The Relationship of Workplace Empowerment and Organizational Commitment Among First Nations and Inuit Health Branch Nurses

By

Tracy Scott, R.N., B.N.

A Thesis

Submitted to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements

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Abstract

There is growing recognition of the relationship between the quality of nursing work environments and nursing work satisfaction and retention. The purpose of this descriptive correlational study was to test a model derived from Kanter's Theory of Structural Empowerment (1993) in a unique nursing population, describing the relationship between First Nations and Inuit Health Branch (FNIHB) nurses' perceptions of workplace empowerment and their commitment to the organization.

A convenience sample of nurses (n=70) employed in isolated and semi isolated nursing stations in Northern Manitoba responded to the Conditions of Work Effectiveness Questionnaire (CWEQ-II) and the Organizational Commitment Questionnaire (OCQ). Nurses in this study had moderate perceptions of structural empowerment and low affective commitment. This finding has important implications for the organization as affective commitment has the strongest relationship with employee retention, job satisfaction, and positive work outcomes. As hypothesized, total empowerment was positively correlated with affective commitment ($r = .664$, p.001). The implementation of structures that facilitate access to work related empowerment would be expected to increase affective commitment for this group of nurses.

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Chapter One: Introduction

Introduction

There is a growing recognition of the importance of nursing work environments as evidence proliferates on the relationship between the quality of these environments and nursing work satisfaction, clinical effectiveness and quality of client care (Aiken, Smith & Lake, 1994). Magnet Hospital research and shared governance approaches have identified the role of organizations in the creation of an empowered workforce (Doherty & Hope, 2000; Gleason Scott, Sochalski, & Aiken, 1999; Havens & Aiken, 1999; Laschinger, Almost, Purdy & Tuer-Hodes, 2003b). Nursing practice councils have gained favor across settings as organizations strive to create conditions that empower nurses with autonomy, authority and accountability for their professional practice (Miller & Meyer, 1996; Walker, 2001).

Kanter's (1993) Theory of Power in Organizations provides a useful framework to study the relationship of work environments to structural empowerment. She maintains that it is the structure of organizations, not individual characteristics, which empower or dis-empower employees (Kanter). An ongoing program of research at the University of Western Ontario has generated considerable empirical support for the theory in nursing settings (Laschinger, 1996). This research has demonstrated the positive relationship of structural empowerment to organizational commitment and, subsequently, to job satisfaction and workforce retention (Finegan & Laschinger, 2001; Laschinger, Finegan & Shamian, 2001 a; McDermott, Laschinger & Shamian, 1996; Wilson & Laschinger, 1994).

This theory has not been tested in the uniquely complex work environment within which First Nations and Inuit Health Branch (FNIHB) nurses are employed. The Office of Nursing Services (ONS) of FNIHB is currently undertaking a Transformation Strategy with this population (ONS, 2004). The purpose of this study is to test Kanter's theory and describe the relationship between FNIHB nurses' perceptions of work empowerment and their commitment to the organization.

Background to the Study

The Canadian Nurses Association has articulated a vision of the ideal professional work environment through the identification of Quality of Worklife Indicators (Lowe, 2002). A recent national review of nursing has called to action employers, educators and policy makers in the improvement of nursing work environments and the health of nurses (Baumann, O'Brien-Pallas, Armstrong-Stassen, Blythe, Bourbonnais, & Cameron et al. 2001). The Canadian Nursing Advisory Committee (CNAC), created in 2001, has prepared 51 recommendations in an urgent call to action for the creation of quality workplaces for Canadian nurses (Decter, 2002).

FNIHB employs 636 registered nurses who provide primary health care and public health services to over 600 aboriginal communities in rural and remote areas across Canada. FNIHB provides a highly complex work environment for nursing. Nurses function in a unique community health nursing role providing comprehensive primary health care in an expanded scope of practice (Tarlier, Johnson & Whyte, 2003). They do so with a population that experiences higher rates of morbidity and mortality than any other segment of Canadian society (Aboriginal Nurses Association of Canada, 2000).

Nurses in these settings are typically the only professional health resource in communities of several hundred people, with inadequate human and financial resources and insufficient (and geographically isolated) management supports (Talier et al., 2002). A recent survey by the Aboriginal Nurses Association of Canada (ANAC) documented a lack of management support as the leading reason nurses in isolated First Nations communities chose to leave their positions. Other workplace issues included overwork and burnout and a lack of access to professional development and education opportunities (ANAC, 2000).The most recent published report on traumatic stress disorders in this population was released in 1994. This study found a 33% prevalence rate of Post Traumatic Stress Disorder (PTSD). The authors note that this rate was twice that of the rate found among Vietnam veterans (Corneil & Kirwin, 1994).

Nurses in these environments are "stressed, personally and professionally isolated, and overworked" (FNIHB, 2003, p.1). Their living and working conditions are inadequate, with an absence of information management and technology supports and infrastructures, as well as limited access to opportunities for continuing education and professional development. Long term recruitment issues have been amplified by a recent global nursing shortage and nursing vacancy rates range from 15 to 53 %. The current environment has led to a crisis management approach to care and a resultant compromise of 'upstream' services with significant financial costs to FNIHB and even greater costs to the consistency and quality of health care services (ONS, 2004).

In recognition of the lamentable state of nursing in the branch, the FNIHB executive committee established the position of Executive Director and the Office of

Nursing Services (ONS) in December 2001 to undertake a strategic leadership role in addressing the challenges (FNIHB, 2003). The mandate of the ONS was to stabilize and sustain nursing human resources, while ensuring a consistent and comprehensive quality of service (ONS, 2004). The ONS responded with the development of a Transformation Strategy, implemented in February 2002, which consists of several components, including a Transformation Plan, Human Resources Plan, and a Management/Information Technology Plan (FNIHB). This comprehensive plan remains primarily in the planning and national development phase, thus allowing this study to be considered a baseline measure of existing workplace structures.

The Transformation Strategy "lays out a clear plan that addresses requirements to stabilize and sustain the nursing workforce in First Nations and Inuit communities" (FNIHB, 2003, p. 11). The strategy calls for fundamental organizational change and intends to "drive from the strategic level to the operational level with as much speed and certainty as possible" (FNIHB, pg. 4). Wide in its breadth and intent, two main components of the strategy, Human Resources and Information Management/ Information Technology (IM/IT), have particular resonance with the current research on quality practice environments. The Human Resource Strategy is viewed as critical to stabilize the nursing workforce and sustain organizational change. Critical indicators of success for the Transformation Strategy include stability of the workforce, quality nursing services, and empowered nurses (ONS, 2004).

There is much support in the post-industrial era for empowered organizations. The fast-paced fluidity of environments, knowledgeable workers seeking meaning from their

work, and autonomous work environments are antithetical to the industrial model of hierarchy, command, and control (Edmonstone, 2000). The move to post-industrial, technological organizations has seen a shift in organizational and managerial approaches. In nursing this shift has been reflected in the implementation of professional practice models and shared governance approaches (Laschinger & Havens, 1996; Porter O'Grady, 1991).

The ONS Human Resource Strategy is based on Magnet hospital literature, the Canadian Health Services Research Foundation (CHSRF) Policy Syntheses Document *Commitment and Care* (Baumann et al., 2001), and the Canadian Nursing Advisory Committee (CNAC) Report. Key objectives of the Human Resource Strategy include a focus on leadership development, quality work environments, nursing education, and professional development opportunities (FNIHB, 2003).

The CNAC recommendations are grouped under the three broad categories of workforce management, professional practice environments, and information management. Professional practice environment recommendations identify the link between respectful, autonomous practice environments and nursing recruitment and retention. Specific suggestions provided by the committee include providing opportunities for nurses to exercise control over their practice and become actively involved in decision making (CNAC, 2002).

The CHSRF document also identified major issues affecting the quality of nursing work life and put forth several recommendations for solutions. Critical issues included issues of: work pressure; job security; workplace safety; workplace support; educational

and professional development; and nursing control or influence on practice, work environments, or leadership. Proposed solutions included the creation of work environments that empower nurses with participation in decision making, such as shared governance structures (Baumann et al., 2001).

Shared governance in nursing is a model of employee empowerment that is profoundly antihierachical (Edmonstone, 2000). This model is not, however, about control, or about reversing hierarchy, it is about acknowledging and applying the three basic principles of responsibility, authority and accountability. Within this model nurses must accept responsibility for their professional practice, be accountable for the decisions they make and have the authority to act on them (Doherty & Hope, 2000). These principles are reflected in the definition of shared governance put forward by Tim Porter-O'Grady (1991):

> Shared governance energizes the practicing nurse by identifying his or her role and accountability for practice and builds a structure that exemplifies the values of the nurse as he or she defines and controls his or her practice. It changes the relationship of the nurse to the organization and to his or her peers. It expands the authority of the nurse and bases it solidly in his or her accountability for nursing practice. It represents the process of ownership and invests the power in the practicing nurse for things that he or she has legitimate accountability (p.461).

The essence of shared governance is the development of organizational structures that allow for formal participation in decision making and high levels of professional

autonomy and accountability. Benefits of shared governance have been cited as both professional and institutional. Institutional benefits include decreased turnover and absenteeism, increased productivity, and more effective use of management skills. Professional benefits include an empowered workforce, increased professional autonomy, increased job satisfaction, increased clinical effectiveness, increased self-esteem, professional pride, and improved quality of client care (Howell, Frederick, Olinger, Leftridge, Bell, Hess et al., 2001; Mitchell, Brooks & Pugh, 1999; Miller & Meyer, 1996; Perry & Code, 1991; Winslow, 2001).

Kanter's (1993) Theory of Structural Power in Organizations is consistent with professional practice models, shared governance structures, and the goals of the ONS Transformation Strategy. This theory is gaining increasing empirical support in the nursing population (Laschinger, 1996). Kanter argues that power in organizations is positional and not a result of individual or personal characteristics. She theorizes that organizational structures of power, opportunity, and relative numbers shape individual behavior in characteristic ways. Kanter maintains that individual work satisfaction, commitment, and effectiveness can be achieved through the creation of empowering work structures or environments.

The Workplace Empowerment Research Program at the University of Western Ontario (UWO), under the leadership of Dr. Heather Laschinger, has tested Kanter's theory extensively, publishing 44 articles (UWO, 2005), lending empirical support for the theory in nursing settings. These studies have found that staff nurses demonstrate only moderate empowerment scores, suggesting the need for significant improvements in

nursing work environments. Perceptions of workplace empowerment have been found to be predictive of: psychological empowerment (Kluska, Laschinger & Kerr, 2004; Laschinger, et al., 2001a; Laschinger, Finegan, Shamian & Wilk, 2001c; Manojlovich & Laschinger, 2002); work effectiveness (Laschinger & Havens, 1997; Laschinger & Wong, 1999; Laschinger, Wong, McMahon & Kaufman, 1999); participation in organizational decision making (Laschinger, Sabiston & Kutszcher, 1997); organizational trust (Laschinger, Finegan Shamian & Casier, 2000); job autonomy (Sabiston & Laschinger, 1995); control over nursing practice (Laschinger & Havens, 1996); job strain (Almost & Laschinger, 2002); levels of burn out (Hatcher & Laschinger, 1996; Laschinger, Almost, Purdy & Kim, 2004; Laschinger, Finegan, Shamain & Wilk, 2003a); occupational mental health (Laschinger & Havens, 1997); job satisfaction (Kutzscher, Sabiston, Laschinger & Nish, 1997; Sarmiento, Laschinger, & Iwasiw, 2004); collaborative behaviors (Almost & Laschinger, 2002); and organizational commitment (McDermott, Laschinger & Shamian, 1996; Laschinger, Finegan, Shamian & Almost, 2001b; Laschinger et al., 2000; Wilson & Laschinger, 1994).

In addition to the strategic goal of empowered nurses, the ONS Transformation Strategy includes the goal of stabilizing and sustaining the nursing workforce (FNIHB, 2003). These goals are not mutually exclusive as recent nursing research has highlighted the relationship of workplace empowerment to organizational commitment. Results of these studies suggest that nurse administrators can empower their staff and improve organizational commitment by manipulating workplace structures to allow greater access to the power and opportunity structures that Kanter maintains are important to overall

work effectiveness (Finegan & Laschinger, 2001; Laschinger et al., 2001; McDermott et al., 1996; Wilson & Laschinger, 1994).

Statement of the Problem

The majority of studies testing Kanter's theory have been conducted in acute care settings. There have been no tests of Kanter's theory or measurements of workplace empowerment in First Nations and Inuit Health Branch settings. Kanter (1993) maintains that bureaucracies are particularly plagued with structures of low opportunity and powerlessness, conditions which result in predictable behavioral responses of controlling behavior, rule mindedness, territoriality, and resistance to change. As noted by Haugh and Laschinger (1996), empowering environments are therefore critical during times of organizational transition. This has particular significance for the ONS Transformation Strategy. An understanding of current perceptions of empowerment and its relationship to organizational commitment in the FNIHB nursing workforce may be instructive in removing barriers to access of power sources, facilitating acceptance of change, increasing organizational commitment and ensuring successful implementation of the strategy.

Purpose of the Study

The purpose of this descriptive correlational study is to test a model derived from Kanter's Theory of Structural Empowerment in a unique nursing population, describing the relationship between FNIHB nurses' perceptions of work empowerment and their commitment to the organization. Information gained from this study will provide a research base to guide the Office of Nursing Services in transforming nursing work

environments through the creation of empowering organizational structures. This study may also be considered for replication as a measure of success for the Transformation Strategy in the creation of a stable and empowered nursing workforce.

Research Hypothesis

The research hypothesis for this study is that Manitoba Region FNIHB nurses' perceived workplace empowerment will be positively related to affective and normative commitment, and negatively or unrelated to continuance commitment.

Definition of Terms

Theoretical and operational definitions of terms that appear in the research questions are as follows:

1. Empowerment: For the purpose of this study, Kanter's (1993) definitions of empowerment and empowering structures will be utilized. Kanter defines empowerment as having control over conditions that make actions possible; and empowering structures as those that provide authority, responsibility, discretion, and autonomous decision making opportunities. Empowerment will be operationalized by respondents' total scores on the Conditions of Work Effectiveness Questionnaire-II (CWEQ-II).

2. Organizational commitment is a multidimensional work attitude, comprised of three components: affective, continuance and normative commitment (Allen & Meyer, 1996). Affective commitment is defined as "identification with, involvement in, and emotional attachment to the organization" (Allen & Meyer, p. 253). Continuance commitment is defined as "commitment based on the employee's recognition of the costs associated with leaving the organization" (Allen & Meyer, p.253). Normative

commitment is defined as "commitment based on a sense of obligation to the organization" (Allen & Meyer, p. 253). The three components of organizational commitment will be operationalized by respondents' scores on the Organizational Commitment Questionnaire (Meyer, Allen & Smith, 1993)

3. First Nations and Inuit Health Branch: First Nations and Inuit Health Branch (FNIHB) is a branch of the Department of Health in the Government of Canada. FNIHB provides public health and health promotion services on-reserve and in Inuit communities. In remote and isolated communities FNIHB also provides primary care services (FNIHB, 2004).

Summary of Chapter

The quality of nursing work environments has become a central feature in recent documents, highlighting the state of nursing in Canada today and in the future. FNIHB has embarked on a strategy to transform nursing through the creation of quality work environments and an empowered nursing workforce. Kanter's Theory of Structural Power in Organizations provides a useful framework to study this transformation and has been empirically tested in nursing populations.

Kanter's (1993) Theoretical Framwork provides guiding principles for organizations, such as the ONS, undergoing change or re-design. Fundamental to her writings is the need to move beyond aspects of the work or the immediate supervisory structure to the structures of power and opportunity. She advocates for modifications of organizational hierarchies in the creation of quality work environments through the establishment of workplace opportunity, participative management, and employee

involvement in decision making (Kanter).

This theory has not been tested in the uniquely complex work environment within which First Nations and Inuit Health Branch (FNIHB) nurses are employed. This study will provide significant information to the Office of Nursing Services through identification of the structural factors that may act as barriers to nursing work empowerment, providing a theory-driven, research based approach to this strategy. Kanter (1993) has provided provocative deliberations on the role and responsibility of organizations for the creation of work environments. She has argued, convincingly that, although there may be limits to individual behaviors, these limits are not as much internal as they are situational or structural. She notes that "there is both tragedy and hope embodied in this perspective" (p.10). The tragedy is that organizational structures can perpetuate disadvantage for many and advantage and power for few. The hope is that structures can be modified, the powerless can be given influence and nursing can be transformed.

Chapter Two: Conceptual Framework

Introduction

The Theory of Structural Power in Organizations was first published by Rosabeth Moss Kanter in her 1977 book, *Men and women of the corporation*. In 1993 Kanter republished under the same title with a new chapter on current workplace issues. Kanter generated her theory through an ethnographic study of a large corporation, to which she ascribed the pseudonym, Industrial Supply Corporation (Indsco). The theory provides an explanatory framework for the influence of organizations and their structures on individual behaviors (Kanter, 1993).

Kanter (1993) situates her writings within the traditions of social science, but also notes a debt to feminist theory. She identifies debates of global versus individual influences on women's work behavior as instrumental in developing her understanding of the role of institutions as the intervening link. Her theory moves beyond an individual focus to a structuralist model of organizations in which opportunity and power structures disadvantage men and women and generate predictable behavioral consequences, with "very few verifiable sex differences" (p. xvii).

Kanter (1993) attributes the origins of modern organizational structures to the role of the manager, which grew out of the 'Administrative Revolution' between 1890 and 1910, during the age of mergers and the emergence of the large corporation. These new managers lacked a class position that would establish their legitimate authority for they were "neither owners nor a traditional ruling class" (p.20). This led to the growth of a managerial ideology that lent control of organizations to a small and exclusive group of

men who possessed "rational" knowledge of organizational control. It is this view of the rational manager that is instrumental in the exclusion of women from management, as illustrated by one of the most pervasive stereotypes of women as "too emotional.... the antithesis of the rational manager" (Kanter, 1993, p. 25). These ideologies of management established the roles of the corporation, the relationships between them, and the capacities within them that persists in organizational structures to this day (Kanter).

Theory of Structural Power in Organizations

Through her study of Indsco, Kanter (1993) identified three central explanatory variables in "an integrated structural model of human behavior in organizations": the structure of opportunity, the structure of power, and the proportional distribution or relative numbers of people (p. 245-246). Kanter contends that the vast amount of individual behaviors in an organization is related to these variables and that a number of empirically verifiable hypotheses can be derived and tested from her Theory of Structural Power in Organizations.

Kanter (1993) asserts that power is essential to effective management and achievement of organizational goals. She proposes that organizational effectiveness is achieved when more people are empowered, "that is allowed to have control over the conditions that make their actions possible" (p. 166). She maintains that it is the role of the manager to create empowering structures that provide employees with access to opportunity, resources, information, and support. These structures include a flattening of hierarchies and participatory decision-making structures (Kanter).

Hierarchies, as a basic characteristic of organizations, create structures of

opportunities that define the ways individuals perceive themselves, their possibilities for movement, and their feelings of achievement. Opportunity refers to inherent prospects for advancement, movement or skill development in one's current job. Positions are generally situated in structures of opportunity that have both direct and indirect effects on mobility (Kanter, 1993).

Directly, certain jobs have real prospects of movement. Indirectly, opportunities for movement affect the attitudes and behaviors of individuals within their jobs. Indicators of opportunity include promotion rates, ladder steps, range and length of career paths, access to challenging work, skill increases, and rewards. Individuals can lack opportunity because their position is a "low ceiling" occupation, they failed in a "high ceiling" occupation or they lack the appropriate background to achieve a 'high ceiling' position. Despite different types of low opportunity positions, individuals in these situations respond in similar ways. These individuals tend to have lower self-esteem and may disengage from their work, either through lower aspirations and commitment or a lack of initiative and a crisis response approach to their work (Kanter, 1993).

Commitment, defined by Kanter as "the sense of overall attachment to the organization" (1993, p. 256), was strongly related in her study of Indsco to opportunities for mobility and growth. Individuals in low opportunity positions are also typically resistant to change and innovation either as a way to criticize management or as a way to maintain a sense of control and power. Resisters may be chronic criticizers or low risk conservatives who have a tendency to stall innovations. Individuals in positions of low opportunity therefore display attitudes and behaviors that cause them to be viewed as

unsuitable for promotion. In contrast, individuals in positions of high opportunity adopt positive attitudes and behaviors, thus furthering their initial advantage (Kanter, 1979a). Kanter (1993) defines power and empowerment as:

> the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet. In this way a monopoly on power means that only a very few have the capacity, and they prevent the majority of others from being able to act effectively. Thus the total amount of power-the total system effectiveness-is restricted, even though some people seem to have a great deal of it. However, when more people are empowered-that is, allowed to have control over the conditions that make their actions possible-then more is accomplished, more gets done. (p. 166).

Power in this sense can mean "efficacy and capacity" not "dominance, control and oppression" (Kanter, 1979a, p.66). The interpersonal aspect of power is referred to as the ability to mobilize others through "generating more autonomy, more participation in decisions, and more access to resources" (Kanter, 1993, p. 166). Productive power is the ability to "do" and is a function of having access to supplies, support and information as well as the ability to get cooperation in doing whatever is necessary. Those within the organization who have access to resources and information, and then utilize this access for effective action, are said to hold organizational power. These individuals are more likely to empower and build effective teams that are highly committed to their leader (Kanter, 1979a).

These capacities are not situated in the skill or style of the leader, but rather, are derived from the systemic power factors of job definition and connections (alliances) inside and outside the organization. Formal power is derived from one's placement in the hierarchy and informal power is obtained from highly visible alliances. Access to power is more easily achieved when one's formal job characteristics allow a high degree of discretion (flexibility and creativity) and are highly visible and central to the goals of the organization. Alliances are sources of informal power derived from social networks and include relationships with "sponsors (mentors and advocates), peers, and subordinates" (Kanter, 1993, p.181).

These systemic aspects of formal and informal power determine the opportunity and power structures found in the organization. These structures influence access to the organizational sources of power; the lines of supply, information, and support. Lines of supply (resources) refer to the manager's ability to control or influence materials, money and resources, including the ability to distribute rewards. Lines of information refer to the manager's ability to be "in the know", formally and informally. Lines of support refer to the manager's formal and informal support to function autonomously and with discretion, i.e. the ability to be innovative and take risk without having to navigate cumbersome approval processes or fear reprisal. Structural (workplace) empowerment is achieved when high levels of formal and informal power facilitate access to the sources of power and opportunity. Access to these sources enables work effectiveness (Kanter, 1979b).

Kanter's (1993) response to what makes a good leader is power, "power outward and upward in the system: the ability to get for the group, for subordinates or followers, a

favorable share of the resources, opportunities, and rewards..." (p. 168). Unlike many other leadership theories, this view has less to do with how leaders relate to followers than with how they relate to other parts of the organization. Managers with organizational power are flexible, highly effective, highly motivated, respected, empowering, and able to motivate subordinates. Conversely, powerless managers, lacking the supplies, information, or support to accomplish activities, are rigid and authoritarian (Kanter).

The third structure, relative numbers, refers to the numerical dominance of men in corporate administration. Kanter (1993) maintains that it is the rarity and scarcity of women, "not femaleness per se", at this level that shapes the environment with similar themes and processes for all minorities or token groups (p. 207). The variable of relative numbers is a quantitative measure of social compositions, that is, "how many people there are of what relevant social types in various parts of the organization" (Kanter, p. 248). As a predominantly female profession, this component of Kanter's theory has limited relevance to nursing.

Kanter (1993) notes that large bureaucracies are particularly plagued with structures of low opportunity and powerlessness. She emphasizes that these conditions of bureaucratic powerlessness result in predictable behavioral responses of controlling behavior, close supervision, rules mindedness, resistance to change, territoriality, and domain control. Succinctly, those without power will attempt to exercise any authority they can through the use of coercive or controlling power tools, such as an insistence on rule adherence and administrative rigidity. These conditions have predictable effects on individuals within the organization and include low aspirations, low motivation, a lack of

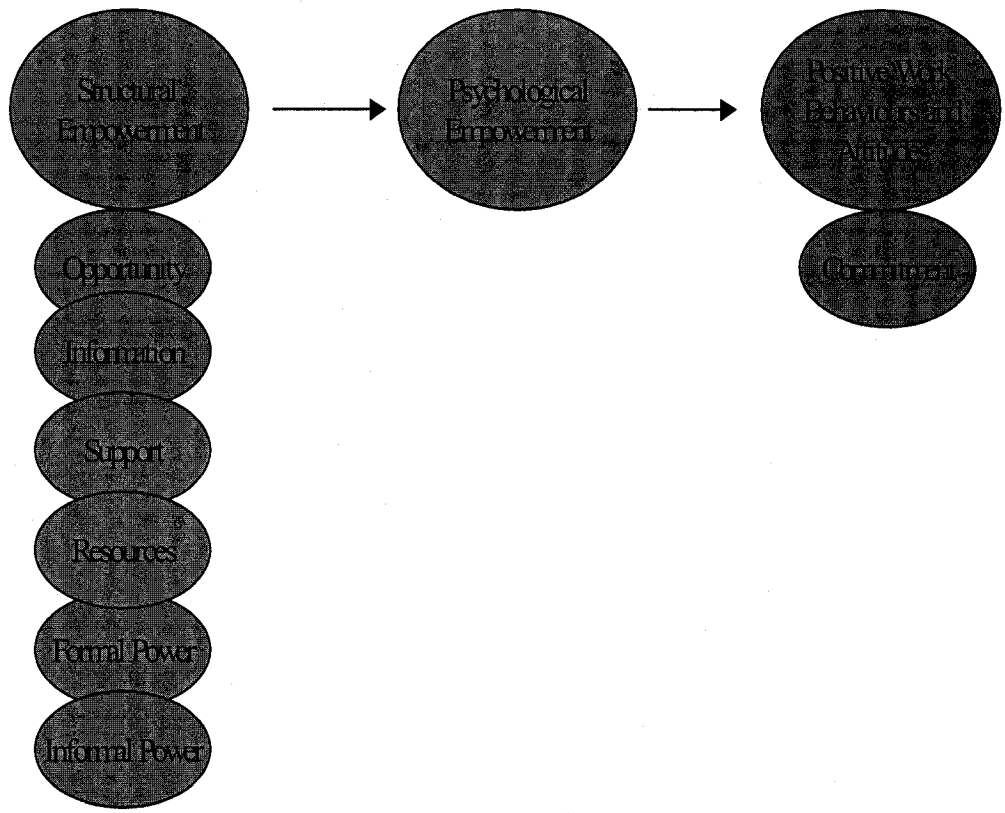
organizational commitment, resistance to change, and personal stress (Kanter).

Kanter and Brown (1982) note an endemic of powerlessness in health care organizations partially caused by the "juxtaposition of two very different sets of organizational goals- the professional and the business objectives" which can result in "complex and conflictual relations between the medical and administrative functions" (p.6). The authors maintain, however, that power dynamics in health care organizations are fundamentally the same as those found in any large organization (Kanter & Brown).

Chandler (1986), interpreting Kanter's theory in a nursing setting, described an individual focus in the nursing literature that failed to address the role of the work environment in the experience of nurses' empowerment. Specifically, she illustrates the tendency of nursing administrators to view nurses exhibiting powerless behaviors as intrinsic personality traits that could be changed if nurses "were socialized to a more professional approach to their work" (p.20). Chandler utilized Kanter's theory to challenge this individual focus. Her original work has provided the basis for a program of research at the University of Western Ontario that is systematically testing the relationship of concepts in Kanter's Structural Theory of Power in Organizations (Laschinger, 1996).

These relationships are depicted in the conceptual model of Kanter's Theoretical Framework provided by Dr. Heather Laschinger (UWO, 2004) in Figure 1.

Figure 1: Conceptual Model



This model demonstrates the relationship between the six measures of structural empowerment to psychological empowerment and positive work behaviours. Structural empowerment is determined by Kanter's six organizational factors (access to information, support, opportunity and resources; informal and formal power). Access to resources refers to the ability to access the money, time, supplies, and resources required to accomplish organizational goals. Access to information refers to the ability to be 'in the know', formally and informally, to have the knowledge of organizational decisions, policies and goals necessary to be effective within the organization. Access to support

refers to feedback and guidance from peers, subordinates and superiors. Support can refer to emotional, professional or technical support. Access to opportunities refers to mobility and growth within the organization, including opportunities to grow and learn (e.g. professional development opportunities, participation on working groups or committees). High levels of formal and informal power facilitate access to these sources of power and opportunity leading to structural empowerment (Kanter, 1979b, Laschinger et al., 2004).

Laschinger's program of research has found that increases in structural empowerment influences employees' feelings of personal empowerment which in turn affects work behaviours and attitudes (Laschinger et al 2001c). For the purpose of this study the outcome of organizational commitment is highlighted in the model as a dependent variable related to structural empowerment.

Organizational commitment and empowerment are the central concepts under review in the current study. The concept of organizational commitment is increasingly identified as an important variable in understanding organizational work behavior (Mowday, Steers & Porter, 1979). Its relationship to nursing retention has received increasing attention in the face of growing shortages (McNeese-Smith, 2001). Conceptual and operational definitions of organizational commitment are varied in the literature, with two basic approaches, behavioral and attitudinal. Behavioral approaches focus on "overt manifestations of commitment", while attitudinal approaches represent a state of identification with the organization and a wish to maintain organizational membership (Mowday et al., p.225).

Mowday et al. (1979) developed an Organizational Commitment Questionnaire to

measure organizational commitment conceptually defined as "the relative strength of an individual's identification with and involvement in a particular organization" (p.226). These authors characterize organizational commitment as an active affiliation, involving three related factors: "(1) a strong belief in and acceptance of the organization's goals and values; (2) a willingness to exert considerable effort on behalf of the organization; and (3) a strong desire to maintain membership in the organization" (p. 226). This version of the OCQ was empirically tested in a nursing population by Wilson and Laschinger (1994) and McDermott et al. (1996).

Allen and Meyer (1996) view organizational commitment as a multidimensional work attitude, a psychological state that characterizes the employee's relationship with the organization and decisions for continued membership. They developed a three component model of commitment, categorizing commitment in three forms: affective, continuance, and normative. Affective commitment is referred to as a person's "identification with, involvement in, and emotional attachment to the organization" (Allen &Meyer, p. 253). These individuals remain with the organization because they want to.

Continuance commitment is defined as "commitment based on the employee's recognition of the costs associated with leaving the organization" (Allen &Meyer, p. 253). Individuals with high continuance commitment stay with the organization because they believe they need to. The third form, normative commitment, is "commitment based on a sense of obligation to the organization" (Allen &Meyer, p. 253). These individuals stay with the organizations because they believe they ought to.

Affective commitment develops as a function of positive or satisfying work experience while normative commitment develops in response to social pressure (e.g. expectations of others and self-presentation concerns). Continuance commitment is a function of a perceived lack of alternatives as well as a perception of significant investments in working with the organization (and therefore high sacrifice in leaving) (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002).

Individuals can experience varying degrees of all three forms of commitment. Each form has different implications for work behavior, with affective and normative commitment positively related to job effectiveness and maintaining organizational membership, whereas continuance commitment is negatively related to these organizational outcomes (Meyer et al., 1993). Affective commitment has been found to have the strongest relationship with employee retention, as well as positive work behaviours such as job satisfaction, involvement and performance.

Conversely, continuance commitment, while still related to employee retention, has been demonstrated to be related to negative or non productive work behaviours such as poor employee engagement, low self esteem and job satisfaction, and low productivity. Nurses who stay in their jobs based on this type of commitment have been found to have higher levels of absenteeism and poor work performance (Laschinger et al., 2000).

Meyer et al. (1993) developed their version of the OCQ to operationally measure affective, continuance, and normative organizational commitment. This model of organizational commitment, and its measures, has undergone the most extensive empirical evaluation to date (Allen & Meyer, 1996). The affective commitment and

continuance commitment subscales of the OCQ were empirically tested in a nursing population by Laschinger et al. (2000) and reported to be reliable by Lachinger et al. (2001a) with alpha co-efficients of .74 for the affective commitment subscale and .75 for the continuance commitment subscale. Meyer et al. (1993) report acceptable reliability for this instrument across numerous studies (range 0.82 to 0. 93).

The conceptual definition provided by Allen and Meyer (1996) has been operationally measured in nursing populations with a reliable instrument, the same instrument which will be used in the current study. Allen and Meyer's conceptual definition of organizational commitment is therefore the most suitable definition for the current study.

Empowerment is another concept for which the literature is replete with varied conceptual and operational definitions (Lewis, 2000). Several concept analyses and definitions are reviewed to illustrate this variation, as well as provide justification for the definition of empowerment chosen for the current study.

Conger (1989) defines empowerment as "the act of strengthening an individual's beliefs in his or her sense of effectiveness...a process of changing the internal beliefs of people" (p.18). This definition is strikingly dissimilar from Kanter's (1993) notion of empowerment as the process of providing structures that allow for control over the conditions that make actions possible. Conceptual definitions of empowerment that focus on changing the beliefs of individuals have little relevance for the current study.

Ellis-Stoll and Popkees-Vawter (1998) and Gibson (1991) utilized the Walker and Avant (1995) method to conduct a concept analysis of empowerment in the nursing

discipline. Ellis-Stoll and Popkees-Vawter provide a conceptual definition of empowerment as "a participatory process through a nurse-client dyad designed to assist in changing unhealthy behaviors" (p.63). Similarly, Gibson defines empowerment as "a process of helping people to assert control over the factors which affect their health" (p.359). These definitions are relational between the nurse and the client and have limited relevance to the current study.

Chandler (1992) provides a useful distinction between the concepts of power and empower. Power is defined as having control, influence or domination over another individual. Conversely, to empower is defined as enabling others to act. Chandler conducted a qualitative study of 56 acute care staff nurses to test the widely held assumption that to empower means to delegate power by sharing control, authority and influence with subordinates. Results of her study suggest that nurses perceived empowerment as "enabling others by increasing resources, capabilities, and effectiveness, and as the ability to act while being recognized, appreciated, and rewarded for such behaviors" (Chandler, p. 70).

Hokanson Hawks (1992) and Rodwell (1996) utilized the Walker and Avant (1988) method to conduct a concept analysis of empowerment in nursing. Hokanson Hawks defines empowerment as "the interpersonal process of providing the resources, tools and environment to develop, build and increase the ability and effectiveness of others to set and reach goals for individual and social ends" (p.610). Rodwell conceptually defines empowerment as "a helping process whereby groups or individuals are enabled to change a situation, given skills, resources, opportunities and authority to do

so...enablement is about changing the nature and distribution of power..." (p.309).

The definitions provided by Chandler (1992), Hokanson Hawks (1992) and Rodwell (1996) are congruent with Kanter's (1993) definition of empowerment and empowering structures as those that provide authority, responsibility, discretion, and autonomous decision making opportunities. As previously noted, Kanter's definition has been operationally measured in numerous studies conducted by the UWO, studies utilizing the same instruments which will be used in the current study. Kanter's conceptual definition of empowerment is therefore the most suitable definition for the current study.

Summary of Chapter

Kanter (1979) proposes that an understanding of what is required to have power, as well as recognition of classic behaviors of the powerless, provides managers with the requisite insight required to understand familiar organizational problems. She has identified that blocked opportunity, powerlessness, and tokenism negatively affect employee aspirations, commitment, leadership abilities, work effectiveness and well-being. Consistent with the CNAC recommendations, she calls on organizations to improve on the quality of employee work lives, not as a matter of "good will" but as a "question of vital social concern" (Kanter, 1993, p. 10).

Kanter's theoretical framework can be used to assess an organization's current structures and identify empowering alternatives. These alternatives involve formal structural changes to organizations, in particular flattening hierarchies and implementing participatory management approaches and autonomous work units. These structures

provide access to information, support, and opportunity for skill development and have particular resonance with shared governance approaches and the goals of the ONS Transformation Strategy.

Kanter's Structural Theory of Power in Organizations has been empirically tested in nursing settings. In particular, the relationship between structural empowerment and organizational commitment has been empirically tested in a nursing setting. This theory is therefore deemed most appropriate as the framework for this study.

Chapter Three: Review of the Literature

Introduction

Kanter's (1993) Theory of Structural Power in Organizations was developed through ethnographic study of a large industrial company. Chandler (1986) was the first to test Kanter's theory in a nursing setting, adapting Kanter's original ethnographic survey items, and establishing the utility of Kanter's theory for nursing. Chandler's original work provided the basis for a program of research, the Workplace Empowerment Program, at the School of Nursing, University of Western Ontario (UWO). Numerous studies from this program have generated significant empirical support for the theory as well as several reliable and valid survey instruments to test the various constructs (Laschinger, 1996).

For the purposes of this study CINHAL and Medline data bases were searched for relevant literature on: shared governance; magnet hospital research; empowerment; and organizational commitment. Searches were limited to recent publications (less than ten years old) with the exception of certain key references. Searches were conducted for all publications authored by Kanter and Chandler, and for all published studies from the UWO Workplace Empowerment research program. Recent nursing administration journals were also hand searched to ensure relevant literature was not inadvertently overlooked. Citations referred to in the reference lists of retrieved articles, as well as those indicated on the UWO webpage, were also retrieved for review. Information regarding the FNIHB Transformation strategy was requested of the Office of Nursing Services, Ottawa.

A review of the literature reveals that staff nurse empowerment scores are moderate, suggesting the need to improve access to the structures of power and opportunity in nursing work environments. Perceptions of workplace empowerment have been found to be predictive of: psychological empowerment (Laschinger, et al., 2001a ; Manojlovich & Laschinger, 2002); work effectiveness (Laschinger & Havens, 1997; Laschinger & Wong, 1999; Laschinger, et al., 1999); participation in organizational decision making (Laschinger, Sabiston & Kutszcher, 1997); organizational trust (Laschinger, Finegan Shamian & Casier, 2000); job autonomy (Sabiston & Laschinger, 1995); control over nursing practice (Laschinger & Havens, 1996); job strain (Almost & Laschinger, 2002); levels of burn out (Hatcher & Laschinger, 1996; Laschinger, et al., 2003a); occupational mental health (Laschinger & Havens, 1997); job satisfaction (Kutzscher, et al., 1997); collaborative behaviors (Almost & Laschinger, 2002); and organizational commitment (McDermott, et al., 1996; Laschinger, et al., 2001b; Laschinger et al., 2000; Wilson & Laschinger, 1994).

These studies illustrate the importance of workplace (structural) empowerment in nursing work environments and provide nursing leaders with a theory based framework to redesign these environments and empower nurses. The majority of studies reviewed were conducted with nurses employed in large acute care settings. No reports were found of studies that examined workplace empowerment specific to FNIHB nursing settings. A review of studies utilizing Kanter's theory in a nursing setting is provided as background for this study, with particular emphasis on studies identifying the relationship between workplace empowerment and organizational outcomes and organizational commitment.

Studies in non-acute settings are specifically reviewed for relevance to the setting of the current study. Finally, studies examining the relationship between work empowerment and work environments (including shared governance approaches) are reviewed.

Related Research on Kanter's Theory

Through her study of Indsco, Kanter (1993) identified three central explanatory variables in "an integrated structural model of human behavior in organizations": the structure of opportunity, the structure of power, and the proportional distribution or relative numbers of people (p. 245-246). Kanter contends that the vast amount of individual behaviors in an organization is related to these variables and that a number of empirically verifiable hypotheses can be derived and tested from her Theory of Structural Power in Organizations.

The first published study utilizing Kanter's theory to test empowerment in nursing was published by Chandler in 1986. Chandler surveyed 286 nurses in two acute-care community hospitals to examine the perceptions of study nurses of the influence of working environments on their personal practice power. Chandler reported a lack of perceived positional power by nurses in her study and was the first to link this lack of power to the structure of nurses' work environments. Chandler's study provided the basis for a program of research in the Faculty of Nursing at the University of Western Ontario (UWO) (Laschinger, 1996).

The Workplace Empowerment Research program was established in 1992 with Dr. Heather Laschinger as the Principal Investigator. This program is designed to "systematically test hypotheses derived from Kanter's theory in the nursing population"

(Laschinger, 1996, p.30). Studies conducted through the UWO have resulted in the development and/or refinement of three valid and reliable instruments for measuring workplace empowerment: the Conditions of Work Effectiveness scale (CWEQ); the Job Activities Scale (JAS); and the Organizational Relationships Scale (ORS). These instruments will be briefly described to facilitate ease of review.

The CWEQ is a 31 item instrument that measures nurses' perceptions of their access to the four work empowerment structures described by Kanter: opportunity; information; support; and resources. Items on this instrument were derived from Kanter's original ethnographic study and modified by Chandler (1986) and a team of nursing experts to fit a nursing population. The survey questions respondents on how they experience working conditions which relate to power derived from access to information, support, supplies, decision-making, critical job activities, and opportunity (Chandler).

Chandler (1986) conducted extensive psychometric analysis of the CWEQ and empirically validated three of the five original factors: support; information; and opportunity. Supplies and job activities were considered unreliable. Chandler reported the alpha reliability coefficients for the reliable factors as: support (.88); information (.81); and opportunity (.76). Laschinger and a panel of nursing experts modified the resources subscale and provided further face and content validity to the instrument (Laschinger, 1996). The four subscales (range 1-5) are summed and averaged and then summed to provide an overall empowerment score ranging from 4 to 20, with higher scores representing strong access to opportunity and power structures in the organization (Laschinger). In 1995 the UWO research program added a global measure of

empowerment (GE) to the questionnaire as a validation index (UWO, 2004).

The UWO research program, based on a review of initial studies, felt it was necessary to add two additional constructs as a test of Kanter's theory, measures of formal and informal power (Laschinger, 1996). The Job Activities Scale (JAS) is a nine item scale that measures staff nurses' perception of formal power in the work environment. The instrument is based on Kanter's descriptions of formal power characteristics: recognition; relevance; and discretion. Item 5 is reverse scored and items are summed and averaged to yield a score ranging from 1-5. High scores represent positional (formal) power. Content and face validity for this scale was established by a panel of nursing experts (Laschinger).

The ORS is an 18 item scale which measures staff nurses' perceptions of informal power within the work environment as described by Kanter (1993). Items measure perceptions of political alliances, sponsor support, peer networking, and relationships in the workplace. Face and content validity for the ORS was established through pilot testing of the instrument with registered nurses (Sabiston & Laschinger, 1995). Items from the ORS are summed and averaged to yield a score ranging from 1-5, with high scores representing high informal power (Laschinger, 1996).

Laschinger, Finegan, Shamian and Wilk (2001c) modified these instruments and developed the CWEQ II which consists of 19 items measuring the 6 components of structural power as described by Kanter (opportunity, information, support, resources, informal power, and formal power). Initial studies utilizing the CWEQ-II report a structural empowerment scale for the four structural of power (access to opportunity,

information, support, and resources, range 4-20) and separate scores for formal power (JAS-II, range 1-5) and informal power (ORS-II, range 1-5).

Later studies create a total empowerment score by summing and averaging each of the subscales to provide a score ranging from 1 to 5. These subscale scores are then summed to provide a score ranging from 6 to 30. The authors report acceptable alpha reliabilities for the revised scales, with a Cronbach's reliability co-efficient of .82 reported for the CWEQ II. The CWEQ II also correlated highly with the global measurement of empowerment (r = 0.56) (Laschinger et al. 2001c).

Work Empowerment and Organizational Outcomes. The first published study from the UWO Ontario found for this review was authored by Laschinger and Shamian in 1994. This study tested the relationship of staff nurses' and nurse managers' perceptions of job-related empowerment and managerial self-efficacy. The results of this study provide support to Kanter's theory through findings related to differential perceptions of power between staff nurses and managers. A descriptive survey design was employed using a proportionate random sampling frame of 200 acute care nurses and a convenience sample of all willing first line managers (n=44). The final sample was comprised of 112 staff nurses (53%) and 27 nurse managers (79%). Staff nurses in this study had moderate levels of empowerment (M = 11.65, SD 2.21) as measured by the CWEQ, suggesting they perceived they had moderate amounts of access to information, support, supplies and opportunity in their work environments (Laschinger & Shamian).

As hypothesized, managers perceived greater access to these empowering structures, with a mean of 14.65 (SD 1.40). Managerial access to the structures of power

and opportunity were significantly related to their perceptions of managerial self-efficacy ($r = 0.79$, $p < .001$). Staff nurses' perceptions of their own job-related empowerment was also significantly related to their perceptions of their immediate managers' power ($r = 0.77$, $p < .001$). This finding provides support for Kanter's theory that powerful managers have the ability to empower others. No significant relationships were found between study variables and demographic information (Laschinger & Shamian, 1994).

Sabiston and Laschinger (1995) employed Kanter's theoretical framework to study the relationship between staff nurses' perceptions of job-related empowerment and autonomy (control over one's work). This descriptive correlational study was conducted with a stratified, proportionate random sample of 103 nurses (60.6% response rate) from a large urban acute care teaching hospital. Nurses in this study perceived a moderate degree of empowerment as measured by the CWEQ ($M = 11.20$, SD 1.90). This study was the first study to test the ORS and JAS instruments. Study nurses perceived greater access to the informal sources of power (measured by the ORS) than the formal sources (measured by the JAS) (Sabiston & Laschinger).

Study nurses perceived their immediate supervisors to have moderate degrees of power measured by the Organizational Description Opinionnaire (ODO). The ODO is an 11 item scale measuring employee's perceptions of the immediate supervisor's power in the organization. Alpha reliability for the ODO in this study was reported as 0.89. Finally, the nurse's perceived moderately high degrees of autonomy as measured by the Job Description Questionnaire (JDQ). The JDQ is a 10 item scale which measures perceptions of autonomy, defined as control over work. Alpha coefficients for the JDQ

for this study were reported to be 0.85 (Sabiston & Laschinger, 1995).

As hypothesized by Sabiston and Laschinger (1995) nurses' perceptions of job related empowerment demonstrated a significant positive relationship with perceptions of autonomy ($r = 0.52$, $p = 0.001$). Results of this study therefore "lend support to Kanter's proposition that those who have access to the sources of job related empowerment have control over their work" (p. 47). The second hypothesis of this study was focused on testing the relationships between formal and informal power and perceived access to job-related empowerment. Data analysis (multiple regression) revealed that 48 % of the variance of job –related empowerment was explained by measures of formal and informal power. These findings were an important contribution to the literature as they provided empirical support to Kanter's contention that formal and informal power influences perceptions of access to the sources of job-related empowerment (Sabiston & Laschinger).

Sabiston and Laschinger (1995) also found a positive relationship between individuals nurses' perceptions of workplace empowerment and perceptions of immediate manager's power in the organization ($r = 0.46$, $p < .001$), providing further support for Kanter's contention that powerful managers empower their staff. Similar to other studies, there were few significant relationships between demographic variables and the CWEQ. A weak but significant relationship was noted between years of experience and job-related empowerment ($r = 0.26$, $p = 0.03$), and the support subscale ($r = 0.24$, $p = 0.05$). The authors postulate that perceptions of empowerment may evolve from experience (Sabiston & Laschinger).

The studies conducted by Laschinger and Shamian (1994), and Sabiston and Laschinger (1995) were limited methodologically by the use of one study site. Results, therefore, cannot be generalized to nurses employed outside of these two institutions.

Laschinger and Havens (1996) used Kanter's Theory of Structural Power to test the relationships between staff nurses' perception of work empowerment and control over practice, work satisfaction and work effectiveness. This study employed a descriptive correlational design with 127 randomly selected nurses (33% response rate) from two urban teaching hospitals in the southwestern United States. The CWEQ, JAS and ORS were used to measure work empowerment, formal power, and informal power, respectively. Gerber's Control over Nursing Practice Questionnaire was used to measure nursing work autonomy, operationally defined as control over issues within the nurse's scope of practice. Bass's Multifactor Leadership Questionnaire was used to provide global measures of job satisfaction and work effectiveness. The authors state alpha reliability coefficients for the study instruments were acceptable with scores ranging from 0.76 to 0.95 (Laschinger & Havens).

Empowerment scores for this group of American nurses were similar to those found in Canadian studies (M=11.00, SD 2.58). Nurses in this study perceived the greatest access to opportunity (M = 3.10, SD 0.79) and the lowest access to resources (M = 2.39, SD 0.66). Perceived formal (M = 2.90, SD 0.54) and informal power (M= 2.93, SD 0.69) were moderate as was perceived control over practice (M = 4.46, SD 1.13). Nurses in this study were only somewhat satisfied with their jobs (M = 3.69 on a 7 point scale, SD 1.61) (Laschinger & Havens, 1996).

Correlations among the study variables demonstrated a strong positive relationship between perceived work empowerment and perceptions of control over practice ($r = 0.625$, $p < .001$). Similar to Sabiston and Laschinger (1995), this finding supports Kanter's contention that access to empowering structures enables workers to exercise control over their work. This study also found strong positive correlations between work empowerment and work satisfaction ($r = 0.656$, $p < .001$) and perceived work effectiveness ($r = 0.566$, $p < .001$) (Laschinger & Havens, 1996).

Hatcher and Laschinger (1996) studied 87 Ontario hospital nurses (59% response rate) in a descriptive correlational design testing the relationship between perceptions of work empowerment and level of burnout. Consistent with previous studies, the authors found moderately low perceptions of work empowerment (measured by the CWEQ) among study nurses ($M = 10.66$, SD 2.22). The authors noted significant correlations between work empowerment and three aspects of burnout: level of emotional exhaustion and depersonalization ($r = -.3419$, $p = .004$; $r = -.2931$, $p = .02$) and personal accomplishments ($r = .3630$, $p = .002$) (Hatcher & Laschinger).

Laschinger et al. (2003a), employed a longitudinal design with a matched random sample of 192 Ontario staff nurses (73% response rate) in a model linking the effects of structural and psychological empowerment at one point in time with reports of burnout three years later. Findings demonstrated that access to workplace empowerment structures resulted in increased psychological empowerment ($r = .435$) at Time 1 and that these feelings of empowerment were predictive of reported burnout levels at Time 2 ($R^2 = .107$). These results further support the previous cross-sectional research conducted by

Hatcher and Laschinger (1996) and add substantively to the body of empirical knowledge supporting the application of Kanter's theory in nursing work environments.

Sarmiento et al. (2004) tested a theoretical model specifying relationships among structural empowerment, burnout, and work satisfaction with a sample of 89 Canadian full time college nurse educators (61% response rate). This study employed a descriptive correlational design and the CWEQ as a measure of empowerment. The authors found moderate levels of empowerment, burnout, and job satisfaction. Consistent with the findings of Hatcher and Laschinger (1996), Sarmiento et al. (2004) found significant correlations between perceptions of work empowerment and three aspects of burnout: emotional exhaustion ($r = -0.50$, $p = 0.01$) depersonalization ($r = -.41$, , $p = 0.01$) and personal accomplishment ($r = 0.42$, $p = 0.01$). Low levels of emotional exhaustion and high levels of empowerment explained 60 % of the variance in perceptions of job satisfaction, with empowerment the strongest predictor ($\beta = 0.49$) (Sarmiento et al., 2004). This study provides further support for the applicability of Kanter's theory across settings, in particular a non-acute care nursing setting.

Further support to Kanter's contention that power increases as one rises in the hierarchy was provided by Goddard and Laschinger (1997), in their Canadian study examining differences in the perceptions of work empowerment between first line and middle management positions. Ninety one nurse managers (convenience sample) from three acute care urban hospitals completed the CWEQ and ODO-A and ODO-B (response rate 82%). The ODO-A is a 17 item scale that measures structural characteristics that, according to Kanter's theory, contribute to or detract from power. The ODO-B (currently

referred to as the Manager's Activities Scale) measures a manager's power as perceived by staff nurses of their managers, or by managers of their own power (Haugh & Laschinger, 1996). Consistent with Kanter's theory, middle managers had significantly greater overall work empowerment scores than first line managers (M= 14.66, SD 2.32 and M=12.82, SD 1.77 respectively). Of note is the finding that empowerment scores for both levels of manager were higher than those found in previous studies of staff nurses, again supporting Kanter's contention that access to power and opportunity increases the higher one is formally situated in the hierarchy (Goddard & Laschinger).

Laschinger and Havens (1997) utilized Kanter's theoretical framework to study the effect of staff nurses' perceptions of work empowerment on perceived occupational mental health and work effectiveness. The sample for this descriptive correlational design consisted of 62 randomly selected staff nurses (44% response rate) working in acute care urban hospitals in North Carolina. This study was designed to test the competing hypothesis that a pre-dispositional need for work achievement would have a moderating effect on the relationship between perceived work empowerment and occupational health (Laschinger & Havens).Nurses in this study had moderate empowerment scores as measured by the CWEQ (M= 11.39, SD 2.26). Scores for perceived formal power, measured by the JAS, were low (M = 2.85, SD .57) and scores for perceived informal power, measured by the ORS, were moderate (M= 3.17, SD .64). This finding supports previous research that staff nurses perceive greater informal than formal power (Sabiston & Laschinger, 1995).

Laschinger and Havens (1997) found that study nurses reported moderate levels of

job tension (M=3.18, SD .63) and high pre-dispositional needs for achievement (M= 6.52 on a seven-point scale, SD .50). They also rated their own and their organization's effectiveness highly (M=5.17 on a seven-point scale, SD 1.14). Perceived work empowerment was strongly negatively related to perceptions of job tension or occupational mental health ($r = -0.69$, $p < .001$). This finding supports Kanter's contention that a lack of access to empowering structures leads to employee disempowerment and stress. Notably, a pre-dispositional need for work achievement did not moderate the relationship between perceived work empowerment and job tension, or occupational mental health. This finding is an important contribution to the literature as it lends empirical support for Kanter's contention that organizational variables, not personality factors, influence work behaviors and attitudes (Laschinger & Havens).

The influence of organizational variables on work behavior was further supported in a study conducted by Manojlovich and Laschinger (2002) whereby the personal attributes of need for mastery and achievement were studied for their impact on job satisfaction. This study found that structural empowerment explained 29.5% of the variance in job satisfaction. Structural and psychological empowerment predicted 38% of the variance in job satisfaction. Neither mastery nor achievement needs were predictive of job satisfaction (Manojlovich & Laschinger).

Laschinger, et al. (2001a) expanded Kanter's Theory by demonstrating that psychological empowerment is an outcome of structural empowerment. A predictive non-experimental design was used with a sample of 404 randomly selected acute care nurses (73% response rate). The rationale for this study was to build on earlier studies from the

UWO Workplace Empowerment Research Program which had provided significant empirical support for the role of structural empowerment in organizations. Structural empowerment, however, describes the conditions of the work environment and not the employee's response to these conditions (Laschinger et al.). This study hypothesized "that structural empowerment would have a direct positive effect on psychological empowerment which, in turn, would have a direct positive effect on work satisfaction" (Laschinger et al., 2001a, p. 46). Job strain was also studied as a mediator between psychological empowerment and job satisfaction. Structural empowerment was measured by the CWEQ II, with study nurses perceiving moderate amounts of structural empowerment (access to opportunity, information, support, and resources) (M= 11.38, SD 2.28). A total empowerment score that sums all six subscales is not provided in this study.

As predicted by the study hypotheses, structural empowerment had a direct, positive effect on psychological empowerment (β =.46). Psychological empowerment had a strong negative effect on job strain (β = -.45) and a direct positive effect on job satisfaction (β = .30). A strong direct effect of structural empowerment on job satisfaction was also demonstrated (β = .38). An intriguing finding was that once the effects of psychological empowerment were accounted for, job strain was not a factor in predicting work satisfaction. This finding suggests that increasing employee access to empowerment structures can ameliorate job strain (Laschinger et al., 2001a).

Further tests of this expanded model were conducted by Kluska, Laschinger and Kerr (2004) in their study on hospital staff nurses' empowerment and effort-reward

balance. This descriptive correlational study of 112 respondents (58% response rate) found that structural empowerment had a significant direct effect on psychological empowerment (β=.46). Empowerment for this group of nurses was moderate (M=18.48, SD 3.00). This study is one of few published studies that provide a total empowerment score as the average and sum of the six subscales. Kluska et al. provide a Cronbach Alpha reliability of .84 for this scale. Means and standard deviations are also provided for the six subscales and are as follows: opportunity (M=4.14, SD 0.69); information (M=2.74, SD 0.91); support (M= 2.68, SD 0.92); resources (M=2.91, SD .81); formal power (M=2.56, SD .83); informal power (M= 3.47, SD .73).

Further research on the relationship between structural empowerment, psychological empowerment and work outcomes was conducted by Laschinger et al.(2004) in their study of the predictors of nurse managers' health. A descriptive correlational design was used in a sample of 202 first line and 84 mid-level hospital nurse managers (response rate reported as 62%). The purpose of this study was to test the relationship between nurse managers perceptions of structural empowerment (as theoretically defined by Kanter) and psychological empowerment to burnout, job satisfaction and physical and mental health. Structural empowerment was found to be the strongest predictor of job satisfaction (β=.53). This is another published study that provides a total empowerment score as the average and sum of the six subscales on the CWEQ II. Laschinger et al. provide a Cronbach Alpha reliability of .87 for this scale.

In summary, numerous studies have demonstrated the relationship between structural empowerment and organizational outcomes in nursing populations. Nurses in

these studies consistently report moderate empowerment scores. These studies have utilized Kanter's Theoretical framework and valid and reliable instruments. Descriptive correlational designs, and non-random samples, and small convenience samples limit the ability to generalize individual study findings to other settings. Small sample sizes and low response rates (<70%) are limitations of several of the studies reviewed. Consistent findings across studies mitigates this limitation to some extent.

Workplace Empowerment and Organizational Commitment. Several nursing studies from this program of research have provided evidence of the correlation between workplace empowerment and organizational commitment. Wilson and Laschinger (1994) provided the first test in a nursing population of the relationship between perceived job empowerment and organizational commitment, utilizing Kanter's Theory of Structural Power. Data were collected from 161 acute care staff nurses (57% response rate) using the Organizational Description Questionnaire (ODQ), Organizational Commitment Questionnaire (OCQ), and the CWEQ.

The authors define organizational commitment as "the strength of an individual's identification and involvement in an organization" (Wilson & Laschinger, 1994, p.42). The authors put forth that organizational commitment is an active affiliation with the organization, consisting of at least three factors: "a strong belief in and acceptance of the goals and values inherent in the culture of the organization; a willingness to exert considerable effort on behalf of the organization; and a strong desire to maintain organizational membership" (Wilson &Laschinger Wilson, p.42).

Organizational commitment was operationalized by Wilson and Laschinger

(1994) through scores on the OCQ (Mowday, et al., 1979). The OCQ consists of 15 items measured on a 7 point Likert scale. Item scores are averaged, with 'higher' mean scores equating to greater organizational commitment (range not reported). The authors report that nurses from this study (of which two thirds were critical care nurses) perceived themselves to be moderately empowered (M= 12.25) and reported moderate commitment (M= 4.41). The authors report strong positive correlations (r = 0.65-0.77) between all of the variables measured by the CWEQ and organizational commitment. Overall feelings of empowerment had the strongest association with organizational commitment (r = 0.77, p <.001), followed by information (0.74), support (0.72), opportunity (0.72) and resources (0.66) (Wilson & Laschinger). Findings from this study are consistent with Kanter's theory that perceptions of power and opportunity affect commitment to the organization.

A replication study of Wilson and Laschinger's (1994) original study was conducted by McDermott et al. (1996). This study utilized the same instruments with a sample of 112 acute care staff nurses from a 450-bed acute care teaching hospital in south central Ontario. A limitation of this study is that it does not describe the method of sampling for the study nurses. McDermott et al. found a significant positive correlation between nurses' perceptions of job-related empowerment and organizational commitment (r = .53; p = .001). Nurses in this study perceived themselves to have moderate workplace empowerment (M=11.65, SD 2.20), but unlike the nurses in the study conducted by Wilson and Laschinger, the most significant relationship was between the structure of opportunity and organizational commitment (r = .51, p = .001) (McDermott et al).

McDermott et al. (1996) found a significant and strong positive correlation between staff nurses' perceptions of empowerment and their perceptions of their manager's power ($r = .61$; $p < .001$). The strongest relationship was found between access to support and perceived managerial power ($r = .51$, $p < .001$), highlighting the importance of management support to staff empowerment. The authors describe a post hoc analysis of the study data that showed a "weak but significant positive relationship between perceived managerial support and organizational commitment" (McDermott et al., p. 46). There is no data provided to support this statement. McDermott et al. report similar findings to Wilson and Laschinger (1994) in regard to the relationship of age, years of nursing experience, and job-related empowerment. The authors' state that this study found that as the age and experience of nurses increased so did empowerment scores. There are no data presented to support this statement.

Laschinger et al. (2000) employed a predictive non-experimental design to test Kanter's theory in a random sample of 412 Canadian staff nurses (73% response rate). The purpose of this study was to test a model that hypothesized a direct effect of empowerment on trust and a mediating effect of trust on organizational commitment-empowered employees would have higher levels of trust, which in turn would enhance affective commitment. The relationship of empowerment to continuance commitment was also tested as a competitive test of Kanter's theory-empowerment was expected to have no direct effect on continuance commitment and the relationship between trust and continuance commitment (if any) was predicted to be weak and negative (Laschinger et al. 2000).

Several definitions of organizational trust were provided in this study. Operationally, trust was measured utilizing a 12 item instrument, The Interpersonal Trust at Work Scale, which was reported to measure "faith in the intentions of and confidence in actions of peers and managers" (Laschinger et al., 2000, p. 419). This instrument was developed by Cook and Wall (1980) and cited in Laschinger et al. 2000. For the purposes of their study, Laschinger et al. defined organizational commitment, as described by Allen and Meyer (1996) as affective, continuance, or normative commitment and operationally measured affective and continuance commitment with the OCQ developed by Meyer et al. (1993). This instrument consists of three subscales with six Likert items each which are summed and averaged to provide possible scores ranging from one (low commitment) to seven (high commitment) per subscale. In this study two of the three subscales were used to measure affective and continuance commitment. Reliability coefficients for this measure were not provided in the report of the study.

Workplace empowerment in this study was measured with the CWEQ-II. Similar to previous studies, this study found nurses structural empowerment scores on the four subscales to be moderate (M = 11.00, SD 2.28). Mean formal power scores were 2.57 (SD 0.68) and informal power scores were 3.46 (SD 0.69). Nurses in this study also reported higher confidence and trust in their peers than in management, and higher continuance commitment than affective commitment. Continuance commitment was rated as 4.42 (SD 1.25) and affective commitment was rated as 3.75 (SD 1.18). In terms of testing the causal links in the study's proposed model, empowerment had a direct effect on affective commitment (β= 0.31) and was not predictive of continuance

commitment. Empowerment was strongly associated with trust (β= 0.51) and trust in management had a significant positive effect on affective commitment (β = 0.29). In addition affective commitment was significantly related to all six measures of empowerment, with the strongest relationship to support (β= 0.37). None of the variables in the model were significantly related to demographic variables (Laschinger et al., 2000).

Further tests of this model were published by Laschinger, et al., (2001a). Utilizing data from the original study, Laschinger et al. conducted a secondary data analysis and provided alpha co-efficients for the OCQ as .74 for the affective commitment subscale and .75 for the continuance commitment subscale.

Finegan and Laschinger (2001) further conducted a gender analysis on the study conducted by Laschinger et al. (2000). As noted this sample consisted of 412 nurses randomly selected from the College of Ontario Nursing Registry, 195 men and 217 women. Independent t-tests on all variables did not show significant differences in gender responses. Results from this analysis demonstrate the generalizability of Kanter's framework to both men and women in nursing settings.

Laschinger et al. (2001b) examined the relationship between job strain in nursing work environments and staff nurses' perceptions of structural and psychological empowerment, work satisfaction, and organizational commitment. Meyers and Allen's affective commitment scale was the instrument used to measure commitment in this study. Measures of normative and continuance commitment were not employed. This sample of 404 hospital staff nurses found that nurses in high strain jobs (high levels of psychological work stress) had lower affective commitment scores than those with lower

levels of job strain (M=3.45, SD 1.22, vs M=3.91, SD 1.12, t =3.49, df = 349, p<.001). Laschinger et al. provide a Cronbach alpha reliability of 0.74 for the affective commitment scale in this study. A full description of findings for this study are provided under the heading of work empowerment and work environments.

The results of the proceeding studies provide further empirical support for Kanter's Theoretical framework and the role of organizations, not individual characteristics, in the creation of workplace empowerment. Empirical support is provided for the relationship between workplace empowerment and organizational commitment in nursing settings. Descriptive correlational designs, and non-random samples, limit the ability to generalize individual study findings to other settings.

Studies in Non-Acute Settings. As previously stated, there have been no tests of Kanter's theory in FNIHB settings. The majority of studies undertaken by the UWO have been conducted within acute care facilities. The notable exceptions are the following studies by Almost and Laschinger (2002) and Haugh and Laschinger (1996).

Haugh and Laschinger (1996) tested Kanter's Structural Theory of Power on comparative perceptions of power between public health nurses (PHNs) and public health managers. This study employed an exploratory comparative survey with a convenience sample of 46 PHN's and 10 nurse managers from three health units in Ontario. The overall sample return rate is reported as 52.2%. Similar to the current study, nurses in this study were experiencing significant program transitions, from a client centered focus to a population based, multidisciplinary delivery system (Haugh & Laschinger).

Survey instruments included the CWEQ and the Organizational Description

Opinionnaire, Part A and Part B (ODO-A and ODO-B). Data analysis revealed moderate empowerment scores for both PHNs (M = 11. 7, SD 2.08) and public health managers (M = 13.71, SD 2.28). This finding further supports Kanter's contention that power increases as one rises in organizational hierarchies. Study staff nurses' perceptions of their own power (measured by the CWEQ) were significantly related to their perceptions of their manager's power (as measured by the ODO-B) ($r = .5252$, $p < .01$), supporting Kanter's contention that powerful managers empower their staff (Haugh & Laschinger, 1996).

Of particular interest was the finding that managers in this study perceived staff to be more significantly empowered then staff nurses' perceived themselves to be (managers rated staff with a mean empowerment score of 13.24, staff self-rated with a mean of 11.77). This finding suggests that empowering strategies were either not in effect or not effective (Haugh & Laschinger, 1996). Also of note, and particularly relevant to the current study, is the finding of moderate empowerment scores within the public health setting, a relatively autonomous practice area (Haugh & Laschinger). These scores are consistent with those rated by nurses in acute care settings.

Almost and Laschinger (2002) examined perceptions of workplace empowerment, collaboration with physicians and managers, and job strain with 63 acute care Nurse Practitioners (ACNP) and 54 primary care Nurse Practitioners (PCNP) from central Ontario, metro Toronto, and southwestern Ontario (68.8% response rate). Results of this study provide support for the proposition that nurse practitioners' perceptions of workplace empowerment impact collaborative work behaviors and levels of job strain. This study utilized the CWEQ instrument to measure perceptions of workplace

empowerment. The Job Activities Scale (JAS) and Organizational Relationship Scale (ORS) provided measures of perceptions of formal and informal power. The Collaborative Behavior Scale- Part A and B was used to measure NP's collaborative interactions with physicians and managers. The Job Content Questionnaire was utilized to measure two components of job strain: psychological demands and decision latitude for a job strain index ranging from 0 (best) to 100 (worst) (Almost & Laschinger).

The NPs in this study perceived themselves to be moderately empowered with mean empowerment scores of 12.89 (ACNP) and 14.71 (PCNP) (range 4-20). Almost and Laschinger (2002) report these empowerment scores to be higher than those reported in studies of staff nurses. In addition they report the job strain levels of the NP's (17.72 ACNP and 11.39 PCNP (range 0-100)) as lower than those reported for both staff and critical care nurses. Collaboration with physicians was reported as moderately high (4.20 ACNP and 4.26 PCNP (range 1-5)) and collaboration with managers as moderate (3.51 ACNP and 4.03 PCNP (range 1-5)) (Almost & Laschinger)

As hypothesized by the authors the combined effect of workplace empowerment and collaborative behaviors explained 43% of the variance in job strain for the ACNP group and 20 % of the variance in job strain for the PCNP group. Utilizing correlation analysis the authors report that workplace empowerment is positively related to collaboration with physicians (ACNP, $r = .42$, $p < .001$; PCNP, $r = .44$, $p < .001$) and managers (ACNP, $r = .44$, $p < .001$; PCNP, $r = .44$, $p = .001$) and negatively related to job strain (ACNP, $r = -.69$, $p < .001$; PCNP, $r = -.37$, $p = .003$). Supporting the second hypotheses, PCNPs had significantly higher perceptions of workplace empowerment

(ACNP, M=12.89; PCNP, M=14.71, t=4.30, p<.001) than ACNPs. The authors identify the community based settings of PCNPs as providing more job flexibility, visibility and relevance; as such these findings are consistent with Kanter's (1993) theory (Almost & Laschinger, 2002).

These studies are limited due to small convenience samples, non-random samples and descriptive designs. The study by Haugh and Laschinger also noted a low response rate. These studies do provide an important contribution to the literature- lending empirical support for Kanter's theory in non-acute autonomous settings, however they lack generalizability to other non-acute settings.

Work Empowerment and Work Environments. Kutzscher et al. (1997) conducted a study testing Kanter's contention that work teams are a strategy for sharing opportunity and power and increasing work effectiveness. This study employed a non-equivalent comparison group, post-test only design, to survey 355 multidisciplinary hospital staff (64% response rate) who did and did not participate in multidisciplinary accreditation preparation work teams. Consistent with Kanter's theory individuals in work teams had higher perceptions of work empowerment than those who did not participate in a work team [t (353) 5.05, p < .001]. Although this study is limited in its design (lack of pretest to establish pre-intervention scores), findings provide empirical support for the development of work teams as an effective management strategy (Kutzcher et al.).

Laschinger et al. (1997) further extrapolate from these findings and state that structuring work environments according to Kanter's theory would be consistent with participative management philosophies, such as shared governance models (Porter-

O'Grady, 1991). Laschinger et al. conducted secondary analysis on two studies linking structural empowerment and staff nurse decisional involvement. Their findings demonstrated that Kanter's model of work empowerment had a strong direct effect on autonomy. The model explained 80.5% of the variance in staff nurses' perceived control over the context of their practice and 74.2 % of the variance in perceived control over the content of their practice. Formal power in this study was found to influence access to empowerment structures both directly and indirectly through informal power. The results of this study provide further empirical support for the need to create organizational structures that increase access to the sources of work related empowerment and empower nurses to be actively involved in decisions affecting both the content and context of their practice (Laschinger et al.).

Laschinger et al. (1999) tested Kanter's theory in a study that explored the effects of empowering leader behavior on staff nurse empowerment, job tension and work effectiveness. Proportionate random samples of 606 nurses employed at two hospitals undergoing a merger were surveyed to determine whether leader behaviors impacted employee perceptions of work empowerment. Five hundred and thirty seven usable questionnaires were returned, representing a response rare of 71%. This study found that staff perceptions of overall workplace empowerment were significantly related to leader-empowering behaviors ($r = 0.61$). The results support the importance of strong leadership during times of organizational change (Laschinger et al., 1999).

Laschinger and Wong (1999) further examined the relationship between accountability and nurses' perceptions of empowerment from Kanter's perspective. The

authors describe the link between accountability for practice (as an important aspect of participative management approaches) and shared governance models. This study employed cross-sectional correlational survey design with 672 randomly selected acute care nurses. Five hundred and thirty nine usable questionnaires were returned for a response rate of 71%. Results of this study demonstrated that higher perceived access to empowerment structures was associated with higher collective accountability and increased productivity (work effectiveness) (R^2= .19, and .20, respectively). These findings provide empirical support for the importance of creating work environments that provide access to empowering work structures as a strategy to increase nurses' accountability and work effectiveness (Laschinger & Wong).

Laschinger, et al., (2001b) provide further support in their study which tested the relationships between job strain, structural and psychological empowerment, work satisfaction, and organizational commitment. This study employed a predictive non-experimental design with 404 (72% response rate) randomly selected staff nurses employed in urban tertiary hospitals. Structural empowerment scores for this study group were moderate (M= 10.5, SD 1.99). The study found that the majority of nurses rated their jobs within a high strain category (36.8%) which was operationally defined as high psychological demands and low decision latitude. Nurses in this category were significantly less empowered, less satisfied with their jobs, and less committed to the organization. However, nurses with high psychosocial demands but high degrees of control (referred to as active jobs) had higher perceptions of psychological and structural empowerment (Laschinger et al.).

This finding demonstrates the moderating impact of decision latitude on psychological demands. Decision latitude is referred to by the authors as "the extent to which a worker has control over the nature of the job and how it is done" (Laschinger et al., 2001b, p. 240). Organizational strategies designed to increase decision latitude include participatory management practices and shared governance models (Porter O'Grady, 1991). These findings provide empirical support for the importance of increasing nursing involvement in decisions and control over practice in positions of high psychological demand. This has particular meaning for the current study as FNIHB nurses practice in highly complex environments with significant psychological demands.

Laschinger, Almost and Tuer-Hodes (2003b) conducted a secondary analyses of data from 3 studies conduced by the UWO Workplace Empowerment Research Program (Almost & Laschinger, 2002, Laschinger et al, 2001c, Tuer-Hodes, 2000).Two of the studies have been reviewed in this literature review, the third study by Tuer-Hodes is an unpublished master's thesis and has not been reviewed by the writer. The purpose of this secondary analysis was to test the relationship between workplace empowerment and magnet hospital characteristics (perceptions of autonomy, control over practice, and collaboration with physicians). A further test of the data was conducted to examine the relationship between high levels of empowerment and magnet hospital characteristics to nurses' job satisfaction. This secondary analysis found that all empowerment structures influenced perceptions of magnet hospital characteristics (average $R^2 = 0.41$). Access to resources and support had the greatest impact on control over practice and autonomy and informal power had the strongest impact on collaborative nurse/physician relationships.

The study provides empirical evidence of the link between structural empowerment and magnet hospital characteristics and lends support for the implementation of strategies derived from Kanters' theory in the creation of work environments that "foster professional nursing practice and promote job satisfaction and commitment among staff nurses" (Laschinger et al., 2003b, pg. 419).

The above studies provide empirical support for the link between Kanter's model and shared governance approaches. Structures created to increase opportunity and power, as defined by Kanter's Theory, increase accountability and control over the context and content of nurses' practice, factors integral to shared governance approaches (Porter O'Grady, 1991).

Further support for the link between Kanter's model and shared governance approaches was found by Erikson, Hamilton, Jones and Ditomassi (2003) in their three year study comparing empowerment and power scores for both members and nonmembers of collaborative governance structures. This study employed the CWEQ, the ORS, and the JAS and measured empowerment in 657 staff over a three and a half year period. Baseline scores were collected on staff participating in a professional practice model framework that employed a collaborative governance structure. The structure was comprised of five interdisciplinary and three nursing committees. The intent of this structure was to "empower professionals to control their own practice" (Erikson et al., p. 98).

This study compared empowerment scores between the baseline and at 2 year and 3 year intervals. Data was compared between the collaborative group members over the

three year period while the second comparison was between collaborative governance committees members and non-members at 1 and 2 years after implementation. Response rates from collaborative members ranged from 54-68%, while non member response rates ranged from 28-39%. Results of this study demonstrated significantly higher mean empowerment scores at the second measurement time for members of the shared governance committees as compared to non-members ($p<.01$) (Erikson et al, 2003).

While not specific to nursing, results of this study demonstrate empirical support for the influence of shared governance structures on empowerment, as defined by Kanter (1993) and operationalized by Laschinger (1996). Low response rates, particularly in the non member group, are a limitation of this study.

Summary of Chapter

Kanter's Structural Theory of Power in Organizations provides a useful framework to study sources of power in work settings, sources that are amenable to change. Studies conducted by the UWO Workplace Empowerment Research Program expanded on Kanter's theory and established empirical support for the theory in nursing populations. These studies have provided empirical support for the use of Kanter's theory as a guide in instituting theory-based approaches to organizational change and the creation of organizational structures that increase access to sources of work empowerment (Laschinger, 1996).

As noted, there have been only a few published studies utilizing Kanter's theory and the study instruments in non-acute care settings. There have been no studies conducted using this framework with FNIHB nurses. This study intends to build on

previous research through the measurement of perceptions of workplace empowerment in FNIHB nurses and the relationship between these measures and organizational commitment. The complex, autonomous work environments of FNIHB nurses are unique to this population and information from this study will add to the body of literature. As well, results of this study will provide important information to the Office of Nursing Services as they strive to transform nursing work environments, empower nurses and increase organizational commitment.

Chapter Four: Methodology

Research Design

This study was conducted using a cross-sectional descriptive correlational design. A non-experimental design was chosen as the intent of the study was not to imply causality, but rather to describe structural empowerment and its relationship to organizational commitment. Correlational research examines the tendency for the variation in one variable (i.e. structural empowerment) to be related to the variation in another (i.e. organizational commitment) and is therefore the most appropriate design for the current study (Polit & Beck, 2004).

Survey methodology was employed in this study with mailed questionnaires. Advantages of survey research include flexibility in administration and scope. Surveys can reach varied and diverse populations and cover a broad range of topics (Polit & Beck, 2004). Survey methodology was chosen for this study as the most cost effective and efficient way to reach a geographically dispersed and isolated population.

The primary disadvantage of survey methodology is the inability to capture complex, in depth human behavior and feelings. As such survey research is not the most appropriate methodology for intensive analysis of human behavior, but rather is better suited to extensive analysis of characteristics, attitudes, activities, beliefs, preferences, and intentions of respondents (Bowling, 2004).

Mailed questionnaires have several advantages as a way to administer surveys. They are cost effective and can be easily employed with large and geographically dispersed populations. Mailed questionnaires are also recommended for highly literate

populations and those who may require control over the timing and pace of response, such as the population for this study (Kellerman & Harold, 2001). In addition, and of particular import to this study, they offer the potential for anonymity. Anonymity, in turn, can decrease the likelihood of social desirability response bias and assist in obtaining candid responses. Self-report questionnaires also have the advantage of eliminating interviewer bias (Polit & Beck, 2004). A common disadvantage of mailed questionnaires is the tendency for this approach to yield lower response rates than those obtained through personal or phone interviews (Bowling, 2004). Dillman's Tailored Design method (2000) was employed as an evidence based approach to increase mailed survey response rates.

Sample Population and Setting

All available FNIHB employed nurses in Manitoba were surveyed to allow for the possibility of a low return rate. A total of 104 nurses were employed by FNIHB, Manitoba Region at the time the surveys were sent out (personal communication, Nursing Recruitment Officer, FNIHB, January 2005). Surveys were sent to the total population of nurses employed with FNIHB in Manitoba Region at the time of the study (n=104). Characteristics of this population included: 13 men and 87 women; 20 first-line managers (nurse in charge) and 80 staff nurses (CHN); and 54 full time, 34 part time and 13 casual employees. Average length of employment, educational background, age, and years nursing are not known for this population. Four of the surveys were returned indicating that these four individuals were no longer employed with FNIHB. Therefore, the final accessible population for this study was 100 nurses from 20 nursing stations. Seventy surveys were returned, representing a response rate of 70%. Polit & Hungler (1999)

identify a response rate of 60% or greater as adequate. Bowling (2004) identifies 75% as a 'good' response rate, noting mailed surveys tend to achieve up to 20% lower rates than interviews. The response rate for this survey is adequate as defined by these sources.

The setting for this study was the nursing stations of all FNIHB employed nurses in Manitoba. FNIHB employs nurses in 21 nursing stations. These settings are geographically dispersed in Northern Manitoba. The majority of these stations are accessible by plane only, with some having winter road access for several weeks in the winter (depending on weather conditions). One station was excluded from the study as there were no nurses employed in this facility at the time of data collection. Permission to access FNIHB nurses in this setting was provided by FNIHB (Appendix A).

Instruments

Two survey instruments and a demographic questionnaire were utilized for this study. The CWEQ II was employed to measure Kanter's six components of structural empowerment (opportunity, information, support, resources, formal power, and informal power). Permission to use these instruments was provided by Dr. Heather Laschinger (Appendix D). The OCQ developed by Dr. John Meyer, was utilized to measure the three components of organizational commitment. Permission to use this instrument was provided by Dr. Meyer (Appendix E).

Demographic characteristics were collected in order to describe the sample and collect information relating to any potentially confounding variables that may have an impact on empowerment or organizational commitment. Demographic variables collected included: age; gender; years of nursing; years of employment with FNIHB; employment

status (full-time, part-time or casual); and educational preparation (see Appendix F).

The CWEQ-II (Appendix G) is a modified version of the original CWEQ. This instrument consists of 19 items, measuring through sub-scales the six components of structural empowerment. The four empowerment structures (opportunity, information, support and resources) are measured by three items each. Kanter's concept of formal power is measured by a three item subscale and a four item subscale measures perceptions of informal power. A two item global empowerment scale forms part of the instrument as a construct validity check.

A total structural empowerment scale is calculated by summing and averaging each of the six sub-scales, resulting in a sub-scale score between 1 and 5. These sub-scale scores are then summed to create a total structural empowerment scale which ranges from 6-30, with higher scores representing higher perceptions of empowerment. Low levels of empowerment are indicated by scores ranging from 6 to 13. Scores ranging from 14 to 22 represent moderate levels of empowerment, while scores from 23 to 30 represent high levels of empowerment. The global empowerment items are summed and averaged to provide a range from 1 to 5, which is not included in the total empowerment score (UWO, 2004).

Laschinger et al. (2001b) substantiated the construct validity of the CWEQ-II in a confirmatory factor analysis that revealed a good fit of the hypothesized factor structure. These authors also reported that the CWEQ-II correlated highly with the global measure of empowerment ($r = 0.56$), therefore providing evidence of construct validity. The UWO Workplace Empowerment Research program has established the validity and reliability of

this instrument in numerous studies, as described in Chapter 3.

As previously stated, studies utilizing these instruments have been conducted primarily in acute care settings. Permission was received from Dr. Laschinger to slightly modify the instrument to fit the practice setting of the sample for this study (see Appendix H). Specifically, the word "hospital" was changed to "organization" for question #1 of the information subscale, and the words "patient care" were changed to "client care" for question #4 of the informal power subscale.

The OCQ (Appendix I) is an 18 item scale with three six item subscales that measure affective, continuance and normative commitment as conceptually defined by Allen, Meyer and Smith (1993) in their three-component model of organizational commitment. Each item utilizes a 7 point Likert scale with 4 reverse scored items. Items are summed and averaged to provide a total organization commitment score ranging from one (low commitment) to seven (high commitment) (Laschinger et al., 2000). The OCQ was developed based on a theoretical framework that established an initial pool of items administered to a sample population and then selected for inclusion (Allen & Meyer, 1996). Allen and Meyer report substantive evidence of the construct validity of the OCQ through a review of numerous studies utilizing the instrument.

The affective commitment and continuance commitment subscales of the OCQ were empirically tested in a nursing population by Laschinger et al. (2000) and reported to be reliable by Laschinger et al. (2001a) with alpha co-efficients of .74 for the affective commitment subscale and .75 for the continuance commitment subscale. Powell and Meyer (2003) provide reliability co-efficients for the affective and normative

commitment subscales of .87 and .89 respectively.

Data Collection

Data collection was achieved through a self-administered survey that was mailed to the sample population in accordance with Dillman's Tailored Design Method (TDM) (2000). Dillman first published his Total Design Method in 1978, a method that he proposed would lead to significantly improved response rates for mailed questionnaires. Several studies subsequently provided empirical evidence of the effectiveness of this method, and a revised version was published in 2000. The Tailored Design Method recommends consideration of the theoretical and administrative aspects of the survey process. Dillman utilizes social exchange theory as an explanatory framework for understanding why individuals do or do not respond to surveys. Using this theoretical framework he has developed an administrative plan to coordinate the survey design and distribution (2000).

Social exchange theory purports that an individual's motivation to action involves a consideration of the rewards, costs, and trust involved in undertaking that action. In relation to survey research, this involves the design and implementation of a process that increases the rewards for responding, reduces the cost of responding, and establishes trust in the responder that the ultimate rewards of responding will outweigh the costs. Dillman notes that this idea should not be equated with economic exchange. He states that social exchange is a broader concept, a function of the ratio between perceived costs and perceived rewards. These rewards and costs may be indirect or direct, and are experienced within each individual's personal context (Dillman, 2000).

This theoretical framework, as well as research findings, form the basis for the TDM elements. Dillman views survey response as social exchange whereby individuals are more likely to respond to surveys if they trust that the rewards of doing so will outweigh the costs. He provides a method of developing and implementing questionnaires that conveys benefits to the responders, as well as provides trust messages. Dillman contends that this method maximizes the quality and quantity of survey response (Dillman, 2000).

In terms of greatest influence, it is the implementation process, and not the questionnaire, that has the greatest influence on response rates. Dillman proposes five techniques or elements in the implementation process that are effective in increasing response rates. These elements are: a respondent-friendly questionnaire; up to five contacts with the questionnaire recipient; inclusion of a stamped return envelope; personalized correspondence; and a token financial incentive included with the survey request (Dillman, 2000).

While each of these techniques has individually been shown to increase response rates, research has shown the most effective technique to be multiple contacts with the responders (Dillman, 2000). The TDM recommends four contacts by first class mail, including:

1. a brief pre-notice letter mailed a few days before the questionnaire mailing
2. a questionnaire mailing with cover letter detailing the importance of responding
3. a thank you post card sent within a week of the questionnaire mailing
4. a replacement questionnaire sent to non respondents 2-4 weeks after the first

mailing

Finally, Dillman recommends a contact by telephone, or priority mail, a week or so after the fourth mailing. The key feature of this mailing is that it is a "different mode of contact" and distinguishable from the previous contacts (Dillman, 2000, p. 151).
The second most effective technique, in order of influence, has been demonstrated to be the use of token financial incentives. In addition, moderate effects have been demonstrated from personalization of correspondence and stamped return envelopes. The use of a postage stamp represents a monetary value for the respondent. Dillman contends that, in a social exchange context, this leads to a perception of trust in the recipient that the questionnaire is important (2000).

A modified version of the Dillman Method was used in this study. A pre-notice on University letter head was faxed to all nursing stations on November 12, 2004 (see Appendix J). This fax was addressed to the Nurse-in Charge of each nursing station with the request to distribute the notice to all staff. This was followed on November 17, 2004 with a mailed letter explaining the study (see Appendix B). Attached to this letter was the questionnaires and a researcher addressed and stamped envelope. This initial mailing was not personally addressed but rather several surveys per station were mailed to the Nurse in Charge. The Nurse in Charge was provided with a cover letter requesting his/her assistance in distributing the surveys to all staff. A reminder notice was faxed to the Nurses in Charge, on December 13, 2004, with a request to distribute the reminder to all staff (see Appendix K). These modifications of Dillman's method were necessitated by the inability of the researcher to obtain information required to personally address

envelopes at the time of the initial mailing.

This initial mailing resulted in 36 returned surveys. Following this initial mailing the researcher was provided by the FNIHB Nursing Directorate with the mailing addresses and location of employment for all FNIHB employed nurses in Manitoba Region. Consequently a replacement questionnaire was mailed on March 18, 2005 in a personally addressed envelope to all nurses on this list (n=104). This final mailing included the letter explaining the study, the questionnaires, and a researcher addressed stamped envelope. This second mailing resulted in an additional 34 returned surveys. Four surveys were also returned indicating these particular nurses were no longer employed with FNIHB in Manitoba Region.

Ethical Considerations

Consent to participate was assumed by completion and return of the survey instruments. This was indicated in a cover letter attached to the survey (Appendix B). This approach allowed for participants to remain anonymous and was chosen as a strategy to improve response rates and mitigate social desirability bias (Polit & Beck, 2004). There were no perceived harmful risks to participants. Findings from this study have the potential to benefit the organization by providing a research base from which to implement and evaluate the ONS Transformation Strategy. This proposal was reviewed and approved by the University of Manitoba Education/Nursing Research Ethics Board prior to data collection (Appendix C).

Data Analysis

Statistical analysis of the data collected was conducted with the Statistical

Package for the Social Sciences (SPSS) version 13.0 (SPSS, 2005). Assistance with data coding and descriptive analysis was provided by the Manitoba Nursing Research Institute (MNRI). A statistician was consulted for further data analysis. All response items were coded and entered into a database. Univariate descriptive techniques were employed to measure means, standard deviations, ranges, frequencies, percentages, and distributions for the sub-scales, total empowerment and organizational commitment scores, and demographic variables. Content analysis was conducted on qualitative notations written on the instruments (Bowling, 2004). Written data unrelated to the survey were collected, transcribed and coded by theme or category. An analysis of these themes was conducted and the resultant themes have been presented in the findings section.

Bivariate analysis was conducted on the demographic variables. Continuous variables (age, years as a nurse, and length of employment) were tested for correlations (Spearman's rho) with the measures of empowerment (total and six subscales) and the three measures of commitment. Nominal demographic variables were grouped and bivariate analysis was conducted (t-tests for equality of means) to test for significant differences between groups. Level of significance was set at $p < .05$. Correlation coefficients (Spearman's rho) were calculated to test the associative hypothesis between structural empowerment (including all six sub-scales: information, opportunity, resources, support, informal power, and formal power) and the three measures of organizational commitment (affective, normative, and continuance). The proportion of variance in the three types of commitment that could be explained by empowerment was calculated utilizing the squared multiple correlation coefficient (R^2) (Polit & Beck,

2004).

Multiple regression analysis was conducted to test for the simultaneous predictive effects of multiple independent variables (demographic variables, empowerment, and the six sub scales) on the dependent variables (the three measures of commitment). Independent variables that were correlated with the three measures of commitment were entered into SPSS and backward stepwise multiple regression analysis was performed, level of significance set at $p < .05$ (Munro, 2001).

Summary of Chapter

This chapter has provided an overview of the research design, procedures, setting, sample, and data collection methods used in this study. Ethical considerations were presented and data analysis procedures were described.

Chapter Five: Findings

Introduction

The purpose of this descriptive correlational study was to test a model derived from Kanter's Theory of Structural Empowerment in a unique nursing population, describing the relationship between FNIHB nurses' perceptions of work empowerment and their commitment to the organization. The research hypothesis for this study was that perceived workplace empowerment would be positively related to affective and normative commitment, and negatively or unrelated to continuance commitment. This chapter presents the findings from this study, demonstrating support for the research hypothesis. Descriptive findings on the demographic characteristics are provided and results of bivariate and multi-variate analyses are presented.

Demographic Characteristics

The study sample consisted of 70 nurses. Surveys were distributed to 100 FNIHB nurses, and seventy surveys were returned, representing a response rate of 70%. Demographic information was collected on age, gender, years nursing, current position, length of employment with FNIHB, employment status, and educational preparation. This information was entered into SPSS and the descriptive statistics calculated are as follows.

Age and gender. The mean age of the participants was 40.90 years, with the range being 25 to 61 (SD=10.06). Males represented 18.6 % of the participants (n=13) and females represented 81.4 % (n=57).

Years as a nurse. The mean length of time that participants had been nursing was 15.12 years, with a range of 1 to 40 years (SD=10.06). The majority of nurses had been

nursing less than 20 years (71.4 %) and one fifth less than 5 years.

Current position. The majority of the nurses (72.9 %, n=51) are currently employed as community health nurses. The remaining participants stated they were the Nurse in Charge (25.7 %, n=18). One participant listed other as current position. The number of Nurse in Charge (NIC) respondents is a significant response as each nursing station has only one NIC, thus 18 responses of 20 staffed nursing stations represents 90% of this sub population.

Length of employment with FNIHB. The average length of employment with FNIHB was 67.74 months (5.6 years) with a range of 1 month to 20 years (SD=71.68 months). Almost half of the nurses had been employed with FNIHB for less than 4 years (48%), with greater than one quarter of the nurses (26.1%) employed for one year or less. These results are indicative of a workforce that remains employed with FNIHB either short term (less than 1 year) or long term (21.3 % of nurses had been employed greater than 10 years).

Employment status. Sixty three respondents were permanently employed with FNIHB. Of these 63 respondents 30% were part-time employees (n=21) and 60% were full-time employees (n=42). Seven respondents were casual employees.

Highest educational preparation. Fifty percent of the participants were diploma prepared (n=35) and 40% were baccalaureate prepared (n=28). The remaining 10% (n=7) were prepared at a graduate level.

In summary, the FNIHB nurses in this sample of 70 nurses were predominantly female, full time employees. Their average age was 41 years, average years of experience

was 15.1 years, and average length of employment with FNIHB was 5.6 years. Diploma and undergraduate preparation were almost equal (50% and 40% respectively). The majority of respondents were community health nurses and not first line supervisors (Nurse in Charge).

Condition of Work Effectiveness Questionniare-II

Scale. Following the analytical tradition of Laschinger, results will be reported with the assumption that this summated rating scale is an interval scale, that is to say, ordinal responses for individual responses using Likert scales will be summated and reported as continuous variables. The possible range of scores for the CWEQ-II is 6-30 (sum of the average score for all six subscales). The mean total empowerment score for participants of this study was 17.37 (SD 3.06), representing moderate empowerment. The range of this score was 14.58 to 23.17. As depicted in Figure 2 this score displays a normal distribution. The mean global empowerment score was 5.66, with a range of 2 to 10 (SD=2.05). Global empowerment was positively correlated with total empowerment ($r = .77$, $p < .001$) providing evidence of the construct validity of the CWEQ-II for this study. Cronbach's alpha for the CWEQ-II was .85, providing evidence of adequate internal consistency reliability for this instrument in the current study.

CWEQ-II Subscales. Notable observations were found in the CWEQ-II subscales of access to opportunity, information, support, resources, and formal and informal power. Access to opportunity was strongly skewed to the left (see Figure 3), with 45.7 % of participants rating themselves as having a lot of opportunity in their present job (5 on a Likert scale of scale of 1-5). The mean score of this scale was 4.49 (SD=0.58). All of the

respondents felt they had some opportunity in their present job (no responses less than 3).

Figure 2: TOTAL EMPOWERMENT

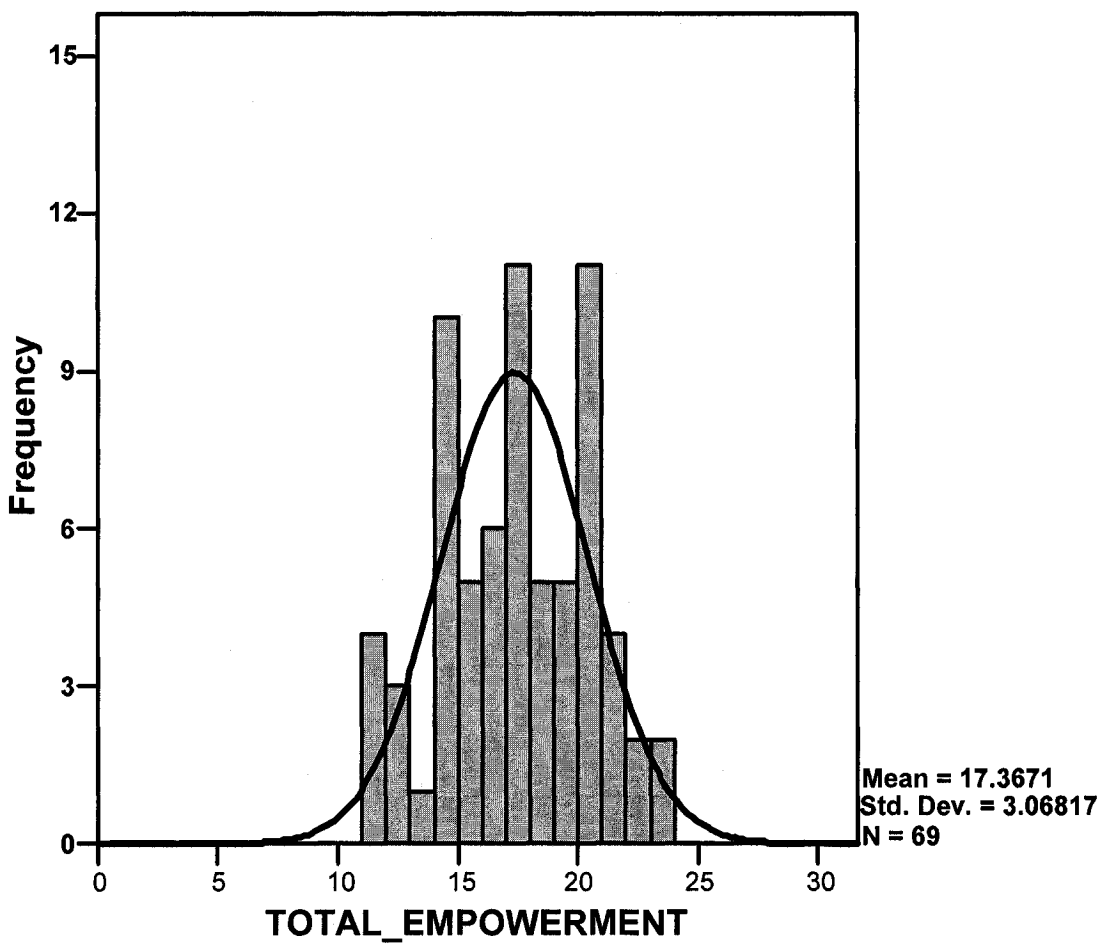
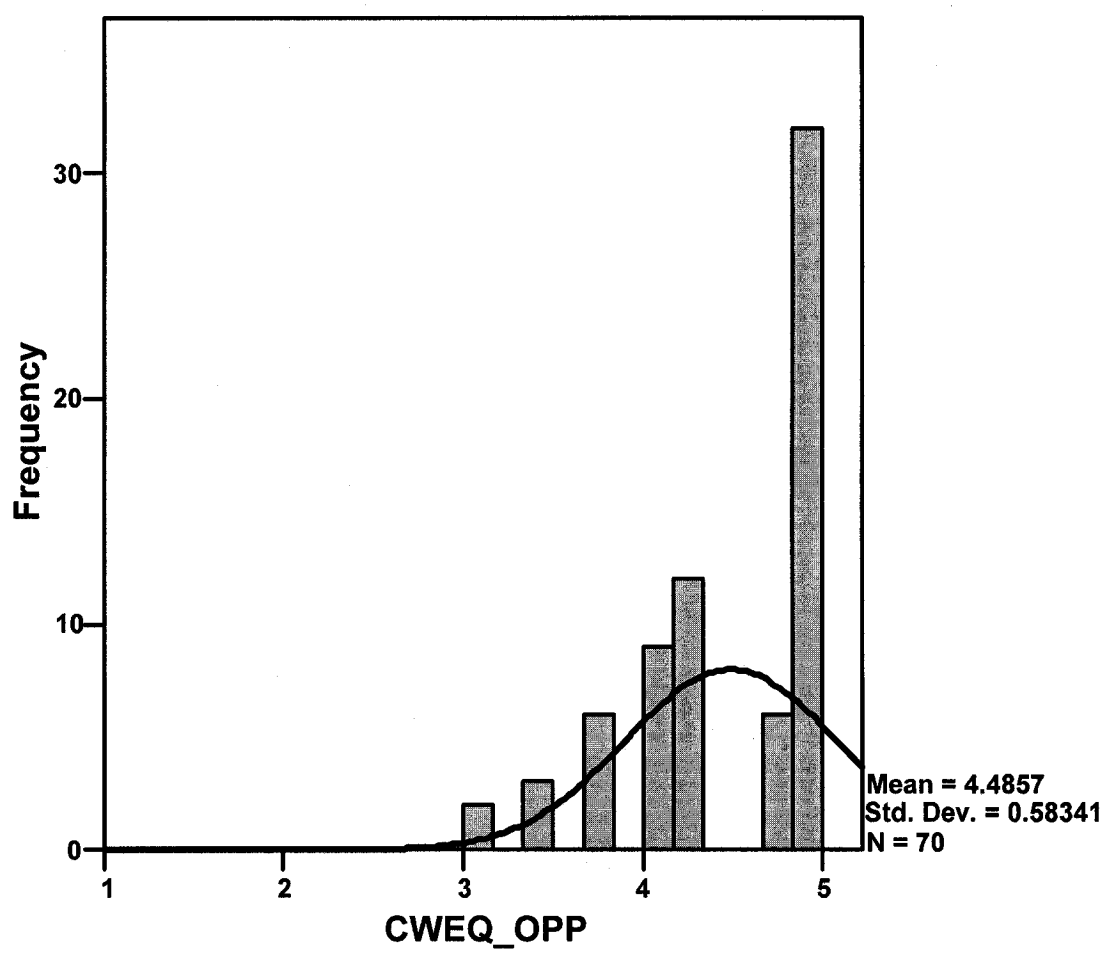
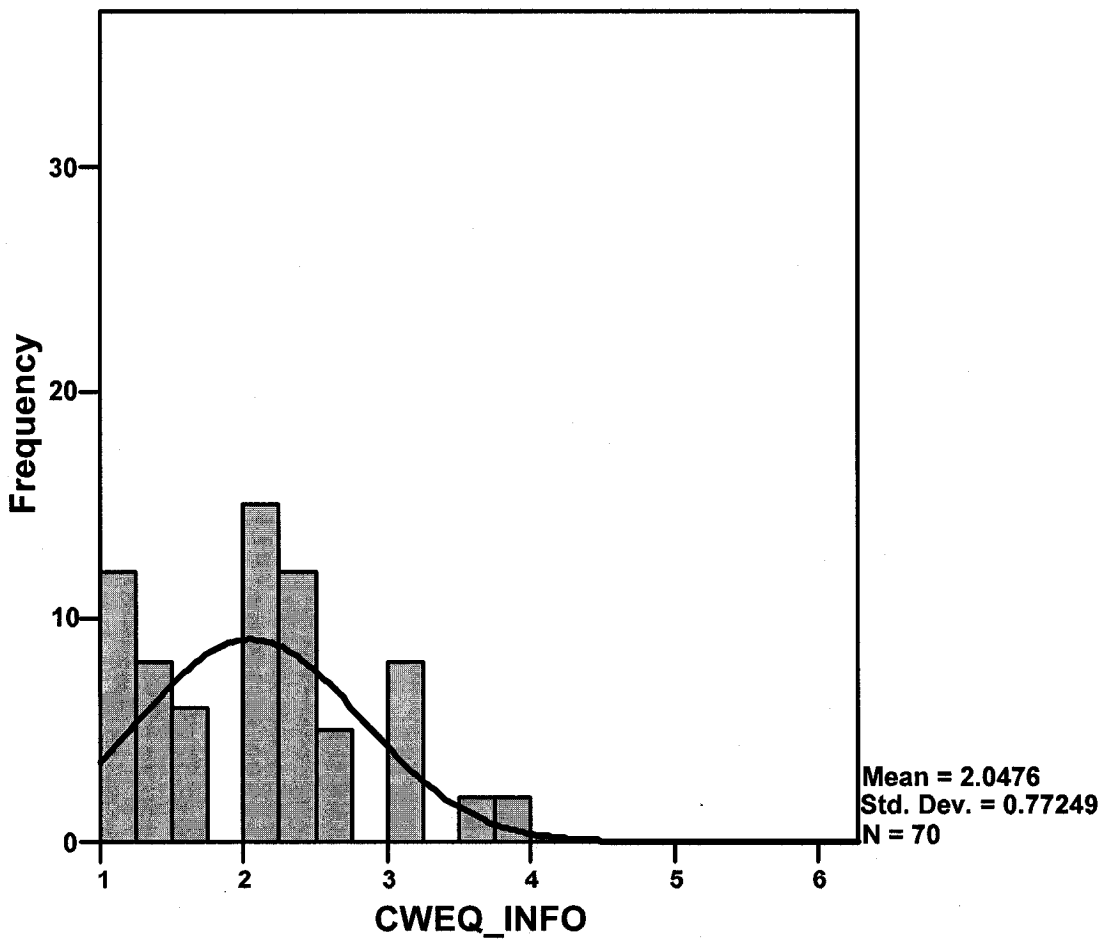


Figure 3: Opportunity



Access to information was slightly skewed to the right (see Figure 4), with moderately low scores for this subcale (M=2.05, SD= 0.77). Seventeen percent of respondents felt they had no access to information in their present job, while only 2.9% felt they had a lot.

Figure 4: Information



While the mean score for access to support was 2.42 (SD=0.98), many participants (20%) felt they had no support and only 2.9 % felt they had some to a lot of support. The majority of respondents (78.6%) rated their access to support as 3 or less (Figure 5). Similarly, 78.6 % of respondents rated their access to resources as 3 or less. However, only 2.9 % felt they had no access to resources. The mean for this sub-scale was 2.59 (SD=0.77) (Figure 6).

The mean score on the formal power subscale was 2.44 (SD= 0.93), with a range of 1 to 5. As depicted in Figure 7 this distribution is slightly skewed to the right, indicating a greater tendency to perceive less than average formal power. The mean score on the informal power subscale was 3.35 (SD=0.75), with a range of 1 to 5 (Figure 8).

CWEQ-II Item Responses. Insight into these sub-scale observations is gained through further description of item responses. The range for all of the sub-scales was 1 to 5, with 1 = none/no knowledge, 3 = some/some knowledge, and 5 = a lot/ a lot of knowledge. Within the access to opportunity sub-scale, almost all of the of respondents (98.6%) felt they had 'a lot' of opportunity for challenging work in their present jobs (20% scored 4 and 78.6 % scored 5). The majority (81.5 %) of respondents also felt they had 'a lot' of opportunity to gain new skills and knowledge in their present job (28.6% scored 4 and 52.9% scored 5). Similarly, 87.1% of nurses felt their present job provided the opportunity to perform tasks that use all of their skills and knowledge (27.1 % scored 4 and 60.0% scored 5).

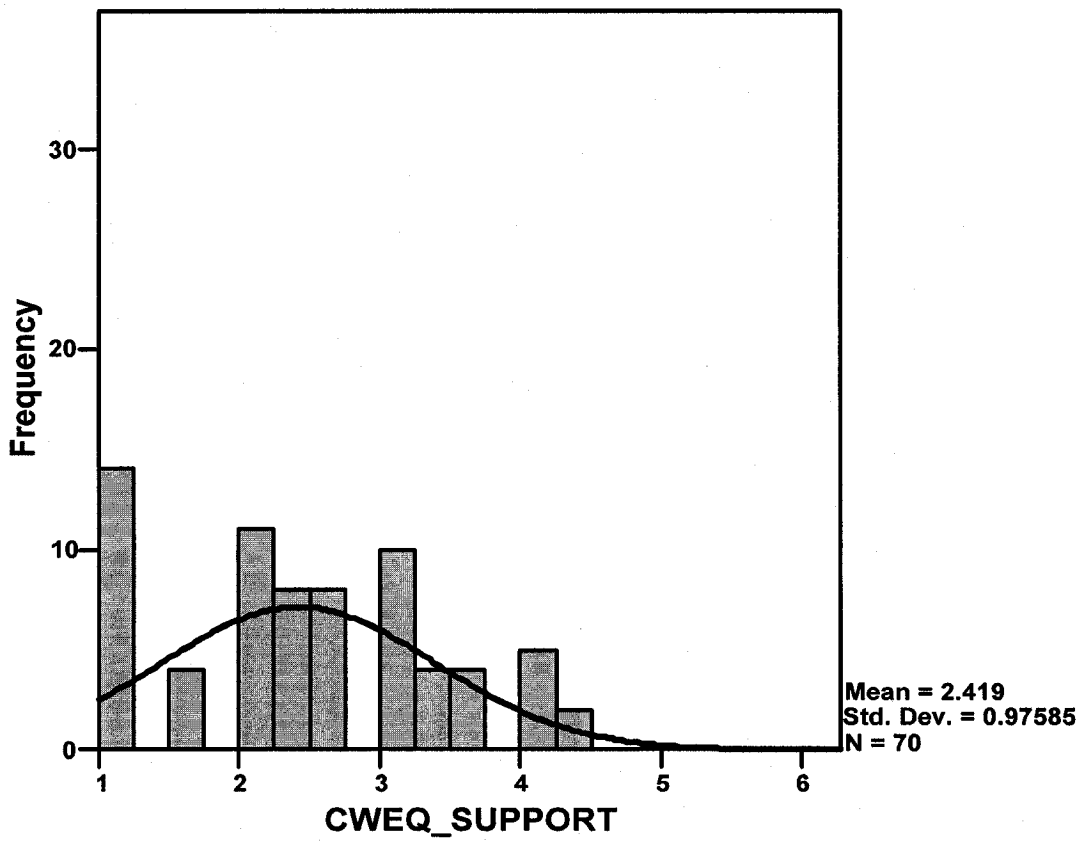
In contrast, within the access to information sub-scale, only 15.8 % of nurses felt they had 'a lot' of knowledge on the current state of the organization, with 84.3 % scoring

this item as 3 or lower. Of note, 17% of nurses felt they had no knowledge of the current state of the organization. Strikingly, 97.1% of nurses scored information on the values and goals of top management as 3 or less, with 41.4 % indicating they had no knowledge of the goals of top management, and 38.6 % indicting no knowledge of the values of top management. Within the access to support sub-scale, 31.4 % of nurses felt that they had no specific information on 'things they did well'. In addition a significant proportion of nurses (25.7%) felt they received no specific information on how they could improve. One fifth of nurses (20 %) also felt they received no helpful hints or problem solving advice.

Within the access to resources sub-scale, nurses in this study responded that they did not have sufficient time available to complete job requirements (75.7% scored 3 or less) or necessary paperwork (84.3 % scored three or less). Acquiring temporary help when needed was particularly difficult for this group of nurses, with 24% stating they had no access to resources for temporary help and more than half of respondents (57%) scored this item as 2 or less.

As noted, nurses in this study perceived lower than average levels of formal power in their positions. A significant number of respondents (45.7%) indicated that there were no rewards for innovation on the job. Conversely, large numbers of nurses felt there was some or more than some flexibility in their job (69.6% scored this item 3 or higher). Moderating the effect of this item, however, was the perceived lack of visibility that this group of nurses felt they had within the organization. Almost one third (29%) of participants felt that their work had no visibility in the organization, 30.4 % scored this

Figure 5: Support



item a 2 and 34.8 % scored a 3 for a cumulative percentage of 94.2% feeling they had some or less than some visibility in the organization. Only 4 respondents scored this item a 4, and no respondents felt they had 'a lot' of visibility in the organization.

Nurses in this study did, however, perceive greater than average informal power (M = 3.35) with almost half (44.3%) of respondents indicating they had 'a lot' of opportunity to collaborate with physicians in their jobs. In addition, 38.6% felt they had 'a lot' of opportunity to be sought out by peers for help with problems. These high scored items were moderated by 50% of respondents scoring the item on "being sought out by

managers for help with problems" as 2 or less, with almost one quarter (24.3%) of nurses indicating they had no opportunity for this activity.

Figure 6: Resources

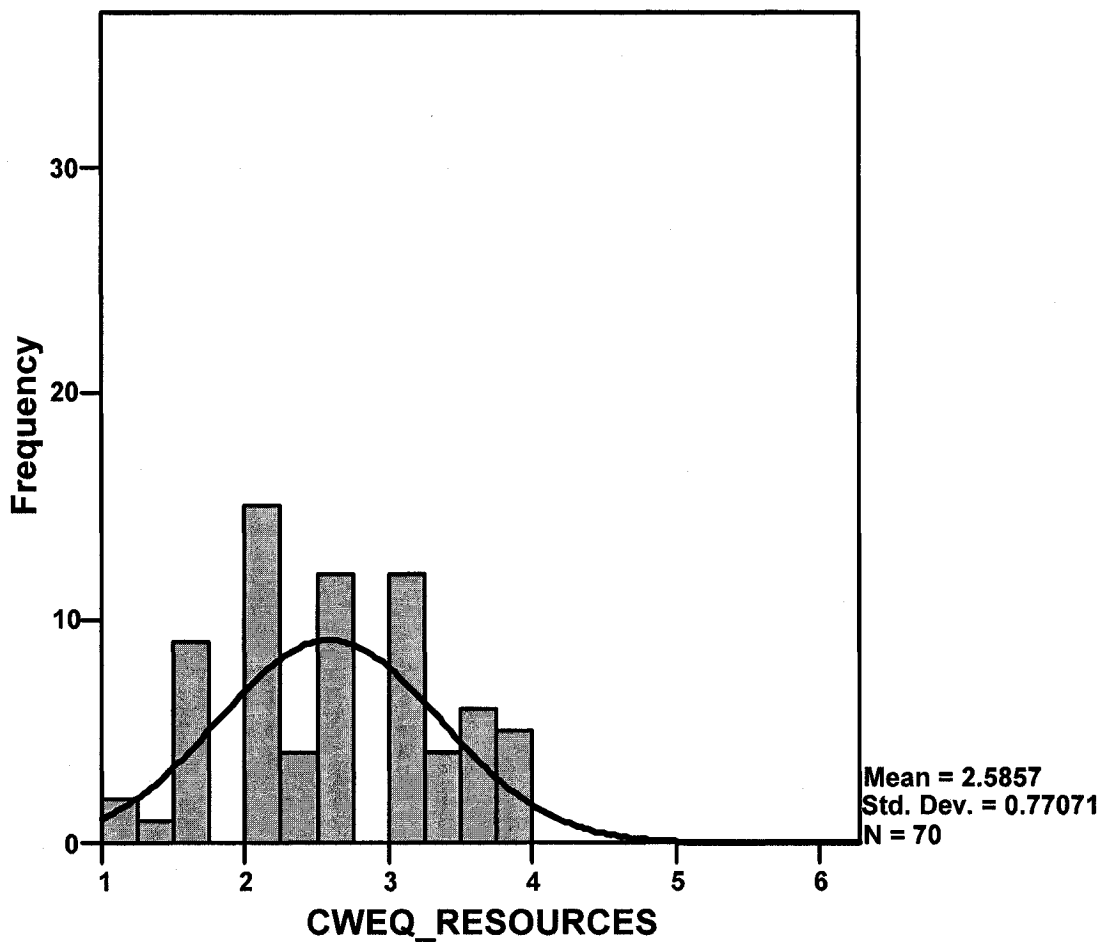


Figure 7: Formal Power

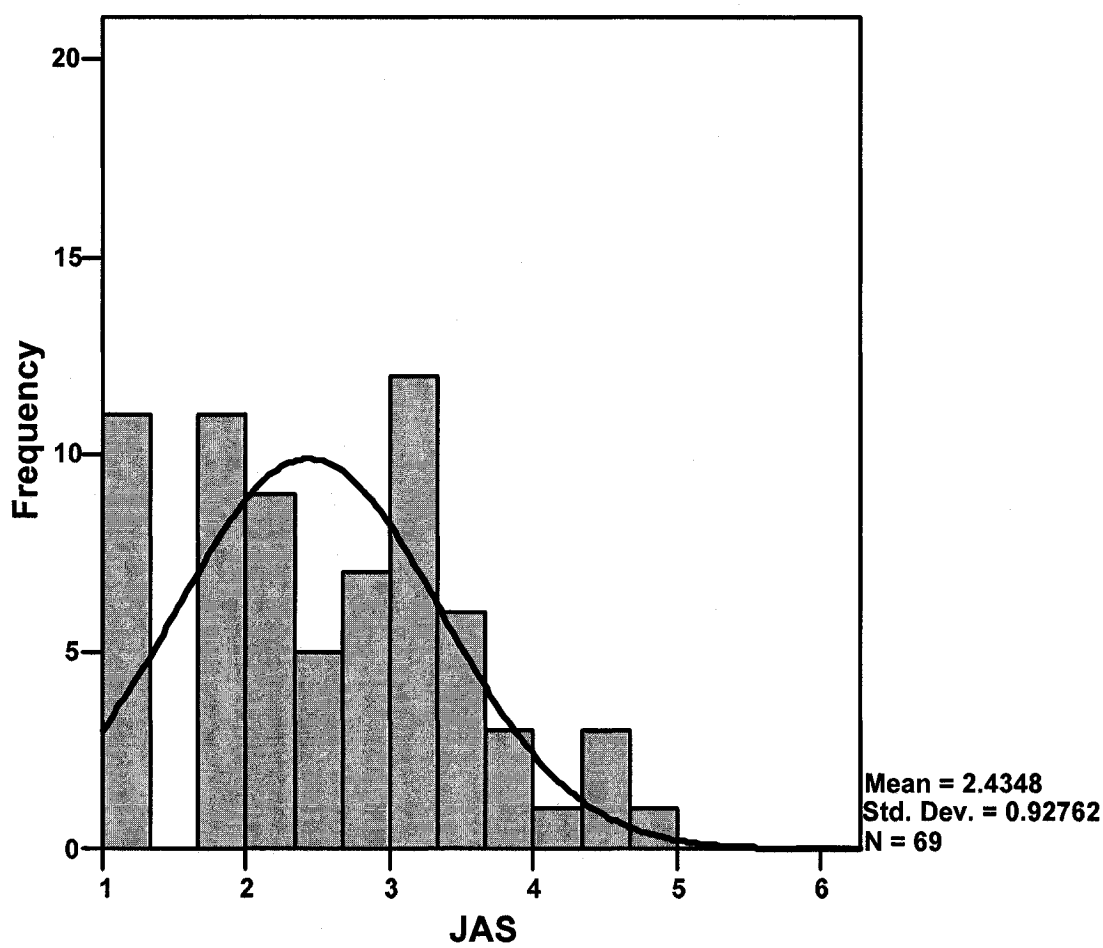
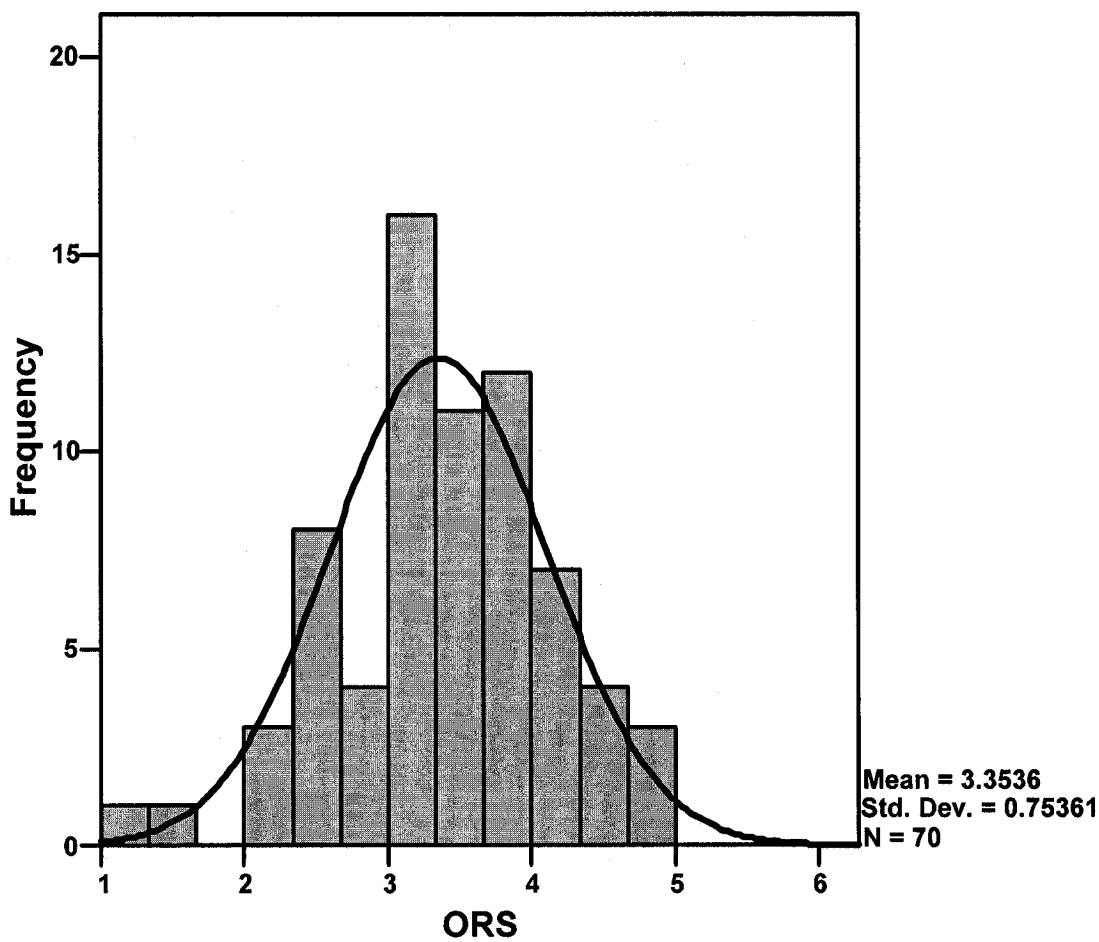


Figure 8: Informal Power



Organizational Commitment Questionnaire

The OCQ provides separate scores for the continuance, normative, and affective commitment measures. These scores can range from 1 to 7. Nurses in this study had greater continuance than affective or normative commitment. Mean continuance commitment was 3.73 (SD=1.4, range 1-6.5). Mean affective commitment was low at 2.99 (SD=1.11, range 1-5.2). Mean normative scores were the lowest at 2.72 (SD=1.0, range 1-4.8). These findings indicate that FNIHB nurses are more likely to maintain organizational membership due to a belief that they need to (continuance commitment), rather than wanting to(affective commitment) or believing that they ought to (normative commitment). Findings for affective, continuance and normative commitment are depicted respectively in Figures 9, 10 & 11.

Tests for reliability of these three measures of commitment (Cronbach's alpha) demonstrate adequate internal reliability consistency (affective commitment = .72; continuance commitment = .81; and normative commitment =.78).

Figure 9: Affective Commitment

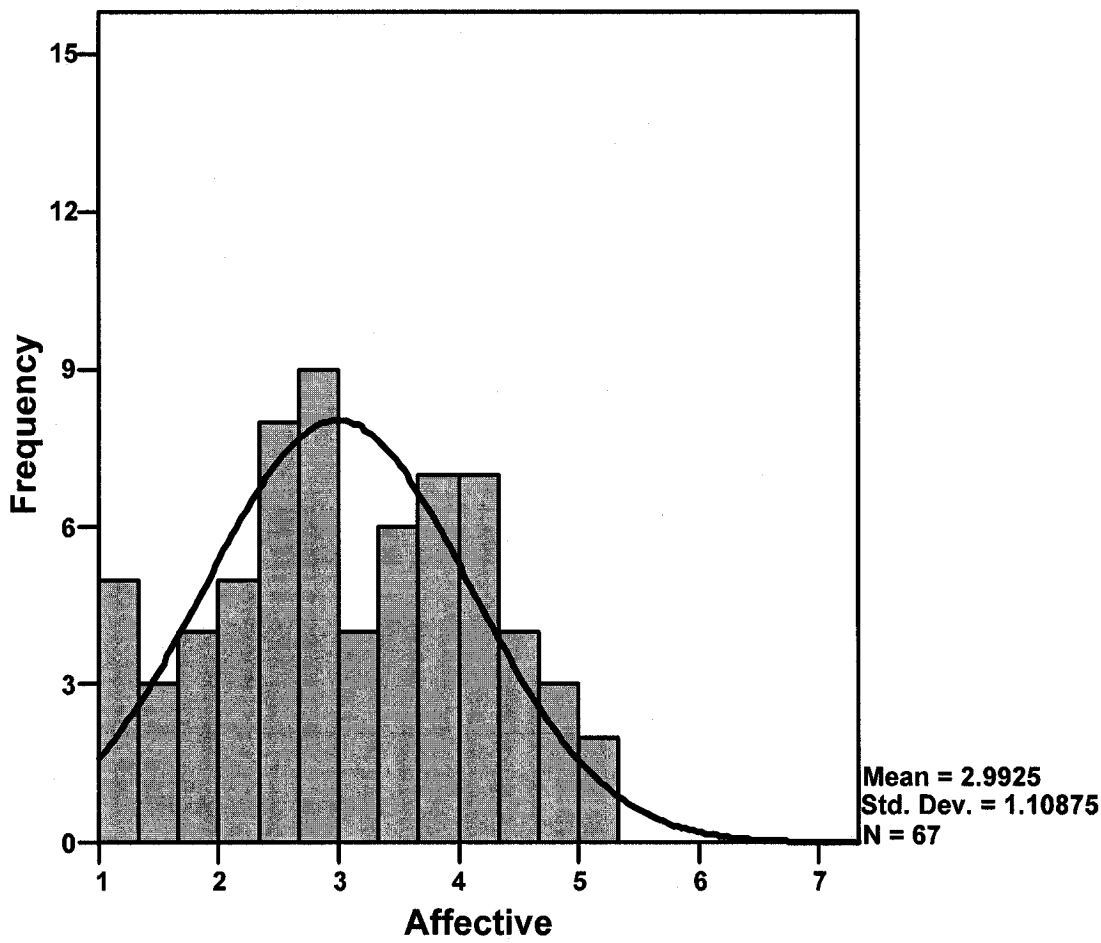


Figure 10: Continuance Commitment

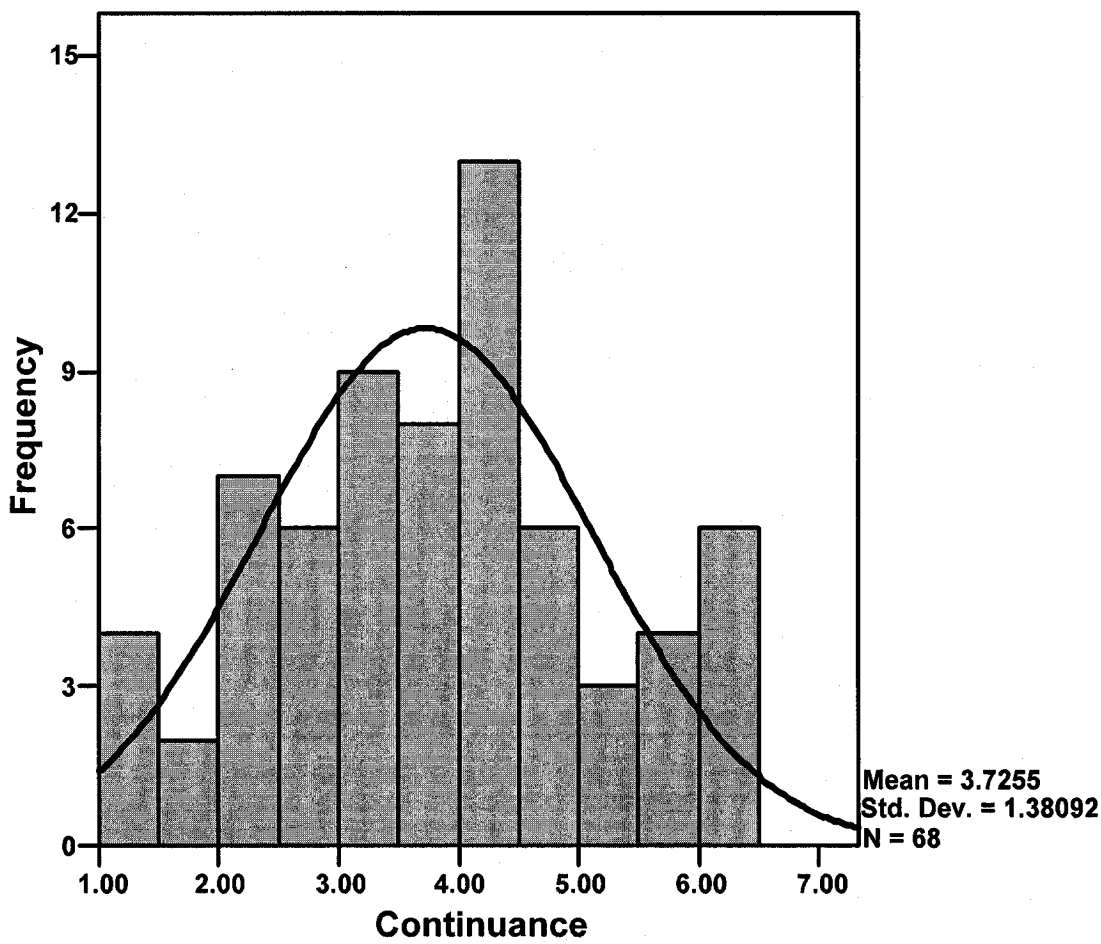
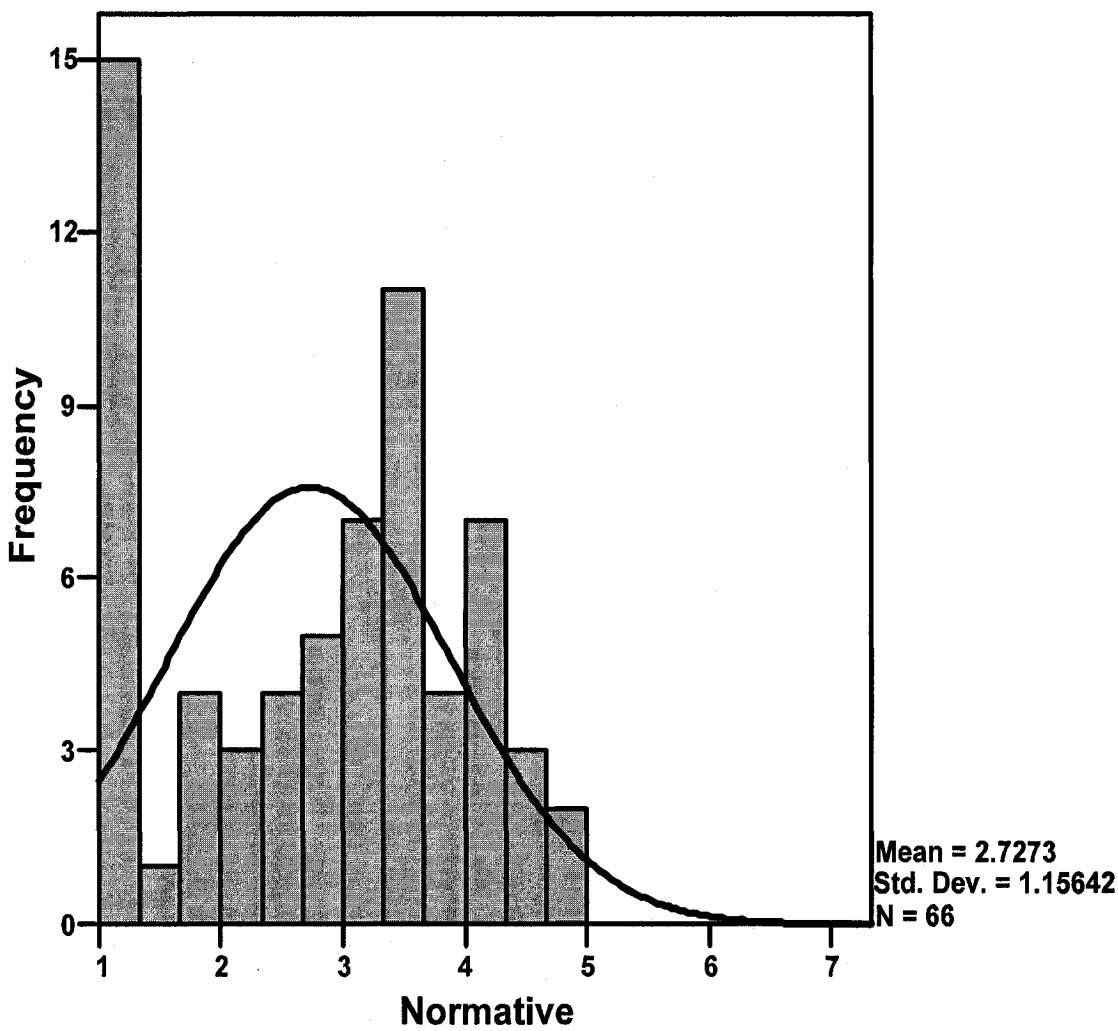


Figure 11: Normative Commitment



Subscale Item Responses. There were numerous notable responses on individual items within the affective, continuance, and normative sub-scales. Within the affective commitment sub-scale 78 % of respondents agreed, and 37.3% strongly agreed, with the statement 'I do not feel emotionally attached to the organization'. Similarly, 74 % agreed, and 36.2 % strongly agreed, with the statement ' I do not feel a strong sense of belonging to my organization'. Consistent with the nature of these responses, 30.9% of respondents strongly disagreed with the statement 'This organization has a great deal of personal meaning for me', and 35.7 % strongly disagreed with the statement 'I really feel as if this organization's problems are my own'. These responses indicate that greater than one third of respondents felt no emotional attachment or sense of belonging to the organization.

Significant responses within the continuance commitment sub-scale include greater than two thirds (66.6%) of respondents agreeing with the statement 'Right now, staying with my organization is a matter of necessity as much as desire'. Of those who agreed with this statement, 21.7% strongly agreed. This necessity does not appear to be related to a lack of alternative employment options as 43.4% disagreed that it would be hard to leave the organization if they wanted to, and 57.2% disagreed that they had too few options to leave. More than half of the respondents (55.7%) did agree with the statement that 'too much of my life would be disrupted' if they decided to leave the organization.

Notable normative commitment responses include more than half of the nurses (59.4 %) agreeing with the statement 'I do not feel any obligation to remain with my current employer'. Of those who agreed more than one quarter (26.1%) strongly agreed.

More than one third (34.8 %) of nurses strongly disagreed that the organization deserves their loyalty and the majority (70%) of respondents disagreed that they owed a great deal to the organization (41.4% strongly disagreed with this item). Furthermore, 42.9% strongly disagreed that they did not feel it would be right to leave the organization right now and 47.1% strongly disagreed that they would feel guilty if they left the organization.

Qualitative Notations

An unexpected finding of this study was the numerous qualitative remarks that respondents wrote on their surveys. Content analysis was performed on these remarks with two themes identified. The first theme identified was a strong sense of commitment to the First Nations community within which the nurses worked. Several nurses crossed out the word 'organization' and replaced it with 'community' for questions related to affective and normative commitment. They indicated that they would feel guilty leaving the community and not the organization, and that they had an emotional attachment and a sense of obligation to the communities (these changes resulted in a non response code in the SPSS data set). Other respondents answered the questions as presented but commented in the margins of their surveys that they feel attached to the community in which they work.

The second theme that emerged from the written notations was the perception that management was unsupportive to staff nurses. This included comments related to criticism from managers, little support or guidance, no valuing of staff, and a lack of trust between staff and managers.

Demographic Variables and Empowerment and Organizational Commitment

Tests for correlations (Spearman's rho) were conducted with the continuous demographic variables of age, years nursing, and years employed with FNIHB, and the study variables of empowerment and organizational commitment. No significant correlations were found. T-tests were employed as an exploratory test to determine whether or not there were significant differences in empowerment and organizational commitment between various groups based on nominal variables. Demographic variables were grouped as follows: roles (Nurse in Charge vs Community Health Nurse); gender (male vs female); age group (25-41 vs 42-62); Tenure (1-35 months vs 36-240 months); education (diploma vs baccalaureate/graduate level); and employment status (part time/casual vs full time). Means and standard deviations on the scales and sub-scales were calculated for these groups. Findings are presented in Table 1 and 2. There were no significant differences for empowerment (total and subscales) and organizational commitment in the age or tenure groups. There were also no significant differences in the normative or continuance commitment for any of the groups.

Significant differences between groups were found for the roles, education, gender, and employment status groups. In particular, part time/casual employees had significantly higher mean scores in the information, resources, and formal power subscales than their full time counterparts. They also perceived greater total empowerment and had higher affective commitment scores. Diploma prepared nurses perceived greater access to information than their baccalaureate/master's prepared colleagues, while Nurses in Charge perceived greater access to resources than community

health nurses. Finally, male nurses perceived greater informal power than female nurses.

As depicted in Figure 11 (p. 84), a large proportion of respondents had very low normative commitment scores. In order to analyze this result further normative commitment scores were grouped into low (<3.5, n=26) and high (>3.5, n=40) scores to test for significant differences between these 2 groups (two tailed t-tests). The high normative commitment group perceived significantly higher total empowerment than the low normative commitment group (M=18.71, SD2.4 versus M=14.97, SD 2.8, $p < .001$). Crosstabs and Chi-Square tests were employed to look for differences related to demographic groups, and no significant differences were noted, however part time versus full time approached significance ($p = 0.078$) with 19.2 % of part time/casual nurses having low normative commitment scores while 73.1 % of full time nurses scored low on this measure.

Table 1

Differences in Mean Scores for Total Empowerment and Subscales

	Opportunity	Information	Support	Resources
	M (SD)	M (SD)	M (SD)	M (SD)
Role				
Nurse in Charge	4.3 (0.51)	2.2 (0.69)	2.4 (0.89)	2.1** (0.53)
Community Nurse	4.6 (0.60)	2.0 (0.80)	2.4 (1.0)	2.8** (0.75)
Gender				
Male	4.5 (0.50)	2.2 (0.83)	2.7 (0.89)	2.6 (0.58)
Female	4.5 (0.60)	2.0 (0.67)	2.3 (0.99)	2.6 (0.81)
Age Group				
25-41 years of age	4.5 (0.62)	1.9 (0.76)	2.4 (0.98)	2.6 (0.72)
42-62 years of age	4.5 (0.56)	2.1 (0.78)	2.4 (0.98)	2.6 (0.82)
Tenure				
1-35 months	4.5 (0.66)	2.0 (0.76)	2.4 (1.11)	2.8 (0.75)
36-240 months	4.5 (0.51)	2.0 (0.74)	2.4 (0.83)	2.4 (0.77)
Education				
Diploma	4.4 (0.56)	2.3* (0.81)	2.5 (0.91)	2.6 (0.69)
Baccalaurete/Master's	4.6 (0.61)	1.8* (0.68)	2.3 (1.0)	2.6 (0.85)
Employment Status				
Part time/Casual	4.5 (0.55)	2.3* (0.76)	2.6 (0.94)	2.8* (0.72)
Full time	4.5 (0.61)	1.9* (0.75)	2.3 (0.98)	2.4* (0.77)

t-test * $p < .05$ t- test ** $p < .001$ M= mean SD= Standard Deviation

Table 1(continued)

Differences in Mean Scores for Total Empowerment and Subscales

	Formal Power	Informal Power	Total Empowerment
	M (SD)	M (SD)	M (SD)
Role			
Nurse in Charge	2.3 (0.93)	3.5 (0.76)	16.90 (2.57)
Community Health Nurse	2.5 (0.97)	3.3 (0.76)	17.85 (3.14)
Gender			
Male	2.6 (0.91)	3.9* (0.43)	18.42 (2.06)
Female	2.4 (0.93)	3.2* (0.76)	17.12 (3.22)
Age Group			
25-41 years of age	2.4 (0.97)	3.3 (0.65)	17.18 (3.39)
42-62 years of age	2.4 (0.91)	3.4 (0.83)	17.53 (2.81)
Tenure			
1-35 months	2.5 (0.92)	3.2 (0.84)	17.51 (3.07)
36-240 months	2.4 (0.95)	3.4 (0.70)	17.12 (3.08)
Education			
Diploma	2.5 (0.90)	3.4 (0.73)	17.63 (2.85)
Baccalaurete/Master's	2.4 (0.96)	3.3 (0.79)	17.11 (3.30)
Employment Status			
Part time/casual	2.79* (0.92)	3.4 (0.68)	18.48* (2.86)
Full time	2.2* (0.85)	3.3 (0.81)	16.60* (3.00)

t test * $p < .05$ M = Mean SD= Standard Deviation

Table 2

Differences in Mean Scores for the Three Types of Commitment

	Affective	Continuance	Normative
	M (SD)	M (SD)	M (SD)
Role			
Nurse in Charge	3.10 (1.3)	4.2 (1.1)	3.01 (1.1)
Community Health Nurse	2.96 (1.1)	3.5 (1.4)	2.66 (1.1)
Gender			
Male	3.04 (1.2)	3.1 (1.6)	2.5 (1.1)
Female	2.98 (1.1)	3.9 (1.3)	2.78 (1.2)
Age Group			
25-41 years of age	2.95 (1.1)	3.7 (1.4)	2.67 (1.2)
42-62 years of age	3.02 (1.1)	3.8 (1.4)	2.78 (1.1)
Tenure			
1-35 months with FNIHB	3.02 (1.1)	3.6 (1.4)	2.71 (1.3)
36-240months with FNIHB	2.94 (1.2)	3.8 (1.3)	2.7 (1.0)
Education			
Diploma	3.16 (1.1)	3.8 (1.4)	2.91 (1.1)
Baccalaurete/Master's	2.82 (1.1)	3.6 (1.4)	2.54 (1.2)
Employment Status			
Part time/casual	3.39* (1.0)	3.7 (1.4)	3.0 (1.0)
Full time	2.71* (1.1)	3.7 (1.4)	2.55 (1.2)

t test * $p < .05$ M = Mean SD= Standard Deviation

Relationship of Empowerment and Organizational Commitment (Research Question)

Correlation coefficients (using Spearman's rho) were calculated to test for a relationship between the three measures of commitment and total empowerment and empowerment subscales and are reported in Table 3. Total empowerment had the strongest correlation with affective commitment ($r = .664$, $p < .01$) followed by the subscale formal power($r = .486$, $p < .01$), and information ($r = .557$, $p < .01$). The only empowerment subscale that did not correlate with affective commitment was opportunity. Total empowerment and the subscales of access to opportunity, access to resources, and informal power were all negatively correlated with continuance commitment, with the strongest correlation in the subscale of informal power ($r = -.349$, $p < .01$). Access to information, access to support, formal and informal power, and total empowerment correlated positively with normative commitment, with the strongest correlation with access to information ($r = .680$, $p < .01$).

These relationships and r squared coefficients are depicted with scatter diagrams in Figures 12, 13 and 14. Total empowerment explained 44% of the variance in affective commitment ($R^2=0.44$) and 35% of the variance in normative commitment ($R^2=0.35$) but only 8 % of the variance in continuance commitment ($R^2=0.08$). Results of this analysis are consistent with the hypothesized relationships.

Table 3

Non-parametric Correlations Between Empowerment and Organizational Commitment

Scale/Subscale	Affective Commitment	Continuance Commitment	Normative Commitment
Opportunity	0.076	-.309*	0.014
Information	.557**	0.048	.680*
Support	.389**	-0.105	.432*
Resources	.272*	-.279*	0.142
Formal Power	.614**	-0.137	.468**
Informal Power	.486**	-.349**	.380**
Total Empowerment	.664**	-.254*	.589**

* $p < 0.05$ (2 tailed) ** $p < 0.01$ (2 tailed)

Figure 12: Affective Commitment and Empowerment

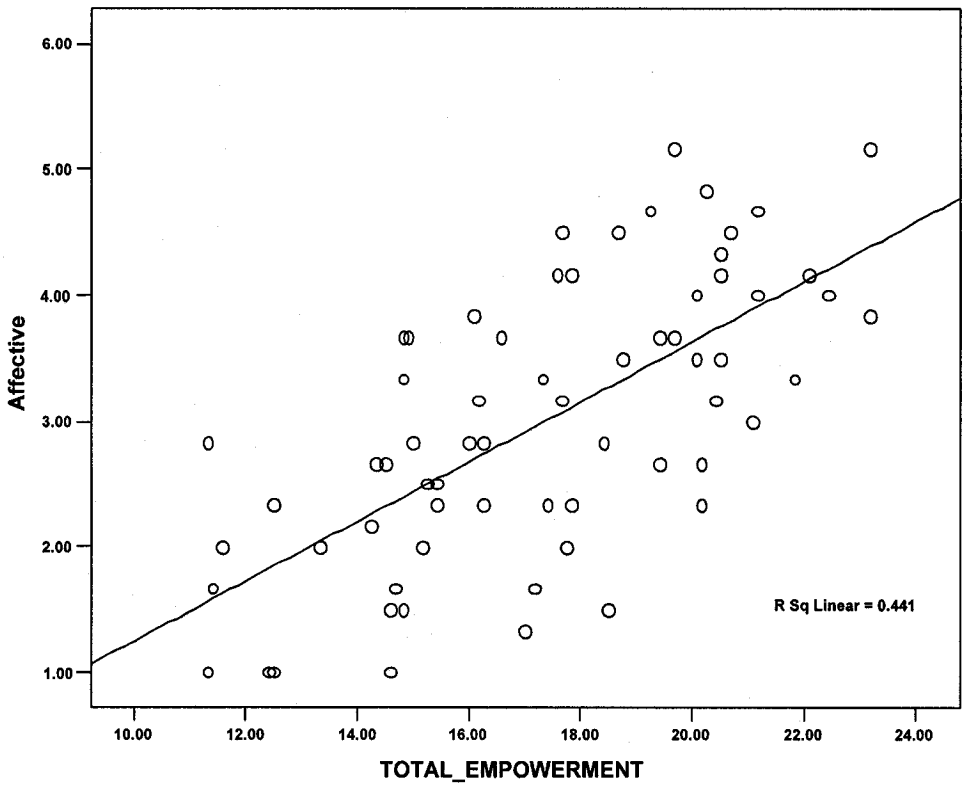


Figure 13: Normative Commitment and Empowerment

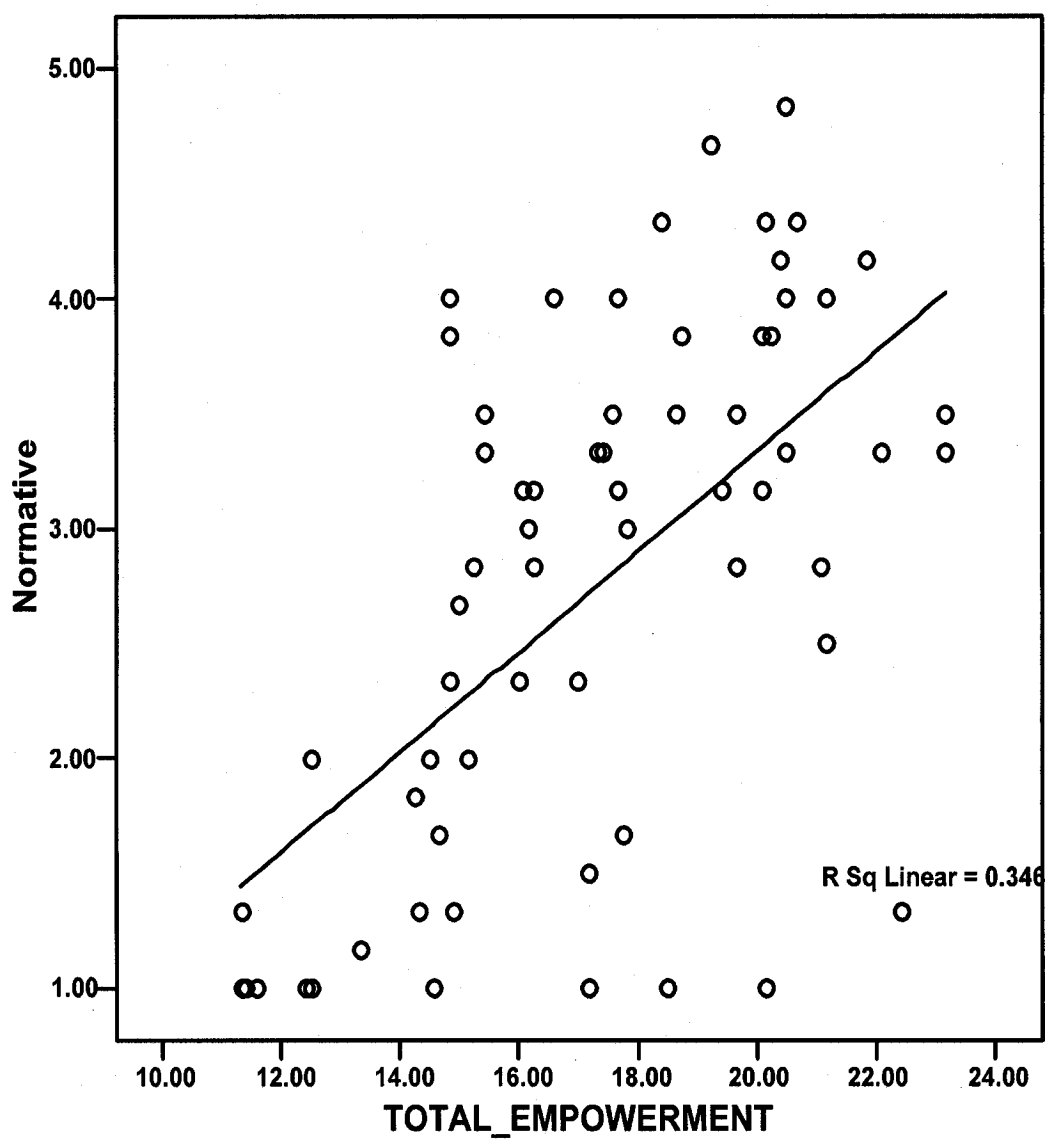
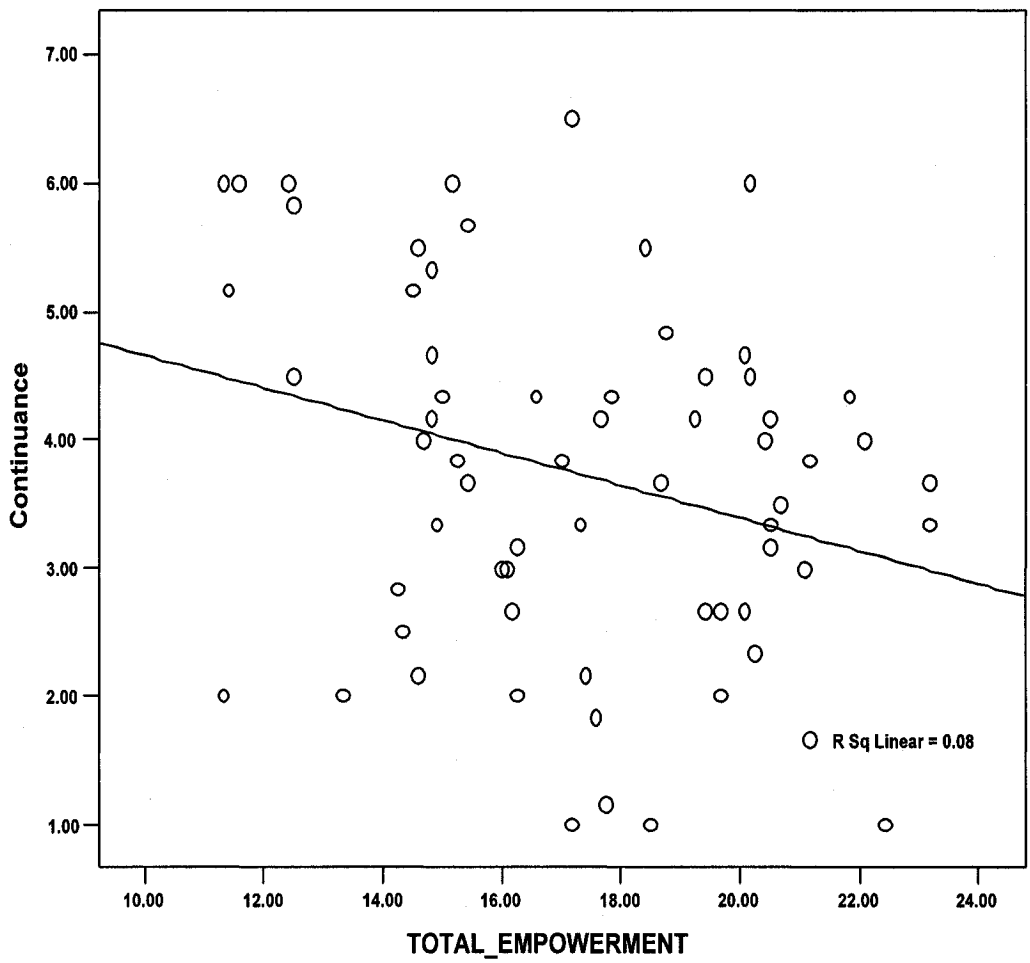


Figure 14: Continuance Commitment and Empowerment



Multiple Regression Analysis

Exploratory multiple regression analysis was conducted to test for simultaneous effects of independent (predictor) variables on the three dependent variables (three types of commitment). Independent variables that were correlated with the three measures of commitment were entered into SPSS and backward stepwise multiple regression analysis was performed, level of significance set at $p < .05$ (Munro, 2001). Variables entered for affective commitment were current employment status (part-time/casual vs full-time), informal power, formal power, access to information, access to resources, and access to support. The final model from this analysis is presented in Table 4. Access to information, formal power, and informal power explained 50.0 % of the variance in affective commitment.

Variables entered for continuance commitment were total empowerment, access to opportunity, access to resources, and informal power. As shown in Table 5, the final model from this analysis explained only 15.7% of the variation in continuance commitment, with access to opportunity the strongest predictor. Variables entered for normative commitment were access to information, informal power, formal power, access to support and total empowerment. In the final model (Table 6) access to information and informal power were significant predictors of normative commitment, explaining 50.5 % of the variation.

Table 4

Model 1: Summary of Regression Analysis for Variables Predicting Affective Commitment

Variables	B	Standard Error	Adjusted R^2
Information	.479**	0.137	
Formal Power	.401**	0.127	0.50
Informal Power	.409**	0.145	

** p <.01

Table 5

Model 2: Summary of Regression Analysis for Variables Predicting Continuance Commitment

Variables	B	Standard Error	Adjusted R^2
Opportunity	-.787**	0.268	0.157
Resources	-.428*	0.208	

* p <.05 ** p<.01

Table 6

Model 3: Summary of Regression Analysis for Variables Predicting Normative Commitment

Variables	B	Standard Error	Adjusted R^2
Information	.829**	0.131	0.505
Informal Power	.558**	0.134	

** p <.01

Summary of Results

The data analysis for this study reveals that FNIHB nurses in this study had moderate empowerment, low to moderate affective and normative commitment, and moderate continuance commitment. Spearman's rho revealed that individual characteristics did not correlate significantly with the three measures of commitment. However, t-tests for group differences revealed significant differences in part-time and full-time staff for access to resources, formal power, total empowerment, and affective commitment. Specifically part-time/casual staff had significantly higher scores on these measures.

As predicted, total empowerment was positively correlated with affective commitment and normative commitment and had a weak but negative correlation with continuance commitment. Empowerment explained 44% of the variance in affective commitment (R^2=0.441) and 35% of the variance in normative commitment (R^2=0.346) but only 8 % of the variance in continuance commitment (R^2=0.08).

Multiple regression analysis revealed models that explained 50% of the variance in affective commitment and 51% of the variance in normative commitment. Significant predictors of affective commitment were access to information, formal power and informal power. Significant predictors of normative commitment were information and informal power. Demographic characteristics did not yield any predictive power in multiple regression analysis for the three measures of commitment.

Chapter Six: Discussion and Implications

Introduction

Kanter's Structural Theory of Power in Organizations provides a useful framework to study sources of power in work settings, sources that are amenable to change. Studies conducted by the UWO Workplace Empowerment have established empirical support for the theory in nursing populations. These studies have found that staff nurses demonstrate only moderate empowerment scores, suggesting the need for significant improvements in nursing work environments. These studies have also provided empirical support for the use of Kanter's theory as a guide in instituting theory-based approaches to organizational change through the creation of organizational structures that increase access to the sources of work empowerment (Laschinger et al., 1997; Laschinger et al., 1999; Laschinger et al., 2003b; Laschinger & Wong, 1999).

The current study tests a model derived from Kanter's Theory of Structural Empowerment and describes the relationship between FNIHB nurses' perceptions of work empowerment and their commitment to the organization. The complex, autonomous work environments of FNIHB nurses are unique to this population of nurses and findings from this study add significantly to the body of literature. Study findings support the research hypothesis and will provide useful information to the Office of Nursing Services as they seek to transform FNIHB nursing work environments through the 'Nursing Transformation Strategy' (ONS, 2004).

Discussion of Findings

Support for Kanter's Theory of Structural Empowerment. Kanter's Theory of

Structural Empowerment (1993) contends that it is organizational structures and not individual characteristics that influence structural empowerment, and that structural empowerment has predictable effects on workplace behaviors and attitudes. Kanter identifies four sources of organizational power: access to information, support, opportunity, and resources. Systemic aspects of formal and informal power influence access to these four structures. Access to these six organizational structures empower individuals, enable work effectiveness, and result in positive work behaviors and attitudes (Kanter).

Consistent with Kanter's theory, workplace empowerment in this study had a positive association with affective and normative commitment and a negative association with continuance commitment. Total empowerment was strongly positively correlated with affective and normative commitment and negatively correlated with continuance commitment Consistent with Kanter's theory, demographic characteristics did not have a predictive effect on commitment scales using multiple regression.

In summary, results of this study support the hypothesized relationships derived from Kanter's theory and the study framework, further validating this theory and its application in this setting.

Comparison of Findings to Literature. As demonstrated in Table 7 and 8, the results of the current study are consistent with published studies utilizing Kanter's theoretical framework with the CWEQ-II and the OCQ. Table 7 provides a comparison of findings from the current study and the three published studies utilizing the CWEQ II (Kluska et al., 2004; Laschinger et al., 2001c; Laschinger et al., 2004). Table 8 provides a

comparison of the current study with the two published studies examining the relationship between workplace empowerment (as defined by Kanter's theory) and the affective and continuance commitment measures of the OCQ (Laschinger et al. 2000; and Laschinger et al., 2001b). No studies were found that measured normative commitment in relationship to Kanter's Theory of Structural Empowerment.

Results of the current study are within the range of reported results, with means for all measures within the reported standard deviations of reported studies. Findings consistent with previous studies lend support to the validity of the study instruments in the current study. A further test of construct validity, the global empowerment score, also correlated strongly with total empowerment in this study ($r = .772$, $p < .01$). Cronbach's alpha for the CWEQ-II and the three measures of commitment (as reported in Chapter 5) demonstrated acceptable internal consistency reliability for these measures.

Table 7

Comparison of Empowerment Scores in Studies using the CWEQ-II

Instruments	Current Study FNIHB Nurses		Laschinger et al., 2001c Hospital Staff Nurses		Kluska et al, 2004 Hospital Staff Nurses		Laschinger et al., 2004 Hospital Nurse Managers	
	M	(SD)	M	(SD)	M	(SD)	M	(SD)
CWEQII	17.34	(3.06)	17.79	(3.31)	18.48	(3.00)	20.1	(2.94)
Opportunity	4.5	(.06)	3.78	(0.79)	4.14	(0.69)	4.13	(.64)
Information	2.0	(0.77)	2.76	(0.88)	2.74	(0.91)	3.83	(.70)
Support	2.4	(0.98)	2.62	(0.84)	2.68	(0.92)	3.04	(.76)
Resources	2.6	(0.77)	2.81	(0.78)	2.91	(0.81)	2.43	(.77)
Formal Power	2.4	(0.93)	2.43	(0.85)	2.56	(0.83)	2.98	(.77)
Informal Power	3.4	(0.75)	2.92	(0.76)	3.47	(0.73)	3.67	(.66)

M = Mean SD = Standard Deviation

Table 8

Comparison of Commitment Scores in Studies using the OCQ

Instrument	Current Study FNIHB Nurses		Laschinger et al. 2000 Hospital Staff Nurses		Laschinger et al. 2001b Hospital Staff Nurses	
	M	(SD)	M	(SD)	M	(SD)
Affective	2.99	(1.1)	3.75	(1.2)	Group1: 3.45	(1.2)
					Group 2: 3.95	(1.1)
Normative	2.73	(1.2)	NM		NM	
Continuance	3.72	(1.4)	4.42	(1.3)	NM	

M = Mean SD = Standard Deviation *NM= not measured

Empowerment. Consistent with previous studies, nurses in this study had moderate empowerment scores (Kluska et al., 2004; Laschinger et al., 2001c; Laschinger et al., 2004). Studies from the Workplace Empowerment Research Program (UWO) have identified moderate empowerment scores in nursing as indicative of the need to improve the structures of power in nursing work settings. Laschinger's program of research has found that increases in structural empowerment influences employees' feelings of personal empowerment which in turn affects work behaviours and attitudes (Laschinger et al., 2001c). Structural empowerment is determined by Kanter's six organizational

factors (informal and formal power and access to information, support, opportunity and resources).

Of the six empowerment subscales, nurses in this study perceived themselves as having the greatest access to the opportunity (M = 4.46). Access to opportunity refers to the opportunity to gain new skills and knowledge on the job, as well as challenging, autonomous work (Kanter, 1979 b; Laschinger et al., 2004). Exceptionally high numbers of nurses in this study felt that they had 'a lot' of opportunity for challenging work (98 %) and attainment of new skills and knowledge (90.5%) in their present jobs.

This finding is not unexpected considering what is known about the challenging and complex environment in which these nurses work. Nurses in these settings are highly autonomous with diverse and complex roles. They are often the only health resource in communities of several hundred people and function as primary (acute) care and community health nurses (Talier et al., 2003). The Aboriginal Nurses Association of Canada (ANAC) in their survey of 189 nurses employed in northern aboriginal communities (56% with FNIHB) found that these independent and challenging roles were one of the main factors that motivate nurses to remain in isolated nursing stations (2000).

Nurses in this study perceived themselves to have the least access to information (M = 2.0). Access to information refers to the ability to be 'in the know', formally and informally, and to have the knowledge of organizational decisions, policies and goals necessary to be effective within one's position (Kanter, 1979b; Laschinger et al., 2004). The majority of nurses in this study (84.3%) felt they had little knowledge of the current state of the organization, with many (17%) stating that felt they had no knowledge in this

area. Strikingly, almost all of the nurses (97.1%) scored information on the values and goals of top management as three or less, with many indicating they had no knowledge of the goals (41.4 %) and values (38.6 %) of top management.

Access to support for this group also was also than average (M = 2.4). Access to support refers to feedback and guidance from peers, subordinates, and superiors. Support can refer to emotional, professional, or technical support (Kanter, 1979b; Laschinger et al., 2004). Many participants (20%) in this study felt they had no support and only a few (2.9 %) felt they had some to 'a lot' of support. The majority of respondents (78.6%) rated their access to support as 3 or less. Within the access to support sub-scale one third of nurses felt that they had ' no specific information on things they did well'. In addition one quarter of nurses (25.7%) felt they received 'no specific information on how they could improve' and one fifth (20 %) felt they received 'no helpful hints or problem solving advice'.

The perception that management was unsupportive to staff was a theme identified from the written notations, which included comments related to criticism from managers, little support or guidance, no valuing of staff, and a lack of trust between staff and managers. Similarly, a lack of management support was the leading reason that nurses in the ANAC survey left, or considered leaving, their positions (2000).

Access to resources was another area of concern for this group of nurses, with the majority of nurses perceiving little or no access to this subscale (78.6 % of respondents rated their resources as 3 or less). Access to resources refers to the ability to access the money, time, supplies, and resources required to accomplish organizational goals (Kanter,

1979b; Laschinger et al., 2004). Nurses in this study responded that they did not have sufficient time available to complete job requirements (75.7% scored 3 or less) or necessary paperwork (84.3 % scored 3 or less). Acquiring temporary help when needed was particularly difficult for this group of nurses, with 24% stating they had no access to resources for temporary help.

As noted in Table 7 (p. 104), subscale scores for this group of nurses are consistent with those of nurses in previous studies (Kluska et al., 2004; Laschinger et al., 2001c; Laschinger et al., 2004). All three published studies reviewed in Table 7 found that access to opportunity was rated as the highest subscale score. Access to information, support, and resources were lower for this group of nurses, but within the standard deviations of the other studies (with the exception of information scores found by Laschinger et al. 2004).

Lower scores on these three structures (information, support, and resources) may be related to certain unique characteristics of this working environment. Specifically, staff nurses and first line managers are employed in semi-isolated and isolated work settings geographically dispersed across northern Manitoba. Middle and senior nursing management are not co-located within these settings, rather these individuals are situated centrally in the city of Winnipeg in southern Manitoba. These geographical separations could conceivably impact the ability of middle and top management to be perceived as providing information, support, and resources to staff nurses and first line managers. However, these speculations should be considered tentative at best as questions testing for this possible relationship were not part of the current study.

Inconsistent with several reported studies, managers (NIC's) in this study did not have significantly higher empowerment scores than staff nurses (CHN's)(Laschinger & Shamian, 1994; Goddard & Laschinger, 1997; Haugh & Laschinger, 1996; McDermot et al., 1996). Interpretation of this finding is limited by the lack of published literature on FNIHB nurses, however, Kanter's theory does provide insight into this result.

Kanter identifies the position of first line supervisor as one that "almost universally creates powerlessness" with "no other organizational category as subject to powerlessness" (Kanter, 1979, p. 68). One particular factor in this powerlessness, one that has particular resonance for this group of first line managers, is that first line managers often administer programs and explain policies that they have had "no hand in shaping" (Kanter, p. 68). This factor is supported by the finding that NIC's in this study perceived equally low perceptions of access to information and support as their CHN colleagues.

Consistent with the literature (Kluska et al., 2004; Laschinger et al., 2001c; Laschinger et al., 2004) nurses in this study perceived greater informal power (M = 3.35) than formal power (M = 2.43). Formal power results from one's placement in the organizational hierarchy, while informal power is derived from alliances and social networks (relationships with mentors, peers, and subordinates). High levels of formal and informal power facilitate access to the sources of power and opportunity leading to greater structural empowerment (Kanter, 1979b; Laschinger et al., 2004).

As noted, nurses in this study perceived lower than average levels of formal power in their positions. Formal power was measured through perceptions of rewards for innovation, flexibility on the job, and visibility of work activities within the organization.

While large numbers of nurses felt there was some or more than some flexibility in their job (69.6% scored this item 3 or higher) a significant number of respondents (45.7%) felt there where no rewards for innovation on the job and little visibility in the organization. Almost one third (29%) of participants felt that their work had no visibility in the organization, and the majority of nurses (94.2%) felt they had some or less than some visibility in the organization. These perceptions of low visibility in the organization may be related to the geographical and professional isolation of this group of nurses.

Nurses in this study did, however, perceive greater than average informal power (M = 3.35). Informal power was measured through perceptions of collaboration with physicians and being sought out by peers and managers for help with problems. Opportunity to seek out ideas from professionals other than physicians was also a measure of informal power. Almost half of the respondents (44.3%) indicated they had 'a lot' of opportunity to collaborate with physicians in their jobs and many (38.6%) felt they had 'a lot' of opportunity to be sought out by peers. Greater than half of the respondents (57.1 %) felt that they had some or more than some opportunity to seek out ideas from other health professionals. These high scored items were moderated by half of the respondents (50%) scoring the item on "being sought out by managers for help with problems" as 2 or less, with one quarter (24.3%) of nurses indicating they had no opportunity for this activity.

Higher than average perceptions of informal power in this group of nurses is consistent with the collaborative, autonomous practice settings within which they work. Scores on this subscale would have been significantly higher had they not been moderated

by the perceptions of this group of nurses that they were not being sought out by managers for help with problems. This lack of communication with managers is consistent with the findings of the ANAC survey (2000) as well as the written notations of the respondents.

An interesting finding of this study was that male respondents perceived greater access to informal power than female respondents. This finding is inconsistent with those of Finegan & Laschinger (2001) who, in their gender analysis, did not find significant differences in gender responses. Insight into this finding can be found in literature referring to Kanter's (1993) concept of tokenism as a framework for understanding why male nurses might perceive and obtain more power than female nurses.

Kanter's (1993) discussion on tokenism focuses primarily on women in male dominated professions and refers to the relative disadvantage of minority groups. This disadvantage results from stereotypical assumptions about the group, leading to attribute assignment to individuals based on their group assignment rather than individual characteristics. Evans (1997) contends that tokenism of males in nursing has the opposite outcome, leading to a distinct advantage for men. This author argues that the partriarchal culture of health care leads to assumptions about this minority group that involve gender stereotypes of men as possessing greater power and prestige. These factors may serve to advance men in nursing through gender alliances and gender privilege (informal power), leading to a disproportionate attainment of status and prestige for male nurses (Kleinman, 2004).

Commitment. Nurses in this study had greater continuance than affective or normative commitment. Continuance commitment is a function of a perceived lack of alternatives to leaving the organization, as well as a perception of significant investments in working with the organization, and therefore high sacrifice in leaving (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002). Individuals with high continuance commitment stay with the organization because they believe they need to.

A lack of alternatives was not supported as a factor in this group of nurses as more than half of the respondents (57.2%) disagreed that they had too few options to leave the organization. However, greater than two thirds (66.6%) of respondents felt they had to stay with the organization as a "matter of necessity", and over half of the respondents (55.7%) felt their lives would be "too disrupted" if they left the organization. What can be surmised from these results is that continuance commitment for this group of nurses was more likely related to perceived high sacrifices in leaving rather than a lack of employment alternatives.

The basis for these perceptions of high sacrifice were unmeasured in this study, however the ANAC survey (2000) did identify higher compensation structures (particularly salary) and contractual commitments (service payback) as factors cited by nurses as reasons they remain in their positions.

Normative commitment was the lowest type of commitment for this group of nurses. Normative commitment is "commitment based on a sense of obligation to the organization" (Allen &Meyer, p. 253) and develops in response to social pressure (e.g. expectations of others and self-presentation concerns). Individuals with high normative

commitment stay with the organizations because they believe they ought to. More than half of the nurses (59.4 %) in this study agreed with the statement 'I do not feel any obligation to remain with my current employer' and more than one third (34.8 %) of nurses strongly disagreed that the organization deserved their loyalty. The majority (70%) of respondents also disagreed that they owed a great deal to the organization.

As noted in the findings, the normative commitment scores were not normally distributed and could be separated into two groups, one with average scores and one with low scores (15% of respondents scored 1 out of 7). These two groups had significant differences in total empowerment, with the high normative commitment group perceiving greater total empowerment. One might speculate that those with higher normative commitment are the individuals who feel a sense of obligation or commitment to the community within which they work.

This speculation is consistent with the findings of the ANAC survey (2000) where long- term nurses (employed > 5years) were more likely to mention the rewards of working with the community members as the main reason for continued commitment to their job. As stated by the authors of this document "nurses come for the practice, and stay for the people" (ANAC, p.26). A sense of commitment to the community was also a major theme in the qualitative notations of this study. As normative commitment as a consequence of empowerment has not been well measured in nursing populations (no published studies were found) it is not possible to compare these findings to the literature. Normative commitment in nursing, particular nursing in FNIHB settings, would benefit from further study.

Affective commitment for this group of nurses was low, representing a lack of 'emotional attachment to, or identification with, the organization' (Allen &Meyer, 1996, p. 253). Affective commitment scores for this group of nurses are also lower than those reported in the nursing literature (Laschinger et al. 2000 & Laschinger et al.2001b). Individuals with high affective commitment remain with the organization because they want to. Affective commitment develops as a function of positive or satisfying work experience.

Within the affective commitment sub-scale the majority (78 %) of respondents agreed, and many (37.3%) strongly agreed, with the statement 'I do not feel emotionally attached to the organization'. Similarly, most (74 %) agreed with the statement ' I do not feel a strong sense of belonging to my organization'. Consistent with the nature of these responses, many (31%) respondents strongly disagreed with the statement 'This organization has a great deal of personal meaning for me'. These responses indicate that greater than one third of respondents felt no emotional attachment or sense of belonging to the organization.

These findings describing commitment indicate that FNIHB nurses are more likely to maintain organizational membership due to a belief that they need to (continuance commitment), rather than wanting to (affective commitment) or believing that they ought to (normative commitment). These findings have particular implications for the organization as affective commitment has been found to have the strongest relationship with employee retention, job satisfaction, and positive work outcomes. Conversely, continuance commitment has been demonstrated to be related to negative or

non productive work behaviours such as poor employee engagement, higher levels of absenteeism, low self esteem and job satisfaction, poor work performance, and low productivity (Laschinger et al., 2000). Low normative commitment is also noteworthy as this type of commitment, although not as strongly associated as affective commitment, is also positively related to job effectiveness and maintaining organizational membership (Meyer et al., 2002).

Relationship of Structural Empowerment and Organizational Commitment

The conceptual model for this study (see Figure 1, p. 20) depicted a proposed relationship between structural empowerment (as determined by Kanter's six structural organizational factors) and organizational commitment. Specifically, increases in perceived empowerment were expected to be positively related to affective and normative commitment, and have a negative or unrelated relationship with continuance commitment.

Consistent with this model (and Kanter's theory), workplace empowerment had a direct positive relationship with affective and normative commitment and a negative relationship with continuance commitment. Total empowerment and five of the six subscales were strongly positively correlated with affective commitment. Total empowerment had the strongest correlation with affective commitment ($r = .664$, $p = <.01$) followed by formal power and information. The only empowerment subscale that did not correlate with affective commitment was opportunity. Access to opportunity, access to resources, informal power and total empowerment negatively correlated with continuance commitment, with the strongest correlation in the subscale of informal power

(r = -.349, p = <.01). Access to information, access to support, formal and informal power and total empowerment were also positively correlated with normative commitment, with the strongest correlation with access to information (r = .680, p =<.01).

Using bivariate correlations, empowerment explained 44 % of the variance in affective commitment ($R^2 = 0.441$) and 35 % of the variance in normative commitment ($R^2 = 0.346$). However, empowerment had little predictive effect on continuance commitment, explaining only 8 % of the variance in this measure ($R^2= 0.08$). Furthermore, multiple linear regression analysis revealed three explanatory models consistent with the study framework and hypothesized relationships. In model 1 (Table 4, p. 98) access to information, formal power, and informal power explained 50% of the variance in affective commitment. In the third model (Table 6, p. 99) access to information and informal power were significant predictors of normative commitment, explaining 51 % of the variation. Linear regression of continuance commitment explained only 16% of the variation, with access to opportunity the strongest predictor (Table 5, p. 98).

Consistent with the literature, and the theoretical framework, demographic factors were not predictive of commitment scores. However, findings related to employment status groups is worthy of further discussion. Although non significant in multiple regression analysis, employment status (PT/casual versus FT) did show significant mean differences in t-test analysis. Part- time/casual respondents perceived greater access than their full-time counterparts to three of the six empowerment subscales, and had

significantly greater total empowerment scores. Perceived access to information, resources, and formal power were all significantly higher for part time/casual employees. The mean total empowerment scores for part time/casual employees was 18.56, whereas the mean score for full time employees was 16.61. Part time/casual employees also perceived significantly higher affective commitment as compared to their full time colleagues.

There were no studies found in the literature review that specifically examined the potential relationship between employment status and empowerment and comparisons to the literature can therefore not be made. This study found several significant t test differences between part-time/casual and full-time nurses, these results are an interesting and important contribution to the literature. Further studies on the relationship between employment status and the study variables would significantly add to the current body of knowledge.

Summary of Discussion. The research hypothesis for this study was supported, demonstrating that structural empowerment had a strong positive impact on affective and normative commitment. These findings support Kanter's theoretical proposition that structural empowerment determines workplace behaviours and attitudes. Nurses in this study perceived only moderate perceptions of empowerment and low access to information, support, resources, and formal power. A strong correlation between empowerment and affective and normative commitment in this study suggests that by implementing structures to facilitate nurses access to work related empowerment FNIHB could increase affective and normative commitment in this group of nurses.

Kanter's Theory of Structural Empowerment has not been previously tested in this population of nurses who are employed in unique, complex, and highly autonomous work environments. Results of this study add significantly to a growing body of knowledge on empowerment and nursing work environments and provide support for Kanter's theory in this setting. This study contributes to the literature as findings related to normative commitment were found to be unreported in the nursing literature, as was the influence of employment status on empowerment and commitment.

Study Considerations

Representativeness of the Sample. The FNIHB nurses who responded to the survey (n = 70) were predominately female, full time employees. Their average age was 41 years, average years of experience was 15.1 years, and the average length of employment with FNIHB was 5.6 years. Half (50%, n= 35) of the respondents were diploma prepared, 40% (n = 28) were baccalaureate prepared and 10% (n = 7) were prepared at the graduate level. One hundred percent of the males in the study population responded to the survey (n = 13), while 68 % of the females responded (n = 57). Twenty one respondents identified themselves as part time (PT), 42 as full time (FT) and 7 as casual, representing 62%, 78% and 54 %, respectively, of PT, FT and casual employees in the study population. The lower response rate of the part-time and casual employees may be related to the movement of these employees between stations.

Fifty one respondents identified their current position as community health nurse, representing 64% of the community health nurses in the study population. Eighteen respondents identified their current position as nurse in charge, representing 90% of the

nurses in charge in the study population. This is a significant response rate from this subsection of the population.

Comparisons between the characteristics of respondents in this study and nursing as a whole within Manitoba and Canada reveal minimal differences. Manitoba's nursing population totals 10, 628 nurses, of which 5% are male and 95% are female. The average age of registered nurses in Manitoba is 45.0 years of age. In Canada as a whole, 67.9% of registered nurses are diploma prepared, 29.8% are baccalaureate prepared, and 2.4% are Master's prepared. Almost half (47%) of Manitoba's nurses work full time, while 46% work part time and 7% work on a casual basis (CNA, 2004).

In summary the sample derived from the population of FNIHB employed nurses is fairly representative of the study population for most of the known demographic characteristics. In addition this sample has similar characteristics as the population of nurses in Manitoba as a whole, with the exception of educational preparation and gender, for which this population has a proportionateley greater number of male nurses and nurses prepared at the baccalaureate and graduate levels. These differences, as well as the uniqueness of the work setting, limit the ability to generalize findings from the current study to other nursing populations and work settings.

Study Limitations. Interpretation of the findings from this study should be considered in view of the study limitations. There is an identified lack of research on nurses in this setting, and in particular on FNIHB employed nurses (Talier et al., 2003), limiting the interpretation of some of the findings in comparison to previous literature. Anecdotal evidence and personal experience of the writer were drawn upon in exploring

some of the findings.

The primary limitation of this study, as with all non-experimental designs, is the inability to reveal a causal relationship between the study variables (Polit & Beck, 2004). The relatively small sample size (n=70) is also a limitation as it is not known how homogenous this population is. Although the sample was fairly representative of the overall population as whole, it was not possible to determine how responders differed from non-responders and there is potential for a non-response bias in the 30 % of the population who did not respond to the survey.

In addition, the nature of the sample (specific to FNIHB nurses) is susceptible to self-selection bias. Self-selection bias refers to the possibility that nurses who choose to work in this particular setting have similar pre-existing traits or characteristics that may influence the variables under study, thus limiting the ability to generalize the results from this study to other settings. As with all survey methodology there is also a risk of social desirability bias, whereby respondents may have a tendency to self-report in a manner consistent with what they believe to be socially desirable rather than a true reflection of their opinions. The use of an anonymous survey may decrease this tendency (Polit & Beck, 2004). The above limitations may be somewhat compensated for as the findings of the current study are similar to those of previous studies and consistent with theoretical predictions.

Implications for Office on Nursing Services

Kanter's theoretical framework can be used to assess an organization's current structures and identify empowering alternatives. The literature provides significant

support for theory based strategies to improve structural empowerment, strategies such as participatory management practices, shared governance systems, and decentralized decision making (Laschinger et al, 2003). Shared governance approaches have considerable congruence with Kanter's (1993) Theory of Structural Empowerment, with this theory described as "instrumental in the development and formation of shared governance models" (Anthony, 2004, p. 2). Shared governance strategies include the development of structures that allow for formal participation in decision making (e.g. practice councils) and high levels of professional autonomy and accountability (Howell et al., 2001).

The results of this study provide empirical support for the relationship between structural empowerment and commitment in FNIHB employed nurses. This unique group of nurses are highly autonomous in their nursing practice yet perceive little control or influence over their work environments, as evidenced by moderately low empowerment scores and low-moderate scores on five of the six structures of power. An understanding of current perceptions of empowerment in the FNIHB nursing workforce may be instructive in removing barriers to access of power sources, facilitating acceptance of change, increasing organizational commitment, and ensuring successful implementation of the 'Nursing Transformation Strategy' (ONS, 2004). Strategies consistent with shared governance approaches have the potential to increase structural empowerment in this group of nurses, and would be worthy of consideration by the Office of Nursing Services.

Clearly these nurses perceive access to opportunities for challenging work which provides for utilization of skills and knowledge. Access to opportunity can be further

enhanced through opportunities for professional growth (e.g. education and professional development), as well as opportunities for personal growth (e.g. participation on practice councils, committees and working groups) (Laschigner & Shamian, 1994).

Nurses in this study, however, perceived much lower access to information, resources and support, and lower than average levels of formal power. Access to information was strongly correlated with affective and normative commitment and was one of the strongest predictors in multiple linear regression modeling. Improvements in access to information would be expected to significantly improve the working environments of these nurses, leading to increased empowerment and affective commitment.

Open, honest access to information is essential in promoting understanding and trust (Lashinger & Shamian, 1994). Managers can provide support both formally and informally. Genuine displays of concern for employee well being (informal support) and tangible recognition and rewards (formal support) are examples of strategies managers can employ in this empowerment structure. While this setting has particular geographic challenges to information sharing, creative strategies such as newsletters or "information hotlines" could be used to keep nurses informed about nursing policies, initiatives, and events (Laschinger et al., 2003). Team building is another initiative which can build perceptions of support and understanding among employees (Laschinger & Shamian, 1994).

Access to resources was another area of concern for these nurses. Increasing access to resources may not be feasible within limited resources and restrictive

bureaucratic policies and processes. However, increasing staff involvement in decisions around allocation of resources can be a strategy to improve empowerment in this area (Laschinger & Shamian, 1994). Access to formal power could be enhanced through activities that increase the visibility of nurses, including opportunities for creative and discretionary decision making. Improvements in informal power could be made through managers actively seeking feedback from nurses, increasing their sense of involvement in organizational decision making (Laschinger et al, 2000).

Laschinger et al. (2001b) in their study testing the relationships between job strain and structural and psychological empowerment found that decision latitude had a moderating impact on structural empowerment for nurses in high strain (psychologically demanding) jobs. Decision latitude is referred to by the authors as "the extent to which a worker has control over the nature of the job and how it is done" (Laschinger et al., 2001b, p. 240). Nurses in high strain jobs with low decision latitude were significantly less empowered, less committed, and less satisfied with their jobs. However, nurses in high strain jobs with high decision latitude experienced greater structural empowerment. These findings provide empirical support for the importance of increasing nursing involvement in decisions and control over practice in positions of high psychological demand, such as the highly complex environments within which FNIHB nurses work.

Organizational strategies designed to increase decision latitude include participatory management practices and shared governance models such as the nursing practice council model. Nursing practice councils have been referred to as shared governance in action (Doherty & Hope, 2000) and are gaining increasing recognition in

nursing as a strategy to increase employee involvement in decision making. The most frequently cited approach is the development of practice, research, education, quality assurance, and management councils (Genrick, Banks, Bufton, Savage & Owens, 2001; Miller & Meyer, 1996; Porter-O'Grady, 1994). These strategies allow nurses formal participation in decision making, providing opportunities to assume authority, responsibility, and accountability for professional practice, and increasing access to the structures of workplace empowerment (Doherty & Hope, 2000; Erikson, et al., 2003).

While geographic distances would pose particular challenges for FNIHB in the implementation of a councilor model, doing so would greatly address the barriers to work empowerment identified by nurses in this study. Creative strategies such as the use of tele-health technology, internet forums, and telephone conference calls could all be employed to increase FNIHB nurses' involvement and participation in decisions that affect their practice.

In summary, there is sufficient evidence in the literature to support that increased access to information, support, resources, opportunities, and formal and informal power can create empowered nurses. Empowered nurses are more committed to their organizations. Improving structural empowerment is an effective recruitment and retention strategy, increasing organizational commitment, and building a sustainable nursing workforce (Wilson & Laschigner, 1994). This study identifies the barriers to empowerment among the study nurses and provides information to the ONS that may assist in achieving two of the strategic goals of the Nursing Transformation Strategy; empowered nurses and a stabilized nursing workforce.

Implications for Nursing Research

A baseline for empowerment and commitment scores has been established for this population of nurses in the Manitoba Region. It would be feasible for the Office of Nursing Services (ONS) to implement specific theory based strategies with this population and repeat the study. Due to the anonymous nature of this study any further studies would be limited in ability to test for respondent specific changes in empowerment or commitment, however changes in mean empowerment and commitment scores of the population as a whole could be measured. A replication of this study could also be conducted with a random representative sample drawn from FNIHB nurses employed across regions throughout Canada. Such a study would increase sample size and examine regional variations, allowing for greater ability to generalize the findings.

As previously noted part- time/casual respondents perceived significantly greater total empowerment and higher affective commitment scores than their full-time counterparts. There were no studies found in the literature review that specifically examined the potential relationship between employment status and empowerment. A study on the relationship between employment status and the study variables may provide useful information to the ONS and would significantly add to the current body of knowledge.

There are some unanswered questions regarding commitment for this group of nurses. Who are the nurses who stay long term, and why? Why do some nurses have such low normative commitment? What are the perceived high sacrifices in leaving that give rise to high continuance commitment? Are there differences in commitment for

aboriginal nurses, or in nurses who have personal ties to the community? These are questions unanswered in the design of this study. The qualitative themes reported in Chapter 5 do, however, provide some insight and identify commitment to community as particularly salient for this group of nurses. It would be valuable to give 'voice' to this sense of commitment in FNIHB nurses through a qualitative study exploring the influence of commitment to community versus commitment to the organization.

Finally, this study has identified that FNIHB staff nurses and their first line managers are not empowered and recommends strategies to their nursing leaders that will increase their access to the structures of power. Kanter (1993) states that good leaders have "power outward and upward in the system: the ability to get for the group...a favourable share of the resources, opportunities, and rewards" (p. 168). There is one final unanswered question that bears consideration, do FNIHB nursing leaders have the power to empower? FNIHB is a large, complex, and bureaucratic organization. Kanter (1993) notes that large bureaucracies are particularly plagued with structures of low opportunity and powerlessness. A study of perceptions of empowerment in FNIHB nursing managers and leaders would contribute to a further understanding of nursing power in this unique work environment.

Summary of Study

This studied examined the relationship between FNIHB nurses' perceptions of work empowerment and their commitment to the organization. Results of this study support the hypothesized relationships derived from Kanter's theory and the study framework, further validating this theory and it's application in nursing settings. The

complex, autonomous work environments of FNIHB nurses are unique to this population and findings from this study add significantly to the body of literature on empowerment and nursing work environments.

Despite highly autonomous work settings and opportunities for challenging work FNIHB nurses perceived only moderate empowerment and had low scores on many of the organizational structures of power. A lack of access to information and support was a significant barrier for these nurses who felt invisible in the organization. They had low normative and affective commitment, and high continuance commitment, staying with the organization because they felt they needed to, not because they wanted to or believed they ought to. Results of this study indicate the need for significant improvements in the work environment of these nurses. Theory based organizational change would increase empowerment in these nurses and improve affective and normative commitment, commitment that leads to retention and job satisfaction.

The quality of nursing work environments has become a central feature in recent documents, highlighting the state of nursing in Canada today and in the future. FNIHB has embarked on a strategy to create quality work environments and empower and sustain the nursing workforce. The results of this study have provided information that has the potential to guide the Office of Nursing Services in modifying the structures within these settings, empowering the powerless and transforming nursing.

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Appendix A

Permission to Access Study Population

Health Canada / Santé Canada

First Nations and Inuit
Health Branch
Suite 300
391 York Avenue
Winnipeg, Manitoba
R3C 4W1

Your file / Votre référence

Our file / Notre référence

100-1-1

30 July 2004

Tracy Scott
Nurse Manager
OSI Clinic
Deer Lodge Centre
2109 Portage Ave.
Winnipeg, MB
R3J 0L3

Dear Tracy:

I am pleased to provide a formal letter of support for your research and approval for you to survey FNIHB nursing staff.

Workplace empowerment and its relationship with organizational commitment is certainly an essential component in providing quality nursing care in our First Nations Communities.

I would encourage you to contact Debi Matias the A/Assistant Director of Nursing when you are ready to initiate the survey of nursing staff. I look forward to the results of your research, and I anticipate that your findings will be quite relevant to the organizational changes being made in Manitoba region, and throughout the country.

Yours truly,

P. Seitz

Pamela Seitz, M.Sc.N.
Director of Nursing

cc: D. Matias

Canada

Appendix B

Study Cover Letter

Dear Study Participant:

My name is Tracy Scott. I am a student in the Master's of Nursing program at the University of Manitoba. As part of my nursing program I am conducting a study to examine the relationship between workplace empowerment and organizational commitment among First Nations and Inuit Health Branch nurses. This study has been approved the Ethical Review Committee of the Faculty of Nursing, University of Manitoba. FNIHB is aware of this study and has provided written approval for the study to be conducted in Manitoba Region.

The purpose of this study is to describe the relationship between FNIHB nurses' perceptions of work empowerment and their commitment to the organization. Information form this study can provide a research base to create or enhance empowering organizational structures. This questionnaire is being mailed to all FNIHB employed nurses in Manitoba Region.

I would like to invite you to participate in this study. If you agree to participate it will take about 15 minutes of your time to complete the attached questionnaire. Your participation in this study is voluntary and anonymous. Your employer will not know if you choose to participate. Consent to participate will be assumed I you complete and return the questionnaire in the enclosed researcher addressed, stamped envelope.

Participation in this study may benefit you indirectly through the provision of research based, theory driven information to the Office of Nursing Services and Manitoba Region regarding the structures in your workplace that act as facilitators or barriers to your perceptions of workplace empowerment. There are no known risks to you from your participation in this study.

Your involvement in this study will remain strictly confidential. All returned questionnaires will be received through my home mailing address and stored securely in my home. Your name will not be recorded anywhere. The written report and any further publication of this study will describe only group information and will not identify you in any way. Data from this study will only be accessed by myself, Dr. Judy Scanlan (Thesis Chair, University of Manitoba, Faculty of Nursing), Dr. Maureen Heaman (Thesis Advisor, University of Manitoba, Faculty of Nursing), and a Statistician from the University of Manitoba.

All participants will receive a follow-up reminder at one week, three weeks, and seven weeks. Due to the anonymous nature of this study, you will receive these reminders even though you may have already completed the questionnaire. Please disregard these notices if you have already completed the questionnaire.

A summary of the results of this study will be distributed widely to all FNIHB nurses. As stated, your consent to participate in this study is assumed by completing and returning the questionnaire. Please call me if you have any questions about this study. I

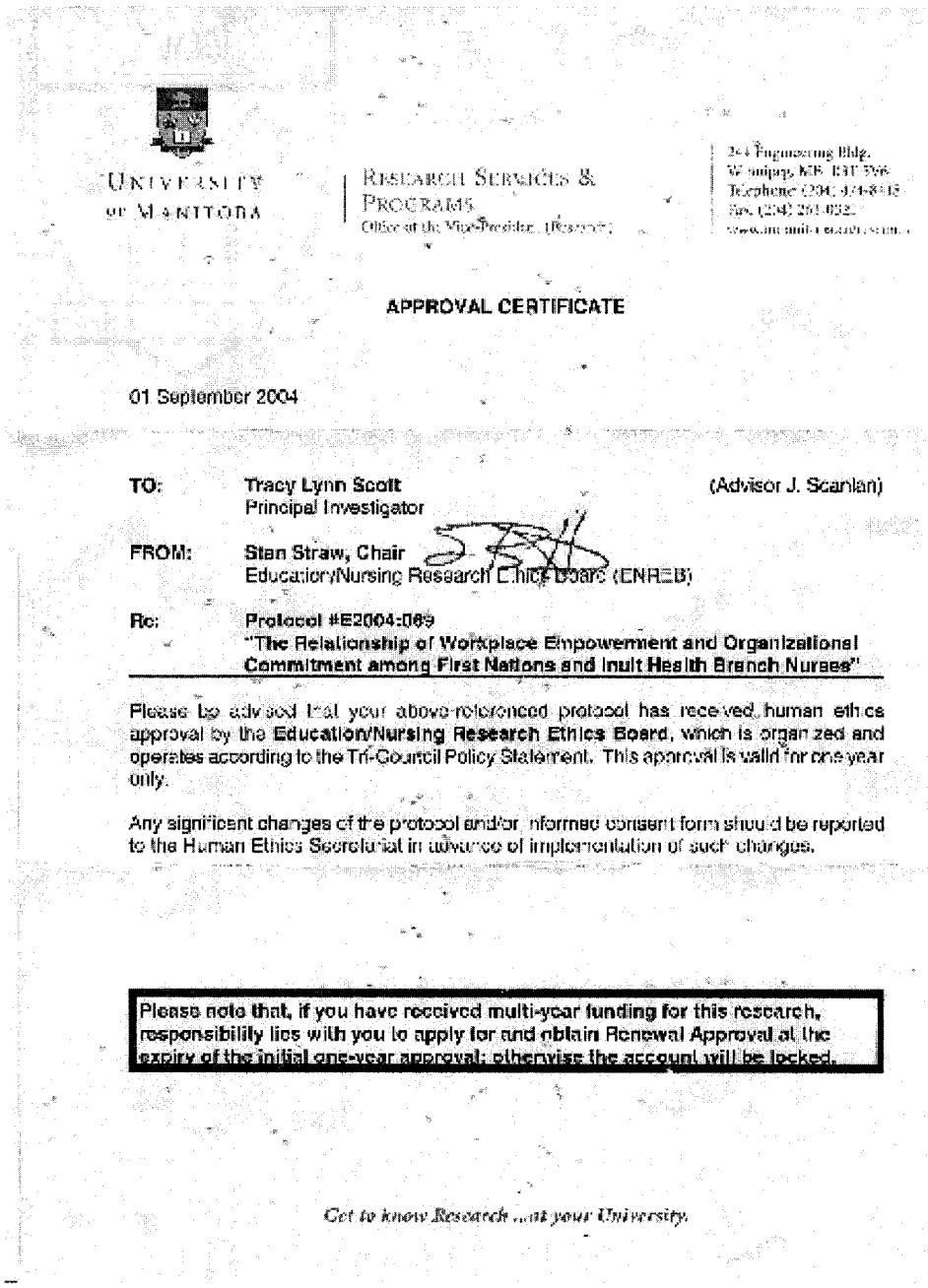
can be reached at (204) 255-4443. You do not have to identify yourself when calling. If you wish to speak to the Chair of my Thesis Committee, Dr. Judy Scanlan, you can call her at (204) 474-8175. **Thank you for your time and attention.**

Sincerely,

Tracy Scott
Master's of Nursing Candidate.

Appendix C

Ethics Approval



UNIVERSITY OF MANITOBA | RESEARCH SERVICES & PROGRAMS
Office of the Vice-President (Research)

APPROVAL CERTIFICATE

01 September 2004

TO: Tracy Lynn Scott (Advisor J. Scanlan)
Principal Investigator

FROM: Stan Straw, Chair
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2004:069**
"The Relationship of Workplace Empowerment and Organizational Commitment among First Nations and Inuit Health Branch Nurses"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note that, if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Get to know Research ...at your University.

Appendix D

CWEQ-II Approval

NURSING WORK EMPOWERMENT SCALE

Request Form

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

Questionnaires Requested:

- ✓ Conditions of Work Effectiveness-I (staff version) (includes JAS and ORS)
- ✓ Conditions of Work Effectiveness-II (includes JAS-II and ORS-II)
- ____ Job Activity Scale (JAS)
- ____ Organizational Relationship Scale (ORS)
- ____ ODO-II or MAS (Manager Activity Scale)

Population Under Study: First Nations and Inuit Health Branch Nurses

Name: Tracy Scott Signature: [signature]

Title: Nursing Services Manager Date: April 22, 2004

Address: 401-286 Smith St
Winnipeg, MB
R3C 1K4

Phone: (H) 204-255-4443
204-957-5057 or 863
Fax 204-947-2908

E-mail: (work) tscott@anahealth.ca (home) dtscott@mts.net

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

Date: May 19, 2004 Signature: [signature]

Dr. Heather K. Spence Laschinger
Professor
School of Nursing
The University of Western Ontario
London, Ontario, Canada N6A 5C1
Tel: (519) 661-4065 FAX: (519) 661-3410
EMAIL: HKL@uwo.ca

file://G:\USERS\tscott\My%20Documents\schoolrequest%20for%20permission.htm 4/1/2004

Appendix E

OCQ Approval

From: "Dave Scott" <dtscott@mts.net>
To: <tscott@amahealth.ca>
Date: 5/31/04 6:33PM
Subject: Fw: Organizational commitment scales

---- Original Message ----
From: "John Meyer" <meyer@uwo.ca>
To: <dtscott@mts.net>
Sent: Monday, May 31, 2004 6:56 AM
Subject: Organizational commitment scales

> Dear Tracy,
> You are welcome to use our commitment scales in your research. I have
> attached a copy of these scales along with the results of a recent
> meta-analysis of research that has used them. We have also made some
> modifications to the continuance commitment scale (see attached in press
> article). Good luck with your research.
> Best regards,
> John
>
> --
> John Meyer
> Department of Psychology
> University of Western Ontario
> London, ON, Canada N6A 5C2
> Phone: (519) 661-3679
> Fax: (519) 661-3961
> Email: meyer@uwo.ca
>
>

Appendix F

Demographic Form

Thank you for agreeing to participate in this study. Your answers will be kept anonymous. Please answer the following questions:

What is your age? _____ **(Years)**

What is your gender?

Male _____

Female _____

How long have you been a nurse? _____ **(Months)**

OR

_____ **(Years)**

What is your current position?

Nurse in Charge _____

Community Health Nurse _____

Other (please specify) _____

How long have you been employed with FNIHB? _____ **(Months)**

OR

_____ **(Years)**

What is your current employment status?

Casual: _____

Part-time: _____

Full-time: _____

What is your highest educational preparation?

Diploma: _____

Under-graduate: _____

Graduate: _____

Other (please specify): _____

Appendix G

Conditions of Work Effectiveness Questionnaire-II

How much of each kind of opportunity do you have in your present job?

	None		Some		A Lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge.	1	2	3	4	5

How much access to information do you have in your present job?

	No Knowledge		Some Knowledge		A Lot of Knowledge
1. The current state of the hospital.	1	2	3	4	5
2. The values of top management.	1	2	3	4	5
3. The goals of top management.	1	2	3	4	5

How much access to support do you have in your present job?

	None		Some		A Lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific comments about things you could improve.	1	2	3	4	5
3. Helpful hints or problem solving advice.	1	2	3	4	5

How much access to resources do you have in your present job?

	None		Some		A Lot
1. Time available to do necessary paperwork.	1	2	3	4	5
2. Time available to accomplish job requirements.	1	2	3	4	5
3. Acquiring temporary help when needed.	1	2	3	4	5

In my work setting/job:

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

How much opportunity do you have for these activities in your present job?

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

	Strongly Disagree				Strongly Agree
1. Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2. Overall, I consider my workplace to be an empowering environment .	1	2	3	4	5

Appendix H

Permission to Modify CWEQ-II

>>> < > 05/19/04 10:09AM >>>

Dear Tracy,

Find attached a copy of your signed request form for use of the empowerment scales. With regard to the study by Joan Almost and Dr. Laschinger with nurse practitioners, the CWEQ was modified somewhat with a few extra items being added to some of the subscales and a few words being changed to fit the practice setting of this sample. I spoke with Dr. Laschinger about some of the changes you wanted to make to the tool. She is fine with you changing the word "hospital" to "organization" for question #1 of the information subscale and the words "patient care" to "client care" for question #1 of the ORS subscale. With regard to question #4 of the ORS subscale about other professionals, Dr. Laschinger was wondering if the nurses you want to survey would have access to these services/relationships on-line. If not, and you don't feel that this question applies to your sample, she said it would be okay to leave it off.

Hope this helps, good luck with your study.
Julia Kim
Research Assistant to
Dr. Heather K. Spence Laschinger

Appendix I

Organizational Commitment Questionnaire

Listed below is a series of statements that represent feelings that individuals might have about the company or organization for which they work. With respect to your own feelings about the particular organization for which you are now working, please indicate the degree of your agreement or disagreement with each statement by circling a number from 1 to 7.

STRONGLY DISAGREE	SLIGHTLY DISAGREE	DISAGREE	NEITHER DISAGREE NOR AGREE	AGREE	SLIGHTLY AGREE	STRONGLY AGREE
1	**2**	**3**	**4**	**5**	**6**	**7**

1. I would be very happy to spend the rest of my career with this organization.

   1 2 3 4 5 6 7

2. I do not feel any obligation to remain with my current employer.

   1 2 3 4 5 6 7

3. This organization deserves my loyalty.

   1 2 3 4 5 6 7

4. I do not feel "emotionally attached" to this organization.

   1 2 3 4 5 6 7

5. This organization has a great deal of personal meaning for me.

   1 2 3 4 5 6 7

6. Right now, staying with my organization is a matter of necessity as much as desire.

   1 2 3 4 5 6 7

STRONGLY DISAGREE	SLIGHTLY DISAGREE	DISAGREE	NEITHER DISAGREE NOR AGREE	AGREE	SLIGHTLY AGREE	STRONGLY AGREE
1	**2**	**3**	**4**	**5**	**6**	**7**

7. I do not feel a strong sense of "belonging" to my organization.

1 2 3 4 5 6 7

8. It would be very hard for me to leave my organization right now, even if I wanted to.

1 2 3 4 5 6 7

9. I do not feel like "part of the family" at my organization.

1 2 3 4 5 6 7

10. I really feel as if this organization's problems are my own.

1 2 3 4 5 6 7

11. I feel that I have too few options to consider leaving this organization.

1 2 3 4 5 6 7

12. If I had not already put so much of myself into this organization, I might consider working elsewhere.

1 2 3 4 5 6 7

13. I owe a great deal to my organization.

1 2 3 4 5 6 7

STRONGLY DISAGREE	SLIGHTLY DISAGREE	DISAGREE	NEITHER DISAGREE NOR AGREE	AGREE	SLIGHTLY AGREE	STRONGLY AGREE
1	**2**	**3**	**4**	**5**	**6**	**7**

14. Even if it were to my advantage, I do not feel it would be right to leave my organization now.

1 2 3 4 5 6 7

15. I would feel guilty if I left my organization now.

1 2 3 4 5 6 7

16. Too much of my life would be disrupted if I decided I wanted to leave my organization now.

1 2 3 4 5 6 7

17. I would not leave my organization right now because I have a sense of obligation to the people in it.

1 2 3 4 5 6 7

18. One of the few negative consequences of leaving this organization would be the scarcity of available alternatives.

1 2 3 4 5 6 7

Appendix J

Pre-notice

December 13, 2004

Last week a questionnaire on workplace empowerment and organizational commitment was sent to all FNIHB employed nurses in Manitoba region.

This survey is anonymous, your name has not been recorded on any documents. If you have already completed and returned the questionnaire to me, please accept my sincere thanks. If not, please do so today. I am especially grateful for your help in completing this survey.

Sincerely,

Tracy Scott
23 Baisinger Dr.
Winnipeg, MB
R2N 3Y1
(204) 255-4443

Appendix K

Reminder Letter

January 06, 2005

Dear Study Participant:

A few weeks ago a questionnaire on workplace empowerment and organizational commitment was sent to all FNIHB employed nurses in Manitoba region.

This survey is anonymous, your name has not been recorded on any documents. If you have already completed and returned the questionnaire to me, please accept my sincere thanks. If not, please do so today. I am especially grateful for your help in completing this survey.

Sincerely,

Tracy Scott
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Winnipeg, MB
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