The Relationship between Structural Empowerment and Job Satisfaction: A Cross-Sectional Study

by

Jose Thomas Karaparambil

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfilment of the requirements of the degree of

MASTER OF NURSING

College of Nursing

University of Manitoba

Winnipeg

Abstract

The purpose of this correlational cross-sectional study was to explore the relationship between workplace empowerment and job satisfaction of nurses working in WRHA hospitals, following major organizational restructuring. Restructuring and downsizing in healthcare are not considered new phenomena. Healthcare organizations underwent numerous reforms in the early and mid-1990s. Two decades later, the healthcare sector is once again the target of restructuring. In 2017, the Winnipeg Regional Health Authority (WRHA) experienced considerable restructuring as the provincial government attempted to improve the effectiveness and efficiency of healthcare delivery to deal with budget short falls and improve quality of care. There has been minimal effort to understand the influences of structural empowerment on job satisfaction in more dynamic organizational contexts, such as organizational restructuring, especially, in Winnipeg, Manitoba.

Kanter's Structural Theory of Organizational Empowerment (1977, 1993) is a framework that explains empowerment within the context of the organization. This study was conducted using a cross-sectional descriptive correlational study. An online survey methodology was used for this study. A total of 177 respondents (n=177) completed 3 questionnaires - Condition of Work Effectiveness Questionnaire-ll, the Mueller and McCloskey Satisfaction Scale, and a demographic questionnaire. The results of the study revealed that overall scores of structural empowerment, each subscale of structural empowerment was positively related to job satisfaction, and mandated overtime was negatively related to job satisfaction. This study furthers our understanding and knowledge about the importance of providing an empowered workplace environment for nurses following organizational restructuring, and its potential to impact job satisfaction.

Acknowledgement

I would like to express my deepest appreciation to Dr. Judith Scanlan, my thesis chair, for your support, encouragement, guidance, and thoughtful feedback that provided throughout the journey. I would like to thank my committee members Dr. Sonia Udod and Prof. Sean Macdonald, who agreed to participate on my thesis committee. Their expertise, constructive comments, and insight that expanded my knowledge and enhance my learning. I also would like to say special thank you to Dr. Rasheda Rabbani and James Plohman for sharing their knowledge and expertise with online survey, data collection, and time and effort in helping in the statistical analysis of this study. Finally, I would like to express my gratitude to my wife and my daughter. Without their tremendous understanding and encouragement in the past few years, it would be impossible for me to complete my study.

Dedication

I dedicated this study to my beloved family, my wife, and my daughter. Thank you all for the endless love, support, understanding, motivation, and sacrifice. I could not have completed this journey without each of you. I share this accomplishment with them. I sincerely love and appreciate you all.

List of Tables

List of Figures

Table of Contents

Chapter-1

Introduction

Hospitals are key participants in the national health system and consume a large share of provincial spending. In Canada, healthcare costs are the largest expense in the national budget and is projected to continue to increase at a faster rate than inflation as the population ages (CIHI, 2017). The Canadian Institute for Health Information (CIHI) estimates that in 2018 a total of $253.5 billion was spent on healthcare, representing about 11.3% of Canada's economy - roughly $6,839 per Canadian (CIHI, 2018a). With the increasing cost of healthcare delivery and the pressures of cost containment, healthcare organizations are striving to find ways to reduce costs while delivering care in more efficient and cost-effective ways. Datta, Guthrie, Basuil, and Pandey (2010) noted that reducing the number of employees was the most common method for reducing organizational costs and those organizations selecting this approach are viewed as "successful" and "legitimate." The three most commonly used strategies for cost cutting through reduced number of staff are downsizing, reengineering, and restructuring (Blythe, Baumann, & Giovannetti, 2001).

Restructuring and downsizing in healthcare are not considered new phenomena. Healthcare organizations underwent numerous reforms in the early and mid-1990s with hospitals undertaking restructuring and downsizing (Burke, Ng, & Wolpin, 2016). Two decades later, the healthcare sector is once again the target of restructuring. In 2017, the Winnipeg Regional Health Authority (WRHA) experienced considerable restructuring as the provincial government attempts to improve the effectiveness and efficiency of healthcare delivery, in an effort to deal with budget short falls.

As a nurse and future leader working in the WRHA, I have seen the impact of organizational restructuring firsthand. On an individual level, organizational restructuring is a predictor of increased workloads, increased stress, increased turnover, higher feelings of insecurity, increased absenteeism, lower commitment, mistrust in management, decreased job satisfaction (Blythe et al., 2001; Brown, Zijlstra, & Lyons, 2006; Burke, 2003; Burke et al., 2016), increased risk of mental health problems (Bamberger et al., 2012; Vaananen, Ahola, Koshinen, Pahkin, & Kouvonen, 2011), and low morale (Kivimaki, Vahtera, Pentti, & Ferrie, 2000). Particularly in the context of restructuring, empowering work settings are critical to overcome the many potential negative consequences and maintain job satisfaction among healthcare employees.

The negative consequences of organizational restructuring have been studied for years (Brown et al., 2006; Burke & Greenglass, 2001; Burke, Ng, & Wolpin, 2011; de Jong, Weizer, Weerd, Nielsen, Mattila-Holappa, & Mockallo, 2016; Rondeau & Wagar, 2006). There is abundant evidence that the structural environment of an organization influences employees' job satisfaction (Cai, & Zhou, 2009; Cicolini, Comparcini, & Simonetti, 2014; Laschinger, Finegan, Shamian, & Wilk, 2004; Lautizi, Laschinger, & Ravazzolo, 2009; Li, Kuo, Huang, Lo, & Wang, 2013). There has been minimal effort to understand the influences of structural empowerment on job satisfaction in more dynamic organizational contexts, such as organizational restructuring. A literature review reveals only one study, conducted in Ontario, Canada, which examined the effect of structural empowerment and psychological empowerment during organizational restructuring and downsizing. This study examined the effect of empowerment on job satisfaction at two points three years apart: first, during organizational restructuring and downsizing and second, during post-organizational restructuring (Laschinger, et al., 2004).

Specifically, in Winnipeg Manitoba, there is a lack of empirical studies conducted on workplace empowerment and job satisfaction in the healthcare sector within the context of restructuring. This study aims to determine the relationship between structural empowerment and job satisfaction of nurses working in WRHA hospitals following major restructuring.

Background of the study

Canada's healthcare system is predominantly publicly funded. Approximately 70% of total health expenditures are incurred in the public sector, largely through provincial governments, and the remaining 30% in the private sector are paid either out-of-pocket by patients and families, or through private health insurance (CIHI, 2018a). In 1957, Canada's federal government agreed to split healthcare costs and provide cash transfers (the money the federal government sends to the provinces to help to pay for the healthcare) through the Canada Health Transfer (CHT) for any province that agreed to operate under a universal hospitalization scheme. However, the proportion of provincial health expenditures provided as a direct cash transfer from Ottawa has fallen. Since 2004, the CHT grew by 6% per year; however, in 2017, this amount fell to 3.5% (Porter, Perry, Stockert, Hall, Astle, & Duggleby, 2019). In 1966, the federal government introduced the Medicare Act, and agreed upon a 50/50 sharing of healthcare costs between provinces and the federal government (Marchildon, 2005). However, today Manitoba pays about 80% of total healthcare costs because of fiscal shortfalls from the federal government (Weil, 2016).

Canada's healthcare system is not delivering value for the money spent. Canada is one of the highest spenders on healthcare when compared to other industrialized countries that offer universal care. Canadians spend an estimated $253.5 billion on healthcare, or $6,839 per person, and costs have been increasing faster than the growth in the economy (CIHI, 2018a). Similarly,

in Manitoba, healthcare spending is steadily increasing, and health spending estimated in 2018 totaled $7,354 per Manitoban (CIHI, 2018a). Though healthcare spending is increasing rapidly, there are increasing delays for accessing timely personal health services in Canada compared to other countries. In 2010, a comparison of 11 countries ranked Canada lowest in several key wait time indicators: seeing a doctor, seeing a specialist, and having elective surgery. Among these comparators, Canada had the largest proportion of adults waiting in emergency departments (ED) for 4 hours or more before receiving treatment (CIHI, 2018a). CIHI reports that ED wait times in the WRHA in 2016 was 5.1 hours, and length of stay in the ED for admitted patient was 43.5 hours, compared to Canadian averages of 3.1 hours and 32.6 hours, respectively (CIHI, 2018b). In addition, during this time the federal government dramatically reduced healthcare funding affecting the provincial government's ability to deliver quality healthcare services to Manitobans. Nevertheless, the province recognized their obligation to provide excellent care to residents and moved quickly to meet the fiscal challenges of managing a healthcare system within the current fiscal restrictions. In order for Manitoba's healthcare system to sustain its ability to provide quality, safe, effective, patient-centered, and timely care there is a need for change (WRHA, 2017).

In 2015, the provincial government hired the Nova Scotia-based Health Intelligence Consultant firm, led by Dr. David Peachey, to review Manitoba's healthcare system and make recommendations to develop clinical service plans based on evidence, sustainability, and equity. Dr. Peachy and colleagues conducted a 15-month study and provided a final report and recommendations titled "*Provincial Clinical and Preventive Service Planning for Manitoba, Doing Things Differently and Better*" (Peachey, Tait, Adams, & Croson, 2017). The recommendations came out of hundreds of conversations with Manitobans from across the

province, including clinical leaders in major specialities, physicians, and other healthcare providers. The report also included relevant literature reviews, qualitative and quantitative acquisitions and analysis, and a detailed environmental scan, underpinned by a data compendium (Peachey et al., 2017).

The recommendations included closing one ED, conversion of two EDs to Urgent Care Centres, merging programs (for example, the Psychiatric department from Seven Oaks and Grace Hospitals were moved to Victoria General Hospital), and elimination of manager positions, among the many recommendations (WRHA, 2017). In August 2017, the above changes resulted in a total of 2,297 nurses who received "position deletion letters," wherein 70 nurses were laid off and 15% of management positions were deleted (Johnson, Stewart, Beaudin, & Klainchar, 2018). The main objective of restructuring was to streamline and concentrate resources rather than having them spread over multiple sites, to deliver more effective and timelier patient care, and reduce costs (Peachey et al., 2017). These changes aimed to address mounting challenges in Manitoba healthcare services - namely, to improve access to quality emergency services as quickly as possible, and reduce ED wait times and length of stay (WRHA, 2017). As a result of these changes, the total length of stay in Winnipeg ED and Urgent Care decreased from 43.5 hours in 2016-17, to 32.6 hours in 2017-18. Wait times for physician assessment also improved, decreasing from 5.1 hours to 4.4 hours (CIHI, 2018b).

Another consulting firm, KPMG LLP, also provided recommendations to improve fiscal sustainability and innovation within the province's healthcare system (KPMG, 2017). These reports provided insight into essential reform in the context of healthcare in Manitoba. According to the KPMG *Health Sustainability and Innovation Review* (HSIR) report, Manitoba's overall health system and governance model were overly complex, fragmented, uncoordinated, and sub-

optimal in relation to its structural design for a population of 1.3 million (KPMG, 2017). In particular, a large number of independent organizations characterized Manitoba's health system; eight independent health delivery organizations in Manitoba included five regional health authorities (RHAs), Diagnostic Services of Manitoba (DSM), Cancer Care Manitoba (CCMB), and Addictions Foundation of Manitoba (AFM), all of whom have independent Board Directors with overlapping jurisdictional responsibility (clinical planning, standard setting, and service delivery). Planning health services occurred in relative isolation from one another, with the pursuit of individual quality improvement initiatives (though they were supposed to work as an integrated system to achieve optimal functioning), which limited the province's ability to deliver expert clinical service and provide advanced management functions (KPMG, 2017).

Furthermore, the WRHA is only responsible, by legislation, for delivering health services in Winnipeg and Churchill. However, the WRHA was assigned a number of provincial programs due to the absence of an overarching organization responsible for province-wide coordination of services. Consequently, many provincial resources situated in the WRHA were not readily available to RHAs outside of Winnipeg (KPMG, 2017). In order to streamline the RHA system, the report indicated a need for a provincial health organization to consolidate resources for optimal provincial-wide use, to provide provincial clinical governance and programs, and to support provincial planning and commissioning (MHSAL, 2017). To this end, the provincial government has made changes in the delivery of healthcare services across the province with regard to the KPMG report (Health System Sustainability and Innovation Review).

To achieve improved access to quality healthcare, provide centralized clinical and business service for regional health authorities, and reduce duplication of management and administrative functions (while reducing costs), a new province wide-health service organization

called “Shared Health Services” was launched on April 1, 2018 (MHSAL, 2017). The main focus of this reform included: standardizing healthcare services across the province, capital planning, streamlining processes, improving communication, negotiating reduced rates for supplies, equipment, and pharmaceutical products (MHSAL, 2017). In order to improve service coordination, provider collaboration, and healthcare delivery, Shared Health Services has taken over planning and operation of the eight provincial healthcare organizations. Health Sciences Center and other healthcare organizations that were previously part of the WRHA now exist under the umbrella of Shared Health Services (MHSAL, 2017). Although changes in the organizational structure often focus on increased efficiency, healthcare staff have been concerned as their managers and leaders have not openly provided the supporting evidence behind the implemented changes. Overall, there was a lack of clear and consistent information shared to employees with regards to healthcare organizational restructuring in the province (Johnson et al., 2018).

A major factor influencing the success of organizational change initiatives is whether the organization provides employees with sufficient, well-structured information about the reason for the change, the nature of the change, and implication of the change for their work, prior to implementing changes. Providing this information ahead of implementation enhances employee support and positive attitudes toward change (O’Connor, Jimmieson, & White, 2017). Accordingly, both WRHA senior leadership and site senior leadership conducted town halls meetings, face-to face communication, staff forums, and sent emails to communicate and answer staff questions related to changes (Johnson et al., 2018). Despite these efforts, the Manitoba Nurses Union and some staff reported there a lack of information from management and leaders regarding the change.

According to the Manitoba Nurses Union, the province announced restructuring without meaningful consultation with nurses. Without adequate information, nurses felt they left in the dark about what these changes mean for their jobs and for patient care (Austman, 2018a). In 2018, the George & Fay Yee Centre for Healthcare Innovation conducted a survey evaluating the impact of organizational change on WRHA staff. Researchers conducted surveys, focus groups, interviews, forum discussions and dedicated lessons learned sessions and/or clinical consolidation project meetings to collect data. Over 750 staff provided feedback, and the researchers received 613 survey responses from five participating sites: St. Boniface Hospital, Grace Hospital, Victoria General Hospital, Riverview Health Centre, and Deer Lodge. Survey participants reported that "information was not given to staff until the last possible minute. Staff had no voice. Staff were barely involved in the process…Not much support was given to staff through these stressful times…Extra training was not given prior to new job starts" (Johnson et al., 2018, p.17). The survey found that front line staff learned about changes primarily through media coverage. Survey participants described internal communication as inconsistent; 42% of survey respondents did not understand the objectives of the changes, and 68% did not feel adequately informed of decisions that impacted their role (Johnson et al., 2018). In their 2010 study, Data et al. reported that effective communication - characterized by openness, helpfulness, accuracy, completeness, and timing - could help to reduce worry and resistance to change among employees during downsizing.

Although most nurses did not necessarily face "deletion' and unemployment, invariably many experienced work changes and career paths were altered, causing increased stress and job insecurity (De Witte, Pienaar, & De Cuyper, 2016). In turn, the changes impacted nurses' health and well-being (de Jong et al., 2016), and commitment, and lowered moral and motivation.

Bamberger et al. (2012) conducted a systematic review of the impact of organizational change on mental health (stress, anxiety, and depression). In five of the six cross-sectional studies, there was an association between organizational change and subsequent mental health problems such as distress, depression, and anxiety (Bamberger et al., 2012). The most recent survey conducted in Winnipeg, to determine the impact of *Healing our Health System*, found that survey participants felt increased anxiety and uncertainty during the change (Johnson et al., 2018). The conclusion is that restructuring generally has a negative impact on employee well-being, which can influence the quality of patient care and outcomes (Aiken et al., 2014; CNA & RNAO, 2010; Laschinger et al., 2004), and may increase job dissatisfaction (Burke et al., 2016). Therefore, healthcare organizational leaders need to actively promote the creation of a healthy work environment for nurses (Cumming et al., 2010, 2018) to improve retention (Fitzpatrick, Campo, Graham, & Lavandero, 2010; Hauck, Quinn Griffin, & Fitzpatrick, 2011; Wagner, 2006), positive patient outcomes, maintain overall organizational performance (Armstrong & Laschinger, 2006; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010), and increase job satisfaction (Laschinger, Sabiston, Finegan, & Shamian, 2001c; Laschinger, et al., 2004; Laschinger, 2012; Lautizi et al., 2009; Wong & Laschinger, 2013).

Dr. Heather Laschinger has conducted extensive nursing research on empowerment using Kanter's theory. Laschinger utilized Kanter's theory as a theoretical foundation for clarifying the ways in which empowerment is understood and experienced by nursing staff, and also developed empirical support for the theory in nursing settings (Cai & Zhou, 2009; Faulkner & Laschinger, 2008; Laschinger, Almost, & Tuer-Hodes, 2003a; Laschinger, Finegan, Shamian, & Wilk, 2003b; Lautizi, et al., 2009). Kanter (1993) maintains that organizations can achieve individual work satisfaction, organizational commitment, and work effectiveness through the creation of

empowering work structures or environments (Kanter, 1993). Empowering work environments provides employees access to information, support, resources, and opportunities to learn and develop (Kanter, 1993). Structural empowerment is predictive of individual psychological empowerment (Laschinger et al., 2004; Laschinger et al., 2003b; Manojlovich & Laschinger, 2002; Wagner, Cummings, Smith, Olson, Anderson, & Warren, 2010), organizational trust (Laschinger, et al., 2001), job autonomy (Laschinger et al., 2003a), reduced job strain, burnout (Laschinger et al., 2003a; Laschinger, Wong, & Grau, 2013), control over nursing practice (Laschinger, et al., 2003a; Wagner et al., 2010), job satisfaction (Cicolini et al., 2014; Laschinger et al., 2004; Lautizi et al., 2009; Wong & Laschinger, 2013), job retention (Fitzpatrick et al., 2010; Hauck et al., 2011), and organizational commitment (Cho, Laschinger, & Wong, 2006; Laschinger, Finegan, & Wilk, 2009; Smith, Andrusyszyn, & Laschinger, 2010). The result of these studies suggests that nurses who view their work environments as empowering (allowing greater access to power, support, information, and opportunity) ultimately have better job satisfaction, commitment, efficiency, quality of patient care, and job retention.

Statement of the Problem

Nursing is one of the most versatile professions within the healthcare workforce and an enabling force for changes in healthcare. Nurses have a significant role in today's healthcare environment, which is characterized by high stress, heavy workload, high physical demands, high levels of patient acuity and a shortage of nurses to meet the increasing demands of patient care, all of which influence the quality of care and patient outcomes (Aiken et al., 2014). Previous research studies show that many nurses are dissatisfied with their work environment (Aiken, Clark, & Sloane, 2002; Aiken et al., 2011; Van Bogaert, Clark, Willems, & Mondelaers, 2013) and many nurses have considered leaving their job because of workload and job dissatisfaction (Aiken,

Clark, Sloane, & Sochalski, 2001; Halter et al., 2017; Hill, 2011). Thus, the problem is not only about retaining nurses, but helping them thrive in the demanding, stressful environments in which they work, to achieve the desired high quality of care the profession and society demands.

As described above, in response to the substantial reduction of federal health transfer payments, to provide quality, safe, effective, patient-centered and timely care for Manitobans, and reduce healthcare costs, the Government of Manitoba has implemented restructuring of its healthcare delivery system. The primary goal of recent healthcare organization restructuring was to improve the quality of healthcare delivery and reduce healthcare costs through reorganizations. The major reform initiatives dramatically changed the working settings of many nurses in Winnipeg hospitals, including increased mandatory overtime as compared to 2017, increased workload, and burnout (Austman, 2018b, October 01), which can impact on nurses' well-being, turnover, and job satisfaction (Burke, et al., 2011, 2016; de Jong et al., 2016). Numerous studies have demonstrated a strong relationship between structural empowerment and nurses' job satisfaction (Lautizi et al., 2009; Wong & Laschinger, 2013), stress and burnout (Laschinger et al., 2013; Lautizi et al., 2009). In addition, structural empowerment is significantly related to patient safety culture, an essential element in delivering efficient, competent and quality patient care (Armellino, Quinn Griffin, & Fitzpatric, 2010; Van Bogaert, et al., 2016). Therefore, empowerment is an increasingly important factor in understanding nurses' job satisfaction in current restructured work environments in Winnipeg. A number of studies have addressed employee perceptions of restructuring and the effect of restructuring on nurses (Aiken, et al., 2001; Blythe et al., 2001; Burke et al., 2011, 2016; de Jong et al., 2016; Burke & Greenglass, 2001) but the topic has been under investigated in Winnipeg or Manitoba.

In Winnipeg, there is a lack of research that examines the relationship between structural empowerment and job satisfaction post-organizational restructuring.

Purpose of the Study

The purpose of this correlational cross-sectional study is to explore the relationship between workplace empowerment and job satisfaction of nurses working in WRHA hospitals, following major organizational restructuring. This study represents an attempt to further our knowledge about the importance of providing an empowered workplace environment for nurses following organizational restructuring, and its potential to impact their job satisfaction.

The primary research question is: What is the relationship between structural empowerment and job satisfaction of nurses working in acute care organizations post-organizational restructuring?

Research Hypothesis

1. The overall score of structural empowerment will be positively related to job satisfaction of nurses working in acute care organizations in Winnipeg, Manitoba.
2. Each sub-scale of structural empowerment will be positively related to job satisfaction of nurses working in acute care organizations in Winnipeg, Manitoba.
3. The overall score of structural empowerment and each sub-scale of empowerment will be positively related to job satisfaction after controlling for demographic factors.
4. The construct validity of current measure of structural empowerment using 6 sub-scale will be high.

Definitions

- ***Organizational restructuring***: Organizational restructuring refers to “planned changes in the formal patters of operation and command” (Cooper, Pandey, & Quick, 2012, p.52).

- ***Bumping***: Bumping is a procedure wherein a laid-off worker can displace a worker in another job or position who has less seniority (Siva, 2004), which means a senior employee has the right to choose the job or position into which she/he may bump, subject to the provision that she/he has the necessary qualification, which results in lay-off of existing junior nurses.
- ***Empowerment***: For the purpose of this study Kanter's (1993) definition of empowerment will be utilized. Empowerment is control over conditions that makes action possible (Kanter, 1993). Laschinger and colleagues links the concept of empowerment directly to job satisfaction (Laschinger et al., 2004; Lautizi et al., 2009).
- ***Job satisfaction***: Job satisfaction is a multi-dimensional concept, which describes how much an individual feels satisfied and content with his/her job. Job satisfaction is defined as "a pleasurable emotional state resulting from the appraisal of one's job or affective reaction to one's job" (Locke, 1969, p. 316).
- ***Job dissatisfaction***: According to Locke (1969) dissatisfaction is the "unpleasurable emotional state resulting from the appraisal of one's job or blocking the attainment of one's job values" (p. 316).

Significance of the Study

The results of this study are important to nursing leaders in identifying the importance of creating empowering workplace environment for nurses, which can increase job satisfaction. Organizational restructuring and reforms have a possible negative impact on job satisfaction and well-being of nurses (Bamgerger et al., 2012). One of the major causes of burnout among nurses is stress associated with poor working conditions in nursing work environments (Laschinger, Wong, & Greco, 2006). As well, healthcare restructuring often implies major transitions for

employees, such as new roles and tasks, new leaders and co-workers, and losing colleagues - resulting in job insecurity, stress, dissatisfaction, and decreased retention (Burke et al., 2016). When nurse leaders create an empowering environment where staff feel engaged, are part of the decision-making process, and have enough information to understand why decisions were made, nurses' stress related to restructuring and changes is reduced, creating a more positive and trusting environment (Hayes, Douglas, & Bonner, 2014). Therefore, it is critically important for current and future nursing leaders to create satisfying workplaces for nurses to do their work in optimal ways that foster job satisfaction and mitigate the negative consequences of organizational restructuring.

Chapter Summary

Nurses perform a crucial role in today's radically changing healthcare environment, which is currently characterised by restructuring. Even though Canada spends billions of dollars in healthcare, Canada's healthcare system placed second last in performance, having the longest wait times in the ED, for specialist care, and second-longest wait times for elective surgery. These findings demonstrate a need to repair, reinvigorate, and redesign our healthcare system for sustainability. In order to improve efficiency and reduce healthcare costs, the Manitoba provincial government decided to change the healthcare organizational structure. As a result, healthcare organizations merged, service provision was restructured, and nurses were faced with many occupation-specific changes in their work environment. nurses experienced increased anxiety and uncertainty. Previous studies related to organizational restructuring and downsizing show these changes can result in job dissatisfaction, decreased commitment, decreased retention, and worsened patient outcomes. therefore, nursing leaders need to provide empowering working conditions for nurses, an essential factor in nurses' job satisfaction and retention.

For nurses to be successful in having a central role in the management of acutely ill patients and delivering high-quality patient care, they must be empowered and satisfied with their work. In Winnipeg, there is a lack of research examining the relationship between structural empowerment and job satisfaction following organizational restructuring. This study will provide new and useful information to healthcare administrators and managers about the impact of structural empowerment on the professional work environment and provide a theoretical basis for the implementation of empowering working conditions.

Chapter 2: Conceptual Framework

Introduction

Kanter's Theory of Structural Empowerment (1977, 1993) is a framework that explains the concepts and terms associated with empowerment. Rosabeth Moss Kanter developed the concept of structural empowerment based on a five-year study of a large industrial corporation and proposed the Theory of Structural Power in Organization in her book, *Men and women of the corporation* (1977, 1993). Over the last two decades, Kanter's theory has been used to demonstrate the link between empowering workplace structures and job satisfaction in healthcare settings (Laschinger, 2008). Kanter (1993) argues that the characteristics of the organization, rather than individual characteristics determine empowerment. More specifically, she argues that both formal job characteristics and informal alliances affect the ability of employees to accomplish their work.

Kanter (1993) proposes that the structure of the work environment correlates with the employee attitudes and behaviours. In her work on organizational empowerment, Kanter (1993) identified three structural determinants of organizational structures that affect the behaviour and attitudes of employees: (a) the structure of power, (b) the structure of opportunity, and (c) proportion. In relation to these structures, power derived from the ability to access information, support, and resources; opportunity refers to expectations for growth and advancement in one's position; and proportion describes the relative number of people, based on their number and social composition (Kanter, 1993).

Kanter (1993) describes structural factors within the work environment, such as information, support, opportunity, resources, and power that enable employees to accomplish their work in meaningful ways and feel empowered. Employees who believe their work

environment provide accesses to these factors are empowered (Stewart, McNulty, Griffin, & Fitzpatrick, 2010; Wong, & Laschinger, 2013). According to Laschinger, Finegan, Shamian, and Wilk (2001), structural empowerment refers to the presence or absence of empowering conditions in the workplace. By having the four structural components of empowerment (access to information, support, resources, and opportunities to learn and develop) along with both types of power (formal and informal discussed below), the employee can become empowered within the work setting. Moreover, empowered nurses have higher levels of job satisfaction, provide better patient-centered care, and have better patient outcomes (Aiken et al., 2012). These structural determinants will now be further discussed and explored.

Structural Theory of Organizational Empowerment

Power

Power is a controversial concept for several reasons. First, the term power is associated with different meanings among individuals, and it is defined using a variety of positive and negative terms. According to Kanter (1993), "power is a loaded term," (p.166) and its connotations tend to be more harmful than positive. It has multiple meanings, which include: authority, influence, force, dominance, and even energy (as defined in physical science). However, for Kanter (1993), power refers to "the ability to get things done by being able to mobilize resources" to meet specific goals within a given time frame (p. 166). For some leaders, power is perceived as striving for a competitive advantage, but the meaning of power in her theory is closer to "mastery" or "autonomy" than domination or control over others (Kanter, 1993, p. 166). Therefore, in this context, power is defined as the ability to get things done, rather than domination, and is more closely related to autonomy (the freedom from external control) than control over others (Kanter, 1993).

The structure of power within the organization comes from three lines or sources of power: access to information, support, and resources (Kanter, 1993). More specifically, the *lines of information* are related to having information about organizational decisions and policy changes. *Lines of resources* relates to the ability to exert influence outward to bring in materials, money, rewards or other needed resources for achieving job demands. *Lines of support* related to allowing employees to undertake risk or innovative activities without having to go through the stifling multilayered approval process. Examples include positive feedback from management and other senior administrative individuals within the organization or opportunity to exercise decisions and autonomy within one's job (Kanter, 1993). According to Kanter (1993), "power is on" when employees have access to information, support, resources, and opportunities to grow. When these sources are unavailable, "power is off," and productive work is impossible. These lines of power are sources of structural empowerment within the organization (Greco, Laschinger, & Wong, 2006; Laschinger et al., 2004). Access to these empowering structures is influenced by formal and informal power systems within the organization.

The degree of power experienced by employees is determined by discretion, visibility, the upward mobility of subordinates, sponsorship by superiors, and good relationships with peers (Kanter, 1993). Formal power is the degree of flexibility, visibility, and relevance that is defined by the job in which the individual is employed (Kanter, 1993). Informal power is related to the degree to which an employee is able to make connections and alliances within and outside of the organization (Kanter, 1993), including the development of effective relationships with peers, superiors, and subordinates within the organization. This informal power leads to a flatter hierarchy and promotion of autonomous workgroups within the organization. High levels of

formal and informal power are needed to assess the lines of power (information, support, and resources) that enable employees to accomplish their work in meaningful ways.

Kanter (1993) suggested, "when people are empowered—that is, allowed to have control over conditions that make their actions possible—then more is accomplished, more gets done" (p. 166). For nurses to be empowered, they need to have the ability to access knowledge and information needed to carry out nursing duties in a hospital setting. This access includes technical knowledge and expertise, as well as informal information concerning what is going on within the organization. Employees who possess sufficient power can accomplish the tasks required to achieve organizational goals, can empower those around them, and create effective work units within the organization. Similarly, leaders who are empowered are more likely to delegate, reward talent, and build a team that places subordinates in significant positions.

In contrast, leaders who regularly limit access to power and opportunity structures perceive themselves to be powerless. Powerless leaders are deemed those who are more dependent on others, ineffective, rule-minded and dictatorial, and less committed to the achievement of organizational goals (Kanter, 1993). As mentioned previously, power –for both leaders and employees – is derived from structural organizational factors such as the work environment and opportunity for growth, rather than personal or social behaviour (Kanter, 1993).

Opportunity

The second key structural determinant of organizations that affects employee behaviours is *opportunity*, which refers to the prospects of professional growth and future development to build on the knowledge and skills needed for a job. According to Kanter (1993), *opportunity* is a "more dynamic concept" (p.161) than the others; it is the relationship between an employee's present position and future job advancement. DeSisto and DeSisto (2006) refer to opportunity as

expectations and the potential for advancement within an organization. Kanter (1993) maintains that opportunity is a critical influence on employee work satisfaction and productivity. Indicators of opportunity include promotion rates, ladder steps, assess to challenging work, increasing skills, and rewards. One important goal of an organization's opportunity structure should be to "motivate performance in the job" (Kanter, 1993).

Kanter suggests that employees with low opportunity for career advancement may become less committed to their organization or their work, may become what is often called a "chronic complainer," and may display negative behaviours (Kanter, 1993, p. 156). Individuals can lack opportunity because their position is a "low ceiling" occupation, they have failed in a "high ceiling" occupation, or they lack the appropriate background to achieve a "high ceiling" position (such as experience or education). Individuals who remain in low opportunity jobs exhibit "stuck" behaviours such as limiting their work aspirations, reduced commitment to the organization, cautiousness, and resistance to change. On the other hand, individuals who have the opportunity to experience advancement generally have higher self-esteem, self-confidence, and an increased ability to market their skills. Their investment in work and higher career aspirations are generally evident. Thus, employees that have access to an opportunity are more likely to be the risk-takers and innovators and be more committed to organizational goals and values (Kanter, 1993).

Proportion

The third structural determinant, proportions is related to the size and social composition of an organization or a group within the organization. To put it slightly differently, Kanter (1993) refers to proportion as "the social composition of people in approximately the same situation" (p. 248). Proportions can be related to sex, gender, race, age, ethnicity, occupation, and other

demographics. Kanter argues that interaction with those who are socially dissimilar tends to be perceived as more uncomfortable and unpredictable than interaction with those who are 'similar.' The profession of nursing is predominantly female, so in this context, male nurses may feel more uncomfortable when interacting with their coworkers than female nurses would. In a group where members are initially strangers to one another and belong to different categories, the level of uncertainty and unfamiliarity may be higher, particularly regarding thoughts of each other's interaction style and competence with a task (Ridgeway, 1992). Take the example of minority workers (with minority status referring to being a member of a group that represents less than 15% of the dominant group), who often experience difficulties because of their higher visibility as 'unfamiliar' and may suffer physical and psychological stress resulting from their minority status (Kanter, 1993). Higher proportions of a given demographic means employees feel more represented in the workforce. Since there are rarely equal proportions of workers in the nursing profession, minority group may perceive empowerment as lacking which may impact job performance and satisfaction (Choi, 2017).

Employees who have access to these three structures- power, opportunity, and proportion- are more productive, experience less burnout, and display higher levels of organizational commitment (Yang, Liu, Chen, & Pan, 2014). When these structures are lacking, employees may feel that the organization does not value their contribution to organizational goals enough to assure that the necessary resources are in place to help them to do their job effectively (Kanter, 1993). As with leaders, powerlessness results when employees do not have access to resources, information, support, and opportunity (Kanter, 1993). Employees, who view themselves as powerless and may feel stuck in their job, believe there is (for them) a lack of opportunities for growth and mobility, or feel a lack of involvement in decision-making. Kanter (1993) contends

that employees can feel more empowered when the workplace environment is highly structured and provides those critical determinants of power, opportunity, and proportions. In turn, this benefits the organization in terms of improved employee attitudes and increased organizational effectiveness.

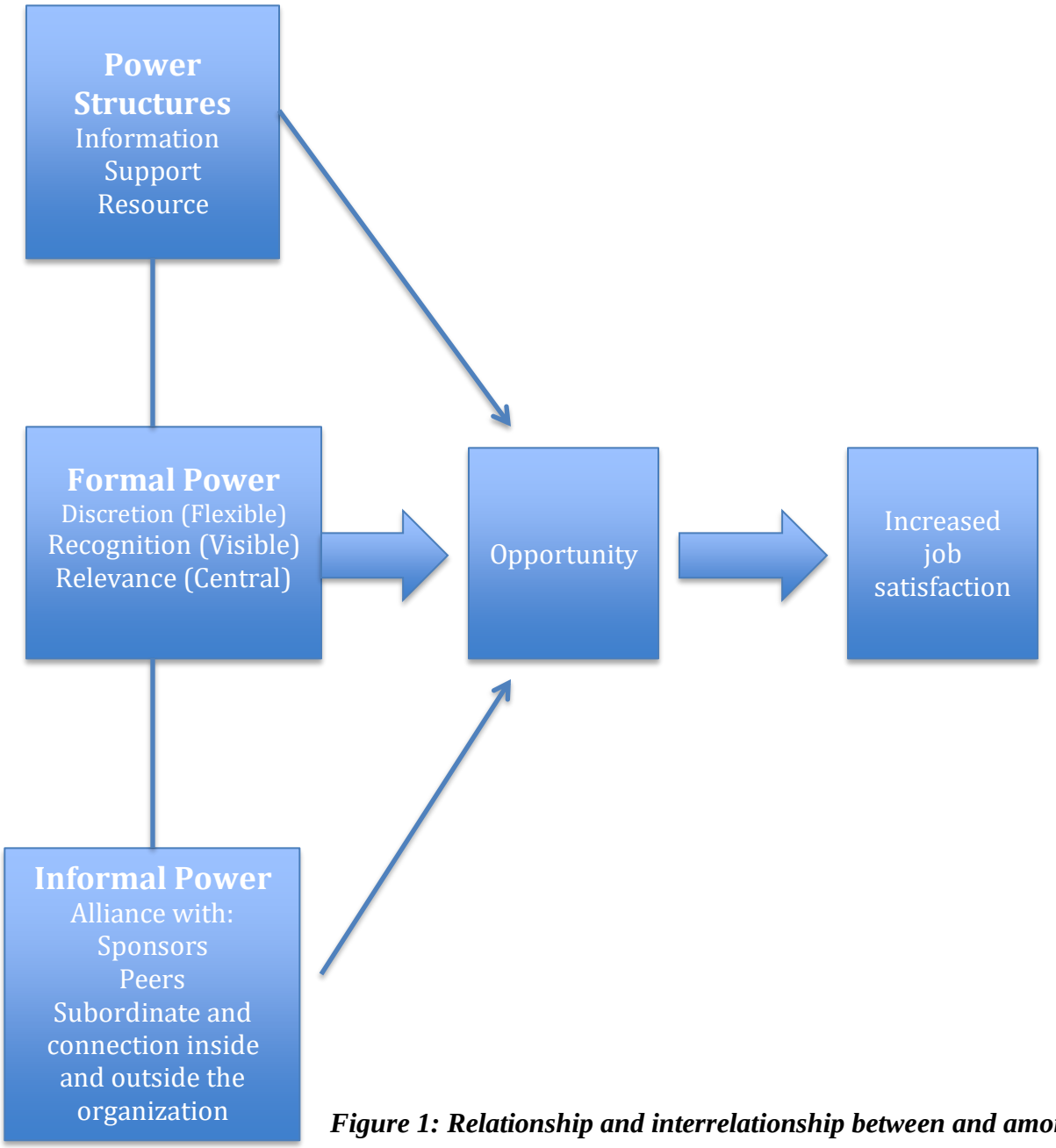


Figure 1: Relationship and interrelationship between and among concepts in Kanter's theory of structural empowerment in organization

Creating an Empowering Environment

According to Kanter (1993), structural factors within the work environment have a significant impact on employee work attitudes and behaviour. Kanter's Theory of Structural Empowerment in Organizations (1977, 1993) proposes that a structurally empowered work environment provides employees access to the four-empowerment structures (access to information, support, resources, and opportunities to learn and develop). With access to these structures, the environment itself is empowering and enhances employees' ability to accomplish work within an organization in a meaningful and significant way (Laschinger, 2008).

So how can an organization improve access to empowering structures?

Organizations should ensure that employees have access to opportunities, resources, support, and information, to enable them to mobilize resources to satisfy their role (Kanter, 1993). As mentioned previously, opportunity is the potential of advancing challenging positions or roles within the organization and the extent to which the job allows the employee to gain skill while being awarded and recognized (Kanter, 1993). In order to enhance opportunity, an organization must identify the gap between job ladders and provide job advancement, good feedback, and encouragement for learning (Kanter, 1993). Access to resources refers to the ability to exert influence in the organization to bring in needed personnel finances, supports, materials, and other supplies needed for the specific task or job. Having the right equipment and supplies to complete the job will always benefit the organization.

Access to information is 'in the know' about the organization's decisions, changes in policies, and future directions, as well as, technical knowledge data, and expertise required to function in one's position effectively. In the hospital context, access to information refers to the availability of content knowledge and expertise required to do one's job; being informed of the

organization's overall goals, values, and policies; and actively participating in the organization's decision-making process. Information can give employees a sense of purpose and meaning and enhance their ability to make decisions that contribute to the organizational goals. The information allows the individual to execute tasks to perform one's job (Tigert & Laschinger, 2004).

Support is the feedback and guidance received from supervisors, peers and subordinates. Support can be described as guidance, problem-solving advice, and constructive feedback from colleagues and senior management, and creating a safe environment where staff feels they can openly ask questions and rely on senior colleagues and managers for assistance. When others receive feedback, it means that the employee has received support (Yang et al., 2014). Therefore, management provide its employees not only with adequate information and resources necessary to do a job, but also an effective support system and the opportunity to learn and grow. Having access to these structures positively affects a variety of employee behaviours, including autonomy (DeSisto & DeSisto, 2006; Wagner et al., 2010), employee decisional involvement, increased commitment, and job satisfaction (Yang et al., 2014). On the other hand, individuals who lack access to these structures see themselves as powerless and may feel stuck in their job, lacking opportunities for growth and mobility and unsatisfied with their job (Kanter, 1993).

Chapter Summary

Kanter (1993) describes structural factors within the work environment, such as information, support, opportunity, resources, and power that enable employees to accomplish their work in meaningful ways and feel empowered. Kanter asserts that power is essential to effective management and achievement of organizational goals. According to Kanter power is the ability to get things done, to mobilize resources, rather than dominance, control, oppression and is more

closely related to autonomy. She maintains that the manager role is to create empowering structures, include a flattening of hierarchies and participatory decision-making structures.

Employees who possess sufficient power can accomplish the tasks required to achieve organizational goals, can empower those around them, and create effective work units within the organization. On the other hand, individuals who lack access to these structures see themselves as powerless and may feel stuck in their job, lacking opportunities for growth and mobility and unsatisfied with their job. On the other hand, individuals who lack access to resources, information, support, and opportunity, see themselves as powerless and may feel stuck in their job. Employees with access to the power and opportunity structures within an organization are highly motivated and able to empower others. Kanter's theory has been empirically tested in healthcare settings. Therefore, Kanter's theory deemed most appropriate as the framework for this study.

Chapter 3: Literature Review

In 2017, in response to demands for improved efficiency, decreased duplication, improved quality of service, and cost containment the Manitoba Conservative government began organizational restructuring of provincial healthcare system and services. Changes included integration of services, conversion of a number of emergency departments to urgent care centres and merging existing programs. Evidence shows that restructuring of healthcare can have significant implications for the nursing workforce (Burke et al., 2016; de Jong et al., 2016; Duffiled, Kearin, Johnston, & Leonard, 2006). These impacts include job dissatisfaction, higher levels of burnout, increase psychological distress, job insecurity, heavy workload, and lower levels of patient care (Burke, Ng, & Wolpin, 2011; Burke at al., 2016; de Jong et al., 2016;). However, nurses who perceive themselves as empowered have a higher level of job satisfaction (Han, Trinkoff, & Gurses, 2015; Kretzschmer, et al., 2017; Lautizi et al., 2009), reduced turnover and intent to leave (Fitzpatrick et al., 2010; Hauck et al., 2011), increased commitment to the organization in which they work (Ahmad & Oranye, 2010; Gholami, Saki, & Pour, 2019) and better patient outcomes (Purdy et al., 2010; Van Bogaert et al., 2016) than nurses who do not feel empowered. The purpose of this study is to explore the relationship between structural empowerment and job satisfaction of nurses post-organizational restructuring. The study findings may provide strategies for change management to improve nurses' empowerment and job satisfaction.

Rosabeth Moss Kanter's Theory of Structural Empowerment (Kanter, 1993) provides the framework for this study. Kanter's theory was originally developed to explain organizational behaviour in the business sector however, it also provides a useful explanatory framework for studying work environments in other settings including, sociology, social work, psychology, and

political science. As in other disciplines, researchers have tested Kanter's theory extensively in nursing settings (Cicolini et al., 2014). The literature review presented here will commence with an analysis of empowerment within the field of nursing, followed by a summary of research that utilizes Kanter's (1993) Theory of Structural Empowerment as a conceptual guide.

For this study, CINAHL (PubMed) and MEDLINE (through EBSCOhost) databases searched for relevant literature on structural empowerment, job satisfaction, and organizational restructuring. The articles selected for this literature review utilized Kanter's Theory of Structural Empowerment and were published in English between 2009 and 2019, in order to include only recent studies to gain insight into the contemporary influence of the concept and the variables of Kanter's theory in the workplace.

Structural Empowerment

Studies have used Kanter's (1993) Theory of Structural Empowerment extensively in nursing settings. Chandler (1986) was one of the initial researchers who demonstrated that Kanter's theory is also relevant to the nursing population (Cicolini et al., 2014). Since then, the relationships between structural empowerment and various employment-related outcomes described within Kanter's theory have been empirically tested and supported in many nursing studies (e.g., Laschinger et al., 2001, a, b, c; Laschinger et al., 2004). In 1992, Dr. Laschinger initiated an entire research program at the University of Western Ontario dedicated to systematically testing a number of hypotheses derived from Kanter's theory (1977; 1993) in the nursing population.

Initially, Chandler tested Kanter's theory in her dissertation and developed the Condition for Work Effectiveness Questionnaire (CWEQ) from the items in Kanter's working conditions. The questionnaire used a 5-point Likert scale to record responses for different areas of work

conditions: opportunities, resources, job activities, information, and support. However, in Chandler's study, the only empirically validated work conditions of the original five tested was support, information, and opportunity. Since then, Laschinger (1996) has tested and revised the CWEQ as a means of expanding Kanter's propositions, introducing two other measurements, formal and informal power, to further examine and test Kanter's theory. Laschinger, Finegan, Shamian, and Wilk (2001b) modified these instruments and developed the CWEQ-II, which consists of 19 items measuring the 6 components of structural power as described by Kanter (opportunity, information, support, resources, informal power, and formal power). The revised version CWEQ-II has demonstrated high internal consistency, with a Cronbach's alpha ranging from 0.68 to 0.93 (Laschinger et al., 2001b; Hauck et al., 2011; Purdy et al., 2010).

Laschinger and colleagues have completed comprehensive work in the area of nurse empowerment and testing Kanter's theory in healthcare settings in Canada (Laschinger et al., 2001, a, b, c, 2004, Manojlovich & Laschinger, 2002). Other countries, such as Australia (Hayes, Douglas, & Bonner, 2014) China (Cai, Zhou, Yeh, & Hu, 2011; Cai & Zhou, 2009; Guo, Chen, Fu, Ge, Chen, & Lu, 2016; Ning, Zhong, Libo, & Qiujie, 2009), Italy (Lautizi et al., 2009), Iran (Gholami et al., 2019), England (Ahmed & Oranye, 2010), and Malaysia (Ahmed & Oranye, 2010) have identified workplace empowerment as a strong predictor of job satisfaction. These studies indicate that empowering working conditions have positive effects on organizational attitudes and behaviours. Various studies, described in more detail in subsequent sections, show that perceptions of workplace empowerment are found to be predictive of many aspects of nursing employment, including job retention (Cai & Zhou, 2009; Hauck et al., 2011; Purdy et al., 2010; Smith, Capitulo, Griffin, & Fitzpatrick, 2012); burnout (Harwood, Ridley, Wilson, & Laschinger, 2010; Orgambidez-Ramos, Borrego-Ales, Vazquez-Aguado, & March-Amegual,

2017; Hayes et al., 2014); innovative behaviour and career success (Dan, Xu, Liu, Hou, Liu, & Ma, 2018); psychological empowerment (Laschinger et al., 2001b; Wagner et al., 2010); job satisfaction (Ahmad & Oranye, 2010; Cicolini et al., 2014; Lautizi et al., 2009; Ning et al., 2009); organizational commitment (Ahmad & Oranye, 2009; Gholami et at., 2019; Yan et al., 2014); and trust in management (Gholami, et al., 2019).

Structural Empowerment and Psychological Empowerment

Laschinger et al. (2001b) expand upon Kanter's theory to demonstrate that psychological empowerment is an outcome of structural empowerment. Wagner et al. (2010) conducted a systematic review of six studies that revealed a significant association between structural empowerment and psychological empowerment for nurses. Three Canadian studies revealed a relationship between structural empowerment and psychological empowerment in dimensions of nurses' job strain, organizational commitment, and job satisfaction. Three other international studies revealed a relationship between structural empowerment and psychological empowerment in nurses' work-related stress, job productivity, and effectiveness.

Structural Empowerment and Organizational Outcomes

According to Kanter (1993), management should create empowering work environments for employees by providing employees with access to information, support, and resources necessary to accomplish their work more effectively, and ongoing opportunities for career development. There is a growing body of evidence that empowering work environments predict positive outcomes for nurses and the organization. Several studies have demonstrated that access to empowering conditions in the workplace leads to increase job satisfaction, improve patient care, job retention, burnout, commitment, and trust (Cicolini et al., 2014; Gholami et al., 2019; Hays et al., 2014). Additionally, nurses working in empowered environments also report improved health

outcomes such as less emotional exhaustion and job strain, and better mental health (Harwood et al., 2010; Hayes et al., 2014). Nurses in these studies consistently report moderate levels of empowerment scores.

Structural Empowerment and Turnover

Nurses are critical to the delivery of healthcare, but the nursing profession is facing significant challenges - most importantly, the growing shortage of nursing staff. The Canadian Nurses Association (CNA) anticipates an increased in nursing shortages in the next two decades; by 2022, the CNA expects a shortfall of 60,000 full-time equivalent nurses in Canada (CNA, 2009). As a result of the shortage, fewer nurses are available to care for patients, leaving those nurses still in practice with even more demanding workloads. According to Purdy et al. (2010), nurses work environments are more challenging and less satisfying than ever before.

Previous studies have shown that high levels of job dissatisfaction arising from working conditions characterized by heavy workloads and limited participation in decision making result in a higher probability of medical errors and increased overtime hours, and higher levels of job-related stress related to low nurse retention in healthcare organizations (McHugh, Kutney-Lee, Cimiotti, Slone, & Aiken, 2011; O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010; Park, Gass, & Boyle, 2016; Purdy et al. 2010). Park et al. (2016) cited a heavy work schedule as the primary reason for increased turnover. A more recent study by Gholami et al. (2019) found that a low level of organizational trust could also be a driving force for nurses deciding to leave their place of employment.

Aiken and colleagues (2012) aimed to study whether hospitals with a good organization of care (improved nurse staffing and work environments) could affect nurse workforce stability and patient care. They conducted a cross-sectional study of 1,105 general acute care hospitals -

488 in Europe and 617 in the USA. The study included 61,168 professional nurses, and more than 130,000 patients. The results showed that a substantial proportion of nurses reported quality of care deficits, high burnout, job dissatisfaction, and intention to leave their current position. The proportion of nurses who declared an intention to leave their job in the subsequent year was 49% for Finland and Greece; 44% for England, Ireland, and Poland; 36% for Germany; 34% for Sweden; and 14% for the USA. Another study conducted by Fitzpatrick, Campo, Graham, and Lavendero (2010) in the USA found that 41% of the participants indicated their intent to leave their position in the following year. In a survey conducted in eastern Canada in 2011, 45.5 % of nurses surveyed reported intention of leaving their job (Rheaume, Clement, & LeBel, 2011). The outcomes of the studies mentioned above demonstrate that nurses who perceive their work environment as unfavourable have a higher intention to leave their job.

Studies have shown that a work environment that provides nurses with opportunities for growth and movement within their organizations, as well as access to information, support, and resources, is empowering. Nurses working in these environments are less likely to indicate intent to leave the nursing profession (Cai & Zhou, 2009; Hauck et al., 2011; Purdy et al., 2010; Smith et al., 2012). Smith et al. conducted a descriptive, cross-sectional study in Massachusetts to examine the relationship between structural empowerment and anticipated turnover among 50 psychiatric nurses. The Condition of Work Effectiveness Questionnaire-II (CWEQ-II) measured structural empowerment (SE) and the Anticipated Turnover Scale (ATS) were used to measure anticipated turnover. Smith et al. found a negative relationship between structural empowerment and nurses' anticipated turnover. Consistent with other studies, nurses felt moderately empowered, suggesting areas of opportunity for further enhancing nurses' access to opportunity, information, resources, and support (Armellino et al., 2010; Cai & Zhou, 2009). Smith et al.'s

study recommends that nurse leaders and managers should implement orientation, educational programs, and provide information available for nurses to increase their perceptions of power within the organization. The potential for nurses wanting to leave their place of employment because they still perceived themselves as lacking access to resources, support, information, and opportunities (Hauck et al. 2011, Lautizi et al., 2009; Gholami et al., 2019). The limitations of Smith et al.'s (2012) study were its small sample size, a response rate of only 53%, and all participants were from the same organization.

Cai and Zhou (2009) conducted a study in two teaching hospitals in central China to examine the relationship between structural empowerment, job satisfaction, and turnover intention of clinical nurses. A convenience sample of 189 female nurses aged 19-55 years completed the Conditions for Work Effectiveness Questionnaire-II (CWEQ-II) to measure the work empowerment structures, the Job Activities Scale (JAS) to measure formal power within the work environment, the Organizational Relationship Scale (ORS) to measure informal power within the work environment, and the Michigan Organizational Assessment Questionnaire (MOAQ) used to measure turnover intention. The results of this study indicated that nurses in central Chinese hospitals also perceived moderate levels of empowerment. The results revealed a positive relationship between structural empowerment and job satisfaction, and a negative relationship between structural empowerment and turnover intention. Participants also perceived that nurses with significantly high workloads tend to leave their profession. There were no statistically significant relationships found between the self-reported turnover intention and the demographic variables of age, nursing experience, or level of education (Cai & Zhou, 2009).

These studies show that throughout various healthcare systems and structures, the nursing work environment is a significant predictor of turnover intention and job satisfaction.

Predictably, positive perceptions of the nursing work environments (support for professional development, adequate staffing, nursing competent, supportive management, and teamwork) decrease intention to leave the current job (Hinno et al., 2011). Hayes et al.'s (2014) work supports this evidence, which suggests that creating empowering nurses' work environments promote job satisfaction and improves job retention.

Structural Empowerment and Quality of Patient Care

There is a large body of evidence demonstrating a significant relationship between empowerment of nurses and the quality of patient care. Goedhart, Van Oostveen, and Vermeulen (2017) conducted a scoping review examining the relationship between the structural empowerment (SE) of nurses and the quality, effectiveness, safety, efficiency, and patient-centeredness of care in twelve cross-sectional observational studies in North American hospitals between 1996 and 2014. The sample size of included studies ranged from 40 to 437 nurses, and from 50 to 1,606 patients, all of which applied validated and reliable instruments to measure SE. The Conditions of Work Effectiveness Questionnaire (CWEQ-I or CWEQ-II) was used to measure SE.

This scoping review found that structural empowerment positively influences patient care on all dimensions: quality, efficiency, patient-centeredness, patient safety, and work effectiveness. Additionally, the researchers concluded that nurses who have access to empowering structures provide a high quality of patient care, and feelings of empowerment resulted in more effective patient care. This review also highlighted the importance of the nursing leader's role in creating positive working conditions and empowerment (mobilize resources, provide support, opportunity, and information) of nurses, to provide quality care to patients.

Armellino et al. (2010) found that an empowering work environment for nurses enhanced quality patient care, through a study that examined the relationship between SE and patient safety culture of registered nurses (RNs) working in adult critical care units in a tertiary hospital in the USA. The researchers received responses from 102 nurses completing the CWEQ-I, the Organizational Relationship Scales-II (ORS-II), the Hospital survey on Patient Safety Culture (HSOPSC), and the Job Activity Scale-II (JAS-II). The majority of respondents indicated feeling moderately empowered; there was a significant correlation between structural empowerment and patient safety culture. The researchers concluded that nurses who view their work environment as empowering were more likely to be satisfied and perceive they delivered safe, quality care.

Another study conducted in 21 Canadian hospitals found that empowering work environments improved patient outcomes and nurses' job satisfaction (Purdy et al., 2010). Purdy et al. (2010) conducted a multi-site, multi-level cross-sectional study to determine the relationship between nurses' perceptions of their work environment and quality and risk outcomes for patients and nurses within 61 medical and surgical units in 21 hospitals in Canada. The study included a convenience sample of 697 nurses and 1,005 patients. The Conditions of Work Effectiveness Questionnaire-II (CWEQ-II) measured structural empowerment and The Work Group Characteristics Measure measured the group process. Two standardized questionnaires measured quality-oriented patient outcomes associated with nursing work effectiveness (1) the Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ), and (2) the Therapeutic Self-care Questionnaire-Acute Care Version. Spreitzer's Psychological Empowerment Questionnaire (PEQ) measured psychological empowerment, and the Nurse Global Satisfaction Questionnaire measured nurse job satisfaction.

Purdy et al. (2010) found that empowering workplaces support positive outcomes for both nurses and patients, including nurse-assessed quality and risks and patient falls. Staffing levels were found to be the most significant predictor of falls and nurse-assessed risk. The study also found a significant relationship between structurally empowering workplaces and group processes (such as nurse-to-nurse support, workload sharing, communication, and cooperation). Additionally, Purdy et al. (2010) found that empowering workplaces enhance individual nurse's psychological empowerment, and in turn, empowers behaviours that lead to quality patient care and increased job satisfaction.

Structural Empowerment, Career Success, and Innovative Behaviour

Nurses' innovative behaviour is essential in the dynamic nature of the Canadian healthcare system. Structural empowerment has become an essential factor in predicting innovative behaviour (Dan et al., 2018; Knol & Linge, 2009). According to Janssen (2003), innovative behaviour is defined as the "intentional generation, promotion, and realization of new ideas within a work role, work group or organization to benefit role performance, a group or an organization" (p. 348). In order to establish a relationship between structural empowerment, innovative behaviour, self-efficacy, and career success of nurses, Dan et al. (2018) conducted a descriptive cross-sectional survey of 411randomly-selected Chinese nurses. The CWEQ-II measured structural empowerment; Scott and Bruce's Personal Innovation Behaviour Scale measured innovative behaviour; the Self-Efficacy Scale measured self-efficacy; and the Career Success Scale measured career success.

Dan et al.'s study showed a positive association between structural empowerment and innovative behaviour and career success. Access to resources and formal power had the most significant impact on career success. Empowered employees with new ideas and innovative ideas

demonstrate increased confidence in their ability to overcome setbacks and respond to challenging tasks efficiently; these employees are less likely to want to leave their current job and seek ways to increase their opportunities for career success. Knol & Linge's (2009) study result show that informal power is significant for innovative behaviour, which can reduce barriers, allow employees to disclose individual and personal interpretations, and provide freedom to avoid formal lines when working on a task.

Structural Empowerment, Occupational Stress, and Burnout

Nurses often work in particularly stressful and burdensome environments (Orgambidez-Ramos et al., 2017). Common contributors to burnout are increased workload, high patient-nurse ratio, and negative practice environment (Harwood et al., 2010; Orgambidez-Ramos et al., 2017). According to Kanter (1993), empowering structures allow employees to accomplish their work in meaningful ways, thereby reducing the impact of occupational stress. A large body of knowledge reveals a significant negative relationship between structural empowerment and occupational stress and burnout (Guo et al., 2016; Hardwood et al., 2010; Hays et al., 2014; Orgambidez-Ramos et al., 2017).

A recent study examined the relationship between structural empowerment and burnout among nurses and found that nurses' perception of the work environment plays a vital role in their experience of burnout. Orgambidez-Ramos et al. (2017) conducted a cross-sectional correlational study to examine the relationship between structural empowerment and burnout among 297 Portuguese nurses. Participants were mainly female, with an average age of 37.42 years, over half of whom were single; the majority (57.89%) were working shifts between 35 and 42 hours a week, with an average work experience of almost 14 years. The researchers used the Structural Empowerment Model self-reported questionnaire to assess the influence of access to

opportunities, resources, information, and support on burnout among nursing staff. The CWEQ-II measured structural empowerment, and the Maslach Burnout Inventory measured burnout. The results of Orgambidez-Ramos et al. (2017) study revealed a negative relationship between the dimensions of structural empowerment and core burnout (emotional exhaustion and depersonalization). Access to opportunities and resources impacted nurses' experience of core burnout (both directly and indirectly) through global empowerment (regarded as a mediator between structural empowerment and core burnout). The findings of this study are consistent with other studies, which demonstrated that nurses who work in an empowering healthcare context have a lower level of burnout than those who work in contexts where they lack formal and informal power (Guo et al., 2016; Harwood et al., 2010). In this sense, nurses' perception of the work environment plays a vital role in their experience of burnout.

Another cross-sectional study conducted in Australia by Hayes et al. (2014) sought to test an explanatory model, drawing on Kanter's Theory of Organizational Empowerment regarding the relationships between the nursing work environment, job satisfaction, job stress, and emotional exhaustion, among 417 hemodialysis nurses. Again, participants were predominantly women (90.9%), who completed an online survey. The 26-item Brisbane Practice Environment Measure (B-PEM) measured the nursing work environment; the Index of Work Satisfaction (44 items Part B) measured job satisfaction; the Nursing Stress Scale measured job stress; and the Maslach Burnout Inventory (MBI) measured emotional exhaustion.

Hayes et al.'s study found a positive relationship between the work environment and job satisfaction. The study result shows that as the level of job satisfaction increases, the incidence of job stress decreases. In addition, job stress was a significant predictor and the main reason for haemodialysis nurses resigning from the current position or leaving the profession altogether.

Stress was not only detrimental to the health and well-being of haemodialysis nurses but also negatively affected patient outcomes. Where high levels of stress and burnout decrease in patient satisfaction, there is an increase patient morbidity, and mortality (Aiken et al., 2011). The results from these studies emphasize the importance of developing empowering work environments for nurses, in order to mitigate occupational stress, prevent the development of burnout, increase job retention, and improve job satisfaction.

Structural Empowerment, Organizational Commitment and Trust

Several studies have demonstrated a strong relationship between structural empowerment and nurses' organizational commitment (Ahmad & Oranye, 2010; Gholami et al., 2019; Yang et al., 2014). Two studies found that modifying the workplace structure to improve access to information, resources, support, and power increased organizational commitment and job satisfaction (Ahmed & Oranye, 2010; Yang et al., 2014). Hauck et al. (2011) found that nurses who perceived themselves as empowered had a higher level of autonomy, job satisfaction, and organizational commitment.

In China, Yang, Liu, Chen, and Pan (2014) conducted a cross-sectional study to identify the effect of structural empowerment and organizational commitment on job satisfaction. The researchers conducted a cross-sectional survey of 574 nurses (with a response rate of 87%). The CWEQ-II measured structural empowerment; organizational commitment questionnaires for Chinese (COCQ) measured organizational commitment, which included five dimensions of commitment: affective, normative, ideal, economical, and opportunity; and the 20-item Minnesota Satisfaction Questionnaire (MSQ) measured job satisfaction. Yan et al. found a significant and positive relationship between structural empowerment and organizational commitment. Nurses perceived themselves as empowered when they worked collaboratively

with other professionals and had the autonomy to make decisions and freedom to act in accordance with their professional knowledge base. Further, studies conducted in England and Malaysia (Ahmed & Oranye, 2010) found that structural and psychological aspects of the work environment were related to organizational commitment.

When changes occur within an organization, nurses often develop a lack of trust and respect for management, which leads to decreased job satisfaction and organizational commitment. Gholami et al. (2019) conducted a study in Iran to clarify the relationship between perception of job empowerment, organizational commitment, and trust among nurses. The researchers used a descriptive cross-sectional study of 160 nurses in four teaching hospitals in west Iran. The CWEQ-11 measured nurses' empowerment; the Williams and Cooper's Pressure Management Indicator measured organizational commitment; and the Mishra's Trust in Management Scale measured organizational trust. Gholami et al. found a positive and significant relationship between nurses' perception of job empowerment, organizational commitment, and trust in management. Nurses' organizational trust decreased when nurses felt that they did not have access to sufficient information, that information was concealed from them, or felt a lack of support from management. A low level of organizational trust was likely to cause nurses to leave their job. Importantly, these findings suggest that sharing the goal and vision of an organization and having access to open communication are essential for achieving organizational trust.

Organizational Restructuring and Job Satisfaction

Studies show that globally, nurses' job dissatisfaction began to rise in the late 1990s during times of organizational restructuring. During this time, restructuring initiatives in healthcare settings designed to increase productivity and minimize operating costs while maintaining the quality of patient care resulted in redeployment and reduction in nursing resources (Blythe et al., 2001;

McGillis Hall, 2005). A study conducted in Greece concluded that nurses' ratings of quality of patient care and job satisfaction were worse after major healthcare restructuring due to Greece's health system experiencing severe economic difficulties (Skefales, Plakas, Fouka, Gono, Vassiliadou, & Bergiannaki, 2014). In 2010, Greece's health budget was cut, mainly through a reduction in healthcare operating costs, eliminating or merging of specialty units, and reduction in public hospital beds (Skefales et al., 2014) - similar to the current healthcare climate in Manitoba. Skefales et al. (2014) sought to explore the potential relationship between this financial crisis, nurses' working conditions, and experiences of burnout. Skefales et al. conducted a study in 2012 wherein 299 Greek nurses completed a cross-sectional quantitative survey. Most of the participants were female (80.9%), and the mean age was 37.8 years. The self-reported questionnaire had two parts; the first part explored the financial conditions, working related conditions, and demographic questionnaire, and the second part used the Maslach Burnout Inventory for Human Service Survey (MBIHSS) to measure burnout.

Of the respondents, 87% reported an increase in workload, increased stress for their future career, and increased emotional exhaustion, which was reported to have a negative impact on their personal lives. Almost one third (27%) of nurses stated they were dissatisfied with their current job, 29.3% indicated they would like to change their working department, and 24.8% reported wanting to change their career, citing emotional exhaustion as the reason. The study is somewhat limited due to convenience sampling and small sample size (only two hospitals), as well as the distribution of questionnaires through various times during nursing shifts.

A study conducted by Burke, Ng, and Wolpin (2011) in California aimed to examine the relationship between restructuring and downsizing and well-being. During 2009 and 2010, the California government faced budget deficits and restructured the healthcare sector, in an attempt

to reduce healthcare costs. The data collected from the two samples (one conducted with staff in a southern California hospital and another online survey of graduate nursing students). A total of 287 (222 nurses and 67 nursing students) participated in the study. The researchers used Quinn and Shepard's 5-item scale to measure Job Satisfaction; the Schaufeli and Baker scale measured work engagement; the Maslach Burnout Inventory (MBI) scale measured burnout; and the Derogatis, Lipman, Rickels, Uhlenhuth, and Cove scale measured psychological well-being.

The researchers found that more restructuring initiatives led to higher levels of emotional exhaustion and cynicism and lower levels of efficacy. Nurses also reported that restructuring initiatives resulted in lower levels of job satisfaction, greater intention to leave the current job, more psychosomatic symptoms, increased workload, and a higher perceived threat to job security. However, restructuring initiatives had no relationship with self-reported absenteeism. Given the likelihood of more widespread restructuring and downsizing in healthcare systems across North America, additional studies using more substantial and representative samples need to be undertaken to document the potential effects of these efforts on nursing staff (Burke et al., 2011).

Nurses' job satisfaction is a global concern because of the potential impact on the quality and safety of patient care (Armellino et al., 2010; Purdy et al., 2010), job retention (Aiken et al., 2012; Duffield et al., 2011; Fitzpatrick et al., 2010), burnout (Lautizi, 2009; Orgambidez-Ramos et al., 2017), and commitment (Gholami et al., 2019; Hayes et al., 2014; Orgambidez-Ramos et al., 2017). According to Purdy et al. (2010), nurses' work environments are more challenging and less satisfying. Organizational restructuring and changes result in decreased opportunities for nurses to participate in decision-making. Nurses had to "bump" into different facilities and jobs. Unfamiliar work environments and roles caused experienced nurses to feel like novices. Nurses

had to make expedient choices that may not have matched their career goals or work preferences (Johnson et al., 2018). Job changes, particularly redeployment, can lead to nurses' feelings of lack of control over their career or practice, uncertainty about the future, and powerlessness (Blythe et al., 2001). Often times, when organizational change is introduced and implemented without consulting nurses, friction can result among the organization and nursing personnel, which can lead to decreased job satisfaction and difficulty for organizations to retain and recruit nurses (Wade et al., 2008).

Structural Empowerment Related to Job Satisfaction

Locke (1969) defines job satisfaction as "a pleasurable emotional state resulting from the appraisal of one's job or affective reaction to one's job" (p.316). Several studies demonstrate a significant relationship between structural empowerment and job satisfaction (Lautizi et al., 2009; Wong & Laschinger, 2013). Wong and Laschinger (2013) observed that the more nurses perceive they have access to workplace empowerment structures, the more they are satisfied with their work, and the more they report higher performance. Access to opportunities to learn and grow in the job is particularly essential to job satisfaction (Lautizi et al., 2009). An employee can be satisfied with the critical content of the job but may become frustrated if the workplace does not allow one to grow or move to roles in other areas of the organization. When nurses feel that their professional decisions are valued and welcomed, have control over their work, and their work is meaningful and able to make an impact on patient care, they are more satisfied with their work and are more likely to perceive the workplace as empowering (Kretzschmer et al., 2017).

Pay, organizational policies, and resources required to do the job are significant factors to increase nurses' job satisfaction (Ning et al., 2009). Ning et al. (2009) used a cross-sectional design to study the relationship between structural empowerment and job satisfaction of 598

nurses from six Chinese hospitals. The respondents were all female with ages ranging from 19 to 54 years. The CWEQ-II measured the structural empowerment and the Minnesota Satisfaction Questionnaire (MSQ) measured job satisfaction. The results supported Kanter's (1993) contention that organizational factors within the workplace are essential in shaping organizational behaviour and attitudes. The study found a positive relationship between structural empowerment and job satisfaction. Nurses reported their work environment as moderately empowering and having less access to resources contributed to feelings of disempowerment. The nurses in Ning et al.'s study (2009) were most dissatisfied with the workload and compensation, work environments, professional promotion, amount of work responsibilities, and organizational policies. The researchers assert that the most crucial measures nurse managers might use to increase job satisfaction are positive communication with staff (provide information, feedback, and employee participation in decision making), encouragement of innovation, and empowerment of nurses to do the job effectively (Ning et al., 2009).

A descriptive correlational survey study by Ahmad and Oranye (2010) analyzed the correlations between empowerment, job satisfaction, and organizational commitment in the workplace in two different countries and cultures: Malaysia and England. The results support the evidence that structural empowerment and psychological empowerment concepts may vary across cultures (Ahmad & Oranye, 2010). The researchers surveyed 556 registered nurses in two teaching hospitals in England and Malaysia. Participants were predominantly female in England and Malaysia (Malaysia 99% female and the mean age was 32.74; England 90.5% female mean age 37.36). Researchers used the Structural Empowerment Scale and Psychological Empowerment Scale to measure empowerment; Stamp's Index of Job Satisfaction Scale to

measure job satisfaction; and Meyer and Allen's Organizational Commitment Scale to measure organizational commitment. The demographic questionnaire also identified differences in socio-cultural factors and work environmental factors.

Ahmad and Oranye (2010) found that there were differences in the level of nurses' empowerment, job satisfaction, and organizational commitment between the two countries, as well as a direct relationship between nurses' perceptions of empowerment and both satisfaction and organizational commitment. Among Malaysian nurses, there was a relationship between organizational commitment and psychological empowerment, and vice versa for English nurses. Nurses who worked in a Malaysian hospital perceived greater empowerment and commitment but were less satisfied than nurses who worked in England. Malaysian nurses are not considered to be professionals and do not possess all the rights and privileges of professional status, in addition to receiving relatively lower pay compared to nurses who work in England, which may be one reason Malaysian nurses were less satisfied than English nurses. The most significant factor that determined Malaysian nurses' job satisfaction was access to opportunities for both formal and informal contact (interaction) with colleagues during working hours.

On the other hand, most of the English nurses were moderately empowered and highly satisfied with their jobs, but less committed to their organization as compared to Malaysian nurses. The most significant factor that determined England nurses' job satisfaction was the pay level, which was higher than in Malaysia. However, one potential reason for lower levels of organizational commitment in England may be that nurses in England were facing downsizing, restructuring, and severe financial crisis. In these circumstances, nurses in England were in a state of job insecurity. Furthermore, the study results show a correlation between demographic characteristics (gender, age, education levels, work experience, work positions, and work status)

and empowerment, job satisfaction, and organizational commitment scores. The higher work position and more flexible employment system (option of working part-time) had more significance in accounting for job satisfaction among nurses in England than in Malaysia, though in Malaysia, nurses' age and level of education were more significant in accounting for empowerment.

Kretzschmer et al. (2017) conducted a study to test predictors of nursing empowerment and job satisfaction in nurses in the USA. The researchers surveyed 484 nurses but did not collect demographic information. Two instruments were used to measure Kanter's concept of empowerment: the CWEQ-II, and the Organizational Relationship Scale (ORS-11). In addition, the Revised Nursing Workforce Index (NWI-R) measured nurse autonomy, control over practice, and nurse-physician relationships. The result of this study showed that United Stated nurses perceive moderate empowerment in their current job on the two subscales of the CWEQ-II, moderate access to information, and average access to resources. Nurses who responded to the survey were satisfied with their job and happy to work in their current hospital until they retired. A correlation analysis between empowerment and workplace environment revealed a significant correlation among all variables. Higher levels of workplace empowerment positively correlated with perception of autonomy, control over practice, inter-professional collaboration, and organizational support/trust. Similarly, there was a positive relationship between higher levels of empowerment and nurses' job satisfaction. On the other hand, Lautizi et al. (2009) study found that Italian nurses did not perceive their work environment as structurally empowering. These nurses did not think their work was highly visible in the organization and felt they lacked prospects for professional growth, leading to feeling of being 'stuck.'

Han, Trinkoff, and Gurses (2015) conducted a study in Illinois and North Carolina (two states in the USA) to examine the relationship between work-related factors (autonomy, work schedule, supervisory, and peer support) and job satisfaction and job retention. The study used cross-sectional secondary data analysis of data from the Nurses Work-life and Health Study (NWHS). The study analyzed data from 1,641 nurses; the average age was 46.4 years and respondents were predominantly female (95%). The study assessed four elements of working conditions: job demands (physical and psychological), autonomy, support (supervisor and peer), and work schedule (long work hours, burden, overtime, and lack of breaks). The Job Content Questionnaire (JCQ) measured job demand and supervisor and peer support; the Nursing Work Index Revised (NWI-R) measured autonomy and work schedule measures included long work hours, burden, overtime and lack of breaks. Han et al.' s study found a relationship between working conditions (job demands, long work hours, mandatory overtime, lack of breaks) and job satisfaction. Nurses who were more dissatisfied and intended to leave their current job were more likely to experience higher psychological demands, lower autonomy, less supportive peers and supervisor, and work longer hours with fewer breaks. The study finding suggests that a supportive working climate could increase nurses' job satisfaction and retention.

Hayes, Douglas, and Bonner (2014) conducted a study and collected data from 417 nurses working in the hemodialysis unit and found nurses' perception of the work environment had a direct positive effect on job satisfaction. Higher levels of job satisfaction predicted lower job-related stress and indirectly reduced emotional exhaustion. These results show that stressful working conditions threaten the health and well-being of nurses. Thus, nursing leaders must find ways to lower nurses' job stress at work. Furthermore, it was shown that more empowered employees are more likely to empower their clients through more effective work practice and

providing better levels of care, which, in turn, produces better service system outcomes and societal health (Laschinger, Smith, Gilbert, & Leslie, 2010).

Studies report that leadership interventions promote positive healthcare work environments. When leaders as authentic, open, and truthful; create conditions that facilitate nurses' autonomy; provide coaching, constructive feedback, and involve staff in decision-making; nurses demonstrate increased job satisfaction, productivity, and performance (Wong & Laschinger, 2013). Wong and Laschinger (2013) conducted a cross-sectional study to test a model linking authentic leadership and empowerment to job satisfaction. A random sample of 280 nurses working in acute care hospitals across Ontario, Canada, participated in this study. Variables were measured using Authentic Leadership Questionnaire (ALQ), CWEQ-II, Global Satisfaction Survey, and General Performance Scale. The study demonstrated that authentic leadership was significantly related to job satisfaction and performance through its effects on empowerment. Additionally, results suggested that the more nurse managers are authentic, the more nurses perceive they have access to empowerment structures in the workplace and are satisfied and perform better in their jobs.

Chapter Summary

The literature review revealed extensive research on empowerment and its importance as experienced by employees. The literature that examined empowerment and job satisfaction found that, in general, nurses were moderately empowered, dissatisfied with their work environment, and planning to leave the current position. Nurses are leaving the profession due to high levels of job dissatisfaction arising from current working conditions such as heavy workload, burnout, lack of autonomy, and reduced advancement opportunities. The literature review shows that

empowered nurses that have higher job satisfaction, lower stress and burnout are more likely to provide quality care and empower patients and less likely to leave the profession.

Leader empowering behaviours such as sharing information, mentoring and career coaching, providing regular feedback on performance, and access to online internal and external information sources have a positive impact on job satisfaction. Other investigators have found that nurse staffing and the quality of the hospital work environment (managerial support, good doctor-nurse relations, as well as nurse's participation in decision making and organizational priorities on patient care) were significantly associated with improved patient outcomes and nurses' job satisfaction. The majority of studies reported here utilized a non-experimental, correlational, cross-sectional design and used the CWEQ-II scale, a reliable and valid tool to measure structural empowerment. To measure job satisfaction, the studies included in this review used various tools, including the Minnesota Satisfaction Questionnaires (MSQ), Hackman and Oldham's Job Diagnostic Survey (JDS), and Index of Job Satisfaction Scale.

Based on an exploration of previous scholarly research, there is an apparent gap in knowledge to understand the influence of structural empowerment and job satisfaction of nurses' post-organizational restructuring. There is a likelihood of more widespread restructuring and downsizing initiatives in healthcare sector in Canada. Therefore, the need for additional studies using more substantial and representative samples need to be undertaken to document the potential effects of these efforts on nursing staff. The result of this study will demonstrate the importance of enhancing empowering work environment for nurses, and the knowledge and evidence derived from this study may help drive our clinical practice, decisions, and changes in the direction of increasing nurses' job satisfaction.

Chapter 4: Methodology

Introduction

The purpose of this research was to explore the relationship between structural empowerment and job satisfaction of nurses post-organizational restructuring. In this chapter, detailed information was provided on the research design and method used to collect and analyze data; outline the sample size determination and setting for the study; and describe the data collection process and instruments used to measure study variables, along with the associated psychometric properties that support the validity and reliability of these measures.

Research Design

This study was conducted using a cross-sectional descriptive correlational design. Cross-sectional study results attempt to capture the complete understanding of what is currently happening, with no attempt to document changes over time, either in the past or the future (Wood & Ross-Kerr, 2006). This design was appropriate for this study as the aim was to understand the relationship between structural empowerment and job satisfaction at a single point in time – that is, post-organizational restructuring (Polit & Beck, 2014). The advantages of cross-sectional designs include being economical and easy to manage, the ability to collect data in a short amount of time at little expense, and the ability to obtain information from large populations (Meyer, Wheeler, Weinberger, Chen & Carpenter, 2014). The disadvantage of cross-sectional studies is that they are limited to a static 'snapshot' in time. Additionally, the description of a particular experience from some individuals in a population or group is not always transferable to other individuals in other situations. The major limitation associated with cross-sectional design is the inability to establish causality (Meyer et al., 2014).

The relationship between structural empowerment and job satisfaction was examined using a non-experimental design. The correlational study design allows for examination of the strength and direction of the relationship of two or more variables, and the tendency for variation in one variable (i.e. structural empowerment) related to the variation in another (i.e. job satisfaction), without necessarily determining cause and effect (Wood & Ross-Kerr, 2006).

An online survey methodology was used for this study, a method primarily used in correlational studies and to gather information from non-clinical populations. This methodology examines a specific population to obtain their actions, knowledge, intentions, opinions, and attitudes toward specific issues (Polit & Beck, 2014). Additionally, online surveys are the most cost-effective and efficient instrument available (Polit & Beck, 2014). In particular, the survey methodology is useful for collecting data about nurses as it provides flexibility for a group with highly variable scheduling and long work hours (Polit & Beck, 2014). Therefore, a survey method was selected to reach as many nurses as possible in the most efficient and cost-effective manner, to explore their attitudes towards workplace empowerment and job satisfaction.

Advantages and Disadvantages of Online Surveys

The advantages of the online survey include low cost by eliminating the need for paper, printing, postage, cost for recording equipment, travel, and transcription cost. Online surveys also allow a researcher to reach many people in a short amount of time and protect respondent anonymity. Online survey creation software packages provide varieties of templates to create and implement online surveys more easily, with visibly pleasing designs (addition of colour, graphics, and bold and font size), and easy follow-up due to the low expense of sending out emails to participants. The online survey methodology offers convenience to the researchers, as responses are automatically stored in a survey database, providing a hassle-free collection of data and

decreased potential for data entry errors (Morris, Fenton, & Mercer, 2004; Wright, 2017). According to Bowling (2009), a well-constructed questionnaire enables researchers to efficiently collect relatively unambiguous data, a feature of quantitative data analysis. Surveys allow respondents to answer questions on their own schedule, have flexibility with completion time, and do not require an interviewer. Given the subject manner and how nurses may feel their answers could influence their jobs, they may not wish to disclose their responses directly to another person. Additionally, an interviewer has the potential to influence responses depending on their own experiences, biases, and attitudes.

The primary disadvantage of the online survey methodology is the inability to capture complex, in-depth human behaviours and feelings. As such, survey research is not the most appropriate methodology for intensive analysis of human behaviour, but rather is better suited to analyze characteristics, attitudes, beliefs, preferences, and intentions of respondents (Polit & Beck, 2014). Online surveys generate somewhat lower data quality than face-to-face surveys (Heerwegh, 2009). The biggest challenge for an online survey is that invitations are easily ignored or deleted (when sent via email) without opening due to fear of a virus or malware, and respondents are held less accountable for responding (Morris et al., 2004). Respondents may share the survey with their friends and colleagues with similar interests or perspectives, which may lead to the over-representation of a particular viewpoint (Ball, 2019). If the survey questionnaire is long and confusing, the chances for participants just hitting buttons at random to finish the survey may increase (Maniaci & Rogge, 2014).

Sample Size

Determining sample size is necessary to evaluate the feasibility of the study. According to Polit and Beck (2014), large samples are ideal for research or statistical analysis because a small

sample runs a higher risk of leading a researcher to reject their research hypothesis erroneously. The larger a sample, the less risk of sampling error and the more likely the findings are representative of the population (Polit & Beck, 2014). In order to determine the correct sample size required identify a relationship between the study variables, the researcher consulted with a statistician to conduct a power analysis to determine the appropriate sample size for this study.

In consultation with a statistician, it was determined that an appropriate total number of participants would be 190. This sample size has 80% power to significantly detect the correlation of effect $f^2 > 0.10$, and total of 127 sample is enough to detect moderate effect of ($f^2 = 0.15$) using multiple linear regression with 12 predictors, two- tailed test and $\alpha = 0.05$, where ($f^2 = R^2 / 1\text{-}R^2$ and R^2 is the squared multiple correlation. The final anticipated sample size was 127.

Sample Population and Setting

The target population included nurses (registered nurses/ RNs and registered psychiatric nurses/RPNs) currently working part-time, full-time or casual positions who have been working in any one of the five acute care hospitals in Winnipeg (including Seven Oaks Hospital, Concordia Hospital, St Boniface General Hospital, Health Sciences Centre, and Grace Hospital). Convenience sampling was used to recruit nurses working on various wards/units at these hospitals. Conversely, the exclusion criteria were retired nurses, nurses who were on long-term absence due to illness or maternity leave (greater than six months in the year prior), licensed practical nurses (LPNs), and nurses who were working in a community setting, sub-acute care, and personal care homes. These criteria ensured that the sample selected was specific to currently employed registered nurses.

Data Collection

The researcher recruited nurse participants through the College of Registered Nurses of Manitoba (CRNM) and the College of Registered Psychiatric Nurses of Manitoba (CRPNM) third party mailing systems. After ethics approval was granted by the University of Manitoba, the researcher sent a letter to the Registrar of the CRPNM and to the Communication Manager of the CRNM to request access to the population, outlining the aim of the study, data collection procedures, copies of the surveys, and questionnaires used. A copy of the ethics approval certificate was also submitted as requested by CRPNM and CRNM. A total of 4000 RN's and 500 RPN's working in Winnipeg, Manitoba received recruitment emails from CRNM and CRPNM to inviting them to participate (Appendices D &E). The recruitment email contained an introductory letter explaining the purpose and importance of the study, the researcher's contact information, a consent form, and a brief biography of the researcher. Participants were asked to give informed consent by clicking on the accept button after the study information was provided, to assure that participants understood the implication of their participation in this study. If a potential participant chooses not to click on the informed consent accept button, he/she was not recruited to this study.

If potential participants met the inclusion criteria, they were sent a follow-up email inviting them to respond to an online questionnaire (Appendix F). A survey link was embedded within the email, which directed them to an independent website for data collection. To encourage nurses to participate in this study, the researcher sent a reminder email to participants 2 weeks after the invitation to complete the survey.

The researcher used Qualtrics (2017) software, an online survey tool, to design, collect, send, and analyze surveys online. This survey tool allows the researcher to post multiple surveys at the same time and the ability to export data directly to SPSS, PDF, Word, Excel, and

PowerPoint. Additionally, this survey software uses cloud-based technology so data can be collected quickly from a large number of respondents through a variety of channels, including websites and mobile to apps, email, and social media. This site uses security technology (Secure Sockets Layer (SSL)) for transmittance of data between participants and the database. Access to the survey link was available through any email browser with secure access. The survey was active for approximately 12 weeks of data collection. Nurses who complete the survey within the allotted time frame were included in this study. No paper surveys were collected.

Ethical Considerations

Ethical approval was received from the University of Manitoba's Fort Garry Campus Education/Nursing Research Ethics Board (ENREB). The general ethical principle is that participants should be unharmed as a result of participating in the research studies and give their informed consent to participate (Bowling, 2009). To protect against the risk of psychological discomfort, the researcher informed the participants that they did not have to answer any question(s) that made them uncomfortable. The researcher reiterated that all information was anonymous and that no repercussions would occur from participating in this study.

In order to assure anonymity, no identifying information (name, address, email address) was requested or collected. However, a separate link was provided to participants who requested study results, where they were instructed to provide their email address, solely for the purpose of receiving study results. Computerized data did not contain names or personal identifying information. The participants in this study were advised that participation was voluntary; they were free to withdraw from the study any time without consequences; completing the survey would take 20-30 minutes; and that the researcher would answer any questions they may have about the study. As well, the researcher informed all participants in writing that their privacy and

confidentiality were maintained throughout data collection, analysis, and reporting. Only the investigator, research assistant, and a statistician or consultant has access to collected survey data. Survey data were stored electronically on a password-protected University of Manitoba server, to which only members of the research team had access.

A common survey link was provided to all participants to complete the online survey. The link to the survey used a separate uniform resource locator (URL), which was not linked to the participant's email address or Internet Protocol (IP) address. Qualtrics automatically assigned randomly generated participate IDs to any completed surveys, a process that maintains participant anonymity. All information collected through the software Qualtrics (2017) requires password access to retrieve any data. Placing the survey on a secure server and requiring passwords assured the respondents that the information they were providing was not intercepted and that their responses were kept confidential (Morris et al., 2004). We will destroy all data after 3 years from the date of completion of the survey. The principal investigator has completed the education requirements for human subjects' protection (Tri-Council Policy Statement (TCPS-2)). There were no known harmful risks involved in participating in the study and no experimental groups**.** There is no direct benefit to nurses, but potential indirect benefits of participants in this study may include a better understanding of, and new strategies to improve, nurse empowerment and job satisfaction. Study findings may also provide nurse leaders with strategies to increase structural empowerment for nurses.

Data Collection Instruments

Three instruments were used for data collection: (1) the Condition of Work Effectiveness Questionnaire-II (CWEQ-II) (Laschinger, Finegan, Shamian, & Wilk, 2001); (2) the Mueller and McCloskey Satisfaction Scale (MMSS) (Lee, Dahinten, & Macphee, 2016); and (3) a

demographic information questionnaire. Previous studies of nurse empowerment have used the CWEQ-II and MMSS, which are standardized questionnaires previously used in nursing populations (Laschinger et al., 2001; Laschinger et al., 2004; Lee at al., 2016; Mueller & McCloskey, 1990; Price, 2002; Wilson, Squires, Widger, Cranley, & Tourangeau, 2008).

Condition of Work Effectiveness Questionnaire-11 (CWEQ-II)

Laschinger et al. (2001) developed the CWEQ-11 based on Kanter's work (1993) and examined Kanter's empowerment dimensions. The CWEQ-II consists of 19 items, split into subscales, which represent the six empowerment structures described by Kanter (1993): opportunity, information, support, resources, and formal and informal power. A Likert scale format asks the participant to respond to a question on a scale of varying degrees of intensity between two extremes and the points between the two extremes (Polit & Beck, 2014). Responses to each item, which include phrases such as "how much access to (empowerment structure) do you have in your current job?" are rated on a five-point Likert scale, which ranges from 'none' (1) to 'a lot' (5). The mean score was calculated for each subscale by adding the total of items in that subscale divided by the total number of items in the subscale. Higher (closer to 5) mean subscale scores indicated higher levels of perceived access to opportunity, information, support, resources, and formal and informal power, and vice versa. The overall empowerment score was calculated by summing all the item scores for all six subscales of the CWEQ-II (score range 6-30). Scores ranging from 6 to 13 represent low levels of empowerment; scores from 14 to 22 denote moderate levels of empowerment; and scores from 23 to 30 indicate high levels of empowerment.

Laschinger et al. (2001) examined the construct validity of the CWEQ-II in a sample of nurses through confirmatory factor analysis, which revealed a good fit of the hypothesized factor

structure. These authors also reported that the CWEQ-II was correlated with the global measure of empowerment (r=0.56), providing evidence of construct validity. Cronbach's alpha is the most commonly used test of internal consistency and used when a measurement instrument employs a Likert scale (Polit & Beck, 2014). Cronbach's alpha produces an estimate of measure reliability based on the average of all possible correlations between all the items within the scale, expressed as a number between 0 and 1. An instrument has adequate reliability if the internal consistency coefficient of 0.80 or higher (Polit & Beck, 2014). Previous studies with staff nurses using the CWEQ-II have reported that the Cronbach's alpha for reliability for the different components of structural empowerment ranged from 0.68 to 0.93 (Hauck et al., 2011; Laschinger, Almost, & Tues-Hodes, 2003; Laschinger et al., 2004). As well, a panel of experts on Kanter's theory has established face and content validity for the CWEQ-II (Laschinger et al., 2001).

Mueller and McCloskey Satisfaction Scale (MMSS)

Job satisfaction was measured using the Mueller and McCloskey Satisfaction Scale (MMSS). The MMSS was developed in 1990 in the American nursing context and is a commonly used instrument in nursing research for measuring job satisfaction. The MMSS (1990) is an eight-factor, 31-item scale, wherein respondents indicate how satisfied or dissatisfied they are with regards to eight work factors: extrinsic rewards, scheduling, family/work balance, co-workers, interactions, professional opportunities, praise/recognition, and control/responsibility for their work. The response format is also a 5-point Likert scale, ranging from 'very dissatisfied' (1) to 'very satisfied' (5). The MMSS has an adequate internal consistency coefficient and Cronbach's alpha for each of the eight subscales range from 0.52 to 0.84 (Mueller & McCloskey, 1990). However, three of the MMSS subscales show a weak internal consistency reliability coefficient (Mueller & McCloskey, 1990; Tourangeau, Hall, Doran, & Petch, 2006). There is limited

evidence of psychometric properties of the MMSS reported since its original development in 1990, and some researchers have questioned the psychometric validity and utility of the MMSS for the use with non-American nurse populations – they have concluded that there is a need for further psychometric testing and refinement of the MMSS (Abu Ajamieh, Misener, Haddock, & Cleaton, 1996; Price, 2002; Tourangeau et al., 2006)

Concerns about the psychometric properties of the MMSS led Lee et al. (2016) to conduct a factor analysis study with Canadian nurses, after which they developed the MMSS 25-item scale. The subsequent use of an exploratory principal component analysis yielded five essential factors. Factors were named (1) "satisfaction with work culture and conditions," (2) "scheduling and family/work balance," (3) collegial relationships," (4) "extrinsic rewards," and (5) "professional opportunities." As a result, the updated MMSS contains 25 of the original 31 items, with the number of items per factor ranging from three to eight. The five factors capture the critical domains of nurse job satisfaction, and the structure is conceptually congruent with the original MMSS (1990). The five-factor model also showed excellent reliability and higher internal consistency than the original MMSS (1990). The test-retest reliability and factorial, criterion-related, and construct validity were all reported to be satisfactory (Lee et al., 2016). The Cronbach's alphas for the five updated MMSS subscales ranged from 0.71 to 0.87, which indicates stronger internal consistency than the original subscale (a = 0.52 to 0.84). Mueller and McCloskey (1990) reported that only four of the eight subscales (those with more than four items) had Cronbach's alphas higher than 0.70. However, Lee et al. (2016) reported that the alphas of all five newly derived subscales were higher than 0.70, regardless of the number of the items in each subscale. The new five-factor 25-items exhibit better reliability than the original MMSS; therefore, this study used the five-factor 25-item scale MMSS (Lee et al., 2016).

Demographic Questionnaire

Participants were asked to complete an 11-item demographic questionnaire, used to describe the sample and collect information relating to any potential confounding variables that may have an impact on the study variables. Demographic variables collected included: place of employment, race, age, sex, education, years of nursing experience, length of shifts worked, shift of the work (days, evenings or nights), number of overtime hours per week, employment status, primary unit of employment, number of years on the nursing unit, job role, work status, and number of hours worked per week, in order to allow comparison and contrast with previous literature on structural empowerment and job satisfaction (Ahmad & Oranye, 2010; Han et al., 2015; Hauck et al., 2011).

Data Analysis Procedures

The Statistical Package for the Social Science (SPSS) for Windows standard version 25.0 (IBM, 2017) was used for data management and statistical analysis. A statistician was consulted for further data analysis. All response items were coded and entered into a database. The descriptive statistical methodology was used to measure mean, median, standard deviation (SD), ranges, frequencies, percentages, for the dependent variable 'total job satisfaction scores', the independent variables, empowerment sub-scale mean scores', and total empowerment scores', and demographic variables, each statistic was calculated based on type and distribution of variables. Demographic characteristics were examined using bivariate analysis. Nominal scale demographic variables were grouped, and bivariate analysis was conducted to test for significant differences between groups. Multiple linear regression analyses were conducted to test the effect of confounding variables (demographic variables and empowerment) on the dependent variable (job satisfaction).

The bivariate parametric or non-parametric analyses such as correlation statistics, independent t-test and one-way analysis of variance (ANOVA) test were conducted based on type of independent variables and distribution of dependent variable. These statistics were used to test for significant relationships between each independent variable (empowerment total, empowerment sub-scale, and demographic) with the dependent variable, job satisfaction total score.

To investigate the first hypothesis – that a positive relationship exists between structural empowerment and job satisfaction, Pearson product – moment coefficients were computed. The Pearson product – moment correlation (r) is used to determine the strength and direction of a linear relationship between two continues variables (Moore, 2000). The Pearson correlation (r) can range from -1 to +1 (these values both showing a perfect negative and a perfect positive relationship). A Pearson r value equal to zero indicate no relationship. The Pearson correlation coefficient indicates the strength of relationship where $r < 0.3$ represent a weak correlation; $r < 0.5$ represents moderate correlation; $r > 0.5$ represents strong correlation. The statistical significance (Sig 2-tailed) indicates the significance value of the Pearson's correlation coefficient between CWEQ-ll and MMSS.

The significance level ($\alpha < 0.05$) is the probability of rejecting the null hypothesis when it is, in fact, true (Polit & Beck, 2014). For this study, significance level was based on a p-value of less than 0.05, and the range of likely values of point estimate of statistic calculated by 95% Confidence Intervals (95% CI). The estimated statistic within the range of 95% CI was considered significant.

Multiple regression analysis was used to ascertain what variables contribute to the explanation of the dependent variable and to what degree (Denis, 2018) - in this case to detect

the effect of the independent demographic characteristic variables and structural empowerment on the dependent variable of job satisfaction. The purpose of using multiple regression is to be able to ascertain more about the relationship between several predictor variables (Denis 2018). In order to perform a linear and multiple regression analysis, there are several assumptions that must be met: autocorrelation assumption, a linear relationship between the predictor variables and the dependent variable, homoscedasticity of residuals (equal error variances), no multicollinearity, and errors (residuals) being normally distributed (Munro, 2004).

There are different types of multiple regression techniques (Denis, 2018). For this study stepwise multiple regression was the method of choice. Multi-collinearity between the independent variables in the model was tested using variance inflation faction (VIF < 5.00 is good). The scatterplot of the residual was plotted to check the normality distribution of predicted outcome. Correlational statistics were used to measure the construct validity of current measurement of empowerment structure.

Limitations

The results of this study are limited to describing the phenomena of interest related to the cross-sectional correlational design. As a cross-sectional study, this research explores the relationship between structural empowerment and job satisfaction only at one point in time, and thus does not reflect improvements or worsening of these variables over time, which may be an important consideration in improving the nursing work environment. The study's results will only be able to show the correlation between variables, not the actual cause of the outcome variable (job satisfaction). As other factors beyond the empowerment structures examined may have an impact on job satisfaction, there will be limited potential to make recommendations for changes to work environments in order to improve job satisfaction.

Additionally, this study uses self-report instruments to collect data, which are at risk of response bias (Polit & Beck, 2014). A convenience sample, rather than random sampling, may result in selection bias, and those who select to participate in the study may be different from those who chose not to participate. The convenience population is often geographically concentrated, so this population is rarely representative of the general population. Furthermore, the results of the study may not be generalizable to a larger population due to the convenience sample survey (Polit & Beck, 2014). Using a convenience sample of participants working in Winnipeg may exclude some populations, and the available participants might be somewhat atypical of the population of interest. There are many potential factors that may limit the applicability of the findings of this study. Nonetheless, understanding the relationship between empowerment and job satisfaction for nurses in Manitoba's changing healthcare landscape is critical to understanding how improvements can be made to ensure employee retention and patient safety.

Chapter Summary

This chapter included a discussion of the appropriateness of the cross-sectional correlational design to answer a research question, which seeks to explore the relationship between structural empowerment and job satisfaction amongst nurses working in acute care hospitals in Winnipeg. The data collection instruments, as well as their reliability and validity, were discussed, and include the CWEQ-ll and updated 25-item MMSS. A demographic questionnaire further described the attributes of this population and allowed analysis of potentially confounding variables. The procedures used to collect and analyse the data were detailed. A discussion of the ethical consideration to safeguard the rights and welfare of the study participants are explored, and a discussion of potential limitations concluded the chapter.

Chapter 5: Results

Introduction

The purpose of this descriptive correlational study was to identify the relationship between structural empowerment and job satisfaction of nurses working in five acute care hospitals in Winnipeg, post-organizational restructuring. The research hypothesis for this study was that structural empowerment is positively related to nurse's job satisfaction. This chapter presents the statistical procedures used, the descriptive statistics, bivariate correlation analysis and multiple regression analysis, (using SPSS v27), and findings from this study, demonstrating support for the research hypothesis. Pearson correlation and multiple regression analyses were used to answer the research question: What is the relationship between structural empowerment and job satisfaction of nurses working in acute care organizations post-organizational restructuring?

Research Hypotheses

1. Overall structural empowerment (CWEQ-ll total score) is positively correlated to job satisfaction (MMSS) of nurses working in acute care organizations in Winnipeg, Manitoba.
2. Each sub-scale of structural empowerment (CWEQ-ll subscale) is positively related to job satisfaction (MMSS) of nurses working in acute care organizations in Winnipeg, Manitoba.
3. The overall score of structural empowerment (CWEQ-ll total score) and each sub-scale of empowerment will be positively related to job satisfaction (MMSS) after controlling for demographic factors.
4. The construct validity of the current measure of structural empowerment (CWEQ-ll) using six sub-scales will be high.

Data Collection

Results were examined through statistical descriptive analysis, correlations, and multiple regression analysis. Data were collected over a 3-month period, longer in duration than anticipated in part due to the Covid-19 pandemic. The number of participants necessary to reach power analysis (80% power at alpha = $\leq$ 0.05) was obtained with respect to number of respondents required for the study, some of the participants did not answer all of the questions. The initial survey resulted in 192 participants responding, but only 92 respondents completed the full questionnaire. The second reminder email resulted in an additional 105 responses. Of the total 297 respondents, 200 completed the full questionnaire, but six did not completed the Mueller and McCloskey Satisfaction Scale (MMSS). However, only a sample of 127 was required to detect a moderate effect size (Cohen, 1988). Therefore, the final sample size of 177 after the missing values for some items was sufficient to detect a moderate effect size. The total sample obtained for this study was 200 yielding a response rate of less than 1%. According to Sheehan (2001), the estimated response rate for on-line surveys is approximately 30 percent

Structural Empowerment and Job Satisfaction Scales

The mean and standard deviations for all scales and subscales used in the study were calculated and summarized in Table 1.

Condition of Work Effectiveness Questionnaire (CWEQ-II)

The mean total empowerment score for respondents in this study was 18.4 (SD = 3.19). On a Likert scale of 1 (none) to 5 (a lot), participants indicated a mean access to opportunity of 4.1 (SD = 0.74), the highest rated subscale item. Access to support was rated with a mean of 2.8 (SD = 0.93), access to resources with a mean of 2.8 (SD = 0.74), access to information was rated with a mean of 2.7 (SD = 0.90). Access to formal power was rated lowest, with a mean of 2.4 (SD =

0.84), and access of informal power was rated with a mean of 3.6 (SD = 0.72). The Cronbach's alpha (Cronbach, 1951) for the combined six subscales of the CWEQ -ll was 0.85 (Table 1).

CWEQ-ll: Subscale 1, Access to Opportunity

The first subscale (Table 1) asked "how much of each kind of opportunity do you have in your present job?" with a mean score for this subscale of 4.1 out of 5, suggested that respondents had greatest access to opportunities in their present job (Table 1). Two (1.5%) participants provided a rating of 1 (none) for access to the "chance to gain new skills and knowledge on the job" opportunity, and two rated their access to the "chance to use all of their own skills and knowledge" as 1 (none).

CWEQ-ll: Subscale 2, Access to Information

The second subscale (Table 1) asked "how much access to information do you have in your present job?" with a mean score of 2.7 out of 5, indicating moderate access to information in their present job (Table 1). Six respondents (6%) provided a rating of 1 (none) for access to the "access to the current state of the hospital"; 32 respondents (16%) provided a rating of 1 (none) for access to "the values of top management"; and 47 respondents (23%) provided a rating 1 (none) for the goals of the top management".

CWEQ-ll: Subscale 3, Access to Support

The third subscale asked, "how much access to support do you have in your present job?" with a mean score of 2.8 out of 5, indicating moderate access to support (Table 1). A total of 30 respondents (15%) provided a rating of 1 (none) for access to "specific information about things (they) do well"; 29 (14.6%) provided a rating of 1(none) for access to "specific comments about things (they) could improve"; and 20 respondents (10%) provided a rating of 1(none) for access to "helpful hints or problem-solving advice".

CWEQ-ll: Subscale 4, Access to Resources

The fourth subscale (Table 1) asked "how much access to resources do you have in your present job?" with an overall rating of 2.8 out of 5, indicating moderate access to resources (Table 2). Ten participants (5%) provided a rating of 1 (none) for access to "time available for to do necessary paperwork"; 7 participants (3.5%) provided a rating of 1(none) for access to "time available to accomplish job requirements"; and 37 participants (18.5%) provided a rating of 1 (none) for access to "acquiring temporary help when needed".

CWEQ-ll: Subscale 5, Formal Power (Job Activity Scale)

The fifth subscale asked participants to describe "how much formal power they receive in their job", by rating job activities in their work setting/job. This subscale was rated the lowest with a mean score of 2.4 out of 5, indicating little to some access to formal power in their job (Table 1). Sixty-six respondents (33%) indicated they received "none" (rating of 1) for "reward for innovation on the job"; 32 participants (16%) indicated they received "some" (rating of 3) "amount of flexibility in their job"; and 50 participants (25%) indicated there was "some" (rating of 3) "amount of flexibility of their work-related activities within the institution."

CWEQ-ll: Subscale 6, Informal Power (Organizational Relationship Scale)

The sixth subscale measured informal power by asking participants "how much opportunity do you have for these activities in your present job?". Overall, the mean score for this subscale is 3.6 out of 5.00 suggesting respondents have some to a lot of access to informal power (Table 1). The majority of respondents indicated that they collaborate "a lot" (rating of 5) in "collaborating on patient care with physicians" and "being sought out a lot by peers for information". Five respondents (2.5%) provided a rating of (none) for "collaborating on patient care with physicians"; 1 respondent (.5%) provided a rating of 1 (none) for "being sought out by peers for

help with problems"; and 37 respondents (18.5%) provided a rating of 1 (none) for "being sought out by managers for help with problems"; and 3 respondents (1.5%) provided a rating of 1 (none) for "seeking out ideas from professionals other than physicians."

Job Satisfaction, the McCloskey/Mueller Satisfaction Scale (MMSS)

Job satisfaction scores were measured using the MMSS, with 25-items rated on a five -point Likert scale ranging from 1 (very dissatisfied) to 5 (very satisfied). The MMSS provides separate scores for five subscales that include work culture and conditions, scheduling and family/work balance, collegial relationship, extrinsic rewards, and professional opportunities. Mean scores were highest for satisfaction with collegial relationships (M = 3.63, SD = 0.68), followed by satisfaction with scheduling and family work balance (M = 3.50, SD = 0.78), extrinsic reward (M = 2.91, SD = 0.94), work culture and condition (M = 2.82, SD = 0.79), and professional opportunities (M = 2.79, SD = 0.75). The Cronbach's alpha for the five subscales of the MMSS was 0.87 (Table 1).

Table 1: Observed means, standard deviation (SD), of instrument scales and subscales used in the study

Scale	Subscale	Mean	SD	n	Alpha Coefficients
CWEQ-ll	Total	18.4	3.19	187	0.85
	Opportunity	4.1	0.74	199	
	Information	2.7	0.90	198	
	Support	2.8	0.93	199	
	Resources	2.8	0.74	198	
	Formal power (JAS)	2.4	0.84	199	
	Informal power (ORS)	3.6	0.72	194	
MMSS	Total	15.3	2.7	183	0.87
	Work culture and conditions	2.8	0.79	193	
	Scheduling and family work balance	3.2	0.78	186	

	Collegial relationships	3.6	0.68	192	
	Extrinsic rewards	2.9	0.94	193	
	Professional opportunities	2.8	0.75	192	

Demographic Characteristics

Demographic information was collected on age, gender, years nursing, current position, length of employment, employment status, education, number of mandatory overtime shift in a month, intent to leave the current position, and intent to leave the nursing profession. The percentage of missing data ranged from 3.5% to 29.5% for the demographic data; actual percentages are reported. The demographic summary for the sample is presented in Table 2.

Of 192 respondents who indicated their sex, the majority of the respondents (92.7%) were females and (6.7%) were males. Of 190 respondents who indicated their age, ages ranged from 23 to 74 years, and the mean age was 40 years (SD = 12.0). Of 193 respondents who indicated their employment status, the majority of nurses were part-time employees (53.4%), 39.4% were full-time employees, and 7.3% were casual employees. Of the 193 respondents who indicated their type and level of education, 28% were Registered Nurses (RNs), 60% had a Bachelor of Nursing degree (BN), 3.6% were Registered Psychiatric Nurses (RPNs), and 2.1% had a Bachelor of Science degree in Psychiatric Nursing (BSc PNs). The remaining 6.2% were at a graduate level.

Of 192 respondents 39.1% indicated they intend to leave and 61% of nurses reports no intention to leave their current position in the next year. Participants provided 10 comments identifying the reasons why they intended to leave their job. Six themes were identified from the

responses provided, including “moving to other province”; “continue education”; “changing position/unit”; “poor working condition”; “retire”; and “flexible work schedule”.

Respondents’ nursing experience ranged from 2 months to 45 years (mean of 18 years of experience). In this study, 29 respondents reported they did one mandatory overtime shift in a month (20%), 25 did two shifts (18%) 11 did three shifts (8%), four did four shifts (3%), and 15 respondents (10%) reported more than four mandatory overtime shifts in a month (Table 2).

Table 2: Demographic characteristics of Winnipeg nurses surveyed

Demographic Characteristics of the sample (n = 193)	Frequency	Percent%
sex		
Male	13	6.7
Female	179	92.7
Age		
20 to 30 years	46	24.0
31 to 40 years	65	34.0
Greater than 40 years	79	42.0
Employment status (n =193)		
Full-time	76	39.3
Part-time	103	53.4
Casual	14	7.3
Level of Education		
RN	54	28.0
BN	116	60.0
RPN	7	3.6
BSC PN	4	2.1
Graduate	12	6.2
Marital Status (n =192)		
Married/partnered	130	68.0
Single/widowed/divorced	62	32.0
Years of Practicing as a nurse		
Less than one year	10	5.0
1 to 5 years	40	21.0
5 to 10 years	43	22.0
Greater than 10 years	100	52.0
Years of employment in current hospital		
Less than one year	12	6.5
1 to 5 years	56	29.0
5 to 10 years	45	23.0

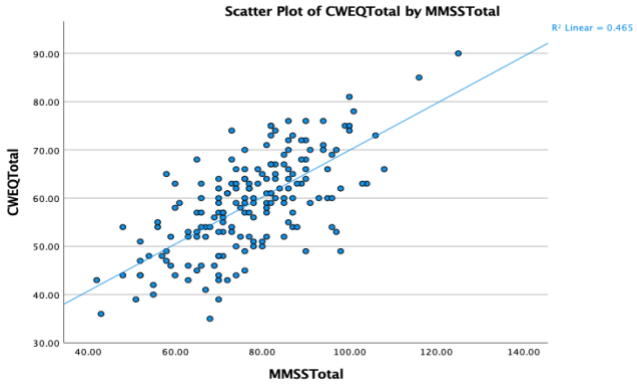
Greater than 10 years	80	41.5
Number of mandatory over-times (n =141)		
None	57	40.0
One shift	29	21.0
Two shifts	25	18.0
Three shifts	11	8.0
Four shifts	4	3.0
More than four shifts	15	10.0
Intend to leave the current position (n = 192)		
Yes	75	39.0
No	117	61.0
Intend to leave the nursing profession (n= 191)		
Yes	25	13.0
No	166	87.0

Relationship between Overall structural empowerment (CWEQ-ll total score) and job satisfaction (MMSS)

Positive relationship existed between structural empowerment and job satisfaction, Pearson product-moment coefficients of correlation were computed because both scores are normally distributed. Preliminary analyses indicated a statistically significant strong positive correlation between structural empowerment and job satisfaction ($r = 0.68$; $p < 0.001$; $n = 177$) indicating that structural empowerment increases as job satisfaction increases. In addition, scatter plot shows a strong linear relationship (the points are close to a straight line) (Figure 1).

A strong positive relationship between CWEQ-ll and MMSS

Figure 1: Scatter plot diagram



Relationship between each subscale of structural empowerment (CWEQ-ll subscale) and job satisfaction (MMSS)

Positive relationship existed between each of the subscales of the CWEQ-ll (i.e. structural empowerment) and job satisfaction, Pearson product-moment coefficients were computed because all subscales are normally distributed, which demonstrated a significant positive correlation between each of the six subscales of the CWEQ-ll and the MMSS (Table 3).

Sig (2-tailed) levels of α for all six subscales were less than ≤ 0.05, indicating a statistically significant correlation between all the subscales of structural empowerment (CWEQ-ll) and job satisfaction (MMSS). With respect to the structural empowerment structures, the measurement of overall job satisfaction was strongly positively related to most strongly to the Job Activities Scale ($r = 0.65$, $p \leq 0.001$), followed by access to support ($r = 0.54$, $p \leq 0.001$). However, the correlation of access to opportunity was weakly positively correlated with job satisfaction ($r = 0.23$; $p \leq 0.002$).

Table 3: Correlation Coefficient Analysis of the six subscales of the Condition of Work Effectiveness Questionnaire (CWEQ-ll) and McCloskey/Mueller Satisfaction Scale (MMSS).

	Pearson Correlation Coefficient (r)	p-value (2-tailed) α=0.05	Sample size (n)
CWEQ-II Access to Opportunity	0.23	0.002	183
CWEQ-II Access to Information	0.31	0.000	181
CWEQ-II Access to Support	0.54	0.000	182

CWEQ-II Access to Resources	0.47	0.000	181
CWEQ-II Formal Power (Job Activities Scale)	0.65	0.000	182
CWEQ-II Informal Power (Organizational Relationship Scale)	0.46	0.000	182

Covariate adjusted relationship between the overall score of structural empowerment (CWEQ-ll total score) and each subscale with job satisfaction (MMSS).

Multiple linear regression model with stepwise procedure were applied to find out the significant predictors of job satisfaction. Seven models were developed to predict the covariate adjusted relationships. The first model was used to predict the relationship of overall score of structural empowerment on job satisfaction. The second model was used to predict opportunity and years of practice as a nurse on job satisfaction, third model was used to predict information and years of employment on job satisfaction; the forth model was used to predict support, years of practice as nurse, and number of mandatory overtime shifts on job satisfaction; the fifth model was used to predict resources and respondents age on job satisfaction; sixth model was used to predict formal power (JAS) and respondents age on job satisfaction; and seventh model was used to predict informal power (ORS) and nurses years of employment on job satisfaction.

Stepwise Multiple Linear Regression Model of satisfaction

Stepwise multiple linear regression was used for all insignificant variables with $p >= 0.05$ were sequentially deleted and only significant variables were kept in the final model. In order to perform a linear and multiple regression analysis, there are several assumptions that must be met: a linear relationship between the predictor variables and the dependent variable, homoscedasticity of residuals (equal error variances), no multicollinearity, and errors (residuals) being normally distributed (Munro, 2004).

A linear relationship between independent and dependent variables were assessed by visual inspection of the scatterplot (Figure 1), the residuals appear randomly scattered and their spread was not increased or decreased across the predicted values, indicating homoscedasticity (Appendix H, Figure 2). As well, to establish that a linear relationship exists between the dependent variable, the partial regression plots were produced. A histogram of MMSS residuals shows an approximately normal distribution of values, and a Q-Q plot of expected normal and observed MMSS values shows points not perfectly aligned, but close enough to normal for continued analysis (Appendix – G**,** Figure 4). In order to detect outliers, a Casewise Diagnostics table examined the residuals are greater than +/-3 Standard Deviation (SD). The studentized deleted residual (SDR_1) scores were within +3 and -3. Leverage points were created (LEV_1) to determine whether any cases exhibit high leverage. All the scores in LEV_1 were below 0.2. Cooks Distance (COO_1) measured to check any cases that were influential COO_1 value above 1 need to investigate) and there were no values above 1 (Cook & Weisberg, 1982) **(**Appendix H, Table 4**).**

Stepwise Multiple Linear Regression Model of Job satisfaction

CWEQ-ll subscales of access to opportunity, information, support, resources, formal power (JAS), informal power (ORS), age, years of practicing as a nurse, and years of employment were significantly and positively correlated to job satisfaction. Mandatory overtime was significantly negatively correlated to job satisfaction. The results of the regression indicated the five predictors explained the above 35% of the variance. Table 5 shows the finals model results.

Table 5: Stepwise regression models summary statistics

	B	95% CI for LL	UL	R^2	Sig.
Model 1 a Constant	20.99	11.87	30.12		
b CWEQ-ll Total	0.96	0.80	1.11	0.47	0.000
Model 2 a Constant	51.43	37.82	65.05		
b CWEQ-ll Opportunity	1.69	0.64	2.74		
Years of practicing as a nurse	0.32	0.12	0.53	0.13	0.000
Model 3 a Constant	59.35	51.57	67.14		
b CWEQ-ll Information	1.67	0.84	2.51		
Years of employment	0.31	0.09	0.53	0.15	0.000
Model 4 a Constant	48.59	41.96	55.21		
b CWEQ-ll Support	3.13	2.41	3.85		
Years of practicing as a nurse	0.24	0.06	0.41		
Mandatory over time	-0.69	-1.22	-0.16	0.42	0.000
Model 5 a Constant	39.58	27.61	51.56		
b CWEQ-ll Resources	2.90	1.92	3.86		
Age	0.31	0.12	0.51	0.25	0.000
Model 6 a Constant	41.04	32.76	49.32		
b CWEQ-ll JAS	3.81	3.08	4.54		
Age	0.21	0.05	0.37	0.48	0.000
Model 7 a Constant	38.34	27.71	48.97		
b CWEQ-ll ORS	2.48	1.76	3.20		
Years of employment	0.21	0.01	0.41	0.30	0.000

Note. a= model with constant only; b=final model with significant covariate/s; B = regression coefficient; CI = confidence interval; LL = lower limit; UL = upper limit; R^2 = Coefficient of determination.

The result of the first regression analysis indicated that overall CWEQ-ll score predicted 47% of the variance in job satisfaction ($R^2 = 0.47$, $F = 152.22$, $B = 0.96$, $P < 0.001$). The second

regression was performed to determine the contribution of each subscale of structural empowerment and demographic variables effect on job satisfaction. The final model of this regression indicated that CWEQ-ll access to opportunity and years of practice as nurse predicted 13% of the variance of job satisfaction ($R^2 = 0.13$, F = 9.149, B = 0.32, P < 0.001). The third regression was performed to examine the contribution of CWEQ-ll access to information and demographic variables on job satisfaction. The final model of this regression indicated access to information and years of employment predicted 15% variance of job satisfaction ($R^2 = 0.15$, F = 11.211, B = 0.31, P < 0.001). The fourth regression was performed to examine the contribution of access to CWEQ-ll support and demographic variables on job satisfaction, which indicated that access to support, years of employment, and mandatory overtime shifts predicted 42% of variance in job satisfaction ($R^2 = 0.42$, F = 29.830, B = -0.69, *P* < 0.001). In this model the Beta value for mandatory overtime was -0.69, (95% CI lower bond -1.22 and upper bond -0.16). The slop coefficient (B) represented the change in the dependent variable for one-unit change in the independent variable; that is an increase in mandatory overtime of one day shift was associated with a decrease in job satisfaction of 0.69 unit.

The fifth regression was performed to examine CWEQ-ll access to resources and demographic variable on job satisfaction. The final model of this regression indicated CWEQ-ll access to resources and age predicted 25% of variance in job satisfaction ($R^2 = 0.25$, F =21.102, B = 0.31, *P* < 0.001) which indicate resource and age partially predicted job satisfaction. The sixth regression was done to examine the contribution of formal power (JAS) and age on job satisfaction, with the final model indicating these contribute to 48% of the variance in job satisfaction (R^2 =0.48, F = 58.104, B = 0.21, P < 0.001). The seventh regression was conducted to examine the formal power (ORS) and demographic variables on job satisfaction, and the final

model indicated ORS and years of employment predicted 30% of variance in job satisfaction (R^2 = 0.30, F =27.281, B = 0.21, P < 0.001).

Based on the regression coefficient beta values and statistical significance there are ten variables significantly contributing to job satisfaction: age, years of practicing as a nurse, years of employment, mandatory overtime, and six CWEQ -ll subscales (access to opportunity, information, support, and resources, as well as formal and informal power) (Table 5). The interpretation of the regression coefficient beta values for each independent variable signified an increase in empowerment for each one unit increase in the value of job satisfaction. However, for each unit increase in mandatory overtime shifts per month there was a decrease job satisfaction. The demographic variables marital status, education, in which hospital currently employed, and occupational status were not statistically significant and were excluded from the final model.

Summary

These results show a significant positive relationship between overall score of structural empowerment and job satisfaction confirming the first hypothesis. There was a significant positive correlation between all six subscales of structural empowerment and job satisfaction confirming the second hypothesis. Multiple regression analysis to control for demographic factors showed all six CWEQ-ll subscales, age, years of practicing as a nurse, years of employment, and mandatory overtime shifts per month were all significantly correlated to job satisfaction (MMSS); with the exception of overtime shifts per month, which showed a negative correlation, all these independent variables were positively correlated with job satisfaction.

Chapter 6: Discussion

Introduction

This chapter includes a discussion of the results of the study relative to the research question and the proposed hypotheses, strengths and limitations of the study, implications for nursing practice, and recommendations for future research.

The results from this study begin to fill gaps in the literature regarding the relationship between structural empowerment and job satisfaction, in the specific context of nurses in western Canadian city, post-organizational restructuring. Overall, total structural empowerment (CWEQ-II total score), as well as the six subscales of empowerment (access to opportunity, information, support, resources, formal power, and informal power), age, years of experience, years of employment, and mandatory overtime shifts were all important predictors of job satisfaction.

Condition of Work Effectiveness Questionnaire-II (CWEQ-II)

Consistent with previous research in this study, participants reported that they were moderately empowered (Ahamed & Oranye, 2010; Bawafaa, Wong, & Laschinger, 2015; Kretzschmer et al., 2017; Purdy et al., 2010; Smith et al., 2010; Smith et al., 2012). Of the six subscales of structural empowerment, respondents in this study were most empowered in their access to opportunity, and moderately empowered in terms of informal power. Participants in this study reported low levels of empowerment in access to information, support, and resources, and were least empowered in their formal power.

The participants reported a relatively high degree of access to opportunity in their job (a rating of 4.1 out of 5) (Ahmad & Oranye, 2010; Bawafaa et al., 2025), suggesting that respondents had opportunities in their present job, which is a key factor in job satisfaction and productivity (Kanter, 1977,1993). However, there were a couple of respondents who reported no

access to gaining and using skills and knowledge on the job. In terms of access to information, this factor was rated lower than opportunity among respondents in the study (rating of 2.7 out of 5), six respondents (6%) provided a rating of 1 (none) for "access to the current state of the hospital"; 32 respondents (16%) provided a rating of 1 (none) for access to "the values of top management"; and 47 respondents (23%) provided a rating 1 (none) for the goals of the top management". This suggests there is room for improvement in communication of values and goals of organization to frontline employees post-restructuring in the study hospitals. Access to support and resources were rated slightly higher (at 2.8 out of 5), but still about 15% of respondents indicated they received no access to specific information about things they do well or comments about things they could improve. Ten percent received no helpful hints or problem-solving advice in their job. A small number of respondents indicated a lack of time for doing necessary paperwork and accomplishing job requirements, but 18.5% reported not having access to temporary help when needed (Ning et al., 2009).

Respondents in this study rated their formal power as 2.4 out of 5. Feelings of limited reward for innovations may be related to data from the third CWEQ-II subscale (access to support) where participants indicated moderate access to support involving receiving feedback and guidance from others. However, the results indicate there is at least some amount of flexibility and visibility of nurses' work within the study hospitals. Respondents in this study had better access to informal power (rating of 3.6 out of 5), in particular collaborating with physicians on patient care and being sought out by their peers for information; however, 18.5% indicated they were not sought out by managers for help with problems (Ning et al., 2009).

Structural empowerment is positively correlated to job satisfaction

The findings of this study indicate that respondents perceived structural empowerment as significantly positively correlated to job satisfaction (Ahmad & Oranye, 2010; Bawafaa et al., 2015; Dahinten et al., 2016; Dan et al., 2018; Kretzschmer et al., 2017; Lautizi et al., 2009; Wong & Laschinger, 2013), where structural empowerment (CWEQ-II total score) explained 68% correlation with job satisfaction (MMSS). The results support the idea that when the work environment provides access to structural components of empowerment (i.e. opportunity, information, support, resources, formal power, and informal power), the level of job satisfaction among nurses increases. In other words, increasing nurses' perception of structural empowerment is positively associated with increases in their levels of job satisfaction. These results are comparable to what was shown by other studies (Ahmad & Oranye, 2010; Bawafaa et al., 2015; Dahinten et al., 2016; Ning et al., 2009; Kretzschmer et al., 2017; Lautizi et al., 2009; Wong & Laschinger, 2013). Dahinten et al.'s (2016) study examined the relationship between structural empowerment, psychological empowerment, and job satisfaction among nurses, and found that job satisfaction was positively associated with structural empowerment. Ning et al.'s (2009) study showed that for a work environment that was moderately empowering, there was a significant positive correlation between empowerment and job satisfaction. However, in Ahmad and Oranye's (2010) study in Malaysia and England, which examined the relationship between nurses' empowerment, satisfaction, and organizational commitment, English nurses were more satisfied with their job but less empowered than Malaysian nurses, who felt more empowered but less satisfied. The difference between the two groups of nurses suggested that culture may play a role in job satisfaction, and the effects of structural empowerment and empowerment are not the same in all contexts. Additionally, the study revealed that work position and opportunities for part-time jobs were important in explaining empowerment among English nurses. In the context

of this study, the relationship between empowerment and job satisfaction is similar to that of Ahmad and Oranye's English study population, likely due to more flexibility to work part-time jobs, better pay, rights and privileges of a professional status and more opportunities for professional developments (Ning et al., 2009).

Subscales of structural empowerment are positively related to job satisfaction

Some of the CWEQ-II subscales were rated lower for respondents in this study, specifically access to information and informal power. This study's opportunity subscale score (r=0.23) was lower than Ning et al.'s (2009) study (r =0.42). Findings of the study suggest that all six subscales of structural empowerment are predictive of job satisfaction, similar to other studies (Bawafaa et al., 2015; de Almeida & Orgambidez-Ramos, & Batista, 2017; Lautizi et al., 2009; Li et al., 2013).

There were strong positive correlations between job satisfaction and formal power (measured by the Job Activities Scale) (r=0.65), which respondents rated most highly in terms of their empowerment. Access to support was also strongly correlated with job satisfaction (r=0.54), for which respondents reported moderate levels of empowerment. Moderate positive correlations were found between job satisfaction and access to resources (r=0.47) and access to information (r=0.31), for which respondents indicated moderate levels of empowerment. Informal power also showed a moderate positive correlation with job satisfaction (r=0.46), which was more highly rated by respondents in terms of their empowerment. The correlation between job satisfaction and access to opportunity, the structural empowerment subscale rated lowest in terms of their empowerment (r=0.23). It is interesting that in this study access to opportunity was rated by respondents as being their most empowered subscale (4.1 out of 5) yet had the weakest correlation with job satisfaction (r=0.23) (Li et al., 2013).

The study supports Kanter's theory of Structural Empowerment (Kanter, 1977,1993). According to the findings, overall, respondents working in five acute care hospitals reported they were moderately empowered, rated access to opportunity as being the greatest, and access to information being the least empowering factor. The findings were similar to those from other studies conducted amongst nurses in Canada and elsewhere, which reported being moderately empowered (Ahmad & Oranye, 2010, Bawafaa, et al., 2015; Dan et al., 2018)

Structural empowerment and job satisfaction controlled for demographic factors

The stepwise linear regression analyses revealed that overall score of structural empowerment and each subscale of empowerment were positively related to job satisfaction after controlling for demographic factors (age, years of experience, years of employment, and mandatory overtime). Of the 12 independent variables tested only four had a significant effect on job satisfaction, specifically total empowerment (R^2=0.47), access to support (R^2=0.35), formal power (R^2=0.45), informal power (R^2=0.28), age (R^2=0.48), years practicing as a nurse (R^2=0.48), years of employment (R^2 =0.30; R^2 = 0.15) and number of mandatory overtime shifts per month (R^2=0.42).

Separate regressions were run of the seven outcomes (total CWEQ-II and six subscales), controlling for demographic characteristics. Consistent with Dahinten et al.'s (2016) study, the first regression model of this study indicated that overall CWEQ-II score predicted 47% of the variance in job satisfaction. The second model demonstrated a contribution of access to opportunity and number of years practicing nursing to 13% of the variance in job satisfaction. The fifth model demonstrated that access to resources and age predicted 25% of the variation in job satisfaction (Bawafaa et al., 2015). Further, results are similar to those from to a recent study conducted by de Almeida et al. (2017), which found that access to opportunities and access to

resources were significant to predict job satisfaction (without controlling for demographic variables).

The third model indicated access to information and years of employment predicted 15% of variance in job satisfaction, and the fourth model indicated access to support, years practicing as a nurse, and mandatory overtime shifts per month contributed to 42% of the variance in job satisfaction. Formal power and age predicted 48% of the variance in job satisfaction (model 6), and informal power and years of employment predicted 30% of the variance in job satisfaction (model 7) (Ahmad & Oranye, 2010; Aiken et al., 2011; de Almeida et al., 2017; Maqbali, 2015). A recent study conducted by de Almeida et al's (2017), found that access to opportunities, information, support, and resources predicted nurses' job satisfaction.

This study demonstrated that both age, years of employment, and years of experience as a nurse were positively correlated with job satisfaction (Ahmad & Oranye, 2010; Chien & Yick, 2016; Maqbali, 2015). On the contrary, mandatory overtime was negatively correlated with job satisfaction – one additional shift per month of mandatory overtime was associated with a 0.18 decrease in MMSS total score (Dall'Ora, Griffiths, Ball, Simon, & Aiken, 2015; Han et al., 2015; Stimpfel, Sloane, & Aiken, 2012). According to Statistics Canada about 26% of Canadian nurses worked overtime in April and May of 2020 (Carriere, Park, Deng, & Kohen, 2020), and this number has likely increased due to the current Covid-19 pandemic, resulting in even more negative impacts on job satisfaction. In addition, post-organizational restructuring initiatives dramatically changed the working settings of many respondents in the study, including increased mandatory overtime as compared to 2017, increased workload, and burnout (Austman, 2018b, October 01), which can impact on nurses' well-being, turnover, and job satisfaction (Burke, et al., 2011, 2016; de Jong et al., 2016).

Four demographic variables should be considered in the context of predicting job satisfaction. These include age, associated with access to resources and formal power; years of employment, associated with access to informal power, access to support, years of practicing as nurse associated with access to opportunity and access to support; and years of practice and mandatory overtime, associated with access to support. These findings agree with other research indicating that demographic variables significantly predict job satisfaction (Ahmad & Oranye, 2010; Aiken et al., 2011; de Almeida et al., 2017; Ning et al., 2009).

Differences in job satisfaction related to demographic factors

At the individual level, there were no significant effects of sex, education level, place of employment, and marital status on nurses' job satisfaction. However, age, nursing experience and mandatory overtime were significantly correlated to job satisfaction.

The findings that 39% of respondents intended to leave their current position, and 13% intended to leave the nursing profession entirely are in contrast to other similar studies in the literature. A previous study conducted by Breau and Rheaume (2014) indicated only 3% of nurses reported an intention to leave their unit or organization. Another study conducted by Fitzpatrick et al. in (2010) found that only 18% of the respondents intended to leave their current position in the next year. Aiken et al. (2013) found about one in five nurses were dissatisfied with their jobs - the major causes of dissatisfaction were an unhealthy work environment, lack of opportunities for advancement, poor relationship with and support from one's manager, lack of work rewards and education opportunities, poor working conditions, workload, and burnout (Aiken et al., 2013; Tourangeau, Cummings, Ferron, Cranley, Harvey, 2010; Heinen et al., 2013). In light of comments provided by respondents in this study, it is likely that the reasons for intending to leave their current position and the entire nursing profession include heavy

workload, stress, conditions of the work environment, and lack of support and resources related to the Covid-19 pandemic (Halter et al., 2017; Hill, 2011; Hu et al., 2020), as well as changes and uncertainty related to organizational restructuring (Burke et al., 2016).

Strengths and limitations of the study

In the literature review, no other nursing research studies were conducted to identify the relationship between structural empowerment and job satisfaction of nurses post-organizational restructuring in western Canada. Therefore, this study contributes new knowledge to our understanding of the interaction between structural empowerment and job satisfaction following organizational restructuring. According to Kanter's theory (1977, 1993), social structural factors in the work environment are essential conditions for empowering employees to accomplish their work. Moreover, structural empowerment is a strong predictor of job satisfaction, which is essential to improve patient care, reduce stress, job retention, increase commitment, and also contribute to financial stability of healthcare organization (Cicolini et al., 2014; Gholami et al., 2019; Hayes et al., 2014). Intra-personal factors such as the nurse's age, experience, and mandatory overtime were reported in two early studies as influencing nurses' job satisfaction (Ahmad & Oranye, 2010; Ning et al., 2009). This study identified the variables that influence respondents' job satisfaction.

The results of this study are limited to describing the phenomena of interest related to the cross-sectional correlational design. As a cross-sectional study, this research explored the relationship between structural empowerment and job satisfaction only at one point in time, and thus does not reflect improvements or worsening of these variables over time, which may be an important consideration in improving the nursing work environment. This study used data collected at a single period of time, leading to results that may be misleading or ambiguous and

limiting causal inferences (Polit & Beck, 2012). In addition, the study's results were only able to show the correlation between variables, not the actual cause of the outcome variable (job satisfaction). As other factors beyond the empowerment structures examined may have an impact on job satisfaction, there will be limited potential to make recommendations for changes to work environments in order to improve job satisfaction.

A second limitation is related to the methods of data collection. This study used only one method (online/e-mail) to connect with the nursing population in Winnipeg, without implementing mixed methods to maximize potential response rates, which could have increased the sample size. In addition, the Covid-19 pandemic likely exerted a negative influence on response rate, in aspects of work-related stress, increased sick calls, mandatory overtime, and heavy workload during the study period. These factors were a challenging time for many staff nurses, and likely had an impact on both response rate and responses provided. Future studies should be conducted in a more stable work environment.

Additionally, this study uses self-report instruments to collect data, which are at risk of response bias (Polit & Beck, 2014). Even though using questionnaires has benefits (such as flexibility and economy), there are some drawbacks to this data collection method, such as the possibility of mono-method bias (i.e. the tendency to answer all questions in a particular pattern) (Polit & Beck, 2012). It is possible that more valid and meaningful data could be collected if the qualitative data on structural empowerment had been collected by interviewing respondents.

A convenience sample, rather than random sampling, may result in selection bias, and those who select to participate in the study may be different from those who did not participate in the study. The convenience population is often geographically concentrated, so this population may not be representative of the general population. Furthermore, the results of the study may

not be generalizable to a larger population due to the convenience sample survey (Polit & Beck, 2014). Using a convenience sample of participants working in western Canadian city, may exclude some populations, and the available participants might be somewhat atypical of the population of interest.

There are many potential factors that may limit the applicability of the findings of this study. Nonetheless, understanding the relationship between empowerment and job satisfaction for nurses in Manitoba's changing healthcare landscape is critical to understand how healthcare organization can make improvements to ensure employee retention and patient safety.

Implications for nursing management

The key implication of this study is that providing an empowering workplace can increase nurses' job satisfaction. Identifying the link between structural empowerment and job satisfaction can assist healthcare leaders in making decisions about developing a supportive and positive work environment for nurses. In the current context of the healthcare system that is under constant stress due to the Covid-19 pandemic and recent restructuring, there is more need than ever for healthcare organizational leaders to actively promote the creation of a healthy work environment for nurses (Cumming et al., 2010; 2018) to improve retention (Fitzpatrick et al., 2010; Hauck et al., 2011), improve patient outcomes, maintain overall organizational performance (Armstrong & Laschinger, 2006; Purdy et al., 2010), and increase job satisfaction (Laschinger et al., 2001; Laschinger, et al., 2004; Laschinger, 2012; Lautizi et al., 2009; Wong & Laschinger, 2013).

Structural empowerment includes providing the opportunity for professional growth in the organization and strategies to increase knowledge and skills (Kanter, 1993). Consistent with other studies, respondents in this study perceived the greatest access to opportunity for personal

growth provide the most 4.1 out of 5 (de Almeida et al., 2017; Smith et al., 2010; Purdy et al., 2010). Access to opportunity was rated more highly than any of the other subscales, consistent with Gholami et al.'s (2019) study. These findings suggest that nursing leaders should implement strategies to increase opportunities for nurses' professional growth and personal development (access to funded internal and external education opportunities, adequate orientation for newly hired nurses) and encourage nurses to becoming involved with various projects and initiatives.

Access to information, rated at only 2.7 out of 5 by respondents, is required to perform an individual's job and thus increase job satisfaction (Kanter, 1993). This structure was also rated relatively low in other studies (Armellino et al., 2010; DeVivo, Quinn Griffin, Donahue, & Fitzpatrick, 2013). Managers may consider providing nurses with access to online internal and external information sources to make information more readily available for patient care decision-making. Healthcare managers should also consider implementing policies for continuing education to keep nursing staff up to date with relevant information required for care. Nursing leaders should encourage staff to read and analyze clinical journals and implement the finding of the research in their practice (Purdy et al., 2010).

Another component of structural empowerment that leads to job satisfaction is access to support (Kanter, 1993), which ranked third of the CWEQ-II subscales, similar to what was shown in Gholami et al's study (2019). This finding may suggest that nurses are not sufficiently supported by managers. Nurse managers should provide support through feedback, guidance, emotional support, hands of assistance, and problem-solving advice (Hagerman, Hogberg, Skytt, Wednessten, & Engestrom, 2017). Hospitals can survey their staff nurses to gain insight into the level of support they receive from their managers or superiors and their colleagues. Based on that survey results nursing leaders can develop plans to improve support among staff and managers.

Increasing access to resources will also facilitate increased job satisfaction which includes access to equipment, supplies, money and adequate personnel needed to meet the organizational goals (Kanter, 1993). Nursing leaders should provide access to adequate resources to perform their duties effectively which translated into positive patient outcome (Purdy et al., 2010).

Formal power is an important factor with regards to increasing job satisfaction. Formal power is enhanced when jobs are flexible, central to the organization's goals, and support employee's creativity, and discretionary decision-making (Kanter, 1993). However, in this study access to formal power scores (Job Activities Scale) were low, which is similar to findings from other studies (Connolly, Jacobs, & Scott, 2018; Dirik & Intepeler, 2017). In this study, about a third of respondents indicated they received none or some reward for innovation on the job, only about 16% received flexibility in their job, and 25% indicated they received flexibility of work-related activities. Structural empowerment through rewards and recognition for a job well done, could contribute to increased job satisfaction (Yurumezogl & Kocaman, 2019). To generate and use innovative ideas and methods in practice, the organization must provide an environment that supports innovation (Luzinski, 2012). Employee empowerment is necessary for all employees to improve individual innovative behaviour and provide the highest quality services in highly competitive circumstances (Raadabadi, Fayazbaksh, Nazari, Mousavi, & Fayazbaksh, 2014).

Informal power is defined as having good relationship with colleagues and managers inside and outside the organization (Kanter, 1993). Perception of access to informal power ranked second of the CWEQ-II subscales, similar to DeVivo et al.'s study (2013). In this study 18.5% of respondents indicated they were not sought out by managers for help with problems. The respondents in this study perceived only a moderate level of effective communication and

team cooperation by superiors, physicians, colleagues, and allied health staff. According to Kanter (1993) managers play a key role in ensuring that these structures are in place.

Nursing is one of the most versatile professions within the healthcare workforce and has a significant role in today's healthcare environment, characterized by high stress, heavy workload, high physical demands, high levels of patient acuity, and a shortage of nurses to meet the increasing demands of patient care, all of which influence the quality of care and patient outcomes (Aiken et al., 2014). Consistent with other studies, this study's results revealed that nurses are moderately empowered, and many nurses have considered leaving their job, mainly due to concerns around heavy workload and poor working conditions (Aiken, et al., 2001; Halter et al., 2017; Hill, 2011; Tourangeau et al., 2010). Thus, the problem is not only about retaining nurses, but helping them thrive in the demanding, stressful environments in which they work, to achieve the desired high quality of care the profession and society demands.

These finding highlight the need for strong leadership to act as the voice on behalf of staff nurses; without strong leadership, nurses cannot have access to structural empowerment components. In addition, organizations should ensure that employees have access to opportunities, resources, support, and information to enable them to mobilize resources to satisfy their role (Kanter, 1993). Effective nurse managers can provide staff nurses with access to structural components of empowerment, including formal and informal power. This study adds to the growing body of evidence regarding the link between structural empowerment and job satisfaction. The results of the study can be used to further advocate for policies that enable to the implementation of work environment improvement strategies, which leads to increase in nurses' job satisfaction.

Recommendations for future research

Using mixed methods by conducting interviews or focus groups to examine the structural empowerment and job satisfaction among nurses would be beneficial to gain a deeper understanding of the issues and challenges nurses are encountering post-organizational restructuring, and how that relates to their job satisfaction. Further research is warranted to understand the effects of the work environment on job satisfaction that have fallen outside the scope of this study, such as nurse resilience. These findings would help inform employers, healthcare organizations, and policy makers of the importance of providing supportive environment for nurses. In addition, this study's findings may help inform stakeholders and support development of targeted programs to meet the diverse needs of nurses, encouraging retention, improving patient outcomes, and increasing overall job satisfaction. Further research is needed to provide a deeper and more comprehensive understanding of the relationship between leadership support for empowering behaviours, structural empowerment, and job satisfaction among nurses.

Conclusion

This study represents a modest beginning in examining the relationship between structural empowerment and nurses' job satisfaction post-organizational restructuring. As well, gaps in the literature related to structural empowerment and job satisfaction of nurses in Canada are addressed. The job satisfaction of nurses has been studied extensively; yet dissatisfaction remains. The present study provides evidence that structural empowerment has the strongest relationship with job satisfaction and suggests that CWEQ-II subscales, age, years of experience, and mandatory overtime are significant factors affecting nurses' job satisfaction. Respondents in this study reported support, resource, formal, and informal power were the strongest predictors of job satisfaction, followed by opportunity and information. However, respondents reported

greater access to opportunities to learn and grow. The results of the study support Kanter's Theory of Structural Empowerment. The results suggest that nurses post-organizational restructuring are moderately empowered and moderately satisfied with their job, and also suggest that certain aspects of structural empowerment are strong predictors of job satisfaction. In general, demographic characteristics contributed little to the explanation of nurses' job satisfaction. The result of this study supports previous research linking structural empowerment and job satisfaction.

Therefore, leaders should develop strategies including providing access to organizational empowering structures such as sharing information about top management's goals and values, providing support, and resources necessary to accomplish their work, and ongoing opportunities for career development. Leaders should also encourage their staff to actively participate in decision-making processes, which will help nurses have a greater sense of autonomy and impact in the workplace, and lead to increased job satisfaction.

References

Abu Ajamieh, A. R., Misener, T., Haddock, K. S., & Cleaton, J. U. (1996). Job satisfaction correlates among Palestinian nurses in the West Bank. *International Journal of Nursing Studies, 33*(4) 422-432. doi:10.1016/0020-7489(95)00068-2

Ahmad, N., & Oranye, N. O. (2010). Empowerment, job satisfaction and organizational commitment: A comparative analysis of nurses working in Malaysia and England. *Journal of Nursing Management, 18,* 582-591. doi: 10.1111/j.1365-2834.2010.01093.x

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van Den, K., Griffiths, P., Busse, R., … RN4CAST consortium. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet, 383*(9931), 1824-1830. doi:10.1016/S0140-6736(13)62631-8

Aiken, L. H., Clarke, S. P., & Sloane, D. M. (2002). Hospital staffing, organization, and quality of care: Cross-national findings. *Nursing Outlook, 50*, 187-194. doi:10.1067/mno.2012.126696

Aiken, L. H., Clarke, S. P., Sloane, D. M., & Sochalski, J. A. (2001). An international perspective on hospital nurses' work environments: The case for reform. *Policy Politics & Nursing practice, 24*(4), 255-263. Retrieved from http://uml.idm.oclc.org/login?

Aiken, L. H., Sloane, D. M., Clarke, S., Poghosyan, L., Cho, E., You, L., …Aungsuroch, Y. (2011). Importance of work environments on hospital outcomes in nine countries. *International Journal for Quality in Health Care, 23*(4), 357-364. Retrieved from http://doi-org.uml.oclc.org/10.1093/intqhc/mzr022

Aiken, L. H., Sermeus, W., Van den Heede, K., Sloane, D. M., Busse, R., MicKee, M., …. Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross

sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal,* 1-14. doi: 10.1136/bmj.e1717

Armstrong, K. J., & Laschinger, H. K. S. (2006) Structural empowerment, magnet hospital characteristics, and patient safety culture: Making the link. *Journal of Nursing Care Quality 21* (2), 124–132. Retrieved from http://uml.idm.oclc.org/login?

Armellino, D., Quinn Griffin, M. T., & Fitzpatrick, J, J. (2010). Structural empowerment and patient safety culture among registered nurses working in adult critical care units. *Journal of Nursing Management, 18*(7), 796-803. doi:10.1111/j.1365-2834.2010.01130.x

Austman, M. (2018a, May, 2). Front Lines. Nurses speak out for patient care.

Austman, M. (2018b, October, 01). Front Lines. Mandatory OT crises continues at St. Boniface.

Ball, H. L. **(**2019). Conducting online surveys. *Journal of Human Location, 35*(3), 413-417. doi:10.1177/0890334419848734

Bamberger, S. G., Vinding, AL., Larsen, A., Nielsen, P., Fonager, K., Nielsen, R. N., …Omland, O. (2012). Impact of organizational change on mental health: A systematic review. *Occupational and Environmental Medicine, 69*(8), 592-598 Retrieved from http://uml.oclc.org/login?

Bawafaa, E., Wong, C. A., Laschinger. H. K. S. (2015). The influence of resonant leadership on the structural empowerment and job satisfaction of registered nurses. *Journal of Research in Nursing, 20*(7), 610-622. doi:10.1177/1744987115603441

Blythe, J., Baumann, A., & Giovannetti, P. (2001). Healthy policy and systems. Nurses' experiences of restructuring in three Ontario hospitals. *Journal of Nursing Scholarship, 33*(1), 61-68. Retrieved from https://doi-org.uml.udn.oclc.org/10.1111/j.1547-5069.2001.x

Bowling, A. (2009). Research methods in health: Investigating health and health services. New

York, NY: McGraw Hill/Open University Press

Breau, M., & Rheaume, A. (2014). The relationship between empowerment and work environment on job satisfaction, intent to leave, and quality of care among ICU nurses. *Dynamics, 25*(3), 16-24.

Brown, H., Zijlstra, F., & Lyons, E. (2006). The psychological effects of organizational restructuring on nurses. *Journal of Advanced Nursing, 53*(3), 344-357. doi: 10.1111/j.1365-2648.2006.03723.x

Burke, R.J. (2003). Hospital Restructuring, Workload, and Nursing Staff Satisfaction and Work Experiences. *Health Care Manager 22*(2), 99-107. Retrieved from http://uml.idm.oclc.org/login?

Burke, R. J., & Greenglass, E. R. (2001). Stress and the effects of hospital restructuring in nurses. *Canadian Journal of Nursing Research, 33*(2), 93-108. Retrieve from http://cjnr.archive.mcgill.ca/article/view/1637/1637

Burke, R. J., Ng, E. S. W., & Wolpin, J. (2011). Hospital restructuring and downsizing: Effects on nursing staff well-being and perceived hospital functioning. *Europe's Journal of Psychology, 7*(1), 81-98. Retrieved from https://org/105964/ejop.v7i1.106

Burke, J., Ng, E. S. W., & Wolpin, J. (2016). Effects of hospital restructuring and downsizing on nursing staff: The role of union support. *Journal of Health Management, 18*(3), 473-488. doi:10.1177/0972063416651598

Canadian Nurses Association (CAN). (2009). Eliminating Canada's RN shortage-News release. Retrieved from https://www.cna-aiic.ca/en/news-room/news-relaeases/2009/eliminating canadas-rn-shortage

Canadian Institute for Health Information. (2017). Health spending. https://www.cihi.ca > health spending.

Canadian Institute of Health Information. (2018a). National health expenditure trends, 1975 to 2018. https://www.cihi.ca/en/health-spending/2018/national-health-expenditure-trends

Canadian Institute of Health Information. (2018b). CIHI data shows emergency department wait times in Winnipeg most improved in Canada. https://healingourhealthsystem.ca/media-181129.php

Canadian Nurses Association & Registered Nurses Association of Ontario. (2010). Nurse fatigue and patient safety: Research report. https://www.cna-aiic.ca/~/media/can/page…/pdf…/fatique_safety_2010_report_e.pdf

Cai, C., & Zhou, Z. (2009). Structural empowerment, job satisfaction, and turnover intention of Chinese clinical nurses. *Nursing & Health Sciences, 11*(4), 397-403. Retrieved from https://doi-org.uml.oclc.org/10.1111/j.1442-2018.2018.2009.00470.x

Cai, C. F., Zhou, Z. K., Yeh, H., & Hu. J. (2011). Empowerment and its effects on clinical nurses in central China. *Internal Nursing Review, 58*, 138-144. doi: 10.1111/j.1466-7657.2010.00848.x

Carriere, G., Park, J., Deng, Z., & Kohen. (2020). StatCan COVID-19: Data to insights for a better Canada. Overtime work among professional nurses during the COVID-19 pandemic. Available at www.statcan.gc.ca

Chien, W., & Yick, S. (2016). An investigation of nurses' job satisfaction in a private hospital and its correlates. *The Open Nursing Journal, 10*, 99-112. DOI: 10.2174/1874434601610010099

Cho, J., Laschinger, H. K. S., & Wong, C. (2006) Workplace empowerment, work engagement

and organizational commitment of new graduate nurses. *Nursing Leadership, 19* (3), 43–60. Retrieved from http://uml.idm.oclc.org/login?

Choi, S. (2017). Workforce diversity and job satisfaction of the majority and the minority: Analyzing the asymmetrical effects of relational demography on whites and racial minorities. *Review of Public Personnel Administration, 37*(1), 84-107. doi:10.1177/0734371X15623617

Cicolini, G., Comparcini, D., & Simonetti, V. (2014). Workplace empowerment and nurses' job satisfaction: A systematic literature review. *Journal of Nursing Management, 22*(7), 855-871. doi:10.1111/jonm.12028

Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.). New York, NY: Lawrence Erlbaum.

Connolly, M., Jacobs, S. & Scott, K. (2018). Clinical leadership, structural empowerment and psychological empowerment of registered nurses working in an emergency department. *Journal of Nursing Management, 26*(7), 881-887. doi: 10.1111/jonm.12619

Cook, R. D., & Weisberg, S. (1982). *Residuals and influence in regression*. New York: Chapman & Hall.

Cooper, C. L., Pandey, A., & Quick, J. C. (2012). *Downsizing is Less Still More?* Cambridge University Press, Cambridge, UK.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*(3), 297-334. doi:10.1007/bf02310555

Cumming, G. G., MacGregor, Y., Davey, M., Lee, H., Wong, C. A., Lo, E., …Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environments: A systematic review. *International Journal of Nursing studies, 47*(3), 363-

385. Retrieved from https://doi-org.uml.idm.oclc.org/10.1016/j.ijnurstu.2009.08.006

Cummings, G. G., Tate, K., Lee, S., Wong, C. A., Paananen, S., Micaroni, S. P. M., & Chatterjee, G. E. (2018). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies, 85*(2018), 19-60. Retrieved from https://doi.org/10.1016/j.ijnurstu.2018.04.016

Dahinten, V. S., Lee, S. E., & Macphee, M. (2016). Disentangling the relationship between staff nurses' workplace empowerment and job satisfaction. *Journal of Nursing Management, 24*, 1060-1070. doi:10.1111/jonm.12407

Dall'Ora, C., Griffiths, P., Ball, M., Simon, M., & Aiken, L. H. (2015). Association of 12 h shifts and nurses job satisfaction, burnout and intention to leave: Finding from a cross-sectional study of 12 European countries. *British Medical Journal Open*, 5:e008331. doi:10.1136/bmjopen-2015-008331

Dan, X., Xu, S., Liu, J., Hou, R., Liu, Y., Ma, H. (2018). Relationship among structural empowerment, self-efficacy, and career success in nursing field in mainland China. *International Journal of Nursing Research*, 1-9, doi: 10.1111/jin.12674

Datta, D. K., Guthrie, J. P., Basuil, D., & Pandey, A. (2010). Causes and effects of employee downsizing: A review and synthesis. *Journal of Management, 36* (1), 281-348. doi:10.1177/0149206309346735

de Almeida, M. H., Orgambidez-Ramos, A., & Batista, P. (2017). Workplace empowerment and job satisfaction in Portuguese nursing staff: An exploratory study. *Central European Journal of Nursing and Midwifery, 8*(4), 749-755. doi: 10.15452/CEJNM.2017.08.0028

Denis, D. J. (2018). SPSS data analysis for univariate, bivariate, and multivariate statistics. Wiley Online Library. doi: 10.1002/9781119465775

DeSisto, M.C., & DeSisto, T. P. (2006). School nurses' perceptions of empowerment and autonomy. *The Journal of School Nursing, 20*(4), 228-233. doi: 10.1177/10598405040200040801

de Jong, T. Weizer, N., Weerd, M., Nielsen, K., Mattila-Holappa, P., & Mockallo, Z. (2016). The impact of restructuring on employee well-being: A systematic review of longitudinal studies. *Work & Stress, 30*(1), 91-114. doi:10.1080/02678373.2015.1136710

DeVivo, D., Quinn Griffin, M. T., Donahue, M., & Fitzpatrick, J. J. (2013). Perceptions of empowerment among ED nurses. *Journal of Emergency Nurses*, *39*(6), 529-533. doi: 10.1016/j.jen.2010.10.011

De Witte, H., Pienaar, J., & De Cuyper, N. (2016). Review of 30 years of longitudinal studies on the association between job insecurity and health and well-being: Is there causal evidence? *Australian Psychologist, 51*, 18-31. doi:10.1111/ap.12176

Dirik, H. F., & Intepeler, S. S. (2017). The work environment and empowerment as predictors of patient safety culture in Turkey. *Journal of Nursing Management, 25*(5), 256-265. doi: 10.1111/jonm.12458

Duffield, C., Kearin, M., Johnston, J., & Leonard. (2006). The impact of hospital structure restructuring on the nursing workforce. *Australian Journal of Advance Nursing, 24*(3), 42-46

Faulkner, J., & Laschinger, H. K. S. (2008). The effects of structural empowerment and psychological empowerment on perceived respect in acute care nurses. *Journal of Nursing Management, 16*(2), 214-221. doi:10.1111/j.1365-2834.2007.00781.x

Fitzpatrick, J. J., Campo, T. M., Graham, G., & Lavandero, R. (2010). Certification, empowerment, and intent to leave current position and the profession among critical care

nurses. *American Journal of Critical Care, 19*(3), 218–226. doi:10.4037/ajcc2010442

Gholami, M., Saki, M., Pour, A. H. H. (2019**)**. Nurses' perception of empowerment and its relationship with organizational commitment and trust in teaching hospital; in Iran. *Journal of Nursing Management, 27*(5), 1020-1029. Retrieved from https://doi.org/10.1111/jonm.12766

Goedhart, N. S., Van Oostveen, C. J., & Vermeulen, H. (2017). The effect of structural empowerment of nurses on quality outcomes in hospitals: A scoping review. *Journal of Nursing Management, 25,* 194-206. doi:10.1111/jonm.12455

Greco, P., Laschinger, H. K. S., & Wong, C. A. (2006). Leader empowering behaviours, staff nurse empowerment and work engagement/burnout. *Nurse Leadership, 19*(4), 41-56. doi:10.12927/cjnl.2006.18599

Guo, J., Chen, J., Fu, J., Ge, X., Chen, M., & Liu, Y. (2016). Structural empowerment, job stress, and burnout of nurses in China. *Applied Nursing Research, 31,* 41-50. Doi: 10.1016/j.apnr.2015.12.007

Hagerman, H., Hogberg, H., Skytt, B., Wadensten, B., & Engstrom, M. (2017). Empowerment and performance of managers and subordinates in elderly care: A longitudinal and multilevel study. *Journal of Nursing Management, 25*(8), 647–656. doi: 10.1111/jonm.12504

Halter, M., Boiko, O., Pelone, F., Beighton, C., Harris, R., Gale, J., …Drennan, V. (2017). The determinants and consequences of adult nursing staff turnover: a systematic review of systematic reviews. *BMC Health Services Research, 17,* 1-20. Retrieved from https://doi-org.uml.idm.oclc.org/10.1186/s12913-017-2707-0

Han, K., Trinkoff, A. M., & Gurses, A. P. (2015). Work-related factors, job satisfaction, and intent to leave the current job among United States nurses. *Journal of Clinical Nursing, 24*(21-22), 3224-3232. doi: 10.1111/jocn.12987.

Harwood, L., Ridley, J., Wilson, B., & Laschinger, H. K. S. (2010). Workplace environment and burnout in Canadian nephrology nurses. *CANNT Journal 20*(4), 12-17

Hauck, A., Quinn Griffin, M. T., & Fitzpatrick, J. J. (2011). Structural empowerment and anticipated turnover among critical care nurses. *Journal of Nursing Management, 19*(2), 269–276. Retrieved from https://doi-org.uml.idm.oclc.org/10.1111/j.1365-2834.2011.01205.x

Hayes, B., Douglas, C., & Bonner, A. (2014). Predicting emotional exhaustion among haemodialysis nurses: A structural equation model using Kanter's structural empowerment theory. *Journal of Advanced Nursing, 70*(2), 2897-2909. doi:10.1111/jan.12452

Heerwegh, D. (2009). Mode differences between face-to-face and web surveys: An experimental investigation of data quality and social desirability effects. *International Journal of Public Opinion Research, 21*(1), 111-121. Retrieved from https://doi.org/10.1093/jpor/edn054

Heinen, M. M., van Achterberg, T., Schwrndimann, R., Zander, B., Mathews, A., Kozka, M., …, and Schoonhoven, L. (2013). Nurses intention to leave their profession: A cross sectional observational study in 10 European countries. *International Journal of Nursing studies, 50*,174-184

Hill, K. S. (2011). Work satisfaction, intent to stay, desires of nurses, and financial knowledge among bedside and advanced practice nurses. *The Journal of Nursing Administration, 41*(5), 211-217. doi:10.1097/NNA.0b013e3182171b17

Hinno, S., Partanen, P., & Vehvilainen-Julkunen, K. (2011). Hospital nurses' work environment,

quality of care provided and career plans. *International Nursing Reviews, 58*, 255-262. Retrieved from https://doi.org.uml.idm.oclc.org/10.1111/j.1466-7657.2020.00851

Hu, D., Kong, Y., Li, W., Han, Q., Zhang, X., Zhu, L., … Zhu. (2020). Frontline nurses' burnout, anxiety, depression, and fear status and their associated factor during COVID-19 outbreak in Wuhan, China: A large scale cross-sectional study. *Clinical Medicine,24* (2020) 100424. doi: 10.1016/j.eclinm.2020.100424

IBM Corp. Released 2017. IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp.

Janssen, O. (2003). Innovative behaviour and job involvement at the price of conflict and less satisfactory relations with co-workers. *Journal of Occupational Organizational Psychology, 76*(3), 347-364

Johnson, K., Stewart, T., Beaudin, P., & Klaichar, J. (2018). Interim evaluation of the Winnipeg Regional Health Authority's Healing our Health system Plan. digitalcollection.gov.mb.ca/awweb/pdfopener?smd=1&did=25918&md=1

Kanter, R. M. (1977). *Men and women of the corporation*. New York, NY: Basic Books.

Kanter, R. M. (1993). *Men and women of corporation* (2nd ed.). New York, NY: Basic Books

Kivimaki, M., Vahtera, J., Pentti, J., & Ferrie, J. E. (2000). Factors underlying the effect of organizational downsizing on health of employees: Longitudinal cohort study. *BMJ: British Medical Journal (International Edition), 320*(7240), 971-975. Retrieved from https://doi-org.uml.idm.oclc.org/10.1136/bmj.320.7240.971

Knol, J., & Linge, V. R. (2009). Innovative behavior: The effect of structural and psychological empowerment on nurses. *Journal of Advanced Nursing, 65*(2), 359-370. doi:10.1111/j.1365-2648.2008.04876.x

KPMG. (2017). Health system sustainability & innovation review: Phase 1 report. Retrieve from https://www.gov.mb.ca>hsir_phase

Kretzschmer, S., Walker, M., Myers, J., Vogt, K., Massouda, J., Gottbrath, D., … Logsdon**,** M. C. (2017). Nursing empowerment, workplace environment, and job satisfaction in nurses employed in an academic health science center. *Journal for Nurses in Professional Development, 33*(4), 196-202. doi: 10.1097/nnd.0000000000000363

Laschinger, H. K. S. (1996). A theoretical approach to studying work empowerment in nursing: A review of studies testing Kanter's theory of structural power in organizations. *Nursing Administration Quarterly, 20*(2), 25-41

Laschinger, H. K. S. (2008). Effect of empowerment on professional practice environments, work satisfaction, and patient care quality: Further testing the nursing worklife model. *Journal of Nursing Care Quality, 23*(4), 322-330. doi: 10.1097/01.NCQ.0000318028.67910.6b

Laschinger, H. K. S. (2012). Job and career satisfaction and turnover intentions of newly graduated nurses. *Journal of Nursing management, 20*, 472-484. doi:10.1111/j.1365-2834.2011.01293.x

Laschinger, H. K. S., Almost, J., Tuer-Hodes, D. (2003). Workplace empowerment and magnet hospital characteristics: Making the link. *Journal of Nursing Administration, 33*(7-8), 410-422. doi:10.1097/00005110-200307000-00011

Laschinger, H. K. S., Finegan, J. E., Shamian, J., & Wilk, P**.** (2004). A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *Journal of Organizational Behaviour 25*(4), 527-545. doi:10.1002/job.256

Laschinger, H. K. S., Finegan, J., & Shamian. J. (2001). The impact of workplace empowerment,

organizational trust on staff nurses work satisfaction and organizational commitment. *Health Care Management Review, 26*(3), 7-24

Laschinger H. K. S., Finegan, J., & Shamian, J. (2001a). promoting nurses' health: Effect of empowerment on job satisfaction and work satisfaction. *Nursing Economics, 19*(20), 42-52

Laschinger, H. K. S., Finegan, J., Shamian, J., & Wilk, P. (2001b). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *Journal of Nursing Administration, 31*(5), 260-272. doi: 10.1097/00005110-200105000-00006

Laschinger, H. K. S., Sabiston, J. A., Finegan, J., & Shamian, J. (2001c). Voices from the trenches: Nurses' experience of hospital restructuring in Ontario. *Canadian Journal of Nursing Leadership, 14*(1), 6-13. Retrieved from http://uml.idm.oclc.org/login?

Laschinger, H. K. S., Almost, J., & Tuer-Hodes, D. (2003a). Workplace empowerment and magnet hospital characteristics: Making the link. *Journal of Nursing Administration, 33*(7/8), 410-422. Retrieved from http://uml.idm.oclc.org/login?

Laschinger, H. K. S., Finegan, J., & Wilk, P. **(**2009). New graduate burnout: the impact of professional practice environment, workplace civility, and empowerment. *Nursing Economics 27*(6), 377–383. Retrieved from http://uml.idm.oclc.org/login?

Laschinger, H. K. S., Finegan, J. E., Shamian, J., & Wilk, P. (2003b). A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *Journal of Organizational Behaviour, 25*, 527-545. doi:10.1002/job.256

Laschinger, H. K. S., Finegan, J. E., Shamian, J., & Wilk, P. (2004). A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *Journal of Organizational Behaviour, 25*(4), 527-545. doi:10.1002/job.256

Laschinger, H.K.S., Gilbert, S., Smith, L. M., & Leslie, K. (2010). Towards a comprehensive theory of nurse/patient empowerment: Applying Kanter's theory to patient care. *Journal of Nursing Management, 18* (1), 4-13. doi: 10.1111/j.1365-2834.2009.01046.x.

Laschinger, H. K. S., Wong, C. A., & Grau, A. L. (2013). Authentic leadership, empowerment and burnout: A comparison in new graduates and experienced nurses. *Journal of Nursing Management, 21*(3), 541-552. doi:10.1111/j.1365-2834.2012.0375.x

Laschinger, H. K. S., Wong, C. A., & Greco, P. (2006). The impact of staff nurse empowerment on person-job fit and work engagement/burnout. *Nursing Administration Quarterly, 30*(4), 358-367

Lautizi, M., Laschinger, H. K. S., & Ravazzolo, S. (2009). Workplace empowerment, job satisfaction, and job stress among Italian mental health nurses: An exploratory study. *Journal of Nursing Management, 17*(4), 446-452. doi:10.1111/j.1365-2834.2009.00984

Lee, S. E., Dahinten, S. V., & Macphee, M. (2016). Psychometric evaluation of the McCloskey/Mueller Satisfaction Scale. *Japan Journal of Nursing Science, 13*, 487-495. doi:10.1111/jjns.12128

Li, I. C., Kuo, H. T., Huang, H. C., Lo, H. L., & Wang, H. C. (2013). The mediating effects of structural empowerment on job satisfaction for nurses in long-term care facilities. *Journal of Nursing Management, 21*(3), 440-448. doi:10.1111/j.1365-2834.2012.01396.x

Locke, E. A. (1969). What is job satisfaction? *Organizational Behaviour and Human Performance, 4*(4), 309-336. doi:10.1016/0030-5073(69)90013-0

Luzinski, C. (2012). An innovative environment where empowered nurses flourish. Journal of Nursing Administration, 42(1), 3-4. doi: 10.1097/NNA.0b013e31823c16fc.

Maniaci, M. R. & Rogge, R. D. (2014). Caring about carelessness: Participant inattention and its effects on research. *Journal of Personality, 48,* 61-83. Retrieved from https://dog.org/10.1016/j.jrp.2013.09.008

Manojlovich, M., & Laschinger, H. K. S. (2002). The relationship of empowerment and selected personality characteristics to nursing job satisfaction. *Journal of Nursing Administration, 32*(11), 586-595

Marchildon, G. P. (2005). *Health Systems in Transitions: Canada* (S. Allin & E. Mossialos, Eds). Toronto, Canada. University of Toronto Press.

Maqbali, M. A. A. (2015). Factors that influence nurses' job satisfaction: A literature review. *Nursing Management, 22*(2), 30. doi: 10.7748/nm.22.2.30e1297

McGills Hall, L. (2005). Strategies to rebuild nursing following restructuring: Canadian perspectives. *Journal of Research in Nursing, 10,* (1), 54-64. Retrieved from https://doi-org.uml.oclc.org/10.1177/136140960501000105

McHugh M. D., Kutney-Lee A., Cimiotti J. P., Sloane D. M., Aiken L. H. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs*, *30*(2), 202–210

Meyer, A., Wheeler, S., Weinberger, M., Chen, R., & Carpenter, W. (2014). An overview of methods of comparative effectiveness' research. *Seminars in Radiation Oncology, 24(*1), 5-13. doi:10.1016/j.semradonc.2-13.09.002

MHSAL. (2017). Achieving a high performing provincial healthcare system: Manitoba health, seniors and active living. Retrieved from https://www.bov.mb.ca > rightcare > pho

Moore, D. S. (2000). *The basic practices of statistics* (2nd ed). New York: W. H. Freeman and Co.

Morris, D. L., Fenton, M. V., & Mercer, Z. B. (2004). Identification of national trends in nursing education through the use of an online survey. *Nurses Outlook, 52,* 248-254. doi:10.1016/j.outlook.2004.04.013

Mueller, C. W., & McCloskey, J. C. (1990). Nurses' job satisfaction: A proposed measure. *Nursing Research, 39*(2), 113-117

Munro, B. H. (2004). *Statistical methods for health care research* (5th ed.). Philadelphia. PA: Lippincott, Williams, & Wilkins.

Ning, S., Zhong, H., Libo, W., & Qiujie, L. (2009). The impact of nurse empowerment on job satisfaction. *Journal of Advance Nursing, 65*(12), 2642-2648. doi: 10.1111/j.1365-2648.2009.05133.x

O'Brien-Pallas, J., Murphy, G. T., Shamian, J., Li, X., & Hayes, L. J. (2010). Impact and determinants of nurse turnover: A pan Canadian study. *Journal of Nursing Management, 18,* 1073-1086. doi: 10.1111/j.1365-2834.2010.01167.x

O'Connor, P. J., Jimmieson, N. L., & White, K. M. (2017). Too busy to change: High job demands reduce the beneficial effects of information and participation on employee support. *Journal of Business and Psychology, 33*(5), 629-643. doi:10.1007/s10869-017-9515-8

Orgambidez-Ramos, A., & Borrego-Ales, Y., Vazquez-Aguado, O., & March-Amegual, J. (2017)**.** Structural empowerment and burnout among Portuguese nursing staff: An explicative model. *Journal of Nursing Management, 25*, 616-623. doi: 10.1111/jonm.12499

Park, S. H., Gass, S., & Boyle, D. K. (2016). Comparison of reasons for nurse turnover in Magnet and Non-Magnet hospitals. *Journal of Nursing Administration, 46*(5), 284-290.

doi:10.1097/NNA.0000000000000344

Peachey, D., Tait, N., Adams, O., & Croson, W. (2017). Provincial clinical and preventive services planning for Manitoba: Doing things differently and better. Health intelligenceinc and associates. Retrieved from https:// www.gov.mb.ca >health > pcpsp

Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: Appraising evidence for nursing practice.* (8th ed.). Philadelphia: Wolters Kluwer Health/ Lippincott Williams & Wilkins.

Porter, P. A., Perry, A. G., Stockert, P., Hall, A. M., Astle, B., & Duggleby, W. (Eds). (2019). Canadian Fundamentals of Nursing (6th ed.). Toronto, ON: Elsevier Canada

Price, M. (2002). Job satisfaction of registered nurses working in an acute hospital. *British Journal of Nursing, 11*, 275-280

Purdy, N., Laschinger, H. K. S., Finegan, J., Kerr, M., & Olivera, F. (2010). Effects of work environments on nurse and patient outcomes. *Journal of Nursing Management, 18*, 901-913. doi:10.1111/j.1365-2834.2010.01172.x

Qualtrics (2017). Retrieved from https://www.qualtrics.com

Raadabadi, M., Fayaz-Bakhsh, A., Nazari, A., Mousavi, S. M., & Fayaz-Bakhsh, M. (2014). Organizational entrepreneurship and administrators of hospitals: Case study of Iran. *Global Journal of Health Science, 6*(3), 249–255. doi: 10.5539/gjhs.v6n3p249

Rheaume, A., Clement, L., & LeBel, N. (2010). Understanding intention to leave amongst new graduate Canadian nurses: A repeated cross-sectional survey. *International Journal of Nursing Studies, 48*(4), 490-500. Retrieved from https://doi.org/10.1016/j.ijnurstu.2010.08.005

Ridgeway, C. L. (1992). Gender, interaction, and inequality. New York, NY: Springer Science+Business Media.

Rondeau, K. V., & Wagar, T. H. (2006). Downsizing and organizational restructuring: What is the impact on hospital performance? *International Journal of Public Administration, 26*(14), 1647-1668. doi:10.1081/PAD-120024416

Sheehan. K. (2001). Email survey response rates: A review. Retrieved from http://jcmc.indiana.edu/vol16/issue2/sheen.html

Silva, A. (2004). Bumping. In R. E. Weir & J. P. Hanlan (Eds). Historical encyclopedia of American labor. Santa Barbara, CA: ABC-CLIO. Retrieved from https://uml.idm.oclc.org/login?

Skefales, A., Plakas, S., Fouka, G., Gono, M., Vassiliadou, M., & Bergiannaki, J. (2014). Burnout and its association with working conditions among Greek hospital nurses in a time of financial crisis. *Open Journal of Nursing, 4,* 548-563. Retrieved from http://dx.doi.org./10.4236/ojn.2014.47058

Smith, L, M., Andrusyszyn, M, A., & Laschinger, H, K, S. (2010). Effects of workplace incivility and empowerment on newly graduated nurses' organizational commitment. *Journal of Nursing Management, 18*(8), 1004-1015. doi:10.1111/j.1365-2834.2010.01165.x

Smith, T., Capitulo, K. L., Quinn Griffin, M. T., & Fitzpatrick, J. J. (2012). Structural empowerment and anticipated turnover among behavioural health nurses. *Journal of Nursing Management, 20,* 679-684

Stewart, J. G., McNulty. R., Griffin, M. T., Fitzpatrick, J. J. (2010). Psychological empowerment and structural empowerment among nurse practitioners. *Journal of the American Academy*

of Nurse Practitioners, 22(1), 27-34. doi:10.1111/j.1745-7599.2009.00467.x

Stimpfel, A. W., Sloane, D. M., & Aiken, L. H. (2012). The longer the shifts for hospital nurses, the higher the levels of burnout and patient dissatisfaction. *Health Affairs, 31*(11), 250-259. doi: http://dx.doi.org.uml.idm.oclc.org/10.1377/hlthaff.2011.1377.

Tigert, J. A., & Laschinger, H. K. S. (2004). Critical care nurses' perceptions of workplace empowerment, Magnet hospital traits and mental health. *The official journal of the Canadian association of critical care nurses, 15*(4), 19-23

Tourangeau, A. E., Hall, L. M., Doran, D. M., & Petch, T. (2006). Measurement of nurse job satisfaction using the McCloskey/Mueller Satisfaction Scale. *Nursing Research, 55*(2), 128-136. doi:10.1097/00006199-200603000-00008

Tourangeau, A. E., Cummings, G., Cranley, L. A., Ferron, E. M., Harvey, S. (2010). Determinants of hospital nurse intention to remain employed: Broadening our understanding. *Journal of Advance Nursing, 66*(1), 22-32. doi: 10.1111/j.1365-2648.2009.05190.x

Vaananen, A., Ahola, K., Koshinen, A., Pahkin, K., & Kouvonen, A. (2011). Organizational merger and psychiatric morbidity: A prospective study in a changing work organization. *Journal of Epidemiology & Community Health, 65*(8), 682-700. Retrieved from http://uml.idm.oclc.org/10.1136/jech.2010.126482

Van Bogaert, P., Clarke, S., Willems, R., & Mondelaers, M. (2013). Nurse practice environment, workload, burnout, job outcomes, and quality of care in psychiatric hospitals: A structural equation model approach. *Journal of Advanced Nursing, 69*, (7), 1515-1524. Retrieved from https://doi-org/10.1111/jan.12010

Van Bogaert, P., Peremans, L., Diltour, N., Van heusden, D., Dilles, T., Van Rompaey, B…Havens, D. S. (2016). Staff nurses' perceptions and experience about structural empowerment: A qualitative study. *PLoS ONE, 11*(4), 1-14. doi:10.1371/journal.pone.0152654

Wade, G., Osgood**,** B., Avini, K., Bucher, L., Foraker, T., French, D., & Sirkowski, C. (2008). Influence of organizational characteristics and caring attributes of managers on nurses' job enjoyment. *Journal of Advance Nursing, 64*(4), 344-353

Wagner, S. E. (2006). Staff retention: From ‘‘satisfied’’ to ‘‘engaged.’’ *Nursing Management, 37* (3), 24–30. https://uml.idm.oclc.org/login?

Wagner, J. I., Cummings, G., Smith, D. L., Olson, J., Anderson, L., & Warren, S. (2010). The relationship between structural empowerment and psychological empowerment for nurses: A systematic review. *Journal of Nursing Management, 18*(4), 448-462. doi:10.1111/j.1365-2834.2010.01088.x

Weil, T. P. (2016). The Canadian healthcare system: It needs enhancement. *Health Services Management Research, 29*(4), 107-114. https://doi-org.uml.idm.oclc.org/10.1177/0951484816673668

Wilson, B., Squires, M., Widger, K., Cranley, L., & Tourangeau, A. E. (2008). Job satisfaction among a multigenerational nursing force. *Journal of Nursing Management, 16*, 716-723. doi:10.1111/j.1365-2834.2008.00874.x

Winnipeg Regional Health Authority (WRHA). (2017, April 7). Media Release: Broad improvements for health care in Winnipeg: Consolidation of health centres builds on excellence. http://healingourhealthsystem.ca/media-170407.php

Wong, C. A., & Laschinger, H. K. S. (2013). Authentic leadership, performance, and job satisfaction. The mediating role of empowerment. *Journal of Advanced Nursing, 69*(4), 4947-4959. doi:10.1111/j.1365-2648.2012.06089.x

Wood, M. J., & Ross-Kerr, J. C. (2006). *Basic steps in planning nursing research: From question to proposal* (6th ed.). Sudbury, MA: Jones and Bartlett Publishers.

Yang, J., Liu, Y., Chen, Y., & Pan, X. (2014). The effect of structural empowerment and organizational commitment on Chinese nurses' job satisfaction. *Applied Nursing Research, 27*(3), 186-191. http://dx.doi.org/10.1016/j.aprn.2013.12.001

Yurumezoglu, H. A., & Kocaman, G. (2019). Structural empowerment, workplace incivility, nurses' intention to leave their organisation and profession: A path analysis. *Journal of Nursing Management, 27*(4), 732-739. doi: 10.1111/jonm.12751

Appendix A

CONDITIONS FOR WORK EFFECTIVENESS QUESTIONNAIRE-II

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

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

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

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

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

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

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

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

In my work setting/job: (JAS)

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

How much opportunity do you have for these activities in your present job: (ORS)

1 = None	2	3 = Some	4	5 = A Lot				
1. Collaborating on patient care with physicians				1	2	3	4	5
2. Being sought out by peers for help with problems				1	2	3	4	5
3. Being sought out by managers for help with problems				1	2	3	4	5
4. Seeking out ideas from professionals other than physicians, e.g., physiotherapists, occupational therapists, dieticians				1	2	3	4	5

Appendix B

MCCLOSKEY/MUELLER SATISFACTION SCALE (MMSS)

HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR CURRENT JOB

Work Culture and Conditions	Very satisfied	Moderately satisfied	Neither satisfied nor dissatisfied	Moderately dissatisfied	Very dissatisfied
1. Encouragement and positive feedback	5	4	3	2	1
2. Recognition of your work from superiors					
3. Recognition of your work from peers					
4. Participation in decision-making					
5. Control over your work setting					
6. Your control over work conditions					
7. Your immediate supervisor					
Scheduling and Family/Work Balance					
8. Weekend off per month					
9. Flexibility in scheduling weekends					
10. Opportunity to work straight days					
11. Flexibility in scheduling hours					
12. Compensation for Working weekends					
13. Hours that you work					

	Very Satisfied 5	Moderately Satisfied 4	Neither Satisfied nor Dissatisfied 3	Moderately Dissatisfied 2	Very Dissatisfied 1
14. Maternity leave time					
15. Opportunity for part-time work					
Collegial Relationships					
16. Opportunity for social contact at work					
17. Opportunities for social contact after work					
18. Delivery of the care method used in your unit (e.g., functional, primary, team)					
19. Opportunities to interact professionally with other disciplines					
20. Physician who work with					
Extrinsic Rewards					
21. Benefit package					
22. Salary					
23. Vacation					
Professional opportunities					
24. Opportunities to write and publish					
25. Opportunities to participate in research					

Appendix C

Participant Demographic Data Form

Thank you for agreeing to participate in this study. The following questions will provide us with information about the personal characteristics of the persons who have answered the questionnaire. As indicated earlier, your answers will be kept anonymous. Please answer the following questions:

1. What is your sex?
    - Male
    - Female
    - Other (please specify)
2. What is your present age?
    - ----------Years
3. What is your highest level of education?
    - RN
    - RPN
    - BN
    - BScPN
    - Graduate
4. What is your marital status?
    - Married/partnered
    - Single/ widowed/divorced
5. What is your occupational status?
    - Fulltime
    - Part-time

- Casual

6. Number of mandatory overtime shift(s) in a month? (Choose a number on the line below from 0-30)

- 0 ----------30

7. How long have you been practicing as a nurse?

- ----------Months
- ----------Years

8. Which hospital have you been employed?

- Health Sciences Centre
- St. Boniface General Hospital
- Grace hospital
- Seven oaks General hospital
- Concordia Hospital

9. How long have you been employed in this hospital?

- ----------Months
- ----------Years

10. In the next year, do you intend to leave your current position?

- Yes
- No
- If yes, please elaborate

_____

11. In the next year, do you intend to leave the nursing profession entirely?

- Yes
- No
- If yes, please elaborate

- ----------

Thank you for your time to completing this questionnaire – your input is of great value to this research project.

College of Nursing
University of Manitoba
89 Curry Place
Winnipeg, Manitoba
Canada R3T 2N2
T: 204 474 7452
F: 204 474 7682
nursing@umanitoba.ca

Appendix D

Invitation to Participate

Research Project Title: Structural Empowerment and Job Satisfaction of Nurses: A Cross-Sectional Correlational Study.

Dear Nursing Colleague:

My name is Jose Thomas Karaparambil, a graduate student at the College of Nursing, University of Manitoba. I would like to invite you to participate in a thesis study exploring the relationship between structural empowerment and job satisfaction of nurses post-organizational restructuring in Winnipeg, Manitoba. If you are working in more than one facility, please complete the survey in reference to where you have a higher equivalent fulltime position (EFT). This topic is important to improve nurses' job satisfaction and enhance patient care outcomes.

If you agree to participate in this study, you will be asked to take approximately 20 to 30 minutes to complete the on-line questionnaire. Participation in this study is entirely voluntary and the answers you provide will be anonymous. You may refuse to participate or to answer any questions. There are no penalties or consequences of any kind if you decide that you do not want to participate.

If you are interested in participating in this study, please click on the following link for more information:

https://umnursing.ca1.qualtrics.com/jfe/form/SV_aYva9Yy9fMTwILP

Thank you in advance for your participation in this study. If you have any general questions regarding this study, please contact Jose Thomas Karaparambil or Dr. Judith Scanlan

This project has been approved by the University of Manitoba, Education and Nursing Research Ethics Board. If you have any questions or concerns, please contact the human research ethics coordinator at humanethics@umanitoba.ca or phone: 204-474-7122.

Sincerely,

Mr. Jose Thomas Karaparambil, RPN, BScPN, MN Student

College of Nursing
University of Manitoba
89 Curry Place
Winnipeg, Manitoba
Canada R3T 2N2
T: 204 474 7452
F: 204 474 7682
nursing@umanitoba.ca

Appendix E

Consent to Participate

Research Project Title: Structural Empowerment and Job Satisfaction of Nurses: A Cross-Sectional Correlational Study.

Principle Investigator:
Jose Thomas Karaparambil
Master of Nursing Student
College of nursing, Rady faculty of health sciences

Co-Investigator:
Judith Scanlan, RN, Ph.D, FCNEI
Associate Professor and Advisor for Jose Thomas Karaparambil
College of nursing, Rady faculty of health sciences

This consent form, a copy of which you may print for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

What is the purpose of the project?

The purpose of this online survey research is to explore the relationship between structural empowerment and job satisfaction of nurses working in acute care hospitals in the Winnipeg

Regional Health Authority (WRHA), post-organizational restructuring. Several studies have identified that empowerment can increase nurses' job satisfaction. However, no recent research has been conducted that specifically investigates the relationship between structural empowerment and nurses' job satisfaction post-organizational restructuring. All Registered Nurses (RNs) and Registered Psychiatric nurses (RPNs), working at Health Sciences Centre, St Boniface General Hospital, Grace Hospital, Seven Oaks Hospital, and Concordia Hospital are being invited to participate in this study.

What will be expected of me as a participant?

As a participant in this study, you are being asked to complete an online survey through a secure password protected online survey account hosted in Qualtrics.com accessible only by the researchers. The survey should take approximately 20-30 minutes to complete.

Benefits and risks

There is no more than minimal risks to participants that is the risk is not greater than what a participant would be encountered in daily life. Participants may benefit indirectly from participating in this study by providing information may facilitate a better leaders' understanding the relationship between empowering work environment for nurses and their job satisfaction.

The online survey includes three questionnaires that will ask about workplace empowerment, job satisfaction, and demographic questions. If you find completing these questions subjects you to undue emotional stress you may refuse to participate or answer any questions by closing your web browser. If you discontinue the survey at any time for any reason, any data you have provided up to that point will be deleted.

Confidentiality

All data collected from this survey will be kept confidential by the researchers. All data are collected into a password protected account on Qualtrics.com, which is only accessible by the

researchers. Qualtrics is a USA based company and does store some of its data on servers located in the USA as such, is subject to the US Patriots Act. After data collection is complete, all data will be downloaded from the Qualtrics website into a password protected data file and stored on the University of Manitoba network drive accessible only by the researchers. The data will then be deleted from the Qualtrics account. No names will be stored with the data. All data obtained as part of this project will be kept confidential and individuals will not be identified in any reports or publication. The data will be kept in electronic format on a password protected computer for 7 years and then deleted in approximately August 2027. Other individuals may be given access to the anonymized dataset in the future for further analysis upon request to the principal investigator. As part of this, some study data and information from the study may be sent outside of the University of Manitoba to other researchers, academic institutions, healthcare facilities, or organizations for further analysis, testing or as part of the research study. Any information sent out of the University of Manitoba will not show your name or address, or any other identifiable personal information about you.

Dissemination of Results

The results of this survey will be reported in aggregate and will not contain any individual identifiers. No individual's data will be reported. Data will also be disseminated in a poster and oral presentations and in a peer-reviewed publication.

At the end of the survey, you will be able to follow a general link to another Qualtrics data collector where you will be asked if you would like to receive a summary report of the study finding to be sent out to you via email. If you indicate you would like to receive a summary report, you will be asked to provide an email address at which you would like to receive the report. Your name and email address will be collected in a separate data collector that is not identifiably linked to the survey data you have provided.

Consent to participate

I understand the information given to me and I am willing to participate by completing the survey. I understand that all data obtained as part of this survey will be kept confidential and that I will not be identified in any reports or publications.

I understand that my participation in this survey is strictly voluntary. I am aware that I am free to withdraw from the survey at any time, for any reason, without penalty of consequence by existing the survey. Any data I have provided up to that point will be deleted. I will not be possible to remove the data I provide in this study after I have completed the survey as the data is being collected anonymously. I understand that neither the agreement to neither participate nor decision to withdraw from the study will have any consequence on my employment as a nurse.

Your participation in this survey indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal right nor release the researcher or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time and / or refrain from answering any questions you prefer to omit without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to the research records for safety and quality assurance purposes.

This research has been approved by the Education and Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 204-474-7122 or
email: humanethics@umanitoba.ca. You may print a copy of this consent form to keep for your records and reference.

Further information

If you have questions about this project or your participation in it, please contact Jose Thomas Karaparambil, Master of Nursing student, College of Nursing, University of Manitoba or Dr. Judith Scanlan, Associate Professor and Advisor, College of Nursing, University of Manitoba. If you understand your role in this study and consent to participate as outlined, please provide your signature below and click on the “Next” button to begin the survey.

College of Nursing
University of Manitoba
89 Curry Place
Winnipeg, Manitoba
Canada R3T 2N2
T: 204 474 7452
F: 204 474 7682
nursing@umanitoba.ca

Appendix F

Follow-up Letter

Re: Empowerment and Job Satisfaction Survey Reminder

Dear Nursing Colleague,

You were recently invited to participate in a research survey, aimed at exploring the relationship between structural empowerment and job satisfaction of nurses post-organizational restructuring in Winnipeg, Manitoba. If you have not already completed the survey, we encourage you to take time to complete the survey. Your feedback is critical to improve nurses' job satisfaction and enhance patient care.

Link to survey:

Simply click on this link to go directly to the survey. Your participation in this research is strictly voluntary and your responses are confidential.

Thank you for your time and feedback

Sincerely,

Jose Thomas Karaparambil — Master of Nursing Student

Dr. Judith Scanlan — Professor and Advisor

Appendix G

Figure – 2. A scatter plot showing a linear relationship between variables

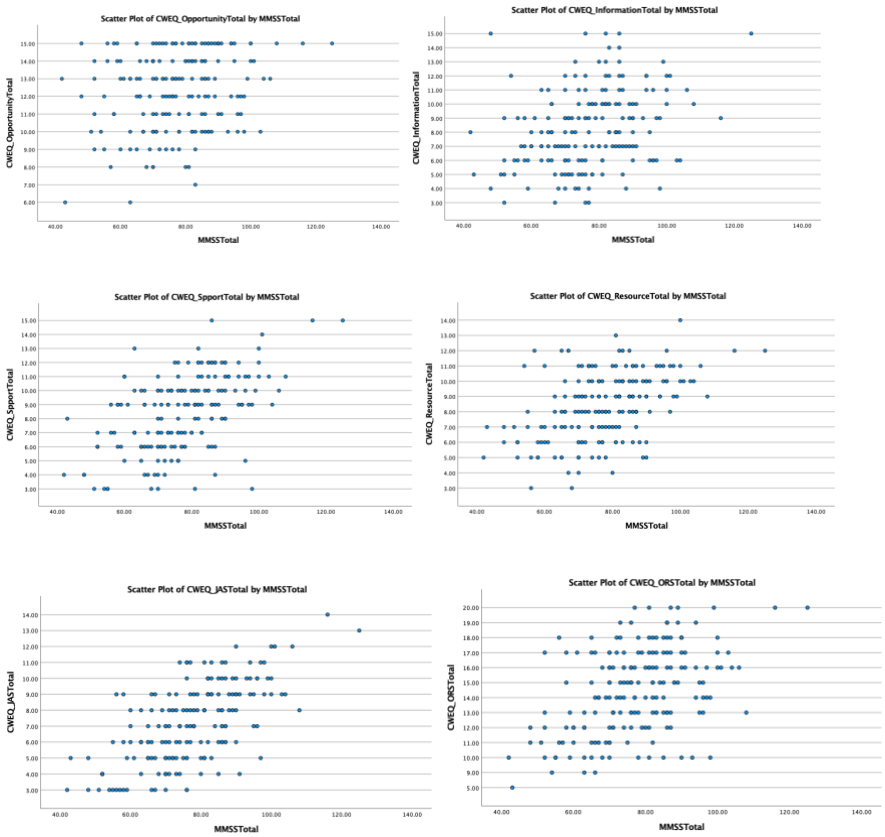
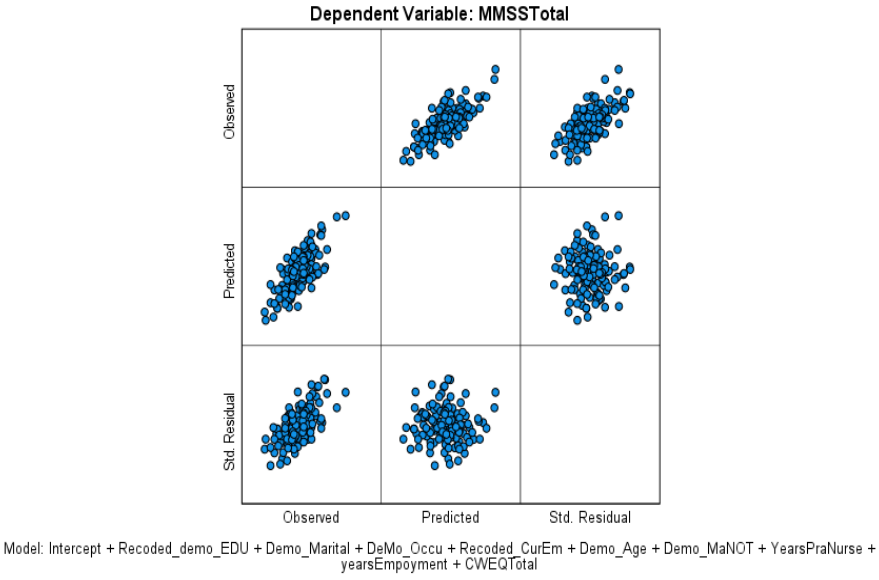


Figure- 3. Linearity between variables



Appendix H

Table 4. The Tolerance and variance inflation factor (VIF) for independent variables; dependent variable of job satisfaction

Model	Collinearity Status Tolerance	VIF
Opportunity	0.76	1.31
Information	0.73	1.36
Support	0.60	1.68
Resource	0.77	1.30
JAS	0.60	1.67
ORS	0.70	1.42
Age	0.20	4.92
Years of experience	0.20	4.85
Mandatory OT	0.93	1.09
Sex	0.93	1.06
Educational status	0.91	1.10
Occupational status	0.91	1.10
Marital status	0.91	1.04

Figure-4. Histogram and Q-Q plot