018) showed a more positive picture with limitations. While the study found 42% of nurses were currently active in health policy advocacy, respondents also reported a lack of knowledge and time to participate in advocacy work. Ninety-four percent stated they would participate in health policy education programs if offered. That these nurses would look to, in decreasing frequency, nursing professional organizations, their employer, and

colleges for continuing education on health policy suggested a perception their prelicensure nursing programs did not cover the content adequately. What is necessary for these and other examples is for the nurse educator to instill this "fight" into all nurses during their prelicensure education.

Legal and Health Policy Knowledge of Other Disciplines

Nursing is not the only public-facing discipline impacted by lacking knowledge in law and health policy matters. Teachers, the group for which the Teacher Political Self-Efficacy (TPSE) survey was developed, physicians, and social workers have also identified a lack of legal and policy knowledge and skills in their respective disciplines and the negative consequences of such a deficit. While the TPSE and teaching are expanded upon in a later chapter, this section focuses on the healthcare team, specifically the similar struggles in medicine and nursing in meeting health policy expectations.

Kapp (2018) encourageed the addition of a legal content elective for physicians. This course, taught by an attorney, divides students into groups small enough to allow individual focus on the students' career plans and include reviewing and discussing health policy issues. Kapp did not start by identifying a lack of knowledge by physicians but did opine that a physician must have an understanding of the "pervasive legal environment" (p. 494) to be able to provide patient-centered care. Topics were similar to those currently emphasized in nursing including abuse, liability and malpractice, confidentiality, and shared decision making, but also included the implications of health policy reform on the physician's practice. Taking an international view, Deliverska and Kehayov (2016) stated healthcare professionals needed to have greater knowledge and ability to apply the law, although healthcare worker seemed synonymous with physicians. Like Kapp, Deliverska and Kehayov described interdisciplinary

learning with a law student and medical students learned side by side. This was a concept not yet discussed within nursing.

Enveloping all disciplines was the summary by Parker (2013) who stated, “Virtually every sector of today’s economy would benefit from employing workers with more than superficial knowledge of the law” (p. 1). Areas of particular importance included health policy, public affairs, and environmental science (Parker, 2013). Law has been viewed as something to be feared, as the source of lawsuits and other negative action. But over the past 20 years, many disciplines have come to realize the importance of getting involved in policy development for their discipline as well as recognizing they do not have the skill to do so. A stronger foundation in legal concepts, with a specific focus on health policy and patient advocacy, is necessary for nursing. It starts in the basic educational program.

Nursing Still Allows Multiple Degrees for Prelicensure Education

Educators in all types of undergraduate programs need to be able to provide health policy education for future nurses. For 2020, AACN (2021b) reported 42% of new nurses graduated with a BSN, 38% with an Associate Degree in Nursing (ADN), and 11% with a Diploma in Nursing. In 2019, the total number of nurses with a BSN climbed to 56% (AACN, 2019a). The National Council of State Boards of Nursing (NCSBN, 2021b) found 88,349 first-time National Council Licensure Examination-Registered Nurse takers had graduated from an ADN program and 94,308 from a BSN program. The difference between these numbers on current graduates versus the numbers of practicing nurses suggested a number of nurses are working with only the associate degree knowledge before they eventually complete an RN-to-BSN program. These numbers demonstrated that nursing cannot rely solely on the traditional BSN programs to instill

knowledge of health policy in nurses. Instead, it is important that nurse educators in all types of undergraduate nursing programs have the knowledge and self-efficacy to teach this material.

New Expectations for Nurse Educators

Nurse Educator Demographics

According to the AACN (2020), the average age of nurse educators with a Doctor of Philosophy is 62.6 for professor, 56.9 for associate professor, 50.9 for assistant professor, and those holding a master's degree being a few years younger. Assuming graduation from their initial college program in their young 20s, these educators completed their basic education in the 1980s-1990s before higher expectations of health policy were part of the curriculum. Although expectations for graduate students are higher, even those have increased with each successive *Essentials* document, limiting the information these nurses learned in graduate school (AACN, 1986, 2020).

Nursing Curriculum Standards

The AACN first published Essentials for Nursing Education in 1986. This early attempt at standardization focused on "Knowledge," which was then at the lowest of Bloom's Taxonomy, updated in 2001 as "Remember" (Iowa State University, 2022). Remembering is further described as recall and recognizing including specific terminology, classifications, and knowledge about, but not performance of, cognitive tasks (Iowa State University, 2022). *Essentials of College and University Education for Professional Nursing* (1986) listed knowledge needed to determine health status, formulate and implement plans, and to coordinate care. Regarding health policy, knowledge needed to demonstrate accountability included "legal parameters of nursing practice of nursing practice and health care" and of the "political action

process" ("Essentials of college and university education," 1986, pp. 63-64). Again, knowledge is the lowest level and does not suggest the attainment of skills to affect health policy.

This lack of competence helps explain why nurses are not involved in health policy but also the lack of self-efficacy of the educator teaching about health policy. For the necessary competencies, the IOM (2011) referred to the AACN's (2008) *Essentials for Baccalaureate Education in Nursing*. They included knowledge of the healthcare system, teamwork, intra- and interprofessional collaboration, patient advocacy, theories of innovation, and the concept of quality improvement. While there are no essentials in associate degree nursing education, these concepts are also threaded into the ADN curriculum.

In 2011, the Institute of Medicine published *The Future of Nursing: Leading Change, Advancing Health*. Broadly, that report recommended nurses achieving higher levels of education be better prepared for expanded nursing roles in health care. Then, as now, nursing undergraduate education includes three pathways: the traditional BSN, the ADN, and the diploma. Citing a number of conflicting studies on the advantage of the four-year BSN over the two-year, the IOM pushed the BSN for its inclusion of "health policy and health care financing, leadership, quality improvement, and systems thinking (p. 170). This would suggest self-efficacy in teaching health policy is important only in faculty of BSN and graduate degree programs as the report went on to recommend a greater number of nurses go on to graduate education. However, the IOM recognized the importance of community colleges in attracting students into nursing as well as describing the increasing trend of community colleges to offer their own BSN programs. Further, while often lacking a discrete health policy course, ADN programs nonetheless have required legal content threaded throughout the program as they are already required to cover a number of the competencies in the *Essential's* guides for undergraduate or

entry-level nursing education (AACN, 2021a). Additionally, nurses at all degree levels care for patients in the acute care, long term care, and community settings and they all need to be prepared for patient advocacy through health care policy. The IOM stressed the importance of teaching these skills in the prelicensure programs. The ability to teach this content begins with an educator's self-efficacy of health policy skills to teach those skills to student nurses.

As mentioned above, the AACN's (2021a) *Essentials* document has increased expectations of teaching health policy content in nursing education programs. The 1986 version required knowledge of essential health policy activities. The 1998 update included identification of factors that influenced health care, still knowledge, but added participation in activities influencing health policy. In 2008, this extended to analyzing legislative processes and advocating for consumers as well as the nursing profession (Modene, 2018). Published after the IOM's (2011) report, AACN's *The Essentials: Competencies for Professional Nursing Education* increased expectations for competencies around health policy work for those earning an undergraduate degree in nursing. This latest update asked, "Can you imagine having a conversation about population health without considering ethics and health policy?" (AACN, 2021a, p. 12). Starting with "describe policy development," it moved on to "propose modifications to or development of policy based on population findings (AACN, 2021a, p. 31). It was no longer sufficient to just have knowledge that health policy existed. Current undergraduate nursing students are expected to graduate with the ability to analyze and synthesize knowledge to advocate for policy change. A pertinent competency for 2021 is 6.1f: "Communicate as informed by legal, regulatory, and policy guidelines" (AACN, 2021a, p. 42). This was emphasized by a policy statement by the NCSBN (2021a) allowing State Board action against nurses who provided COVID misinformation.

Self-Efficacy of the Nurse Educator

Self-efficacy is the belief one has in their ability to organize and execute a course of action to meet a particular goal (Bandura, 1997). If a person does not believe they have the ability to get something done, they won't try (Bandura, 1997). Bandura (as cited in Nugent et al., 1999) identified two factors of teacher self-efficacy. The first was the teacher must believe the students would actually benefit from the teaching plan developed by the teacher. The second, and more relevant to this study, was the teacher must be able to provide the requisite skill and knowledge to the students.

A nurse educator with years of clinical experience is hired in part due to that experience as well as a demonstrated ability to teach. Further, the current demands on nursing work force require the educator to cover concepts not covered in their own education, both undergraduate and graduate (Modene, 2018). This brings in the question of self-efficacy for the educator.

One difficulty in increasing one's knowledge in health policy is it is often mentioned only implicitly, leaving nurses unclear on sources ranging from state or federal government, professional organizations, and even their workplace (Taft & Nanna, 2008). Why are these topics not being taught to nurse educators? Beyond the possibility that the nurse educator might have graduate education outside nursing education, Fitzgerald et al. (2020) found only 35% of nurse educator programs included the NLN's (2022) core competency "function as a change agent and leader" (p.1), noting this was a specific competency recommended by the IOM nine years earlier. Issel et al. (2006) also found nursing faculty were only marginally competent in the area of policy and planning.

Staebler et al. (2017) found health policy content covered in undergraduate programs tended to be threaded throughout the curriculum rather than discrete policy classes as was found

in some graduate programs. This was significant as it meant all undergraduate faculty needed to be skilled in teaching this content. However, 64% of BSN faculty cited lack of time as a barrier to teaching this content. Over 40% of faculty in BSN, Master of Science in Nursing (MSN), Doctor of Philosophy, and Doctor of Nursing Practice (DNP) programs cited lack of faculty expertise as a barrier to teaching policy content (Staebler et al., 2017). This study further explored faculty expertise as measured through self-efficacy.

Benefit to Nursing Students

While this study looked at attributes of the nurse educator with an eye toward increasing the nurse's knowledge and skills related to health policy work, the intermediary was the nursing student. Nursing students often receive an overview of state and federal statutory and administrative regulation of healthcare, payment systems for health care, knowledge of health policy in general, and other topics culminating in general advocacy for consumers and the nursing profession. These topics are included in the AACN (2021a) *Essentials* guides and are covered to some extent in both associate and baccalaureate programs.

Nursing students are not acquiring the skills necessary to successfully advance health policy objectives (Thomas et al., 2020). Byrd et al. (2012) found a significant improvement in political astuteness after several health policy focused on learning activities in senior nursing students but even with that improvement, only 10% of the graduates were deemed "politically astute, asset to nursing" (p. 437). Primomo (2007) stated baccalaureate nursing students identified a need to be more politically aware following administration of the Political Astuteness Survey, which is described later. Primomo and Björling (2013), citing the AACN's (2011) *Essentials* document, stated nurse educators at all levels must teach advocacy, knowledge, and skills to students, and described novel teaching experiences that would increase

the student nurses' knowledge of law and health policy work but as described below, it was the faculty with a higher degree of self-efficacy who would implement such approaches to educating these students in areas that had not been traditionally well covered based on the preceding research. Conger and Johnson (2000) found graduate students were more likely to be politically active following a health policy course, concluding that even at the graduate level this topic was not covered adequately in graduate programs lacking such a specific course. This suggested the knowledge was not coming from their undergraduate programs. The question to be explored then was why, when the topic of political advocacy should be included in undergraduate nursing programs, were nurses lacking the information they needed to impact health policy? One possibility was the low self-efficacy of educators to cover this important topic.

Research Gap

Modene's work (2018) was the only research into a nurse educator's self-efficacy on teaching health policy. That study, which was conducted in the mid-Atlantic states and focused on nurse educators in BSN programs was limited in three particular ways. First, geographically, the study was limited to nurse educators in the mid-Atlantic states. With its proximity to Washington, D.C., the headquarters of the American Nurses Association and the National League for Nursing, nurse leaders in the mid-Atlantic states might have a higher level of political self-efficacy than educators elsewhere in the United States. Secondly, this study focused on BSN programs; a focus solely on the university level programs does not accurately represent nursing education. Finally, the faculty breakdown itself might be skewed from other nursing programs not focused on research and advocacy such as associate degree and diploma nursing programs and RN-to-BSN post-licensure programs. Universities might be more likely to have doctoral-

prepared faculty when compared to community colleges where the focus is solely on student education.

While we have some understanding about political self-efficacy for faculty teaching in traditional BSN programs, we know little about faculty teaching in ADN and RN-to-BSN programs. According to the AACN (2021b), 42% of new nurses are graduating with a BSN, 38% with an ADN, and 11% with a diploma. The gap of previous research on this subject was the lack of inclusion for academic-based educators outside the traditional BSN program. If nurse educators at all levels of undergraduate nursing education are tasked with covering this content, we need to better understand the self-efficacy of these nurse educators. This study sought to fill that gap.

Statement of the Problem

As a whole, nurse educators are not prepared to teach health policy, leading to nursing as a discipline being unable to meet the goals laid out by the IOM, the AACN, and the ANA. Lack of adequate education has led to lack of knowledge and subsequent poor education to that educator's students. Price et al. (2018) found the confidence in AACN (2008) Standard IV: Health Care Policy, Finance, and Regulatory Environments in students who did not have a preceptorship was significantly lower than in students who did complete a preceptorship. This finding suggested that area of nursing knowledge was not being taught adequately by the academic educator in contrast to the IOM's (2011) recommendation that such health policy education start in undergraduate programs.

Statement of Purpose

Major policy (IOM, 2011) and nursing (AACN, ANA, NLN) organizations recognized the importance of nurses learning the skills of political advocacy and health policy. Based on the

IOM (2011) recommendation to start early and the AACN (2008) standard to include health policy education in undergraduate nursing programs, it was necessary to know if the current nurse educator workforce providing that education was prepared.

There are a number of proposals on how to increase self-efficacy of nurse educators as they transition from providing clinical care to teaching clinical care to nursing students (Doneski, 2017; Garner et al., 2018). There were several suggestions on how to teach health policy to nursing students at both undergraduate and graduate degree levels as well as practicing nurses (Byrd et al., 2012; Primomo & Björling, 2013). What was missing was an assessment of nurse educators' ability and willingness to implement these experiences. With this knowledge, nursing education could prioritize the professional development necessary to improve the educator's self-efficacy, thereby leading to better student attainment of the essentials of baccalaureate nursing.

The purpose of this study was to describe the political astuteness and political self-efficacy in undergraduate nurse educators and explore the possible correlation between political astuteness and political self-efficacy in the nurse educator. Additionally, the possible correlation between demographic factors and political self-efficacy was explored. Political self-efficacy is an indirect measure of the nurse educator's ability to teach health policy to undergraduate nursing students.

Research Questions

Q1 How do current nurse educators perceive their political self-efficacy measured with Teacher's Political Self-Efficacy-M Scale?

Q2 How do nurse educators rate their understanding and skills of the policy process measured with the Political Astuteness Inventory?

Q3 Is there a relationship between the nurse educator's political self-efficacy and their political astuteness?

Q4 What demographic or professional factors impact nurse educators' political self-efficacy and political astuteness? These factors included age, gender, education level, years as a RN, years as a nurse educator, and program: Associate Degree in Nursing (ADN), Bachelor of Science in Nursing (BSN), or RN-to-BSN.

Design and Methodology

This was a descriptive, cross-sectional study exploring the political astuteness, teacher political self-efficacy, and factors impacting these attributes in nurse educators. The independent variable for Research Question 3 was the faculty's political astuteness score, which was measured using Clark's (1984) Political Astuteness Inventory (PAI). The dependent variable was the faculty's self-reported self-efficacy on policy, which was measured using the Teacher Political Self-Efficacy Scale-Modified by Modene (2018). This instrument was based on Hammon's (2010) Teacher Political Self-Efficacy Scale (TPSE), updated and validated by Modene for use with nurse educators. The data were analyzed to identify a correlation between political astuteness and the self-efficacy of the nurse educators. For Research Question 4, the effect of demographic and professional factors on the dependent variables of the nurse educator's political self-efficacy and political astuteness was explored.

Nurse educators were invited to participate in the study primarily through the Facebook group "Teachers Transforming Nursing Education." Snowball sampling was also utilized. Details of this process are discussed in Chapter III.

The study was based on Bandura's (1997) social cognitive theory, of which self-efficacy is a primary component. Social cognitive theory posits a reciprocal interaction among the person, environment, and behaviors. Self-efficacy is influenced in part by those interactions and serves as a facilitator to meeting one's goals. For this study, the goal was for the educator to be able to impart to the learner the knowledge and skills of health policy work.

Operational Definitions

Health Policy*:* Defined by the World Health Organization (2020) in part as decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. In keeping with the current literature, this study focused specifically on policy coming from organizations and state and federal bodies.

Nurse Educators. Full or part-time educators in accredited nursing programs teaching undergraduate nursing students in the classroom, online, or clinical setting.

Political Astuteness. Awareness, knowledge, and involvement in the political system (Primomo & Björling, 2013).

Political Self-Efficacy. The educator's belief in their skill and knowledge as sufficient to take part in political activities which influence health policy (Hammon, 2010).

Self-Efficacy. The person's belief in their capability to execute the action necessary to attain a specific result (Bandura, 1997).

Teacher Self-Efficacy. The confidence or belief in one's ability to teach through which the nurse educator bridges the theory-practice gap (Nugent et al., 1999).

Significance of the Study

The nursing profession is in the midst of a growing recognition that nursing goes beyond patient care at the bedside. Prompted in part by the IOM and market realities, nursing professional organizations such as the ANA and AACN are pushing for nurses to be more politically active and for nurse educators to teach the knowledge and skills necessary for such policy work. However, many nurse educators did not receive health policy education during their own nursing education, and it remains largely unknown if nurse educators have acquired this knowledge on their own or feel prepared to teach it to students. This study explored if nurse

educators had the political astuteness and self-efficacy to effectively teach health policy to current nursing students. If so, those graduates might go on to become politically active nurses, making an impact on health policy and the health of their patients.

Summary

As recommended by the IOM (2011) and the AACN (2019a), nurses need to take a leadership role in the development of health policy, which impacts nursing care, the nursing profession, and the health care system broadly. Research found nurses lacked sufficient knowledge of the law and policy, impacting nursing as well as the process of becoming more active politically. This study examined whether undergraduate nurse educators felt prepared to instill that knowledge and the educator's own knowledge and self-efficacy for health policy work such that they could pass it on to the student nurse.

CHAPTER II

LITERATURE REVIEW

The purpose of this study was to describe the political astuteness and political self-efficacy in undergraduate nurse educators and explore the possible correlation between political astuteness and political self-efficacy in the nurse educator. Additionally, the possible correlation between demographic factors and political self-efficacy was explored. Political self-efficacy is an indirect measure of the nurse educator's ability to teach health policy to undergraduate nursing students.

In the previous chapter, we established that policy experts both in and outside of nursing recognized the importance of greater nursing participation in health policy. To help meet that goal, the standards of the American Association of Colleges of Nurses viewed health policy as required at all levels of nursing education (Anderson et al., 2020). Still, Alhassan et al. (2019) reported nurses continued to demonstrate low levels of activity in the health policy arena. This begged the question from whom would new nurses learn to be politically active if the nurse educators from which nursing practice was learned did not practice political advocacy? Anderson et al. (2020) described some faculty teaching health policy as not being adequately prepared for the task, which was one measure this study explored. If a deficit in political astuteness and/or self-efficacy about teaching the content was found, that conclusion would lead nursing, specifically nursing education leaders, to identify the professional development necessary to improve the nurse educator's ability to teach this important topic.

Search Criteria

A review of the literature on the overall concept of nurses' political participation was conducted through CINAHL, PubMed, and Google Scholar, with those databases also searching the Proquest database. The search terms included nurses' self-efficacy, social cognitive theory (and related social learning theory), health policy, health policy nursing, patient advocacy, political participation, and political astuteness. The returns included several dissertations, a number of research articles, and information articles including editorials and concept analyses.

Inclusion criteria were sources written in English; material related to nursing was limited to publication since 2000 but material on social cognitive theory was not date-restricted. For comparison, some historical documents were also utilized. Sources included experimental, position papers, and descriptive works.

Exclusion criteria included non-English language and patient focused applications of concepts rather than nurse educator focused.

Social Cognitive Theory

A Brief Overview of the Evolution of Social Cognitive Theory

The overarching framework for this study was social cognitive theory (SCT). This section provides an overview of the theory with particular focus on the importance of modeling and self-efficacy. While the focus of this study was the self-efficacy of the nurse educator, this section also included literature on how self-efficacy and modeling fit into the political activity of nurses.

The roots of SCT can be found in another theory. Albert Bandura published his social learning theory (SLT) in 1977 (as cited in McLeod, 2016), going with the behavioralist theories of the time in addition to ascribing a mediating process taking part between the environmental

stimulus and the learner's response. He also added observational learning to his theory with learning taking place through observation of others, which Bandura called models. The behaviors imitated by the learner are further mediated by societal expectations (McLeod, 2016). Expanding on SLT, Bandura inserted the cognitive and self-reflective step, changing the name of his theory to social cognitive theory (Pajares, 2002). In SCT, an individual's behavior is the outcome of reciprocal interaction between behaviors, environmental factors, and personal factors. These personal factors include affective, biological, and four cognitive processes including attention, retention, production or imitating the behavior observed, and motivation or recognizing the benefit of the behavior (Pajares, 2002). In a learning situation, an educator using Bandura's theory could focus on the environment, behaviors, and self-beliefs.

Bandura (as cited in Schunk & DiBenedetto, 2020) identified three influences—behavioral, personal, and environmental factors—making up triadic reciprocality. Bandura (Films Media Group, 2003) compared this triad to earlier behavioral and psychoanalytic theorists. Psychoanalytic theory posits an individual's personal forces direct their behavior. Behavioralists believe an individual's behavior is modified by their environment. In the triad, personal, behavior, and environment factors each impact and are affected by the others. Personal factors include cognitive, affective, and physiologic or biological events including the subject knowledge held by the individual, goals the individual wished to attain, and physiological experiences in response to stimuli. Together these factors are instrumental in the development of one's self-efficacy. Behavioral factors include choice of activities as well as the effort or persistence the individual will demonstrate in completing those activities. The personal factor of self-efficacy is of significant impact on the choices of behavior as well as the effort and persistence of that behavior (Bandura, 1997). Environmental factors include feedback,

instruction, and models. Stajkovic and Luthans (1998) expanded the discussion on SCT and the extension toward self-efficacy. Social is what individuals learn from being members of society. Cognitive involves the ongoing thought process people carry out including motivation, attitudes, and action. Finally, environment, which Stajkovic and Luthans focused on as the business organizational environment, is the source of much knowledge and experience but it is processed differently by the individual and the decision to act depends in part on that individual's personal characteristics. Much of this cognitive piece goes into the concept of self-efficacy.

Bandura (1997) posited the individual seeks agency or making things happen as a result of one's own action. Setting and meeting goals results in growing self-efficacy as the individual develops the perceived ability to complete tasks (Schunk & DiBenedetto, 2020). Environmental factors such as feedback and modeling could also increase self-efficacy, which in turn increases the likelihood of the individual participating in the particular behavior. However, people do not routinely just find themselves impacted by these environmental factors but rather place themselves in environments they feel will increase knowledge and self-efficacy (Schunk & DiBenedetto, 2020).

Self-Efficacy

A primary focus in SCT is on self-efficacy. Bandura (1997) defined self-efficacy as the belief one holds in their ability to organize and carry out behaviors and attain a goal. Efficacy beliefs are separate from actual performance. Individuals try to manage a situation within their perceived capabilities but avoid those activities they perceive as exceeding their abilities (Bandura, 1977). These efficacy beliefs developed from mastery (self) experience, vicarious (observed) experience, social persuasion, and arousal (Cziraki et al., 2018). Factors influencing self-efficacy included the individual's self-assessment of ability, difficulty of the task, required

effort, support, and previous successes or failures (Cziraki et al., 2018). Vicarious experience was gained by observing someone else performing a skill, social persuasion included being told one has the ability to be successful, and arousal was physiological response to the behavioral and could be negative as with anxiety or positive (Cziraki et al., 2018). Focusing on nursing, Cziraki et al. (2018) defined leadership self-efficacy "as the individual's assessment of their knowledge, skills and abilities needed to lead others" p. 49). Cziraki et al. stated leadership self-efficacy predicted actual performance of leaders and self-efficacy was strengthened through opportunities to practice management skills and informal mentoring.

Knowledge Differs from Self-Efficacy

It is important to distinguish self-efficacy from knowledge. Bandura (1997) used the example of using a condom in order to protect oneself from sexually transmitted diseases. There is a difference between simply knowing the skill of applying the condom and being able to demonstrate the skill in difficult situations such as negotiating with a partner, resisting pressure for unsafe sex including when intoxicated, or being caught in an aroused situation without a condom. The person with the skill might still lack the efficacy to persist toward meeting their goal of safe sex.

One area knowledge and efficacy share is in the strength of specifics. Just as a strong knowledge of math does not mean strong knowledge in other fields, high efficacy in one area, like obstetrics, does not translate to high efficacy in others such as health policy. There is no concept of general self-efficacy; instead, one's self-efficacy varies by subject and situation. An individual with high efficacy in math would be driven to set higher goals in math and be more persistent in meeting those goals but might not be equally likely to set such high goals in writing.

Building Self-Efficacy

As mentioned above, self-efficacy develops through mastery experiences, vicarious experiences (i.e., modeling), verbal persuasion (i.e., feedback), and physiological and affective states (Bandura, 1997).

With active mastery experience, the individual builds self-efficacy through successful agency or meeting of goals through their own action. Failure to meet the goals undermines one's efficacy (Bandura, 1997). Other factors include the individual's beliefs of their ability based in part on past experiences, task difficulty, effort required, and cognitive evaluation and memory of past experiences.

Vicarious experiences, or observational learning through models, were an early part of Bandura's (1997) work with children (Vinney, 2019). He found young children who were shown adults being violent toward an inflated "Bobo doll" were more likely to respond with aggressive behavior when frustrated (Films Media Group, 2003). Seeing or even visualizing someone deemed similar to self be successful raises the self-efficacy of the observer. Bandura included the use of media in modeling, with viewing of violent television increasing violent behaviors (Films Media Group, 2003). This was not just learning through everyday social interaction. Instead, the learner sought out those who were proficient in a given area to compensate for their own lack of opportunity to practice the action (Bandura, 1997). One barrier to the effectiveness of vicarious learning was observation could lead to simple mimicry. This was solved through the model sharing their thought process and as they engaged in problem solving. For example, watching a nurse assist a patient out of bed would lead to mimicry unless the nurse described a rationale for body mechanics and patient safety or fall risk.

Verbal persuasion is also referred to as feedback. The decrease in self-efficacy experienced after failure could be mitigated through positive feedback from significant others. When told they have the capabilities to master certain tasks, the individual is more likely to increase and persist in their effort to meet the goal (Bandura, 1997). Individuals experience a greater improvement in self-efficacy when they are told they have the ability to accomplish a goal than when they are told they accomplished the goal through ability and hard work.

Finally, physiological and affective states impact one's self-efficacy, particularly when the goal is physical performance or dealing with stress (Bandura, 1997). High stress decreases physical performance and the stress reaction actually feeds the stress the individual is experiencing through anticipation. The resultant aversive thoughts lead to the poor performance the individual fears as it is difficult to ignore hyperventilating, sweating, difficulty sleeping, and stomach upset.

In SCT, these four factors are mediated by cognitive processes. One's efficacy influences how situations are interpreted with a higher self-efficacy leading to more positive anticipatory outcomes to situations. This leads to greater persistence. People might choose not to take action if they view themselves as ordinary and the models of behavior as extraordinary, not recognizing the effort the model put into reaching the goal. For example, using the model of an exemplary educator could actually demotivate a novice from trying harder, believing it impossible to reach that model's level of expertise. Motivational processes also serve a mediating role. Cognitive motivation is when the individual forms positive beliefs about the outcome based on their past experiences. The motivated person would be more persistent.

Self-Efficacy Applied Outside of Nursing

Bandura (1997) applied his ideas of self-efficacy to a number of specific situations. Two relevant to this study included teacher's self-efficacy and political self-efficacy. Teacher self-efficacy is related to the belief the teacher has of being able to develop and implement an environment in which learning needs are met regardless of the motivation of the students (Bandura, 1997; Guskey & Passaro, 1994). The teacher with high self-efficacy believes the student can learn as long as appropriate techniques and effort are used in teaching. The teacher with low self-efficacy is more likely to expect less of the student and implement a more rigid environment of negative inducements to get students to study. Bandura stated students learn more from teachers who have a high or positive self-efficacy over those who do not.

Political self-efficacy was a topic of discussion long before nurses were encouraged to be more active in the health policy arena (Bandura, 1997).

> Those who doubt they can have any affect see little point in attempting to shape legislative activities. The politically uninvolved relinquish influence to politically efficacious constituencies who are more than happy to use the government systems as an agency to advance their parochial interests. (Bandura, 1997, p. 482)

From a societal view, a lack of trust in the political system leads not only to less participation but also to politicians having difficulty getting long-term fixes of short-term problems implemented. Viewing the system as intractable reduces self-efficacy as well as group functioning (Bandura, 1997). Viewing the system as influenceable increases group effort to change the system. When discussing political self-efficacy, Bandura cautioned not to use actions as a measure. For example, participation in political campaigns or voting is not a measure of self-efficacy. Self-efficacy is a belief in one's power to make a difference, not just the knowledge of how to vote

(Bandura, 1997). Indeed, the current study measured the impact of such activity on one's self-efficacy.

Self-Efficacy in Health Care

Often, nurse managers move into their positions due to their clinical skills, rather than leadership training, and might lack self-efficacy as a leader. Van Dyk et al. (2016) surveyed nurse managers, finding the manager's self-efficacy was directly related to their experience and recommended educational programs to increase the self-efficacy of less experienced managers. Patterson and Krouse (2015) described nurse educators as leaders in nursing education, many of whom lacked any education in leadership yet were expected to create an environment responsive to ongoing changes in health care. The participants recognized gaining leadership skills would require time and mentorship, adding nursing was not good at mentoring leaders (Patterson & Krouse, 2015). To increase the self-efficacy of nurses in the area of health policy, it is necessary to have educators with high self-efficacy in the area of policy to serve as role models and mentors of these students.

Stajkovic and Luthans (1998) defined self-efficacy as the belief of one's ability to change the environment to meet their desired goals. If an employee was unable to have belief in their behavioral, cognitive, and motivational ability to succeed, they were more likely be unsuccessful in the task. Still, self-efficacy alone is not the sole factor of success. A person with high self-efficacy is unlikely to attempt a particular behavior if such performance would have negative consequences from the environment (i.e. workplace; Stajkovic & Luthans, 1998). With this, we see the connection between self-efficacy and the SCT. Stajkovic and Luthans also brought up an important distinction between self-efficacy and self-esteem. Self-esteem is a more general self-assessment of ability to perform in a number of situations and tends to be more stable across

time. In contrast, self-efficacy is specific to a particular situation or action and could vary as new information is presented and experiences are gained.

Self-efficacy is not static. Schwank et al. (2018) studied occupational therapy students, assessing the self-efficacy of the students related to therapeutic use of self in patient care. They found an increase in self-efficacy after a workshop on therapeutic relationships. The participant's self-efficacy continued to rise 10 months after the workshop as the students gained experience in working with patients. Logsdon et al. (2010) explored the self-efficacy of nurses' teaching patients about postpartum depression (PPD). This descriptive study asked participants to complete an instrument assessing self-esteem, self-efficacy of teaching about PPD, and attitudes toward mental disorders. More than half of the nurses did not provide PPD teaching to the patients (Logsdon et al., 2010). Teaching about PPD was associated with the nurse's self-efficacy, self-esteem, expectation that they should be teaching PPD, PPD continuing education, teaching other topics to patients, and observing other nurses provide teaching (Logsdon et al., 2010). Both of these studies demonstrated an individual's self-efficacy could increase over time, supporting Bandura's determinants of self-efficacy as described above by Cziraki et al. (2018).

Self-Efficacy in Nursing Education

As was discussed previously, nurse educators might come to their role with little knowledge and no experience in health policy work. Further, the recent push for increased health policy knowledge and action by nurses rose after the education of current nurse educators (AACN, 2021b; NCSBN, 2021a). This means the nurse educator is being asked to teach content that was likely not taught to them and certainly not emphasized as essential. They often lack experience working with health policy, particularly if they teach in less research and advocacy focused programs. Nurse educators were not adequately teaching nursing students the skills

necessary to be active in health policy, citing weaknesses both in the curriculum and learning activities (Thomas et al., 2020). Finally, health policy work is not a priority in the curriculum of some nursing programs that focus on direct care priorities, providing an environmental influence to focus on other topics of the curriculum (Hernandez, 2020; Thomas et al., 2020). To understand the importance of self-efficacy in actual performance of behaviors, it is necessary to have a measure of self-efficacy relating to health policy of nurse educators.

The concept of self-efficacy has been explored in nursing education, most often in the context of new nurse educator in either the classroom environment or expanding their roles in the clinical setting to include education of nursing students (Bourne et al., 2021; Dozier et al., 2019). These studies explored factors related to the educator's self-efficacy as well as outcomes of that self-efficacy. Nugent et al. (1999) recognized health care was changing, and with it, nursing practice and education. They emphasized a shift from acute care to community-based care, stating those nurse educators with higher confidence or self-efficacy in their abilities to help students bridge the theory-practice gap would be more adaptive and therefore more successful educators. To do so, schools of nursing hire nurses with current clinical knowledge as they are likely to have greater self-efficacy conveying nursing content to students compared to teachers with less experience in the clinical setting. This concept of clinical expertise leading to increased self-efficacy would apply not just to acute care clinical nursing but to other content areas including community health, policy, and leadership. This self-efficacy does not apply only to clinical knowledge but also teaching strategies. Dozier et al. (2019) stated teacher efficacy influenced the faculty's use of strategies in the classroom to help students be more engaged and learn.

Nugent et al. (1999) split teacher self-efficacy between personal efficacy and teaching efficacy. Teaching efficacy is the belief the student will learn from the experience directed by the teacher. Dozier et al. (2019) further divided teacher efficacy into efficacy in instructional strategies, efficacy in student engagement, and efficacy in classroom management. Notably content knowledge was not included in this definition of teacher self-efficacy, allowing the definition to be content neutral. Personal efficacy is the belief the teacher has the personal traits to bring about change in the students. An educator with personal efficacy is said to have a strong knowledge base and is clinically competent. Compare this to Bandura's (1997) findings that a person will have a higher level of self-efficacy if they believe they have the traits to reach a goal versus the less affirming ability to reach the goal through hard work. Soodak and Podell (1996) identified personal efficacy as most closely resembling Bandura's concept of self-efficacy with teaching efficacy being more related to controlling external factors in the learning environment.

Unfortunately, the terminology in this area was not consistent between researchers. Shin et al. (2021), looking at teaching by nursing clinical instructors, defined teaching efficacy as the belief held by the teacher about their ability to organize the teaching environment and implement the teaching plan. While the authors went on to describe this efficacy much as Nugent et al. (1999) and Soodak and Podell (1996), not having categories of personal efficacy and teaching efficacy could lead to diluting the importance of the topical (i.e., clinical) expertise over setting up the teaching experience. However, they did go on to state clinical competency was not a measure of teaching effectiveness in their study, reinforcing that they were not looking at the nursing knowledge possessed by the participants. With the focus on teaching, they did find Bandura's factors of mastery experience, vicarious experience through preceptorship models, feedback and support of the nurses will increase the teacher efficacy and success as clinical

instructors (Shin et al., 2021). Dozier et al. (2019) had a similar definition stating teacher efficacy included efficacy in instructional strategies, student engagement, and classroom management with no mention of experience in the topic being taught. With these differences, it is important to be clear about the application of the term self-efficacy perceived by a teacher. In this study, self-efficacy related to the teacher's perceived ability to teach the content of (health) policy and political activity. As the content was included, it fit best with personal efficacy described above.

Nugent et al. (1999) found nurse educators who had courses in nursing education, previous exposure to teaching, and experience teaching had higher levels of self-efficacy. This finding supported Bandura's (1997) theory that self-efficacy in nurse educators grows with mastery or vicarious experiences. Mastery experiences for nurse educators typically mean clinical experience and their teaching experience (Bourne et al., 2021). Vicarious experiences could be through observation of nurses in other specialty areas including policy work as well as other experts such as lobbyists or legislators.

As nurses, it is likely nurse educators would also lack knowledge and experience in health policy and, therefore, lack self-efficacy in the area (Hernandez, 2020). Applying Bandura's (1997) four factors of mastery experience, vicarious experience, verbal persuasion, and physiological and affective states, an educator could gain higher self-efficacy through success in teaching and participation in policy making. Observing educators who model policy making or policy teaching helps the person less experienced learn the behaviors. This necessitates finding role models from whom those less experienced faculty learn the behaviors and cognitive processes of health policy development. Being encouraged by other faculty peers or mentors, and by the positive feelings after success in teaching are other factors that could

increase an educator's self-efficacy, both of which require a greater recognition of the importance of self-efficacy of the nurse educator in the area of health policy.

Impact on Nursing Education

As described above, a person with high self-efficacy is more likely to pursue goals and be more persistent in meeting them. Allinder (1995) found educators with high self-efficacy were more likely to put higher effort into teaching including greater persistence in meeting teaching and learning goals as well as providing clear expectations to the students. This in turn leads to students having higher self-efficacy in reaching for their goals. This idea also applied outside the academic setting. Zamani-Alavijeh et al. (2019) found nurses and other healthcare providers with patient education goals had greater success and more satisfaction related to their higher levels of self-efficacy. Inexperienced practitioners providing patient education experienced physiologic symptoms such as insomnia and feeling flushed, leading to poor teaching experience. In contrast, having strong knowledge of their subject increased self-efficacy and increased the effectiveness of their teaching (Zamani-Alavijeh et al., 2019).

Much of the research on self-efficacy of educators took place outside nursing, although the themes identified likely were applicable to nursing education. A teacher with high self-efficacy would also be more effective at helping their students learn. Fritz et al. (1995), working with elementary school teachers, found teachers with high self-efficacy had greater job satisfaction, put more effort into their teaching, and were open to more ideas about the curriculum and how to teach it. Ashton (1984) found those teachers with high self-efficacy had more positive expectations for their students, better strategies for student success, and more democratic classroom environments. At the college level, these attributes would serve adult learners well, leading to greater success. Dozier et al. (2019) stated faculty with higher self-

efficacy were better able to engage their students through the use of various teaching methods and technology. Bourne et al. (2021) explored low self-efficacy in the nurse educator, finding the clinical instructor with low self-efficacy was likely to lack confidence and be less successful in helping students meet learning objectives.

Summary

The self-efficacy of a teacher is at the core of that teacher's ability to help the nursing student learn how to be a nurse. The educator develops self-efficacy through a combination of mastery experiences including political participation, vicarious learning from other policy minded nurses and educators, feedback from peers and experts in the field of nursing and health policy, and through their own physiological and affective responses. With higher levels of self-efficacy in health policy, the educator would be more positive about the ability of their students to learn, have greater persistence in meeting the teaching and learning goals, and more innovative in the teaching techniques used in the learning environment. This in turn might lead to greater learning by the student nurses and a greater likelihood they would go forward to be more active in policy work.

Health Policy in Nursing

Exemplifying the current importance of health policy education in nursing, the American Association of Colleges of Nursing established a "Faculty Policy Think Tank" made up of policy experts from schools across the United States (Anderson et al., 2020). Anderson et al. (2020) pointed out nursing's advocacy role has ranged from fighting for the patient for which the nurse is providing care to being active in development of health-related legislation but with the current need for change in health care, nurses need to take a more active role in policy making. Note Anderson et al. (2020) used the terms advocacy and health policy, potentially resulting in

confusion of what health policy is within nursing. Similarly, Mund (2018) pointed out student registered nurse anesthetists have limited exposure to healthcare policy and advocacy as if the two were different. Earlier it was stated that many organizations went by the mantra of "health in all policies" (American Public Health Association, n.d.; CDC, 2016). With that focus in mind, all policy has an effect on the health of the individual or the population. Advocacy is defined as supporting a cause and acting on behalf of another person with nurses specifically focusing on the health and safety of patients (National Association of Neonatal Nurses, n.d.).

Barriers to increasing health policy content in nursing programs, both undergraduate and graduate, included lack of time, disinterest in the content by faculty, lack of policy expertise by faculty, lack of recognition from administration of the need for such courses, and subsequent lack of support for faculty development of content and experience related to policy (Anderson et al., 2020). Key education needs identified by the task force included understanding how policy affects nurses at all levels, the inability for nurses to be involved in policy decisions due to lack of experience and education in policy, and lack of recognition for the successes of nurse leaders in the area of health policy (Anderson et al., 2020). Recommendations from the task force for nurse educators included utilizing faculty who had knowledge and expertise in health policy to teach those topics, mentor other faculty through instruction and health policy experiences to develop faculty who could teach policy, and mentor students who have a particular interest or strength on policy (Anderson et al., 2020). Another recommendation, essential to those already mentioned, was to establish an environment in which faculty could explore the impact of policy on their practice and research (Anderson et al., 2020).

As Anderson et al. (2020) noted, a recurring issue with nursing involvement in health policy work was the inconsistent use of terminology. Dzubak (2018), focusing on issues related

to health insurance reform, advised nurses to be educated on health care law and policies, without distinguishing the two, and to become a nurse advocate or a political advocate by working with their legislator, seemingly using the term advocacy and policy interchangeably.

So, what is health policy? There is growing recognition that all policy is health policy or as the CDC (2016) stated, *Health in All Policies* to make it clear that all policies should be considered for their impact on health. De Cordova et al. (2019) defined health policy as "decisions, plans, and actions undertaken to achieve specific healthcare goals within a society" (p. 38), listing a number of nurses known for their policy work including Lillian Wald and Margaret Sanger. Such a broad definition could leave nurses asking, "Can I do what they did?" But health policy is not all Affordable Care Act, Medicaid expansion, and developing new equitable rules about safe, affordable housing. As VandeWaa et al. (2019) stated, health policy also includes nursing issues such as safe patient ratios, workplace violence, mandatory overtime, bullying, and hazards in the workplace. Each of these could start at the local, even employer, level of health policy change. As Cohen (2016) stated, the average nurse has greater expertise than the typical health policy analyst, needing only to translate clinical problems to health policy problems.

Although focusing on graduate students, de Cordova et al. (2019) stated health policy must be viewed by nurses as something in which they could effect change rather than something applied to nursing practice. The authors reported greater than 25% of graduate nursing programs did not require a health policy course, although the content might be integrated into other courses, and a significant majority of the programs did not include a pretest using the political astuteness survey prior to any health policy class to evaluate student learning in the course. De Cordova (2019) also found a low level of political involvement in the graduates of these

programs. This finding did not bode well for the AACN's (2008) goals of finding nurses educated and experienced to teach health policy courses but did reinforce the importance of assessing our current nurse educators both in their self-efficacy and their political astuteness as precursors to teaching health policy.

Political Astuteness

Political Astuteness Is a Foundation for Policy Work

It is recognized that nurses need to be more involved in health policy work and nurse educators play an integral role in educating nurses for that role. The ultimate goal is to increase the political astuteness of current and future nurses. Political astuteness was defined by Primomo and Björling (2013) as an awareness of health policy issues, an understanding of the legislative and policy process, knowledge and skills such as who policymakers are, and general political involvement including voting, testimony at policy hearings, and participation in professional groups. Primomo and Björling noted most nurses were not active in the health policy process, citing again a lack of knowledge and skill. Political astuteness in nurses is necessary for greater involvement by nurses in policy processes (Primomo & Björling, 2013).

VandeWaa et al. (2019) stated nurses have not taken the opportunity to be politically active, again citing nurses as not being astute about political activity. The authors described a "gridlocked Congress," resulting in a shift of many health policy issues to the state legislatures where nurses could use their expertise as well as the reputation of being a trusted profession to influence outcomes. VandeWaa et al. cited little evidence of nurses' involvement in politics, adding the number of congressional members who are nurses has gone from seven to three in the 2019 Congress. The goal of their research was to describe the astuteness and participation of nurses and from that information allow nurse leaders to decide on next steps to increase nurses'

political activity (VandeWaa et al., 2019). Using the Political Astuteness Inventory (PAI), VandeWaa et al. found nurses voting decreased between 2016 and 2018 although the percentage of nurses registered to vote increased during that time. Between 2016 and 2018, all measures of political participation including attendance at a nursing association meeting, attendance of an association conference, supporting a congressional candidate, or writing a letter regarding a health-related issue decreased, with that difference not completely explained by 2018 being a non-presidential election year (VandeWaa et al., 2019). Additional findings, and those most relevant to nurse educators and this study, were low numbers for political astuteness. Less than half of the nurses knew the name of their state or federal representatives, only 30% could identify two nursing related issues under discussion, and less than 10% could identify at least two issues discussed at the conferences of their national organizations. In summary, nurses did not know the issues, the representatives, nor the process for change (VandeWaa et al., 2019). Although nurses did vote at a higher percentage than the public at large, they were not necessarily voting in an informed manner. VandeWaa et al. ended with stating nurse leaders were in a position to educate and motivate nurses to be more active politically.

Abood (2007) listed five factors that gave nurses the power to influence health policy: expertise in healthcare, role as a nurse working with patients, respect of nurses by the public, and the ability to reward politicians through support and voting. Unfortunately, years later, the literature supported the conclusion that nurses as a group lacked the political astuteness necessary to increase the profession's influence on health policy (Byrd et al., 2012; Primomo & Björling, 2013; VandeWaa et al., 2019).

One consistent barrier identified was the lack of education on how to participate in political activity. Lewinski and Simmons (2018) found 42% of participants planned to engage in

health policy work but 72% were interested in continuing education on health policy. Notably, Lewinski and Simmons did not directly assess for knowledge of health policy work but found 76% would seek out that education from a professional organization, 49% from their employer, and 30% from a university. Hewlett (2008) also identified membership in a professional organization as a leading factor for political participation among nurses. Several nursing organizations both employ lobbyists and educate their members on health policy activities (American Nurses Association, n.d.; Emergency Nurses Association, 2022). These findings were concerning considering the decreasing enrollment of such organizations (Williams, n.d.). Short (2008) stated nurses did not understand health policy issues, citing lack of the subject being covered in nursing programs, and called on universities to increase policy teachings in their curriculum as well as to work with practicing nurses to increase their competency in this area. Farley (2004) found a lack of knowledge of the political process was a primary barrier to the lack of political participation by nurses, adding socialization of nurses to be passive as another significant barrier. This trait of passivity ran counter to increasing one's self-efficacy in the area. Farley (2004) specifically called out higher education in the area of politics as having been shown to increase health policy involvement by nurses in addition to having a mentor, experience in politics, and professional organization membership. As these mirrored the attributes of self-efficacy development, these factors strongly support two conclusions. First, a nurse educator with high self-efficacy is more likely to have the knowledge and skills to be active in health policy work and second, that nurse educator could pass on to their students the knowledge and traits necessary for a nurse to be more politically active and advocate for nursing. This study helped identify which nurse educators had the ability to educate these students.

Learning Political Astuteness

Findings of nurses needing, but not getting, training on how to translate their clinical knowledge into health policy work led Lewinski and Simmons (2018) to identify a lack of professional development as a barrier for health policy work by nurses. Their encouraging results from a survey of nurses found agreement that advocacy for the population's health was recognized as being within the role of the nurse and most participants were interested in professional development on health policy work (Lewinski & Simmons, 2018). That a majority of nurses surveyed were interested in health policy focused professional development suggested nurse educators could increase health policy activity of both new and veteran nurses through appropriate teaching.

It was well substantiated in the literature that as a group, nurses tended to lack political astuteness (American Nurses Association, n.d.; Benton et al., 2017; IOM, 2011; Primomo & Björling, 2013). With some factors such as age, gender, and experience being outside the influence of the nurse educator, the lack of policy content in the curriculum and the difficulty in synchronizing that curriculum with legislative calendars are within reach for the educator to change. Byrd et al. (2012) explored the effect of public policy learning activities on the political astuteness of undergraduate nursing students, concluding the activities did increase political astuteness. With students largely totally unaware of political activity, their scores increased significantly with policy learning activities. Ultimately, students learn the importance of health policy action from their nursing faculty so it is imperative to identify faculty with a high level of political self-efficacy who would be more likely to implement and maintain such learning activities as described by Byrd et al..

The nurse educator's role in increasing political astuteness in the nurse is through teaching and modeling political astuteness and helping nurses recognize the connection between politics and nursing practice. This includes both didactic coursework and experiential learning including simulation (Primomo & Björling, 2013). For example, the ANA and many state nursing associations hold legislative days to give nurses some experience and guidance on involvement in the political process. According to Primomo and Björling (2013), these legislative days are effective at increasing political astuteness as measured by the Political Astuteness Inventory.

Another example of improving political astuteness was described by Eaton et al. (2017) in which an interdisciplinary group of health professions students started work with a case study individually and then in small groups. Larger group discussion added insights into the lobbying and legislation steps of health policy change. Student proposals were displayed for a gallery walk attended by state legislators who listened to a presentation of the top three groups and held a question and answer period with the students. The students' political astuteness was measured before and after the exercise using the Political Astuteness Inventory, demonstrating a significant improvement following the exercise.

Summary

Political astuteness is a term incorporating an awareness of health policy including the process of health policy and legislative work and how to be involved in that process. Research has shown for decades nurses lacked political astuteness, with this deficit being a barrier to the goal of AACN (Anderson et al., 2020) and the IOM (2011) for nurses to be more active in the crafting of health policy. That goal could be accomplished through a focus on teaching health policy at all levels of nursing education as recommended by the AACN. That, in turn, requires

nursing faculty with both the political astuteness and the self-efficacy to teach the material and serve as a model to the students in nursing programs. The first step is to accurately assess the political astuteness and self-efficacy of nurse educators, followed by taking steps as necessary to increase professional development of the faculty and an emphasis on placing the right faculty in the role to teach this important topic.

CHAPTER III

METHODOLOGY

In this section, the methods utilized to complete this research are described including the instruments used, reliability and validity of measurements made, the sample and setting under study, and protection of those study participants. Data collected were analyzed to reach a conclusion about the population of study. The following research questions guided this study:

Q1 How do current nurse educators perceive their political self-efficacy measured with Teacher's Political Self-Efficacy-M Scale?

Q2 How do nurse educators rate their understanding and skills of the policy process measured with the Political Astuteness Inventory?

Q3 Is there a relationship between the nurse educator's political self-efficacy and their political astuteness?

Q4 What demographic or professional factors impact nurse educators' political self-efficacy and political astuteness? These factors include age, gender, education level, years as a registered nurse, years as a nurse educator, and program. (Associate Degree in Nursing (ADN), Bachelor of Science in Nursing (BSN), or RN-to-BSN).

Research Design

To address the above research questions, a quantitative, descriptive correlational design was used. The purpose of this study was to describe the political astuteness and political self-efficacy in undergraduate nurse educators and explore the possible correlation between political astuteness and political self-efficacy in the nurse educator. Additionally, the possible correlation between demographic factors and political self-efficacy was explored. The political self-efficacy was an indirect measure of the nurse educator's ability to teach health policy to undergraduate

nursing students. This non-experimental strategy was described by Scollon (2020) as the identification of relationships between factors. Because there was an identified correlation between self-efficacy and ability to perform an action, be it teaching or participating in political advocacy, this research first looked for a correlation between self-efficacy and the political astuteness of the educator. Secondly, this study explored the possible relationships among personal or professional factors such as age, education level, and whether their educational preparation included a discrete health policy course, and the educators' self-efficacy.

Creswell and Creswell (2018) stated quantitative research is the approach used to test theories through the relationships between variables. Variables are measured using instruments, for example, the PAI and TPSE-M instruments chosen for this study. This study used an electronic self-report survey for data collection. Remler and Van Ryzin (2015) described how structured questionnaires efficiently gather information from both people and organizations. The researcher developed the survey in Qualtrics®, a web-based survey software program.

Research Participants

The study's population of interest included nurse educators teaching in nationally accredited undergraduate nursing programs.

Inclusion Criteria

1. Nurse educators in the United States employed full-time or at least 50% part-time in a nationally accredited nursing program.
2. Although they may hold some administrative duties in the nursing school, these faculty spend greater than 50% of their workload instructing undergraduate nursing students.

3. Nurse educators must be teaching undergraduate nursing content using face to face, online, or hybrid modalities. This includes classroom or didactic and clinical courses
4. Nurse educators must hold a graduate degree in nursing.
5. Nurse educators must be able to communicate in English.

Exclusion Criteria

1. Nurse educators of non-nationally accredited nursing programs.
2. Incomplete surveys will be discarded.

It was anticipated there would be no significant difference in the demographics of the nurse educators in the sample as compared to the published demographics of nurse educators in the United States. The NLN (2017) provided the following demographics: Nurse educators are predominately White Non-Hispanic at 81%, African American at 9%, and Hispanic at 3%. Gender was 93% female, 6.4% male. The average age for a professor, associate professor, and assistant professor was 57.1, 56.0, and 49.6 years (AACN, 2020). While associate degree programs did not necessarily use those terms of rank, the age of those educators was expected to be similar.

Setting

This study took place across the United States. As described below, participants were recruited using Facebook

Sample Recruitment

Academic nurse educators were recruited through various techniques. Primary recruitment was through the Facebook group “Teachers Transforming Nursing Education” with over 12,000 members (see Appendix A). This convenience sampling was appropriate as the

sample group was readily available (Creswell & Creswell, 2018). Snowball sampling was also utilized. With these two methods, a sufficient sample size was obtained.

A power analysis was conducted using G*Power to determine the appropriate sample size of 91 participants. A multiple linear multiple regression analysis with an effect size of 0.20, power of .80, and alpha of .05 with 10 predictors was used. LoBiondo-Wood and Haber (2018) stated an effect size of .20 is assumed for a moderate effect. The response rate from the Facebook group was difficult to predict but was sufficient to meet the necessary sample size.

Methods of Data Collection

Data Collection

Links were posted to the social media site during the recruitment period. When participants click on the link, they will be directed to the informed consent page (see Appendix B). Here they affirmed they were current academic nurse educators teaching primarily in an undergraduate nursing program.

Data collection took place from August 2022 through September 2022 to allow participants to complete the survey upon returning for the fall term. The participants were located within the United States. Only faculty who taught undergraduate nursing students were invited to participate in the study.

Instrumentation Used

The study used two instruments, further described below, that were entered into Qualtrics® for data collection. The first was the Political Astuteness Inventory, described by Primomo and Björling (2013) as a 40-question tool exploring the participant's knowledge and experience in political action (see Appendix C). The second was a modified version of the Teacher Political Self-Efficacy (TPSE) scale described by Hinnant-Crawford (2016) as a

measuring tool of the self-efficacy of the educator to take part in political activity. The modified instrument is titled TPSE-M (see Appendix D).

Teacher Political Self-Efficacy

Hammon (2010) developed the original Teacher Political Self-efficacy (TPSE) instrument using SCT as the theoretical framework. The intent of the instrument was to measure the voice of the K-12 teacher through a measurement of that teacher's self-efficacy in education policy development. Item were chosen based on research in political science literature, highlighting constructs that had been used in previous studies to explore political activity. In keeping with Bandura's (1997) theory, the items were written to evaluate the perceived capability, that is the self-efficacy of the teacher and not the actual ability to do so. The options on the instrument ranged from *Strongly Disagree* to *Strongly Agree*. Twenty items were chosen from a larger pool for reliability testing.

Reliability and validity of the instrument was measured in separate studies. Reliability testing of TPSE took place in two school districts, a smaller district of K-12 teachers and a larger district that allowed only K-8 teachers to participate. The sample was made up of 287 teachers. Of 287 surveys distributed, 48 valid surveys were returned. A series of questions were answered using a 5-item Likert scale from *Strongly Disagree* to *Strongly Agree*, with all but one question receiving responses across the full range of options. An instrument is deemed reliable if the Cronbach's alpha is greater than .70 (Statistics Solutions, 2021). Cronbach's alpha for this study was .939. All items had a correlation of greater than .40 so none were removed based on this first study (Hammon, 2010).

The second study took place in two large school districts as well as 90 doctoral students from a university currently employed as K-12 teachers. Of 1,090 surveys, 109 were returned and

103 deemed valid. All but six of the items had correlations greater than .40 and it was determined eliminating any of those would only increase the Cronbach's alpha to .864 from .858. By combining the groups from study one and study two, Cronbach's alpha increased to .899 (Hammon, 2010).

Validity was further confirmed as Hammon (2010) went on to explore the correlation between the teacher's self-efficacy and the participant's political self-efficacy as citizens using two existing instruments. The Perceived Political Self-Efficacy was reliable with coefficient alphas of .83 to .96 and valid based on its own testing. The second instrument was developed by Niemi et al. (1999) with a coefficient alpha of .80. Pearson correlation found a positive and significant correlation between the TPSE and the two political self-efficacy as citizens instruments used.

Hammon (2010) found a significant difference between male and female teachers with males being higher in TPSE score overall, higher political self-efficacy, and lower levels of instructional efficacy.

Hammon (2010) described all public policy, particularly K-12 education policy, as political. Thus, the TPSE provided a measure of the educator's capability to influence that policy. Similarly, the American Public Health Association (n.d.) recognizes health in all policies, highlighting the impact of policies implemented by state and local governments on social determinants of health. To that end, an updated version of the TPSE was developed to measure the political self-efficacy of nurse educators.

Modene (2018) modified the TPSE for use with nurse educators, naming her instrument the TPSE-M. Modifications made include changing language from an education point of view, including references to education organization, to professional nursing organizations. For

example, the National Council for Teachers of English and the like were replaced with the American Nurses' Association and similar.

Initial reliability of the TPSE-M was carried out using a test-retest process with 22 Ph.D. nursing students. Participant confidentiality was maintained through use of a third party to pair the two responses. Cronbach's alpha was .919 for the first and .939 for the second, comparable to the original TPSE Cronbach's alpha of .939 and .898. The TPSE-M Cronbach's alpha was greater than the recommended .80, allowing the instrument to be used in Modene's (2018) research. Permission to use this instrument was obtained both from Dr. Hammon and Dr. Modene (see Appendices E and F).

Political Astuteness Instrument

The Political Astuteness Inventory (PAI) was developed specifically for nurses by Clark in 1981. In recent years, it has been used by many researchers, prominent among them is Primomo (2007) who updated the instrument "to include the use of the internet for obtaining health policy information and communicating with policymakers" (p. 262). The 40 questions are answered Yes or No, and include "I voted in the last election" and "I know how to contact a lobbyist" in addition to questions about professional organizations and policy participation (Primomo & Björling, 2013). The full question list is in Appendix G. Scoring one point for each "Yes" response, the participant was classified as "totally unaware politically (0-9 points), slightly aware of the implications for nursing (10-19 points), showed a beginning political astuteness (20-29 points), and politically astute and an asset to the profession of nursing (30-40 points)" (Primomo, 2007, p. 262). Clark did not perform reliability testing on his instrument (Modene, 2018). Primomo proposed content validity based on similarity to other instruments measuring political activity. Reliability for the PAI by Cronbach's alpha was .81 (Primomo, 2007).

Due to the death of Dr. Clark, permission to use this instrument was initially obtained from Janet Primomo as she was the last to modify it for use in nursing. Additionally, permission was obtained from the publisher of Dr. Clark's latest text (see Appendix H).

Ethical Considerations

Prior to data collection, an exemption was obtained by the Institutional Review Board (IRB) at the University of Northern Colorado (see Appendix I). Participants reviewed the informed consent document on the initial screen of the survey including information about the purpose of the study, risks and benefits, voluntary nature of the study, and that they might end participation at any time prior to completing the survey. Proceeding past the informed consent page on the first screen served as consent to participate in the study. No incentive was offered for participation initially.

The risks inherent to this study were no different than the risk of discussing experience with any subject taught in a nursing program. There could be some discomfort in admitting particular behaviors. The population under study, nurse educators, were not a high-risk group. All survey results were stored on a password protected computer at the researcher's home. No unencrypted data were stored on removable drives. Data were collected in a confidential manner and were aggregated for analysis.

Data Analysis

General Overview of Data Analysis

Data were collected in Qualtrics and SPSS was used for analysis. Incomplete surveys will be excluded from the analysis. Data were housed on the desktop computer of the researcher. No unencrypted data will be stored on a mobile device. Variables were coded for analysis with

descriptive and psychometric analyses conducted as described below. This analysis provided a general description of the sample and an evaluation of the reliability of instruments.

Histograms and scatterplots were reviewed to confirm assumptions or normality and homogeneity for regression analysis. Tests for outliers were performed. Instrument reliability was assessed using Cronbach's alpha.

Research Question One

Q1 How do current nurse educators perceive their political self-efficacy measured with the Teacher's Political Self-Efficacy-M Scale?

The measure for this question was the score obtained after completing the TPSE-M survey. The items on the survey were summed to get a total score. Descriptive statistics including frequencies, mean, and standard deviation were used to describe the self-efficacy of the nurse educators. This was done using SPSS.

Research Question Two

Q2 How do nurse educators rate their understanding and skills of the policy process measured with the Political Astuteness Inventory?

The measure for this question was the score obtained after completing the PAI survey. The items on the survey were summed to get a total score. Descriptive statistics including frequencies, mean, and standard deviation were used to describe the political astuteness of the nurse educators. This was done using SPSS.

Research Question Three

Q3 Is there a relationship between the nurse educator's political self-efficacy and their political astuteness?

Preliminary descriptive statistics were analyzed including the mean, median, standard deviation, variance, skewness, kurtosis, and range. This provided information about the general distribution of responses, for example, determining if the responses are skewed. Analysis

determined if there was sufficient spread or if the data seemed to lack variance. For items showing abnormalities, content of the items was examined to note any patterns.

Psychometric procedures to assess reliability and item analysis were performed. Internal consistency reliability was estimated with Cronbach's alpha coefficients for the TPSE-M survey and the PAI survey, assessing for a Cronbach's alpha > .70. The inter-item correlations for the survey scores will also be examined; assessing for inter-item correlations between .3-.5. The corrected item-total correction for each item on each scale was evaluated. To increase internal consistency, items were deleted for scores with corrected item-total correction values less than .2 - .3 unless the Cronbach's alpha of item deleted was less than the total Cronbach's alpha for that scale.

Research Question Four

Q4 What demographic or professional factors influence nurse educators' political self-efficacy and political astuteness?

Demographic data collected included age, years of nursing experience, years of teaching experience, program level in which they were teaching, gender, highest earned degree, membership in professional organizations, formal health policy training, and presence of a health policy role model (see Appendix J). Descriptive statistics were calculated for all data. Multiple linear regression was performed to identify relationships between the variables and the outcome of greater political self-efficacy (Creswell & Creswell, 2018).

Limitations and Delimitations

The limitations of this study came primarily from the non-randomized nature of recruitment. Limitations in this study included bias such as self-report bias and selection bias, and timing of the study. Althubaiti (2016) described self-report bias in the context of social desirability, as the participant did not want to be seen as undesirable. Nurse educators were

viewed as experts in healthcare (Duquesne University, 2020b). As such, educators might respond to surveys in a way to support that perspective. Alternatively, they might not have completed a survey where they felt they were not doing "well," which is a form of selection bias. This could result in higher than actual measurements of self-efficacy of nurse educators. One way to minimize the self-report bias is to use a valid instrument (Althubaiti, 2016). Both instruments used in this study had established reliability and validity. Similarly, Clancy (2019) described referral bias as when a patient referred to a specialty clinic might be sicker than those not referred. Viewed as a referral, snowball sampling might increase selection bias as potential participants refer other more politically minded colleagues to participate.

A delimitation for this study was the population under study. The experiences of students learning policy from nurse educators was not explored in this study. Also, due to the growing expectation of health policy knowledge and skills in undergraduate nurses, this study did not explore the political self-efficacy of graduate nursing education. Further, this study does not explore the outcome of the self-efficacy. While research described above demonstrated an educator with higher political self-efficacy should be able to teach this topic better, such a measure will be part of future research.

Summary

The purpose of this study was to explore the correlation between the nurse educator's self-efficacy and their political astuteness. This helped determine if nurse educators had the knowledge and experience as well as the self-efficacy to teach the topic of health policy advocacy to undergraduate nursing students. Additionally, the demographic questions explored factors intrinsic to the nurse educator that might result in greater likelihood of nurse educators being politically astute and confident with teaching this topic.

CHAPTER IV

RESULTS

The purpose of this study was to describe the political astuteness and political self-efficacy in undergraduate nurse educators and explore the possible correlation between political astuteness and political self-efficacy in the nurse educator. Additionally, the possible correlation between demographic factors and political self-efficacy was explored. The political self-efficacy is an indirect measure of the nurse educator's ability to teach health policy to undergraduate nursing students.

This chapter describes the study sample selection and demographics. Additionally, the data analysis for demographic variables and the four research questions are provided.

Research Questions

The following research questions guided this study:

Q1 How do current nurse educators perceive their political self-efficacy measured with Teacher's Political Self-Efficacy-M Scale?

Q2 How do nurse educators rate their understanding and skills of the policy process measured with the Political Astuteness Inventory?

Q3 Is there a relationship between the nurse educator's political self-efficacy and their political astuteness?

Q4 What demographic or professional factors impact nurse educators' political self-efficacy and political astuteness?

Data Analysis

Data from the participants, who are described below, were exported from Qualtrics and analyzed using Statistical Package for the Social Sciences (SPSS®) Version 28. Data were

reviewed visually for any errors or missing data. Two entries were removed as they were labelled "Survey preview" from Qualtrics. Another 10 were removed as the respondent answered no questions after the consent form, thereby denying consent to participate in the study. Other missing date were discarded from analysis by SPSS®. This included 10 who did not complete the PAI and 15 who did not complete the TPSE-M. Eliminating these left 132 participants for analysis, well above the 91 required by the power analysis.

Due to a small number of males (n = 5) and females (n= 2), the variable "gender" was eliminated from analysis. Due to a small number of RN-to-BSN faculty (n= 7), the BSN and RN-to-BSN groups were combined for analysis, leaving groups as associate degree and bachelor degree programs.

Demographic data were provided through descriptive statistics. Variables used included state of residence, years as a nurse, years as a nurse educator, highest nursing degree earned, health policy training, level teaching, and membership in a professional organization. State of residence was merged into categories by region. Data in years were merged into categories of 10 years. Means, standard deviations, and ranges were calculated for data in years.

Prior to regression for the PAI and TPSE-M, tests were performed for multicollinearity, normal distribution, outliers, and homoscedasticity to ensure there were no violations of assumptions.

Sample Description

Sample Selection

The final sample was recruited from the "Teachers Transforming Nursing Education" Facebook group along with snowball sampling. As such, no direct emails were needed. This group had over 13,000 members during the time of the study.

Qualtrics collected responses from 159 participants. Of those who clicked on the link, 10 did not respond to any question, possibly ending participation after reviewing the consent form. This left 149 who completed at least one question and were included in further analysis. The Political Astuteness Inventory was completed by 137 and the Teacher Political Self-Efficacy-Modified instrument was completed by 132. Therefore, the final number of participants who completed all data collection points was 132.

Sample Demographics

Sample demographics are presented in Table 1. Professional demographics are shown in Table 2. Only 139 participants answered the question of age. Nearly one-half the participants were greater than 50 years old, and the average age was 49 years. This was comparable to the average age of associate professors with MSN and Ph.D. faculty at 49.6 years and 50.9 years, respectively (AACN, 2020). Of the 138 participants who provided gender, 94.9% were female, 3.6% were male, and 1.4% other.

State of residence was divided into geographic groups; West, Southwest, Midwest, Northeast, and Southeast (National Geographic, 2022). Each region was represented in the results with highest represented from Colorado making up 15.7% and the West region at 29.7%.

The sample was closely split between teaching in associate degree and traditional bachelor's degree programs at 46.4% and 49.3%. Because the sample size of RN-to-BSN educators was comparatively small, these educators were combined with the traditional BSN group for analysis. No participants chose graduate as the focus was on undergraduate education.

With a range of 3 years to 60 years, the average years as a nurse was 22.93. As a nurse educator, the average was 9.7 years with a range from 1 year to 59 years. At 61%, most of the participants held an MSN. Doctoral degrees included 22 DNP (16.4%) and 24 Ph.D.s (17.9%).

The sample included primarily full-time educators at 124 (92.5%). Over 80%, or 111, of the participants recalled taking a health policy class including 22 in their undergraduate education, 63 in their MSN, and 26 at the doctoral level. Membership in a professional nursing organization was reported by 109 (81.3%) of the participants. This was far greater than the statement that 18% of nurses were members of the American Nurses Association (Walton, 2017). However, there were no comparable data for the number of nurse educators belonging to other professional organizations.

Table 1

Personal Demographics of Nurse Educators

Variable	Category	*n*	%
Age (years)	21-30	4	2.8
	31-40	32	23.0
	41-50	37	26.6
	51-60	43	30.9
	61-70	22	15.8
	71-80	0	0
	81-90	1	<1
	Missing	10	7.2
Gender	Female	141	95.3
	Male	5	3.4
	Other	2	1.4
	Missing	1	0.7
State (Region)	West (WA, OR, CA, NV, UT, CO, WY, MT, AK, HI, ID)	44	29.7
	Southwest (AZ, NM, OK, TX)	19	12.8
	Midwest (ND, MN, SD, NE, KS, IA, MO, IL, IN, OH, WI, MI)	37	25.0
	Southeast (AR, LA, MS, AL, GA, FL, SC, NC, KY, TN, WV, VA, MD, DE)	30	20.3
	Northeast (PA, NY, NJ, CT, RI, ME, NH, VT, MA)	18	12.2

Table 2

Professional Demographics of Nurse Educators

Variable	Category	*n*	%
Primary level teaching	Associate Degree (ADN, AAS)	67	45.6
	Traditional Bachelor's Degree (BSN)	73	49.7
	RN to BSN	7	4.8
	Graduate	0	0
	Missing	2	1.3
Years as a nurse	1-10	18	12.1
	11-20	55	36.9
	21-30	41	27.5
	31-40	26	17.4
	41-50	6	4.0
	51-60	3	2.0
Years as an educator	1-10	99	66.4
	11-20	36	24.2
	21-30	9	6.0
	31-40	3	2.0
	41-50	0	0
	51-60	1	0.7
	Missing	1	0.7
Highest nursing degree earned	Associate (ADN)	1	0.7
	Bachelor's (BSN)	5	3.4
	Master's (MSN)	91	61.1
	Doctorate (DNP)	26	17.4
	Doctorate (PhD)	26	17.4
Full-time/Part-time	Full-time	138	93.2
	Part-time	10	6.8
	Not reported	1	0.7
Remember formal education in Health Policy	No	26	17.4
	Yes, undergraduate	24	16.1
	Yes, MSN	72	48.3
	Yes, Doctoral	27	18.1
Membership in a professional organization	Yes	119	79.9
	No	30	20.1

Research Question One

The first research question was how do current nurse educators perceive their political self-efficacy measured with Teacher's Political Self-Efficacy-M Scale? Each item in this instrument was answered on a Likert scale with "1" being *strongly disagree* and "5" being *strongly agree*. Both the individual item mean and the total instrument mean are reported in Table 3.

The overall mean of score is 2.74. Although the instrument does not categorize scores beyond the *strongly disagree* to *strongly agree* category, this low value showed the nurse educator had a less than *neither agree or disagree*, demonstrating a low level of self-efficacy. In contrast, a score of four or above indicated a stronger political self-efficacy. Interestingly, only one statement, "I encourage and support other nurses and nurse educators who engage in health policy related activities" had a mean score greater than four.

Table 3

Teacher Political Self-Efficacy-Modified Mean Scores

Question	*M*
I state my opinions about health policy issues openly even in public and challenging settings.	3.43
I stay informed about national and state health policy initiatives.	3.77
I try to influence the health policy perspectives of my administrators.	2.81
I develop and maintain relationships with local and state government officials.	2.07
I respond to emails from or surveys sponsored by local, state or national professional nursing organizations that seek nurse educators' inputs.	3.63
I have made a formal presentation on an instructional best practice or a policy initiative at a profession specific meeting or conference.	1.81
I encourage and support other nurses and nurse educators who engage in health policy related activities.	4.02
I have participated in a deliberate information campaign in opposition to a particular health policy or position.	2.25
I solicit support for greater nurse involvement in health public policymaking from elected and appointed government officials.	2.85
I have distributed information for the purpose of informing and influencing the health policy perspectives of others.	2.50
I have served as a member of a work group or committee charged with researching and developing recommendations on a health policy issue.	1.96
I have served as a member of a committee or work group at the state or national level and sponsored by a specialized professional organization (e.g.,. Pennsylvania State Nurses Association, American Nurse Association, Academy of Medical-Surgical Nurses, etc.).	1.76
I use the means available to me to monitor the health policy positions and actions of elected government officials.	3.07
I try to influence the health policy perspectives of people or groups in my community	3.05

Table 3 Continued

Question	*M*
I keep informed about the health policy related positions and actions of local, state or national affiliates of professional nursing organizations	3.37
I have expressed in writing to government officials my perspectives on health policy matters.	2.57
I have provided assistance with routine school responsibilities to a peer in order to facilitate his/her greater involvement in health policy related activities.	2.33
I am positively supported by family and friends when I participate in activities of a political or civic or professional nature outside the usual work day or work week.	3.33
I have served as a representative on a community group looking at constructive ways to improve community health outcomes.	2.25
I have played a role in the selection of members/leaders of school sponsored committees or work groups dealing with health policy matters.	2.08
Mean score	2.74

Research Question Two

The second research question was how do nurse educators rate their understanding and skills of the policy process measured with the Political Astuteness Inventory? This 40-item instrument gave one point for a "Yes" response and zero points for a "No" response. The scores were then totaled resulting in a score of four categories: "Totally Unaware Politically" for 1-9 points, "Slightly Aware" for 10-19, "Beginning Astuteness" for 20-29, and "Politically Astute" for 30-40. Results for each question are shown in Table 4.

The mean PAI score was 19.4, placing this sample group of educators in the "Slightly Aware" category of astuteness. The range was 1.0 to 4.5. The top statements receiving "Yes" responses were largely related to voting, with keeping abreast of health issues being the outlier. Being registered to vote (99%) and knowing where to vote (98%) were followed by keeping abreast of health issues (95%) while voting in the last or last two elections was 93% and 91%,

respectively. Items with the lowest “yes” responses were knowledge of committee membership for their representative (9%), attendance of nurses’ association meetings (6%), and being a resource for an elected representative (3%).

Table 4

Political Astuteness Inventory Mean Scores

Question	Frequency of "Yes" (%)
I am registered to vote.	132 (99)
I know where my voting precinct is located or how to obtain a mailed ballot.	131 (98)
I voted in the last general election.	124 (93)
I voted in the last two elections.	122 (91)
I recognized the names of the majority of candidates on the ballot at the last election.	110 (82)
I was acquainted with the majority of issues on the ballot at the last election.	112 (84)
I stay abreast of current health issues.	127 (95)
I belong to the state professional or student nurses' organization.	72 (54)
I participate (committee member, officer, etc.) in that organization.	18 (14)
I attended the most recent meeting of my district nurses' association.	8 (6)
I attended the last state or national convention held by my organization.	22 (16)
I am aware of at least two issues discussed and the stands taken at that convention.	51 (38)
I read literature published by my state nurses' association, professional magazines, or other literature on a regular basis to stay abreast of current health issues.	96 (72)
I know the names of my state senators in Washington DC.	98 (73)
I know the names of my representative in Washington DC.	92 (69)
I know the name of the state senator from my district.	87 (65)
I know the name of the representative from my district.	84 (63)
I am acquainted with the voting record of at least one of the above in relation to a specific health issue.	65 (49)
I am aware of the stand taken by at least one of the above on one current health issue.	73 (54)
I know whom to contact for information about health-related policy issues at the state or federal level.	72 (54)
I know whether my professional organizations employ lobbyists at the state or federal level.	56 (42)
I know how to contact the lobbyist.	30 (22)

Table 4 Continued

Question	Frequency of "Yes" (%)
I support my state professional organization's political arm.	48 (36)
I actively supported a candidate for the U.S. or state Senate or House of Representatives (Assembly)(campaign contribution, campaigning service, wore a button, or other) during the last election.	27 (20)
I have written, telephoned, or contacted electronically regarding a health issue to one of my state or national representatives in the last year.	46 (34)
I am personally acquainted with a senator or representative or a member of his or her staff.	17 (13)
I serve as a resource person for one of my representatives on his or her behalf.	4 (3)
I know the process by which a bill is introduced in my state legislature.	83 (62)
I know which senators or representatives are supportive of nursing.	48 (36)
I know which House and Senate committees usually deal with health-related issues.	42 (31)
I know the committees on which my representatives hold membership.	12 (09)
I know of at least two issues related to my profession that are currently under discussion at the state or national level.	86 (65)
I know of at least two health-related issues that are currently under discussion at the state or national level.	91 (68)
I am aware of the composition of the state board that regulates the practice of my profession.	84 (63)
I knew the process whereby one becomes a member of the state board that regulates my profession.	58 (43)
I attend public hearings related to health issues.	17 (13)
I find myself more interested in public issues now than in the past.	93 (69)
I have provided testimony at a public hearing on an issue related to health.	14 (10)
I know where the local headquarters of my political party are located.	39 (29)
I have written a letter to the editor or other piece for lay press speaking out on a health-related issues.	16 (12)
Mean score	19.45

Research Question Three

The third research question asked if there was a relationship between the nurse educator's political self-efficacy and their political astuteness. This relationship was examined using

Pearson's correlation after reliability testing of the two instruments. Cronbach's alpha for the PAI for this study was .916. For the TPSE-M, Cronbach's alpha was .918 for this study. Recommended values of Cronbach's alpha varied between .70 and .95 (Tavakol & Dennick, 2011). As such, these two instruments were reliable for continued analysis

New variables were created in SPSS for this analysis. The TPSE_Mean was the mean score of the 40 items on the TPSE-M instrument from 1.05 to 4.50. The PAI_Total was the total "yes" responses of each nurse educator, ranging from 3 to 40. The correlation between the two values was .739, $p < .001$. An r value greater than 0.7 represented a strong correlation between the two variables (Mindrila & Balentyne, n.d.).

Research Question Four

The fourth question explored what demographic or professional factors impact nurse educators' political self-efficacy and political astuteness. These demographic factors initially included state of residence by region, and gender. Professional factors included highest degree earned, years as a registered nurse, years as a nurse educator, completion of health policy training during nursing education, membership in a professional organization, and program level taught.

Teacher Political Self-Efficacy Regression

An initial regression identified multicollinearity concerns. To resolve this, the "level taught" groups were combined into two groups: BSN, to include RN-to-BSN, and ADN. Also excluded was highest degree being an associate or bachelor's degree, leaving MSN, DNP, and Ph.D. Additionally, because of insufficient number of participants in the male (n=5) and other (n=2), this variable was removed from further analysis. An initial regression of the participants'

region of residence found no significance. As such, these regions were also removed from further analysis with a focus primarily on professional factors.

The TPSE regression included 132 participants. The *R* square value was .152, significant at p =.014. The only variable showing significance was membership in a professional organization at .039. Results are presented in Table 5.

Table 5

Regression Analysis for Variables Predicting Mean Teacher Political Self-Efficacy Score

Variable	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	β	*t*	*p*	Part
Years as a nurse	.000	.008	-.003	-.026	.979	-.002
Years as a nurse educator	.010	.011	.104	.937	.350	.078
Highest degree PhD	.217	.201	.107	1.077	.284	.090
Highest degree DNP	.109	.199	.052	.548	.585	.046
Received health policy training in doctoral program	.366	.230	.186	1.596	.113	.133
Received health policy training in master's program	.307	.186	.196	1.648	.102	.137
Received health policy training in undergraduate program	.042	.234	.019	.178	.859	.015
Teaching at the BSN or RN to BSN level	.178	.137	.113	1.296	.197	.108
Membership in a nursing professional organization	.370	.177	-.185	2.089	.039	.174

Note. n = 132

Political Astuteness Inventory
Regression

As described in the TPSE section, some variables were combined or removed during the PAI regression. The PAI regression included 136 participants. The *R* squared value was .241, significant at <.001. Two variables showed significance in this analysis: receiving health policy training in their doctoral program (.008) and receiving health policy training in the MSN program (.046). Results are in Table 6.

Table 6

Regression Analysis for Variables Predicting Total Political Astuteness Inventory Scores

Variable	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	β	t	p	Part
Years as a nurse	.119	.071	.168	1.669	.097	.129
Years as a nurse educator	.142	.095	.149	1.493	.138	.115
Highest degree PhD	2.516	1.892	.123	1.330	.186	.103
Highest degree DNP	1.770	1.846	.084	.959	.340	.074
Received health policy training in doctoral program	5.951	2.158	.300	2.758	.007	.213
Received health policy training in master's program	3.559	1.763	.225	2.019	.046	.156
Received health policy training in undergraduate program	3.409	2.229	.152	1.530	.129	.118
Teaching at the BSN or RN to BSN level	.963	1.288	.061	.748	.456	.058
Membership in a nursing professional organization	2.112	13652	.105	1.279	.203	.099

Note. N = 137

Summary

This chapter included the data and analysis for the demographics of the study and the four research questions. The demographic data were presented both to describe the sample of nurse educators responding to this survey and to identify through linear regression which of the variables affected either the TPSE-M mean score or the PAI total score. Additionally, the correlation between the TPSE-M mean score and the PAI total score was calculated. The next chapter summarizes these results and discusses implications for these findings for nursing education and future research.

CHAPTER V

DISCUSSION AND IMPLICATIONS

The purpose of this study was to describe the political astuteness and political self-efficacy in undergraduate nurse educators and explore the possible correlation between political astuteness and political self-efficacy in the nurse educator. Additionally, the possible correlation between demographic factors and political self-efficacy was explored. Political self-efficacy is an indirect measure of the nurse educator's ability to teach health policy to undergraduate nursing students.

The following research questions guided this study:

Q1 How do current nurse educators perceive their political self-efficacy measured with Teacher's Political Self-Efficacy-M Scale?

Q2 How do nurse educators rate their understanding and skills of the policy process measured with the Political Astuteness Inventory?

Q3 Is there a relationship between the nurse educator's political self-efficacy and their political astuteness?

Q4 What demographic or professional factors impact nurse educators' political self-efficacy and political astuteness?

This chapter discusses the results presented in Chapter IV and how those results applied to nursing education, specifically with increasing health policy self-efficacy and work by nurses in direct patient care and academia.

Summary of Research Data

This section summarizes the demographics of the nurse educators in the sample and then described the TPSE-M and PAI scores. Analysis included the effect of demographics on the instrument scores and correlation between the TPSE-M and PAI scores.

Demographics

A total of 163 nurse educators participated in the study. Of the 149 who completed at least one question, and were included in the demographics, 132 completed the TPSE-M and 137 completed the PAI. SPSS used these responses when looking for demographic effects on the scores but applied casewise deletion to discard those who had not completed both instruments when doing correlation calculation.

Nurse educators from all geographic regions of the United States were represented in the sample. The highest numbers came from the West at 44 and Midwest at 37. The least represented came from the Southwest at 19 and Northwest at 18. At 22, Colorado was the most represented state, likely due to snowball sampling from the study's home location being in that state.

Educator age ranged from 26 years to 84 years with a mean of 49 years. This was on the younger end of average age reported by AACN (2020) as 50 years for associate professors, 56 years for assistant professors, and 59 years for professors. While data on rank were not collected in this study, this lower average age might suggest those in the sample are ranked lower than the average nurse educator in academia. This would have an effect on conclusions drawn from the data if years as a nurse educator were significant.

Perhaps more important than age was the number of years the educators had worked as a nurse as this led to the year of their undergraduate nursing education. The range was 3 years to 60 years with a mean of 23 years. Comparing this sample with that of Modene in 2018, this

sample had about seven years less experience. Notably, Modene's sample included only educators teaching at CCNE accredited traditional four-year schools of nursing. This meant about half of participants in this study received undergraduate education prior to 2000. That meant the pre-licensure education was based on standards published in 1986, which required only knowledge of essential health policy activities, or standards published in 1998 that added actual participation in activities influencing health policy (Modene, 2018). Not until the 2021 standards did AACN update the standards for BSN programs to include increased competencies of analyzing and including health policy work as part of patient care (AACN, 2021a). With 17% recalling no health policy training in their nursing education and only 24% having such content in their undergraduate programs, a large majority of these participants might not recognize the importance of covering this content in their own undergraduate classrooms. This might lead to a continuation of most nurses not receiving any health policy training.

Years as a nurse educator provided an estimate of when the nurse educator had earned a graduate degree in nursing as graduate degrees are typically needed to be a full-time nurse educator. The range of years as a nurse educator was 1 to 59 years with a mean 10 years. With one-third of nurse educators expected to retire by 2025, it is likely the mean age of nurse educator will decrease. Subtracted from years as a nurse, the average nurse educator worked as a nurse 13 years before becoming a nurse educator.

Highest degree earned was also collected. As most schools and state guidelines require a graduate degree in nursing, it was not unexpected that 61.1%, held an MSN, 17.4% a DNP, and 17.4% a Ph.D. Related to their level of education was the completion of health policy training in their education. Health policy training was reported by 16.1% participants in their undergraduate education, 48.3% in their MSN program, and 18.1% in their doctoral education. Participants

were not able to choose more than one option to that question. This meant a participant might have had a health policy class in both their MSN and Ph.D. program but only chose the highest or most impactful. Considering again the numbers of nurses who never received education beyond the undergraduate level, these reported numbers demonstrated a need to increase health policy training in undergraduate programs as recommended by the AACN (2021a).

The sample's breakdown by gender lacked sufficient representation from nurse educators who were male or other. While the sample of this study was 95.3% female, 3.4% male, and 1.4% other, the most recent demographics for the nursing profession at large was 93% female and 7% male (NLN, 2019). Due to the small sample of males in this study, this demographic was not used in data analysis. This lack of data from nurse educators who were male might have influenced study results as Hammon (2010) found male teachers had higher TPSE scores, indicating higher political self-efficacy.

Inclusion criteria required participants to work at least 50% teaching undergraduate nursing students including RN-BSN. Of the responses, 93.2%, were from full-time nurse educators. Teaching at the associate degree level were 45.6%, and at the BSN level was 49.7%. An additional seven participants reported teaching primarily at the RN-to-BSN level. Due to this small number and a possible related issue with multicollinearity, these RN-to-BSN educators were merged with the BSN educators for analysis. This close split between associate degree and bachelor's degree level educators added information not previously collected in studies looking at political astuteness that focused on BSN or graduate level programs. With AACN (2021a) reporting 65% of nurses were educated at the baccalaureate level or higher and the most common prelicensure degrees were the BSN at 41.8% and associate at 37.7%, it was important to include the associate degree program educators when exploring the PAI and TPSE. These numbers

showed many nurses worked with only the prelicensure degree, whether ADN or BSN. Further, the AACN's latest essentials guide no longer differentiated between baccalaureate and graduate education but rather initial professional degree, which would include the associate degree student and advanced practice education. Educators at all levels must be able to convey health policy knowledge to these students. Educators at the diploma level were not included in this study.

Professional nursing organizations are recognized for their role in health policy work (Chafee et al., 2012). Additionally, Lewinski and Simmons (2018) found many nurses look first to these professional organization as sources of health policy education and guidance. In this sample, 79.9% of participants reported membership in professional nursing organizations. Although exact numbers on membership in professional organizations are difficult to find, this value is considerably greater than the percentages available. Williams (n.d.) reported less than 10% of nurses belong to a professional organization. At the recent assembly, the Colorado Nurses Association (CNA, 2022) listed 2,124 members or 2.9% of the nurses in Colorado. As CNA membership also includes membership to the national American Nurses Association (ANA), some estimates can be made of membership in the ANA. As such, the results of this study might be skewed to a higher level of political astuteness and teacher political self-efficacy based on the above average membership in our sample. In addition, membership in an organization does not necessarily reflect active participation in the organization and the latter question was not asked in this study. To that point, only 40 members attended the CNA assembly.

Summary

While the demographics of this study were generally similar to those in the nursing profession, some differences might have influenced the results of the research questions. First,

studies often left out nurse educators at associate degree level programs (Modene, 2018). This study included those educators at a percentage similar to the percentage of degrees earned by new nurses, associate versus bachelors (AACN, 2021b). As research has found males possess higher political self-efficacy (Gooch, 2018; Hammon, 2010), the lower response to males in this study might have resulted in a lower than actual level of self-efficacy for nurse educators. The higher number of nurse educators reporting membership in a professional organization might have increased self-efficacy to a higher level in the nurse educator population as sources (Byrd et al., 2012; Primomo, 2007; Primomo & Björling, 2013) predicted such membership would increase PAI in nurses.

Research Question One: Teacher's Political Self-Efficacy

Q1 How do nurse educators perceive their political self-efficacy as measured by the Teacher's Political Self-Efficacy-M scale?

This scale was originally developed by Hammon (2010) and then modified for the nurse educator population by Modene (2018). With 20 items, this Likert scale included 1–*strongly disagree,* 2-*disagree,* 3-*neither agree or disagree,* 4-*agree, and* 5-*strongly agree.* Questions included "I state my opinions about health policy issues openly even in public and challenging settings" and "I have participated in a deliberate information campaign in opposition to a particular health policy or position." These questions tended to be action oriented for which the participant identified their own level of such activity.

In this study the scores on the TPSE-M ranged from 1.05, or just above *strongly disagree* to 4.50, close to *strongly agree.* The mean score for the participants was 2.74, below a *neither agree or disagree* score. This value was even below Hammon's (2010) 2.89 found for K-12 educators, to which she stated such a score was anticipated due to the ongoing marginalization of

the teacher's voice. While nurses have not reported such marginalization as a reason to not be politically active, Mason et al. (2018) reported a decrease in nurses' influence through the media between the original Woodhull study 20 years ago and 2018. The average score in this study was also lower than the 3.14 of Modene's (2018) study, although both Modene's and this study identified a level of disinterest among nursing educators with respect to political action.

At 4.02, the highest scored item in the TPSE-M scale, and the only one to score greater than four, was "I encourage and support other nurses and nurse educators who engage in health policy related activities." This response supported the discussion below that participants in this study were more likely to work with groups rather than individual action, for example, relying on the professional organizations to take on such advocacy roles on behalf of nurses. In this study, the lowest scored item, at 1.76, was "serving as a member of a committee or work group at the state or national level in a professional organization." Given that only 40 out of 2,124 members attended the CNA's assembly, there seemed to be low levels of participation by nurses as a whole within these organizations. In this study, "made a formal presentation on a best practice . . . at a professional meeting" also scored low (1.81). Overall, the higher TPSE-M item scores in this study tended to be related to group activities such as staying informed and responding to emails reaching out to nurse educators, suggesting the study participants did not have the self-efficacy to take individual action in support of their profession.

Items on the survey such as "serving as a resource to improve community health outcomes" (2.25), working with a "school sponsored committee" dealing with health policy matters (2.08), and being part of a "campaign in opposition to a particular health policy" all scored in the 2's or *disagree*. This was remarkable as such activity could be seen as promoting one's own community as a nurse rather than being political; yet it scored low as an individual

action item. This finding suggested a low level of self-efficacy was keeping these participants from supporting their communities in health policy matters. Research continues to find barriers to nurses' involvement in health policy work including lack of time, lack of knowledge, and even lack of confidence (Anders, 2021). Looking back to Bandura's (1997) theory of self-efficacy, one develops self-efficacy through their own actions as well as vicariously through others. To that end, as long as the participants' low self-efficacy prevents them from seeking out new mastery experiences or vicarious experiences, it is unlikely their self-efficacy will improve.

The scores from this study's TPSE-M scale supported the conclusion that nurse educators lacked the political self-efficacy to take on a stronger role of advocacy through health policy work. Bandura (1997) identified mastery experiences, vicarious experiences, verbal persuasion, and physiologic feedback as factors making up self-efficacy. Based on the low scores on most of the individual policy activities in this study, the nurse educator will not increase their self-efficacy to the detriment of their profession and their community.

Research Question Two: Political Astuteness

Q2 How do nurse educators rate their understanding and skills of the policy process measured with the Political Astuteness Inventory?

Political astuteness was defined by Primomo (2007) as awareness of the political process. It was the knowledge piece of this study in contrast with the action piece of the TPSE-M. Political astuteness was measured using the 40-item Political Astuteness Instrument. Responses were yes/no with each yes receiving one point. Scoring then categorized the points into four categories: totally politically unaware at 0-9 points, slightly aware at 10-19, beginning political astuteness at 20-29, and politically astute at 30-40. With questions including "I voted in the last two elections" and "I am registered to vote," there was a degree of action as found in the TPSE-

M. However, about half of the questions were knowledge-based such as knowing the names of state and federal senators and representatives, knowing how to contact those officials, knowing where to vote or how to get a ballot, and knowledge of specific political issues.

Scores ranged from 3 to 40, with a mean of 19.4. Like the TPSE-M, this mean was just below half of the possible total in the "slightly aware" category. By category, 9.4% were totally unaware, 40.3% slightly aware, 34.2% beginning astuteness, and 9.4% at politically astute. Again, Modene's (2018) findings were slightly higher with a mean score of 23. These low scores supported the findings that many nurses cited lack of knowledge as a reason for not being more politically active (Primomo & Björling, 2013). VandeWaa et al. (2019) pointed out nurses' knowledge of nursing issues and the political process had decreased between 2016 and 2018. The lower mean score as compared to Modene's mean score might be explained by a continued drop in political astuteness by nurses.

While the correlation between knowledge and self-efficacy is discussed in more depth in the next section, Nugent et al. (1999) stated having the knowledge to pass on to students was necessary for the teacher to develop personal self-efficacy, without which the teacher would be less likely to pass on knowledge to the student. There is an expectation that nurse educators teach from an evidence-based practice and are responsible for mentoring the student nurse to develop their own evidence-based practice (Mthiyane & Habedi, 2018). As an educator, it would be expected to have at least a higher than average level of knowledge in subjects to be taught, which the AACN (2021a) increasingly stated included health policy. In contrast, the participants in this study had not reached the level of beginning astuteness.

Byrd et al. (2012) described a significant improvement in the political astuteness of BSN students following public policy activities in the nursing program but an educator lacking in

political astuteness themselves might not able to provide these activities. Staebler et al. (2017) reported that only 21% of faculty were active in state and federal policy work but 86% stated they were teaching political advocacy concepts. It could be argued that knowledge measured by the PAI would be higher in those who teach health policy courses. That idea conflicted with the findings of Staebler et al. (2017) that health policy content is often threaded throughout the undergraduate curriculum rather than discrete policy classes as was found in some graduate programs. If health policy is to be taught in fundamentals, pediatrics, and mental health nursing, all educators must be at a higher level of astuteness.

The top three responses from the PAI in this study were being registered to vote at 99%, knowing where/how to vote at 98%, and staying abreast of current health issues at 95%. Voting in the previous and two previous elections came in fourth and fifth to round out the only "yes" answers by at least 90% of the respondents. While it was good to see such a high percentage of nearly 4 million strong (AACN, 2019b) voting, this was a low level of political activity that did not require the nurse's specialized knowledge to influence. As was seen with TPSE-M, lower scores involved individual action such as attending the national convention (16%) or local districts' nurses' association (6%). These and other responses demonstrated little support for local, state, or national professional organizations, coinciding with the drop in membership to these organizations. Only 42% of participants were aware their professional organization had lobbyists, suggesting the participants did not act politically even through their professional organizations. A majority of participants knew the names of their state and federal representatives. While 95% of participants reported staying abreast of health issues, just over half (54%) were aware of the stand taken by any of their representatives on at least one issue. With 34% of participants having contacted their representative, these educators were not sharing

their expertise with those in charge of crafting policy at the state and national levels. As was seen with the TPSE-M data, this low participation represented an abrogation of the nurse educator's responsibility to work toward improved health in their community.

With a mean score of 19.45, participants had not reached the level of beginning astuteness. Far from being politically astute, an educator with such poor knowledge of the political process cannot convey this knowledge to their students any more than an educator who does not know the stages of labor can teach an obstetrics class; yet that is what is expected of nurse educators in programs in which this content is threaded. Even in programs with a discrete health policy class, this study did not demonstrate enough "politically astute" educators for nursing schools. Because of this, undergraduate nursing programs will continue to poorly educate their students in political astuteness unless changes are introduced.

Research Question Three: Correlation Between Teacher Political Self-Efficacy-Modified and Political Astuteness Inventory

Q3 Is there a relationship between the nurse educator's political self-efficacy and their political astuteness?

Following the presentation of data and discussion in the preceding chapter, it would seem evident that there was a correlation between the TPSE-M and the PAI scores. Accordingly, a Pearson's correlation analysis found a correlation of .739 with $p<.01$. While there was considerable overlap of the questions on each instrument, there were sufficient differences to support continued use of both depending on the data sought.

While much of the focus in this study was on self-efficacy, the central component of Bandura's (1997) social cognitive theory was reciprocal determinism. The three corners of the triad are behaviors, personal factors, and environmental factors. Both knowledge and self-

efficacy fell under the personal factors as related factors. The PAI focused more on knowledge than the TPSE-M. With nurse educators often citing lack of knowledge as a reason to not be more politically active, a lower score on the PAI would logically mean a lower score in political self-efficacy as was demonstrated in this study. Bandura's theory of self-efficacy identified mastery and vicarious experiences as two significant factors for self-efficacy but the educator with less knowledge was less likely to seek those experiences. Nugent et al. (1999) described the nurse educator with high personal self-efficacy as one who had a high level of current clinical knowledge. If the goal was to increase self-efficacy and therefore the policy action by these nurse educators, it is important to not just focus on mastery experiences and vicarious experiences as identified in Bandura's theory but also to provide education on health policy to these educators. Because knowledge and self-efficacy are related under the SCT, political self-efficacy should increase with a concurrent increase in political astuteness. The corollary to that is a person with higher political self-efficacy is more likely to persist in health policy activity, leading to a heightened desire to learn more about that health policy.

This correlation applies to the classroom as well. When an educator has a high level of self-efficacy, they are more likely to use more active teaching strategies as well as have greater student engagement and classroom management while those with lower self-efficacy use more passive teaching techniques such as lecture (Dozier et al., 2019). Research found an increase in PAI following health policy focused activities in the classroom or at legislative offices (Byrd et al., 2012; Primomo & Björling, 2013). With the positive correlation between PAI and TPSE scores, this increase in PAI would likely result in a subsequent increase in political self-efficacy for those students, leading to more politically active nurses following licensure.

This study supported the relationship in Bandura's (1997) SCT of knowledge and self-efficacy working jointly to influence an individual's behavior. In the context of low scores in both the PAI and TPSE-M in our study, if we are to see nurses take a more active role in health policy, we need to start by increasing the political astuteness of the educator, which should lead to greater self-efficacy. These attributes can then be learned by the student nurse.

Research Question Four: Demographic Factors Affecting Teacher Political Self-Efficacy-Modified and Political Astuteness Inventory Scores

This study sought to identify relationships between various demographic factors and the scores on the two instruments. In exploring a potential bias of previous research in this area performed by Modene (2018), participants were categorized by region of residence for this study. The hypothesis was educators in regions far from the national headquarters of our federal government and many nursing organization, which also serve as high areas of lobbying activities, would have lower scores on both the PAI and TPSE-M. A regression analysis of these relationships supported the null hypothesis that there was no difference in the regional groups. While this outcome was unexpected, the overall low scores of the TPSE-M and PAI might explain the lack of relationship. When less than half of the participants communicated with their legislators, participated in community-based policy initiatives, or participated in their professional organization, it was unlikely this study would be able to identify differences by region. For those participants who were more politically active, such activity could take place locally or statewide, both in professional organizations and through government entities, reducing the draw of the national seats of government or organization.

With the variable of region of residence examined, attention was turned to other variables to identify influences on the dependent variables of the TPSE-M and PAI. The factors used in the regression analysis included years as a nurse; years as a nurse educator; highest degree of Ph.D., DNP, or MSN; receiving health policy training in their doctoral, MSN, or undergraduate education; teaching at the ADN or BSN level; or membership in a professional organization.

Variables Influencing Teacher Political Self-Efficacy

For TPSE-M, significance was found at .039 only with the membership in a professional organization. Because the TPSE-M is more action oriented, membership in a professional organization would increase that self-efficacy through a combination of organizational and individual support and education as well as the opportunity for vicarious learning. The self-efficacy theory describes self-efficacy being developed through mastery experiences, vicarious experiences, feedback from others, and physiological feedback (SimplyPsychology, 2020). This section describes examples of how professional organizations provided three of those four factors, which might lead to increased political self-efficacy for those members.

Byrd et al. (2012) identified participation (not just membership) in a professional organization as a significant factor predicting posttest political involvement. An example of this idea is a nurse educator working closely with the organization's health policy liaison learning the process of working with lobbyists through a combination of observation and interaction. For example, the Colorado Nurses Association (CNA, 2022) has the Government Affairs and Public Policy (GAPP) committee. This group reviews bills at the state level and provides input to legislators through the CNA's lobbyist. In this way, the participants learn not only from other nurses but also through discussions and feedback from the lobbyists on various measures including funding, education, and regulatory matters related to healthcare in Colorado. Wyoming

Nurses Association (WNA, n.d.) also has an advocacy page on their website that currently hosts a video about the "2021 WNA Nurses Day at the Legislature virtual event." These events have been sponsored by nursing organizations statewide and federally and offer an opportunity for nurses to meet with legislators or their staff to discuss health and nursing related issues, an opportunity a solitary nurse might find difficult to arrange. Primomo and Björling (2013) found a nurse legislative day significantly increased political astuteness. While that study was not exploring political self-efficacy, this study found a correlation between political astuteness and political self-efficacy, suggesting the legislative day would increase self-efficacy as well.

Taylor (2016) shared the story of a professional organization member who started at a nurses' day at the statehouse, which eventually led to an internship learning more about policy work. Catallo et al. (2014) stated low levels of professional organization participation limited the impact nurses could make in health policy work. Nursing organizations provide support to nurses through their websites (ANA, n.d.). As described by Catallo et al., the ANA's (n.d.) site included testimony recordings, guidelines on how to work with politicians, and an opportunity to sign up to become more involved.

As was mentioned previously, nurses do not join professional organizations in high numbers. In Canada, about half of nurses are members of the Canadian Nurses Association (Catallo et al., 2014). Those numbers are far lower in the United States with reported membership in the American Nurses Association near 10% (Williams, n.d.). Barriers to membership have been reported by numerous researchers to include lack of time, heavy nursing workloads, and cost (Catallo et al., 2014; Walton, 2017).

The participants in this study reported a higher percentage of membership in professional organizations as compared to other reports. Professional organizations serve their members

through a number of offerings including regular meetings of policy groups, sponsorship of "legislative days" through which nurses can meet with legislators, and "how-to get involved" resources on their websites. Through the associated knowledge increase and networking, these members will see a higher level of political self-efficacy as found in this study.

Variables Influencing Political Astuteness

For PAI, significance was found at .007 for health policy training at the doctoral level and .046 for health policy training at the MSN level. While this result was positive in that nurse educators were apparently getting the education they needed to be politically active, it was negative that the undergraduate education system was not teaching the students what they needed to be active in health policy. Schnur (2020) reported 18% of nurses hold a graduate degree. This means the other 82% of nurses who are needed to become involved in health policy are not receiving the education necessary to learn those skills.

Primomo (2007) has been a leading researcher in the area of political astuteness in undergraduate nursing students. She cited role models, professional organizations, and exposure to political activities as factors found in nurses who are politically active. Seeking to find if political astuteness could be increased through academic preparation, she found a significant increase in political astuteness following an activity in which students presented a policy briefing on a health-related activity and wrote a letter to the editor or legislator regarding that bill (Primomo, 2007). These mastery activities, preceded by the necessary education of the process, increased political astuteness directly (Primomo, 2007). With the correlation between political astuteness and self-efficacy described in this study, there was likely also an indirect increase in self-efficacy, although Primomo did not explore that.

Getting out of the classroom, Primomo and Björling (2013) performed a pre/post PAI test on nurses and student nurses taking part in a legislative day. Their study found years as an RN and highest degree as significant variables to higher PAI but also found a significant increase in political astuteness following the legislative day. As with Primomo's (2007) earlier work, this showed having nurses participate in political advocacy would increase their political astuteness.

Byrd et al. (2012) performed a similar study with BSN students in a community health course. This course included learning sessions with the health department and state legislature as well as a legislative assignment and policy project (Byrd et al., 2012). The outcome was a significant increase in political astuteness for the students with 147 politically unaware students dropping to 4 in the posttest and 1 politically astute increasing to 31.

These studies demonstrated two things. First, activities as part of a nursing course could increase the political astuteness in students. Second, there is a need to increase the political astuteness of educators to the higher "politically astute" level if they are expected to meet the learning needs of their students. How to accomplish this is discussed in Implications.

Political astuteness is a direct measure of the participant's knowledge or awareness of health policy activity. This study found a low level of political astuteness in participants overall but significantly higher in those who completed a health policy course in their graduate education. Research showed the individual's political astuteness could be increased through health policy directed activities in nursing school.

Social Cognitive Theory

Bandura's (1997) SCT stated learning takes place through the interaction of three factors: behavioral, environmental, and personal (Schunk & DiBenedetto, 2020). The personal factors, specifically self-efficacy, were the primary focus in this study as it was of great influence to the

behaviors one participates and persists in (Bandura, 1997). In this study, the behavior of focus was health policy work. One's environment including instruction, feedback, and role models was also an important piece of this study as it influenced one's self-efficacy but also provided information to increase one's political astuteness (Byrd et al., 2012; Primomo, 2007).

Bandura (1997) distinguished knowledge from self-efficacy. With self-efficacy being the belief in one's ability to reach a goal, knowledge is about having factual information. This study did find a high correlation between knowledge and self-efficacy, enough to support increasing knowledge of health policy as a step to increasing self-efficacy and subsequent action by the nurse educator.

Self-efficacy is built through four factors: mastery experiences, vicarious experiences, verbal persuasion (feedback), and physiological and affective states (Bandura, 1997). This study supported these factors as follows. Mastery experiences allow the individual to participate in activities which, when successful, increase self-efficacy. These experiences were described in the previous section (Byrd et al., 2012; Primomo, 2007; Primomo & Björling, 2013). Vicarious experiences were supported most commonly through professional organization through health policy groups in which nurses discussed relevant policies and learned from each other how to proceed (CNA, 2022; WNA, n.d.). Feedback from others came from fellow nurses. "I encourage and support other nurses and nurse educators who engage in health policy related activities" was one of the highest scored responses on the TPSE-M instrument. Additional feedback will come from the professional organizations' members. Not explored in this study were physiological and affective states, essentially the "gut reaction" people experience.

This study found nurse educators had a low score in political astuteness and a low score in political self-efficacy. With the SCT describing self-efficacy as a high influencer to taking

action, this low political self-efficacy and astuteness will lead to nurses being less likely to participate in health policy work. Bandura (1997) went on to say setting and meeting goals, in this case health policy goals, would result in an increase in self-efficacy. As that self-efficacy increases, the individual is more likely to place themselves in an environment in which they could further increase their knowledge and self-efficacy (Schunk & DiBenedetto, 2020). This would include joining a health policy group or participating in a legislative day. The findings of this study showed low scores in many activities in which the participant would insert themselves into an environment would lead to this increase in knowledge and self-efficacy. In the case of nurse educators represented in the current study, there might be a need for some environmental push to increase activity.

Implications

This section presents the implications of this study to four groups: nurse educators, academic leaders, students, and the profession of nursing.

College Leadership

A frequently identified barrier to nurse educators becoming more politically active and engaging students in health policy work is time (Anderson et al., 2020; Staebler et al., 2017; VandeWaa et al., 2019). Nurse faculty work 56 hours per week, finding work-life balance difficult to attain (Thomas et al., 2018). Lack of administrative priority, while the lowest of several barriers, was also cited by approximately 25% of nursing faculty at the BSN level (Staebler et al., 2017). This researcher was told by college leadership that legal education was not relevant to nursing education (Anonymous, personal communication, June 22, 2022).

These leaders should recognize the importance of their faculty being more politically astute and active. In contrast, some school policies prohibit such activity if it might interfere with

the current position, specifically stating no employee could use time on the job to influence the passage or defeat of a legislative measure (University of Texas, 2016). While it is reasonable to prevent an educator from representing their school in an action against the school, college leaders must recognize political activity is an expectation of nurses and nurse educators are in a position to be information leaders.

Simply allowing such action does not solve the problem of time. College leaders should develop work expectations that permit or even encourage health policy work by faculty. In doing so, faculty should be allotted time for such activities with these activities then viewed by the college as service or scholarship.

Nursing Program Directors

This study identified a low level of political astuteness and political self-efficacy in nurse educators. These educators were poorly equipped to teach this content to current and future nursing students, resulting in continued low political astuteness in nurses.

At the nursing program level, the director could set policy to ensure the best person is teaching the class. While available policies for course assignments seemed to focus on equality in credit hour or anticipated work for a particular class (Michigan State University, 2015), it was likely the directors also took into consideration the faculty member's knowledge and expertise when assigning classes. While the actual policy was not discoverable, a recommendation for the University of Northern Colorado suggested workload assignments consider the professional development of the faculty (University of Northern Colorado (UNC), 2013). Both service and scholarship were broadly defined in that document, allowing the director some latitude to accept health policy work in either category.

Looking back at the low PAI scores in this study, it was evident why there was recurring desire for additional health policy training (Farley, 2004; Lewinski & Simmons, 2018). Anderson et al. (2020) recommended providing an environment in which faculty could explore the impact of policy on their own practice and research. To get there, Anderson et al. also recommended providing the education and mentoring needed to nurse educators to increase their own knowledge and have the best qualified faculty teach this content to the students. Using information from this study, the director could evaluate potential faculty through the use of the PAI or TPSE-M instruments. Additional assessment would be an examination of the faculty member's transcripts to see a discrete health policy class taken at the graduate level and participation in a professional organization, particularly in policy matters, as both of these were found significant in this study. For those lacking such education, the program should provide release time and cover the cost of such a course as professional development. These individuals would be the most qualified to be effective teachers of health policy content.

Related, those educators would have course assignments not just at the graduate level but also at the undergraduate level where quality health policy education could meet the needs of those nurses who will never earn a graduate degree. Finally, the director should allow time, whether through release or scheduling, to allow the interested nurse educator to participate in health policy work. This work might be at state or federal legislatures or at the local community or college committees focusing on health policy. Such activity by the faculty member would also bring recognition to the college. The director should consider these activities as part of the educator's annual evaluation as recognition of its importance.

Nurse Educators

There were several takeaways in this study for the nurse educator. First, awareness of the low level of political astuteness should be a wake-up call. While not every educator will be interested in learning more about and teaching health policy, for those who do, this study supported joining a professional organization such as the American Nurses Association. Taylor (2016) and Woodward et al. (2016) stated these organizations provide support for nurses wanting to increase their health policy skills. The aforementioned WNA (n.d.) and CNA (2022) are also examples of these organizations.

Another way to increase political astuteness, as identified in this study, is taking formal courses in the area of health policy. As described in the previous section, such coursework and participation should be considered part of the educator's workload, requiring a conversation between faculty and director. With schools of nursing continuing to struggle with hiring qualified faculty (AACN, 2020), the educator might find flexibility in workload.

Bandura's (1997) self-efficacy theory also supported learning vicariously. While it might feel uncomfortable for the experienced nurse educator to need a mentor, the experience of working closely with one more experienced in policy work could increase the educator's knowledge and self-efficacy. At the recent CNA (2022) meeting, the Government Affairs and Public Policy (GAPP) group was actively recruiting members so opportunities are out there but the educator must take the step. Also at that meeting were the CNA's lobbyists, sharing information about candidates, issues, and voting patterns.

Another point for nurse educators is to look at their own classroom. Research by Primomo (2007) and Byrd et al. (2012) demonstrated practicing health advocacy skills in and out of the classroom was effective at increasing political astuteness. Dozier et al. (2019) reported

teachers with low levels of self-efficacy used out of date teaching methods. As they increase their knowledge and self-efficacy, the nurse educator must review their teaching methods to be sure the students are learning the skills they need.

The nurse educator is in a central position to make a difference in the future teaching of health policy content through increasing their own knowledge and experience, working with college leadership to make health policy content a priority, and update their own content to increase learner engagement and success. The first step is to increase their own political astuteness.

Nursing Students

This study failed to find a health policy class in undergraduate nursing education as a significant factor to increase political astuteness and political self-efficacy in participants. This finding identified the need to improve health policy education at the undergraduate level. The ANA (2015) *Code of Ethics* stated nurses have a responsibility to participate in political activity. Byrd et al. (2012) found membership in a professional organization increased political astuteness in undergraduate nursing students. Incorporating professional values and joining a professional group such as the National Student Nurses' Association (2022) would increase their political astuteness separate from content provided in their nursing program.

Staebler et al. (2017) reported nearly 50% of BSN educators reported lack of student interest as a barrier to engaging students in health policy topics. As described in the previous section, the nurse educator with a higher self-efficacy is more successful at engaging the students (Dozier et al., 2019). The educator should take the steps discussed in the previous section. The student should provide feedback about the educator's teaching techniques and content to ensure the best outcome from the class.

The implications for the student are simple. A poor education of health policy content decreases their political astuteness, self-efficacy, and ability to actively participate in health policy work after licensure. The student and educator must recognize the importance of health policy content and take steps to increase their political astuteness.

Significance to Nursing Education

This study was significant to nursing education as it described a fundamental weakness in nursing education, which has significant effects on the profession of nursing. Lewinski and Simmons (2018) stated 72% of nurses were interested in continuing education on health policy. While 76% of those would seek such education from professional organizations and the websites of the ANA (n.d.), CNA (2022), and WNA (n.d.) gave evidence of these organizations stepping up to provide such information, 30% of the sample would seek such information from a university.

At the undergraduate level, 100% of the students would expect the nursing education program to teach the content important to being a nurse. Nursing students, particularly at the BSN level, believe their employers expect nurses to have knowledge of health policy (Thomas, et al., 2020). Unfortunately, the low PAI and TPSE-M scores described in this study suggested the faculty at the schools of nursing are poorly equipped to provide this education. Despite the desire of those students, they had a mean score of 2.2 out of 4 in a survey of their perceived competency in health policy behaviors (Thomas et al., 2020). This finding was important as while this study evaluated the effectiveness of the undergraduate health policy course from 30 years ago, the study by Thomas et al. (2020) found similar low numbers in current undergraduate programs.

Nurse educators, nursing program directors, and college leadership need to recognize the importance of covering the health policy content as described in the AACN's essentials guide (AACN, 2021a). Based on the numbers in this study, current and future nurse educators, particularly those who wish to teach health policy content, must take steps as identified in this study to increase their political astuteness and self-efficacy. This means educators must actively participate in professional nursing organizations with a focus on health policy work. Concurrently, they must increase the content in their health policy course or the health policy section of their current course to meet current AACN expectations. Faculty and directors should explore developing a health policy course if none exists. College leadership must not just allow these nurse educators to be more active in health policy but encourage the faculty to do so through release time, professional development, and positive evaluations for success in the health policy realm.

Numerous nursing and non-nursing organizations are calling on nursing to take their place as a leader in health policy work (AACN, 2021a; ANA, n.d.; IOM, 2011). Nurses and nursing students continue to call for additional education, and time, to be more politically active. This is an opportunity for nursing education to take the lead and empower current and future nurses to influence health policy.

Study Limitations

There were some limitations to this study including sampling techniques, lack of responses from some segments of the nurse educator population, and the use of self-reported data.

Due to concerns that different recruiting methods could result in disparate populations, complicating data analysis, it was decided to rely primarily on Facebook alone. This led to two

points of self-selection, first to be in a Facebook nursing group and second to participate in the research. The population on Facebook might somehow be atypical of all nurse educators, either less knowledgeable and looking for help from the group or more experienced and looking to share best practices with others. Either would skew results.

Another piece of data missing was the response rate. Although an approximate number of members is known for Facebook groups, there was no way to know how many people read about the study but did not respond. This data would provide additional information for self-selection bias and is more readily available with recruitment methods requiring individual contact.

Males and non-binary genders were underrepresented in this sample. Because males have been found to be higher in political activity, this alone could have resulted in lower scores for the sample. Although anecdotal, there seemed to be a lower percentage of males on the Facebook group used for this study, leading to a possibly unrepresentative sample. It is possible that a combined Facebook and email or just email recruitment strategy would give more representative results.

This study relied on self-reported data. Some data, such as age and gender, were left blank by a small number of respondents. More concerning was the potential for scoring up on the surveys such as a "yes" on the PAI survey or an *agree* on the TPSE-M where a "no" or *neither agree or disagree* would be more accurate. Self-report bias is when a participant provides an inaccurate response for reasons such as social desirability, denying drug use, or minimizing alcohol intake (Althubaiti, 2016). Students evaluate instructors on their knowledge, trustworthiness, skills as a coach, and role modeling (Niederriter et al., 2017). Although safeguards were taken to protect confidentiality, some participants might have rated themselves higher in some area due to this concern for social desirability and acceptance by students.

Additionally, some of the responses relied on memory. Did I take a class 10 years ago in my MSN program? How clearly do I remember that senator's name? Unreliable memory can also lead to self-report bias (Chong-ho, 2022).

Recommendations for Future Research

Research by Primomo and Björling (2013) and Byrd et al. (2012) found certain activities in and out of the classroom increased political astuteness in nursing students at the undergraduate and graduate level. Research is needed beyond the immediate class period to see if this higher PAI score actually resulted in higher levels of political activity as a nurse, particularly at the undergraduate nurse level.

Research is also needed about formal health policy mentoring programs, which could be established by a state nurses association or center for nursing excellence to determine if participants have changes in political astuteness and/or self-efficacy over time.

Another option for future research would be to focus on faculty who specifically teach health policy, exploring factors that make them the most qualified, if indeed they are. If nursing is going to reach the goal of increasing political self-efficacy and subsequent action by nurses, we need the most qualified educator to excite and empower the students.

Lastly, with AACN updating their essentials with new policy-focused competencies, political astuteness and/or self-efficacy should be reevaluated among nurse educators to see if they are meeting these new expectations.

Conclusion

The purpose of this study was to describe the political self-efficacy and political astuteness of undergraduate nurse educators in both associate degree and baccalaureate programs, identify a correlation between political self-efficacy and political astuteness, and to

identify professional and personal demographic factors that would influence political self-efficacy and political astuteness.

The data were analyzed and compared to that of previous research. Political self-efficacy, measured with the Teacher Political Self-Efficacy-Modified scale, showed participants in this study at 2.74, below the midpoint of the scale and falling into the *disagree* category. Because self-efficacy has been found to influence one's willingness to take and persist in action, a self-efficacy level this low suggested nurse educators were unlikely to take part in health policy work such as advising policymakers and working on committees to promote policies that are positive for their communities. Likewise, these participants would be less likely to engage their students in the classroom and guide their students, soon to be nurses themselves, how to work with health policy.

Political astuteness, or awareness or knowledge of health policy work, scored similarly to the TPSE-M. The mean PAI score was 2.89, placing study participants in the *slightly aware* category of astuteness or knowledge. With nurse educators expected to have knowledge at or greater than the average knowledge of a subject they teach, it was discouraging to see such a low score. As with the self-efficacy score, this political astuteness score suggested educators were not prepared to teach the health policy content to their students. Such a conclusion was supported by the nurses who were seeking additional training in the health policy arena through professional organizations and colleges.

A positive correlation was found between the political self-efficacy scores and the political astuteness score. While the two instruments measured areas of health policy readiness, the correlation suggested an increase in self-efficacy would lead to an increase in political astuteness, with the opposite also true. Increasing a nurse educator's participation on a school

committee focused on health policy would increase the self-efficacy but that educator would also increase their knowledge through that activity.

The demographic factors influencing political self-efficacy and political astuteness helped guide the next steps. For political self-efficacy, membership in a professional organization was found to increase self-efficacy. The positive feedback, role modeling, and opportunity for mastery experiences increased one's belief they could be successful in the area of health policy. To that end, educators, and nurses in general, are encouraged to join and participate in professional organizations.

The demographic factors influencing political astuteness included completing a health policy course in the master's or doctoral level education. Not all graduate programs have a discrete health policy class but those nurses seeking to increase their political knowledge should explore taking such a class for professional development. Also important in this finding was the undergraduate health policy course, where offered, was not significant in improving political astuteness. It is incumbent upon the nurse educator to increase their own knowledge and self-efficacy of health policy work; examine their own classes to be sure they are providing active, engaging coursework; and help current nursing student increase their own political astuteness and self-efficacy so they can be assets to the profession of nursing.

The study supported the conclusion that nursing education needs to demonstrate more recognition of health policy work as an expected part of being a nurse, no different than caring for a patient in the hospital. This was reflected in the AACN's (2021a) latest guidelines, currently being implemented at schools across the country.

REFERENCES

Abood, S. (2007). Influencing health care in the legislative arena. *Online journal of issues in nursing*, *12*(1), 3

Akhtar, A., & Ward, M. (2020, May 6). *Then and now: Here's how being a nurse has changed in the last 50 years.* https://www.businessinsider.com/how-being-a-nurse-has-changed-2019-4

Alhassan, A., Kumi-Kyereme, A., Wombeogo, M., & Fuseini, A.-G. (2019). Nurse participation in political activities: Level and practices of registered nurses in Tamale, Ghana. *OJIN: The Online Journal of Issues in Nursing*, 24(2). https://doi.org/10.3912/OJIN.Vol24No02PPT63

Allinder, R. M. (1995). An examination of the relationship between teacher efficacy and curriculum-based measurement and student achievement. *Remedial and Special Education 4*, 247-254.

Althubaiti, A. (2016). Information bias in health research: definition, pitfalls, and adjustment methods. *Journal of Multidisciplinary Healthcare*, *9*, 211–217. https://doi.org/10.2147/JMDH.S104807

American Association of Colleges of Nursing. (n.d.). *Vision and mission*. https://www.aacnnursing.org/About-AACN/AACN-Governance/Vision-and-Mission

American Association of Colleges of Nursing. (1986). *Essentials of colleges and university education for professional nursing.* American Association of Colleges of Nursing

American Association of Colleges of Nursing. (2008). *Essentials of baccalaureate education in nursing*. https://www.aacnnursing.org/Education-Resources/AACN-Essentials

American Association of Colleges of Nursing. (2011). *Essentials of master's education in nursing*. https://www.aacnnursing.org/Education-Resources/AACN-Essentials

American Association of Colleges of Nursing. (2019a). *Fact sheet: The impact of education on nursing practice*. https://www.aacnnursing.org/Portals/42/News/Factsheets/Education-Impact-Fact-Sheet.pdf

American Association of Colleges of Nursing. (2019b). *Nursing fact sheet.* https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet

American Association of Colleges of Nursing. (2020, September). *Nursing faculty shortage.* https://www.aacnnursing.org/news-information/fact-sheets/nursing-faculty-shortage

American Association of Colleges of Nursing. (2021a, April 6). *The essentials: Core competencies for professional nursing education.* https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

American Association of Colleges of Nursing. (2021b, July). *The impact of education on nursing practice.* https://www.aacnnursing.org/news-information/fact-sheets/impact-of-education

American Association of Medical Colleges. (2021, January). *Physician specialty data report.* https://www.aamc.org/data-reports/workforce/report/physician-specialty-data-report

American Nurses Association. (n.d.). *Advocacy.* https://www.nursingworld.org/practice-policy/advocacy/

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements.* https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

American Nurses Association. (2019, July). *Nurse staffing advocacy*. https://www.nursingworld.org/practice-policy/nurse-staffing/nurse-staffing-advocacy/

American Nurses Association. (2022, January 12). *Amid a persistent pandemic and longstanding staffing crisis, Americans rank nurses the most honest and ethical professionals.* https://www.nursingworld.org/news/news-releases/2021/amid-a-persistent-pandemic-and-longstanding-staffing-crisis-americans-rank-nurses-the-most-honest-and-ethical-professionals/?fbclid=IwAR0rSvX3G0U58lq12tzOO0-8XDB0qvdBGGxjZk-5nmPC3EtbM7EqcCHSk_g

American Public Health Association. (n.d.). *Health in all policies.* https://www.apha.org/topics-and-issues/health-in-all-policies

Anders, R. L. (2021). Engaging nurses in health policy in the era of COVID-19. *Nursing Forum*, *56*(1), 89–94. https://doi.org/10.1111/nuf.12514

Anderson, A. L., Waddell, A., Brennan, P., Burnett, C., Anderson, C., & Short, N. M. (2020). Advancing health policy education in nursing: American Association of Colleges of Nursing Faculty Policy Think Tank. *Journal of Professional Nursing: Official Journal of The American Association of Colleges of Nursing*, *36*(3), 100–105. https://doi.org/10.1016/j.profnurs.2019.09.002

Ashton, P. (1984). Teacher efficacy: A motivational paradigm for effective teacher education. *Journal of Teacher Education 35*(5), 28–32. https://doi.org/10.1177/002248718403500507

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavior change. *Psychological Review 84*, 191-192.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. W.H. Freeman and Company.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Jossey-Bass.

Benton, D. C., Al Maaitah, R., & Gharaibeh, M. (2017). An integrative review of pursing policy and political competence. *International Nursing Review*, *64*(1), 135–145. https://doi.org/10.1111/inr.12275

Bourne, M., Smeltzer, S., & Kelly, M. (2021). Clinical teacher self-efficacy: A concept analysis. *Nurse Education in Practice, 52*. https://doi.org/10.1016/j.nepr.2021.103029

Byrd, M. E., Costello, J., Gremel, K., Schwager, J., Blanchette, L., & Malloy, T. E. (2012). Political astuteness of baccalaureate nursing students following an active learning experience in health policy. *Public Health Nursing, 29*(5), 433–443.

Catallo, C., Spalding, K.,. & Haghiri-Vijeh, R. (2014). *Nursing professional organizations: What are they doing to engage nurses in health policy?* SAGE Open. DOI: 10.1177/2158244014560534

Centers for Disease Control and Prevention. (2016). *Health in all policies.* https://www.cdc.gov/policy/hiap/index.html

Centers for Disease Control and Prevention. (2022, August 23). *Health topics a-z.* https://www.cdc.gov/health-topics.html

Chafee, M. W., Mason, D. J., & Leavitt, J. K. (2012). A framework for action in policy and politics. In D. J. Mason, J. K. Leavitt, & M. W. Chafee (Eds.), *Policy and politics in nursing and health care* (6th ed., pp. 1-11). Elsevier Saunders.

Chong-ho, Y. (2022, September 23). *Reliability of self-report data*. https://www.creative-wisdom.com/teaching/WBI/memory.shtml

Clancy, L. (2019, June 6). Discussing your study's limitations. https://www.internationalscienceediting.com/study-limitations/

Clark, M. (1984). *Community nursing: health care for today and tomorrow*. Appleton and Lange.

Cohen, S. (2016). Health policy repertoires and toolboxes. *Policy, Politics, and Nursing Practice, 17*(1), 3-4. DOI: 10.1177/1527154416655508

Colorado General Assembly. (2018). *Community college bachelor science degree nursing HB18-1086*. https://leg.colorado.gov/bills/hb18-1086

Colorado Nurses Association. (2022). *Government affairs & public policy (GAPP).* https://www.coloradonurses.org/gov-t-affairs-public-policy

Conger, C. O., & Johnson, P. (2000). Integrating political involvement and nursing education. *Nurse Educator, 25*(2), 99-103.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, Quantitative, and mixed methods approaches* (5th ed.). SAGE Publications.

Cziraki, K., Read, E., Spence Laschinger, H. K., & Wong, C. (2018). Nurses' leadership self-efficacy, motivation, and career aspirations. *Leadership in Health Services*, *31*(1), 47–61. https://doi.org/10.1108/LHS-02-2017-0003

D'Antonio, P., Fairman, J., & Lewenson, S. (2020). Historical perspective on policy, politics, and nursing. In D. J. Mason, J. K. Leavitt, & M. W. Chafee (Eds.), *Policy and politics in nursing and health care* (8th ed., pp. 17-24). Elsevier Saunders.

de Cordova, P. B., Steck, M., Vermeesch, A., Pierre, N., Rankin, A., Ohlendorf, J. M., Lawrence, S., & Derouin, A. (2019). Health policy engagement among graduate nursing students in the United States. *Nursing Forum*, *54*(1), 38–44. https://doi.org/10.1111/nuf.12295

Deliverska, M., & Kehayov, A. (2016). Legal education of healthcare providers. *Journal of Educational and Instructional Studies in the World, 6*(S1), 134-140.

Doneski, A. L. (2017). *Evaluating the self-efficacy of novice educators in nursing and allied health care programs as it pertains to faculty development* [Doctoral dissertation, Lindenwood University]. ProQuest Dissertation Publishing, Publication No. 10637426.

Dozier, A., Hsiao, E., Dees, D., Noviello, S., & Bochenko, M. (2019). An investigation of nursing faculty teacher efficacy in nursing schools in Georgia. *ABNF Journal 30*(2), 50-57.

Duquesne University. (2020a, May 22). *How healthcare policy is formed.* https://onlinenursing.duq.edu/blog/healthcare-policy-formed/

Duquesne University. (2020b, June 24). *Legal concerns for nurse educators working with students.* https://onlinenursing.duq.edu/blog/legal-concerns-clinical-nurse-educators-working-students/

Dzubak, J. (2018). Healthcare today: A review of reform, and how it impacts nurses. *Ohio Nurses Review, 93*(1), 6-7.

Eaton, M., deValpine, M., Sanford, J., Lee, J., Trull, L., & Smith, K. (2017). Be the change: An interprofessional team-based health advocacy summit. *Nurse Educator, 42*(5), 226–230. https://doi.org/10.1097/NNE.0000000000000382

Ely-Pierce, K. (1999). Legal issues for case managers: What you don't know can hurt you. *Family and Community Health, 22*(3), 78-91.

Emergency Nurses Association. (2022). *Government relations*. https://www.ena.org/government-relations

Essentials of college and university education for professional nursing: Report to the membership of AACN. (1986). *Journal of Professional Nursing, 3*(1), 54-69.

Farley, N. (2004). *Political activism of registered nurses in the state of Washington: Pathways and roadblocks* [Doctoral dissertation, Gonzaga University]. ProQuest Dissertations Publishing (Publication number 1420515).

Fee, E., & Garofalo, M. E. (2010). Florence Nightingale and the Crimean War. *American Journal of Public Health, 100*(9), 1591. https://doi.org/10.2105/AJPH.2009.188607

Films Media Group. (2003). *Bandura's social cognitive theory: An introduction*. Films On Demand. https://0-digital-films-com.catalog.poudrelibraries.org/PortalPlaylists.aspx?wID=106050&xtid=44898

Fitzgerald, A., McNelis, A. M., & Billings, D. M. (2020). NLN core competencies for nurse educators: Are they present in the course descriptions of academic nurse educator programs? *Nursing Education Perspectives, 41*(1), 4–9. doi: 10.1097/01.NEP.0000000000000530

Fritz, J. J., Miller-Heyl, J., Kreutzer, J. C., & MacPhee, D. (1995). Fostering personal teaching efficacy through staff development and classroom activities. *Journal of Educational Research, 88*(4), 200–208. https://doi.org/10.1080/00220671.1995.9941301

Fulcher-Smith, L. M. (1991). *Views and knowledge of registered nurses in Hawaii on legal issues: Implications for the professional practice of nursing* [Doctoral dissertation, University of Southern California]. ProQuest LLC (Accession No. 109870209).

Fuller, W. (2016, September). The future of advocacy and leadership: Faculty and mentorship is key. *The Florida Nurse*. https://www.nursingald.com/publications/1395

Garner, S. L., Killingsworth, E., Bradshaw, M., Raj, L., Johnson, S. R., Abijah, S. P., Parimala, S., & Victor, S. (2018). The impact of simulation education on self-efficacy towards teaching for nurse educators. *International Nursing Review*, *65*(4), 586–595. https://doi.org/10.1111/inr.12455

Gimbel, S., Kohler, P., Mitchell, P., & Emami, A. (2017). Creating academic structures to promote nursing's role in global health policy. *International Nursing Review*, *64*(1), 117–125. https://doi.org/10.1111/inr.12338

Gooch, T. (2018). *Political astuteness in TN nurse practitioners: Strategies to inform.* [Unpublished doctoral dissertation]. Lincoln Memorial University.

Guskey, T. R., & Passaro, P. D. (1994). Teacher efficacy: A study of construct dimensions. *American Educational Research Journal, 3J*, 627-643.

Hammon, M. C. (2010). Teacher political self-efficacy: Construct development and validation [Doctoral dissertation, University of Tennessee]. https://trace.tennessee.edu/utk_graddiss/695

Hernandez, A. (2020, January 13). *Health policy in nursing education*. https://www.myamericannurse.com/health-policy-in-nursing-education/

Hewlett, C. (2008). *Political participation of nurses* [Doctoral Dissertation, University of Maryland, Baltimore]. ProQuest Dissertations Publishing (Publication No. 3315131).

Hinnant-Crawford, B. (2016). Education policy influence efficacy: Teacher beliefs in their ability to change education policy. *International Journal of Teacher Leadership 7*(2).

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. The National Academies Press.

Iowa State University. (2022). *Revised Bloom's taxonomy.* https://www.celt.iastate.edu/teaching/effective-teaching-practices/revised-blooms-taxonomy/

Issel, L. M., Baldwin, K. A., Lyons, R. L., & Madamala, K. (2006). Self-reported competency of public health nurses and faculty in Illinois. *Public Health Nursing*, *23*(2), 168–177. https://doi.org/10.1111/j.1525-1446.2006.230208.x

Jezewski, M. A., Brown, J., Wu, Y. W., Meeker, M. A., Feng, J. Y., & Bu, X. (2005). Oncology nurses' knowledge, attitudes, and experiences regarding advance directives. *Oncology Nursing Forum*, *32*(2), 319–327. https://doi.org/10.1188/05.onf.319-327

Kapp, M. B. (2018). Teaching legal competencies through an individualized elective in medicine and law. *Gerontology & Geriatrics Education, 39*(4), 491-494. DOI: 10.1080/02701960.2016.1247072

Lewinski, A. A., & Simmons, L. A. (2018). Nurse knowledge and engagement in health policy making: Findings from a pilot study. *Journal of Continuing Education in Nursing*, *49*(9), 407–415. https://doi.org/10.3928/00220124-20180813-06

LoBiondo-Wood, G., & Haber, J. (2018). *Nursing research* (9th ed.). Elsevier.

Logsdon, M., Foltz, M., Scheetz, J., & Myers, J. (2010). Self-efficacy and post-partum depression teaching behaviors of hospital-based perinatal nurses. *The Journal of Perinatal Education, 19*(4), 10-16. DOI:10.1624/105812410X530884

Mason, D., Nixon, L., Glickstein, B., Han, S., Westphaln, K., & Carter, L. (2018, September 27). *The Woodhull study revisited: Nurses' representation in health news media 20 years later. Journal of Nursing Scholarship, 50,* 695-704. https://doi.org/10.1111/jnu.12429

McLeod, S. A. (2016). *Albert Bandura's social learning theory*. https://www.simplypsychology.org/bandura.html

Michigan State University. (2015, March 10). *Guidelines for teaching assignments.* https://www.canr.msu.edu/facultystaff/faculty_development/guidelines-teaching-assignments

Miller, B. (2018). Nurses preparation for advanced directives: An integrative review. *Journal of Professional Nursing 34*(5), 369-377. https://doi.org/10.1016/j.profnurs.2018.07.001

Mindrila, D., & Balentyne, P. (n.d.). *Scatterplots and correlation*. https://www.westga.edu/academics/research/vrc/assets/docs/scatterplots_and_correlation_notes.pdf

Modene, R. (2018). *Health policy engagement among nurse educators: A descriptive, cross-sectional study into political astuteness and political self-efficacy and the impact of personal and professional factors* [Doctoral dissertation, Indiana University of Pennsylvania]. ProQuest Dissertation Publishing.

Mthiyane, G. N., & Habedi, D. S. (2018). The experiences of nurse educators in implementing evidence-based practice in teaching and learning. *Health SA = SA Gesondheid, 23,* 1177. https://doi.org/10.4102/hsag.v23i0.1177

Mund, A. (2012). Education news: Policy, practice, and education. *AANA Journal, 80*(6), 423-426.

Mund, A. (2018, April). *Professional socialization and political advocacy.* https://www.aana.com/docs/default-source/aana-journal-web-documents-1/journal-online-content/online-content-education-news-professional-socialization-and-political-advocacy-april-2018.pdf?sfvrsn=e4505fb1_6

National Association of Neonatal Nurses. (n.d.). *Introduction: Health policy and advocacy toolkit.* https://nann.org/uploads/About/1.5.3.1_Federal_Health_Policy__Advocacy_Toolkit.pdf

National Council of State Boards of Nursing. (2021a, December 2). *Policy statement: Dissemination of non-scientific and misleading COVID-19 information by nurses.* https://wvrnboard.wv.gov/Documents/Policy%20Brief-DisseminationofCOVID19Info-NCSBN.pdf

National Council of State Boards of Nursing. (2021b). *2021 NCLEX pass rates.* https://www.ncsbn.org/15858.htm

National Geographic. (2022, August 26). *United States regions*. https://education.nationalgeographic.org/resource/united-states-regions

National League for Nursing. (2017). *Nurse educator demographics*. https://www.nln.org/news/research-statistics/newsroomnursing-education-statistics/nurse-educator-demographics-2137b25c-7836-6c70-9642-ff00005f0421

National League for Nursing. (2019). Disposition of full-time nurse educators by gender, 2019. https://www.nln.org/docs/default-source/uploadedfiles/default-document-library/disposition-of-full-time-nurse-educators-by-gender-2019-pdf.pdf?sfvrsn=390ca00d_0

National League for Nursing. (2022). *NLN core competencies for academic nurse educators*. https://www.nln.org/education/nursing-education-competencies/core-competencies-for-academic-nurse-educators

National Student Nurses Association. (2022). *Health policy and advocacy committee.* https://www.nsna.org/health-policy-and-advocacy-committee.html

Niederriter, J., Eyth, D., & Thoman, J. (2017). *Nursing students' perceptions on characteristics of an effective clinical instructor.* SAGE Open Nursing 3. https://doi:10.1177/2377960816685571

Niemi, R. G., Craig, S. C., & Mattei, F. (1991). Measuring internal political efficacy in the 1988 national election study. *American Political Science Review,* 85(4), 1407-1413.

Nugent, K., Bradshaw, M., & Kito, N. (1999). Teacher self-efficacy in new nurse educators. *Journal of Professional Nursing 15*(4), 229-237.

Pajares, F. (2002). *Overview of social cognitive theory and of self-efficacy*. http://people.wku.edu/richard.miller/banduratheory.pdf

Parker, C. (2013). Legal education for all (or more than just lawyers). *Chronicle of Higher Education 60*(2), A28-A29.

Patterson, B. J., & Krouse, A. M. (2015). Competencies for leaders in nursing education. *Nursing Education Perspectives, 36*(2), 76-78. doi: 10.5480/13-1300

Price, D., Buch, C., & Hagerty, B. (2018). Measuring confidence in nursing graduates within the framework of the AACN essentials. *Nursing Education Perspectives, 36*(2), 116–117. https://doi.org/10.5480/13-1162.1

Primomo, J. (2007). Changes in political astuteness after a health systems and policy course. *Nurse Educator, 32*(6), 260-264.

Primomo, J., & Björling, E. A. (2013). Changes in political astuteness following nurse legislative day. *Policy, Politics & Nursing Practice, 14*(2), 97–108. https://doi.org/10.1177/1527154413485901

Reinhart, R. J. (2020, January 6). *Nurses continue to rate highest in honesty, ethics.* https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-ethics.aspx

Remler, D. K., & Van Ryzin, G. G. (2015). *Research methods in practice: Strategies for description and causation* (2nd ed.). SAGE Publications.

Schunk, D., & DiBenedetto, M. (2020). Motivation and social cognitive theory. *Contemporary Educational Psychology*, *60*. https://doi.org/10.1016/j.cedpsych.2019.101832

Schwank, K., Carstensen, T., Yazdani, F., & Bonsaksen, T. (2018). The course of self-efficacy for therapeutic use of self in Norwegian occupational therapy students: A 10-month follow-up study. *Occupational Therapy International*. https://doi.org/10.1155/2018/2962747

Schnur, M. (2020). U.S. nurses in 2020: Who we are and where we work. *Lippincott Nursing Center*. https://www.nursingcenter.com/ncblog/may-2020/u-s-nurses-in-2020

Scollon, C. N. (2020). *Research designs*. DEF Publishers. http://noba.to/acxb2thy

Shin, S., Kang, Y., Hwang, E. H., & Kim, J. (2021). Factors associated with teaching efficacy among nurse educators in hospital settings. *Journal of Clinical Nursing*, *30*(7-8), 1111–1119. https://doi.org/10.1111/jocn.15656

Short, N. (2008). Influencing health policy: Strategies for nursing education to partner with nursing practice. *Journal of Professional Nursing*, *24*(5), 264-269.

SimplyPsychology. (2020, August 9). *Self-efficacy theory*. https://www.simplypsychology.org/self-efficacy.html

Soodak, L. C., & Podell, D. M. (1996). Teacher efficacy: Toward the understanding of a multi-faceted construct. *Teaching and Teacher Education, 12*, 401-411.

Staebler, S., Campbell, J., Cornelius, P., Fallin-Bennett, A., Fry-Bowers, E., Kung, Y. M., LaFevers, D., & Miller, J. (2017). Policy and political advocacy: Comparison study of nursing faculty to determine current practices, perceptions, and barriers to teaching health policy. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing*, *33*(5), 350–355. https://doi.org/10.1016/j.profnurs.2017.04.001

Stajkovic, A., & Luthans, F. (1998). Social cognitive theory and self-efficacy: Going beyond traditional motivational and behavioral approaches. *Organizational Dynamics 26*(4), 62-74.

Statistics Solutions. (2021). *Cronbach's alpha.* https://www.statisticssolutions.com/cronbachs-alpha/

Taft, S., & Nanna, K. (2008). What are sources of health policy that influence nursing practice? *Policy, politics, & Nursing Practice, 9*(4), 274-287.

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2*, 53-55. https://doi.org/10.5116/ijme.4dfb.8dfd

Taylor, M. (2016). Impact of advocacy initiatives on nurses' motivation to sustain momentum in public policy advocacy. *Journal of Professional Nursing 32*(3), 235-245. https://doi.org/10.1016/j.profnurs.2015.10.010

Thomas, C., Bantz, D., & McIntosh C. (2018). Nurse faculty burnout and strategies to avoid it. *Teaching and Learning in Nursing, 14*, 111-116. https://doi.org/10.1016/j.teln.2018.12.005

Thomas, T., Martsolf, G., & Puskar, K. (2020). How to engage nursing students in health policy: Results of a survey assessing students' competencies, experiences, interests, and values. *Policy, Politics, & Nursing Practice, 21*(1), 12–20. https://doi.org/10.1177/1527154419891129

U.S. Department of Health and Human Services. (n.d.). *About HHS.* https://www.hhs.gov/about/index.html

University of Texas. (2016). *Operating procedure 5-2020 prohibitions on political activity*. https://policies.utexas.edu/policies/prohibitions-political-activity

VandeWaa, E. A., Turnipseed, D. L., & Lawrence, S. (2019). A leadership opportunity: Nurses' political astuteness and participation. *The Journal of Nursing Administration*, *49*(12), 628–630. https://doi.org/10.1097/NNA.0000000000000827

Van Dyk, J., Siedlecki, S. L. & Fitzpatrick, J. J. (2016). Frontline managers' confidence and self-efficacy. *Journal of Nursing Management 24*, 533–539.

Vinney, C. (2019, January 20). *Social cognitive theory: How we learn from the behavior of others*. https://www.thoughtco.com/social-cognitive-theory-4174567

Wakefield, M. (2005). Health care quality in rural America: What's in it for nurses? *Nursing Economic$ 23*(1), 36-38.

Walerius, T., Hill, P. D., & Anderson, M. A. (2009). Nurses' knowledge of advance directives, patient self-determination act, and Illinois advance directive law. *Clinical Nurse Specialist, 23*(6), 316–320. https://doi.org/10.1097/NUR.0b013e3181be3273

Walton, K. R. (2017). *Barriers to membership in a professional organization for advanced practice nurses*. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=5287&context=dissertations

Washington State Nurses Association. (2021, December 13). *Healthcare workers launch campaign for safe staffing legislation*. https://www.wsna.org/news/2021/healthcare-workers-launch-campaign-for-safe-staffing-legislation

Williams, L. (n.d.). *Declining membership in professional nursing organizations*. https://onlinenursing.cn.edu/sites/default/files/Research_0.pdf

Willmott, L., White, B., Yates, P., Mitchell, G., Currow, D. C., Gerber, K., & Piper, D. (2020). Nurses' knowledge of law at the end of life and implications for practice: A qualitative study. *Palliative Medicine, 34*(4), 524–532. https://doi.org/10.1177/0269216319897550

Wood, R., & Bandura, A. (1989). Social cognitive theory of organizational management. *Academy of Management Review, 14*(3), 361-384.

Woodward, B., Smart, D., & Benavides-Vaello, S. (2016). Modifiable factors that support political participation by nurses. *Journal of Professional Nursing, 32*(1), 54-61. http://dx.doi.org/10.1016/j.profnurs.2015.06.005

World Atlas. (2022). *The most popular professions in the United States.* https://www.worldatlas.com/articles/the-most-popular-professions-in-the-united-states.html

World Health Organization. (2020). *Health policy*. https://www.who.int/topics/health_policy/en/

Wyoming Nurses Association. (n.d.). *How to get involved in the legislative process.* https://wyonurse.nursingnetwork.com/page/95451-how-to-get-involved-in-the-legislative-process

Zamani-Alavijeh, F., Araban, M., Harandy, T., Bastami, F., & Almasian, M. (2019). Sources of health care providers' self-efficacy to deliver health education: A qualitative study. *BMC Medical Education 19*(6). https://doi.org/10.1186/s12909-018-1448-z

APPENDIX A

POSTINGS FOR SOCIAL MEDIA

The postings below would be posted about a week apart, depending on response rate.

Posting 1:
Are you a full or minimum 50% part-time nurse educator in an undergraduate nursing program? Consider participating in an online survey evaluating political astuteness and self-efficacy. The survey is confidential and will take less than 15 minutes of your time. This research is conducted by Mark Longshore, a student in the PhD in Nursing Education program at the University of Northern Colorado. Click the link for more information and/or to participate. Please feel free to forward the link to any nursing education colleagues.
https://unco.co1.qualtrics.com/jfe/form/SV_esVVhTUbvIFQ3uC

Posting 2:
I am looking for full or minimum 50% part-time nurse educators working primarily with undergraduate nursing students. You are invited to participate in a web-based online confidential survey evaluating political astuteness and self-efficacy. This survey will take less than 15 minutes of your time. This research is conducted by Mark Longshore, a student in the PhD in Nursing Education program at the University of Northern Colorado. Click the link for more information and/or to participate. Forwarding this link to colleagues is appreciated.
https://unco.co1.qualtrics.com/jfe/form/SV_esVVhTUbvIFQ3uC

APPENDIX B

CONSENT FOR PARTICIPATION

UNIVERSITY OF
NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Factors Influencing Political Self-Efficacy and Political Astuteness in Undergraduate Nurse Educators
Researcher: Mark Longshore, JD, MSN, RN
e-mail: long2474@bears.unco.edu

Advisor: Michael Aldridge, Ph.D., RN. Phone: (970) 351-1699

I am a student in the Ph.D. in Nursing Education program at the University of Northern Colorado. I am exploring the influence of various factors on the political self-efficacy of nurse educators in the United States.

Inclusion criteria include:

1. Nurse educators in the United States employed full-time or at least 50% part-time in a nationally accredited nursing program.
2. Although they may hold some administrative duties in the nursing school, these faculty spend greater than 50% of their workload instructing undergraduate nursing students.
3. Nurse educators must be teaching undergraduate nursing content using face to face, online, or hybrid modalities. This includes classroom or didactic and clinical courses
4. Nurse educators must hold a graduate degree in nursing.
5. Nurse educators must be able to communicate in English.

As a participant in this research, you will be asked to complete two surveys as well as provide some demographic information including your education and years in nursing. It is estimated to take approximately 15 minutes to complete these surveys. The questions asked will not ask for any identifying information nor provide information allowing you to be traced to your institution. As with any online data collection, confidentiality cannot be guaranteed, but I will take steps to keep your information confidential. All data will be stored on a secure computer and destroyed after three years. Results will be presented in aggregated form.

Risks to you are minimal. You may feel anxious or frustrated completing the surveys but the results will have no bearing on you employment. There will be no direct benefits to you for your participation. Benefits to nursing include identifying factors important in improving political advocacy education in undergraduate nursing programs.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Please take your time to read and thoroughly review this document and decide whether you would like to participate in this research study. If you decide to participate, your completion of the research procedures indicates your consent. Please keep or print this form for your records. If you have any concerns about your selection or treatment as a research participant, please contact Nicole Morse, Office of Research Compliance Manager, University of Northern Colorado, Greeley, CO; 970-351-1910 or nicole.morse@unco.edu.

Thank you for assisting with this important research.

Sincerely,

Mark Longshore

APPENDIX C

POLITICAL ASTUTENESS INVENTORY

Please indicate with a yes or a no response.

1. I am registered to vote.
2. I know where my voting precinct is located or how to obtain a mailed ballot
3. I voted in the last general election.
4. I voted in the last two elections.
5. I recognized the names of the majority of candidates on the ballot at the last election.
6. I was acquainted with the majority of issues on the ballot at the last election.
7. I stay abreast of current health issues.
8. I belong to the state professional or student nurses' organization.
9. I participate (committee member, officer, etc.) in that organization.
10. I attended the most recent meeting of my district nurses' association.
11. I attended the last state or national convention held by my organization.
12. I am aware of at least two issues discussed and the stands taken at that convention.
13. I read literature published by my state nurses' association, professional magazines, or other literature on a regular basis to stay abreast of current health issues.
14. I know the names of my state senators in Washington DC.
15. I know the names of my representative in Washington DC.
16. I know the name of the state senator from my district.
17. I know the name of the representative from my district.
18. I am acquainted with the voting record of at least one of the above in relation to a specific health issue.
19. I am aware of the stand taken by at least one of the above on one current health issue.
20. I know whom to contact for information about health-related policy issues at the state or federal level.
21. I know whether my professional organizations employ lobbyists at the state or federal level.
22. I know how to contact the lobbyist.
23. I support my state professional organization's political arm.
24. I actively supported a candidate for the U.S. or state Senate or House of Representatives (Assembly)(campaign contribution, campaigning service, wore a button, or other) during the last election.
25. I have written, telephoned, or contacted electronically regarding a health issue to one of my local, state or national representatives in the last year.
26. I am personally acquainted with a senator or representative or a member of his or her staff.
27. I serve as a resource person for one of my representatives on his or her behalf.
28. I know the process by which a bill is introduced in my state legislature.
29. I know which senators or representatives are supportive of nursing.
30. I know which House and Senate committees usually deal with health-related issues.
31. I know the committees on which my representatives hold membership.
32. I know of at least two issues related to my profession that are currently under discussion at the state or national level.
33. I know of at least two health-related issues that are currently under discussion at the state or national level.

34. I am aware of the composition of the state board that regulates the practice of my profession.
35. I know the process whereby one becomes a member of the state board that regulates my profession.
36. I attend public hearings related to health issues.
37. I find myself more interested in public issues now than in the past.
38. I have provided testimony at a public hearing on an issue related to health.
39. I know where the local headquarters of my political party are located.
40. I have written a letter to the editor or other piece for lay press speaking out on a health-related issues.

APPENDIX D

TEACHER POLITICAL SELF-EFFICACY-MODIFIED SCALE

Using the response format below, rate your level of agreement by choosing one of the five responses for each item.

Strongly disagree.	Disagree	Neutral/Undecided	Agree	Strongly agree
(1)	(2)	(3)	(4)	(5)

1. I state my opinions about health policy issues openly even in public and challenging settings
2. I stay informed about national and state health policy initiatives.
3. I try to influence the health policy perspectives of my administrators.
4. I develop and maintain relationships with local and state government officials.
5. I respond to emails from or surveys sponsored by local, state or national professional nursing organizations that seek nurse educators' inputs.
6. I have made a formal presentation on an instructional best practice or a policy initiative at a profession specific meeting or conference.
7. I encourage and support other nurses and nurse educators who engage in health policy related activities.
8. I have participated in a deliberate information campaign in opposition to a particular health policy or position.
9. I solicit support for greater nurse involvement in health public policymaking from elected and appointed government officials.
10. I have distributed information for the purpose of informing and influencing the health policy perspectives of others.
11. I have served as a member of a work group or committee charged with researching and developing recommendations on a health policy issue.
12. I have served as a member of a committee or work group at the state or national level and sponsored by a specialized professional organization (e.g. Pennsylvania State Nurses Association, American Nurse Association, Academy of Medical-Surgical Nurses, etc.).
13. I use the means available to me to monitor the health policy positions and actions of elected government officials.
14. I try to influence the health policy perspectives of people or groups in my community
15. I keep informed about the health policy related positions and actions of local, state or national affiliates of professional nursing organizations
16. I have expressed in writing to government officials my perspectives on health policy matters.
17. I have provided assistance with routine school responsibilities to a peer in order to facilitate his/her greater involvement in health policy related activities.
18. I am positively supported by family and friends when I participate in activities of a political or civic or professional nature outside the usual work day or work week.
19. I have served as a representative on a community group looking at constructive ways to improve community health outcomes.
20. I have played a role in the selection of members/leaders of school sponsored committees or work groups dealing with health policy matters.

APPENDIX E

PERMISSION FROM DR. HAMMON TO USE TEACHER POLITICAL SELF-EFFICACY (ORIGINAL) INSTRUMENT

RE: TPSE instrument
Hammon, Cathy <mary-hammon@utk.edu>
Mon 2/14/2022 7:39 AM
To:

- Longshore, Mark <long2474@bears.unco.edu>

1 attachments (15 KB)
Teacher Political Self Efficacy Scale.docx;
Hello Mark:

This email serves to provide the permission you have requested. Attached is the TPSE Scale used in my dissertation research. This permission assumes you will properly cite and reference my research. Good luck with your dissertation.

Dr. Hammon

From: Longshore, Mark <long2474@bears.unco.edu>
Sent: Saturday, February 12, 2022 5:49 PM
To: Hammon, Cathy <mary-hammon@utk.edu>
Subject: TPSE instrument

You don't often get email from long2474@bears.unco.edu. Learn why this is important

Dr. Hammon,

I am a student in the Nursing Education PhD program at the University of Northern Colorado. I am planning to explore the Political Astuteness of nurse educators and how that may impact their self-efficacy in teaching that subject. To that end I am writing to request permission to use your instrument, the TPSE.

If you do grant permission, I would appreciate a clean copy of the instrument as well. I have been able to find pieces of it in various research arcticles but prefer to go with a complete copy.

Please let me know if you have any questions. I appreciate your consideration of sharing your instrument.

Best regards,
Mark Longshore
Ph.D. student, University of Northern Colorado
long2474@bears.unco.edu
970-412-2563

APPENDIX F

PERMISSION FROM DR. MODENE TO USE TEACHER POLITICAL SELF-EFFICACY- MODIFIED INSTRUMENT

Transcript, Email exchange via Linkedin

Absolutely
Rebecca, I reached out to Dr. Hammon and received permission to use her TPSE. As you made some changes to the instrument, would you give me permission to use your TPSE-M instrument? Thanks, Mark
Thanks Rebecca. I will reach out to the school. -Mark
Good morning Mark. Unfortunately it is not my tool as you indicated so I can't give permission. What I did to get Dr Mary Clark's permission (because it is her husband tool and he gave her permission to give it out) I called the university of San Diego school of nursing department to try to get in touch with her. They took my email and sent the message to her and within a day or two I had an email from Dr Clark granting permission. Hope this helps and good luck.
Dr. Modene, I am reaching out to you in hopes of getting permission to use the Patient Astuteness Inventory you used for your Ph.D. dissertation. I am planning to replicate your study with some small changes but have been unable to contact the author of the instrument for permission. If you are not comfortable granting permission, if you could direct me to Dr. Clark I would appreciate that assistance as well. Thanks, Mark Longshore JD, MSN, RN Ph.D. Student University of Northern Colorado

APPENDIX G

PERMISSION FROM JANET PRIMOMO TO USE THE MODIFIED POLITICAL ASTUTENESS INVENTORY

Re: Political Astuteness Inventory
Janet Primomo <jprimomo@uw.edu>
Sun 2/13/2022 2:27 PM
To:

- Longshore, Mark <long2474@bears.unco.edu>

2 attachments (386 KB)
Political astuteness inventory only.doc; Policy Politics Nursing Practice-2013-Primomo-1527154413485901.pdf;
Dear Mark,
I am pleased to learn that you are interested in studying political advocacy among nursing faculty and how that influences their ability/comfort level teaching legal issues and health policy. I am now retired and my scholarship has transitioned. I am delighted to know the Political Astuteness studies still spark interest among some researchers and faculty. Given your JD as well as nursing degrees, you are a natural to move this science forward.

I attached the Political Astuteness Inventory [PAI] that I used with some new suggestions highlighted in yellow. As you noted, I did receive permission from Mary Jo Clark to use the tool that was published in her Community Health Nursing text.

The last address I have for Dr. Clark is mjoclark@cox.net If you don't hear back, I think you would be fine using the tool for your class project. She has approved its use for others.

If you are interested in linking with others who are using the PAI in research, let me know and I can connect with others who have asked about it for use in their research. You have probably already reviewed the "Cited Article" from my studies. I attached the 2013 article although I suspect you have it.

Primomo, J. & Bjorling, E. (2013). Changes in political astuteness following nurse legislative day. *Policy, Politics, & Nursing Practice*,*14*(2), 97-108. doi:10.1177/1527154413485901

If you wanted to work on revising the tool, it might be good to bring *Byrd et al. in. Rather than 'yes/no' responses, scaling the responses is a possibility. Another option would be to place the items into theoretical categories (see below), which I started to do but did not test it out. That could be done later after data collection.

V Voting
PO Involvement in professional organizations
EO Knowledge of elected officials
PPK Knowledge of political processes
PPI Involvement in political process
GA General Awareness

*Mary E. Byrd, Joanne Costello, Kathleen Gremel, Jeanne Schwager, Lynn Blanchette and Thomas E. Malloy Political Astuteness of Baccalaureate Nursing Students Following an Active Learning Experience in Health Policy Public Health Nursing. Volume 29, Issue 5, pages 433–443 September/October 2012

Please let me know if I can be of further help. All the best! Janet

APPENDIX H

PERMISSION FROM PEARSON TO USE CLARK'S POLITICAL ASTUTENESS INVENTORY

Re: Permission to use instrument
Longshore, Mark <Mark.Longshore@frontrange.edu>
Fri 3/11/2022 8:45 PM
To:

- Moretsky, Michael <michael.moretsky@pearson.com>

Thank you Micheal. I appreciate it.

-Mark

From: Moretsky, Michael <michael.moretsky@pearson.com>
Sent: Friday, March 11, 2022 5:29:21 PM
To: Longshore, Mark
Subject: Re: Permission to use instrument

Hello Mark,

I am terribly sorry about the delay in getting back to you. Yes, you may use the instrument. Thank you!

Michael Moretsky
National Sales Representative

Pearson
Pearson Higher Education Services

APPENDIX I

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

Date:	08/01/2022
Principal Investigator:	Mark Longshore
Committee Action:	**IRB EXEMPT DETERMINATION – New Protocol**
Action Date:	08/01/2022
Protocol Number:	2207040769
Protocol Title:	Factors Influencing Political Self-Efficacy and Political Astuteness in Undergraduate Nurse Educators.
Expiration Date:	

The University of Northern Colorado Institutional Review Board has reviewed your protocol and determined your project to be exempt under 45 CFR 46.104(d)(702) for research involving

Category 2 (2018): EDUCATIONAL TESTS, SURVEYS, INTERVIEWS, OR OBSERVATIONS OF PUBLIC BEHAVIOR. Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 45 CFR 46.111(a)(7).

You may begin conducting your research as outlined in your protocol. Your study does not require further review from the IRB, unless changes need to be made to your approved protocol.

As the Principal Investigator (PI), you are still responsible for contacting the UNC IRB office if and when:

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

- You wish to deviate from the described protocol and would like to formally submit a modification request. Prior IRB approval must be obtained before any changes can be implemented (except to eliminate an immediate hazard to research participants).
- You make changes to the research personnel working on this study (add or drop research staff on this protocol).
- At the end of the study or before you leave The University of Northern Colorado and are no longer a student or employee, to request your protocol be closed. *You cannot continue to reference UNC on any documents (including the informed consent form) or conduct the study under the auspices of UNC if you are no longer a student/employee of this university.
- You have received or have been made aware of any complaints, problems, or adverse events that are related or possibly related to participation in the research.

If you have any questions, please contact the Research Compliance Manager, Nicole Morse, at 970-351-1910 or via e-mail at nicole.morse@unco.edu. Additional information concerning the requirements for the protection of human subjects may be found at the Office of Human Research Protection website - http://hhs.gov/ohrp/ and https://www.unco.edu/research/research-integrity-and-compliance/institutional-review-board/.

Sincerely,

Nicole Morse
Research Compliance Manager

University of Northern Colorado: FWA00000784

APPENDIX J

DEMOGRAPHIC QUESTIONS

1. What is your age? (Drop down)

2. What is your gender? (Drop down)

3. In what state do you work? (Dropdown)

4. What is your highest degree in nursing?
    a. ADN
    b. BSN
    c. MSN
    d. DNP
    e. PhD

5. How many years have you worked as a nurse? (Drop down)

6. How many years have you worked as a nurse educator? (Drop down)

7. What is the primary level (>50%) of nursing education you are teaching?
    a. Associate degree (ADN)
    b. Traditional Bachelor of Science in Nursing (BSN)
    c. RN to BSN
    d. Graduate education

8. Do you work full or part-time?
    a. Full-time
    b. Part-time

9. Do you remember receiving formal education in health policy?
    a. No
    b. Yes undergraduate (ADN, BSN)
    c. Yes MSN
    d. Yes Doctoral (PhD, DNP, etc.)

10. Do you belong to a nursing professional organization?
    a. Yes
    b. No