THE EFFECT OF LEADER EMPOWERING BEHAVIOURS ON STAFF NURSES WORKPLACE EMPOWERMENT, PSYCHOLOGICAL EMPOWERMENT, ORGANIZATIONAL COMMITMENT, AND ABSENTEEISM

By

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EFFECT OF LEADER EMPOWERING BEHAVIOURS ON STAFF NURSE PERCEPTIONS

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Abstract

The purpose of this study was to examine the relationship between staff nurses' perceptions of their leader's use of empowering behaviours and their perception of workplace empowerment, psychological empowerment and organizational commitment, and absenteeism. A correlation study was conducted by survey in three acute care teaching hospitals, that had recently merged and undergone restructuring and downsizing. Data was collected from a sample of 191 staff nurses employed full time.

Six separate measuring instruments were used: (a) Leader Empowering Behaviours Scale; (b) three tools to measure the Kanter's (1977) construct for workplace empowerment: Conditions of Work Effectiveness Questionnaire, Job Activities Scale and the Organizational Relationship Scale; (c) Spreitzer's (1995) Psychological Empowerment Scale; and (d) Meyer and Allen's (1991) Organizational Commitment Scale. Absenteeism was measured from data on days absent collected from the employees' payroll files.

Data was analysed using the Statistical Package for Social Science programs (SPSS) analysis. The findings confirmed that nurses' perceptions of leader empowering behaviours were: (1) significantly related to their perceptions of workplace empowerment structures; access to opportunity, information, support and resources, formal power, informal power and global empowerment ($p=<.001$); (2) significantly related to their

perceptions of psychological empowerment gestalt and the subscales autonomy, impact (p=<.001) and meaning (p=.006), but not significantly related to confidence (p=.139); (3) significantly related to their perceptions of overall organizational commitment, affective and normative commitment (p=.001), but not significantly related to continuance commitment (p=.617); and (4) not significantly related to absenteeism.

The study suggest the need for further study and consideration of methodological issues in the study of leadership and absenteeism.

Dedication

This dissertation is dedicated to my husband, Gregory, and my sons, Joshua and Zachary, whose support, encouragement, and love made this endeavour possible. And to my mother who was a model of great strength and love.

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Chapter 1

Introduction

Nurses are working in environments in acute care organizations that are in a state of rapid change. The pressures of these workplace changes on nurses demand supportive and empowering leadership. The challenge then for leaders is how to maintain the commitment of staff nurses dealing with these rapidly changing work environments and at the same time retain an adequate quality of patient care. Although much has been written about the importance of empowering leadership, there are few empirical studies in which leader empowering behaviours were linked to factors influencing staff nurses' responses to their work environment. The objective of this study is to examine the effects of empowering leadership on nurses' perceptions of their workplace and their attendance behaviours, in a recently merged acute care hospital organization. In particular, this study will measure nurses' perceptions of workplace empowerment, psychological empowerment, and organizational commitment, and their attendance behaviours and the association of these variables with the manager's use of leader empowering behaviours.

Background

Changes in Acute Care Organizations

The Canadian health care system, in response to economic pressures, is under-going dramatic changes and restructuring in an effort to control increasing costs and meet the

increasing demands for health care services. These changes are pervasive and often unpredictable which create many challenges for healthcare organizations and their workforce to continue to provide quality health care services (Ingersoll, Kirsch, Merk, & Lightfoot, 2000). In response to economic pressures, acute care administrations have instituted various strategies to restructure and redesign the patient care delivery systems, work organizations, roles, processes and practices to conserve financial resources (Havens & Aiken, 1999; Baumann et al., 1995; McKee, Aiken, Rafferty, & Sochalski, 1998; Sochalski, Aiken, & Fagin, 1997; Shamian & Lightstone, 1997). Current strategies for change are often different from redesign efforts of the past. For example, they are usually broader in scope involving multiple levels of the organization, and often have vague goals and poorly defined time lines for completion (Ingersoll et al., 2000). Thus, both managers and staff are being challenged in new and unfamiliar systems of authority and relationships to search for ways to "do more with less" with cost control and quality health care becoming the two driving forces.

Along with these changes in the organization of the acute care setting, there is emerging evidence that there is a current shortage of nurses, specifically in critical care areas (Freeman & O'Brien-Pallas, 1998) and an imminent, severe shortage of nurses in general across Canada (MOH, 1999; RNAO/RPNAO, 2000; Ryten, 1997). The achievement of continuity and cost-effective quality of care in acute care settings will be highly dependent on the retention and recruitment of experienced and knowledgeable nurses.

The Problem

1. Impact of Restructuring on Nursing Management in Hospital

Nurse managers who have a pivotal role in the hospital and are key in both facilitating care and ensuring the quality of worklife of nurses (McGillis-Hall & Donner, 1997; Everson-Bates, 1992) have been seriously impacted by the restructuring of acute care settings. The introductions of organizational designs, such as, program management and flattening of the hierarchy, which often resulted in the elimination of senior nursing positions and a reduction in the number of nurse managers. The senior nursing position, such as, the Vice President or Directors of Nursing, which traditionally provided leadership and professional identity at the institutional planning and policy levels were often moved to programme management or resource positions within the organization with a consequent loss of prestige and ability to influence decisions that affect their worklife (Shamian & Lightstone, 1997).

In many cases, the manager's scope of responsibility changed from managing one unit in a centralized structure to managing multiple units in a decentralized structure. In this new structure, the nurse manager supervised more people than in the traditional hierarchy and at the same time had to delegate more decisions to subordinates. Traditionally, nurse managers have been buffers for the organization, providing support to staff through any change processes. However, in their new expanded role, nurse managers, were further removed from their contact with front-line staff lessening their ability to relate to staff priorities and their clinical concerns.

2. Impact of Restructuring on Staff Nurses in Acute Care Hospitals

Hospital restructuring policies have affected nurses as employees and professionally as members of the nursing team. Restructuring polices have led to uncertainty about their job security and a perceived loss of control over their work activities, as well as, their ability to practice within professional standards. While, in the past, nurses expected that the organization would provide job security and support in return for satisfactory performance, restructuring had broken this psychological contract (Cameron, Horsburg, & Armstrong-Strassen, 1994). In response, nurses have been left to feel powerless, and having to deal with not only job insecurity, but incessant change and having to do more with less.

In addition to loss of job security, nurses experienced their role to be devalued by the act of replacing nursing positions with less-qualified health care workers. Moreover, they felt further devalued and disempowered when the nursing leadership was severely weakened by the elimination of the chief nurse and the reduction of nurse managers. In addition, the relations between nurse managers and nurses have become more distant, with less communication and fewer avenues to transmit concerns about nursing and patient care (Blythe, Baumann, & Giovenntti, 2001). As a consequence, nurses perceive that the remaining nurse managers are ineffective in bargaining for retaining nursing positions, supporting the need for resources, and being effective advocates for nursing. Thus, the assurance of a supportive work environment that does not impinge on nursing practice and patient care is difficult to obtain. Nurses also express concern that they are

being under represented in the institutional hierarchy, thus limiting their power to influence change or to act in a meaningful way to improve current conditions (Tilman, Salyer, Corley, & Mark, 1997; RNAO/RPNAO, 2000; Baumann et al., 2001). Research literature and evidence from a recent provincial inquest (Sinclair, 2000) confirm that nurses' limited participation in decision making is inefficient and dangerous to patient safety (Baumann et al.).

Nurses are also reporting that they are overextending themselves to maintain the quality of care under deteriorating conditions (Shamian & Lightstone, 1997; O'Brien-Pallas & Baumann, 1999). With fewer nurse managers, staff nurses are given greater areas of responsibility, such as the supervision of health care aides and the task previously performed by unit managers. Many of the nurses felt that they did not have the management experience, or the perceived authority to adequately perform these additional administrative duties (Blythe et al., 2001). At the same time, demands placed on clinical nursing care are increasing as a result of an aging population, increased patient acuity and advances in medical technologies permitting reduced length of hospital stays. Despite the need for more intensive nursing care, organizational changes have led to reduced nurse to patients ratios. Although limited scientific evidence exists that health outcomes are compromised, recent studies have reported that the severe work pressures on nurses are enough to affect patient care (Shullanberger, 2000) and lower nurse to patients ratios have lead to complications and poorer patient outcomes (Kovner & Gergen, 1998; Lancaster, 1997).

As a result of these changes, there has been a cost to the organization in the form of nurses' disillusionment and distrust of hospital management (Blythe et al., 2001; RNAO/RPNAO, 2000; MOH, 1999); decreased morale, high levels of stress, lower organizational commitment, and reduced job satisfaction (Blythe et al.; Corey-Lisle, Tarizian, Cohen, & Trinkoff, 1999; Geddes, Salyer, & Mark, 1999; Shamian & Lightstone, 1997; Walker, 2000; Burke & Greenglass, 2000); increased absenteeism (Akyeampong, 1999; Akyeampong & Usalcas, 1998) and high rates of extended absenteeism for psychological reasons (Bourbonnais & Mondor, 2001).

A Proposed Solution

1. The Need for Empowering Leadership

Extensive literature has focussed on the impact of hospital restructuring on staff nurses as individual employees, particularly their levels of satisfaction and productivity. Most of the studies have used both quantitative and qualitative methodologies with data collected through the use of questionnaires, focus groups and interviews with staff nurses. As the majority of the quantitative studies were of a descriptive, correlational design, cause and effect relationships could not be inferred. Despite, the interpretative problems associated with these studies, they provide extensive information about full-time nurses' perceptions of quality of worklife and interrelationships with acute care hospitals' restructuring strategies. In particular, these studies raised a number of issues and concerns surrounding nursing leadership that warrant further investigation. A consistent concern identified by nurses was the deterioration of the relations with nurse managers as

a result of restructuring and perceived change in styles of management which in some organizations made nurses feel powerless and less committed and loyal to the organization (Blythe et al., 2001; Laschinger, Sabiston, Finegan, & Shamian, 2001).

It has been proposed by a number of nursing authors and researchers that in order to effectively manage the changes and challenges in the health care system, nurse managers must move away from the traditional management paradigm of hierarchal power and control to a model of leadership that shares power and control with their subordinates (Porter-O'Grady, 1992, 1997; Gunden & Crissman, 1992; Medley & Larochelle, 1995; Morrison, Jones, & Fuller, 1997; McDaniel, 1997; Sofarelli & Brown, 1998; Lachinger, Wong, McMahon, & Kaufman, 1999; Trofino, 2000). By sharing power and control, the leader empowers nurses to play a pivotal role in the process of change and to optimize opportunities for professional practice. They argue that lack of empowerment in the nurses' everyday work can be an obstacle to their ability to give quality nursing care according to professional standards. Thus, it is important that nurses be empowered to engage in decision-making that leads to effective judgements about the delivery of patient care.

2. The Need for Empowered Nurses

The concept of employee empowerment has been widely used in management and organization literature in the past decade. This increased interest in empowerment literature is the result of the fact that management, practitioners and researchers have noted the potential importance of empowerment on employees motivation to improve

quality and productivity (Yukl, 1989; Bennis & Nanus, 1985; Block, 1987; Kanter, 1979, 1983). Such empowered employees are identified as self-motivated, committed individuals who are willing to expend high levels of effort, initiative, and persistence in accomplishing their work.

While the importance of empowerment has been widely supported in the nursing literature during the past decade (Kuokkanen & Leino-Kilpi, 2000), most of the research has been done in one ongoing research program designed to test Kanter's (1977) theory of structural power in nursing populations (Laschinger, 1996). A number of studies from this work have found that nurses working in acute care settings who are empowered, reported higher level of organizational commitment (Wilson & Laschinger, 1994; McDermott, Laschinger, & Shamian, 1996); exhibited less burnout (Hatcher & Laschinger, 1996) and perceived more psychological empowerment which in turn was shown to influence organizational commitment, job strain, and work satisfaction (Laschinger, Finegan, Shamian, & Wilk, 2001), and organizational trust (Laschinger, Finegan, Shamian, & Casier, 2001). Empowerment is said to provide well-being at both the individual and organizational level.

A Proposed Strategy: "The Way to Do It"

1. Managers' Utilization of Leader Empowering Behaviours

Many of the writings on empowerment have discussed conceptually the leader's role in creating an empowered workforce (Hui, 1994). From this perspective, empowerment does not reduce the role of the managers in the organization, but rather the managers'

actions become even more important in creating an environment for empowerment to occur. According to Kanter (1977) managers are positioned ideally to create structural conditions necessary for employee empowerment. Conger and Kanungo (1988) argue that in addition to creating empowered work structures, manager or leaders must eliminate situations that foster powerlessness and use leadership behaviours that motivate staff to accomplish goals. When managers remove disempowering elements from the work environment, employees are more likely to find their work meaningful, have a greater sense of autonomy, and have a strong belief that they can have an impact at work (Conger & Kanungo; Spreitzer, 1995a, 1995b).

The search for behaviours that can increase leader effectiveness has been a recurring theme in the leadership literature (Bennis & Nanus, 1985; Bass, 1985; Kouzes & Posner, 1987; Kanter, 1979). After reviewing previous conceptualizations and categorizations of leader behaviours, Yukl (1989) provided a comprehensive taxonomy of leader behaviours that are considered to be important to leader effectiveness. However, Hui (1994) noted that the taxonomy did not provide a direct link to possible leader empowering behaviours, nor did the taxonomy identify empowerment as a possible mechanism through which leader effectiveness is enhanced (Hui). Using the categorization of leader empowering behaviours by Conger and Kanungo (1988) as a framework, Hui provided a core set of leader empowerment behaviours and a measure with acceptable psychometric properties to test the effects of these behaviours on employee empowerment and other outcome variables. However, there has been limited empirical research to validate the association

of leader empowering behaviours with workplace outcomes in nursing populations. Only two published studies (McMahon, 1998; Laschinger et al., 1999) were found that empirically examined the relationship between leadership empowering behaviours (Hui) and nurses' perceptions of empowerment.

Summary

In summary, the profound effect that hospital restructuring has had on nurses, the current predictions of shortages of nurses, the increasing rates of absenteeism among nurses, and the potential negative effect on patient care mandates, demands that every effort be taken to improve the current working conditions for nurses working in acute care settings. The role of leadership is a dynamic one between the leader and followers. Thus, leaders should be aware of what behaviours their subordinates expect from them. However, the empirical data linking the impact of specific leader empowering behaviours on staff nurses' perceptions of workplace empowerment has been limited, yet encouraging. Although, there is an extensive body of nursing literature on leadership, organizational commitment, absenteeism and emerging literature on empowerment, there is a lack of empirical research that has explicitly examined the impact of leader empowering behaviours on these variables. An examination of these variables will add to the understanding of the issues and concerns consistently identified by nurses in response to restructuring strategies and assist nursing in the development of solutions.

Purpose of the Study

The purpose of the current study is to examine the effects of leader empowering behaviours on staff nurses' perceptions of workplace empowerment, psychological empowerment, and organizational commitment, and absenteeism. This research study proposes the following relationships.

Hypotheses

It is hypothesized that:

1. Staff nurses' perceptions of workplace empowerment are higher when they perceive their manager using high leader empowering behaviours.
2. Staff nurses' perceptions of psychological empowerment are higher when they perceive their manager using high leader empowering behaviours.
3. Staff nurses' perceptions of overall organizational commitment, affective commitment and normative commitment will be higher, whereas continuance commitment will have no relationship, when they perceive their manager using high leader empowering behaviours.
4. The number of sick leave days and episodes of sick leave days will be lower, when staff nurses perceive their manager using high leader empowering behaviours.

Significance of the Study

Nursing leaders have a rich tradition of helping to shape the health care system. With the current restructuring of the health care system, leadership is even more crucial as nurse managers are challenged to deal with the juxtaposition of two very different sets

of organizational goals - the professional and the business objectives. Inevitably these goals compete with each other, creating the need for an empowered organization (Brown & Kanter, 1982). To create an empowered organization demands a style of management that involves a power sharing process that is focussed towards the accomplishment of the organizational goal of cost-effective, quality patient care.

The researcher's background as a nurse and administrator supports the challenge of dealing with the professional and business objectives. At the same time, recognizes that achievement of these objectives are complex and that the managers' use of leader empowering behaviours is only one of a number of organizational strategies that may hold promise for creating empowering work environments, that supports professional nursing practice and achievement of cost-effective, quality patient care.

Therefore, the current study will add and enhance our understanding of the process of nursing leadership and empowering behaviours of leaders that affect work behaviours and attitudes of nurses which would ultimately be linked with the achievement of organizational goals.

Definition of Terms

For the purpose of this study, the following definitions were used.

Staff Nurse

A staff nurse is a nurse who is registered with the College of Nurses of Ontario (CNO) under the authority of the Nursing Act, S.O.1991, C.32 and its regulations, and is authorized to use the title Registered Nurse (RN). In this study a staff nurse is

responsible for direct patient care and has been employed in one of the hospitals in the study in a full-time position for more then one a year.

Acute Care Hospital

The hospitals in this study are tertiary acute care teaching hospitals that provide a full range of health care services to a large metropolitan region.

Nurse Manager

A manager is the person who has 24-hour accountability for one or more patient care units. The major functions of the role include patient care management, human resource management and fiscal/operational management according to the job descriptions of the position in the institution.

Absenteeism

In this study absenteeism is defined as a failure to appear for a scheduled shift. The total absent days were calculated by summing the hours absent and dividing by 11.25 hours; the number of hours worked per 12-hour shift according to the collective agreement for nurses at the three hospitals. The absent episodes were based on the number of consecutive shifts absent during one of the following time periods: short term (1 to 3 days) and longer term (4 to 5 or more days).

Outline of the Thesis

Chapter 1 includes the background of the study, the purpose of the study, hypotheses, significance of the study and definitions of terms.

Chapter 2 reviews the theoretical concepts and related empirical nursing research. More specifically the following are presented: (a) Hui (1994) conceptualization of leader empowering behaviours; (b) Kanter's (1977) theory of organizational empowerment; (c) Spritzer's (1995) multidimensional model of psychological empowerment; (d) Allen and Meyer's (1990) multidimensional construct of organizational commitment; and (e) empirical literature on absenteeism in nursing populations.

Chapter 3 describes the research design and methodology and measurement tools used in this study. Chapter 4 presents the analysis and findings of the study. Finally, Chapter 5 presents a summary and discussion of the findings, limitations of the study, implications for nursing, hospital administrators and nurses managers, and implications for future research.

Chapter 2

Review of the Theoretical Literature

Introduction

This section contains a review of the theoretical postulates of the mechanisms by which leader empowering behaviours influence staff nurses' perceptions of work attitudes. The theoretical framework in Figure 1 proposes the linkages between the major variables and elaborates the hypotheses of this study. The empirical support for the following concepts will be reviewed: Conger and Kanungo's (1988) empowerment process and Hui's (1994) model of leader empowering behaviours; Kanter's (1977) theory of organizational empowerment; Spreitzer's (1995a) psychological empowerment; and Allen and Meyer's (1990) multidimensional model of organizational commitment. In addition, the empirical literature related to absenteeism in healthcare will also be reviewed.

Extensive literature has focussed on the impact of hospital restructuring on staff nurses as individual employees, particularly their levels of satisfaction and productivity. A consistent concern identified by nurses was the deterioration of the relations with nurse managers as a result of restructuring and a perceived change in the styles of management which in some organizations made nurses feel powerless and less committed and loyal to the organization (Blythe et al., 2001; Laschinger, Sabiston, et al., 2002).

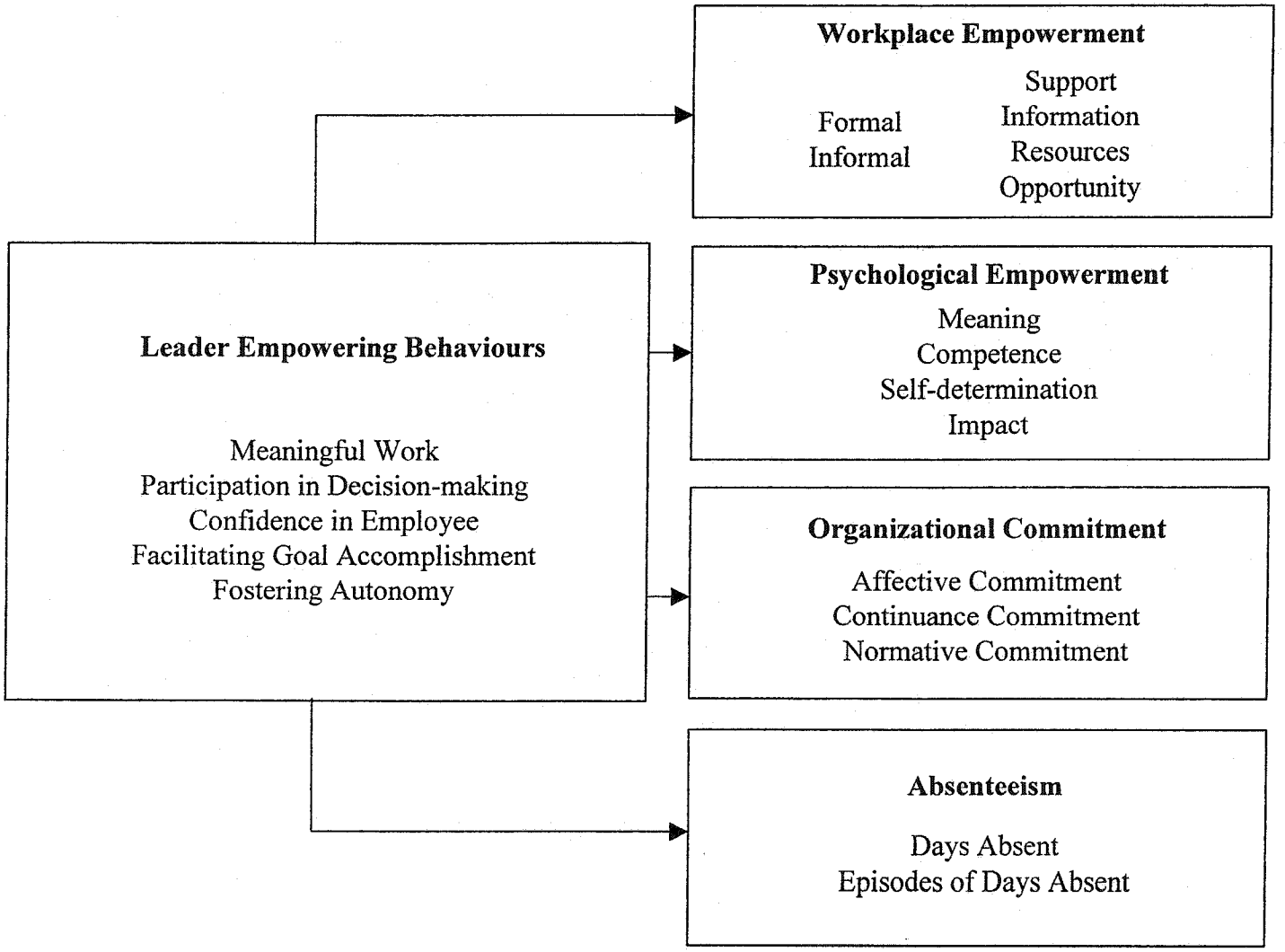

Figure 1. Theoretical framework.

Staff nurses perceived that nurse managers, while dealing with their own uncertainties and ambiguity about their expanded roles, were experiencing difficulties meeting the multiple needs of their staff and addressing the increasing distance between themselves and their staff. Whereas, other managers were perceived as more concerned about restructuring as a budgeting process, to which the staff would have to submit (Blythe et al., 2001). Thus, what is the role of the nurse manager in supporting staff nurses during these organizational changes.

The Role of the Nurse Manager: Management versus Leadership

The literature provides an exhaustive number of definitions of management and leadership with a recurrent theme of discussion surrounding the difficulties of differentiating between the two (Sofarelli & Brown, 1998). Traditionally, the role of the manager is to plan, organize and control human and material resources in order to achieve the most efficient outcomes for the organization. In order to ensure stability and control, they often possess legitimate sources of power which they use to delegate and control situations and outcomes (Kouzes & Posner, 1987). In contrast, leaders are people who often receive their power through inspiring trust, communicating a vision, focussing on the group process, demonstrating concern for subordinates and the empowering of others (Bennis & Nanus, 1985; Kouzes & Posner; Porter-O'Grady, 1992). Sofarelli and Brown suggest that if two phrases were chosen to describe the differences between management and leadership they would be "legitimate power and control" vs "empowerment and change" (p. 203).

In his review of theory and research on managerial leadership Yukl (1989) uses the terms of manager and leader interchangeable and suggests "that it is neither desirable nor feasible to attempt to resolve the controversy over the appropriate definition of leadership" (p. 253). Yukl argues that leadership and management involve different processes, but may be part on one person's role. Regardless of the controversy over the difference in the definition between leadership and management, the nursing team requires managers with well-developed management skills, as well as, leadership skills which focus on empowering people and solving problems in a constantly changing work environment. Therefore, it is imperative that the nurse managers "let go" of their traditional methods of control and develop and use leader empowering behaviours. These leadership skills and attitudes are necessary to facilitate the nurses and organization through the transitions necessary for success in a redesigned empowering work environment (Laschinger et al., 1999). Bridges (1993) argues "it is not the changes that can get you," but the transitions which people must go through to come to terms with the new situation (p. 3).

Theories of Empowering Leadership Behaviours

The 1980's saw a major paradigm shift as management researchers became interested in transformational leadership in response to economic competition. Organizations were forced to transform and revitalize the way things were done in order to survive (Yukl, 1989; House & Aditya, 1997). As a result, a new group of leadership theories emerged that use motivational theory as a framework and attempt to explain how leaders are able

to achieve follower commitment and loyalty and stress leader behaviours, such as, empowering and supportive behaviours. Thus, transformational leadership involves the influence of the leader on subordinates with the intention to empower subordinates to participate in the process of transforming and revitalizing the organization (Yukl; House & Aditya). These theories are relevant to the current organizational structures and acute care settings, where every employee, not just the leader, must be motivated and committed to reaching organizational goals. No longer do managers have the time to monitor employee behaviours and correct problems. Rather, each employee must be in charged of his/her own work and responsible for the overall results of the team. Therefore, leadership is the beginning phase of empowerment in which everyone must be involved.

Most of the research on transformational leadership theories has been descriptive and qualitative limiting the conclusions about specific relationships, however, these studies do provide insight into the nature of empowering leadership (Yukl, 1989). Three of the current theories that are described as empowering and have been empirically tested in nursing populations are outlined below: (1) Bass's (1985) Theory of Transformational leadership; (2) Kouzes and Posner's (1987) Model of Leadership Behaviours; and (3) Hui's (1994) Model of Leader Empowering Behaviours.

Bass's Theory of Transformational Leadership

The early theory of transformational leadership was developed by Burns (1978), who described leadership as a process that motivates followers by appealing to their higher

ideals and moral values. Building on this earlier theory by Burns, Bass (1985) defined transformational leadership in terms of the leader's effect on followers. He proposed a more detailed theory to describe transformational processes in organizations and to differentiate between transformational, charismatic and transactional leadership. From his perspective, transactional leaders motivate subordinates to achieve desired outcomes by setting clear expectations, goals and rewards and providing necessary clarification of the work required. In contrast, transformational leaders seek to empower and motivate followers to look beyond their self-interest for the good of the organization. The transformational leader raises individuals' needs and desires to achieve more, to work harder and to strive for the highest performance. Although transformational and transactional leadership are viewed as distinct, they are not mutually exclusive (Bass). Leaders may use both types at different times in different situations, with transformational leadership building on the transactional base to motivate employees to give that extra effort. Bass and Avolio (1990) theorized that transformational leadership is multi-factor and captures a broad range of leadership behaviours including transformational transactional and non leadership behaviours.

Most of the research on transformational leadership has used the Multi-factor Leadership Questionnaire (Bass & Avolio, 1990) which has found a correlation between transformational leadership and motivation, self-efficacy, performance, group effectiveness and satisfaction with the leader (Bass, Avolio, & Goodheim, 1987; Deluga, 1988; Dunham & Klafehn, 1990) and job satisfaction (Dunham-Taylor, 2000; Medley &

Larochelle, 1995; Morrison et al., 1997), psychological empowerment (Morrison et al.), workplace empowerment (McKay, 1995), and organizational commitment (Bycio, Hackett, & Allen, 1995).

Two of the above studies examined the relationship between transformational leadership and the constructs of empowerment in the workplace. McKay (1995) used a descriptive correlational design to explore the relationship between staff nurses' perceptions of workplace empowerment and transformational leadership behaviours. A convenience sample of 94 nurses from an acute care setting completed three questionnaires; the Conditions of Workplace Empowerment Questionnaire (CWEQ), the Job Activity Scale (JAS) and the Organizational Relationship Scale (ORS) that measured Kanter's (1977) construct of workplace empowerment. The results indicated that nurses who perceived their managers to be transformational leaders had significantly ($p=.001$) higher empowerment scores than those who perceived their managers to be transactional leaders. In addition, a strong relationship was found between measures of workplace empowerment and the leadership outcomes of extra effort ($r=0.57$, $p=.001$), leadership satisfaction ($r=0.52$, $p=.001$), and leadership effectiveness ($r=0.66$, $p=.001$).

In the second study, Morrison et al. (1997) used a descriptive design to explore the relationship between leadership style and empowerment and its effects on nurses' job satisfaction. A convenience sample of 275 (64% of total population) staff members of a nursing department in an acute care setting were studied. Participants completed the Bass (1985) Multi-factor Leadership Questionnaire, Psychological Empowerment Scale

(Spreitzer, 1995a), and the Job Satisfaction Questionnaire (Warr, Cook, & Wall, 1979). The findings indicated that both transformational and transactional leadership were positively related to job satisfaction with correlations of 0.64 and 0.35 respectively. However, only transformational leadership was positively related to psychological empowerment as conceptualized by Spreitzer with a correlation of 0.26. Whereas, psychological empowerment was found to be positively related to job satisfaction with a correlation of 0.41. Although empowerment had a significant influence on job satisfaction of nursing staff, the impact of transformational leadership was significantly greater in scope. Morrison et al. suggest that these results add to the clarification of the relative importance of leadership and empowerment in determining how nursing staff feel about their jobs. They further note that this is an important finding because leadership has not been included in most studies of empowerment.

In summary, the descriptive correlational designs of the studies cannot establish a cause and effect relationship between leadership style and empowerment. However, the findings indicate that interventions to improve the quality of nurses' worklife require not only the influence of leadership style, but also the empowerment of staff nurses.

Kouzes and Posner's Model of Leadership Behaviours

Kouzes and Posner (1987) describe leadership as a reciprocal relationship between those who choose to lead and those who decide to follow. In their study of more than 1300, they extrapolated 5 behaviours that outstanding leaders used to affect employees and influence the accomplishment of organizational goals. These leadership behaviours

were identified as: (1) challenging the process which involves risk taking, being innovative and change oriented; (2) inspiring a shared vision; (3) enabling others to act through empowering and building teamwork and trust; (4) modelling the way by setting examples of high standards; and (5) encouraging the heart by being supportive, caring, and encouraging, while recognizing and celebrating accomplishments. According to Kouzes and Posner (1987, 1999) managers who use all five behaviours are more effective in influencing employees to achieve positive organizational goals.

McNeese-Smith (1995, 1997) was the first to empirically test the impact of managers' use of the leadership behaviours (Kouzes & Posner's, 1987) in a nursing population. Two separate studies used ex post facto, correlational designs to examine the impact of a manager's leadership behaviours on employees, job satisfaction, productivity, and organizational commitment. In study one, the sample comprised 41 department managers and 471 staff nurses from 2 Seattle community hospitals. A replication study was conducted 2 years later with 19 managers and 221 full-time staff nurses from a large Los Angles hospital. Despite the differences in locations and samples, the findings from the studies supported a positive significant correlation between the manager's use of the 5 leadership behaviours and employees' productivity, job satisfaction and organizational commitment. The generalizability of these results and the casual direction are limited by the nonexperimental design and by the settings that are all acute care. However, the fact that the results were replicated in two different settings lends credibility to the findings. Despite the methodological limitations, McNeese-Smith

(1997) suggests that the two studies provide support for the contention that leadership behaviour influences employee outcomes. This perspective suggests that as management structures are changed in acute care settings, managers should focus on leader empowering behaviours that ensure staff empowerment and the maintenance and enhancement of both job satisfaction and organizational commitment.

The following section contains a review of the empirical literature on the four concepts and absenteeism measured in this study.

Leader Empowering Behaviours

Conger and Kanungo and Hui's Conceptualization of Leader Empowering Behaviours

In response to Conger and Kanungo's (1998) recommendation for the need to study a more direct link between empowerment practice and leadership Hui (1994) conceptually extended and empirically tested Conger and Kanungo's model of the empowerment process.

Conger and Kanungo's Empowerment Process

Conger and Kanungo (1988) describe an empowerment process in which empowerment is viewed as a motivational process rather than a relational construct. In the relational construct the leader shares the power with the employee through delegation. Thus, delegation is considered a key component of empowerment and to empower implies the granting of power which is interpreted as the possession of formal authority and control over organizational resources. However, if the leader does not delegate, the employee will never be empowered. Conger and Kanungo point out that identifying

delegation as the only dimension of empowerment is rather limiting in explaining the complex nature of empowerment. They suggest that a more motivational approach be taken in which empowerment means enabling rather than delegating and implies " creating conditions for heightening motivation for task accomplishment through the development of a strong sense of personal efficacy" (p. 474).

Conger and Kanugo (1988) argue that the need to empower subordinates becomes critical when they feel powerless. Thus, it is the role of the manager to identify conditions within the organization that foster a psychological state of powerlessness. These conditions could include organizational changes, poor communication and networking systems, authoritarian (high control) management style, low incentive reward systems, and job design factors such as; lack of role clarity, limited participation in decision making, limited advancement opportunities, and limited contact with management at all levels. Once the conditions are identified, it is the responsibility of the manager to use leadership strategies and techniques that alleviate the feelings of powerlessness and heightens a sense of self-efficacy. To support this empowerment process Conger and Kanungo identified four leadership practices that could be considered as empowering: (1) expressing confidence in subordinates accompanied by high performance experiences; (2) fostering opportunities for subordinates to participate in decision making; (3) providing autonomy from bureaucratic constraint; and (4) setting inspirational and/or meaningful goals.

While Conger and Kanungo (1988) discussed the different empowering leadership practices in the context of empowerment, the relationship between leadership practices and managerial strategies and techniques needed to alleviate the conditions of powerlessness and to provide self-efficacy is rather elusive in the model (Hui, 1994). However, Conger and Kanungo did note that "a more direct link between empowerment practices and leadership should be studied" (p. 480).

Hui's Conceptualization of Leader Empowering Behaviours

After a review of the literature, summarized in Table 1, Hui (1994) provided revisions and conceptual definitions of the categories of leadership practices identified by Conger and Kanungo (1988) and added a fifth category which was facilitating the accomplishment of organizational goals. Hui terms the above leadership practices as "Leader Empowering Behaviours." The conceptual definitions of the five categories of empowerment behaviours as identified by Hui are described below:

1. Enhancing the Meaningfulness of Work

Leader behaviours aimed at providing purpose and meaning to followers' work so that followers can identify themselves as important members of the organization and are motivated to perform their tasks. This includes helping the follower to understand the importance of their contributions to and of their role to the organization.

2. Fostering Opportunities for Participation in Decision-Making

Leader behaviours aimed at soliciting inputs from followers in problem situations and inducing active involvement from followers in decision-making processes. This

Table 1

Leadership Empowerment Behaviour (LEB) Categories and Current Literature (adapted from Hui, 1994)

	Enhancing the Meaningfulness of Work	Fostering Participation in Decision-making	Expressing Confidence in High Performance	Providing Autonomy from Bureaucratic Constraints	Facilitating Goal Accomplishment
House & Aditya (1977)			Communicate high expectations and confidence in followers.		
Kanter (1979)		Encourage participatory management.		Freedom from rule-mindedness.	Provide necessary information, teach required skills.
Bennis & Nanus (1985)	Create common vision and goals.		Have positive self regards and focus on accomplishments.		
Burke (1986)	Provide purpose and direction. Stimulate followers with exciting ideas.	Encourage participation in decision-making.			Develop followers.
Block (1987)	Set goals and create meaningful work.	Encourage followers to express opinions and to call meetings.		Turn the organizational pyramid upside down, reduce command levels.	Provide as much information as possible.

	Enhancing the Meaningfulness of Work	Fostering Participation in Decision-making	Expressing Confidence in High Performance	Providing Autonomy from Bureaucratic Constraints	Facilitating Goal Accomplishment
Kouzes & Posner (1987)	Give people important work to do over critical issues.			Give followers autonomy over tasks and resources.	Build relationships for others; find sponsors.
Conger & Kanungo (1988)	Setting inspirational goals or meaningful goals.	Fostering opportunity for participation in decision- making.	Expressing confidence in high performance.	Providing autonomy from bureaucratic constraints.	
Conger (1989a)			Express confidence through verbal persuasion; allow experience of actual accomplishments.		
Conger (1989b)		Fostering initiatives and responsibility.	Express confidence; manufacture early accomplishments to build morale.		
House (1988b)			Express confidence in followers and high performance expectations.	Autonomy from bureaucratic constraints and supervision.	Select individuals with abilities to do task, train followers.

includes creating opportunities for followers to express their job-related opinions, and making decisions together with followers.

3. Expressing Confidence in High Performance

Leader behaviours aimed at cultivating the confidence of, as well as showing confidence in, the follower's ability to perform at a high level. This includes recognizing the accomplishments of the followers, and conveying to followers that they are capable of fulfilling the leader's performance expectations.

4. Facilitating the Accomplishments of Organizational Goals

Leader behaviours aimed at maximizing the likelihood that followers may achieve their performance goals by enhancing the skills of the followers and providing resources required for effective performance. This included training followers in their areas of deficiencies, providing necessary resources and removing obstacles to performance.

5. Providing Autonomy from Bureaucratic Constraints

Leader behaviours aimed at minimizing administrative details and rule mindedness so that followers can initiate task behaviours and perform their jobs with effectiveness and efficiency. This includes simplifying organizational rules and procedures, reducing command levels, and encouraging followers to achieve the organizational goals.

A review of the literature revealed three studies (McMahon, 1998; Laschinger et al., 1999; Adhearne, 2000) that used the Leader Empowering Behaviours Scale developed by Hui (1994). Summaries of the three studies and the study by Hui to examine the effects

of the leader empowering behaviours on empowerment experiences are presented in Table 2.

In summary, the study by Hui (1994) provided a set of core leader empowerment behaviours and a measure with acceptable psychometric properties to empirically test the effects of leader empowering behaviours on employee empowerment and other outcome variables. The four studies provided further support for acceptable reliability of the measure. The studies found that leader empowering behaviours have both a direct and indirect effect on performance (Hui; Adhearne, 2000), and a strong positive relationship with workplace empowerment as conceptualized by Kanter (1977). It was also found that the leader empowering behaviours' subscales have different strengths of relationship with outcome variables. Hui suggests that managers should focus on different leader behaviours depending on the desired outcomes. These studies also highlight the importance of manager's leadership behaviours in empowering their employees to achieve work effectiveness.

However, the findings of the studies must be viewed with caution given the cross-sectional nature of the designs. Although, it is not possible to make strong cause and effect statements, Hui (1994) suggested causal inferences based on covariance structural analysis. However, he concluded that despite the sophisticated statistical techniques to infer causal relationships, reverse causal relationships are possible, especially in non-experimental design. For example, Hui found that expressing confidence in employees high performance led to in-role performance. However, it is possible that the leader

Table 2

Summary of Studies that Used Leadership Empowerment Behaviours (LEB) Scale (Hui,1994)

Title/Authors	Design	Setting/Sample	Constructs	Measures	Findings
1. Effects of leader empowerment behaviours and follower's personal control, voice, and self-efficacy on in-role and extra-role performance : An extension and empirical; test of Conger and Kanungo's empowerment process model (Hui, 1994).	Field study.	Convenience sample 1. 53 Managers enrolled in a two executive business education programs 2. 244 matched pairs of supervisors and staff	1. Leader empowering behaviours 2. Empowerment experience (personal control, self-efficacy & voice) 3. Performance (in-role, extra -role	1. Leader Empowering Behaviours Scale 2. Adapted scales 3. Organizational citizenship Behaviours (OCB) (Podsakoff, Mackenzie, Moorman & Fetter, 1993)	1. Exploratory and confirmatory factor analysis found that items loaded on their hypothetical constructs 2. Cronbach's alpha ranging from 0.71to 0.90) 3. Leader empowering behaviours affected performance both directly and indirectly empowerment experience

Title/Authors	Design	Setting/Sample	Constructs	Measures	Findings
2. The effect of leadership behaviour on staff nurse workplace empowerment McMahon (1998).	Descriptive correlational.	Randomly selected sample of 100 nurses from one acute care teaching hospital of a recent merger.	1. Leader empowering behaviours 2. Kanter's (1977) theory of workplace empowerment	1. LEB Scale (Hui, 1994) 2. Conditions of work effectiveness Questionnaire (CWEQ), Job Activity Scale (JAS), Organizational Relationship Scale (ORS) (Laschinger, 1996)	1. Cronbach's reliability alphas ranged from .81 to .97 for the LEB scale and .69 to .88 for the other scales 2. Significant relationships were found between the LEB scale and the workplace empowerment 3. Different strength of relationships were found among the subscales

Title/Authors	Design	Setting/Sample	Constructs	Measures	Findings
3. Leader behaviour impact on staff nurse empowerment, job tension and work effectiveness (Laschinger et al., 1999).	Cross-sectional correlations survey.	Proportionate random sample drawn from 2200 RNs employed at 2 merged sites. Sample size 537 (71% return rate).	1. Leader empowering behaviours 2. Kanter's (1977) theory of workplace empowerment 3. Occupational stress 4. Work effectiveness	1. LEB Scale (Hui, 1994) 2. CWEQ, JAS, ORS 3. Lyons JOB Tension Index (1971) 4. The Global Work Effectiveness Scale (Hackman & Oldman, 1975)	1. Cronbach's alpha for LEB Scale ranged from .77 to .96 2. Cronbach's alphas ranged from .69 to .93 For other scales: 3. Leader empowering behaviours significantly influenced staff nurse's perceptions of workplace empowerment. Higher levels of empowerment predicted lower levels job tension and increased work effectiveness 4. Different strengths of relationships were found among the subscales

Title/Authors	Design	Setting/Sample	Constructs	Measures	Findings
4. An Examination of the effects of leadership empowerment behaviours and organizational citizenship behaviours on sales team performance (Adhearne, 2000).	Survey methodology.	Convenience sample. International pharmaceutical company, 1123 sales (72 managers) representatives in 306 teams.	1. Leader empowering behaviours 2. Organizational citizenship: altruism, courtesy, cheerleading, sportsmanship and civic virtue	1. Leader empowering behaviours Scale (Hui, 1994) 2. New scale	1. Confirmatory factor analysis found that the hypothesized dimensions fit the data well as all the scales had good reliabilities Leadership empowerment behaviours was found to have a direct effect on citizenship behaviours and fostering opportunities for participation in decision-making was found to lead to increase sales performance

expressed high confidence in their employees to perform at a high level, because the employee exhibited exemplary in-role performance. In this case, the leader may not be empowering the employee to perform at a high level, but is only responding to how the employee performed in the past. Thus, employees who do not perform well, then would not be empowered.

Although, Hui (1994) and Adhearne (2000) considered the use of self report measures as problematic, they reported that as neither the statistical control nor methodological control eliminated the relationship between leader empowering behaviours and empowerment experiences, the relationship could not be attributed to common method variance. Neither of the nursing studies identified a concern with common method variance, although this limitation would also apply.

Workplace Empowerment

Kanter's Theory of Organizational Empowerment

Rosabeth Kanter (1977), in her book, Men and Women of the Corporation, details a structural theory of organizational behaviours, which evolved from her qualitative study of work environments in a large American corporation. According to Kanter, employee work behaviours and attitudes are shaped in response to work conditions and situations, rather than inherent personal characteristics. Hence, the structural aspects of the job are more important in influencing effectiveness and success of an individual in the organization.

Kanter (1977) considers power as the critical structural element that affects behaviours in organizations. In contrast to the traditional views of power as domination and control, Kanter defines power as the efficacy and capacity to accomplish organizational goals. The power to accomplish these goals evolves from the individual's capacity to access and mobilize the resources, information, and support necessary to carry out a task, and the ability to get cooperation in doing what is necessary (Brown & Kanter, 1982). Both, Kanter argues, are derived from one's position in the formal (job definition/ activities) and informal systems (connections) of the organization Kanter maintains that individuals with a high degree of formal and informal power have access to organizational sources of power which includes lines of information, support, resources, and opportunity. The relationship among the Concepts in Kanter's Structural Theory of Power in Organizations is depicted in Figure 2. The three concepts formal power, informal power and job related empowerment structures are described below:

1. Formal Power

Formal power is accumulated from jobs that are designed or located in the organization to allow discretion, recognition and relevance (Kanter, 1977).

(a) Discretionary power is derived from jobs that have a broad range of objectives and/or a low level of standardization and structures that provide opportunities for individuals to be involved in decision making, thus, increasing their discretionary power (Brown & Kanter, 1982).

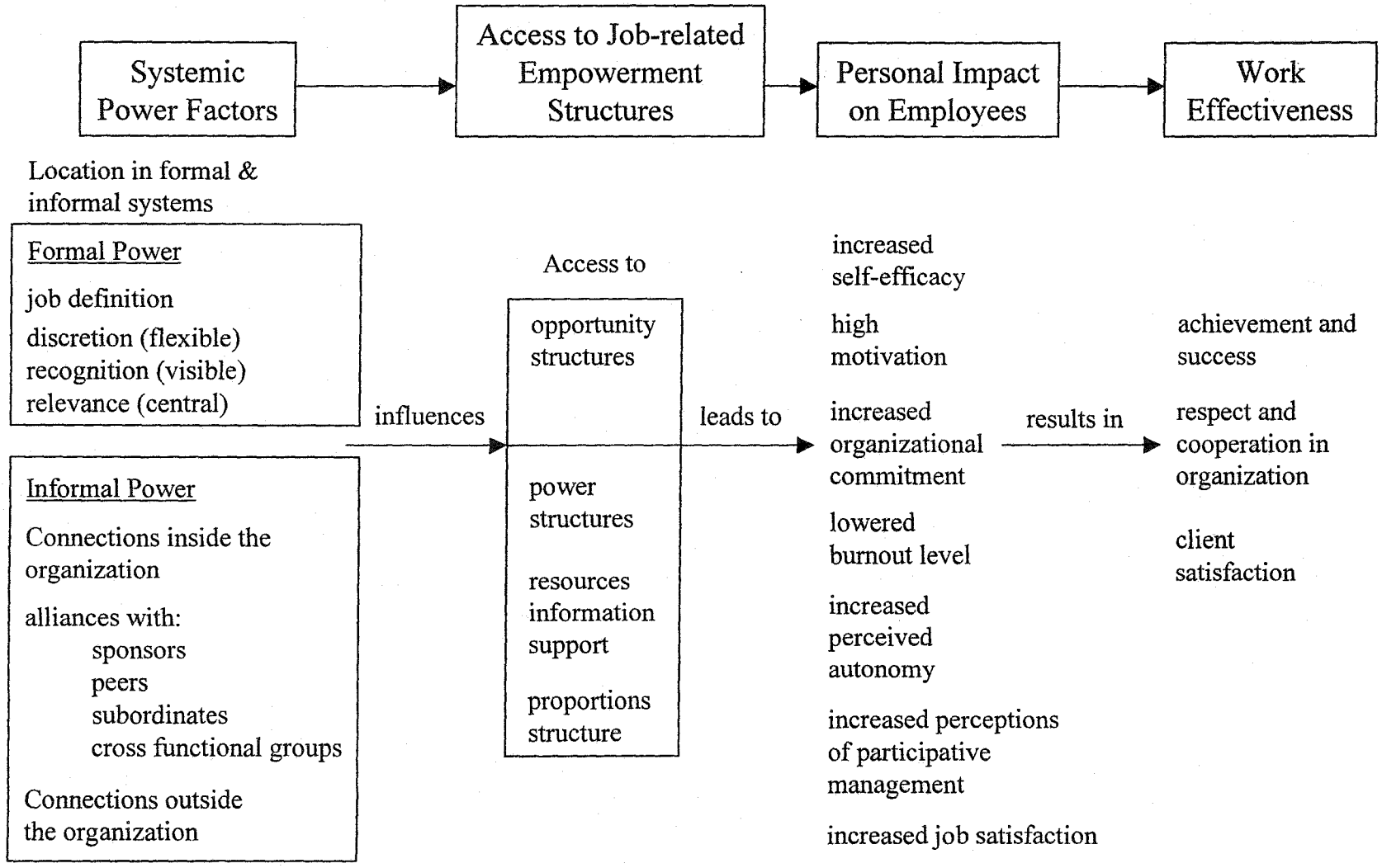

Figure 2. Relationships of concepts in Kanter's structural theory of power in organizations (Laschinger, 1996).

(b) Recognition, or the ability to attract the attention of others in the organization is obtained through participation in activities which involve risk taking and innovation (Kanter, 1977). Recognition is also increased in jobs in which an individual's contribution is acknowledged as having a direct impact on organizational outcomes (Brown & Kanter, 1982).

(c) Relevance refers to being central to the solution of pressing organizational problems. Individuals who play an important role in solving problem and issues of significance to the operation of the organization, are in a position to maximize power (Kanter, 1977; Brown & Kanter, 1982).

2. Informal Power

Informal power is developed through social connections with: (1) sponsors, (higher-level people who confer approval, prestige, or backing); (2) peer networks (circle of acquaintances that provide reputation and information, the grapevine often being faster than formal communication channels); (3) subordinates (who can be developed to relieve managers of their burdens and to represent the manager's point of view); and (4) cross functional groups (Kanter, 1977, 1979; Brown & Kanter, 1982). These alliances enable powerful individuals to get the cooperation they require to get things done (Kanter, 1977). Kanter maintains that these close connections need to be stable and long-term, especially those outside of the immediate work group.

3. Job-related Empowerment Structures

Kanter (1977) argues that employees' access to information, support, resources, and opportunity affect attitudes and behaviours of employees to work conditions.

(a) The structure of information refers to the need to be "in the know". Individuals need to have access to technical knowledge and expertise to carry out their job, as well as information concerning the activities of the larger organization to make informed decisions about organizational issues. This information may be acquired through both formal and informal channels of communication (Brown & Kanter, 1982; Laschinger, 1996).

(b) The structure of support refers to approval and backing of significant people in the organization that will permit maximum effectiveness. Individuals who receive positive feedback from superiors, combined with the opportunity to exercise discretion in one's job, will experience an important component of power. Individuals will have the freedom to proceed with innovative risk-taking activities, without multi-level approval (Kanter, 1977; Brown & Kanter, 1982; Laschinger, 1996).

(c) The structure of resources or supply means having the ability to obtain material, money, supplies and equipment and rewards necessary to meet the demands of the job (Kanter, 1977; Brown & Kanter, 1982; Laschinger, 1996).

(d) The structure of opportunity relates to job conditions that provide the individual in an organization with the chance to advance, to increase their status, to access rewards and to receive recognition for and/or develop their skills and knowledge.

Kanter (1977) maintains that opportunity is a key influence on employees' overall mode of work involvement. Individuals in high-opportunity jobs are more likely to be highly motivated and committed and actively participate in change and innovation. On the other hand, Kanter notes that individuals who have limited opportunity and are aware of being "stuck" in their positions tend to be less committed to the organization and are cautious and resistant to change and innovations. As well, these employees can be less interested in their work and maybe very critical and hostile toward the organization. However, too much mobility, may result in low interest in the present job. Thus, any position must be viewed in the larger organizational context, as people tend to relate to the present in part in terms of their expectations and prospects for the future.

According to Kanter (1979), it is the mandate of management to create conditions for work effectiveness by ensuring that employees have access to empowerment structures of information, support and resources to achieve organizational goals and opportunity for development. Kanter claims that employees who have access to these structures are more productive, experience less burnout and have higher levels of organizational commitment. In contrast, individuals who have limited access to these structures to accomplish tasks are powerless. Powerless individuals develop feelings of helplessness, insignificance, frustration and failure which in turn decreases their ambition, commitment and work effectiveness (Kanter, 1977; Brown & Kanter, 1982; Laschinger, 1996).

Nurse managers who have greater access to the sources of empowerment than staff nurses (Kanter, 1977; Laschinger & Shamian, 1994; Goddard & Laschinger, 1997) can

motivate and empower their subordinates by sharing the sources of power. Kanter maintains that "power begets power" in that organizational power can grow by being shared and empowering others to accomplish things on their own. However, the sharing of power does not mean giving it or throwing it away, but rather, developing independent followers and ensuring access to empowering structure. According to Brown and Kanter (1982) powerful leaders aspire upward and outward, tending to let go of their control and developing more independent followers. Kanter notes that people prefer to work with leaders who are perceived to be powerful and have the "clout" to succeed. Whereas, nurse managers who are powerless tend to focus their attention on maintaining whatever little power they have. They tend to be dictatorial, focus on rules and lose sight of either the outcomes or the goals, and can become territorial and turf-minded. All of these tendencies in a powerless boss prove that she or he is not exercising authority or leadership in a productive way (Brown & Kanter).

In summary, Kanter's (1977) theory of workplace empowerment places emphasis on the structural characteristics of the job in determining access to the structures of power and opportunity within the workplace, rather than personality traits. This is important as the structural characteristics of the job can be manipulated and changed, whereas individual personalities cannot. Therefore, Kanter provides a framework which can be used by managers to enhance the work behaviours of nurses to promote effective delivery of healthcare (Laschinger, 1996).

Research on Kanter's Theory of Organizational Empowerment in Nursing

Initial Studies and Development of Quality of Work Effectiveness Questionnaire

In 1992, the research program at the University of Western Ontario headed by Dr. Heather Laschinger, initiated a research program to systematically test hypotheses, derived from Kanter's (1977) theory, in the nursing population. Despite the frequent citing of Kanter's work in the literature, prior to this initiative, few studies were found that used Kanter's theoretical model as an explicit framework for analysis (Laschinger, 1996). Chandler (1986) was the first nurse researcher to test Kanter's theory using the CWEQ, developed by Kanter, on 246 nurses in 2 acute care hospitals. The sample consisted of nurse administrators, nurse managers, and staff nurses. The CWEQ developed by Kanter measured 5 areas of work conditions: (1) opportunities, (2) supplies, (3) support, (4) information, and (5) job activities; and included items rated on a 5-point Likert scale. A sample of staff nurses was interviewed to ascertain the antecedents of perceived work conditions. Staff nurses identified support (with accessibility and visibility as important aspects), opportunity, and information as important environmental factors for work effectiveness.

The results supported Kanter's (1977) proposition that access to structural determinants of information, support and opportunity influences nurses' perceptions of their work environment and is a critical factor in creating an empowered work environment and subsequent work effectiveness. However, the scores on all scales were low to moderate indicating a lack of perceived empowerment in their work setting.

Chandler (1986) conducted psychometric analyses of the CWEQ and recommended revisions in particular, to the sub scale used to measure resources. A factor analysis found that three of the five original factors (support, information and opportunity) were empirically validated. Structured interviews were conducted to gain semantic clarity.

Since 1992, the research program at the University of Western Ontario has produced a series of studies building on the work of Chandler (1991). Kanter's (1977) theory appeared to have face validity and to have potential for application to the nursing population. However, little empirical support has been established in the nursing population. In the early studies, Kanter's CWEQ (Chandler) was used to measured perceived job-related empowerment structures in nursing organizations. Summaries of the studies testing Kanter's Structural Theory of Power in Organizations in nursing populations reported in this paper and descriptive statistics results are presented in Table 3.

The initial studies of staff nurses' perceptions of workplace empowerment have been found to be significantly related to organizational commitment (Wilson & Laschinger, 1994; McDermott et al., 1996), job burnout (Hatcher & Laschinger, 1996); job satisfaction (Laschinger & Havens, 1996), job autonomy and perceived control over nursing practice (Sabiston & Laschinger, 1995; Laschinger & Havens), and work effectiveness (Laschinger & Wong, 1999).

In studies of nurse managers, support was found for Kanter's (1977) contention that accesses to empowerment structures of power and opportunity increases as one rises in

Table 3

Summary of Studies on Staff Nurses Workplace Empowerment (Kanter, 1977)

Title/Authors	Design	Setting/Sample	Constructs/ Measures	Means for Workplace Empowerment Scales CWEQ (Range 4-20), Subscales, JAS, ORS (Range 1-5)		Findings
1) Staff nurses' and nurse manger's perceptions of job related empowerment and managerial self-efficacy (Laschinger & Shamian, 1994).	Descriptive correlational	27 nurse managers and a proportionate random sample of 112 full time nurses in a urban acute care teaching hospital.	1. Kanter' (1977) theory 2. Managers' self efficacy: Managerial Self Efficacy Questionnaire (MSEQ) (Quinn, 1988)	1. CWEQ, Staff Managers Subscales: *Opportunity*: staff managers *Information:* staff managers *Support:* staff managers *Resources:* staff managers	11.65 (2.21) 14.65 (1.40) 2.97 (.66) 3.86 (.58) 2.98 (.71) 3.95 (.51) 2.77 (.70) 3.48 (.68) 2.96 (.59) 3.30 (.60)	1. First-line managers perceived a greater degree of empowerment than staff nurses. 2. Managers' scores on the MSEQ were high suggesting a high degree of self-efficacy. 3. Significant relationship was found between perceived overall empowerment and managers' self - efficacy.
2) Staff nurse perception of job empowerment and organizational commitment (Wilson & Laschinger, 1994).	Descriptive correlational	92 nurses in an acute care hospital.	1. Kanter's 91977) theory 2. Manager's power (ODO-B) 3. Organizational commitment (OCQ; Mowday, Steers, & Porter, 1979)	1. CWEQ Subscales: Opportunity Information support resources	12.22 (2.20) 3.25 (.75) 2.83 (.79) 3.07 (.84) 2.97 (.67)	1. Perceptions of power and opportunity are related to organizational commitment.

Title/Authors	Design	Setting/Sample	Constructs/ Measures	Means for Workplace Empowerment Scales CWEQ (Range 4-20), Subscales, JAS, ORS (Range 1-5)		Findings
3) Staff nurses work empowerment and perceived autonomy (Sabiston & Laschinger, 1995).	Descriptive correlational	Proportionate stratified random sample of 102 full time staff nurses selected from the hospital payroll.	1. Kanter's (1977) theory CWEQ Formal power (JAS) Informal power (ORS) 2. Job characteristics (JDQ) 3. Autonomy Quality of Employment survey (Quinn & Sheppard, 1994)	1. CWEQ Subscales: Opportunity Information Support Resources 2. JAS 3. ORS	11.20 (1.90) 2.81 (.63) 2.81 (.63) 2.76 (.63) 2.81 (.59) 2.72 (.35) 3.06 (.46)	1. Nurses had moderate scores on overall workplace empowerment. 2. Work empowerment was strongly related to formal power, informal power, and autonomy. 3. 48% of the variance of job related empowerment was explained by formal and informal power.
4) Power and opportunity in public health nursing work environments (Haugh & Laschinger, 1996).	Exploratory comparative survey	Convenience sample of 46 public health nurses and 10 nurse managers in three public health units.	1. Kanter's (1977) theory 2. Organizational descriptions 3. Organizational power of nurse managers	1. CWEQ Subscales: Opportunity Information Support Resources	11.77 (2.08) 3.19 (.55) 2.90 (.59) 2.95 (.81) 2.75 (.65)	Staff nurse empowerment was found to be significantly related to perceptions of their immediate manager's power.

Title/Authors	Design	Setting/Sample	Constructs/ Measures	Means for Workplace Empowerment Scales CWEQ (Range 4-20), Subscales, JAS, ORS (Range 1-5)		Findings
5) Staff nurse work empowerment and perceived control over nursing practice (Laschinger & Havens, 1996).	Descriptive correlational design/mail survey	200 randomly selected staff nurses in an acute care hospital, 33% return rate (127 nurses).	1. Kanter's (1977) theory 2. Formal power (JAS) 3. Informal power (ORS) 4. Work Autonomy Gerber's Control over Nursing Practice (1990) 5. Bass & Aviolio's Multifactor Leadership Questionnaire (1990)	1. CWEQ Subscales: Opportunity Information Support Resources 2. JAS 3. ORS	10.90 (2.62) 3.03 (.73) 2.77 (.77) 2.72 (.77) 2.38 (.70) 2.92 (.54) 2.97 (.65)	Strong positive correlation between access to empowerment structures and overall work satisfaction.
6) The effect of workplace empowerment on staff nurses' occupational mental health and work effectiveness (Laschinger & Havens, 1996).	Descriptive correlation survey	Randomly selected 150 full time staff nurses/acute care hospital. Return rate of 44% (62 nurses).	1. Kanter's 91977) theory 2. Formal Power (JAS) 3. Informal power (ORS) 4. Occupational mental health: Lyons JOB Tension Index (1971) 5. Work effectiveness: Hackman and Oldmam's Job Diagnostic Survey (1976)	1.CWEQ Subscales: Opportunity Information Support Resources 2. JAS 3. ORS	11.39 (2.26) 2.59 (.70) 2.59 (.47) 2.75 (.75) 2.79 (.72) 2.85 (.57) 3.17 (.64)	Strong correlations with job tension and access to resources and support. 3. Workplace empowerment related to few demographic variables.

Title/Authors	Design	Setting/Sample	Constructs/ Measures	Means for Workplace Empowerment Scales CWEQ (Range 4-20), Subscales, JAS, ORS (Range 1-5)	Findings
7) Laschinger and Wong, 1999.	Cross-sectional correlational design	Randomly selected sample (672) of 2,200 registered nurses employed in a medical centre. Response rate of 71% (537) usable questionnaires.	1. Kanter's (1977) theory 2. Collective accountability: Specht-Ramler accountability Index (1991) 3. Productivity Scale (McNeese-Smith, 1996) 4. Work effectiveness Hackman and Oldman's (1975) Job Diagnostic Scale	1. CWEQ 10.90 (1.96) Subsales: Opportunity 2.86 (.56) Information 2.65 (.65) Support 2.75 (.67) Resources 2.65 (.54) 2. JAS 2.53 (.43) 3.ORS 3.25 (.59)	1. Informal power directly influences accountability both directly and indirectly through access to empowerment structures. 2. Higher perceive access to empowerment structures was associated with higher collective accountability and increase productivity.
8) Organizational trust and empowerment in restructured healthcare settings (Laschinger, Finegan, Shamian, & Casier, 2000).	Non-experimental predictive survey	600 from acute care, randomly selected nurses from College of Nurses of Ontario registry. Final sample 195 men (70.1% return rate); 217 female (75.6% return rate).	1. Kanter's 11977) theory 2. Organizational trust 2 Interpersonal Trust; Work Scale (Cook & Wall, 1980) 3. Organizational Commitment (OCQ) (Meyer, Allen, & Smith, 1993)	1.CWEQ 111.00 (2.28) Subscales: Opportunity 3.29 (.76) Information 2.53 (.89) Support 2.56 (.63) Resources 3.00 (.71) 2. JAS II 3.04 (.99) 3. ORSII 3.46 (.69)	Support found for the proposition that staff nurses' empowerment affects their trust in management and their affective commitment.

Title/Authors	Design	Setting/Sample	Constructs/ Measures	Means for Workplace Empowerment Scales CWEQ (Range 4-20), Subscales, JAS, ORS (Range 1-5)	Findings
9) Testing Karasek's demands-control model in restructured healthcare settings (Laschinger, Finegan, Shamian, & Almost, 2001).	Non-experimental predictive survey	404 randomly selected nurses employed in tertiary care hospitals (72% return rate).	1. Kanters' (1977) theory 2. Psychological empowerment (Spreitzer, 1995) 3. Organizational commitment (OCQ, Allen & Meyer, 1990) 4. Job satisfaction: Four-item global measure (Laschinger et al., 1999) 5. Job content Job Content Questionnaire (Karasek, 1979)	1. CWEQ11 High Strain group 10.51 (1.99) Low Strain group 11.81 (2.31) Active group 11.73 (2.07) Others not reported.	1. Nurses with higher levels of job strain were found to be significantly more empowered , more committed to the organization and more satisfied with their work. 2. Support for Karasek's Demands/Control theory was established.
10) Impact of structural and psychological empowerment on job strain in nursing work settings (Laschinger, Finegan, Shamian, & Wilk, 2001).	Non-experimental predictive survey	600 from acute care, randomly selected nurses from College of Nurses of Ontario registry. Final sample; 192 men and 210 women (72% return rate).	1. Kanter's (1977) theory 2. Psychological empowerment (Spreitzer, 1995) 3. Job satisfaction: Four-item global measure (Laschinger et al., 1999) 4. Job strain job content questionnaire (Karasek, 1979)	1. CWEQ 11.38 (2.28) Subscales: Opportunity 3.29 (.76) Information 2.53 (.83) Support 2.55 (.83) Resources 3.00 (.71) 2. JAS II 2.51 (.67) 3. ORS II 3.46 (.68)	1. As predicted structural empowerment had a direct positive effect on psychological empowerment which in turn had a positive effect on job satisfaction dn a direct negative effect on job strain. 2. The amount of variance accounted for in the model was 58%.

the organizational hierarchy (Haugh & Laschinger, 1996; Laschinger & Shamian, 1994; Goddard & Laschinger, 1997). Although, the managers' scores on workplace empowerment scales were higher than those of staff nurses, both groups were moderate in their ratings. This finding can be problematic in that managers who perceive themselves as having limited power maybe ineffective and unable to empower their staff (Goddard & Laschinger, 1997). According to Brown & Kanter (1982), powerful managers tend to be highly motivated and, in turn, are able to motivate their staff. Whereas, powerless managers fail to lead and are more likely to over control their subordinates by demanding conformity to rules and regulations, withholding information, and focus on performance according to procedure manuals. As a result, the staff's access to empowering structures of opportunity, support, information, and resources are weakened generating more organizational powerlessness (Kanter, 1977; Kanter & Brown).

Studies of Expanded Model of Kanter's Organizational Empowerment Theory

More recent studies provided further support for Kanter's (1977) theory and expanded the previous knowledge about the effects of empowerment on the quality of nurses' work life. Four studies that tested an expansion of Laschinger's (1996) model of workplace empowerment has found that staff nurses perceptions' of workplace empowerment to be significant predictors of psychological empowerment, organizational commitment, autonomy, job strain, and job satisfaction (Laschinger, Finegan, Shamian, & Casier, 2001; Finegan & Laschinger , 2001; Laschinger, Finegan, Shamian, & Almost, 2001; Laschinger, Finegan, Shamian, & Wilk, 2001). Overall, the staff nurses perceived

that structural empowerment in their workplace resulted in higher levels of psychological empowerment. This heightened feeling of psychological empowerment strongly influenced the degree of job strain, job satisfaction, and organizational commitment experienced by nurses.

Although managerial interventions were not part of these studies, Laschinger, Finegan, Shamian, & Wilk (2001) contend that the strong relationship between structural empowerment and psychological empowerment ($r=0.85$) is consistent with Conger and Kanungo's (1988) contention that when managers remove disempowering elements from the work setting, employees are more likely to find their work meaningful and have a greater sense of autonomy, and have an impact at work. They also note that this finding is also consistent with Laschinger et al. (1999) who found that staff nurses experience higher level of empowerment when managers used leader empowering behaviours that fostered employee perceptions of autonomy, confidence and meaningfulness of their work. Furthermore, these results suggest that access to psychological empowerment is the human response to managerial interventions to create empowering work environments (Spreitzer, 1995a). Implicit in this contention is the supposition that some management interventions had occurred to achieve the findings of the study. Therefore, it is probable that managers' leadership interventions may have affected staff nurses' perceptions of workplace empowerment and psychological empowerment, which in turn, resulted in lower job strain and higher job satisfaction.

Summary of Research on Kanter's Theory of Organizational Empowerment

In summary, more than 30 studies have been conducted to test Kanter's (1977) workplace empowerment theory in a variety of nursing populations and settings. The results of the studies have clearly supported the importance of nurses having access to necessary organizational structures as antecedents to be empowered in their work environment. Access to these empowering structures is promoted by formal and informal job characteristics. In one study (Laschinger et al., 1999) leader empowering behaviours were found to be an antecedent to formal and informal power. Nurses who have access to these structures reported a number of positive consequences including, increased organizational commitment, increased job satisfaction, reduced job strain, increased psychological empowerment and work effectiveness.

Despite the supportive evidence, the findings of the studies must be viewed with caution. Laschinger (1996) noted that the earlier studies were limited by the use of survey methodology and the common problem of low return rates (40-50%). As well, the generalizability of the reported findings is limited by selection criteria of participants and healthcare agencies and the use of a variety of sampling techniques. The majority of participants have been full-time registered nurses from urban acute care teaching hospitals. However, the findings were consistent with theoretical predictions and similar outcomes in 13 independent studies offset these limitations somewhat.

Later studies used larger samples of randomly selected staff nurses and more definitive testing using more sophisticated statistics of Structural Equation Modelling

(SEM). However, given the cross sectional nature of the design, it is not possible to make strong cause and effect statements. Laschinger, Finegan, Shamian, & Wilk (2001) note that support for a priori theory driven predictions offsets this limitation to some extent and allows generalization to theory rather than to population (Serlin, 1987).

The sample for the studies used an equal proportion of men and women which was not representative of the total nursing work force. To rule out this potential source of bias, Laschinger, Finegan, Shamian, and Casier (2001) repeated the analysis on a proportionate stratified random subsample representative of the gender proportions of the nursing work force in Ontario (88% females, 12% males). The resulting models did not differ significantly and explained similar amounts of variances and produced very similar patterns of relationships among variables. Finegan and Laschinger (2001) also found little evidence to suggest that men and women responded differently to their workplace. The construct of psychological empowerment as conceptualized by Spreitzer (1995a), used in the studies to test an expanded model of Kanter's (1977) theory of workplace empowerment, is presented in the next section.

Psychological Empowerment

Spreitzer's Multidimensional Model of Psychological Empowerment

Psychological empowerment is viewed as a motivational construct where power and control are seen as motivational states internal to the individual (Conger & Kanungo, 1988). Conger and Kanungo argue that empowerment increases employee's convictions about their own effectiveness. This view of motivation as a psychological construct shifts

the responsibility for motivation from the employee to the organization. Thomas and Velthouse (1990) argue that psychological empowerment is multifaceted and that the essence cannot be captured in a single concept. Thomas and Velthouse and Spreitzer (1995a) defined empowerment more broadly as intrinsic task motivation manifested in four cognitions reflecting an individual's orientation to his or her work. The four dimensions are identified as: meaning, competence (which is synonymous with Conger and Kanungo's self-efficacy), autonomy (self-determination), and impact. Spreitzer argues that together these four cognitions reflect an active orientation to a work role, whereby an individual feels able to shape his or her work role and context.

1. Meaning

The dimension of meaning is the value of a work goal or purpose, judged in relation to an individual's own ideals or standards (Thomas & Velthouse, 1990). Spreitzer, Kiziolos, & Nason (1997) describe meaning serves as the "engine" of empowerment, or the mechanism through which individuals get energized about their work. Thomas and Velthouse note that if employees' hearts are not in their work and if the work activity conflicts with their value systems, then they will not feel empowered. Low degrees of meaningfulness are believed to result in apathy and feeling detached and unrelated to significant events. Whereas, higher levels of meaningfulness result in commitment, involvement and concentration of energy (Thomas & Velthouse).

2. Competence

The dimension of competence or self-efficacy, is an individual's belief in his or her capacity to perform job activities with skill (Gist, 1987). Without a sense of personal confidence in their abilities, employees will feel inadequate and lack a sense of empowerment (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). Spreitzer (1995a) notes that in addition to a personal belief in what they do, empowered people believe in their abilities and capacities.

3. Autonomy

The dimension of autonomy (self-determination) is a sense of choice in initiating and regulating actions (Deci, Connell, & Ryan, 1989), that is a sense of control over one's work. Employees will feel empowered when they believe they are not just following the orders of someone up the hierarchy, but have the autonomy and freedom to make decisions about work methods, pace, and effort (Spreitzer, 1995a). Individuals who have more autonomy on the job are more likely to have high levels of work satisfaction (Conger & Kanungo, 1988; Thomas & Velthouse, 1990).

4. Impact

The dimension of impact refers to the degree to which an individual can influence strategic, administrative, or operating outcomes at work (Thomas & Velthouse, 1990). Thomas and Velthouse note that a sense of autonomy reflects the degree of control over means, whereas, impact reflects the degree of control over ends. Therefore, for

employees to feel empowered, they must believe that their actions are influencing the system and progressing toward a goal.

Spreitzer's Validation of Psychological Empowerment

Spreitzer's Examination of the Four Dimensions of Psychological Empowerment

Despite growing interest in empowerment in the organizational studies literature, substantive research was limited by the lack of a theoretically derived measure of psychological empowerment in the work context (Spreitzer, 1995a). A study by Spreitzer took the initial step toward the development and validation process of a multidimensional measure of psychological empowerment in the workplace (presented in Chapter 3). The measurement model suggested that each of the four dimensions contribute to an overall construct of empowerment and that the dimensions are not construct equivalent (Spreitzer). An index of empowerment was constructed by aggregating the items from the four dimensions of empowerment. The Cronbach's alpha reliability coefficient for the overall empowerment construct was .72 for the industrial sample and .62 for the insurance sample.

More recently, Spreitzer et al. (1997), using data from prior studies (Spreitzer, 1995a, 1995b, 1996), examined the contribution of each of the four dimensions of psychological empowerment in predicting three expected outcomes of empowerment: work effectiveness, work satisfaction and job related strain. The findings suggest that different dimensions of psychological empowerment are related to different outcomes and no single dimension predicts all the outcomes. Her study supported the proposition that low

role ambiguity, wide supervisory span of control, access to information and a participative environment create opportunities for empowerment in the workplace. Spreitzer et al. (1997) argue that employees need to experience each of the empowerment dimensions in order to achieve all of the outcomes of empowerment.

Although, the research extends prior research on empowerment, the focus has been limited to a few key organizational outcomes. Spreitzer et al. (1997) recommend that future research must examine the relationship of psychological empowerment to other organizational outcomes (e.g., absenteeism) and behavioural outcomes (e.g., organizational commitment). The cross sectional design of the research does not assess true causality, but rather identifies associations between the variables of interest. In fact the reverse may be true, with work effectiveness, work satisfaction and work strain having influence on the employee's perceptions of empowerment.

The generalizability of the results is limited because her study included only managers as subjects. Presumably because of their level in the organization they have some degree official power and influence, thus their level of empowerment may be positively biased. Spreitzer (1995a) suggested that future research be directed at lower levels of the organization, where empowerment interventions tend to be targeted and in a number of diverse organizational settings (service-orientated, non-profit), where the respondents might be less sensitized to empowerment issues than the managers. In addition, front-line employees are presumed to have limited influence and are the most often associated with having an impact on the achievement of organizational goals.

As well, Spreitzer (1995a, 1995b, 1996) research did not examine the influence of upper management on employees' perceptions of empowerment. Since the role of the leader is most frequently presented as a key factor in developing employee empowerment (Bennis & Nanus, 1985; Block, 1987; Kouzes & Posner, 1987), there is a need to examine the relationship of leader empowering behaviours and psychological empowerment.

Organizational Commitment

Multidimensional Construct of Organizational Commitment

In an attempt to understand the complex relationship between workers and their employing organizations, researchers have focussed on organizational commitment in the workplace. However, limited consensuses has been reached on what the term commitment means (Mowday, Porter, & Steers, 1982; Meyer & Allen, 1997). Organizational commitment has been conceptualized from two traditional approaches: attitudinal and behavioural. The attitudinal approach focuses on the process by which people come to think about their relationship with the organization or the mind set in which individuals consider the extent to which their own values and goals are congruent with those of the organization (Mowday et al., 1982). Commitment is viewed as involving an active relationship with the organization such that the individuals are willing to give something of themselves in order to contribute to the organization's well being (Mowday et al.). In this approach attitudinal commitment is studied using the measurement of commitment as an attitude or mind set along with other variables that

were presumed to be the antecedents to, or consequences of, commitment. Although the aim of this research was to establish causal connections, most of the researchers used cross sectional designs in which commitment and its antecedents and/or consequences were measured at the same time. Meyer and Allen note that at best this kind of research established whether relevant variables were related to each another, but could not clearly establish causality.

The behavioural approach relates to the process whereby individuals are locked into an organization and how they deal with this problem (Mowday et al., 1982). The focus of the behavioural approach examines the conditions under which an individual becomes committed to a course of action (e.g., maintaining employment with an organization). Meyer and Allen (1997) suggest that employees who are committed to remaining with their organization might develop a positive view of the organization to avoid cognitive dissonance or maintain some positive self-perceptions of being "in control"or doing what one "wants to do." This involves a judgement by the employee whereby the employee calculates the costs and benefits of continuing a certain line of action.

Recent research conceptualizes organizational commitment as a multidimensional construct. As a result of considerable attention to theory development, commitment is recognized as a multidimensional construct, with antecedents, correlates and consequences that vary across dimensions (Meyer, Stanley, Hercovitch, & Topolynysky, 2002). Allen and Meyer (1990) and Meyer and Allen (1991) noted that the various definitions of commitment reflect three broad themes. That is commitment has been

viewed as reflecting an affective orientation toward the organization, a recognition of cost associated with leaving the organization and a moral obligation to remain with the organization. Meyer and Allen's Three Component Model of Organizational Commitment characterized these three themes in the literature as affective, continuance and normative commitment, respectively.

1. Affective Commitment

Affective commitment is an emotional attachment to an organization. Employees with a strong sense of effective commitment to the employing organization will remain members of that organization because "they want to." The affective attachment approach is best characterized by Mowday et al. (1982) as the degree to which an individual identifies with, is involved in, and enjoys membership in an organization. Meyer and Allen (1991) suggest that affective commitment appears to be strengthened by work experiences that satisfy employees' need for comfort in the organization (e.g., good interpersonal relationships, role clarity) and contribute to their feelings of competence and self worth in their work role (e.g., participation, feedback, challenge). Finally, the impact of work experience on employees' affective commitment appears to be a function of the degree to which an employee attributes the experience to the organization and its concern for employees (Meyer & Allen, 1997).

2. Continuance Commitment

Continuance commitment is an attachment to the organization based on employees' awareness of the costs associated with discontinuing membership in the organization.

Employees with a strong sense of continuance commitment to the employing organization will stay with that organization because they need to. The employees remain as a result of calculating their accumulated investments that would be lost if they left the organization, or as they recognize that the availability of comparable alternatives is limited (Meyer & Allen, 1991; Meyer et al., 1993). Meyer and Allen suggest that continuance commitment increases as a function of actions or decisions, inside or outside the workplace, that makes retention of investments (e.g., benefits such as pensions, health insurances; professional status, job skills) contingent on their continued employment in the organization. The lack of employment opportunities also increases the perceived cost associated with leaving the organization resulting in stronger employee continuance commitment to the organization (Meyer, Allen, & Topolnytsky, 1998).

3. Normative Commitment

Normative Commitment is an attachment to an organization based on an ethical imperative that an employee feels is the right thing to do (Meyer & Allen, 1991). Employees in an organization with a strong sense of normative commitment will remain with the organization because they ought to. Normative commitment develops from the internalization of an obligation to stay with an organization through familial or cultural socialization that emphasizes the appropriateness of remaining loyal to an employing organization (Weiner, 1982), or through receipt of benefits from the organization (e.g., tuition, training) (Scholl, 1981; Meyer & Allen).

Common to all three forms of commitment is the view that commitment is a psychological state that links the employees' relationship with the organization and the decision to continue or discontinue membership in the organization (Allen & Meyer, 1990, 1996). Meyer and Allen (1997) suggest that regardless of the definition, "committed" employees are more likely to remain in the organization than are "uncommitted" employees" (p. 11). Beyond this, Meyer and Allen (1991, 1997) argue that the consequences of the three forms can be quite different. Employees with strong affective commitment are more likely to behave in a way that considers the best interest of the organization because of their attachment to and sense of identity with the organization. This tends to be true of employees with normative commitment, but the effect is not as strong. On the other hand, those who are primarily committed to the organization based on continuance commitment, might be motivated to do little more than are required to maintain employment (Allen & Meyer, 1996).

In a review of the antecedents of organizational commitment, Meyer et al. (2002) demonstrated that demographic variables play a relatively minor part in the development of organizational commitment regardless of its form. However, two studies have shown that older employees with longer tenure tend to have higher affective and continuance commitment (Allen & Meyer, 1996; Hackett, Bycio, & Hausdorf, 1994). In contrast, work experiences were found to have much stronger relationships, particularly with affective commitment. Meyer et al. argue that this finding support the argument that attempts to recruit or select employees, based on their predisposition to affective

commitment, will be less effective than the management of their work experience following entry to the organization (Irving & Meyer, 1994; Meyer, Bobocel, & Allen, 1991). Meyer et al. (1991) found that best predictors of affective commitment were the job quality (scope) and decision quality variables after one year of employment. This finding suggests that the managers can influence decision quality with the use of leader empowering behaviours: enhancing the meaningfulness of work and facilitating participation in decision making by providing opportunity and encouragement to express job-related opinions and by consulting employees on issues pertaining to their work.

In a meta-analysis, Meyer et al. (2002) also found that of the work experience variables, perceived organizational support has the strongest positive correlation with affective commitment. This finding is consistent with the argument that organizations wanting employees with high levels of affective commitment must demonstrate commitment by providing a supportive work environment (Eisenberger, Huntington, Hutchison, & Sowa, 1986). Organization can demonstrate support by providing strong leadership. Bycio et al. (1995) in a correlational study of randomly selected hospital nurses (n=1,376) examined the effects of leadership behaviours (Bass, 1985) on the dimensions of the organizational commitment model (Allen & Meyer, 1990). As predicted, the transformational scales had a strong positive relationship with affective commitment and were significantly larger than those involving those involving continuance or normative commitment. Although the research was not designed to allow causal inferences, Bycio et al. argue that the finding is consistent with the view that the

empowering aspect of transformational leadership enhances the employee's emotional attachment to the organization reflected in affective commitment, but not the less emotion based-facets of continuance and normative commitment.

With regard to the consequences of commitment, Meyer et al. (2002) reported affective commitment had the strongest positive correlation with other work behaviours (i.e., attendance, job performance, organizational citizen behaviour) followed by normative commitment, whereas continuance commitment was unrelated or negatively related to these work behaviours. One of the variables of interest in this proposed study, absenteeism, was found to correlate negatively with affective commitment (r=-.15) and positively with normative and continuance commitment (r=.05). There were not enough studies to make comparisons for continuance and normative commitment (Meyer et al.).

Impact of Organizational Change on Commitment

Meyer et al. (1998) note that change in the level of affective, continuance, and normative commitment are not mutually exclusive and that all three could be affected by organizational change. The extensive changes and downsizing in acute care hospitals, in particular, those resulting in workforce reductions, have the potential to influence the employee's commitment profile. The current downsizing involving the reduction of managers, has the potential for increased responsibility and job enrichment. Thus, employees whose jobs are "enriched" by the change may actually become more committed to the organization and those who are overworked" or experience role ambiguity and conflict are likely to be less committed (Meyer et al.).

Meyer et al. (1998) further note that continuance commitment might be affected by the availability of job security with the current employer and the availability of employment elsewhere. Those employees who realize the tenuous nature of their employment situation might develop stronger continuance commitment, whereas those with highly marketable skills maybe come less committed. Finally, they suggest that altered perceptions of the organization's investment in its employees may change the degree of normative commitment. Those employees who receive extra training accompanying organizational change and those who experience "survivor guilt" might develop stronger normative commitment (Meyer et al.). This "survivor's guilt"experienced by some remaining employees might also be translated into a sense of obligation to work harder to justify the decision to retain them (Brockner, Davy, & Carter, 1985; Meyer & Allen, 1997). Whereas, those employees who perceive cuts in training budget and reductions in benefits may experience a decrease in normative commitment.

Organizational change can also influence commitment through its impact on the psychological contract each employee has with the organization. Morrison and Robinson (1997) state that psychological contracts represent employees' beliefs about the reciprocal obligation between them and their employment relationship with the organization. More specifically, "they define a psychological contact as a set of beliefs about what each party is entitled to receive, and obligated to give, in exchange for another party's contributions" (p. 228). Meyer et al. (1998) suggest that affective commitment is likely to be weaker, when employees view the organization as having violated a trust by implementing

changes that are in its own best interest, but detrimental to the employees' well-being. Whereas, the employee's level of continuance commitments will be influenced by the changes in the contractual relationship that make costs and tangible benefits derived from continued employment more salient. At the same time, employees' level of normative commitment may be influenced by whether their obligations to the organization have been successfully fulfilled (e.g., tuition payments). For those who have not yet repaid their debts, their level of normative commitment may be a determining factor in their decision about whether to remain with the organization. In contrast, those who realize that they have fulfilled their obligations might experience a lower normative commitment (Meyer et al.).

Organizational Commitment of Nurses in Acute Care Settings

The development of organizational commitment in nurses in acute care environments has important ramifications. Organizational commitment has been shown to be a consequence of the perceptions of nurses' workplace empowerment (Wilson & Laschinger, 1994; McDermott, Laschinger, & Shamian, 1996), workplace empowerment and organizational trust (Laschinger, Finegan, Shamian, & Casier, 2001), and psychological empowerment (Laschinger, Finegan, Shamian, & Almost, 2001). Consequences of organizational commitment included a desire and intent to remain in the workplace, high attendance, high retention, and increased job effort especially during periods of increased workloads. Nurses who are committed to the organization have fewer incidences of absenteeism from work (Dahlke, 1996), greater degree of innovative

productivity and spontaneous problem-solving (Allen & Meyer, 1990; McDermott et al., 1996) improved participation in decision making and work empowerment (Wilson & Laschinger, 1994; McDermott et al., 1996), less burnout (Lee & Henderson, 1996); increased job satisfaction (Price & Mueller, 1981; Acorn, Ratner, & Crawford, 1997; McNeese-Smith, 1995, 1997; Blegan, 1993) and reduced nurse turnover (Mueller, Wallace, & Price, 1992; Parasuraman, 1989).

Studies have also shown a strong relationship between managerial strategies (Brewer & Lok, 1995) and leadership (McNeese-Smith, 1995, 1997) and the organizational commitment of nurses. Brewer and Lok found that when managers structure the processes of decision-making and participation, nurses experience a high level of commitment in the workplace. Thus, nurse managers play an important role in manipulating the work environment to increase organizational commitment (Brewer & Lok; McDermott et al., 1996). In response to the changes associated with the restructuring of acute care settings, nurse managers will be challenged to maintain and/or enhance the current levels of staff nurses' organizational commitment. Therefore, additional research will be required to enable nursing leaders to appreciate the process of organizational commitment and the impact of leader behaviours on staff nurse commitment and the achievement of organizational goals.

Absenteeism

Absenteeism is a complex and costly problem for management and uniquely problematic for nursing because the provision of essential patient care cannot be

postponed. Gellatly (1995) notes that employee's absenteeism is poorly understood, with a limited number of studies having examined the effects of personal, job content and organizational factors as the independent variables. The vast majority of the studies have focussed on the impact of work attitudes, such as, job satisfaction. However, meta-analyses of absence literature have revealed a weak inverse relations between job satisfaction measures and absences (Hackett, 1989; Hackett & Guion, 1985). Hackett & Guion found that regardless of the index of absence considered or facets of job satisfaction used, the relationship is weak at best ($r<0.15$). Gauci-Borda and Norman (1997) in a review of nursing research literature found that none of the studies supported a significant relationship between job satisfaction and absence.

Gellatly (1995) notes that the empirical evidence (Meyer et al., 1993; Hackett et al., 1994; Gellatly; Somer, 1995) assessing the relationship between commitment type and absenteeism is sketchy. These studies found that the correlations between affective commitment and measures of voluntary absences are greater than between affective commitment and involuntary absences. In contrast to affective commitment, absenteeism does not seem to be significantly related to continuance commitment. The relationship between absenteeism and normative commitment has received limited attention (Meyer & Allen, 1997).

In a study of 165 nursing and food service workers in a mid-size chronic care hospital Gellaty (1995) found employees who reported higher affective commitment were less likely to be absent, believed they had more work alternatives and viewed their

supervisor as fairer, than employees who reported lower affective commitment. The study also established an inverse relationship between employee perceptions of fair treatment and absence frequency, suggesting that when employees believe they are being treated unfairly by management, one way of restoring equity is to reduce attendance. Gellatly suggest that it is reasonable to expect that activities aimed at increasing commitment, such as, supervisor consideration, job challenge, and participation in decision making, may also increase attendance. Although there are no empirical evidence linking measures of leader empowering behaviours and employee absenteeism, it is reasonable to expect that the higher the nurse perceives her leader to have used leader empowering behaviours which provide meaning and facilitate participation in decision-making will have a positive effect on reducing absenteeism.

Many researchers list age and tenure as personal characteristics in their models of absence. However, in a meta- analysis, Hackett (1989) found that age, but not tenure was inversely related with avoidable absenteeism. No reliable relationship was found among age, tenure and unavoidable (e.g., illness) absenteeism.

Conclusions

The literature clearly recognizes that the role of leadership is a dynamic one between a leader and followers, in which the leader can have a significant influence on how subordinates feel about their work. Despite this recognition, there has been a paucity of empirical literature that identifies the relationship between the nurse manager's leadership behaviours and staff nurses' work attitudes. Limited evidence was found that supports a

relationship between the managers' use of leader empowering behaviours and staff nurses' perceptions of workplace empowerment, psychological empowerment and organizational commitment. Interestingly, absenteeism has been conceptualized as an individual or management problem, but has not been studied as a dependent variable of leadership, workplace empowerment, and/or psychological empowerment in nursing populations. Since the empirical literature supports relationships between nurses' perceptions of workplace empowerment, psychological empowerment and organizational commitment and the achievement of organizational goals, there is a need to examine the relationship of leader empowering behaviours on nurses' perceptions of these variables. In addition, an impending nursing shortage is exacerbated by employee absenteeism which leads to diminished quality of patient care (Gauci-Borda & Norman, 1977; Shamian & Villeneuve, 2000). Thus, there is a need to examine the relationship between leader empowering behaviours and absenteeism. As well, methodological concerns of many of the studies in nursing populations limit the generalizability of many of findings, which warrants an examination of what current nurse managers are doing and not doing that influences the nurses' ability to function effectively with the changes in a recently merged acute care institution.

Chapter 3

Methodology

Introduction

The purpose of this chapter is to describe the research design and method including study setting, sampling process, survey instruments, data collection process and data analysis approaches.

Design

A descriptive, cross-sectional design was used to determine the impact of nurse managers leader empowering behaviours on staff nurses. After exposure to the leadership behaviours, the staff nurses were measured for their perceptions of workplace empowerment, psychological empowerment and organizational commitment, and absenteeism. This study provided information about the nursing group at a point in time, and demonstrated the relationship between the variables.

Setting

The study was conducted in three large acute care university teaching hospitals that offer a wide range of tertiary health care services. These sites have recently merged and undergone restructuring, downsizing, and redesign of patient care delivery systems. These changes are representative of the current changes in other acute care settings.

Therefore, the nurses in this organization are expected to have similar concerns and issues to nurses working in acute care settings that were presented in Chapter 1.

Sample

The target population for this study was registered nurses who worked full-time for a period of one year in an acute care hospital. Since organization's personnel policies did not permit access to the names and status of full-time nurses employed in their institution, the sample was derived from the seniority list of all nurses employed within the organization. The list is produced and updated on a regular basis by the Health Care Corporation in compliance with the union contract with the Ontario Nurses Association (ONA) and is public information.

Three hundred and fifty nurses were sampled. A power analysis was conducted to determine the sample size of full-time registered nurses required for this study. A sample size of 192 was needed to achieve a power of .80 with alpha significance level of .05 and a medium effect of .20. This sample of 350 subjects was proportionally randomly selected from the seniority list of full-time registered nurses from the medical-surgical clinical areas at the three sites. The nurses from the psychiatry, long-term care, and rehabilitation clinical areas were not included in the study to minimize sector-specific issues that may impact upon the work environment and the study results (RNAO/RPNAO, 2000). This method acknowledged a characteristically low return rate of return of mailed questionnaires and a proportionate representation from each clinical area and each nurse manager.

Inclusion Criteria

The following two criteria were used for inclusion in the study: (1) participants were employed by the organization since April 1, 2000 and worked on a full-time basis; and (2) participants were registered nurses in staff nurse or non-management positions within the organization.

Ethical Approval

In June 2001 a research proposal was reviewed by the vice-president of the corporation and the Executive Management Team, who granted permission to conduct the study within their facilities. Following this agreement, the research project protocol and subject consent form were reviewed and approved by the McMaster University Research Ethics Board.

Recruitment

The researcher met with all managers of the clinical units to explain the research proposal and to ensure their cooperation and seek their assistance in ensuring that the staff nurses were encouraged to complete the questionnaire. The staff nurses were notified of the research study through their manager and written information and notices via e-mail which described the study and expectations of the participants.

Coded questionnaire packages, a consent form for release of absentee data, a letter of explanation and researcher-addressed stamped return envelope were delivered to the participants on their clinical unit by the researcher. The letter of explanation provided a brief overview of the study, its benefits to the nursing group, and the individual

importance of the respondent to the success of the study. The letter also assured anonymity and confidentially of subjects. Return of the completed questionnaires constituted consent to participate in part of the study. However, completion of the consent form for release of absentee data from the employing organization was required to measure absenteeism data.

All completed questionaries were accepted and utilized in the study. A follow-up letter was sent to all subjects who had not returned a questionnaire at two weeks. In an attempt to maximize returns, non respondents were sent a second set of questionnaires through the corporation's internal mailing system. Dillman (1978) suggests that a second follow-up should be mailed to non responders exactly three weeks after the original mailing. This mailing included a cover letter that addressed the lack of receipt of the questionnaire and a restatement of the original letter's appeal, a replacement questionnaire and consent form and a stamped self-addressed envelope. The questionnaires were returned directly to the researcher for processing.

The anonymity of all study participants was maintained by limiting access to the names, codes and completed questionnaires to the researcher only. All data and tracking of who required a follow-up letter and second set of questionnaires and data entry were completed by the researcher. To ensure confidentiality, all data were reported in aggregate with no individual names or institutions reported.

Survey Instruments

Six self-report survey instruments were used to measure the variables in this study. One questionnaire was used to measure each of the following concepts: leader empowering behaviours, psychological empowerment and organizational commitment, and three to measure the concept of workplace empowerment. A summary of the Cronbach's Reliability coefficients found for the 6 instruments in the current study are reported in Table 4. In addition, absentee data were collected from the personnel files of the nurses who granted permission. Demographic data were collected to gain a profile of the subjects in this study including age, gender, highest level of education, hospital work site, clinical area, hospital tenure, and tenure in the current clinical unit tenure.

1. Leader Empowering Behaviours Scale

The Leader Empowering Behaviours (LEB) Scale was used by staff nurses to rate their managers' use of leader empowering behaviours. The LEB Scale is a 27-item measure of leader empowering behaviours described by Conger and Kanungo (1988) in their model of the empowerment process and expanded by Hui (1994). The scale consists of 5 subscales designed to measure the following five categories of behaviours:

(1) enhancing the meaningfulness of work (6-items);

(2) fostering opportunities for participation in decision making (5-items);

(3) expressing confidence in the performance of the employee (5-items);

(4) facilitating the accomplishment of organizational goals (6-items); and

(5) providing autonomy from bureaucratic constraints (5-items).

Table 4

Summary of Cronbach's Reliability Coefficients for Study Instruments

Instrument		Alpha Coefficients
1. Leader Empowering Behaviours Scale		.9644
Subscales:	Meaningful Work	.9647
	Participation in Decision-Making	.9470
	Confidence in Employee	.9317
	Facilitating Goal Accomplishment	.9267
	Fostering Autonomy	.6305
2a. Conditions of Work Effectiveness Questionnaire (CWEQ)		.9310
Subscales:	Support	.8869
	Information	.8426
	Resources	.8431
	Opportunity	.8601
Global Empowerment Scale		.8000
2b. Job Activities Scale (JAS)		.7508
2c. Organizational Relationship Scale (ORS)		.8769
3. Psychological Empowerment Scale (PES)		.8601
Subscales:	Meaning	.9186
	Competence	.8737
	Self-determination	.8093
	Impact	.8897
4. Organizational Commitment Scale (OCS)		.7791
Subscales:	Affective Commitment	.7547
	Continuance Commitment	.7137
	Normative Commitment	.7984

The possible responses ranged from 1 (strongly disagree) to 7 (strongly agree). The subscale scores were summed and averaged. Independently, the subscale scores provide a means of classifying the empowering behaviours used by leaders. Additionally, an

overall leadership score is obtained by summing and averaging the 27-items. The higher the scores the more empowering the leader.

Validity. Hui (1994) conducted factor analysis with items loading mostly on their hypothetical construct leader empowering behaviours. The different categories of leader empowering behaviours measured this same underlying construct. Adhearne (2000) studied the effects of leader empowering behaviours and organizational citizenship on sales team performance and in a confirmatory analysis further established that the five dimensions of leader empowering behaviours loaded on their hypothetical factors with Cronbach's alphas ranging from 0.84 to 0.97.

Reliability. All of the subscales of the LEB Scale had high Cronbach's alpha reliability coefficients ranging from 0.71 to 0.90 (Hui, 1994). Using the same scale Laschinger et al. (1999) tested a model linking leader empowering behaviours to staff nurse perception of workplace empowerment, occupational stress and work effectiveness and similarly found Cronbach's alphas ranging from 0.63 to 0.96.

2. Workplace Empowerment Scales

Workplace empowerment was conceptualized using Kanter's (1977) construct for structural empowerment and included the following components: perceived access to the work empowerment structures of opportunity, information, support and resources, formal power, and informal power. The staff nurses rated their perceived level of workplace empowerment using the following questionnaires:

(a) Conditions of Work Effectiveness Questionnaire (CWEQ) (Laschinger, 1996);

(b) Job Activities Scale (JAS) (Laschinger); and

(c) Organizational Relationship Scale (ORS) (Laschinger).

The combination of the CWEQ, the JAS, and the ORS provides a measure of Kanter's (1977) concept of work empowerment (Laschinger, 1996). Individual nurses who have high scores on these scales perceive themselves to be working in an empowered environment. The JAS and the ORS have been found to be predictors of CWEQ scores in several independent studies (Sabiston & Laschinger, 1995; Laschinger & Havens, 1996; Laschinger et al., 1999).

(a) Conditions of Work Effectiveness Questionnaire (CWEQ)

The 33-item CWEQ was used to measure staff nurses' perceptions of their access to four work empowerment structures including: support, information, resources and opportunity (Kanter, 1977). Items were derived from Kanter's original ethnographic study of work empowerment and modified by Chandler (1986) for use in a nursing population. The questionnaire has four subscales: (1) support (9-items); (2) information (8-items); (3) resources (7-items); and (4) opportunity (7-items). Two global items were added to the questionnaire as a validation index. The possible responses range from 1 (none) to 5 (a lot) on the subscales: resources, support, and opportunity. The mean score of each subscale is obtained by summing and averaging items with a range 1 to 5, a high score indicating higher levels of perceived access to information, support, resources, and opportunity. An overall empowerment score is obtained by summing the means of the four subscales which provides a possible score range from 4 to 20. The Global

Empowerment Score (GES) is obtained by summing and averaging the two global empowerment items at the end of the questionnaire. The higher the score, the higher the perception of access to opportunity and power structures in the organization.

Validity. Items for the four subscales were derived from an ethnographic study of work empowerment and modified by Chandler (1986; 1991) for use in a nursing population. Chandler conducted a factor analysis on the questionnaire to establish construct validity with a nursing population with three factors emerging: support, information and opportunity. The subscale resource was considered unreliable and was subsequently modified by a panel of nursing experts (Laschinger, 1996). Face and content validity were established by a panel of nursing experts (Wilson & Laschinger, 1994).

Reliability. Alpha reliability coefficients for the total scale have been strong with a range from 0.80 to 0.95 across studies conducted from 1992 to 2001 in research programs (Laschinger, 2002). Reliability coefficients for the individual subscale range from 0.56 to 0.98 for information, 0.73 to 0.93 for support, 0.57 to 0.91 for opportunity and 0.63 to 0.91 for resources (Laschinger). The global empowerment scale (GES) has alpha coefficients ranging from 0.78 to 0.94 across studies (Laschinger). The test-retests of the CWEQ have been found to be acceptable, demonstrating discrimination among respondents from various levels in the organizational hierarchy (Laschinger, 1996).

(b) Job Activities Scale (JAS)

The JAS (Laschinger, 1996) is a 9-item Likert scale which measures staff nurses' perceptions of formal power within the work environment characterized by recognition, relevance and discretion (Kanter, 1977). The mean score of the scale is obtained by reverse scoring item number five, then summing and averaging all items with a range of 1 to 5, with a high score indicating that the job activities represent position power. Face and construct validity were established by a panel of experts. Cronbach's alpha reliability coefficients range from 0.53 to 0.91 in studies this instrument (Laschnger, 2002). Alpha reliability was improved with deletion of items and/or refinement of items following psychometric analyses of several data sets (Laschinger, 1996).

(c) Organizational Relationship Scale (ORS)

The ORS (Laschinger, 1996) is a 18-item Likert-type scale that measures staff nurses' perception of informal power within the work environment characterized by political alliances, sponsor support, peer networking and subordinate's relationships in the work setting (Kanter, 1977). Items are summed and averaged to yield a score that ranges from 1 to 5. High scores represent a strong network of alliance in the organization of high informal power. Content validity was established through pilot testing of the instrument with a convenience sample of registered nurses. This scale has been found to have a strong internal consistency with Cronbach's alpha reliabilities ranging from 0.85 to 0.93 in studies using this instrument (Laschinger, 2002). High scores indicate high informal power which represents a strong network of alliances in the organization.

3. Psychological Empowerment Scale (PES)

Psychological empowerment was conceptualized using Spreitzer's (1995a) multidimensional constructs which examines the individual's perceptions of psychological empowerment in the workplace. Staff nurses rated their level of psychological empowerment with the PES, which consists of 12 empowerment items representing the four theoretical dimensions of meaning, competence, autonomy, and impact. Each of the four dimensions was measured by three items on a 5-point Likert scale. The possible responses range from 1 (strongly disagree) to 5 (strongly agree) on all items. The mean score for each dimension is obtained by summing and averaging the three items, with high scores indicating higher levels of each dimension. An overall psychological empowerment score is obtained by summing and averaging the 12 items, with a high score indicating a high level of perceived psychological empowerment.

Validity. Discriminant validity among the four dimensions of psychological empowerment was established by Spreitzer (1995a), in a study of two samples with one consisting of managers from an industrial organization and the other of lower-level managers from an insurance company. Convergent validity was also established in that the four dimensions combined to an overall construct of empowerment in a second order confirmatory factor analysis (CFA). The CFA established an excellent fit for the industrial sample achieving a goodness of fit index (AGFI) equal to 0.93 and a moderate fit for the insurance sample with the AGFI equal to 0.83. Each of the items in the factor

analysis loaded strongly on the appropriate factor with each of the four factors significantly correlated with each other for both samples.

Reliability. The instrument demonstrated acceptable levels of internal consistency and test-retest reliability on each subscale. Test-retest reliabilites for each of the subscales ranged from 0.73 to0.85. Cronbach's alpha reliability coefficients for the four dimensions were meaning (range 0.85 to 0.87), competence (range 0.79 to 0.81), self-determination (0.82), and impact (0.88) and the overall empowerment construct (0.72) (Spreitzer, 1995a, 1995b, 1996; Spreitzer et al., 1997). Laschinger, Finegan, Shamian, and Wilk (2001) in a study of nurses in acute care settings using the Psychological Empowerment Scale found alpha reliability coefficients for the dimensions were high (range 0.87 to 0.92) and 0.89 for the overall psychological empowerment.

4. Organizational Commitment

Organizational commitment was conceptualized using Meyer and Allen's (1991) multidimensional concept which included three dimensions of commitment: affective, continuance, and normative. Staff nurses rated their perceived levels of organizational commitment with the: (1) Affective Commitment Scale (ACS) (6-items); (2) Continuance Commitment Scale (CCS) (6-items); and (3) Commitment Scale (NCS) (6-items).

All measures were self-assessments and used a 7-point Likert response format ranging from1 (strongly disagree) to 7 (strongly agree). The scores of items number 3, 7, 10, and 13 are reversed. The mean score of each dimension is obtained by summing and averaging the assigned items, with a high score indicating higher levels of perceived

affective, continuance or normative commitment. An overall organizational commitment score is obtained by summing and averaging the means of the 3 scales. The higher the score the higher the perception of overall organizational commitment.

Validity. Allen and Meyer (1996) reviewed and evaluated more than 40 studies relevant to the construct validity of the measures of affective, continuance and normative organizational commitment. For the most part the results of both exploratory and confirmatory analyses provided evidence to suggest that the three dimensions are distinctive constructs. Factor analyses have provided evidence that the three constructs were distinguishable from related constructs of job satisfaction, career, job and work values, career commitment, occupational commitment, and perceived organizational support (Allen & Meyer, 1996; Meyer & Allen, 1997). Meyer and Allen argue that further evidence of the construct validity of the three component model of commitment is demonstrated in that the patterns of empirical findings match the hypothesized relations among the three commitment components and other variables presumed to be antecedents and consequences of commitment.

Reliability. Allen and Meyer (1996) in their review of 40 studies found that internal consistency of the measures has been typically estimated using coefficient alphas. The median reliabilities across both versions (8-items or 6-items per dimension) of the Affective, Continuance and Normative Commitment Scales are 0.85, 0.79, and 0.73 respectively. In only a few exceptions, were the reliability estimates found to be less than 0.70. Laschinger, Finegan, Shamian, & Casier (2001) in a study of nurses in acute care

settings, reported Cronbach's alpha for affective commitment (0.74) and continuance commitment (0.75). Normative commitment was not measured.

5. Absenteeism

Absenteeism was measured from the hospital data base. Data were provided by the Personnel Department listing the date and hours taken for sick leave. The hours were converted to days based on a 11.25 hour day, which is based on a 12-hour workday as established by collective agreement between the Ontario Nurses Association (ONA) and the Health Care Corporation. Total days absent included all the sick leave days taken by the 171 subjects in the study. The total days were then subdivided into short term (1 to 3 days) and long term (4+ days). Episodes of days absent were calculated according to the start and return dates of the days absent due to sick leave.

A time span of one year was used to collect the absentee data. This is considered a midterm source of a variance and is the most common interval for absenteeism records and absence patterning (Harrison & Martocchio, 1998). Harrison and Martocchio note that aggregation of absent data over a year moves absenteeism data from "the individual, social and organizational changes defined with an annual cycle into the realm of behavioural persistence across such changes" (p. 3). This time frame also corresponds to periods over which global attitudes will remain fairly stable (Rosse & Hulin, 1985). Thus, job attitudes will be at their peak relevance and peak correlation with absenteeism.

Data Analysis

The Statistical Package for Social Science programs (SPSS) was used for data analysis. Descriptive statistics of means, standard deviations, and percentages were used to summarize demographic data information. Descriptive statistics were also used to describe the responses to the study variables and the absenteeism data collected from the personnel files of the staff nurses.

The research hypotheses were examined using ANOVA, Pearson product moment correlation coefficients, and step-wise regression analysis. Group differences were tested using analysis of variance (ANOVA). ANOVA allows comparison among more than two sample means and test the significance of the differences between means. ANOVA decomposes the total variability of a set of data into components: (1) the variability resulting from the independent variable (leader empowering behaviours); and (2) all other variability, such as individual differences and measurement unreliability. Variation between groups is contrasted with variations within groups to yield a F-ratio (Polit & Hungler, 1995). The F-ratio tells us if there is a significant difference between the variables, but not the strength of the relationship, which is measured by correlation analysis (Norman & Streiner, 2000).

The Pearson Correlation Coefficients (r) were used to describe the strength of the relationship between leadership total score and its subscales scores with the staff nurse variables. The correlation coefficient ranges from -1 to +1, with the closer the value is to -1 or +1, the stronger the linear association. Whereas, values found close to zero are

indicative of some weak or nonexistent linear associations. A negative coefficient means an association exists, where, as one variable goes up, the value of the other variable goes down, indicating a negative relationship. A positive coefficient means an association exists where, as one variable goes up, the value of the other variable goes up, indicating a positive relationship (Norman & Streiner, 2000). Pearson moment correlation coefficients greater than 0.40 were considered to be important.

The multiple regression coefficient (R^2) measures the magnitude of the relationship between the dependent and independent variables. Five step-wise multiple regressions were performed to determine the relative importance of the different possible explanatory variables using the correlations from the data. The following independent variables were entered step-wise into each of the multiple regression models: leader empowering behaviours (Hui, 1994) scores, age, gender, hospital tenure, and clinical unit tenure. The first regression analysis examined the strength of these variables on the dependent variable workplace empowerment, the second on the dependent variable psychological empowerment, the third on the dependent variable organizational commitment, and the fourth and fifth on dependent variables days absent and episodes of days absent, respectively. Workplace empowerment, psychological empowerment, and organizational commitment was also entered in the fourth and fifth multiple regression. The value of R^2 can range from 0.00 to 1.00, with the larger the R^2 value the stronger the association.

Chapter 4

Results

Sample

A total of 350 questionnaires was distributed to a randomly selected sample of full time registered nursing staff on 38 clinical units. Of these, 215 (61%) were returned for data analysis. Of the 215, 12 were not completed, 9 were from nurses who indicated they were not working, and 3 that were incomplete. Of the 191 completed questionnaires, 170 (90%) of the respondents had granted permission for access to personnel files. The 191 respondents represent 22% of the study population of nurses (867) and 54% return rate of the questionnaires given. It was not possible to determine if those who responded to the survey were similar or not to those individuals who were sampled, but did not respond. Because of the organization's confidentiality policies, it was not possible to follow-up on non-respondents.

Demographic Data

The demographic data revealed that 95.3% of the sample was female and 4.7% was male. The majority of the respondents were prepared at the RN diploma level (89.5%), with the remainder being prepared at the baccalaureate (10%) and master's (0.5%) levels. The participants average age was 43.12 years with 16.15 years tenure in the hospital and

10.89 years in the current clinical unit. The demographic variables are presented in Table 5.

Table 5

Observed Frequencies, Means, SDs for Nurses Individual Demographic Characteristics

		Mean	SD
Age		43.12	7.94
Hospital tenure		16.15	7.83
Clinical unit tenure		10.89	7.38
		n	%
Gender	female	182	95.3
	male	9	4.7
Level of education	diploma	171	89.5
	baccalaureate	19	9.9
	masters	1	0.5
Specialty area	medical	39	20.6
	surgical	35	18.5
	maternal/child	30	15.9
	critical care	37	19.6
	operating room	32	16.9
	emergency	16	8.5

Leader Empowering Behaviours

The overall leader empowering behaviour score as measured by the Leader Empowering Behaviours (LEB) Scale (Hui, 1994) indicated that this sample of nurses (n=191) perceived their leaders to have low to moderate leader empowering behaviours ($\bar{X}$=3.39, SD=1.21), in a scale of 1 to 7. The means of the subscales with the exception

of expressing confidence in employees ($\bar{X}$=3.92, SD=1.59), were below or at the mean of the total score. The results are presented in Table 6.

Table 6

Observed Means, SDs of the Leadership Empowerment Behaviours (LEB) Scale and Subscales

Instrument	Means	Standard Deviations
Leader Empowering Behaviours (LEB)*	3.39	1.21
Subscales:		
enhancing meaningful work	3.21	1.50
participation in decision-making	3.10	1.59
expressing confidence in employees	3.92	1.59
facilitating goal accomplishment	3.36	1.16
providing autonomy from bureaucratic constraints	3.39	0.99

* Score ranges 1-7 (highest)

Three leader groups were constructed based on their LEB scores to test the strengths of relationships among the leader empowering behaviour subscales and staff nurse outcome variables and explore which subscale had the higher means. Subjects were divided into the following three groups based on their LEB scores: low group (n=77) LEB group (scores<3), moderate (n=94) LEB group (scores between 3-5), and high (n=20) LEB group (scores>5), based on the 7-point Likert scale. The mean scores of each of the staff nurse variables were compared among the three groups, using ANOVA, in order to get a better understanding of how the specific subscales of LEB Scale were

related to staff nurses' perceptions of workplace empowerment, psychological empowerment, and organizational commitment, and absenteeism. The percentages of nurses in each of these three LEB groups by speciality area and hospital are presented in Table 7.

Table 7

Observed Frequencies and Percentages for Nurses in the Specialty Areas and Hospitals, by the Three Leadership Empowerment Behaviour (LEB) Groups

Specialty Area	Low (%) n=77	Moderate (%) n=94	High (%) n=20
Medical	41.0	46.2	12.8
Surgical	45.7	48.6	5.7
Maternal/child	30.0	50.0	20.0
Critical care	43.2	54.1	2.7
Operating room	37.5	46.9	15.6
Emergency	37.5	56.3	5.0
Total	39.7	49.7	10.6
Hospital A	34.2	51.3	14.5
Hospital B	47.6	40.5	11.9
Hospital C	40.8	53.5	5.6
Total	39.7	49.7	10.6

Staff Nurse Variables

1. Workplace Empowerment

Workplace empowerment was measured using three different measures all of which used a 5-point Likert scale, and included: (1) the Conditions of Work Effectiveness Questionnaire (CWEQ) which assessed the structural determinants of workplace

empowerment (support, information, resources and opportunity), and the Global Empowerment Scale (GE) which included two validation items for the total workplace empowerment score; (2)the Job Activities Scale (JAS) which assessed formal power; and (3) the Organizational Relationship Scale (ORS) which assessed informal power. Overall empowerment scores which was calculated by summing the means of the four subscales ranged from 4 to 20. The scores indicated that the sample of nurses perceived themselves to be moderately empowered which was validated by the corresponding moderate global empowerment score. The CWEQ subscales for the total group all averaged over the midpoint of the 5-point Likert scale, with the subscale opportunity being the most empowering factor, and with the subscales information and resources being the least empowering factors. Nurses perceived themselves to have a higher moderate amount of informal power than formal power. The results are shown in Table 8.

Hypothesis 1 As predicted staff nurses' perceptions of workplace empowerment as proposed by Kanter (1977) were higher when they perceived their leader as using high leadership empowering behaviours. There was a statistically significant difference in means between the low, moderate and high groups of leader empowering behaviours (LEBs) and workplace empowerment ($p=<.001$). The overall workplace empowerment scores indicated that the higher staff nurses perceived their leaders' empowering behaviours, the higher their overall workplace empowerment mean scores. The corresponding global empowerment scores followed a similar pattern of mean scores.

Table 8

Comparisons of Observed Means and SDs of the Conditions of Work Effectiveness Questionnaire (CWEQ) Scales and Subscales, Job Activities Scale (JAS), and the Organizational Relationship Scale (ORS), and Global Empowerment Scale Among the Three Leadership Empowerment Behaviour (LEB) Groups

Instrument	Total Group Mean (SD)	Low Mean (SD)	Moderate Mean (SD)	High Mean (SD)	F-test	p-value
Condition of Work Effectiveness (CWEQ)*	10.81 (2.18)	9.37 (1.67)	11.41 (1.64)	13.45 (2.35)	54.13	<.001
Subscales:						
opportunity	3.11 (.62)	2.83 (.60)	3.21 (.53)	3.71 (.58)	21.96	<.001
information	2.52 (.72)	2.20 (.69)	2.63 (.59)	3.23 (.75)	22.51	<.001
support	2.64 (.75)	2.18 (.59)	2.86 (.58)	3.37 (.95)	38.53	<.001
resources	2.54 (.65)	2.17 (.56)	2.71 (.54)	3.15 (.71)	32.17	<.001
Global Empowerment Scale	2.82 (.98)	2.35 (.88)	3.04 (.88)	3.53 (1.07)	18.99	<.001
Job Activities Scale (JAS)	2.65 (.52)	2.38 (.48)	2.76 (.43)	3.15 (.53)	27.75	<.001
Organization Relationship Scale (ORS)	3.24 (.57)	2.92 (.51)	3.37 (.47)	3.84 (.46)	35.82	<.001

* Score range 4-20 (high) (all other scale ranges 1-5)

SD = Standard Deviation

As well, there was a statistically significant difference in means ($p<.001$) between low, moderate and high LEB groups and total mean workplace empowerment scores (CWEQ), as well as, the mean scores of the subscales of the CWEQ. In contrast, the within groups differences of workplace empowerment is different for each LEB group. All LEB groups found opportunity was the most empowering workplace factor, which is consistent within the total group. The least empowering workplace factor, for the low and high LEB groups , was resources, whereas, information was found to be the least empowering workplace factor for the moderate LEB group. This finding is consistent with the total study group which found information to be the least empowering workplace factor. This is due to the fact that the majority of the nurses are in the moderate LEB group.

In addition, there were significant differences in means between low, moderate, and high LEB groups and formal power ($p=<.001$) and informal power ($p=<.001$). In effect, the higher the staff nurses perceived their leader's empowering behaviours, the higher they perceived their jobs as having formal and informal power. These results are reported in Table 8.

Moderate to strong relationships were found between the LEB Scale and its subscales and the workplace empowerment scales; CWEQ, JAS, ORS and Global Empowerment Scale. This is consistent with theoretical predictions which suggest that these leadership behaviours are important correlates of workplace empowerment. The strongest correlation was found between the overall LEB score and overall workplace

empowerment (CWEQ) score and the CWEQ subscale, support, while the weakest correlation was found between the overall LEB score and the workplace empowerment subscale score, information.

The strongest relationships were found between the LEB subscales, meaningful work, participating in decision making, facilitating goal accomplishment and the workplace empowerment (CWEQ) subscale, support. The weakest correlations were found between the LEB subscales: expressing confidence in employees and facilitating goal accomplishment and the two workplace empowerment (CWEQ) subscales, opportunity and information. In addition, overall leadership empowering behaviours were strongly correlated with formal power and informal power. The results are reported in Table 9.

The results of step-wise multiple regression analysis is shown in Table 10. In the model, 48% of the variability of workplace empowerment in the sample can be accounted for by the leader empowering behaviour "enhancing the meaningfulness of work", age, and another leader empowering behaviour, "facilitating goal accomplishment".

2. Psychological Empowerment

Staff nurses' perceptions of psychological empowerment were measured by Spreitzer's (1995b) Psychological Empowerment Scale (PES) on a 5-point Likert scale. The overall psychological empowerment score indicated that the nurses in this study perceived themselves to be moderately psychologically empowered. In particular, they perceived themselves to have high psychological empowerment on the dimensions of

Table 9

Correlations Among the Leadership Empowerment Behaviours (LEB) Scale and Subscales, the Conditions of Work Effectiveness Questionnaire (CWEQ) Scales and Subscales, Job Activities Scale (JAS), and Organizational Relationship Scale (ORS)

Scales	LEB	EMW	PDM	ECE	FGA	FAB
CWEQ - Overall Empowerment	.66	.68	.60	.48	.60	.47
Subscales:						
opportunity	.46*	.45*	.47*	.33	.43*	.27
information	.42*	.49*	.40*	.26	.35	.23
support	.62*	.62*	.55*	.47*	.60*	.45*
resource	.57*	.59*	.50*	.44*	.51*	.43*
Global Empowerment	.48*	.50*	.40*	.37	.42*	.37
JAS - Formal Power	.55*	.51*	.53*	.50*	.50*	.42*
ORS - Informal Power	.54*	.50*	.53*	.43*	.45*	.44*

*$\geq .40$

LEB = Leader Empowering Behaviour; EMW = Enhancing Meaningful Work
PDM = Participation in Decision-Making; ECE = Expressing Confidence in Employee
FGA = Facilitating Goal Accomplishment
FAB = Fostering Autonomy Bureaucratic Constraints

meaning and competence, moderate psychological empowerment on the dimension of autonomy (self-determination), and low psychological empowerment on the dimension of impact. The results are shown in Table 11.

Hypothesis 2 The second hypothesis predicted that staff nurses' perceptions of psychological empowerment would be higher if they perceived their leader as using high leader empowering behaviours. This prediction was confirmed . There was a statistically

Table 10

Model Summary of Step-Wise Multiple Regression Analysis for Variables Associated With Workplace Empowerment

Model	Variables Entered	R	R Square	F	P
1	Enhancing meaningful work	.679	.461	157.249	<.001
2	Age	.688	.473	82.271	<.001
3	Facilitating goal accomplishments	.698	.479	57.737	<.001

significant difference in means ($p<.001$) between the degree of perceived leader empowering behaviours and overall psychological empowerment. The higher the staff nurses perceived their leader's empowering behaviours the higher their psychological empowerment. As well, significant differences in means were found between the low, moderate, and high LEB groups and the psychological empowerment subscales of meaning ($p=.006$), autonomy ($p=.001$) and impact ($p<.001$). However, no significant difference was found between the LEB groups and the subscale, confidence ($p=.139$). The pattern of the subscale mean scores for each LEB group varies, with meaning, the most psychologically empowering for the high group, meaning and confidence for the moderate group and confidence for the low group. Impact is perceived by staff nurses in all LEB groups as the least psychologically empowering. The results are presented in Table 11.

A moderately strong positive correlation was found between overall leader empowering behaviours (LEB) and overall psychological empowerment. The LEB

Table 11

Comparison of Observed Means and SDs of the Psychological Empowerment Scales and Subscales Among Leadership Empowerment Behaviour (LEB) Groups

Instrument	Total Group Mean (SD)	Low Mean (SD)	Moderate Mean (SD)	High Mean (SD)	F-test	p-value
Psychological Empowerment*	3.76 (.53)	3.53 (.52)	3.84 (.46)	4.26 (.45)	19.43	<.001
Subscales*						
meaning	4.43 (.72)	4.27 (.81)	4.48 (.67)	4.82 (.30	5.20	.006
competence	4.49 (.59)	4.44 (.59)	4.48 (.61)	4.74 (.36)	2.00	.139
autonomy	3.95 (.78)	3.72 (.91)	4.04 (.61)	4.40 (.67)	7.86	.001
impact	2.17 (.90)	1.71 (.75)	2.35 (.80)	3.05 (.92)	27.00	<.001

*score 1-5 (high)

SD = Standard Deviation

subscales had positive, but weak correlations between the psychological empowerment subscales of meaning and autonomy, but did show a moderately strong correlation with the psychological empowerment subscale impact. The psychological empowerment subscale, confidence had a weak, but positive correlation with LEB subscales expressing confidence in employee and fostering autonomy from bureaucratic constraints. The results are reported in Table 12.

Table 12

Correlations Among the Leadership Empowerment Behaviours (LEB) Scale and Subscales and Psychological Empowerment

Scales	LEB	EMW	PDM	ECE	FGA	FAB
Psychological Empowerment	.42*	.38	.39	.39	.36	.36
Subscales:						
meaning	.25	.22	.24	.26	.24	.15
confidence	.13**	.05**	.06**	.26	.12**	.15**
autonomy	.27	.27	.23	.19	.25	.28
impact	.47*	.45*	.48*	.37	.36	.39

*≥. 40 ** non-significant

LEB = Leader Empowering Behaviour EMW = Enhancing Meaningful Work
PDM = Participation in Decision-Making ECE = Expressing Confidence in Employee
FGA = Facilitating Goal Accomplishment
FAB = Fostering Autonomy from Bureaucratic Constraints

The results of the step-wise multiple regression analysis is shown in Table 13. For psychological empowerment the model explains only 23% of the variance of psychological empowerment in the sample and this is accounted for by the independent

variables, leader empowering behaviour "participation in decision-making", age, and another leader empowering behaviour "expressing confidence in employees". This reflects the importance of other factors not measured in this study.

Table 13

Model Summary of Step-Wise Multiple Regression Analysis for Variables Associated With Predicting Psychological Empowerment

Model	Variables Entered	R	R Square	F	P
1	Participation in decision-making	.396	.157	33.911	<.001
2	Age	.452	.204	23.243	<.001
3	Expressing confidence in employees	.483	.233	18.264	<.001

3. Organizational Commitment

The overall organizational commitment score measured on a 7-point Likert scale by the OCQ, indicated that the nurses perceived themselves to be moderately committed to the organization. Specifically, they perceived themselves to have higher continuance commitment, moderate affective commitment and lower normative commitment. The results are reported in Table 14.

Hypothesis 3 The third hypothesis predicted that staff nurse's perceptions of overall organizational commitment, affective commitment, and normative commitment would be higher, if they perceived their leader as using high leadership empowering behaviours; and continuance commitment would not be affected lower. This prediction is confirmed

Table 14

Comparison of Observed Means and SDs of the Organizational Commitment Scales and Subscales Among the Three Leadership Empowerment Behaviour (LEB) Groups

Instrument	Total Group Mean (SD)	Low Mean (SD)	Moderate Mean (SD)	High Mean (SD)	F-test	p-value
Organizational Commitment**	3.52 (.87)	3.15 (.79)	3.71 (.84)	3.98 (.87)	13.06	<.001
Subscales**						
affective	3.62 (1.27)	3.04 (1.24)	3.88 (1.13)	4.57 (1.05	18.055	<.001
continuance	3.97 (1.30)	3.93 (1.47)	4.04 (1.21	3.74 (.97)	.484	.617
normative	2.97 (1.24)	2.47 (1.09)	3.23 (1.20)	3.63 (1.33)	12.142	<.001

**score 1-7 (high)

SD = Standard Deviation

in that there was a statistically significant difference for overall organizational commitment ($p<.001$), affective commitment ($p<.001$), and normative commitment ($p<.001$), whereas, continuance commitment was not statistically significant ($p=.617$). Overall, the higher the staff nurses' perceived their leader's empowering behaviours the higher their perceived overall Organizational Commitment (OCQ) and the higher their perceived affective and normative commitment. Continuance commitment was perceived as higher by the moderate LEB group. The results are presented in Table 14.

The patterns of commitment dimensions varied among the LEB groups and were consistent with predictions. In the low and moderate LEB group, staff nurses indicated that their continuance commitment was higher followed by affective commitment and lowest for normative commitment. The high LEB group indicated that their affective commitment was the highest followed by continuance commitment and normative commitment. The results are presented in Table 14.

Moderately strong correlations were found between overall leader empowering behaviours (LEB) and the LEB subscales and the overall organizational commitment, affective and normative commitment. No significant relationship was found between overall leader empowering behaviours and continuance commitment. In fact, it was negatively correlated. The results are reported in Table 15.

The results of the step-wise multiple regression analysis is presented in Table 16. The model accounted for only 20% of the variance in the organizational commitment of staff nurses can be accounted for by the leader empowering behaviour, "enhancing the

meaningfulness of work", hospital tenure, and another leader empowering behaviour, "fostering autonomy from bureaucratic structures".

Table 15

Correlations Among the Leadership Empowerment Behaviours (LEB) Scale and Subscales and Organizational Commitment (OCS) Scales and Subscales

Scales	LEB	EMW	PDM	ECE	FGA	FAB
Organizational Commitment	.34	.35	.31	.20	.31	.35
Subscales:						
affective	.43*	.41*	.01	.34	.38	.37
continuance	-.09**	-.07**	-.09**	-.15	-.07**	-.01**
normative	.37	.39	.34	.24	.35	.32

*≥.40 **non significant

LEB = Leader Empowering Behaviour; EMW = Enhancing Meaningful Work
PDM = Participation in Decision-Making; ECE = Expressing Confidence in Employee
FGA = Facilitating Goal Accomplishment
FAB = Fostering Autonomy from Bureaucratic Constraints

Table 16

Model Summary of Step-Wise Multiple Regression Analysis for Variables Associated With Organizational Commitment

Model	Variables Entered	R	R Square	F	P
1	Enhancing meaningful work	.337	.114	12.634	<.001
2	Hospital tenure	.417	.174	19.234	<.001
3	Fostering autonomy from bureaucratic structures	.443	.196	14.782	<.001

4. Absenteeism

Number of days absent for each full-time staff nurse (n=171) was obtained from personnel records for the period April 1, 2000 to March 31, 2001. The means and standard deviations were calculated. The nurses in this study averaged 3.85 episodes of days absent in one year for a total of 2,286 days ($\bar{X}$=13.37, SD=18.50). Following categorization of the number of days absent into short term leave (1 to 3 days) and long term leave (4+ days), it was found that nurses used an average of 3.38 episodes of short term leave with an average of 1.44 days per episode and an average of 0.62 episodes of long term leave with an average of 14 days per episode. The individual average was calculated by dividing the group mean by the number of episodes in each category. The results are reported in Table 17.

Hypothesis 4 Absenteeism was predicted to be affected by the staff nurses' perceptions of their leader as using high leadership empowering behaviours. The absenteeism variable was computed both as "days absent" and episodes of days absent. There were no significant differences in the means between low, moderate, and high LEB groups and days absent and episodes of days absent. The hypothesis was not supported . The results are reported in Table 16.

No correlations were found between leader empowering behaviours and the categories of days absent. Step-wise multiple regression analysis revealed no linear relationship between the independent variable leader empowering behaviours and the dependent variables days absent and episodes of days absent.

Table 17

Comparison of Observed Means, SDs for Days Absent and Episodes of Days Absent Among the Three Leadership Empowerment Behaviour (LEB) Groups

Instrument	Total Group Mean (SD)	Low Mean (SD)	Moderate Mean (SD)	High Mean (SD)	F-test	p-value
Total days absent	13.46 (18.47)	11.43 (13.77)	14.93 (20.42)	14.21 (22.08)	.694	.501
Total number of episodes	3.88 (2.67)	3.97 (2.44)	3.86 (2.78)	3.68 (3.07)	.092	.912
Total days absent (1-3 days)	4.78 (3.31)	4.76 (3.31)	4.69 (3.87)	5.25 (4.56)	.176	.839
Number of episodes (1-3 days)	3.38 (2.30)	3.38 (2.31)	3.27 (2.63)	3.26 (3.00)	.039	.962
Total days absent (4+ days)	8.70 (18.48)	6.66 (14.25)	10.28 (20.45)	9.01 (22.66)	.719	.488
Number of episodes (4+ days)	0.62 (.97)	0.63 (.83)	0.42 (.88)	0.42 (.77)	.450	.639

SD = Standard Deviation

Chapter 5

Discussion

This chapter presents an overview and discussion of the findings of the study, methodological limitations, implications for acute care and nursing administrations and future research.

Summary of Study Findings

This study examined the relationship between leader empowering behaviours utilized by nurse managers and the extent to which staff nurses perceived themselves to be empowered and committed to the organization and their use of sick leave. Overall, the results of this study support the majority of the hypothesized effects of leader empowering behaviours on nurses' experiences. However, no relationships were found between leader empowering behaviours and absenteeism and the psychological empowerment subscale, competence or organizational subscale continuance commitment. The following is a summary of the findings of this study:

1. Staff nurses perceived that the managers used low to moderate levels of leader empowering behaviours, which is consistent with the findings reported in studies of nurses in acute care settings (McMahon, 1998; Laschinger et al., 1999).

2. Staff nurses perceived themselves to have moderate levels of workplace empowerment on all workplace empowerment scales which is consistent with other studies in nursing populations (Laschinger, 1996; Laschinger, 2002).
3. Staff nurses perceived high levels of overall psychological empowerment, with perceived high levels of meaning and confidence, moderate levels of autonomy, and low impact which is consistent with the findings in acute care settings (Laschinger, Finegan, Shamian, & Wilk, 2001; Laschiger, Finehgan, Shamian, & Almost, 2001).
4. Staff nurses perceived themselves to have moderate levels of overall organizational commitment, high continuance commitment, moderate affective commitment, and low normative commitment. Similar findings were reported by Laschinger, Finegan, Shamian, & Casier (2001). However, normative commitment was not measured.
5. Staff nurses had an average of 13.37 days (average of 3.88 episodes) absent due illness. This finding is similar to the average of 13 days per year for full-time nurses in Canada (Akyeampong, 1999). Contrary to predictions, the nurse perceptions of leader empowering behaviours were not related to their absenteeism.
6. Staff nurses perceptions of the managers use leader empowering behaviours were significantly related to the nurses' perceptions of:
    6.1. Workplace empowerment, access to opportunity, information, support and resources, formal power, informal power and global empowerment. These findings are consistent with other studies in acute care settings (McMahon, 1998, Laschinger et al., 1999).

6.2. Overall psychological empowerment and the subscales of autonomy, impact and meaning, but not significantly related to the subscale confidence (p=>14).

6.3. Overall organizational commitment, affective and normative commitment, but not significantly related to continuance commitment (p=.62).

This is the first known study that has examined the effects of managers use of leader empowering behaviour (Hui, 1994) on staff nurses' perceptions of psychological empowerment, organizational commitment and absenteeism in nursing populations. Therefore, comparisons with other studies is limited.

The findings of this study do provide, however, additional empirical support for Kanter's (1977) theoretical proposition that organizational aspects of the work environment are important in shaping the work attitudes and behaviours of nurses working in acute care environments. In addition, the findings highlight the importance of leader empowering behaviours in influencing nurses' perceptions of their access to opportunity, information, support, and resources, and degree of formal and informal power in their work environment. The strong relationship between LEB and the workplace empowerment, subscale support highlights the importance of providing staff nurses with support to make decisions related to their work and to have access to the people and resources necessary to complete their work in a manner that achieves professional goals of quality patient care. Although, nurse managers must work within the challenges of reduced human and financial resources, their actions must ensure that staff nurses have access to resources to achieve organizational goals.

The demographic variable of age and the leader empowering behaviours of enhancing the meaningfulness of work and fostering goal accomplishments were found to be a strong predictor of workplace empowerment. This finding suggests that older nurses perceived themselves to have greater access to opportunity, information, resources and support and had jobs which were seen as relevant and discretionary in achieving organizational goals. McMahon (1998) suggests that older nurses over time learn to work within the political and operational structures of the organization, becoming more adept at assessing empowerment structures to accomplish their work goals. As well, the finding suggests that nurses perceived themselves to be empowered when their leader assisted them in understanding the goals and objectives of their department, the importance of their work in the overall effectiveness of the organization and overcoming obstacles to the achievement of performance goals.

The weaker relationship between LEB and LEB subscales and the workplace empowerment subscales, opportunity and information, lends support to staff nurses' contention that the restructuring and downsizing of acute care organizations have limited nurses opportunity to not only education and advancement beyond their current level, but also to information about the organizational activities and plans. Kanter (1989) contends that professional are often motivated by the desire to see their work contribute to an excellent final product. Therefore, it is incumbent upon good leaders to develop strategies that are based on contribution rather than promotion. Some strategies that have been used to promote this concept, include clinical laddering within the profession,

release time to work on special projects, encouraging nurses to publish and/or present their successes at conferences, and providing opportunities for educational leaves. However, for these strategies to be successful they need to be accompanied by the necessary resources to fulfil expectations.

It is also important that managers make more information available to their staff by creating open communication structures and developing extensive networking. Brown and Kanter (1982) contend that powerless managers often neglect to pass on key information, so it necessitates that employees ask for or create alternative sources that may be more informative than the manager, thus further increasing their powerlessness. Consequently to be seen as empowering, nurse managers must provide direct and immediate communications in order to give nurses the information that supports the accomplishment of organizational goals.

Conger and Kanungo (1988) suggest that major organizational changes may seriously challenge employees' sense of control and competence as they deal with the uncertainty of change and acceptance of new responsibilities. The nurses in this study have had to deal with many stressors associated with a recent merger, in addition, to changes in leadership and job uncertainty. Despite these challenges the nurses in this study perceived their work as very meaningful and that they had a high level of confidence in their job performance abilities. Contrary to predictions, however, the psychological empowerment subscale, confidence, was not related to leader empowering behaviours. Nurses in this study perceived themselves to have high confidence in their skills required

to deliver quality nursing care, independent of leader empowering behaviours. According to Thomas and Velthouse (1990), intrinsically motivated behaviour is not dependent upon the supervision of others nor the reward mediated by others. Therefore it is possible for an individual to experience empowerment even if his/her job characteristics are not enriched by leader empowering behaviours.

Both leader empowering behaviours, facilitating participation in decision-making and expressing confidence in employees' performance, and the age of staff nurses were found to explain about 23% of the variance of psychological empowerment. The unexplained variance suggests the presence of other important factors not measured in this study, for example, the relationship of workplace empowerment to psychological empowerment and health problems associated with job strain. Karesek (1979) conceptualized job strain as a combination of a high degree of psychological workload demands and low decision-making latitude. Job demands are the psychological stressors in the work environment such as workload, time pressures and conflicting demands. Decision latitudes refers to employees' control over their task and conduct during the day. Laschinger, Finegan, Shamian, & Almost (2001) found that nurses in the high strain category were significantly less empowered, both structurally and psychologically, less committed to the organization and less satisfied with their jobs. The leader empowering behaviours described in this study were found to be highly correlated with workplace empowerment, psychological empowerment and organizational commitment, suggesting

that these leadership behaviours may have a positive effect on reducing job strain experienced by staff nurses.

The nurses in this study indicated higher levels of continuance commitment than affective and normative commitment suggesting that some nurses are staying with the organization not because they "want to" but because of the cost associated with leaving. However, the organization needs more than nurses who continue their membership in the organization by default. Meyer and Allen (1997) argue that organizations who rely heavily on remaining employees to achieve organizational goals will benefit most from a workforce with high affective commitment, who view their jobs with increased workload and responsibility as enriched. Whereas, employees with increase continuance commitment are unlikely to be highly motivated and be less productive doing only what is necessary to remain in their jobs (Meyer & Allen; Allen & Meyer, 1996). Nurses with strong affective commitment are more likely to have higher job satisfaction, job involvement and contribute more to the accomplishment of organizational goals (Allen & Meyer; McNeese-Smith, 1995, 1996, 2001) and less job strain (Laschinger, Finegan, Shamian, & Almost, 2001). Thus, affective commitment may help nurses cope with the negative effects of organizational restructuring and change.

The managers' use of leader empowering behaviours and the subscales enhancing the meaningfulness of work and fostering autonomy from bureaucratic constraints had a moderate relationship with affective commitment. The lack of relationship with continuance commitment is consistent with predictions, and is attributed to the fact that it

develops as a result of an event that increase the employees' awareness of the cost of leaving the organization. Therefore, it is less dependent on the influences of leader empowering behaviours.

It was also found that leader empowering behaviours enhancing the meaningfulness of work, fostering autonomy from bureaucratic constraints and hospital tenure accounted for 20% of the variance in staff nurses' overall organizational commitment suggesting that leadership empowering behaviours and tenure are only part of the influences upon nurses. McNeese-Smith (1995, 1996) also found low to moderate correlations between a manager's use of leadership behaviours (Kouzes & Posner, 1987) and organizational commitment in a nursing population, whereas, a number of studies have found a significant positive link between workplace empowerment and organizational commitment (Wilson & Laschinger, 1994; McDermott et al., 1996). These findings suggest that as management structures are streamlined in acute care organizations, managers should use empowering leadership behaviours to focus on workplace empowerment, as a first-line intervention to enhance organizational commitment.

The nurses in this study also had a higher number of reported days absent due to illness than the 11.8 absent days reported for full-time workers in health occupations, but equal to that for nurses in Canada (Akyeampong, 1999). However, contrary to predictions the nurse perceptions of leader empowering behaviours were not related to absenteeism. Multiple regression analysis of leader empowering behaviours, gender, age, hospital tenure, workplace empowerment, psychological empowerment and

organizational commitment as the predictor variables and total days absent and episodes of days absent, as the dependent variables, produced no significant relationships.

Employee absenteeism is a costly and complex problem and is probably one of the benchmarks of what is going on in hospitals. Although many factors have been studied, very few reliable predictors of absenteeism have been found. A recent study by Zboril (2002), found that predictors of high rates of absenteeism among nurses were moderate to high job satisfaction, full times work, 12 hour shifts and working in acute care settings. Shamian, Kerr, Spence-Lashinger, and Thomson (2002) also found that nurses working full time work in acute care hospitals had higher levels of burnout, poor general health and loss of control over practice. At the same time the nursing shortage is exacerbated by employee absenteeism which leads to diminished quality of patient care (Gauci-Borda & Norman, 1997; Shamian & Villeneuve, 2000). Therefore, further study is required to identify the predictors of absenteeism and strategies that foster conditions that reduce the levels of absenteeism.

Limitations

This study has a number of limitations, including the use of a cross-sectional design which does not allow for true assessment of causality, but rather associations between the variables of interest. It is important to note that the formulation of the hypotheses and interpretation of the results have proceeded based on the assumption that leader empowering behaviours were the cause and not the consequences of nurses' perceptions of workplace empowerment, psychological empowerment and organizational

commitment. The direction of causality, however, could be reversed. Nonetheless, support for some a priori-driven predictions in this study offset this limitation to some extent. However, the generalizablity of these results may also be limited to the full-time nurses population in acute care settings.

Second this design does not eliminate the potential effects of implicit leadership theories. A number of studies have suggested that people carry around with them a number of theories about what makes an effective leader. These implicit theories have been found to correspond closely with the conceptual models of leadership researchers. When subordinates are asked to rate the behaviour of a leader, they are likely to attribute more desirable behaviours to leaders of high performing groups than to leaders of low performing groups, even though the actual behaviour of the leaders is the same (Yukl, 1989; Adhearne, 2000). When provided with cues of good/poor performance by a leader, followers tended to evaluate that leader high/low in the dimensions of leadership. Thus, the potential limitation is that the nurses rated their manager high/low in leadership empowerment behaviours because they perceived the manager's performance to be good/poor in some overall sense and not because the manager was actually using the particular behaviour. Yukl suggests that accurate measurement is also unlikely when respondents are given the difficult task of retrospectively rating how often or how much a leader exhibited some behaviour over a period of time.

Another limitation of the study is that the data on leader empowering behaviours, empowerment and organizational commitment were simultaneously collected and subject

to common methods variance problems. Therefore, respondent bias and interpretation cannot be controlled. Future research designs should incorporate methods that control for common methods variance, including the independent measures of leader empowering behaviours, empowerment and organizational commitment.

The results may have also been influenced by non responders and the subjects who refused permission to access their sick leave data. In the current health care work environment nurses are feeling powerless, frustrated, disillusioned and suspicious of management, some of which may have prevented staff from responding or granting consent to access their personnel files. The hospital policies on confidentiality prevented further study of this group of nurses.

The collection of absence data retrospectively would have limited the causal relationships between the variables, if there had been any significant findings. Therefore, future research should avoid difficulties in inference of causality by collecting absence data both prospectively and retrospectively for comparisons and to establish causality between the variables of interest.

Implications for Hospital and Nursing Administrations

The most important work relationship for employees is often the first line manager. Thus, the behaviour of the manager is an important determinant of employees' relationship to work and is a critical link in the success of the organization (Brown & Kanter, 1982). To improve opportunities for staff nurses to work with empowered managers, strategies need to be implemented to create an empowered organization. In an

empowered organization health administrators and professionals will need to learn a new way of managing that involves a team-orientated, participatory and power sharing process. According to Brown and Kanter the productive power of the total system will be increased by redistributing the power so that employees generally have the tools, information and support to make more informed decisions, act more quickly and thus accomplish more. The use of multi-disciplinary teams is already seen in health care in response to the need for organization to empower and capitalize on front line workers to improve efficiency and provide a seamless continuum of care.

It is demanding to be a successful manager and an empowering leader, but the situation calls for both. The present cohort of nurse managers is facing a very different hospital environment, with flatter organizations and increasing responsibilities and span of control. Therefore, even the most educated and the most appropriately selected nurse manager will require further education and orientation. Education and orientation plans need to be developed based on an educational need's assessment and linked to the strategic objectives of the organization and nursing department. Leader will benefit from education if it is preceded by a diagnosis of strengths and developmental requirements and multiple approaches, given the range of behaviours required by the many roles of empowering leaders (Howard, 1997). In particular, educational sessions should focus on the importance of leader empowering behaviours and the development and practice of the appropriate skills that can be transferable to the work environment and evaluated as to their impact on the achievement of positive employee and organizational outcomes. This

is particularly important as leadership behaviours can be taught and measured (Bass, 1985; McNeese-Smith, 1996).

Several implications for administrators of nursing faculties can be inferred from the results of this study. As nurses continue to practice in rapidly changing health care environments, the empowerment of nurses becomes important to enhance individual and organizational productivity. The challenge for nursing faculties is to shape the educational system and develop and use empowering teaching strategies to role model and socialize nursing students who will become the future workforce of the acute care settings. Nursing faculties have the opportunity to shape and influence the development of future and current nursing leaders. They must seize this opportunity and extend their curriculum to include both undergraduate and graduate education in management and leadership. As well, emphasis must be placed on nursing research that focuses on education, practice and administration which can have a direct effect on the outcomes and quality of health care system.

Implications for Nurse Managers

The findings of the study support the use of empowering leadership behaviours as an important strategy that impacts on the nurses' perceptions of their workplace empowerment, psychological empowerment and organizational commitment. Therefore, to create an empowering work environment the leader must eliminate their traditional controlling roles and do more than relinquish the power of their position, or delegation of authority. Rather, the nurse managers must be enablers of professional nursing practice,

by facilitating a work environment that has the appropriate information, resources, support, and opportunity to get the job done. Nurse managers can use the results of this study to examine the current work environment and remove the barriers between nurses and patients. In particular, nurse managers can used the leader empowering behaviours of enhancing the meaningfulness of work and facilitating participation in decision making to create job redesign. Job redesign that increases nurses' workplace empowerment, psychological empowerment and organizational commitment must support true professional practice and have the input of practising nurses at all stages of the change process. To be meaningful, nurse participation must go beyond simply soliciting input to active and substantive participation, consultation, and a sense of reasonable control over the process and potential impact on their work.

At the same time, nurse managers must have a genuine commitment to a shared vision of nursing and not merely appease nurses with token rights or delegation without support of empowerment structures. Clifford (1992) notes that if management does not share in decision-making, the effort to empower will frustrate employees, resulting in an increased dependence on authoritarian structures. This can be evident in some recent attempts by acute care institutions to establish share governance models, when managers have demonstrated limited, if any, honest interest in sharing authority for decision-making. Anecdotal accounts indicate that nurses feel express frustration and mistrust of management's motives for instituting such strategies, when appropriate resources are not allocated to permit active participation. For example, the majority of participation in

shared governance, scheduling, and many committees are limited to days off and in many cases decisions are not considered and/or acted upon by managers.

In the current work environment, nurse managers are also experiencing a sense of powerlessness, therefore, it cannot be expected that suddenly by using leader empowering behaviours all of the issues facing nurses in the work environment will be resolved. However, nurse managers can take the first step on one unit. They can get to know their nurses and their issues, meet and collaborate with other colleagues who are facing similar challenges, become familiar with the relevant research, share success stories (McDermott et al., 1996) and participate in the policy and political process both internally and externally to their organization (Decter & Villeneuve, 2001). Nurse managers must also encourage, support and provide opportunities for their nurses to do the same and become actively involved in being part of the solution, rather than part of the problem. It is critical that nurse managers and nurses work together to develop a sense of mutual trust, an empowered work environment, and commitment to goals that support cost effective quality patient care (Laschinger, Finegan, Shamian, & Almost, 2001).

Therefore, the findings provide information to the literature on the impact of leadership on nurses outcomes. In light of the current and looming nursing shortages, further research is needed to establish an empirical relationship between leader empowering behaviours, staff empowerment and commitment and the retention of nursing staff. However, this research should considers the findings of the study as previous studies have identified absence as an antecedent to turnover (Gauci, Borda, &

Norman, 1997). Further research is also needed to establish an empirical relationship between leader empowering behaviours, empowerment and actual patient outcomes.

Implications for Research

The current study builds on existing leadership literature by providing further evidence for leadership empowering behaviours (Hui, 1994) and their relationship to workplace empowerment. This was the first known study that examined the impact of leader empowering behaviours (Hui) on psychological empowerment, organizational commitment and absenteeism, on a nursing population. Therefore, the findings provide information to the literature on the impact of leadership on nurses outcomes. Further research is needed to establish empirical relationship between leader empowering behaviours, staff empowerment and commitment and actual patient outcomes. Laschinger et al. (1999) suggest that as professionals nurses are capable of reliably evaluating their effectiveness and that empowerment/effectiveness relationship would be replicated using more objective measures.

Future research studying the link between leadership behaviours and empowerment and organizational commitment should consider methodological issues. Controversies about the nature of leadership are related to the debates about the appropriate research methodology for studying. Yukl (1989) suggests that as a result of the limitations of both quantitative and qualitative research multiple methods should be used in research on leadership. Future research on nurse managers should include a detailed ethnographic analysis, which is considered a promising method of studying leadership. Considering

the dramatic changes in health care organizations, the nursing profession, and the role of the nurse manager in the last five years, it is timely and appropriate to understand the culture or aspects of culture in which leadership must occur. It is important to identify if leadership is embedded in the culture of an organization and how that cultures shapes and is being shaped by leadership processes.

The increasing nurse absentee rates necessitate further investigation. Nearly all empirical research on absenteeism is based on the hypotheses that considers it a dependent rather than an independent construct. In the same way it is regarded as dysfunctional to the organization. However, Hackett and Bycio (1996) in a study of nurses suggest that occasional absences maybe used as a coping mechanism and that the costs must be balanced against the benefits of employees regaining control of abnormal and/or emotional fatigue. Future research should consider the role of the nurse manager in monitoring the abnormal emotional and/or fatigue levels of nurses and developing strategies to intervene and reduce the use of unscheduled absences. As well, research should be directed toward considering absenteeism an independent construct. Studies should be directed toward examining the impact of absenteeism of nurses on colleagues' absenteeism, level of job satisfaction, work effectiveness, workplace empowerment, psychological empowerment, organizational commitment and patient outcomes.

Summary and Conclusions

Within the current restructuring of the health care system, nurse managers will require new leadership skills to create an empowered work environment. Nursing

managers occupy a pivotal and key role within acute care organizations. It is an opportune time for nursing administrators to demonstrate vigorous leadership for those values which are fundamental to nursing; excellence in patient care and a professional supportive environment in which nurses can provide and coordinate care. However, this leadership must not be based on "gut feeling" but on current knowledge of leadership effectiveness.

The leader empowering behaviours described by Conger and Kanungo (1988) and Hui (1994) in this study are illustrative of the kind of skills required by nurse managers to revitalize nurses and allow them to become empowered, committed and productive employees. As suggested by this study, leadership behaviours are important in increasing staff nurse access to power structures of the organization, enhancing the meaningfulness of work, encouraging participation in decision-making that impact on their work life and increasing their desire to work with the organization because they "want to" and not because they "have to." Encouraging autonomous practice and expressing confidence in the ability of staff to perform at a high level was somewhat less important.

It is demanding to be a successful manger and leader, but the current situation in acute care settings calls for both.

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Appendices

Appendix A: Approval letter.

Appendix B: Correspondence from Dr. John Meyer to use Organizational Commitment Scale (electronic).

Appendix C: Correspondence from Dr. Gretchen Spreitzer to use Psychological Empowerment Instrument (electronic).

Appendix D: Correspondence from Dr. Chun Hiu to use Leader Empowerming Behaviours Questionnaire (electronic).

Appendix E: Letter of permission from Dr. Heather Laschinger to use the CWEQ, JAS and QRS Instruments.

Appendix F: Letter and Questionnaire Package.

Appendix G: Follow up letter.

Appendix H: Second letter and Questionnaire Package.

McMaster University

HAMILTON HEALTH SCIENCES CORPORATION

RESEARCH ETHICS BOARD

March 21, 2001

PROJECT NUMBER: 01-054

PROJECT TITLE: "The Impact of nurse manager's leader empowering behaviours on staff nurse workplace empowerment, organizational commitment, absenteeism and patient outcomes"

PRINCIPAL INVESTIGATOR: G. Peachey

As you are aware your study was presented at the March 20, 2001 Research Ethics Board meeting where it received **final** approval. The submission, including the consent form was found to be acceptable on both ethical and scientific grounds.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

We wish to advise the Research Ethics Board operates in compliance with ICH Good Clinical Practice Guidelines and the Tri-Council Policy Statement.

Investigators in the Project should be aware that they are responsible for ensuring that a complete consent form is inserted in the patient's health record. In the case of invasive or otherwise risky research, the investigator might consider the advisability of keeping personal copies.

A condition of approval is that the physician most responsible for the care of the patient is informed that the patient has agreed to enter the study. Any failure to meet this condition means that Research Ethics Board approval for the project has been withdrawn.

PLEASE QUOTE THE ABOVE-REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE.

Sincerely,

Peter McCulloch/dm

Peter B. McCulloch, MD, FRCP(C)
Chair, Research Ethics Board

All correspondence should be addressed to the REB Chair and forwarded to:
REB Secretary, Henderson Campus, 90 Wing, Room 13
Telephone: (905) 527-4322, ext. 42013

Appendix B

To: Greg Peachey <gregpeachey@cogeco.ca>
Subject: Re: re consent to use organziational commitment questionnnaire.
References: <000c01c1d012$a13246e0$c102a8c0@co530168a>
Content-Type: text/plain; charset=us-ascii
Content-Transfer-Encoding: 7bit

Dear Gladys,

Unfortunately, I do not have a copy of the original e-mail message I sent to you. Our policy has always been to allow the use of our commitment scales for research purposes. There is no charge for using the scales as long as they are used for research purposes only and no fees are charged to participating organizations or respondents. I hope this helps.

Best regards, John Meyer
--
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 C

Gladys,
Yes you are most welcome to you use my Psychological Empowerment Scale in your graduate work. I look forward to hearing of your findings when your research is completed.
Gretchen M. Spreitzer
Department of Organizational Behavior and HRM
University of Michigan Business School Room A2144
701 Tappan St.
Ann Arbor, MI 48109-1234
734.936.2835 (office)
734.936.0282 (fax)
spreitze@umich.edu

Appendix D

Gladys,

Glad that you are interested in the leader empowering behaviours questionnaire. I'd be grateful if you may share the results with me.

good luck.

Regards

Hui, Chun, Ph.D
Department of Management
The Chinese University of Hong Kong
Shatin, Hong Kong
Phone: (852) 2609-7825
Fax: (852) 2603-5473
Home Fax: (852) 2603-7727
E-mail: huichun@cuhk.edu.hk

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.

Form(s) used: ✓ Conditions of Work Effectiveness (CWEQ) (staff version)

✓ CWEQ (manager version)

✓ Job Activity Scale (JAS)

✓ Organizational Relationship Scale (ORS)

✓ ODO-B or MAS (Manager Activity Scale)

Population Under Study: Staff nurses, nurse managers

Name: GLADYS PEACHEY Signature: _____

Title: Graduate Student Date: _____

Address: McMaster University, Hamilton, Ontario
Home
23 Wenegarden Trail
Dundas, Ont. Phone: 905-628-4372

Permission is hereby granted to copy Nursing Work Empowerment Scale.

Date: Feb. 14/2001 Signature: H Laschinger

Dr. Heather Spence Laschinger

Professor

School of Nursing

The University of Western Ontario

Appendix F

Gladys Peachey,
School of Nursing,
System-Linked Research Unit,
McMaster University, Room 3N46,
1200 Main Street West,
Hamilton, Ontario, Canada, L8N 3Z5

Dear Participant;

This letter is to seek your assistance in a study on "**The Impact of Leader Empowering Behaviours on Staff Nurse Empowerment, Organizational Commitment, and Absenteeism**". Nurses are very concerned about the quality of work life, quality of patient care, relations with management, and the impact of work conditions on nurses' feelings and attitudes. The information collected from this study will provide information regarding the importance of appropriate leadership behaviours and their impact on staff nurses' quality of work life.

The completion of the questionnaire will be greatly appreciated and offer you an opportunity to contribute to the understanding of the work life of nurses and assist in developing management strategies that will improve the current work environment. This study can only provide meaningful information if all respondents complete and send back their questionnaires.

Enclosed is a questionnaire and a consent form permitting the Hamilton Health Sciences Corporation to release the number of sick leave days you used from April 1,2000 to March 31,2001 to myself. The questions in the questionnaire are designed to get your perceptions of your current work environment. They are not intended to be difficult or have a right or wrong answer. The results will not be used for evaluating either you or your manager. **Please be assured that your responses to the questionnaire and sick leave data will be strictly confidential.** The questionnaire has been assigned a number code, known only to the researcher, for the purpose of enumerating the returns. The information you will provide will be kept in a secure place and analyzed by the researcher and presented in a final report which will only show summary statistics. You will not be individually identified in any reports or publications.

Your interest and cooperation in replying to the questionnaire are crucial to the study, and I look forward to your timely reply and thank you for your input. Upon completion of the questionnaire you will be given a certificate for your College of Nurse's of Ontario Quality Assurance Program.

If you have any questions or concerns about this matter, please feel free to personally contact me. I ask you to fill out the questionnaire quickly and return it using the enclosed self addressed stamped envelope by June, 8, 2001.

Sincerely Yours,

Gladys Peachey, R.N., PhD. Candidate
(905) 628-4372 (Home)

Research Questionnaire

The Impact of Leadership Behaviours on Staff Nurse Workplace Empowerment, Organizational Commitment, Absenteeism, and Patient Outcomes

Gladys Peachey, R.N., PhD. Candidate,
Faculty of Health Science, School of Nursing,
McMaster University,
Hamilton, Ontario

Please complete the questionnaire and return in the envelope provided.

Your responses will be kept confidential

□□□

Demographic Data (Please complete the following information.)

1. Date questionnaire completed: _____/_____/_____
   Year Month Day

2. What is your gender? □$_1$ Male □$_2$ Female

3. What is your birthday? _____/_____/_____ Age: _____
   Year Month Day

4. What is your highest level of education?

   □$_1$ RN Diploma
   □$_2$ Baccalaureate in Nursing
   □$_3$ Masters
   □$_4$ Other (specify) _____

5. At which hospital are you working?

   □$_1$ McMaster
   □$_2$ Henderson
   □$_3$ General

6. What is your position classification or title at this hospital? _____

7. How long have you worked at this hospital? □□ years □□ months

8. Which clinical area are you working in now?

☐$_1$ Medical unit	☐$_2$ Orthopedic Unit
☐$_3$ Surgical Unit	☐$_4$ Maternal/Newborn Unit
☐$_5$ Psychiatric/Mental Health Unit	☐$_6$ Pediatric Unit
☐$_7$ Burn Unit	☐$_8$ Critical Care Unit
☐$_9$ Emergency	☐$_{10}$ Operating Room
☐$_{11}$ Other (specify) _____	

9. How long have you worked on this unit? ☐☐ Years ☐☐ Months

Listed below are a series of statements that represent Conditions of Work Effectiveness. (Please circle the answer that best describes your response to the following questions related to your present job.)

A. 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 knew skills and knowledge on the job.	1	2	3	4	5
3. Access to training programs for learning new things.	1	2	3	4	5
4. The chance to learn how the hospital works.	1	2	3	4	5
5. Tasks that use all of your own skills and knowledge.	1	2	3	4	5
6. The chance to advance to better jobs.	1	2	3	4	5
7. The chance to assume different roles not related to your current job.	1	2	3	4	5

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

	No Knowledge		Some Knowledge		Know A Lot
1. The current state of the hospital.	1	2	3	4	5
2. The relationship of the work of your unit to the hospital.	1	2	3	4	5
3. How other people in positions like yours do their work.	1	2	3	4	5
4. The values of top management.	1	2	3	4	5
5. The goals of top management.	1	2	3	4	5
6. This year's plan for your work unit.	1	2	3	4	5
7. How salary decisions are made for people in positions like yours.	1	2	3	4	5
8. What other departments think of your unit.	1	2	3	4	5

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

	None		Some		A Lot
1.Specific information about the 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
4. Information or suggestions about job possibilities.	1	2	3	4	5
5. Discussion of further training or education.	1	2	3	4	5
6. Help when there is a work crisis.	1	2	3	4	5

7. Help in gaining access to people who can get the job done.	1	2	3	4	5
8. Help in getting materials and supplies needed to get the job done.	1	2	3	4	5
9. Rewards and recognition for a job well done.	1	2	3	4	5

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

	None		**Some**		**A Lot**
1. Having the supplies necessary for the job.	1	2	3	4	5
2. Time available to do the necessary paperwork.	1	2	3	4	5
3. Time available to accomplish the job requirements.	1	2	3	4	5
4. Acquiring temporary help when needed.	1	2	3	4	5
5. Influencing decisions about obtaining human resources (permanent) for your unit.	1	2	3	4	5
6. Influencing decisions about obtaining supplies for your unit.	1	2	3	4	5
7. Influencing decisions about obtaining equipment for your unit.	1	2	3	4	5

E. In my work setting/job

	None		**Some**		**A Lot**
1. the amount of variety in tasks associated with my job.	1	2	3	4	5
2. the rewards for unusual performance on the job.	1	2	3	4	5

3. the rewards for innovation on the job	1	2	3	4	5
4. the amount of flexibility in my job.	1	2	3	4	5
5. the number of approvals needed for non-routine decisions.	1	2	3	4	5
6. the relation of tasks in my job to current problem areas in the organization.	1	2	3	4	5
7. my amount of participation in educational programs.	1	2	3	4	5
8. my amount of participation in problem solving forces.	1	2	3	4	5
9. the amount of visibility of my work related activities within the institution.	1	2	3	4	5

F. How much opportunity do you have for these activities in your current job?

	None		**Some**		**A Lot**
1. Collaborating on patient care with physicians.	1	2	3	4	5
2. Receiving helpful feedback from physicians.	1	2	3	4	5
3. Being sought out by physicians for patient information.	1	2	3	4	5
4. Receiving recognition by physicians.	1	2	3	4	5
5. Having physicians ask your opinion.	1	2	3	4	5
6. Being sought out by your supervisor for ideas about ward management issues.	1	2	3	4	5
7. Having immediate supervisor ask for your opinion.	1	2	3	4	5

8. Receiving early information of upcoming changes in work unit from your immediate supervisor.		1	2	3	4 5
9. Chances to increase your influence outside your unit. (e.g. nomination to influential committees by supervisor)	1	2	3	4	5
10. Seeking out ideas from auxiliary workers on the unit (e.g. secretaries, ward clerks, housekeeping)	1	2	3	4	5
11. Getting to know auxiliary workers as people.	1	2	3	4	5
12. Seeking out ideas from auxiliary workers outside the unit. (e.g. admission clerks, technicians)	1	2	3	4	5
13. Being sought out by peers for information.	1	2	3	4	5
14. Receiving helpful feedback from peers.	1	2	3	4	5
15. Having peers ask your opinion on patient care issues.	1	2	3	4	5
16. Being sought out by your peers for help with problems.	1	2	3	4	5
17. Exchanging favours with peers.	1	2	3	4	5
18. Seeking out ideas from professionals other than physicians (e.g. physiotherapists, occupational therapists, dieticians)	1	2	3	4	5

G. Global Empowerment

	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

Listed below are a series of statements that represents conditions of psychological empowerment. (Please indicate the degree of your agreement or disagreement with each statement by circling one of the five alternatives.)

	Strongly Disagree				**Strongly Agree**
1. The work I do is important to me.	1	2	3	4	5
2. My job activities are personally meaningful to me.	1	2	3	4	5
3. The work I do is meaningful to me.	1	2	3	4	5
4. I am confident about my ability to do my job.	1	2	3	4	5
5. I am self-assured about my capabilities to perform my work activities.	1	2	3	4	5
6. I have mastered the skills necessary for my job.	1	2	3	4	5
7. I have significant autonomy in determining how I do my job.	1	2	3	4	5
8. I can decide on my own how to go about doing my work.	1	2	3	4	5
9. I have considerable opportunity for independence and freedom in how I do my job.	1	2	3	4	5
10. My impact on what happens in the department is large.	1	2	3	4	5
11. I have a great deal of control over what happens in my department.	1	2	3	4	5

12. I have significant influence over what happens in my department. 1 2 3 4 5

Below is a list of statements that may be used to describe the behaviour of your leader (the supervising manager with whom you have the most contact). This is not a test of your ability. It simply asks you to describe as accurately as you can, the behaviour of your leader. If some questions seem similar or if they do not seem to apply, please answer them anyway by selecting the response that describes your leader's behaviour most accurately. (Please indicate the degree of your agreement disagreement with each statement by circling one of the seven alternatives)

	Strongly Disagree						**Strongly Agree**
1.My leader helps me understand the importance of my work to the overall effectiveness of the organization.	1	2	3	4	5	6	7
2. My leader helps me understand how my job fits into "the bigger picture".	1	2	3	4	5	6	7
3. My leader helps me understand how the objectives and goals of my department relate to that of the organization.	1	2	3	4	5	6	7
4. My leader helps me realize that I am part of a larger team.	1	2	3	4	5	6	7
5. My leader helps me understand the purpose of what I do at work.	1	2	3	4	5	6	7
6. My leader makes me believe that my work can "make a difference" in this organization.	1	2	3	4	5	6	7
7. My leader provides many opportunities for me to express my opinions.	1	2	3	4	5	6	7
8. My leader often consults me on issues pertaining to work.	1	2	3	4	5	6	7

9. My leader encourages me to take the initiative in expressing my job-related opinions.	1	2	3	4	5	6	7
10. My leader makes many decisions together with me.	1	2	3	4	5	6	7
11. My leader encourages me to make important decisions that are directly related to my job.	1	2	3	4	5	6	7
12. My leader recognizes my good work by using it as an example for others.	1	2	3	4	5	6	7
13. My leader always shows confidence in my ability do a good job.	1	2	3	4	5	6	7
14. My leader believes that I can handle demanding tasks.	1	2	3	4	5	6	7
15. My leader focuses on my successes rather than my failures.	1	2	3	4	5	6	7
16. My leader believes in my ability to improve even when I make mistakes.	1	2	3	4	5	6	7
17. My leader helps me overcome obstacles to my performance.	1	2	3	4	5	6	7
18. My leader helps me identify what I need in order to achieve my performance goals.	1	2	3	4	5	6	7
19. My leader provides the opportunity for training so I can perform effectively.	1	2	3	4	5	6	7
20. My leader always makes sure that I have the resources needed for effective performance.	1	2	3	4	5	6	7
21. My leader helps me to develop good working relationships with those people who can affect my performance.	1	2	3	4	5	6	7

22. My leader takes a "sink or swim" attitude toward the difficulties that arise in my work.	1	2	3	4	5	6	7
23. My leader encourages me to contact directly the people from whom I need information.	1	2	3	4	5	6	7
24. My leader makes it more efficient to do my job by keeping the rules and regulations simple.	1	2	3	4	5	6	7
25. My leader insists that I rigidly follow rules and procedures even when they interfere with my performance.	1	2	3	4	5	6	7
26. My leader allows me to do my job my way.	1	2	3	4	5	6	7
27. My leader encourages me to cut through the bureaucracy to get things done.	1	2	3	4	5	6	7

Listed below are a series of statements that represent conditions of organizational commitment. (Please indicate the degree of your agreement or disagreement with each statement by circling one of the seven alternatives.)

	Strongly Disagree						**Strongly Agree**
1. I would be happy to spend the rest of my career with this organization.	1	2	3	4	5	6	7
2. Right now, staying with my organization is a matter of necessity as much as desire.	1	2	3	4	5	6	7
3. I do not feel any obligation to stay with my current organization.	1	2	3	4	5	6	7
4. I really feel as if the organization's problems are my own.	1	2	3	4	5	6	7
5. It would be very hard for me to leave my organization right now, even if I wanted to leave.	1	2	3	4	5	6	7

6. Even if it were to my advantage, I do not feel that it would be right to leave my organization now.	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. Too much in my life would be disrupted if I decided to leave my organization now.	1	2	3	4	5	6	7
9. I would feel guilty if I left my organization now.	1	2	3	4	5	6	7
10. I do not feel "emotionally attached" to this organization.	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. This organization deserves my loyalty.	1	2	3	4	5	6	7
13. I do not feel like "part of the family" at my organization.	1	2	3	4	5	6	7
14. 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
15. 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
16. This organization has a great deal of personal meaning for me.	1	2	3	4	5	6	7
17. One of the few negative consequences of leaving this organization would be the scarcity of available alternatives.	1	2	3	4	5	6	7
18. I owe a great deal to my organization.	1	2	3	4	5	6	7

Absentee Data

1. Please indicate the number of days absent from April 1, 2000 to March 31, 2001

_____ days

2. Please indicate the reasons and number of days absent from your regular scheduled days of work from April 1, 2000 to March 31, 2001.

$\square_1$	Education	_____ days
$\square_2$	Worker's Compensation	_____ days
$\square_3$	Sick Leave	_____ days
$\square_4$	Family	_____ days
$\square_5$	Other	_____ days

I would like a certificate for my College of Nurse's of Ontario Quality Assurance Program.

☐ Yes ☐ No

Thank you for assisting in this study.

Please return your questionnaire in the envelope provided.

If you have any questions or comments about the information contained within this survey or about the study, please feel free to contact me.

Gladys Peachey
(905) 628- 4372
or
The Systems Linked Research Unit,
McMaster University,
1200 Main St. West,
Hamilton, Ontario, L8N 3Z5
(905) 525-9140, Ext 22660

Appendix G

Reminder to complete and return questionnaire for study

The Impact of Leader Empowering Behaviors on Staff Nurse Empowerment, Organizational Commitment, and Absenteeism

Dear Nurse and Colleague:

On June 8,2001, an envelope was delivered to your nursing unit with a request for you to participate in the above study by completing the enclosed questionnaire and returning it to Gladys Peachey by June 24,2001. If you did not receive or misplaced the questionnaire, please call me for a replacement at 905-628-4372.

Your interest and cooperation in completing the questionnaire is crucial to the study. I appreciate that you have busy work situations and home responsibilities. As well, you may feel that nobody really listens to your input or if they do listen does much if anything in response. I can not guarantee that my study will make a difference. However, I do feel that it is important that nurses at all levels be heard and that we share our perceptions about our work life and that this information be collected and reported in a scientific manner. I believe that it is only through a concerted effort by all nurses, supported by appropriate and reliable information, will we be heard. Therefore, your response to this questionnaire is crucial and offers you an opportunity to contribute to a greater understanding of the work life of nurses and in particular the perceptions of nurses who work at the Hamilton Health Sciences Corporation.

This is an independent study, but the information will be useful in assisting administration and nursing groups with current information on your work life and assist them in developing strategies to improve your work environment.

Please be part of the solution by participating in this study and providing crucial information on your perceptions of the current work life by completing the questionnaire. I believe that the minute we stop talking and sharing information is the minute we lose not only the battle, but the war on nursing.

If you have any questions or concerns I would love to hear from you. I ask you to complete the questionnaire and return it using the enclosed self addressed stamped envelope as soon as possible.

Sincere Thanks and Appreciation,

Gladys Peachey, R.N.
905-628-4372 (Home)

Appendix H

Dear Nurse and Colleague:

Once again I seek your participation and critical input in my study on "The Impact of Leader Empowering Behaviours on Staff Nurse Empowerment, Organizational Commitment, and Absenteeism". On May 18,2001 an envelope was delivered to your nursing unit with a request for you to participate in the above study by completing the enclosed questionnaire and consent form. A reminder was sent to you on June 8,2001. **As your name was randomly selected from the union seniority list of full time nurses working on your unit, your input, by completion of the questionnaire, is crucial to this study.** This study can only provide reliable data, if the randomly selected nurses complete and return the questionnaires.

I have enclosed another copy of the questionnaire and a consent form for you to complete and return by July 7,2001. The questions in the questionnaire are designed to get your perceptions of your current work environment. They are not intended to be difficult or have a right or wrong answer. The results will not be used for evaluating either you or your manager. Please be assured that your responses to the questionnaire and sick leave data will be strictly confidential. The information you will provide will be kept in a secure place and analyzed by myself and presented in a final report which will only show summary statistics. You will not be individually identified in any reports or publications.

I understand that you have a busy work life and other responsibilities, with limited available time to complete a questionnaire. As well, you may feel that nobody really listens to your input or if they do listen, positive change is not always evident in the work environment. **So, why should you complete another questionnaire?** I strongly believe that the study, but only with your crucial input through completion of the questionnaire, will contribute to the understanding of the work life of nurses and provide reliable and current data to administration in the development of management strategies that will assist in the improvement of nurses' work life.

Upon completion of the questionnaire you will be given a certificate for your College of Nurse's of Ontario Quality Assurance Program.

Please complete the questionnaire and consent form and return it using the enclosed self addressed stamped envelop by July 7, 2001.

If you have any questions or concerns about this matter, please feel free to contact me.

Sincere Thanks and Appreciation,

Gladys Peachey, R.N.
905-628-4372 (Home)