Rural Manitoba Nurse Leaders' Perceptions of Practice Environment Empowerment Structures

By

Ariel Wilcox

A thesis submitted to the Faculty of Graduate and Postdoctoral Studies of

The University of Manitoba

in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

College of Nursing

University of Manitoba

Winnipeg, Manitoba

Abstract

Background: Current and ongoing nursing shortages limit access to patient care and reduce the availability of essential health resources for rural populations. In response to these pressures, health care systems must transform to better support nurse retention. For nurse leaders, improving rural nurses' job satisfaction through access to empowerment structures and organizational support must be a priority. **Purpose:** This study investigated how rural nurse leaders understand and create empowered practice environments. It also addressed a significant gap in knowledge regarding nurse recruitment and retention in rural Manitoba communities. **Research Questions:** 1) How do nurse leaders describe and understand structural empowerment? 2) What organizational structures do nurse leaders identify as essential to empowered environments, including support, resources, information, and opportunity? 3) How do nurse leaders create structures that support empowered environments? **Methods:** Using a qualitative descriptive design, participants were recruited through purposive and snowball sampling. Data was collected through semi-structured interviews, which provided a rich understanding of the context in which nurse leaders create empowered working environments. **Findings and Implications:** Two themes emerged from the data: *Support and Relationships* and *Rural Roots*. As Manitoba has one of the highest rural populations in Canada, approaches informed by structural empowerment can strengthen rural nurse leaders' capacity to participate in health transformation. This study contributes to understanding rural nurse leaders' perspectives and can inform rural policy and practice environment structures. Its findings may support strategies that create empowered practice environments by reducing nurse role stress and ambiguity, increasing positive emotions, and improving job satisfaction to support retention.

Acknowledgements

I would like to take a moment to acknowledge those who have supported and encouraged me in my personal and professional journey to achieve my masters.

Dr. Judith Scanlan, my advisor and committee chair, thank you for being so kind and warm in guiding me through (at times) a grueling process. Your kind words and immense support have helped to make this accomplishment possible.

Thank you to my committee members, Dr Malcolm Doupe and Dr Sonia Udod who have both greatly contributed to my learning and thesis journey.

I am thankful for the financial support received from the Irene E Nordwich Foundation, the Dr. S.J. Winkler Memorial Award, the Rose Mary and Fredrick Allan Johnson Scholarship, the Graduate Nursing Students Association scholarships, Friends of the Canadian Simmental Foundation Scholarship, and Research Manitoba.

A big thank-you to all 10 participants who volunteered their time to meet with me and share their knowledge and experience which brought my research to life and truly reinforced the purpose of it.

To my husband Anthony, my three young children Emma, Daxson, and Cade thank you for all of your support and patience these last 4 years!

Table of Contents

Chapter 1: Introduction

In the following chapter, I will outline why this study is important and its purpose in relation to the pertinent research questions (see Appendix A). Discussion following will provide definition of key concept contexts with discussion surrounding the conceptual framework being used and the need for this study to occur.

Background

Globally, nurses account for the largest portion of all health care professionals (Bish et al., 2014). The current and ongoing shortage of nurses impacts access to patient care and creates decreased resource accessibility, particularly for rural populations (Hauenstein et al., 2014). Current health care delivery demands transformation to address nurse retention. Improving job satisfaction of nurses by creating access to empowerment structures and organizational support must be a priority for nursing leaders (Patrick & Laschinger, 2006). Pursuing research which focuses on rural nurse leaders' understanding of empowerment is crucial to address significant gaps in understanding recruitment and retention in rural Manitoba communities (Hughes, 2017; Jackson & Silas, 2024).

Rural health care faces additional recruitment and retention challenges due to infrequent nurse development, orientation, ongoing employee support, educational opportunities, and geographical location (Bish et al., 2014, 2015; Burman & Fahrenwald, 2018; Krebs et al., 2008; McCoy, 2009; Meub, 2018; Strasser, 2003). In rural areas of Manitoba, recruitment and retention difficulties are exacerbated by a lack of graduate prepared nurse leaders. Working in rural acute care, I observed the underutilization of evidence informed practice by nurse leaders and the negative impact on nurses and

patient well-being. Often, nurses are promoted to leadership positions related to years of clinical experience; therefore, they are unprepared to lead, and struggle to develop their leadership skills (Kelly et al., 2014). Nurse leaders must understand and utilize research to create healthy, attainable, and sustainable working environments where successful outcomes and optimal patient care results. Graduate education positively influences job satisfaction and informs knowledge translation to evidenced best practices (Jankelová & Joniaková, 2021).

Empirical evidence supports a strong, direct relationship between empowering workplaces, nurses' job satisfaction, and retention. Inadequate nurse practice environments, stressors in the workplace, and rural living directly impact nurses and nurse leaders' empowerment (Laschinger et al., 1997; Smith et al., 2023). Nurse leaders are in ideal and influential positions to create change and empower practice environments (Cziraki et al., 2020; Khan et al., 2018; Manning, 2016; McSherry et al., 2012; Spano-Szekely et al., 2016; Wei et al., 2019). Through serving as exemplars and mentors, nurse leaders encourage participation in activities to create empowering work environments and elicit job satisfaction, resulting in retention (Tian et al., 2020). The literature asserts that job satisfaction alone influences and supports retention making it arguably, one of the most important retention strategies (Ben Ahmed & Bourgeault, 2022; Bish et al., 2015; Ke et al., 2017; Patrick & Laschinger, 2006; Poindexter, 2022).

Purpose and Research Questions

The purpose of this study is to investigate how rural nurse leaders understand and create empowered practice environments. Empowered nurse leaders enhance job

satisfaction, increase organizational support that facilitates increased recruitment and retention of rural nurses in Manitoba (Loughery et al., 2025; Wilson & Laschinger, 1994; Yesilbas & Kantek, 2024). The research questions posed are:

1) How do nurse leaders describe and understand structural empowerment?

2) What organizational structures do nurse leaders identify as essential to empowered environments? (i.e., support, resources, information, opportunity), and

3) How do nurse leaders create structures supporting empowered environments? (see Appendix A)

Statement of the Problem

Nursing turnover is an unfortunate, increasingly familiar issue as evidenced by nursing shortages, a measurement used in healthcare workforce analyses, indicating someone left a job (Kovner et al., 2014). Nursing turnover rates are at an all-time high post the COVID-19 pandemic; in 2023's first quarter registered nursing vacancies increased by nearly 24%, the highest numerical increase observed among Canada's occupations (Bell et al., 2023; Ben Ahmed & Bourgeault, 2022; Falatah, 2021; Government of Canada, 2023; Jankelová & Joniaková, 2021; Kurtzman et al., 2022). 'Nursing turnover' is frequently linked to 'nursing shortages', functioning almost synonymously. Increased nursing turnover and nursing shortages significantly influence healthcare by increasing organizational liabilities and accruing associated costs (Kurtzman et al., 2022), decreasing employee productivity, producing low staff moral and cohesiveness (Falatah, 2021), increasing workloads, decreasing recruitment and retention capabilities, and reducing the safe, quality patient care delivered (Cziraki et al., 2020; Dahinten et al., 2016; Meub, 2018; Yasin et al., 2020).

The World Health Organization (2024) estimates a shortfall of 10 million healthcare workers by the year 2030 (Bell et al., 2023). As nurses account for the largest portion of all healthcare workers (about 50%), this predicted shortfall is alarming (Udod, 2023; World Health Organization, 2021). Canada is no exception to this trend; by 2030 a deficit of 117,600 nurses is predicted (Baumann & Crea-Arsenio, 2023; Scheffler & Arnold, 2019). As of June 2023, Manitoba had approximately 3,000 vacant nursing positions that are predicted to increase (Jackson & Silas, 2024). Workplace distress and dissatisfaction are commonly cited causes for nurse turnover (Hughes, 2017). Empowered nursing leadership is important to improve current nurse working environments. Nurse leaders play significant roles in creating positive working environments and have a major impact on rural nursing retention and recruitment, which ultimately impacts quality of care (Ben Ahmed & Bourgeault, 2022; Cummings et al., 2018; Falatah, 2021; Kuşcu Karatepe & Türkmen, 2023; Maier et al., 2023; Omery et al., 2019).

Definition of Terms

The term nurse leader is commonly referred to interchangeably as a manager, administrator, boss, and employer in the literature, and embodies all leaders who have staff reporting directly to them. The nurse leader who commonly practices in a hierarchal organization assumes “power” and influence on workplace functions. Leadership is defined as the ability to enable, empower, influence, inspire confidence, and generate support with others and is not to be confused with the concept of management, although both are closely related and often intertwined (McEwen & Wills, 2023). This individual may have differing educational or experiential backgrounds and are employed in nursing

leadership positions, for example client services manager (CSM), clinical resource nurse (CRN), chief nursing officer (CNO), chief nursing executive (CNE), nursing manager, and nursing administrators.

Merriam-Webster (2026) defines empowerment as the “granting of power to perform various acts or duties”. Empowerment is a widely used concept which addresses challenges in overcoming of feelings of powerless. The significance of empowerment as a concept is important to explore, as many studies and theories found that it is crucial to create positive outcomes for the individual, team, and organization (Kuokkanen et al., 2007). McEwen & Wills (2023) assert that, “empowerment is consistent with the contemporary views of leadership” (p. 384). When leaders create empowering environments, they motivate and create a productive, valuable, and beneficial power in employees, which in turn creates positive further systemic influence that is often cyclical (Kanter, 1979; Spreitzer et al., 1999). Empowering leaders are linked to increased job satisfaction, increased organizational commitment, increased productivity, organizational success, positive outcomes, proactive behaviours, and increased expertise (McEwen & Wills; Spreitzer, 2008; Ta’an et al., 2020).

The definition of rural pertains to those areas not declared as population centers (Government of Canada Statistics Canada, 2022). Small towns, villages, and other populated places in Manitoba with less than 1,000 population, are considered rural (Government of Canada, 2021; Government of Canada Statistics Canada, 2022).

Research Study's Conceptual Framework

Dr. Rosabeth Kanter's Theory of Structural Empowerment is the conceptual framework for this study (Kanter, 1977, 1993; World Health Organization, 2023). Structural empowerment is defined by the extent to which employees think they have access to empowering structures in their work settings (Sarmiento et al., 2004). Kanter's theory provides a useful framework for improving health care organizations by investigating nurse leaders' understanding of empowerment, and how it influences one's job satisfaction, and retention (Armstrong & Laschinger, 2006; Donahue et al., 2008; Laschinger et al., 2001; Lautizi et al., 2009; Ning et al., 2009; Seenandan-Sookdeo, 2012).

Kanter's Theory of Structural Empowerment originated in 1977, when Rosabeth Moss Kanter, a doctoral student in the field of sociology at Harvard, wrote her iconic work on cooperate power, *Men and Women of the Cooperation*. Kanter believed there was a need to investigate organizations to provide a perspective of organizational structure, the origin of empowerment, and how it can be used to improve outcomes. It was in this ethnographic research, over 5 years in which Kanter described the distribution of power in an organization. The implications of Kanter's findings exclusively considered, "…the advantages of a social structural model over a more traditional social psychological and individual models of the sources of work behaviour" (Kanter, p. 6). Kanter's theory has remained constant and is substantiated in nursing literature as a supported theory in establishing empowering working nursing conditions (Eriksson & Engström, 2018; Greco et al., 2006; Kanter, 1993; Kretzschmer et al., 2017; Laschinger et al., 2001; Lautizi et al.,

2009; Ning et al., 2009; Patrick & Laschinger, 2006; Ta'an et al., 2020; Wong & Laschinger, 2013; Yesilbas & Kantek, 2024).

The structural model proposed by Kanter (1977, 1993), places several elements together which previously appeared in fragments in other works. The intention of the theory pulled these fragments together in a way that created conceptual clarity, unity, and coherence, which could then be translated into action (Kanter). Kanter's theory offered new hypotheses, specifically related to organizational power and structure, and described how this power could either be oppressive or productive and determined the effectiveness of the system (Greco et al., 2006; Kanter). Kanter declared power as the ability to "get things done" by mobilizing human and material resources to accomplish organizational goals. Kanter argued that empowering work environments ensured employees had access to certain concepts to become empowered (Laschinger, Finegan, et al., 2009); Kanter's approach expanded on the critical views of people in organizations (Kanter, 1977). The theory's central purpose was to identify organizational and structural dilemmas, regarding empowerment and powerlessness, and guide change efforts (Kanter).

The literature encompassing the concept empowerment, commonly reference and utilize Kanter's Theory of Structural Empowerment which has been evaluated extensively in various settings since it originated in 1977 (Armstrong & Laschinger, 2006; Kretzschmer et al., 2017; Laschinger et al., 2001; Lautizi et al., 2009; Ning et al., 2009; Orgambídez-Ramos & Borrego-Alés, 2014a; Ozbozkurt et al., 2021; Ta'an et al., 2020; Wong & Laschinger, 2013; Yesilbas & Kantek, 2024). Her theory of structural empowerment explains what employees require in their work environments to allow them to perform their

jobs effectively (Read & Laschinger, 2015). Structural empowerment consists of the individual's access to resources, supports, opportunities, and information in the workplace (Lautizi et al., 2009). However, some literature refutes Kanter's theory because it only accounts for organizational aspects in that, "it does not address the nature of empowerment as experienced by employees" (Spreitzer, 2008). Spreitzer (1995) added psychological empowerment which consists of meaning, competence, self-determination, and impact. For a complete understanding of empowerment in the workplace, some scholars assert that it is imperative to view both perspectives, structural and psychological empowerment, as the overall empowerment picture (Dahinten et al., 2016; Laschinger et al., 2010; Laschinger et al., 2009; Spreitzer, 2008; Spreitzer et al., 1999). However, for the purpose of my study I have chose to focus solely on Kanter's theory as I believe altering organizational structures, encouraging empowerments' consequences are fundamental foundations to facilitate nurse leader recruitment and retention.

Relationships in Kanter's Theory

Kanter's theory has been open to interpretation in the literature, as in her writings no distinct visual representation was discussed (Kanter, 1977; Laschinger et al., 1997). Upon examining the theory, while concepts remain the same within context, some researchers present the concepts with nuanced differences (see Appendix H). Kanter (1977) stated that the main concepts of structural empowerment in organizations are the structures of power and opportunity. The structure of power consists of access to three factors: information, support, and resources (Kanter). The structure of opportunity is access to job conditions which provide individuals a chance to advance in the organization by developing skills and

knowledge (Kanter). It is through the means of both formal and informal power that one facilitates access to the structures (Bish et al., 2014; Eriksson & Engström, 2018; Greco et al., 2006; Kanter, 1993; Laschinger et al., 1997, 2001, 2010; Lautizi et al., 2009; Miller et al., 2001; Orgambídez-Ramos & Borrego-Alés, 2014a).

The theory implies that one central concept, structural empowerment, is generated by the relationship of the sub-concepts: access to information, support, opportunities, and resources. These sub-concepts have a direct relationship with formal and informal power. Laschinger et al. (1997) simplify Kanter's relationship findings (1977,1993) where, "employee empowerment evolves from both the formal and informal systems of the organization" and from these systems, "individuals who have access to opportunity, information, support, and resources are empowered and have control over conditions that make their actions possible, resulting in improved organizational effectiveness" (p. 342).

Kanter (1977) posits the difficulties in creating empowered structures in rural areas is related to the lack of growth, individuals working alone or in small teams, and that leaders are not in a position to develop others or transfer power to them (Kanter, 1979). This understanding increases the theory's relevance for use in this study. In rural communities, nurses comprise the majority of health care professionals and are revered as community leaders (Bish et al., 2014; Burman & Fahrenwald, 2018; Eo et al., 2014). Understanding how rural nurse leaders influence and create empowerment structures may facilitate initiatives designed in a contextually sensitive manner for rural nurse leaders and their staff.

Applying Kanter's Theory in Nursing

Many nursing scholars have studied Kanter's theory and adopted it from a social context to a nursing context (Eriksson & Engström, 2018; Laschinger et al., 2001; Orgambídez-Ramos & Borrego-Alés, 2014a; Patrick & Laschinger, 2006; Ta'an et al., 2020). Kanter's theory has been used extensively in nursing research (Al Sabei et al., 2022; Armstrong & Laschinger, 2006; Boamah, 2018; Donahue et al., 2008; Eriksson & Engström, 2018; Laschinger et al., 2001; Laschinger et al., 2009; Orgambídez & Almeida, 2020; Seenandan-Sookdeo, 2012; Trus et al., 2018). These scholars used the theory to enhance the understanding of empowerment as a concept, specifically as it pertains to the context of nursing practices, research, and theory. The use of Kanter's theory in the nursing literature has assisted in framing features of health care organizations that empower nurses and created an array of positive effects and results (Laschinger et al., 2009). This perspective/theoretical approach is pertinent regarding rural nursing as understanding these features promotes recruitment and retention of nurses, which currently is a high-priority issue of the current workplace shortage in rural settings (Bell et al., 2023; Ben Ahmed & Bourgeault, 2022; Bish et al., 2014; Falatah, 2021; Government of Canada, 2023; Jankelová & Joniaková, 2021; Kurtzman et al., 2022).

Kanter's theory is important to consider, not only due to the empirical support offered in the literature, but also for the significant clinical and practical values it holds. The theory's framework can be used to create engaged professional nurses and empowered nurse leaders which is important as, "the biggest challenge for establishing empowering workplaces… resides in the role of effective leadership" (Wong & Laschinger,

2013, p. 30). Kanter's theory is critical in preserving the quality of the healthcare delivery system, as well as the present and future health of all Canadians (Greco et al., 2006). As discussed, empowered staff perform better, have increased job satisfaction, (Lautizi et al., 2009; Ning et al., 2009; Ta'an et al., 2020; Wong & Laschinger, 2013), increased self-esteem, better work progress (Trus et al., 2012), and develop into authentic leaders (Wong & Laschinger, 2013). Kanter's Theory of Structural Empowerment has exhibited a direct impact by increasing job performance (Kretzschmer et al., 2017; Laschinger et al., 2009; Lautizi et al., 2009; Ning et al., 2009), creating the ability to foster quality inter collaborative relationships (Kretzschmer et al., 2017; Laschinger et al., 2009; Ning et al., 2009), increasing the sense of community (Patrick & Laschinger, 2006), providing abilities to achieve organizational goals (Dahinten et al., 2016), decreasing burnout, increasing quality patient care, increasing nurse and patient satisfaction (Lundin et al., 2024; Ta'an et al., 2020), decreasing turnover and increasing retention (Lautizi et al., 2009), having a positive effect on workplace attitudes and behaviours (Trus et al., 2012), enhancing organizational commitment, and improving the sense of experience (Dahinten et al., 2016).

It is important to take time, summarize, and think critically about Kanter's Theory of Structural Empowerment to establish if the theory fits its purpose when used in nursing practice, research, and theory (Chinn & Kramer, 2018). This framework directly supports and illustrates how Kanter's theory fits the overall purpose of this study. Kanter's theory is significant for use to understand how rural nurse leaders can use the theory to understand practice to produce desired organization, staff, and patient outcomes.

Summary

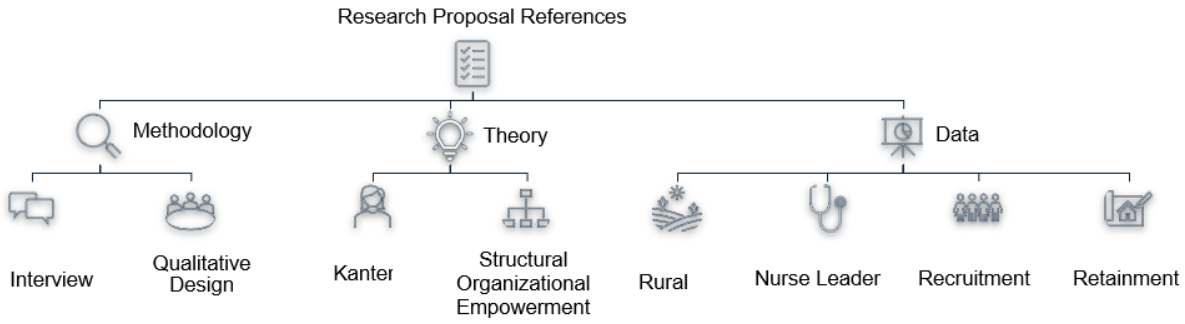
In summary, “The performance of nurses is substantial because they are the largest group of workers in most of the healthcare institutions and spend the most time with their patients” (Ta’an et al., 2020, p. 636). Kanter’s Theory of Structural Empowerment is relevant to understanding nurse leaders’ perceptions regarding empowerment and how this knowledge can positively impact nurse recruitment and retention. Rural health care is underserved historically and demands immediate transformation if we are to meet the population’s healthcare needs and wants. If rural nurse leaders understand the utility of structural empowerment, potential exists for its understanding to impact all levels of the organization(s), eliciting positive systemic changes.

Chapter 2: Literature Review

A literature review was conducted regarding rural nurse leaders and structural empowerment. Literature was strategically retrieved primarily from CINAHL, PubMed, OVID, Google Scholar, and Cochrane databases. Grey literature was included from the University of Manitoba’s MSpace. Search keywords/terms included: nurs*, lead*, empower*, Canad*, rural, structural, Manitoba. Terms were used alone to begin the search and then in combination. Relevant articles were reviewed for additional applicable literature potentially missed in the database search by bibliographic review. Articles were categorized and checked for duplications. The literature collected was catalogued into one folder, critiqued, and then notes were assembled to inform the following review and my thesis research regarding rural nurse leaders and the understanding of structural empowerment. A total of 122 references were included as they met criteria which were

that their contents pertained to nurse leaders, structural empowerment, rural nursing and/or qualitative methodology. Note Figure 1's reference inclusion decision tree below.

Figure 1. Reference Inclusion Decision Tree



Discussion of Conceptual Issues

Empowerment, as a concept, lacks adaptation for practice as it is described in different forms or contexts, used for both group and individual perspectives, is commonly a process and a result, and some argue, it has numerous definitions within diverse disciplines (Abel & Hand, 2018; Bradbury-Jones et al., 2008; Conger & Kanungo, 1988; Ozbozkurt et al., 2021). In the scholarly literature, empowerment is commonly referred to in managing challenges or overcoming a sense of powerlessness to gain mastery over one's life (Kuokkanen et al., 2007; Wåhlin, 2017). From an organizational perspective, empowerment is the transferring, delegation, or sharing of leader's responsibilities, authorities, resources to subordinates, which creates a share of power, thus empowerment (Conger & Kanungo, 1988; Inglis, 1997; Kanter, 1979; McEwen & Wills, 2023). In the leadership literature, empowerment is the notion of individuals who have power derived from accessible working conditions to accomplish one's work in a way which is meaningful (Laschinger et al., 2010). Empowerment stems from powerlessness,

such as radical social movements regarding a class system or in reference to minority or marginalized groups (Abel & Hand, 2018; Conger & Kanungo, 1988; Inglis, 1997). Empowerment is found in numerous disciplines in the literature including educational, political, psychological, sociological, and managerial/economic frameworks (Abel & Hand, 2018; Kanter, 1979; Kuokkanen et al., 2007; Spreitzer, 2008) Wahlin, 2016). In corporations, empowerment derives from emancipation from organization productivity or a process of personal growth (Bradbury-Jones et al., 2008). Empowerment theories are categorized primarily in the literature as having a psychological approach, structural approach, and the critical perspective. Where psychological empowerment focusses on internal personal beliefs and motivations and critical empowerment questions traditional power dynamics, the following study focussed exclusively on the structural approach whereby focussing on external systems, workplace environments, and community set ups (Laschinger et al., 2009; Spreitzer, 1996; Spreitzer et al., 1999).

Empowerment Versus Power

Kanter (1977, 1979, 1993) often alternated between the use of empowerment and power in her writings; these concepts were used synonymously. Conger and Kanungo (1988) were among the first to explore how empowerment and power are often viewed as synonymous concepts. However, they explain the synonymity is refutable; empowerment is enabling, and power is more akin to the concept of delegation. Empowerment cannot be limited to just gaining or exercising power, it is a more complex concept (Kuokkanen et al., 2007). Power implies a hierarchal system, where power is given or taken - not shared, and where leaders have command requiring others to be dependant (Men & Stacks, 2013).

Power denotes control rather than the notion of fairness, sharedness, and trust that are associated with empowerment (Brunetto & Teo, 2013; Conger & Kanungo, 1988). Rather than power signifying only that of dominance, control, and oppression, power can imply efficacy and capacity. “When the power is working well and is on the system is productive. Where when the power is off, and all are limited in senses the system bogs down to pressures” (Kanter, 1979, p. 66). Declaring that people need power to be effective at work is correct, but this does not explain where the power comes from, or why certain people in certain jobs appear to have more of it than others (Kanter, 1977). Kanter defines power as the “capacity to mobilize resources” and relays how informal and formal powers are required for mobility. Formal power is concerned with jobs that promote visibility and centrality to organizational goals, offer job recognition, and facilitate flexibility in decision making. Informal power results from the development of effective personal relationships, associations, or alliances within the organization by networking with colleagues, superiors, and subordinates from within and outside the organization itself (Bish et al., 2014; Eriksson & Engström, 2018; Greco et al., 2006; Kanter, 1977, 1979; Laschinger et al., 2001, 2010; Miller et al., 2001; Patrick & Laschinger, 2006). Kanter (1977) revealed how employees who have access to formal and informal power can acquire access to opportunity, resources, support, information, and furthermore, attain the central concept of structural empowerment. Laschinger et al. (2009) noted, “high levels of structural empowerment come from access to these social structures in the work setting” (p. 229). In rural settings, this access is notably different than in any other fields of nursing, as rural nurse leaders

continue to face additional difficulty in providing this access due to location alone (Hauenstein et al., 2014).

Kanter's sub-concepts help define the structural sources of power for empowerment: access to opportunity, resources, support, and information. Access to "opportunity refers to expectations and future prospects" (Kanter, 1979, p. 246). Opportunity creates a means for mobility and growth within the organization by increase one's knowledge and skills (Ning et al., 2009; Orgambídez-Ramos & Borrego-Alés, 2014a). Access to opportunity in nursing literature is exceptionally important for new nurses where, "opportunity means providing new graduate nurses with chances to safely develop new competencies and knowledge, to develop their leadership skills and to take on new challenges (Read & Laschinger, 2015, p. 1613). Opportunity is commonly referred to as the key structure or influential concept in structural empowerment, as it has direct influence on employee work, satisfaction, and productivity (Kanter, 1979; Miller et al., 2001). Laschinger (2012) notes, "the lack of an opportunity structure is what nurses have identified as causing dissatisfaction, burnout, turnover, and shortages. Lack of positive work conditions, lack of administrative support, and isolation from power precipitate nursing dropouts" (p.16). Access to resources, "… relates to one's ability to acquire the financial means, materials, and supplies required to do the work" (Laschinger et al., 2009, p. 229). Access to support concerns receiving feedback and guidance from peers such as colleagues, leadership or superiors, and subordinates. Such resources may consist of emotional support, helpful advice, or hands-on assistance (Bish et al., 2014). Access to information refers to acquiring the informal and formal knowledge base that is prudent to

be effective in the workplace (Orgambídez-Ramos et al., 2014). This is particularly important regarding rural nursing leadership as, “to be effective, managers need to be ‘in the know’ in both the formal and informal sense” (Kanter, 1979, p. 66).

Empowerment in Nursing Leadership

Analyzing Kanter’s theory through a nurse leaders’ lens will aide in understanding the concept of empowerment which is relevant to nursing. Regarding nurse leaders, empowerment is integral to analyze theoretical constructs, bridge understandings of the theory’s concepts which contribute to the nursing profession and more specifically, nurse leaders. Empowerment and access to opportunities are related to increased nursing commitment and knowledge (Greco et al., 2006). Furthermore, empowerment as a relational dynamic is a process in which the leader shares power with colleagues. Kanter’s theory is useful for nurse leaders to improve nursing work which benefits the individual, group, organization, all outside organization members and all that that entails (meaning all the other areas that the above listed go on to influence – similar to the ripple effect) (Bish et al., 2014; Dahinten et al., 2016; Greco et al., 2006; Kanter, 1979; Kretzschmer et al., 2017; McDonald et al., 2010; Ning et al., 2009; Read & Laschinger, 2015; Ta’an et al., 2020; Wong et al., 2013).

The research illustrates that positive leader-employee relationships result in employee empowerment (Jankelová & Joniaková, 2021; Laschinger et al., 2009; Marufu et al., 2021; McClain et al., 2022) which promotes commitment both directly and indirectly (Laschinger et al., 2009). Nurse leaders must effectively communicate and support others in all interpersonal interactions (Hauenstein et al., 2014). The attribute of creating

supportive and mutually beneficial relationships requires a relationship that is built on trust and respect that is mutually shared; empowerment is both provided and received (Wahlin, 2016). These relationships promote leaders to take employees' beliefs about themselves and work environments into account to design meaningful empowering working environments in nursing settings (Laschinger et al., 2009). Supportive mutual relationships increase job satisfaction, patient satisfaction, create healthy work environments, increase profession outlook, increase patient outcomes, create respect, increase collaboration and communication, and facilitate new conversations of awareness between employees and those in leadership roles (Cowden et al., 2011; Hughes et al., 2022; Hughes, 2017; Kanter, 1979; Kuokkanen et al., 2007; Labrague et al., 2020; Laschinger et al., 1997; Miller et al., 2020; Ning et al., 2009; Omery et al., 2019; Sawatzky & Enns, 2012; Ulrich et al., 2014; Wong et al., 2013). Nurse leaders occupy a key role in providing empowerment, by creating a social climate conducive to effective working relationships, promoting retention, decreasing burnout, and building positive organizational outcomes (Laschinger & Fida, 2014; Omery et al., 2019). Team role ambiguity decreases when teamwork is effective, tasks are known and understood, and one possesses the ability to perform such behaviours naturally by the means of communication (Brunetto & Teo, 2013).

Competent, empowered nurse leaders build stronger relationships with others as competence is associated with thoughts of being valued (Dahinten et al., 2016). Competence helps nurture an engaging, transparent, and organized climate, which is critical to elicit a positive work environment (Spreitzer, 1995). Competent, empowered

individuals and employees take a proactive approach towards influencing and shaping the work environment (Spreitzer et al., 1999). Competent nurse leaders shape appropriate educational endeavors to foster increased empowerment (Jennings et al., 2007). Individuals(employees) are increasingly likely to be empowered if one has charismatic and competent, inspirational leaders (Spreitzer et al., 1999). The impact of empowerment can be distributed from one employee to another creating large scaled organizational impact (Conger & Kanungo, 1988). Empowerment and impact from leaders influence positive consequences among employees and are measured by the amount of change they elicit in an environment (Abel & Hand, 2018). Currently, this is especially important in health care where the impact of empowerment is required for future success (Sawatzky & Enns, 2012). Highly influential leaders provide essentials for structural empowerment and impacts are visible through positive outcomes, such as increased job satisfaction leading to nurse recruitment and retention (Abel & Hand, 2018; Spreitzer, 1995).

Consequences of Empowerment and Nursing Leadership

A consequence of empowerment is autonomy (Lautizi et al., 2009). Perceived empowerment decreases perceptions of restraints and controls, thus increasing the autonomy one experiences (Brunetto & Teo, 2013; Greco et al., 2006; Laschinger et al., 1997); and creating an environment in which nurses act independently and provide quality care (Lautizi et al., 2009; Lundin et al., 2024). If nurses perceive autonomy, they are more likely to have control over the working environment. Increased autonomy is positively associated with increased perceived empowerment in the workplace (Kretzschmer et al., 2017; Patrick & Laschinger, 2006). When nurses experience autonomy, they have

increased job satisfaction, provide high-quality care, desire to uphold the profession, and experience decreased strain and turnover (Kretzschmer et al., 2017; Lautizi et al., 2009; Lundin et al., 2024). Empowered nurses are autonomous patient advocates who display improved autonomy and an awareness of their role in accomplishing organizational goals (Godsey et al., 2020; Ta'an et al., 2020). Autonomy can be an attribute of empowerment as well, where both are associated with collaboration, self-confidence, and authority to one's own practice (Sawatzky & Enns, 2012).

Empowered staff perform better, gain increased job satisfaction, (Lautizi et al., 2009; Lundin et al., 2024; Miller et al., 2020; Ning et al., 2009; Omery et al., 2019; Ta'an et al., 2020; Van Niekerk et al., 2023), increased self-esteem, better work progress (Trus et al., 2018), 2012), and develop reliable leaders (Laschinger & Fida, 2014; McSherry et al., 2012; Wong & Laschinger, 2013). Structural empowerment has a direct impact on job performance (Heras et al., 2021; International Affairs & Best Proactive Guidelines, 2012; Kretzschmer et al., 2017; Laschinger et al., 2009; Lautizi et al., 2009; Ning et al., 2009), that fosters inter-collaborative relationships (Ben Ahmed & Bourgeault, 2022; Kretzschmer et al., 2017; Laschinger et al., 2009; Ning et al., 2009), increased sense of community (Patrick & Laschinger, 2006), achievement of organizational goals (Cummings et al., 2018; Dahinten et al., 2016; Kurtzman et al., 2022), decreased burnout, quality patient care, increased nurse and patient satisfaction (Laschinger & Fida, 2014; Lundin et al., 2024; Muir et al., 2022; Omery et al., 2019; Patrick & Laschinger, 2006; Ta'an et al., 2020), decreased turnover and increased recruitment and retention (Lautizi et al., 2009; Marufu et al., 2021), increased impact on workplace attitudes and behaviours (Heras et al., 2021; International

Affairs & Best Proactive Guidelines, 2012; McClain et al., 2022; Trus et al., 2018), organizational commitment, and the sense of experience (Dahinten et al., 2016; Fernet et al., 2021), all of which are essential to sustain the rural nursing workforce and future of health care (Laschinger & Fida, 2014). Organizations successful in providing structural empowerment also are successful from an economic standpoint (Bish et al., 2015; McEwen & Wills, 2023) which is positively correlated with improved overall outcomes, increased satisfaction, easier recruitment, and new nurse ease of transition (Abel & Hand, 2018; Laschinger et al., 2010; Laschinger & Fida, 2014; Read & Laschinger, 2015).

Decades of successfully using Kanter's theory in the nursing discipline, nursing researchers altered the framework to illustrate how the theoretical concepts connected and/or linked to nursing research specifically. Laschinger's research program at the University of Western Ontario's Faculty of Nursing has had a profound influence on the use of Kanter's theory in nursing (Laschinger et al., 2001). In her work, structural empowerment is the central concept, with sub-concepts (commonly noted as "structures"): access to opportunities, resources, information, and support, through means of formal and informal power. Kanter's theory has been used and supported in research concerning internationally educated nurses (Eriksson & Engström, 2018), graduate nurses (Read & Laschinger, 2015), nurse leaders (Laschinger et al., 1997; Lundin et al., 2024; Patrick & Laschinger, 2006; Wong et al., 2013), nurses in rural locations (Bish et al., 2014), and urban locations (Kretzschmer et al., 2017), in various areas of patient care (Hauck et al., 2011; Laschinger et al., 2009; Lundin et al., 2024; Miller et al., 2001; Travers et al., 2020), academia (Orgambídez-Ramos & Borrego-Alés, 2014a), and nursing in other countries

such as China (Ning et al., 2009), Portugal (Orgambídez-Ramos & Borrego-Alés, 2014a), Australia (Bish et al., 2014), Jordan (Ta'an et al., 2020), Spain (Orgambídez-Ramos & Borrego-Alés, 2014b), Canada (Greco et al., 2006; Laschinger et al., 1997, 2001; Patrick & Laschinger, 2006; Wong et al., 2013), Italy (Lautizi et al., 2009), and Sweden (Eriksson & Engström, 2018; Lundin et al., 2024). Kanter's theory has also demonstrated usefulness in generality by being used to create hypotheses and generate ideas such as Conger, Kanungo, (1988) and Spreitzer's, (1995, 1999) psychological empowerment theory. By expanding Kanter's model of structural empowerment, these researchers offer a broader understanding of the empowerment process (Laschinger et al., 2001, 2009; Trus et al., 2012). Spreitzer (2008) explained how, "Kanter's original research has now served as the foundation of the large body of empowerment research from a social structural perspective" (p. 55). A "well-constructed theory has the advantage of being generalizable across similar situations within the domain to which it applies" (Chinn & Kramer, 2018, p. 189) which, notably, Kanter's theory has repeatedly achieved. Thus, this research illustrates a solid structure and the usefulness of its use in rural nursing leadership.

Rural Relevance and Implications

There is less focus on rural healthcare settings and more focus on urban contexts (Krebs et al., 2008; Tort-Nasarre et al., 2023). There are notable contextual differences between rural and urban nursing which limit the transferability and applicability of the empowerment research in these two settings and there is less empirical work regarding empowerment in rural settings (Bish et al., 2014). Rural nurses work under conditions which can lead to an increase in powerlessness where, "lacking growth prospects

themselves and working alone or in small teams, they are not in a position to develop others or pass on power to them" (Kanter, 1979, p. 70). Rural nurse leaders need to mobilize concepts in Kanter's theory to better equip individuals and employees to deliver high-quality care while advocating for rural communities' resource allocation (Bish et al., 2014). Given that nursing shortages impact health care globally, they are amplified in rural areas already known to be underserved (Tamata & Mohammadnezhad, 2023). Nursing shortages are exacerbated in rural areas as the "retention of nurses is a significant challenge for rural nurse leaders given the varying demands of rural nursing practice and ongoing isolation" (Burman & Fahrenwald, 2018, p. 129). In addition, the "rural nurse is a generalist but must also have knowledge of specialized areas" (McCoy, 2009, p. 129). Rural nursing shortages are intensified by organizational challenges such as scarce staff, limited resources (financial and physical), lack of organizational support, scarcity of research initiatives, and recruitment and retention issues because of geographical location (Bish et al., 2014, 2015; Burman & Fahrenwald, 2018; Hauenstein et al., 2014; Krebs et al., 2008; McCoy, 2009; Meub, 2018; Strasser, 2003). Rural nurses are embedded in their communities with intimate knowledge and expertise that can be used as opportunity to pivot from the past to a brighter future with rural nurses at the forefront of healthcare system change (Catton, 2021; Tort-Nasarre et al., 2023).

Rural nursing is unique, as rural nursing differs from urban nursing in both cultural and social structures (Burman & Fahrenwald, 2018; Strasser, 2003). Socially, the relationships between leaders, nurses, and patients are often personal and enduring. It is common that nurses know their clients/patients beyond a strictly professional relationship

(Strasser, 2003). Culturally, “people in rural communities often value very high self-sufficiency, self-reliance and independence coupled with stoicism which comes primarily from the … culture” (McCoy, 2009; Strasser, 2003, p. 458). Consequently, health is given low priority creating worsened conditions often requiring more acute care/services such as emergent transfers to tertiary centres and increased use of emergency room medicine (Strasser, 2003). Empowered staff are imperative to retain nurses and provide optimal patient centred care. Rural nurse leaders’ roles require resourcefulness, innovation, collaboration, and empowerment (Burman & Fahrenwald, 2018; Hauenstein et al., 2014). Rural nurse leaders face increased adversity to provide access to resources, information, support, and opportunity (Hauenstein et al., 2014). Urgent attention must address the future development and sustainability of rural nursing and its’ leaders’ empowerment perceptions, not only for the vitality of nursing, but for the organizational whole (Bish et al., 2015). Considering the unique challenges faced by rural nurse leaders is exacerbated by the lack of research to understand these issues, this study focusses on understanding how rural nurse leaders can create empowering environments to mitigate nurse turnover and facilitate staff retention.

Summary

Work environments which provide access to information, resources, support, and opportunities, through means of formal and informal power, both empower nurses and nurse leaders, and enable work to be accomplished in meaningful ways (Wong & Laschinger, 2013). “The benefits that rural nurse leaders may have from understanding the concept of structural empowerment are plentiful” (Bish et al., 2014, p. 35). In Kanter’s

(1997,1993) theory, opportunity exists to underpin tools to enhance nurses' ability to represent rural nursing in activities occurring at the regional, provincial, and national levels using the six sub-concepts of empowerment (Bish et al., 2014). "Adopting an approach informed by structural empowerment may see rural nurse leaders equipped with a greater sense of capability to participate in health reform and a greater preparedness to lead rural nursing in the future" (Bish et al., 2014, p. 35). If rural nurse leaders understand the value of empowerment, the potential then exists for its application to filter through all levels of the system (Bish et al., 2014). Rural nurse leaders can become a means to better equip nurses to aim for high-quality care, services, and advocacy (Bish et al., 2014). Creating empowered staff by utilizing knowledge (both old and new), generating a supportive and healing environment, identifying resources which can be used to address health problems and improve overall health, and providing a supportive environment to promote well-being and accomplish goals such as optimal patient care. Without empowerment, the nursing discipline, and health care in general, genuinely may be at stake. Therefore, in relation to the above review, this research is an opportunity to examine empowerment structures in rural Manitoba nursing leaders to understand where the current situation

Chapter 3: Research Methodology

The aim of this study was to explore structural empowerment among rural nurse leaders, to better understand the effects on recruitment and retention outcomes by utilizing a qualitative exploratory descriptive design. This design is best used when the phenomenon is complex, and information is required directly from those experiencing the phenomenon (Bradshaw et al., 2017). Interviews provide a "… rich understanding of the

context in which interventions are delivered" with ability to "… address a range of questions about an intervention, including applicability" (Polit & Beck, 2021). By learning from experiences and descriptions of the participants of their understanding of empowerment, knowledge from this study can inform interventions aimed to create empowered practice environments by reducing nurse role stress and ambiguity, increasing positive emotions, and increasing job satisfaction supporting retention (Bradshaw et al., 2017; Orgambídez & Almeida, 2020).

Research Methodology

This study being of qualitative methodology is within the constructivist paradigm which values disassembling old ideas and reconstructing them by putting ideas together in new ways (Polit & Beck, 2021). This is fitting for this study as I am taking old ideas from Kanter's theory and the new ideas generated from rural nurse leaders and presenting these findings in a new way. The use of this research design is appropriate for several reasons. Qualitative descriptive designs are relatively easy to carry out, and are ideal in understanding prevalence, attitudes, and knowledge among health personnel, which suits the proposed study (Kesmodel, 2018; Polit & Beck, 2021; Wang & Cheng, 2020). The proposed methodology is inexpensive, relative and easy to conduct, and can address multiple perspectives (Polit & Beck, 2021; Wang & Cheng, 2020). Qualitative description is appropriate given my research focusses on knowledge grounded in real human experience (Sandelowski, 2004). As a subjective focus, employing a qualitative methodology is a useful strategy to discover factors contributing to rural nurse leaders' structural empowerment as they experience it. Exploring the research questions qualitatively will

provide valuable information to guide health care organizations and rural nurse leaders in the development of structural empowerment.

The purpose of this study was to investigate how rural nurse leaders understand and create empowered practice environments. The proposed research questions were: 1) How do nurse leaders describe and understand empowerment? 2) What organizational structures do nurse leaders identify as essential to empowered environments? (i.e., support, resources, information, opportunity), and 3) How do nurse leaders create structures supporting empowered environments?

Setting

This study was set in rural Manitoba's Southern Health-Santé Sud region (SHSS). SHSS contains the fastest growing, increasingly diverse population in Manitoba (Southern Health-Santé Sud, 2024). The region has grown 20% between 2010-2020 and is projected to increase by 25% by 2030 (Southern Health-Santé Sud, 2019), encompassing 21 Rural Municipalities, 7 municipalities, 4 towns, 1 village, 7 First Nation communities, and many Metis, Hutterite, Francophone, and Mennonite communities (Southern Health-Santé Sud, 2019, 2024). It has also the largest group of rural nurses and is the most rurally populated health region in Manitoba with the highest percentage of rural spending (Southern Health-Santé Sud, 2022).

Sample

The participants were officially designated rural nurse leaders (n=10), including for example, chief nursing officers, directors of nursing care, and nurse managers. Additional inclusion criteria were that leaders be employed for a minimum 6 months in a permanent

position in SHSS Manitoba's health region. Recruitment was by purposive sampling and snowball sampling. Purposive with snowball sampling were selected as they are best methods to access this study's, potentially difficult to reach population (Etikan, 2016; Polit & Beck, 2021). The researcher determined a sampling frame from SHSS's website and chose convenient locations where potential participants are more readily available/present. An example of this is that the researcher attended a monthly Provincial Nursing Leadership Council's meeting to describe the study and ask for access to participants (see Appendix B). The researcher's information was given to enable the researcher to follow up with interested persons directly and provide them with information about the study. In accordance with SHSS's listed board of directors and facilities, the population consists of approximately 50 nurse leaders from which a representative sample was collected (Southern Health-Santé Sud, 2024). Following approval of access, an email study description was sent by an administrative assistant to all eligible participants (see Appendix C). If interested in participating in the study, the participants contacted the researcher by email or phone to arrange a mutually convenient time for an interview to take place. A follow up email was sent 2 weeks after initial contact to potentially increase participation. Additional measures for recruitment included posting study advertisements (see Appendix D) in staff areas in the facilities in the region.

Sample Recruitment

Recruitment strategies for this study incorporated a range of options including presentations and posters. Including snowball sampling provides opportunity to recruit additional participants whose colleagues or friends may also work in SHSS, enhancing the

potential pool of participants. An honorarium for each participant consisting of a $50 e-visa gift card was offered as appreciation and recognition of the time involved by this busy population and to encourage participation by the respecting and valuing of their time, whether in person or virtual.

Data Collection

Data was collected by conducting semi-structured interviews in person (n=2) or virtually (n=8) if preferred with each participant after completion of a consent form and demographic questionnaire (see Appendix E and F). An interview guide (see Appendix G) was created using Kanter's Structural Empowerment Framework (see Appendix H) to inform and guide the interview question development. Each single timed interview lasted a maximum of 1 hour in length and were digitally recorded. The 10 interviews occurred over a 3-month period. **I**nterviews were chosen as they provide a "… rich understanding of the context in which interventions are delivered" with ability to "… address a range of questions about an intervention, including applicability" (Polit & Beck, 2021).

Data Analysis

Data was analyzed using constant comparative content analysis (Bradshaw et al., 2017). Interviews were transcribed verbatim by a professional transcriptionist from Transcript Heroes Transcription Services and then was analyzed using constant comparative content analysis. NVivo, a data analysis software may be used to facilitate the data analysis (Bradshaw et al., 2017). All data was stored in a password protected file on a UM secure OneDrive platform. Transcribed interviews were reviewed and read independently to discover meaning in individual and overall data set(s). Key phrases and

sentences were identified and coded to compare for similarities, differences, and potential meaning(s) with the concepts embedded in Kanter's theory. Descriptive statistics was used to analyze demographic data/characteristics of the participants.

Rigor and Trustworthiness

Trustworthiness of the data was ascertained using the criteria of credibility, dependability, confirmability, and transferability (Bradshaw et al., 2017; Mabuza et al., 2014). All 10 successful applicants/participants were well informed and voluntary. Rigor was ascertained by having sufficient, abundant data whereby reaching saturation via appropriate methods. Credibility in the research was marked by providing concrete details by showing rather than telling, 2 member reflections and analysis by the study's academic advisor and the other internal thesis committee of 4 transcripts (2 transcripts each) (Mabuza et al., 2014; Tracy, 2010). This study will influence and affect audiences through naturalistic generalizations and transferable findings (Tracy, 2010). Transferability was provided by thick description of prolonged engagement during interviews and purposive sampling as described (Mabuza et al., 2014). Data saturation was achieved with the 10 interviews as statements became repetitive and consistent themes became apparent (Polit & Beck, 2021). Confirmability and transferability were ensured by practicing the strategy of reflexivity and ensuring triangulation by corroborating evidence from participants (verbal and non-verbal), rendering a more holistic picture of rural nurse leader perceived empowerment under study (Mabuza et al., 2014). This study has meaningful coherence by achieving what it purports to be about by using the methods and procedures

stated, and interconnecting the literature, research purpose/questions, findings, and interpretations with each other (Tracy, 2010).

Ethical Considerations

Approval from the University of Manitoba's REB 1 was successfully sought and granted. Confidentiality and anonymity were ensured by deidentifying demographics i.e. no names or locations noted in any research documents (ex. transcripts). Consent forms and personal information disclosures were completed and stored separately from interview transcripts so they could not be linked nor individuals identified. A mutually agreed interview location helped increase participant's privacy, foster openness and gave space for more detailed responses. Information obtained for the study has and will be kept stored for 7 years (August 2032).

Reflexivity and Positionality

Having been employed as a frontline nurse in rural Manitoba for the past 10 years and a witness to the underutilization of evidence informed practice by rural nurse leaders to facilitate recruitment and retention. My interest is rural nurse leaders' potential to understand and utilise empowerment, whereby creating empowered work environments, mitigating turnover and positively impacting rural health care (Holmes, 2020). I will be reflexive by identifying preconceptions I bring to this study (Holmes, 2020). My pre-study beliefs are that rural nurse leaders are not empowered which is negatively impacts rural work environments decreasing recruitment and retention strategies. During my research I will be keeping a journal and reflecting on my thoughts and feelings as I progress in my understanding, positionality, and interpretation of the data. I will spend time thinking about

how I locate myself in the subject whereby thinking that rural nurse leaders are often promoted to a position of leadership by clinical experience and seniority and often unprepared to lead. I am influenced by working in rural health care where I have only observed nurse leaders struggling with being a leader. I can identify that this may lead to my bias in thinking all rural nurse leaders do not understand nor are empowered. I see myself as an outsider to nurse leadership and hold innate biases to not feeling empowered during my career by those in rural nurse leader positions. I reflect that although this is my perception and therefore my reality, this is malleable, and I am open to the idea that these thoughts I have are not absolute and true and have changed over time.

Limitations

The study is limited as participants were recruited from one health region in rural Manitoba. Purposive sampling is limited by a non-random selection of participants which may impede the ability to draw inferences about rural nurse leader populations (Etikan, 2016; Polit & Beck, 2021). Essentially, the opportunity was not equal for all qualified individuals to participate, meaning the findings are not necessarily transferable to the entire rural nurse leader population (Etikan, 2016). Kanter's framework, in which this study was based, does not account for variance such as the type or location of the organization and the possible cultural differences that exist within organizations (Chandler, 1986; Laschinger et al., 2001, 2010; Laschinger et al., 2009; Lautizi et al., 2009; Spreitzer, 2008; Ta'an et al., 2020; Trus et al., 2018). A general assumption is that all organizations hold a desire to create empowered employees. Kanter's 1977, 1993 assumes that behaviours in organizations are generated from structures rather than individuals themselves. Where

responses are, "… not as much internal, rooted in the person, as they are structural and situational" (p. 10). Kanter's theory does not consider the individual perspective regarding empowerment such that, "…Kanter's theory is on the employees' perception of the actual conditions of the working environment, and not on how they interpret this information psychologically" (Laschinger et al., 1997; Orgambídez-Ramos & Borrego-Alés, 2014a, p. 29; Spreitzer, 2008; Wong et al., 2013). However, for this study, the researcher focussed primarily on empowerment structures while acknowledging and being aware that structural empowerment is not in itself the whole interpretation of rural nurse leaders' empowerment.

Summary

Following defense and approval by the thesis committee, the above proposed qualitative exploratory descriptive design recruited rural nurse leaders (n=10) by purposive and snowball sampling in the SHSS's rural Manitoba health region. Data was retrieved from a demographic questionnaire and (1:1) interviews. Descriptive statistics analyzed the demographic data's characteristics. Data was analyzed by constant comparative analysis. Interviews were transcribed verbatim by a professional transcriptionist. Interviews were listened to and transcripts were reviewed individually and collectively to identify overall data set(s) and coded for comparison. Trustworthiness and rigor were upheld throughout the research study processes. Study results will be disseminated to the thesis committee and academic resources for publication and for knowledge translation in nursing practice.

Chapter 4: Findings

The purpose of this study was to investigate how rural nurse leaders understand and create empowered practice environments. A deeper understanding of empowerment among rural nurse leaders can clarify whether and how they perceive themselves as empowered, offering organizations valuable guidance for developing empowering leadership practices. Empowered nurse leaders enhance job satisfaction, increase organizational support that facilitates increased recruitment and retention of rural nurses in Manitoba (Boamah, 2018; Patrick & Laschinger, 2006; Penconek et al., 2024; Ta'an et al., 2020; Trus et al., 2018).

To explore empowerment among rural nursing leaders, all nursing leaders in one rural region of Manitoba were invited to participate in this study. 7 were virtually recorded audio and visual by zoom, 1 was conducted by zoom audio recorded without video virtually, 2 were zoom audio recorded without video and in person. The participants were representatives of rural nursing leaders in the region who occupy rural nurse leader roles (see Table 1). Nine participants identified as female, and one identified themself as male. One participant was 31-41 years of age, 8 participants 41-50, and 1 participant 51-60 years of age. Eight participants obtained their undergraduate nursing degree, one their nursing diploma, and one a graduate degree. Years worked as a nurse ranged from 13 years to 32 years with a mean of 19 years. Eight participants had been in a rural nurse leader role for 1-10 years and 2 greater than 10 years. Fifty percent of participants declared working in acute settings and the other 50% declared working in long term care and other. Eight participants worked in their leadership position full-time, whereas 2 participants were

part-time. Part-time nurse leaders illustrated flexibility and an ability to adapt to challenges when they were not at work. Some days participants noted they were not physically there in the workplace to fulfil their role. However, when they were in place, they found creative solutions in a smaller time frame and had excellent communication skills to maintain efficiency when part time. Due to the smaller number of designated rural nursing leaders in this region, identifiable data was removed from the results which could compromise the confidentiality of the participants.

The research questions addressed in the interviews were:

1) How do nurse leaders describe and understand structural empowerment?

2) What organizational structures do nurse leaders identify as essential to empowered environments? (i.e., support, resources, information, opportunity), and

3) How do nurse leaders create structures supporting empowered work environments?

During data analysis two themes emerged. Theme 1: Support and Relationships and Theme 2: Rural Roots. The following will discuss these themes and their subthemes found therein data collection (See Appendix I).

Theme 1) Support and Relationships

A highly developed theme that emerged from the data was the concept of building connections with staff and colleagues creating a working alliance which was conducive to nurse leaders feeling of empowerment in their workplaces. This theme was defined by the ways in which participants felt support and relationships affected and influenced their sense of empowerment in the workplace. The forms or types of support and relationships contributed to how the participants perceived their workplace and played a major

determinant to their success as a rural nurse leader. All participants noted the struggle and process in forming bonds with others and developing this supportive network that is constantly evolving and changing. The theme, support and relationships were represented in four categories: i) Developing and Sustaining Relationships (Autonomy), ii) Quality of Relationships (‘*Being Human’*), and iii) Insight of a Leader.

Developing and Sustaining Relationships

All participants described developing and sustaining relationships as a key aspect in their role as a rural nurse leader. The work in not only growing working relationships but the importance of upholding these healthy relationships proved pivotal in the participant’s ability to complete meaningful work exhibiting job satisfaction. Within this category, a sub-category emerged and was labelled as autonomy. All participants described the importance of building relationships with staff and colleagues, through self reflection, and/or with the community. By building supportive, high-quality functioning relationships, participants indicated they had an increases overall sense of empowerment by means of support from other individuals and themselves. One participant noted the importance of how nurse leaders crucial to start building relationships early on.

> *I think it is hard for people, especially when you’re getting to know new people. There’s some unknown of, “What will happen if I go talk to this person?” But I really try hard to start building that relationship early on. (NL6)*

Supportive relationships with colleagues, and in this case subordinates, were described by one participant as being especially important.

> *Engagement from staff and developing relationships, getting to know them, and have had great team experiences in doing that [building relationships at work, being supportive, job satisfaction]. (NL1)*

Taking care of direct report staff was important for participants to create relationships that could withstand the stress of time and change. A connected network was central in many discussions to accomplish tasks and meaningful work. Investing time as a rural nurse leader helped to strengthen their smaller teams and increased job satisfaction for both participant and staff and resulted in better work outcomes. Participants stressed the importance of supporting staff; those staff members who were trained to provide essential technical, administrative, and operational knowledge and support to provide patient care and keep the organization running smoothly.

> *That's why Southern Health is great, is because I can reach out to any allied health or [really] any working individual, and even if it's not them, they might point me in the right direction to help out a staff member. (NL9)*

Some examples discussed within interviews were health care aides/nurse aides/orderlies, managers, maintenance, unit clerks, registration clerks, housekeeping, dietary. Without essential support staff such as health care aides, unit clerks, registration and administration, nursing jobs would be difficult; these supportive bonds between them reaffirm them in the work they are doing.

> *So just like you've advocated for residents or your patients, you are now advocating for your staff … it is essential to be present for your staff and give them [your] time. (NL5)*

Working with colleagues and developing relationships across partners or as some participants noted their counterparts were relevant in feeling empowered to lead their staff. Feeling confident and welcomed into their leadership roles occurred when reciprocal communication was established early on. Learning as a leader was encouraged and welcomed, and participants discussed their leadership teams working together to accomplish important goals. This supportive, accessible network was essential as one participant stated.

> *You're not hesitant to connect with somebody and ask questions. We've got group chats ... and just having those connections and those relationships is huge support. (NL2)*

Colleagues who were in similar roles in different locations/sites shared their struggles and offered support in times of need. One participant discussed the benefit of being able to collaborate with their partners and receive feedback. Less experienced participants learned from those who were in the role longer. Talking to someone who has had experience as a nurse leader was beneficial to grow participants as rural nurse leaders. This sense of safety and support was fundamental to their relationships with others.

> *I try to be an encouraging colleague to other team members when they're experiencing challenging situations. (NL8)*

Participants often worked with many other nurse leaders in different roles such as in direct patient care areas, co-managerial work, or as superiors. There were fewer numbers of staff in smaller rural sites; participants know their peers on a personal level, which were not often replicated in larger facilities with higher employee numbers.

And supporting people, both in work and personally, because they were sick, their kids were sick (NL1).

Supportive relationships developed with colleagues such as doctors, receptionists, janitorial staff, and maintenance staff were integral to effective patient care. Participants suggested and described how these relationships could prove difficult as they were in varying roles but were similar in one end goal: patient care.

I also found support in our nurse practitioner and Clinical Resource Nurse … we just worked together to identify just ways that we could support each other in our roles. (NL2)

Relationships and support for some participants also were noted through reflection regarding one's own practice as a rural nurse leader and the interchange of roles.

I try really, really hard to do what I've said I'm going to do it… I try really, really hard to be dependable, and consistent, so that the [staff] have that trust there, that they can trust me in my leadership role, that I'm going to do what I say I'm going to do. (NL8)

Autonomy. All participants described some form of independence as integral to one feeling empowered in their work. In the study, autonomy was understood as the degree to which nurse leaders were able to provide support and guidance to nurses to make decisions, influence patient outcomes, and exercise professional judgment in creating and sustaining healthy work environments. The ability to be autonomous meant to be independent and able to make decisions independently- which participants highlighted as being integral to working in smaller more isolated rural health care environments. Being

dependable and consistent encouraged participants to be autonomous and take control of their practice.

> *I think autonomy can play a role in some of this too, in feeling supported, being able to give staff some ability to choose some of the ways that the work happens. (NL6)*

This quality was something that many participants acknowledged as a source of empowerment via a supportive relationship with one's nursing leader.

> *I lean much more towards empowering my staff and giving them a sense of autonomy, letting them make mistakes, and space to make mistakes, letting them explore a little bit more. (NL 9)*

By empowering staff and giving them a sense of autonomy and control over their practice, participants noted how they believed autonomy played a role in staff not feeling supported and empowered in the workplace and led to increased decision-making capabilities bringing a sense of accomplishment in one's work.

> *Feeling supported and being able to give staff some ability to choose some of the ways that the work happens. As a manager, I don't feel like I want to direct every single part of the way that they do their work, there's some things that are a must, but sometimes it's, OK- so these are the things I need to see… but how you bring about these things, there's actually a couple different paths that could be taken. I want the team to decide what they think would be the best… I feel that they're often in a better position to determine that than I am, because I'm not the one who must do the work every day. (NL6)*

One strategy to increase autonomy experienced by leading nurses was to:

> *Let them try those things and don't be a micromanager and be in [their] space all the time, let them do that: try to give them the ability to make choices and contribute or be included in the how, as much as possible. (NL 6)*

Quality of Relationships

The data revealed that empowerment was influenced not only by the existence of relationships, but also by the traits and values embedded within them. Participants identified trust, accountability, honesty, transparency, open communication, respect, integrity, and kindness as essential qualities of high-quality relationships. These relationships were meaningful because of their authenticity and genuineness, which participants described as major attributes contributing to workplace empowerment. When working with subordinates or direct reports, one participant described how this quality deepened relationships with staff, stating:

> *By actually being accountable to them and genuine. I think it's important to be really honest and transparent with people- and let them know if I don't have an answer to something, which, of course, nobody has answers all the time, right? That I will follow-up on that and find out for them, and then it's important to come back and actually let them know that you've done that follow-up. (NL1)*

When asked how genuine and authentic they were with staff all participants responded:

> *When you say you're going to do something … you follow through or provide some feedback if it's not how you would like it to be … I think that I'm very open with what's happening, so I try to keep the staff in the loop on what's happening so that they're not surprised. So I work really hard at communication. (NL5)*

Authentic, open and honest communication positively attributed to better working relationships overall.

> *…having someone that you can have that trust relationship with, or who can just help you through some of those feelings that go along with those types of things, I think can be helpful. (NL6)*

This communication was not only important with the participants and their subordinates, but also with the participants' leaders as well. That the direction of communication flowed both ways, was consistent, accurate, and timely.

> *I've been honest with [them], right, and so if they have questions, I am honest with my answers. And I feel like I get that from my supervisors as well… so it goes both ways. (NL5)*

'Being Human'. Germane to every interview with participants was the idea that '*being human'* was inevitable. This terminology was referenced both directly and indirectly when discussing relationships and spoke to the quality of that relationship. In this context, '*being human'* reflected an understanding that staff have lives beyond the workplace, as well as personal limitations and a need for balance. This awareness encouraged nurse leaders to approach staff with empathy, compassion, morality, and reciprocity within relationships that were often changing. Participants posited how human beings tend to crave social connection and validation to thrive in groups or teams where they felt heard and were welcomed as an integral part of the unit.

> *I think just noticing what people do and validating that, because I think it's important that people feel like they get recognized, not only … for the good things that they do,*

and don't only get conversations when you're looking for some sort of correction. It also creates, I think that, validating those positive things, creates the trust relationship for when you do need to talk about something that maybe could have been done better, or because then they can know that it's coming from a good place, because you've already built this relationship of trust, right? (NL6)

Participants described how nurse leaders understood what it was to be human and how it was integral to discover common understanding with those around them to develop and sustain comfortable and healthy working relationships.

... I am approachable and non-judgmental too, right? - which is why, I guess maybe I know things about the staff that I just, I don't really need to know sometimes, but they are, there's comfort right, that they can disclose things to me. But outside of just following up and being open and honest with some of our new grads, just by owning that, we don't always do this well, so let me know if there's struggles. (NL3)

Approaching [their work] with the understanding that because they were a nurse leader did not mean that they know everything. Normalizing behavior that all human beings make mistakes and it was how nurse leaders handle these mistakes that made the difference in contributing to an empowering workplace.

I know we've had some other newer managers, and it's like nothing is too small to ask, or it's stuff you think you should know that all of a sudden, is at the back of your brain. Ask, right. I think that is the biggest thing, is just constant learning. Ask the questions, reach out to your coworkers, be able to say you don't know if you don't know. And owning mistakes or errors and open mind right. (NL3)

One participant summed up '*being human'* and how to be human in a nurse leader role.

> *Be humble, you're going to make mistakes, learn from the mistakes. Accept the criticism and the repercussions with grace and then learn from it and do better. And keep putting in that extra effort to grow yourself, because it'll make things better for you, and it'll create a better team environment in your workplace as well. (NL9)*

Insight of a Leader

Participants illuminated the importance of self-awareness through having consistent and regular awareness whereby analyzing their own values and assumptions. Being intentional in leading self by purposely directing thoughts, behaviors, and emotions to lead others was perceived to be motivating and a pillar to great leadership. Participants discussed how being a nurse leader it was important that they '*show up'*. Participants were candid about their emotions and how they acknowledged the importance of their relationships within themselves as nurse leaders encouraging them in their roles. One participant explored difficult times and the possibility of making an error and acknowledged when their staff were struggling and the working relationship was in demise that they too were struggling within themselves.

> *But I own it. I feel the same. I said, "Yeah, you're going to see me cry. I might be happy. I might be sad. You're going to see me cry at some point. (NL3)*

Harboring harmful feelings was deemed unhealthy for everyone. Being open and honest helped to free negative emotions, thoughts, and behaviors, creating a stronger connection within their team.

I feel like I'm very open and I've tried to encourage that amongst my teams, to be really honest with how they're feeling and transparent. (NL10)

When asked about self-care and nurturing this self-relationship, participants often neglected their own self and helped others instead, often to their self-detriment. However, participants shared how they tried to mitigate this by redirecting their energy into maintaining their own health in their leadership role.

Truthfully, I haven't always done a great job of that [leading self], I still don't know that I do a great job of that. I am trying to have more work life balance now than I have maybe ever prioritized before. (NL6)

Many participants described their leader role as requiring a constant conscious effort to support their staff through active listening. During the workplace stresses of COVID, participants explained this introspection as essential to maintaining a successful nurse leadership career with complete role engagement - such as by checking in with their staff. COVID played a pivotal moment in understanding their relationship with themselves and stressed the awareness of their importance in their role as a nurse leader. Creating work-life balance, giving time to create and nurturing oneself was discussed by all participants.

I try to have some pretty good boundaries and to create some work life balance. So, I work from eight to five, and after 5 p.m., this is my time, right. (NL10)

But not being fulltime... If I were to do this fulltime, I would just be burned out. This way, it's like I do have time at home to do other activities or engage in other endeavours, so that it isn't all work all the time. (NL7)

Similar ideas were summated by one participant discussing their relationship with intentional self care.

> *No, it [having a relationship with yourself] is actually important. I think it is incredibly important. I found it's not easy, you have to be deliberate about it, especially when you're a manager having the overall work life balance, you can't work all the time. In a nursing leader role that is particularly tricky, as opposed to being a direct care nurse, because you finish your shift, you may do overtime, you may end up staying longer than expected, but at the end of that, you hand off your work to someone else. In a nurse leader role whatever you didn't do is there waiting for you the next day… but it must wait. (NL1)*

Becoming a Leader. A more specific analysis of participants' insights was how they compartmentalized their journeys and the pathway to a nurse leadership role, for instance, learning what it meant to be a nurse leader and the role demands. The participants discussed what it was like to becoming a leader and how their perceptions or understandings shaped who they are as a nurse leader. Participants described there was a learning curve in becoming a leader. Participants expressed a desired for an increase in responsibilities, better work-life balance, and a dissatisfied fulfillment in their former non leadership role.

> *I have younger kids at home, so it's important for me to find a work life balance. And they are active so I, like so part of it is that I have to go. I have to – I'm driving them different places, right, to their activities. So I can't be on working all evening, because I actually have another hat to wear so. (NL5)*

How participants became leaders and what being a leader meant to them was role modeled by their superiors who directly influenced them both positively and negatively. Participants desired to emulate positive leadership by carrying forward their previous leaders' values into their own leadership practices. Participants desired to emulate their positive past leaders while avoiding some of the negative ones.

> *I would say, when I was in my [administrative] role, in a small facility with a low EFT. Right away, I would say, leader, my director, manager at the time really kind of spoke to me, and just identified that there's capacity there, there's gifting there, there's ability there …, facilitated [me] just taking some of the regional leadership courses that were available, encouraged me to do that. Then [I] started kind of dabbling, being given extra assignments because it fit with my skill set. (NL8)*

Participants found support and guidance were essential in becoming a leader where *it was okay to ask for help. (NL6)* When certain leadership skills needed development or additional tools were required, *I just reached out to a lot of people and asked for training. (NL2)*

When developing from a front-line employee to a nursing leader, previous fellow coworkers now saw the participant as a leader. The development of being a leader requires growth in new ways. One participant described that when moving from coworker to leader, their colleagues trusted them in this change given their past experiences, bonds, and trust; this experience facilitated becoming a leader and making difficult decisions.

> *…because they know that it's coming from a good place, because you've already built this relationship of trust, right. (NL6)*

Given their pre-existing relationship(s) with staff being a leader was supported.

> *I feel like whenever you go through challenging situations, if there is something challenging or serious or stressful events, going through those together that bonds you, and you develop [their] trust based on how you perform in those situations. (NL7)*

For the participants being a nursing leader meant:

> *… being present, sharing with them in conversations. Being open, if something difficult is coming up; transparent, if there's changes coming. Engaging them for feedback, I think is important too, versus just being the one to make the decision, and tell them how something is going to be. I think employee confidence gets built based on the support that they have in place, right they need to know that they're in an environment where their coworkers are going to support them, where the rest of the team is going to support them, and their leadership. (NL10)*

Reflection of a Leader. As the participants became officially designated in their role as a nurse leader, they were thoughtful about what was important in an empowered nursing leadership practice. Reflecting as a nurse leader was essential to answer why they were in their roles and what it meant to them. Looking back on their development, participants explored and examined what, who, where, when, and why being a rural nurse leader was their future. Participants explored now that they were in nurse leader position can reflect on their previously held *becoming a leader* connotation.

> *There's going to be times where you're going to really question why you took that position. (NL3)*

Reflecting on mentors and role models, participants aimed to be more like these individuals. Emulating the values and missions of past leaders resounded with each individual participant's own values and missions.

> *Integrity, communication, I've been honest with them, right, like so, if they have questions, I am honest with my answers. I feel like I get that from my supervisors as well, right. I think that's what I get, so I can trust them, and that is what I relay down to my staff, it's the same both ways. (NL5)*

Developing and maturing through a variety of roles, some in leadership and some not, those previous experiences gave way to the leader participants became.

> *Previous leadership in the many roles that that I've played, essentially knowing what I liked and didn't like, being a leader, that's what it came down to. If I appreciated something as a staff member, I wanted to reflect the same. I've had the honour of having some great managers and peers, and I've tried to just maybe attain that level of support and leadership. (NL4)*

Being able to articulate and reflect on past experiences with fellow mentors or leaders, one participant reflected on these experiences.

> *If I think about the past, I've had a lot of really good managers who have allowed me to ask questions and to understand why, why we are doing what we're doing to understand the process. I have used that in my leadership here as well in making sure that the staff understand and that they have the freedom or the being comfortable to ask questions about why we're doing what we're doing. It helps get*

them onboard and feel like they are part of the process instead of just being dictated to. (NL5)

Another participant explained how this reflective practice was helpful but also a challenge as it was a constant work in progress. Participants never stopped reflecting on their practice as a leader, the true importance of this reflective process was ongoing. This reflective practice occurred continuously as reflection facilitated their understanding and meaning of how they were as a leader.

Thinking about kind of senior leadership and my colleagues, I think this is something that we have struggled with each other, building that trust and confidence, I think it is a work in progress. A lot of it just has to do with open communication and being clear with expectations, minimizing miscommunications and try and build that trust up again. (NL9)

Participants reflected on how they felt a 'tap on the shoulder' to enter nursing leadership. For some it was a challenging situation, such as the COVID-19 pandemic which forced them into a nursing leadership role

COVID helped me realize my leadership capacity and skills were already there. That is where some of my skills were noticed. (NL8)

Others felt that they always knew they wanted to be a nursing leader.

I had a passion to be a leader. I've always known that I wanted to get into management, so I think that the only thing really that I had going, because I knew nothing else, was just the desire to advocate and support my staff and make this a better place to be in. (NL5)

The meaning of being a nursing leader and reflecting on the pivotal role participants played in empowering staff and encouraging healthy workplaces was evident in the participants' responses and discussion.

> *For me, showing up and being present is a big part of what I have learned works well as a leader. Not just in those times when things are going well, but also when things aren't going well. If you can walk alongside someone as a leader, I think buys you a lot of integrity amongst your staff, and they feel like they're supported. (NL10)*

Theme 2) Rural Roots

The second theme that emerged from the data related to participants having a deep-seated connection to their community that was unique and distinctive from their urban counterparts. It was evident that the complexity of living in a rural setting coupled with contextual differences existing site to site directly impacted participants perceived empowerment. This theme had three subthemes i) Growing Your Own, ii) Smaller Versus Larger (Resources and Community), and iii) You Are Not Alone.

Growing Your Own

In the participants' health region, SHSS, it has been noted to have been the fastest growing region in Manitoba over the last 10 years (Southern Health-Santé Sud, 2024). Not only was it the fastest growing, but it also employs the largest amount of rurally employed nurses in Manitoba (Southern Health-Santé Sud, 2024). Participants addressed the importance of encouraging individuals from the SHSS rural communities to become health care professionals and stay or return to the region post education. Participants described those rural dwellers who became health care workers often returned to rural living at some

point in their career. Once rural roots were established, participants felt it was beneficial to *'keep watering these roots'* and encourage opportunity and growth. The participants described growing their own as a form of succession planning. They emphasized the importance of planting seeds for future leaders in their current employees by supporting them to feel empowered and satisfied in their work. One participant described how they encouraged the development of others.

> *I support the bridging programmes for HCAs from uncertified to certified, as well as helping at a site level with management and myself. It's more of I'm going to help you find a different job if that's what you want, and if that's what you need. I love my staff, I love to keep my staff, but if this is their pathway, I will do whatever I can to support them. I've reached out to other management to getting a different job under a different pathway that supports them. (NL4)*

One participant acknowledged that not all employees had this drive to go further in the organization. Some staff 'stand out' with values and qualities demonstrating *growing your own* such as taking on additional roles or responsibilities with initiative, exhibiting creativity and a desire for continual improvement, and providing others with support.

> *It [What Matters to You document] tries to identify what employee's goals are, right, what they need from their team environment to be supported, what they think their team can do better, what they excel in, those types of things. And I feel like you can build off that information and those questions to get an idea of how the team is functioning, what the needs are on the unit those types of things (NL10)*

These attributes in employees could be utilized in different ways to continue growth in the organization. Participants discussed providing resources, opportunities, and supports and how they assisted in developing their employee's potential and enriching one's work. Occasionally it was the nurse leader who was in the position to provide these ideas and *grow their own*.

> *I think, identifying opportunities that I see within staff to try to grow, right …whether it's an area that they have interest in and they want to expand their horizons further … maybe I've seen as a strength and try to tap into them seeing that as a strength too, to grow them within the organization, has kind of been my goal as well. (NL10)*

Retaining rural health care workers was essential to growing and developing future nurse leaders.

> *Presenting them with educational opportunities that the region is putting on, and "Hey, this would be something that maybe you would find valuable". Encouraging them to go and validating that I see the things that they're doing to grow their leadership on the unit. There are people that are taking an active role in doing things, just trying to support them. I think it's also important for succession planning, we should be thinking about the future and growing people to replace us, even if we're not planning to go anywhere, you also never know what other opportunities present themselves at that, education or support maybe helps them feel confident to apply for; it just helps get people ready for the next thing. (NL6)*

Participants described how it was important for rural nurse leaders to continue to develop themselves to become better leaders. Remaining knowledgeable in their role and present in a rapidly changing health care environment were essential for participants.

> *My health region has, is supporting me and other managers, or people who want to go into management in taking the Red River Health Services Leadership Management course, or something like that through Red River College. (NL5)*

It was beneficial for all employees to remain in their role while continuing to develop and improve upon their practice and procure job satisfaction. When working in rural areas, participants often had a large span of control due to organizational demands related to fewer formal leadership positions. Consequently, mentoring was important to develop your newer staff One participant described how mentorship was essential to recruiting new staff and retaining senior staff: identifying and developing leadership potential.

> *I have about 45 staff or so that report to me, a compliment of mostly nurses and healthcare aides… some of the more formal things [education]. I do try to set up mentorship between new hires and my more experienced staff. A lot of my mentorship, more directly, is with the nurses. As the team leader, I mentor the nurses, and in turn, I expect them to mentor their healthcare aides that includes just regular check-ins, reviewing cases. If there's an acute change in a resident condition, we might brainstorm and troubleshoot together. It's kind of individualized based on what their needs are. (NL9)*

The concept of '*growing your own'* takes on a more literal meaning when rural families begin to settle and grow. A participant explained why they chose to remain in their site and

take on a leadership role; it started with one word, *family* responding to question, "What keeps you as a rural nurse leader?"

> *Family, I'm family oriented., that's where my mind is, it's where my heart is. I'm community oriented, the reason I really took this job is so I can come back to my family, my community. even if this wasn't my [original rural] community, the site knows that I'm about community. This is my community on site; this can be my community in the town. (NL4)*

Smaller Versus Larger Rural

The term rural has a wide range of inclusion from isolated areas where only a few people reside to small rural areas with less than 2,500 people up to the larger rural communities consisting upwards of 10,000 to 30,000 residents. (Government of Canada, 2021; Government of Canada Statistics Canada, 2022). With this large spectrum, there were notable differences in participant findings related to perceived empowerment. Participants differed in where they were employed on this spectrum. Participants exposed notable disparities between those that were employed in smaller population density areas versus larger. Participants discussed the isolated geography and their perception that it depends on how *'isolated'* they were for determining what they may or may not have had.

> *We try to meet mostly by teams, but it's been identified, too, that this work is very personal and collaborative, and so coming together physically at a central location is, has been beneficial. We're trying to balance the fiscal responsibility of paying everybody to travel, and the time that that takes, right, especially when we're so far apart geographically… Then we take it [work we have done], we look at it, we make*

> *sure that we can reasonably do it, given our rural lens, and sometimes limited resources, as compared to Winnipeg. Are there any modifications we need to do with it? And then kind of go from there but if there are modifications that we have to make, because it just doesn't work in our structure, in our setting because of those resource limitations or geography or site-specific limitations then this gets looked at. (NL8)*

The variation in the size of the organizations in rural areas contributed to resources. Larger sites tend to possess more resources than smaller organizations. Opportunities were fewer in smaller sites, forcing rural staff to commute to larger sites for things like continued education and mandatory information sessions or course work for continued employment. In the health region exists three larger regional sites based in designated small cities. These larger sites offer a multitude of services ranging from chemotherapy, dialysis, labour and delivery, surgery (day and admit), and multiple inpatient wards. Urban centre nursing has increased supports often in facility. Services can be provided on site in a timely matter. As these larger sites serve a diverse and growing number of people, there are more nurse leaders, supports and resources, creating an increase in opportunities to develop and become established. Individuals residing further from these cities perceived access to resources, support, and opportunities narrowed and that as the population sparsity increased, it led to an increase in independent work, difficulties with communications, diversity in nurse leadership roles and responsibilities, among other geographical challenges. One participant described how … *everybody's really separated*… *so sometimes it's difficult to feel supported*. (*NL2)*

Some sites had only one computer accessed by all employees. If learning was online then connectivity access, and/or the availability to employees often was viewed as a challenge. If staff had personal access to computers off site, they could be used for learning the same way they would at work.

Not a lot of our staff have access to computers here at work. Internet at times is not great. (NL2)

To mitigate some of these challenges, participants described innovative and creative strategies in their work and how the day-to-day functions were carried out and explored strategies to alleviate these unique challenges. Quick response or QR codes (a machine-readable 2D barcode that instantly directs your smartphone or scanner to digital content, such as a website URL or app download) for learning were utilized by two participants so employees could access education on their personal devices. Southern Health-Santé Sud had intranet that required a password. This system was recently modified so that all employees could access regional resources online making resources more accessible. On this page no usernames or passwords were required to gain access. Education could be accessed more readily as well as other opportunities and resources. One participant explored how new educational roll outs had been facilitated by training one staff member and having that staff member training the next and so on.

With myself and the CRNs we're doing it, then another staff member does it, and it's a domino effect. Sometimes when we enact something new, we decide whether it needs to be, it can be informal, formal like a memo, or an actual educational rollout because our staff do so well in communicating with each other

and supporting each other. For example, we just put out a new stat stock med cart with a sign-out binder. Essentially, we're saying to nursing, "Here's your stat stock that you go to sign it out of the binder." Staff will provide help to each other; they'll support each other and help utilize ourselves. And we don't have to do anything. (NL4)

The smaller the community (example say 400 vs. 1500) in which rural nursing leaders work, the smaller the population of health care workers in that area. Therefore, participants in these smaller settings relied on more than collegial relationships for completing their daily work. Many participants remarked how these multidisciplinary working relationships were unique to rural communities where all disciplines often had only a few individuals: one doctor, two nurses, one health care aide, and one clinical resource nurse (CRN) creating a close and strong support network among health care providers, perceived as unique to rural nurse leaders. "*They are not just my colleagues; they are my friends" (NL2)*.

Much of it is the group that I work alongside here. The CRNs, our nurse practitioner, our dietitian, they're actually all very – we always eat lunch together, and vent if we need to vent for a little bit or, but it's just been, having them as a support has been so, so helpful in my role. (NL2)

Resources. Participants discussed the label '*resources'* in terms of available materials, assets (such as financial), and other individuals as a resource. Participants acknowledged that they also appreciated that in their roles were often resource for their subordinates and colleagues. Rural nurse leaders and their colleagues exhibited an

obligation to acquire and maintain a broad knowledge and skill set in their rural healthcare workplace.

I just had tremendous respect for their [nurses] knowledge, skill, abilities. (NL 1)

With limited resources there were barriers for nurse leaders to provide or create empowering structures such as access to opportunities, knowledge, information, and resources. Most rural sites rely on internet Wi-Fi or cell service for staff to access these structures. As a resource, Wi-Fi and cell service had been a notable challenge.

Some of our sites have challenges with Wi-Fi and reliable Wi-Fi. It's important to have enough workstations and tablets and those kind of things for staff to be able to access. We recognize that's something that's definitely a limitation in our organization. (NL1)

Rural sites had at least one computer which was directly connected to the regional intranet. However, some staff members had difficulties accessing the computer. A resource was developed in the region to mitigate the restriction of resources by providing a direct link to regional computers to resources such as training, policy and procedure information, patient care information, and human resource connections.

We have to support what's there a lot [computer usage], because they do find that it's difficult to utilize that resource, that StaffNet [intranet]. It is new, we just launched it several months ago. Something staff are getting used to. Logins are a bit of an issue if it's regional computer, if they haven't used a computer within 3 months, then they're [kicked] off, and we have to start over again. (NL8)

Additional advances to StaffNet were in creating ability to access it outside of the health centre system and even on a personal device. This created access 24/7 to staff to utilize resources without needing to go into a work site and log on to a hospital or site unit.

> *Now also it's on a browser, so I can go on my phone, I don't need a special password to get on StaffNet anymore. that accessibility, that way has just improved. Just trying to really be creative, think outside the box for folks in how I can resource them and support them in that way. (NL8)*

Rural nurse leaders often embody and embrace multiple roles outside of what was expected of them in their formal leadership role. Participants declared that they wore many hats in smaller sites with fewer individuals, often having to act as IT, maintenance, or human resources, when required. When asked about their site capabilities with regards to IT support they explained that *"the maintenance is our IT"* but if they did not know how to fix it then laughed stating*, "… we are IT support or maintenance!" (NL2)* Knowing who to call if something goes wrong was an expectation of rural nurse leaders. A participant explained the importance of their staff knowing when and who to call for certain issues, especially during hours when not available on site.

> *If there's an issue with how the (knowing who to go to) building's operating, they know how to get the physical plant lead to help them fix the issue, right. Making sure they have connections with the team to know who to go to when they need help. (NL10)*

Being a nurse leader in rural areas, participants were on site regularly and likely the central figure to whom the majority of site staff report. Participants noted they themselves were

resources for others and that the span of control could be quite large. When the span of control was larger than anticipated, resource management and communication could prove difficult amongst staff. In rural sites having a large number of direct reports was not unusual as nurse leaders in larger sites within the region generally all carry a compliment of 3+ nurse care units.

> *Having more direct reports rather than just one unit, it is the entire facility or a large [geographic] area to maximize use … I have over 250 staff across areas, so there's something about this to that makes it more difficult. (NL2)*

Participants described how they were typically isolated at their site as nurse leaders. Participants had direct access to their leaders who proved an essential resource for nurse leaders.

> *I feel supported by senior leadership and [I] meet regularly with them. They take my concerns seriously. They help advocate for what I've brought up. So feel like that. I feel – so moving resources. (NL5)*

A major contributor and resource challenge for rural nurse leaders was financial constraints they encountered from numerous areas. Participants assumed that rural sites received fewer fiscal resources compared to their urban counterparts. Often perceived as hand me downs, resource competition or the required sharing of resources.

> *Funding is always just such an issue with us, even, especially being [in long term care], we get our resources later than the region as a whole. (NL2)*

Money allocation was difficult in most environments, but the added complexities related to the rural aspect added stress to the amount of money and where it was allocated.

Participants compared themselves to others in larger metropolises whereby their perception was urban cities were allocated the largest number of financial resources, and as you moved further away from these urban areas, and the demographics became less densely populated, increasingly geographically distanced, and much smaller patient populations, the funds (if any) were minimal. One participant explained that money was an important decision and motivating factor. *For a lot of people, time and money is a challenge and often a deciding factor. (NL9)*

> *There's so much available, but not a lot that they can get paid for… nobody wants to come in on their day off to sit through education that they don't get paid for. That's one of my biggest frustrations, is that we don't get that. There's not this extra funding for education. (NL2)*

Participants depicted how they must be resourceful regarding budget constraints. By being resourceful, there was more '*buy in'* from staff in the uptake of resources and opportunities available to them in their health care roles.

> *Have flexibility with less staff to do a mass resource roll out by having share time between shifts. … we usually set it up so that they come in between [shifts], just before day to evening shift change… so they can just leave at the end of it and go to report. (NL2)*

One participant discovered that through this timed educational strategy, their employees believed that money and time were not an issue and more likely to participate. Conversation with others who control the budget was important. These conversations allowed for discussions regarding financial constraints where rural nurse leaders could

advocate for their perceived or tangible essential needs (such as medical devices, administrative devices).

> *Financially, I think that I don't have a lot of control over my budget, but we meet once a month to kind of look to see, OK, how things are going and, and they're asking good questions to make sure that finance can support me where is needed. And then we work with other managers, so like collateral managers, who we support each other as well in our different roles. (NL5)*

Community. When organized and grouped, the concept of '*community*' was regularly defined as the support felt from other human beings and/or groups such as the local outreach support for healthcare, local businesses offering support (such as monetary donations or offering items at lower costs to health care employees), and community members stepping into support roles (such as hospital volunteer greeters, gift shop employees, and patient companions). Participants relayed the importance of community during interviews. Community for some was the physical community in which they served, or their community of co-workers, and for some referenced the health region itself. In rural areas, close-knit communities are important for those living and working there. Often in smaller communities, individuals know others personally and therefore, related to their colleagues differently than say urban counterparts. Such as, smaller communities have smaller groups of individuals working (smaller hospitals may have only 20 nurse positions where larger hospitals can have hundreds of nurse positions across many units). It is easier and more likely that the 20 nurses at the smaller site working in one

unit interact more often and become closer than the hundreds of nurses that move around and are spaced among multiple units.

> *I'm community oriented, the reason I really took this job is so I can come back to my family, my community …this is my community on site, this can be my community in the town, that's kind of my psychological support. (NL4)*

Community was not just where they were from, but it was also a part of their working and personal family environments. Different health care disciplines (e.g. dietary, social work, occupational therapy, physiotherapy, respiratory therapy, physicians, nurses, health care aides etcetera) worked together in close proximity, cohesively providing patient care on regular basis.

> *… the group is very cohesive in that sense of happy to support, provide direction, share resources, etcetera. (NL8)*

Being thought of as *'one of us'* and how they were a community member carrying personal relationships inside and outside of work was helpful for participants to understand what was required in their nurse leadership role in a challenging rural environment.

> *It helps that I was a nurse on the floor before coming into this position, so I understand a lot of what they are working with and how the systems in place sometimes failed them and failed us. (NL2)*

A participant laughed that their tight group network made resources and support easier because everyone knew everyone, their roles, and their expectations. As a rural nurse leader, the staff could not hide from them when on shift- especially when there may only be a few individuals working at any time.

A bonus being in a small community… when things are mandatory then they [employees] see me coming, then they always feel guilty! (NL2)

Participants concluded that it was challenging to direct friends and tell them what to do - but *also rewarding as these relationships were built on respect and the knowledge of the good place they [directions and orders] all come from. (NL3)*

Intimate, enduring working relationships impacted participants and personally bonded connected them to their profession. Participants reflected how personal relationships made becoming a leader an easier choice and transition. Knowing those in different roles opened doors and possibilities for succession planning. When asked, one participant explained they were in their leader role because, *"I was friends with the person who was previously in my role." (NL9*) Feeling comfortable with those with whom you worked minimized the fear of reaching out when you needed help.

But the group is very cohesive in that sense of happy to support, provide direction, share resources. (NL8)

If the immediate group did not know the answer, they knew who to reach out to next. The smaller sites had many similar connections with other smaller sites bonding over their similarities.

If I need permission for something, I know who to reach out to [from other sites], other resources. (NL1)

This tight, wide-reaching network proved beneficial for numerous reasons. Additional support and resources facilitated the translation of important information or knowledge to specialized groups such as geriatrics, mental health, family first public health, and

palliative care. A participant in long-term care acknowledged struggles with caring for certain patient populations who were incontinent, had difficulty with movement issues, and chronic illness which necessitated long term care. These connections in both the community outside of health care, and the community within health care, cultivated personal and professional work relationships that benefited nurse leaders. This participant explained that knowing community members provided an opportunity for smaller sites to build a personalized approach to developing staff.

> *Sometimes I'll have speakers come in on anything from incontinent products to, we're having [health professional] this week come in to talk from [a health centre], talk about a certain type of illness that one of our residents has. (NL2)*

You Are Not Alone

Nuances present in every participant's interview indicated that as a rural nurse leader '*you are not alone'*. Given the geographical distances (some extensive) and diverse populations participants served, participants all believed they were never alone as a rural nurse leader, or simply as a human being despite the geographical distances. In many ways it was easy to feel alone and, in a silo, when their workplace was distanced geographically or simply within the facility where there were fewer people. Many participants reinforced this as a form of support for the fact that 'you are not alone as a rural nurse leader.'

> *You know you're not alone, even if it's a new place or region; there's others that are just like you. (NL4)*

Participants reinforced the feeling of not being alone while working as a rural nurse leader. Participants detailed how they felt supported by their coworkers and those in similar roles to them in the region.

> *We just worked together to identify ways that we could support each other in our roles. I'm not alone in my role… those people have been super helpful in helping me to take care of myself in this role, and to not feel alone in it. (NL2)*

Participants' leaders and/or senior administrators were a key resource for not feeling alone These leaders were pivotal to support participants to accomplish their missions and goals. Their leader's support empowered participants to feel that they were a resource to use whenever needed to accomplish meaningful work.

> *Our director, too, has been just so encouraging, and lets me know on a regular basis how appreciative they are of the things that I'm working with and doing. I think those people have been super helpful in helping me to take care of myself in this role, and to not feel alone in it. (NL2)*

When listening to participants talk about the concept of not being alone, they also referred to the concept in the perspective of being in a rural care space. They mentioned support was not just in the workplace but with their close working relationships outside working hours.

> *We also kind of have started an informal kind of book club, where we'll read a book on leadership or whatever, and we'll talk about it, and kind of encourage each other to use some of the practices and principles that we've picked up. (NL9)*

Summary

In summary, data analysis revealed the findings of two themes which provide empowered working environments: Theme 1: Support and Relationships and Theme 2: Rural Roots. Within each of the themes, 3 sub-themes emerged from the data. Participants expressed the importance of feeling supported in high-quality relationships both within themselves and other leaders. Developing and sustaining high-quality relationships in which they felt supported had a positive impact on experiencing empowerment in the workplace. The second theme, rural roots, demonstrated how working in rural healthcare challenged the participants positively and negatively in their sense or beliefs of workplace empowerment. Participants explored and evaluated what being a rural nurse leader meant for them facilitating empowered working environments in a uniquely challenging setting(s).

Chapter 5: Discussion of the Findings

The findings of this study give context of the current evidence concerning rural nurse leaders and their perceptions of workplace empowerment. The findings of this study provide insight into how the rural nurse leader participants perceive factors which shape structural empowerment in the workplace. Given the ongoing context, complexities, and challenges in rural healthcare; participants identified factors regarding access to opportunities for growth, resources, and support as key influencers in workplace empowerment. As leaders in rural areas carry a unique challenge, it is imperative that rural nurse leaders utilize their positions to create positive, meaningful impacts on workplace empowerment.

> "If rural nurse leaders understand the value of structural empowerment, potential exists for the benefits of its application to filter through all levels of an organization. This may assist with the process of formulating strategies to facilitate an open, honest, and responsive culture… Adopting an approach informed by structural empowerment may see rural nurse leaders equipped with a greater sense of capability to participate in health reform and a greater preparedness to lead rural nursing in the future." (Bish 2014 p. 35)

Usefulness of the Framework. The theoretical framework was useful in that it allowed me to gather relevant information regarding workplace structural empowerment from the literature and data from the current study, organize the data into a logical fashion, making it more accessible and useful to both readers and researchers (Ta'an et al., 2020; Wilson & Laschinger, 1994). My study's findings fit well into a discussion format whereby

topics were separated into three of the four central concepts that comprise Kanter's (1977) Structural Empowerment Theory's Framework (opportunities, resources, and support). Kanter posited that these concepts (or workplace structures) empower employees, ultimately improve both the satisfaction and organizational productivity of the individual and workplace (Kanter, 1977, 1993; Laschinger et al., 2010; Yesilbas & Kantek, 2024). Like Kanter's theory, participants relayed that by having and providing access to opportunity, resources, and support in turn increases job satisfaction. The literature suggests that the concepts within Kanter's theory are interrelated, creating a synergy among concepts that was also reflected in the data (see Appendix H). In other words, one concept appears to influence or reinforce another. This alignment indicates that health care organizations' investments in any one empowerment-related concept may have a cumulative effect, strengthening rural nurse leader's perceptions of an empowered work environment (Jafari et al., 2021). Participants also elicited this finding where various matters could be similarly categorized across multiple concepts. For example, a high-quality relationship provides not only support but could also be seen as a resource for some and an opportunity for others. Power (informal and formal), while not directly referenced, was also alluded to with participants acknowledging an existing power differential between leaders and employees in the workplace when discussing access to opportunities, resources, and support.

Using concepts of Kanter's structural empowerment theory, this study identified potential areas for remedial work environment factors that could bring substantive improvements to rural nurse working environments and facilitate greater job satisfaction, organizational thriving, success and retention. For participants, opportunities to access

empowerment structures such as resources, information, and support facilitated growth, development, and power acquisition creating work settings where empowerment was evident at all levels of the organization (Bish et al., 2014). Creating working environments where high levels of perceived structural empowerment were important as numerous studies and literature demonstrated strong links between empowered workplaces and increased job satisfaction, psychological wellbeing, work and cost effectiveness, workplace retention, and patient satisfaction (Bish et al., 2014; Jafari et al., 2021; Loes & Tobin, 2022; Ta'an et al., 2020; Trus et al., 2018; Wong et al., 2013).

Access to Opportunities

Opportunity yields power and has a direct impact on people's attitudes and behaviours in the workplace (Al Sabei et al., 2022; Bish et al., 2014; Hauck et al., 2011). Participant's found creating opportunities to gain experience personally and professionally gives people purpose and the ability to find joy in their work. When nurse leaders build on learning opportunities, they gain competence resulting in reduced anxiety and increased comfort in their position (Herron et al., 2025). All participants in the study considered the variety of opportunities accessible to them as a significant facilitator to their nursing practice. Many talked positively about daily learning because of rural healthcare is a generalist practice – taking advantage of opportunities made them believe that they were becoming more prepared, based on these experiences, to work in any rural practice setting (Loughery et al., 2025). Opportunities discussed, for example, were continuing one's education (bridging programs, returning for additional degrees), increasing the depth or breadth of knowledge through certifications, professional development opportunities (i.e.

taking non credit coursework, workshops, and training to maintain and acquire knowledge and skill development, post graduate studies, specific area education (e.g. geriatrics, emergency medicine, and leadership), and increasing community engagement. Increasing community engagement for participants was notably accomplished by taking opportunities to make local partnerships (local faith groups, businesses, and social clubs), to learn more about what the community members, teaming up with local influencers for change, sharing power by engaging community members in shared decision making, and by hiring local rural workers that share the same background and life experiences as the patients receiving care.

Mentorship was recognized by participants as a conduit for nurses transitioning into rural health communities, fostering a sense of belonging which can improve retention. The utilization of mentorship formed a commitment to staff development and support while enhancing the attractiveness of rural employment to those who do not reside in rural areas. Participants noted that it was important to give their experienced nurses an opportunity to become skilled mentors for nurses in rural workplaces (Brook et al., 2019; Bumby, 2020). Mentors created opportunity on site for participants to use their more senior staff to impart their knowledge to incoming staff and new leaders. This type of onboarding offered opportunities for participants to designate a senior staff nurse as a leader (Ejebu et al., 2024).. This opportunity offered by participants created an awareness of one's value and displayed appreciation for their more senior staff(s) contributions to the workplace.

All participants identified staff with preexisting rural roots and the importance of '*growing your own'* nursing workforce and leaders. The literature and research establish that rural health care providers often come from a rural context and return to their community, friends, family, and sense of home or belonging (Burman & Fahrenwald, 2018; Tort-Nasarre et al., 2023). The awareness that rural nurse leaders and their employees benefit from taking the time to give opportunities leave their rural community and develop as a health care professional with the goal of returning to rural employment upon completion of advanced education or role changes were mutually beneficial to the organization and the staff leaders.

Participants encouraged their employees to remain in rural health care settings by developing their staff. Participants examined how rural students had ties to their home base and were comfortable to return to when education was completed. Participants explained individuals who grew up in rural communities were more likely to return to who and what they know and felt comfortable and familiar with. Such comfort was in the familiarity of one's rural family roots, people in the community that they know and the custom of rural living. This strengthens the rural workforce by providing opportunity to individuals who wish to move (internal mobility, lateral transferring, upward mobility, and/or career advancement) in the organization to desired roles or areas and facilitating in rural nurse leader's retention (Barrowclough et al., 2023).

Participants explored community ties, family, relationships with colleagues, decreased cost of living, peaceful/quiet atmosphere, work–life balance, and outside recreational activities as opportunities which enhance workplace empowerment (Loughery et al.,

2025). Integrating into a smaller rural community can be difficult for outsiders. For participants who originally came from rural areas, decisions to remain in or leave rural Manitoba communities were strongly shaped by several interconnected factors: a sense of comfort and security, existing relationships, and familiarity with the rural way of life (Baxter, 2025). Participants identified the importance for organizations to prepare their own rural staff and retain them by providing opportunities to keep educating nurses in rural areas or integrating nurses to the community (Nyaradi et al., 2025).

Participants emphasized that although career development and continuing learning opportunities were viewed as essential to rural nursing practice, access to these opportunities was often perceived as uneven. Geographic distance, professional isolation, workforce shortages, time constraints, and financial limitations shaped whether rural nurses and nurse leaders could participate. Participants noted education and skill-development opportunities were typically offered at larger centralized rural sites; however, travel requirements, lack of reimbursement, and limited time away from work created barriers for staff in smaller or more isolated communities.

Distance education can reduce access barriers and create more equitable opportunities for rural nurse leaders to participate in education and skill development. Participants utilized virtual learning tools which allow individuals to engage in a range of educational programs without the added burden of travel, thereby increasing access to professional development across geographically dispersed rural sites. Learning with colleagues from other sites and regions participants voiced can also strengthen knowledge sharing, support information exchange, and promote lifelong learning.

It was especially important for participants to meet their people where they were at in the organization and workplace. Participants noted that not all individuals required or were interested in participating in opportunities. Some participants believed that they were empowered at work, whereas others were active participants in continuous learning to feel enriched and satisfied in their work. Literature and participants alike discussed the idea of laggers or nay sayers producing decreased opportunity uptake within organizations and workplaces (Fida et al., 2018; Laschinger et al., 2010). Literature outlines that there needs to be upward influence to help sway these individuals to join in the uptake of opportunities (Spreitzer et al., 1999)

Access to Resources

It is widely recognized in the literature that rural nurse leaders face resource-allocation challenges like those encountered by their urban counterparts. However, these challenges are intensified in rural contexts because of geographic distance, socioeconomic inequities, resource limitations, and health workforce maldistribution (Bish et al., 2014). Participants identified perceived financial constraints as a major resource-related challenge in their workplaces. They described rural sites as receiving fewer fiscal and material resources than urban centres, including essential medical equipment (e.g., blood glucose monitors and cardiac monitors), non-medical equipment (e.g., beds, carts, and chairs), and reliable internet access, all of which are necessary for adequate patient care. Participants also described receiving “hand-me-down” resources from larger health regions, such as Winnipeg, or from larger regional sites. Participant accounts suggested that smaller, more isolated sites often had to compete for limited

resources while also relying on resource sharing and mobilization among other smaller rural sites. Participants explained that this sharing was coordinated through open communication about site-specific needs and priorities with other nurse leaders by email, phone, and virtual meetings.

A 2025 study by Loughery et al. reported that 49.3% of participants viewed inadequate resources, infrastructure, and informatics—including electronic charting, usable equipment, internet access, and emergency medical services—as barriers in rural Manitoba health care. Participants in this study expressed similar concerns about limited access to equipment, technology, and diagnostic services compared with urban settings. They also noted outdated facilities, non-functioning equipment, and continued reliance on faxing or other inefficient technologies. Participants in both this study and Loughery et al.'s study who had experiences in urban health care described the differences in resources and interdisciplinary support between rural and urban settings as substantial (Loughery et al., 2025). Resource-related challenges were consistent across practice settings, but participants indicated that these concerns were more pronounced in smaller hospitals and more isolated areas.

Participants described creativity and innovation as essential strategies for making the best use of limited rural resources. They explained that rural nurse leaders often needed to remain current and support staff learning despite limited access to equipment, funding, and formal educational supports. Smaller sites frequently shared equipment, staffing, and funds, requiring leaders to coordinate resources carefully and adapt them to local needs. Participants also improved access by offering condensed, practical learning

tools, including QR-coded information sheets, online or remote learning modules, and interactive resources that could be viewed on phones or tablets. These approaches allowed staff to access information more readily and apply new knowledge in practice, thereby supporting workplace empowerment. Access to technology also enabled participants to build professional networks and sustain continuous learning opportunities with colleagues (Patrick & Laschinger, 2006).

Participants explained that larger rural regional sites often had access to formal funding sources, such as foundations, whereas smaller rural sites frequently did not. In these smaller communities, local fundraising and volunteer support became important resources for addressing the population's health centre needs. Community members contributed by sharing workload and filling service gaps, including delivering meals, providing visits or respite support, assisting with non-health-care activities, and supporting recreational or social programming. Participants described the community as a valuable resource that helped compensate for limited regional resources. These contributions also signalled that community members valued their local health centres and the health-care workers employed there, which participants associated with a stronger sense of workplace empowerment.

Participants described rural nurse leaders themselves as valuable resources within smaller sites because they often assumed responsibilities beyond their formal nursing leadership roles. These additional tasks included functions typically associated with human resources, administration, physiotherapy, respiratory therapy, social work, occupational therapy, or other health-care roles. Similarly, Loughery et al. (2025) found

that rural Manitoba nurses were often required to adapt beyond traditional nursing responsibilities by assisting with tasks such as health-care aide duties, housekeeping, or laundry services. Although participants noted that carrying multiple roles could interfere with their leadership responsibilities and contributed to frustration, they also viewed this flexibility as necessary to support staff and maintain optimal patient care. Their ability to respond to varied needs, guide others through uncertainty, and serve as a knowledgeable point of contact positioned rural nurse leaders as key resources within their workplaces. When competent and knowledgeable rural nurse leaders model this adaptability, they can contribute to more empowering work environments (Wittenberg et al., 2023).

Access to Supports

Overall, the concept of support was a central finding that emerged in the analysis. Participants universally discussed when working in secluded and isolated rural areas, both in person and virtual support were key to facilitating workplace empowerment. Participants defined support similar to Kanter's theory which support relates to sources that function to maximize effectiveness such as receiving specific, constructive feedback, tangible help from peers, subordinates, and leaders (Kanter, 1977, 1993; Laschinger et al., 2010). Participants asserted that support consisted of constructive feedback through effective two-way communication. Effective communication participants defined as consistent open lines of communication with constant feedback and evaluation from leaders and colleagues.

Participants vocalized the power of relationships in building supportive, empowering work environments. Like Herron et al.'s findings (2025), this study found that each

participant illustrated the importance of relationships and social connections as vital to supporting nurses practicing in rural settings. Effective leadership included not only how they led their staff but, in turn, how they were led by their superiors. Many of the participants discussed teamwork and positive working relationships with staff; many became friends with their colleagues both inside and outside work (Loughery et al., 2025).

Participant explained a common nursing phrase, *'how can we care for others if we do not care for ourselves' and 'you cannot pour from an empty cup."* Acknowledging the understanding that each participant has a relationship with who they were as a person referring to one's emotional intelligence, insight, and reflexivity. Nurse leaders who emphasize and have a greater sense of self identification effectively increase nurse perceptions of workplace empowerment (Wong et al., 2013). Participants insightfully acknowledged this by the importance of checking in and supporting the individual within. By taking care of themselves, participants indicated they were better prepared to provide others with support and empower their staff in the workplace. Maintaining this constant self-awareness translates across leaders and to others, impacting how they communicated and built relationships with others (Taggart & Wheeler, 2025; Tekleab et al., 2008).

Participants described '*being human'* as a relational approach grounded in empathy, authenticity, and mutual recognition. Across interviews, they emphasized that treating others with the same respect and understanding they hoped to receive helped build trust and made a safer place for staff to be vulnerable (Barrowclough et al., 2023; Laschinger & Fida, 2014). Participants also acknowledged their own mental and physical health

challenges, experiences of loss, and role-related struggles. Rather than concealing these realities, they viewed openness about human vulnerability as important to developing trusting relationships and fostering empowerment through shared life experiences (Okoli et al., 2022). For participants, being authentic and '*being human'* meant sharing moments of grief and happiness with staff in ways which supported relational transparency, self-awareness, and moral leadership (Ferrucci & Fitzpatrick, 2024).

Central elements of human flourishing include positive, supportive relationships (e.g. opportunities to contribute to positive interactions with others), engagement and interest in one's activities, meaning and purpose in life, and positive emotions (e.g., feeling respected) (Herron et al., 2025). In participant interviews, they described the importance of establishing connections to person, place, and profession and emphasized the impact and significant value in social connections and teamwork, sense of community, and increasing competency at work (Barry et al., 2024; Herron et al., 2025). Participants who felt supported, who understood the impact and influence one can have in rural healthcare, was vital to an empowering workplace. Participants were in agreeance that competent, authentic, healthy rural nurse leaders ought to be recognized as a critical factor in enhancing the quality of care by supporting innovation influencing staff behaviors and ensuring the delivery of evidence-based practice as these skills empower nurses to lead effectively and strengthen team dynamics (Herron et al., 2025).

Mentorship

The findings showed that Kanter's concepts are often intersected rather than functioning as separate categories. Participants described some resources as

opportunities, some opportunities as support, and some forms of support as resources. Mentorship was one of the clearest examples of this overlap because it operated simultaneously as an opportunity for growth, a source of practical knowledge, and a supportive workplace relationship.

Defining Mentorship. Merriam-Webster (2026) defines mentorship as the "influence, guidance, or direction given by a mentor" (Webster, 2026). Within the structural empowerment literature, mentorship is described as a broad empowering process that benefits the mentor, mentee, and workplace (Ben Ahmed & Bourgeault, 2022; Ejebu et al., 2024; Rowen et al., 2024; Ward-Smith et al., 2023).

Mentorship as Opportunity, Resource, and Support. Participants described mentorship in differing yet related ways. For some, mentorship represented an opportunity to "grow their own" future leaders. For others, it was a resource that allowed rural teams to make effective use of the knowledge already present within the workplace. Participants also understood mentorship as a supportive relationship between experienced and less experienced staff. In this study, mentorship was commonly described as the pairing of senior or experienced staff with new or less experienced staff to share knowledge, information, resources, and practical guidance.

Mentorship and Empowerment. Participants emphasized that mentorship supported both individuals in the relationship by strengthening job satisfaction, retention, and feelings of empowerment. Baxter (2025) similarly found that colleagues supported new nurses by answering questions and guiding them through unfamiliar procedures. When mentor–mentee relationships were established early in employment, they

strengthened employees' connection to the workplace and encouraged meaningful participation. Meaningful mentorship can therefore foster organizational commitment by increasing access to support, information, resources, and opportunities for employees and rural nurse leaders (Al Sabei et al., 2022; Barrowclough et al., 2023; Ben Ahmed & Bourgeault, 2022; Rowen et al., 2024).

Limitations

Limitations should be considered when interpreting the study's findings. This study is limited to the voluntary participants in one rural health region and thus findings cannot be transferred to other rural settings. This could be mitigated by conducting similar research in other health regions. The data used in this study is a self-report and as such response bias may explain rural nurse leaders exhibited mainly positive feedback on self-perceptions of existing workplace empowerment (Podsakoff & Organ, 1986). Relying on self-reports of participants may also be socially desirable. (recall and social desirability bias) (Ta'an et al., 2020; Wang & Cheng, 2020). Data was collected once from a single point in time which limits any direct cause and effect.

Implications

Understanding what factors influence workplace empowerment are essential for informing rural nurse leaders' retention and recruitment. The existing literature demonstrated nurse leaders had low to moderate empowerment (Jafari et al., 2021; Patrick & Laschinger, 2006; Trus et al., 2018). The strong correlation between structural empowerment and work related well being found in this study indicates a strong need for policy and structural enhancement for nurse and nurse leaders' structural empowerment

in rural health organizations (Niinihuhta et al., 2021). Nurse leaders who are supported and empowered by their superiors will, in turn, direct the same support and empowerment to their staff nurses (Laschinger et al., 2013; Niinihuhta et al., 2021).

This study's findings indicated that nurse leaders who use empowerment structures in the workplace perceived higher levels of employee engagement which contributed to their job satisfaction and ultimately led to retention and recruitment. Supporting what was found, rural nurse leaders can integrate empowerment techniques in their practice such as by offering opportunities for engagement (staff development, community, and education), support in the workplace, and providing resources for nurse working abilities. From an employee training perspective, it is important for nurse leaders to build a good working environment, and encourage student placements in rural settings, as well as providing opportunities to recruit rural dwelling health care workers for retention.

Recommendations for Future Research, Education and Practice

This study focused on rural nurse leaders; the voice of staff nurses was absent. Future research that focuses on rural frontline nurses/staff, and their perception of how their leaders shape their perception(s) of workplace empowerment would add to the literature. Research looking at if the perspectives of nurse leader empowerment are similar to their employees and coworkers can provide additional useful information. Rural nurse leaders may benefit from learning approaches to leveraging their position of power and furthering workplace empowerment through their communication and actions. Future practice should focus on rural nurse leaders and what they can do in their position of power to create empowered working environments given the nuances of rural nursing practice.

Education opportunities should exist for nursing students to practice in rural healthcare organizations during their undergraduate programs to introduce them to the vast opportunities available in rural health care settings (Zimmer et al., 2014). Expanding satellite nursing education for individuals to learn where they live and eventually will practice can help with recruitment and retention. Expanding continuing education opportunities and minimizing the cost of additional role training in rural healthcare sites can help build up staff empowerment.

Rural health care organizations can positively impact nurse leaders' retention, turnover intentions, empowerment and work-related well-being by offering mentorship from fellow senior leaders (Labrague et al., 2020; Laschinger et al., 2013; Niinihuhta et al., 2021). Implementing mentorship programs (role model, community model, professional model), techniques for encouraging employee feedback (anonymous digital surveys and 1:1 recurring meetings/check ins), and accommodating for learning opportunities (structured time off or during shift). Evaluating the effectiveness of rural recruitment and retention strategies such as mentoring, rural placements, and professional development may also prove useful in determining site overall empowerment.

Community engagement opportunities and discussing community needs can prove beneficial. Collaboration with community and stakeholders can serve to unlock new resources required to implement empowerment initiatives (Van Niekerk et al., 2023). Such initiatives participants discussed were providing rewards to employees for working in the community's health care site (discounts at local businesses), health center fundraising

and maintenance/upkeep, supporting volunteers to aid in non-nursing specific tasks (door greeters, meal tray handouts, taking patients to various appointments).

Summary

This qualitative descriptive study explored how rural nurse leaders in Manitoba's Southern Health-Santé Sud region understood and implemented empowering workplace structures. Drawing on interviews with the 10 participants, this study identified access to opportunities, resources, and support as central dimensions of perceived workplace empowerment, consistent with Kanter's theory of structural empowerment.

The findings showed that rural nurse leaders face ongoing challenges in creating and sustaining empowering work environments, particularly in contexts shaped by geographic distance, limited resources, and workforce pressures. Ensuring rural nurse leader job satisfaction requires organizational support, adequate resource allocation, effective information sharing, and opportunities for continued personal and professional growth.

Structurally empowered rural nurse leaders are positioned to influence change within their organizations and across the broader health community. By strengthening empowerment structures, rural health systems may improve job satisfaction, support retention and recruitment, and promote healthier practice environments for nurses and those they lead.

This study contributes rural Manitoba nurse leaders' voices to the literature by highlighting the importance of relationships among health-care workers, sites/organizations, and the surrounding community. These relationships emphasized the

value of strengthening rural roots and supporting residents who wish to live, work, and lead within their own health care communities. In a rapidly changing health-care system and amid persistent nursing shortages, it is imperative that rural nurse leaders engage with empowering structures which foster supportive working environments eliciting job satisfaction, improving patient outcomes, and strengthening rural Manitoba nurse retention.

Conclusion

Manitoba has the highest rural population in Canada other than the Atlantic region (Government of Canada Statistics Canada, 2022). Understanding nurse leader empowerment is crucial to gain insight into future retainment of nurse leaders, and subsequently nurses. Where “structurally empowered rural nurse leaders are important in driving change within their own organizations and contributing to broader health reform, they must be capable of leading and developing an open, honest, and responsive culture that supports quality safe patient care, multidisciplinary and interprofessional practice, more equitable resource allocation, and retention of a highly skilled and professional workforce” (Bish et al., 2014, p. 31). Adopting approaches informed by structural empowerment, equips rural nurse leaders with the capacity to participate in health transformation (Bish et al., 2014). This study will add an understanding of rural nurse leader empowerment perspectives (which are virtually absent) and be of valuable contribution to inform rural Manitoba health policy and practice environment empowerment restraints. Findings will be shared with both academic and practice

audiences through peer reviewed publications, reports, study infographics, and presentations.

References

Abel, S. E., & Hand, M. W. (2018). Exploring, defining, and illustrating a concept: Structural and psychological empowerment in the workplace. *Nursing Forum*, *53*(4), 579–584. https://doi.org/10.1111/nuf.12289

Al Sabei, S. D., Al-Rawajfah, O., AbuAlRub, R., Labrague, L. J., & Burney, I. A. (2022). Nurses' job burnout and its association with work environment, empowerment and psychological stress during COVID-19 pandemic. *International Journal of Nursing Practice*, *28*(5), 1–10. https://doi.org/10.1111/ijn.13077

Armstrong, K. J., & Laschinger, H. K. S. (2006). Structural empowerment, magnet hospital characteristics, and patient safety culture. *Journal of Nurse Care Quality*, *21*(2), 132.

Barrowclough, M., Morel, T., Chua, S., & Wu, S. (2023). Where are they going, and what can we do to keep them? Intent to leave among nurses in British Columbia, Canada. *The Canadian Journal of Critical Nursing Discourse*, *5*(2), Article 2. https://doi.org/10.25071/2291-5796.155

Barry, R., Kernaghan, L., Green, E., & Seaman, C. E. (2024). The influence of connection on early career nurses' rural experiences: A descriptive phenomenological study. *Journal of Nursing Management*, *2024*, 1–10. https://doi.org/10.1155/2024/8867213

Baumann, A., & Crea-Arsenio, M. (2023). The crisis in the nursing labour market: Canadian policy perspectives. *Healthcare*, *11*(1954), 1–9. https://doi.org/10.3390/healthcare11131954

Bell, D. B., Black, G., Butts, J., Goel, D. V., Lafontaine, D. A., Lee, D. V., MacNaughton, D., Martin, D. D., & Philpott, D. J. (2023). *Taking back health care: How to accelerate people-centred reform now* (Project 1; Taking Back Health Care, pp. 1–19). Public Policy Forum.

Ben Ahmed, H. E., & Bourgeault, I. L. (2022). *Sustaining nursing in Canada: A set of coordinated evidence-based solutions targeted to support the nursing workforce now and into the future*. Canadian Federation of Nurses Unions.

Bish, M., Kenny, A., & Nay, R. (2014). Perceptions of structural empowerment: Nurse leaders in rural health services. *Journal of Nursing Management*, *22*(1), 29–37. https://doi.org/10.1111/jonm.12029

Bish, M., Kenny, A., & Nay, R. (2015). Factors that influence the approach to leadership: Directors of nursing working in rural health services. *Journal of Nursing Management*, *23*(3), 380–389. https://doi.org/10.1111/jonm.12146

Boamah, S. A. (2018). Linking nurses' clinical leadership to patient care quality: The role of transformational leadership and workplace empowerment. *Canadian Journal of Nursing Research*, *50*(1), 9–19. https://doi.org/10.1177/0844562117732490

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2008). Power and empowerment in nursing: A fourth theoretical approach. *Journal of Advanced Nursing*, *62*(2), 258–266. https://doi.org/10.1111/j.1365-2648.2008.04598.x

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, *4*, 1–8. https://doi.org/10.1177/2333393617742282

Brook, J., Aitken, L., Webb, R., MacLaren, J., & Salmon, D. (2019). Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review. *International Journal of Nursing Studies*, *91*, 47–59. https://doi.org/10.1016/j.ijnurstu.2018.11.003

Brunetto, Y., & Teo, S. (2013). Retention, burnout and the future of nursing. *Journal of Advanced Nursing*, *69*(12), 2772–2773. https://doi.org/10.1111/jan.12309

Bumby, J. C. (2020). Evidence-based interventions for retention of nursing students: A review of the literature. *Nurse Educator*, *45*(6), 312–315. https://doi.org/10.1097/NNE.0000000000000797

Burman, M. E., & Fahrenwald, N. L. (2018). Academic nursing leadership in a rural setting: Different game, same standards. *Journal of Professional Nursing*, *34*(2), 128–133. https://doi.org/10.1016/j.profnurs.2017.11.003

Catton, H. (2021). COVID-19: The future of nursing will determine the fate of our health services. *International Nursing Review*, *68*(1), 9–11. https://doi.org/10.1111/inr.12673

Chandler, G. E. (1986). *The relationship of nursing work environment to empowerment and powerlessness*. University of Utah.

Chinn, P. L., & Kramer, M. K. (2018). *Knowledge Development in Nursing: Theory and Process* (10 th). Elsevier.

Conger, J. A., & Kanungo, R. N. (1988). The empowerment process: Integrating theory and practice. *Academy of Management Review*, *13*(3), 471–482. https://doi-org.uml.idm.oclc.org/10.2307/258093

Cowden, T., Cummings, G., & Profetto-Mcgrath, J. (2011). Leadership practices and staff nurses' intent to stay: A systematic review. *Journal of Nursing Management*, *19*(4), 461–477. https://doi.org/10.1111/j.1365-2834.2011.01209.x

Cummings, G. G., Tate, K., Lee, S., Wong, C. A., Paananen, T., 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*, 19–60. https://doi.org/10.1016/j.ijnurstu.2018.04.016

Cziraki, K., Wong, C., Kerr, M., & Finegan, J. (2020). Leader empowering behaviour: Relationships with nurse and patient outcomes. *Leadership in Health Services*, *33*(4), 397–415. https://doi.org/10.1108/LHS-04-2020-0019

Dahinten, V. S., Lee, S. E., & MacPhee, M. (2016). Disentangling the relationships between staff nurses' workplace empowerment and job satisfaction. *Journal of Nursing Management*, *24*(8), 1060–1070. https://doi.org/10.1111/jonm.12407

Donahue, M. O., Piazza, I. M., Griffin, M. Q., Dykes, P. C., & Fitzpatrick, J. J. (2008). The relationship between nurses' perceptions of empowerment and patient satisfaction. *Applied Nursing Research*, *21*(1), 2–7. https://doi.org/10.1016/j.apnr.2007.11.001

Ejebu, O.-Z., Turnbull, J., Atherton, I., Rafferty, A. M., Palmer, B., Philippou, J., Prichard, J., Jamieson, M., Rolewicz, L., Williams, M., & Ball, J. (2024). What might make nurses stay? A protocol for discrete choice experiments to understand NHS nurses' preferences at early-career and late-career stages. *BMJ Open*, *14*(2), 1–9. https://doi.org/10.1136/bmjopen-2023-075066

Eo, Y. S., Kim, Y. H., & Lee, N. Y. (2014). Path analysis of empowerment and work effectiveness among staff nurses. *Asian Nursing Research*, *8*(1), 42–48. https://doi.org/10.1016/j.anr.2014.02.001

Eriksson, E., & Engström, M. (2018). Internationally educated nurses' descriptions of their access to structural empowerment while working in another country's health care context. *Journal of Nursing Management*, *26*(7), 866–873. https://doi.org/10.1111/jonm.12617

Etikan, I. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1–4. https://doi.org/10.11648/j.ajtas.20160501.11

Falatah, R. (2021). The impact of the coronavirus disease (COVID-19) pandemic on nurses' turnover intention: An integrative review. *Nursing Reports*, *11*(4), 787–810. https://doi.org/10.3390/nursrep11040075

Fida, R., Laschinger, H. K. S., & Leiter, M. P. (2018). The protective role of self-efficacy against workplace incivility and burnout in nursing: A time-lagged study. *Health Care Management Review*, *43*(1), 21–29. https://doi.org/10.1097/HMR.0000000000000126

Fernet, C., Gillet, N., Austin, S., Trépanier, S.-G., & Drouin-Rousseau, S. (2021). Predicting nurses' occupational commitment and turnover intention: The role of autonomous motivation and supervisor and coworker behaviours. *Journal of Nursing Management*, *29*(8), 2611–2619. https://doi.org/10.1111/jonm.13433

Godsey, J. A., Houghton, D. M., & Hayes, T. (2020). Registered nurse perceptions of factors contributing to the inconsistent brand image of the nursing profession. *Nursing Outlook*, *68*(6), 808–821. https://doi.org/10.1016/j.outlook.2020.06.005

Government of Canada, S. C. (2021, November 17). *Dictionary, Census of Population, 2021 – Rural area (RA)*. https://www12.statcan.gc.ca/census-recensement/2021/ref/dict/az/Definition-eng.cfm?ID=geo042

Government of Canada, S. C. (2023, July 24). *Nurses: Working harder, more hours amid increased labour shortage*. https://www.statcan.gc.ca/o1/en/plus/4165-nurses-working-harder-more-hours-amid-increased-labour-shortage

Government of Canada Statistics Canada. (2022, February 9). *Population growth in Canada's rural areas, 2016 to 2021*. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021002/98-200-x2021002-eng.cfm

Greco, P., Laschinger, H. K. S., & Wong, C. (2006). Leader empowering behaviours, staff nurse empowerment and work engagement/burnout. *Nursing Leadership*, *19*(4), 41–56.

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

Hauenstein, E. J., Glick, D. F., Kane, C., Kulbok, P., Barbero, E., & Cox, K. (2014). A model to develop nurse leaders for rural practice. *Journal of Professional Nursing*, *30*(6), 463–473. https://doi.org/10.1016/j.profnurs.2014.04.001

Heras, M. L., Rofcanin, Y., Escribano, P. I., Kim, S., & Mayer, M. C. J. (2021). Family-supportive organisational culture, work–family balance satisfaction and government effectiveness: Evidence from four countries. *Human Resource Management Journal*, *31*(2), 454–475. https://doi.org/10.1111/1748-8583.12317

Herron, R., Waddell-Henowitch, C., Smith, N., Pylypowich, A., Lawrence, B., & Pellerin, S. (2025). A case study of new nurses' transition from education to rural practice in times of adversity. *Creative Nursing*, *31*(1), 20–29. https://doi.org/10.1177/10784535241255398

Holmes, A. D. (2020). Researcher positionality—A consideration of its influence and place in qualitative research—A new researcher guide. *Shanlax International Journal of Education*, *8*(4), 1–10. https://doi.org/10.34293/education.v8i4.3232

Hughes, R., Meadows, M. T., & Begley, R. (2022). American organization for nursing leadership nurse leader core competencies: A framework reaching across the continuum and leadership levels. *Journal of Nursing Administration*, *52*(12), 629–631. https://doi.org/10.1097/NNA.0000000000001221

Hughes, V. (2017). Standout nurse leaders…What's in the research? *Nursing Management*, *48*(9), 16–24. https://doi.org/10.1097/01.NUMA.0000522171.08016.29

Inglis, T. (1997). Empowerment and emancipation. *Adult Education Quarterly*, *48*(1), 3–17. https://doi.org/10.1177/074171369704800102

International Affairs & Best Proactive Guidelines. (2012). *Managing and mitigating conflict in health-care teams*. Registered Nurses' Association of Ontario.

https://rnao.ca/sites/rnao-ca/files/Managing-conflict-healthcare-teams_hwe_bpg.pdf

Jackson, D., & Silas, L. (2024, January 22). Unsafe staffing: Nurses have solutions. *The Winnipeg Free Press*. https://www.winnipegfreepress.com/opinion/analysis/2024/01/22/unsafe-staffing-nurses-have-solutions

Jafari, F., Salari, N., Hosseinian-Far, A., Abdi, A., & Ezatizadeh, N. (2021). Predicting positive organizational behavior based on structural and psychological empowerment among nurses. *Cost Effectiveness and Resource Allocation*, *19*(1), 38. https://doi.org/10.1186/s12962-021-00289-1

Jankelová, N., & Joniaková, Z. (2021). Communication skills and transformational leadership style of first-line nurse managers in relation to job satisfaction of nurses and moderators of this relationship. *Healthcare*, *9*(3), 346. https://doi.org/10.3390/healthcare9030346

Jennings, B. M., Scalzi, C. C., Rodgers, J. D., & Keane, A. (2007). Differentiating nursing leadership and management competencies. *Nursing Outlook*, *55*(4), 169-175.e4. https://doi.org/10.1016/j.outlook.2006.10.002

Kanter, R. M. (1977). *Men and Women of the Cooperation*. Basic Books Inc.

Kanter, R. M. (1979). Power failure in management circuits. *Harvard Business Review*, *57*(4), 65–75.

Kanter, R. M. (1993). *Men and Women of the Cooperation* (2nd ed.). Basic Books Inc.

Ke, Y., Kuo, C., & Hung, C. (2017). The effects of nursing preceptorship on new nurses' competence, professional socialization, job satisfaction and retention: A systematic review. *Journal of Advanced Nursing*, *73*(10), 2296–2305. https://doi.org/10.1111/jan.13317

Kelly, L. A., Wicker, T. L., & Gerkin, R. D. (2014). The relationship of training and education to leadership practices in frontline nurse leaders. *The Journal of Nursing Administration*, *44*(3), 158–163. https://doi.org/10.1097/NNA.0000000000000044

Khan, B. P., Quinn Griffin, M. T., & Fitzpatrick, J. J. (2018). Staff nurses' perceptions of their nurse managers' transformational leadership behaviors and their own structural empowerment. *The Journal of Nursing Administration*, *48*(12), 609–614. https://doi.org/10.1097/NNA.0000000000000690

Kovner, C. T., Brewer, C. S., Fatehi, F., & Jun, J. (2014). What does nurse turnover rate mean and what is the rate? *Policy, Politics, & Nursing Practice*, *15*(3–4), 64–71. https://doi.org/10.1177/1527154414547953

Krebs, J. P., Madigan, E. A., & Tullai-McGuinness, S. (2008). The rural nurse work Environment and structural empowerment. *Policy, Politics, & Nursing Practice*, *9*(1), 28–39. https://doi.org/10.1177/1527154408316255

Kretzschmer, S., Walker, M., Myers, J., Vogt, K., Massouda, J., Gottbrath, D., Pritchett, M., Stikes, R., & 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. https://doi.org/10.1097/NND.0000000000000363

Kuokkanen, L., Suominen, T., Rankinen, S., Kukkurainen, M.-L., Savikko, N., & Doran, D. (2007). Organizational change and work-related empowerment. *Journal of Nursing Management*, *15*(5), 500–507. https://doi.org/10.1111/j.1365-2834.2007.00733.x

Kurtzman, E. T., Ghazal, L. V., Girouard, S., Ma, C., Martin, B., McGee, B. T., Pogue, C. A., Riman, K. A., Root, M. C., Schlak, A. E., Smith, J. M., Stolldorf, D. P., Townley, J. N., Turi, E., & Germack, H. (2022). Nursing workforce challenges in the postpandemic world. *Journal of Nursing Regulation*, *13*(2), 49–60. https://doi.org/10.1016/S2155-8256(22)00061-8

Kuşcu Karatepe, H., & Türkmen, E. (2023). Nurse performance: A path model of clinical leadership, creative team climate and structural empowerment. *Journal of Clinical Nursing*, *32*(3–4), 584–596. https://doi.org/10.1111/jocn.16419

Labrague, L. J., Nwafor, C. E., & Tsaras, K. (2020). Influence of toxic and transformational leadership practices on nurses' job satisfaction, job stress, absenteeism and turnover intention: A cross-sectional study. *Journal of Nursing Management*, *28*(5), 1104–1113. https://doi.org/10.1111/jonm.13053

Laschinger, H. K. S., Anne Sabiston, J., & Kutszcher, L. (1997). Empowerment and staff nurse decision involvement in nursing work environments: Testing Kanter's theory of structural power in organizations. *Research in Nursing & Health*, *20*(4), 341–352. https://doi.org/10.1002/(SICI)1098-240X(199708)20:4<341::AID-NUR7>3.0.CO;2-G

Laschinger, H. K. S., & Fida, R. (2014). A time-lagged analysis of the effect of authentic leadership on workplace bullying, burnout, and occupational turnover intentions.

European Journal of Work and Organizational Psychology, *23*(5), 739–753. https://doi.org/10.1080/1359432X.2013.804646

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

Laschinger, H. K. S., Finegan, J., & Wilk, P. (2009). Context matters: The impact of unit leadership and empowerment on nurses' organizational commitment. *The Journal of Nursing Administration*, *39*(5), 228–235. https://doi.org/10.1097/NNA.0b013e3181a23d2b

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

Laschinger, H. K. S., Wilk, P., Cho, J., & Greco, P. (2009). Empowerment, engagement and perceived effectiveness in nursing work environments: Does experience matter? *Journal of Nursing Management*, *17*(5), 636–646. https://doi.org/10.1111/j.1365-2834.2008.00907.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. https://doi.org/10.1111/j.1365-2834.2012.01375.x

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. https://doi.org/10.1111/j.1365-2834.2009.00984.x

Loes, C. N., & Tobin, M. B. (2022). Does empowerment enhance nurses' organizational commitment? *Journal of Nursing Management*, *30*(7), 3123–3130. https://doi.org/10.1111/jonm.13725

Loughery, J., Gudi, S. K., Harrigan, T., & Duff, E. (2025). Facilitators, barriers, and educational preparedness of early-career nursing graduates entering practice in rural and remote areas: A mixed-method study. *Nursing Reports*, *15*(11), 410. https://doi.org/10.3390/nursrep15110410

Lundin, K., Engström, M., Skytt, B., Strömberg, A., & Silén, M. (2024). Individual and unit level insights from hospital staff ratings on structural empowerment, leadership-management performance, well-being, and quality of care. *BMC Health Services Research, 24*(1491), 1-14. https://doi.org/10.1186/s12913-024-11945-6

Mabuza, L. H., Govender, I., Ogunbanjo, G. A., Mash, B. (2014). African primary care research: Qualitative data analysis and writing results. *African Journal of Primary Health Care & Family Medicine, 6*(1), 1-5. https://doi.org/10.4102/phcfm.v6i1.640

Maier, C. B., Köppen, J., Kleine, J., McHugh, M. D., Sermeus, W., & Aiken, L. H. (2023). Recruiting and retaining bachelor qualified nurses in German hospitals

(BSN4Hospital): Protocol of a mixed-methods design. *BMJ Open*, *13*(8), 1–8. https://doi.org/10.1136/bmjopen-2023-073879

Manning, J. (2016). The influence of nurse manager leadership style on staff nurse work engagement. *The Journal of Nursing Administration*, *46*(9), 438–443. https://doi.org/10.1097/NNA.0000000000000372

Marufu, T. C., Collins, A., Vargas, L., Gillespie, L., & Almghairbi, D. (2021). Factors influencing retention among hospital nurses: Systematic review. *British Journal of Nursing*, *30*(5), 302–308. https://doi.org/10.12968/bjon.2021.30.5.302

McClain, A. R., Palokas, M., Christian, R., & Arnold, A. (2022). Retention strategies and barriers for millennial nurses: A scoping review. *JBI Evidence Synthesis*, *20*(1), 121–157. https://doi.org/10.11124/JBIES-20-00577

McCoy, C. (2009). Professional development in rural nursing: Challenges and opportunities. *The Journal of Continuing Education in Nursing*, *40*(3), 128–131. https://doi.org/10.3928/00220124-20090301-08

McDonald, S. F., Tullai-McGuinness, S., Madigan, E. A., & Shively, M. (2010). Relationship between staff nurse involvement in organizational structures and perception of empowerment. *Critical Care Nursing Quarterly*, *33*(2), 148–162. https://doi.org/10.1097/CNQ.0b013e3181d9123c

McEwen, M., & Wills, E. M. (2023). *Theoretical Basis for Nursing* (6th ed.). Wolters Kluwer.

McSherry, R., Pearce, P., Grimwood, K., & McSherry, W. (2012). The pivotal role of nurse managers, leaders and educators in enabling excellence in nursing care: Excellence

in nursing care. *Journal of Nursing Management*, *20*(1), 7–19. https://doi.org/10.1111/j.1365-2834.2011.01349.x

Men, L. R., & Stacks, D. W. (2013). The impact of leadership style and employee empowerment on perceived organizational reputation. *Journal of Communication Management*, *17*(2), 171–192. https://doi.org/10.1108/13632541311318765

Merriam-Webster. (2026, July 28). *Thesaurus results for empowerment*. https://www.merriam-webster.com/thesaurus/empowerment

Meub, C. (2018). *The decision to enter management*. University of Manitoba.

Miller, C., Wagenberg, C., Loney, E., Porinchak, M., & Ramrup, N. (2020). Creating and implementing a nurse mentoring program: A team approach. *The Journal of Nursing Administration*, *50*(6), 343–348. https://doi.org/10.1097/NNA.0000000000000895

Miller, P. A., Goddard, P., & Laschinger, H. K. S. (2001). Evaluating physical therapists' perception of empowerment using Kanter's theory of structural power in organizations. *Physical Therapy*, *81*(12), 1880–1888. https://doi.org/10.1093/ptj/81.12.1880

Muir, K. J., Wanchek, T. N., Lobo, J. M., & Keim-Malpass, J. (2022). Evaluating the costs of nurse burnout-attributed turnover: A markov modeling approach. *Journal of Patient Safety*, *18*(4), 351–357. https://doi.org/10.1097/PTS.0000000000000920

Niinihuhta, M., Terkamo-Moisio, A., Kvist, T., & Häggman-Laitila, A. (2021). Nurse leaders' work-related well-being-relationships to a superior's transformational leadership style and structural empowerment. *Journal of Nursing Management*, 2791–2800. https://doi.org/10.1111/jonm.13806

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

Omery, A., Crawford, C. L., Dechairo-Marino, A., Quaye, B. S., & Finkelstein, J. (2019). Reexamining nurse manager span of control with a 21st-century lens. *Nursing Administration Quarterly*, *43*(3), 230–245. https://doi.org/10.1097/NAQ.0000000000000351

Orgambídez, A., & Almeida, H. (2020). Exploring the link between structural empowerment and job satisfaction through the mediating effect of role stress: A cross-sectional questionnaire study. *International Journal of Nursing Studies*, *109*, 1–7. https://doi.org/10.1016/j.ijnurstu.2020.103672

Orgambídez-Ramos, A., & Borrego-Alés, Y. (2014a). Empowering employees: A Portuguese adaptation of the conditions of work effectiveness questionnaire (CWEQ II). *Psychological Thought*, *7*(1), 28–36. https://doi.org/10.5964/psyct.v7i1.88

Orgambídez-Ramos, A., & Borrego-Alés, Y. (2014b). Empowering employees: Structural empowerment as antecedent of job satisfaction in university settings. *Psychological Thought*, *7*(1), 28–36. https://doi.org/10.5964/psyct.v7i1.88

Ozbozkurt, O. B., Yesilkus, F., & Korkmazyurek, H. (2021). Analyzing the relationship between structural empowerment and perceived supervisor support. *Journal of Transnational Management*, *26*(1), 4–17. https://doi.org/10.1080/15475778.2021.1885900

Patrick, A., & Laschinger, H. K. S. (2006). The effect of structural empowerment and perceived organizational support on middle level nurse managers' role satisfaction. *Journal of Nursing Management*, *14*(1), 13–22. https://doi.org/10.1111/j.1365-2934.2005.00600.x

Penconek, T., Tate, K., Lartey, S. A., Polat, D., Bernardes, A., Moreno Dias, B., Nuspl, M., & Cummings, G. G. (2024). Factors influencing nurse manager retention, intent to stay or leave and turnover: A systematic review update. *Journal of Advanced Nursing*. https://doi.org/10.1111/jan.16227

Podsakoff, P. M., & Organ, D. W. (1986). Self-Reports in Organizational Research: Problems and Prospects. *Journal of Management*, *12*(4), 531–544. https://doi.org/10.1177/014920638601200408

Poindexter, K. (2022). Mentorship for new graduates: Responding to the challenge of transitioning to practice in a tumultuous and demanding health care environment. *National League for Nursing*, *43*(3), 143–144. https://doi.org/10.1097/01.NEP.0000000000000978

Polit, D. F., & Beck, C. T. (2021). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Wolters Kluwer.

Read, E. A., & Laschinger, H. K. S. (2015). The influence of authentic leadership and empowerment on nurses' relational social capital, mental health and job satisfaction over the first year of practice. *Journal of Advanced Nursing*, *71*(7), 1611–1623. https://doi.org/10.1111/jan.12625

Sandelowski, M. (2004). Using qualitative research. *Qualitative Health Research, 14*(10), 1366-1386. https://doi-org.uml.idm.oclc.org/10.1177/1049732304269672

Sarmiento, T. P., Laschinger, H. K. S., & Iwasiw, C. (2004). Nurse educators' workplace empowerment, burnout, and job satisfaction: Testing Kanter's theory. *Journal of Advanced Nursing*, *46*(2), 134–143. https://doi.org/10.1111/j.1365-2648.2003.02973.x

Sawatzky, J. V., & Enns, C. L. (2012). Exploring the key predictors of retention in emergency nurses: Key predictors of retention in emergency nurses. *Journal of Nursing Management*, *20*(5), 696–707. https://doi.org/10.1111/j.1365-2834.2012.01355.x

Scheffler, R. M., & Arnold, D. R. (2019). Projecting shortages and surpluses of doctors and nurses in the OECD: What looms ahead. *Health Economics, Policy and Law*, *14*(2), 274–290. https://doi.org/10.1017/S174413311700055X

Seenandan-Sookdeo, K.-A. I. (2012). The Influence of Power in the Canadian Healthcare System. *Clinical Nurse Specialist*, *26*(2), 107–112. https://doi.org/10.1097/NUR.0b013e31824590ba

Smith, S., Lapkin, S., Halcomb, E., & Sim, J. (2023). Job satisfaction among small rural hospital nurses: A cross-sectional study. *Journal of Nursing Scholarship*, *55*(1), 378–387. https://doi.org/10.1111/jnu.12800

Southern Health-Santé Sud. (2019). *Southern Health-Santé Sud Community Health Assessment* (p. 375) [Health Status]. https://www.southernhealth.ca/assets/AnnualReports/SH-SS-2019-Community-Health-Assessement_Final.pdf

Southern Health-Santé Sud. (2022). *Annual Report 2022-2023*. https://www.southernhealth.ca/assets/AnnualReports/SH-SS-Annual-Report-2022-2023.pdf

Southern Health-Santé Sud. (2024). *Home*. Southern Health-Santé Sud. https://www.southernhealth.ca/

Spano-Szekely, L., Quinn Griffin, M. T., Clavelle, J., & Fitzpatrick, J. J. (2016). Emotional intelligence and transformational leadership in nurse managers. *The Journal of Nursing Administration*, *46*(2), 101–108. https://doi.org/10.1097/NNA.0000000000000303

Spreitzer, G. M. (1995). *Psychological empowerment instrument*. https://webuser.bus.umich.edu/spreitze/Pdfs/EmpowerInstrument.pdf

Spreitzer, G. M. (1996). Social structural characteristics of psychological empowerment. *The Academy of Management Journal*, *39*(2), 483–504. https://doi.org/10.2307/256789

Spreitzer, G. M. (2008). Taking stock: A review of more than twenty years of research on empowerment at work. In J. Barling & C. Cooper, *The SAGE Handbook of Organizational Behavior: Volume I - Micro Approaches* (pp. 54–72). SAGE Publications Ltd. https://doi.org/10.4135/9781849200448.n4

Spreitzer, G. M., De Janasz, S. C., & Quinn, R. E. (1999). Empowered to lead: The role of psychological empowerment in leadership. *Journal of Organizational Behavior*, *20*(4), 511–526. https://doi.org/10.1002/(SICI)1099-1379(199907)20:4<511::AID-JOB900>3.0.CO;2-L

Strasser, R. (2003). Rural health around the world: Challenges and solutions. *Family Practice*, *20*(4), 457–463. https://doi.org/10.1093/fampra/cmg422

Ta'an, W. F., Alhurani, J., Alhalal, E., Al-Dwaikat, T. N., & Al-Faouri, I. (2020). Nursing empowerment: How job performance is affected by a structurally empowered work environment. *The Journal of Nursing Administration*, *50*(12), 635–641. https://doi.org/10.1097/NNA.0000000000000951

Taggart, J., & Wheeler, L. B. (2025). Collaborative learning as constructivist practice: An exploratory qualitative descriptive study of faculty approaches to student group work. *Active Learning in Higher Education*, *26*(1), 59–76. https://doi.org/10.1177/14697874231193938

Tamata, A. T., & Mohammadnezhad, M. (2023). A systematic review study on the factors affecting shortage of nursing workforce in the hospitals. *Nursing Open*, *10*(3), 1247–1257. https://doi.org/10.1002/nop2.1434

Tekleab, A. G., Sims, H. P., Yun, S., Tesluk, P. E., & Cox, J. (2008). Are we on the same page? Effects of self-awareness of empowering and transformational leadership. *Journal of Leadership & Organizational Studies*, *14*(3), 185–201. https://doi.org/10.1177/1071791907311069

Tian, H., Iqbal, S., Akhtar, S., Qalati, S. A., Anwar, F., & Khan, M. A. S. (2020). The impact of transformational leadership on employee retention: Mediation and moderation through organizational citizenship behavior and communication. *Frontiers in Psychology*, *11*(314), 1–11. https://doi.org/10.3389/fpsyg.2020.00314

Tort-Nasarre, G., Vidal-Alaball, J., Pedrosa, M. J. F., Abanades, L. V., Arcarons, A. F., & Rosanas, J. D. (2023). Factors associated with the attraction and retention of family and community medicine and nursing residents in rural settings: A qualitative study. *BMC Medical Education*, *23*(662), 1–12. https://doi.org/10.1186/s12909-023-04650-1

Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837–851. https://doi.org/10.1177/1077800410383121

Travers, J. L., Schroeder, K., Norful, A. A., & Aliyu, S. (2020). The influence of empowered work environments on the psychological experiences of nursing assistants during COVID-19: A qualitative study. *BMC Nursing*, *19*(1), 98. https://doi.org/10.1186/s12912-020-00489-9

Trus, M., Doran, D., Martinkenas, A., Asikainen, P., & Suominen, T. (2018). Perception of work-related empowerment of nurse managers. *Journal of Research in Nursing*, *23*(4), 317–330. https://doi.org/10.1177/1744987117748347

Trus, M., Razbadauskas, A., Doran, D., & Suominen, T. (2012). Work-related empowerment of nurse managers: A systematic review. *Nursing & Health Sciences*, *14*(3), 412–420. https://doi.org/10.1111/j.1442-2018.2012.00694.x

Udod, S. (2023). A call for urgent action: Innovations for nurse retention in addressing the nursing shortage. *Nursing Reports*, *13*(1), 145–147. https://doi.org/10.3390/nursrep13010015

Ulrich, B., Lavandero, R., & Early, S. (2014). Leadership competence: Perceptions of direct care nurses. *Nurse Leader*, *12*(3), 47–50. https://doi.org/10.1016/j.mnl.2014.03.012

Van Niekerk, L., Bautista-Gomez, M. M., Msiska, B. K., Mier-Alpaño, J. D. B., Ongkeko, A. M., & Manderson, L. (2023). Social innovation in health: Strengthening community systems for universal health coverage in rural areas. *BMC Public Health*, *23*(1), 55. https://doi.org/10.1186/s12889-022-14451-8

Wåhlin, I. (2017). Empowerment in critical care – a concept analysis. *Scandinavian Journal of Caring Sciences*, *31*(1), 164–174. https://doi.org/10.1111/scs.12331

Wang, X., & Cheng, Z. (2020). Cross-sectional studies: Strengths, weaknesses, and recommendations. *Chest Journal*, *158*(1), S65–S71. https://doi.org/10.1016/j.chest.2020.03.012

Wei, H., Roberts, P., Strickler, J., & Corbett, R. W. (2019). Nurse leaders' strategies to foster nurse resilience. *Journal of Nursing Management*, *27*(4), 681–687. https://doi.org/10.1111/jonm.12736

Wilson, B., & Laschinger, H. K. S. (1994). Staff nurse perception of job empowerment and organizational commitment: A test of Kanter's theory of structural power in organizations. *Journal of Nursing Administration,* 24(4S), 39-47. https://journals.lww.com/jonajournal/Fulltext/1994/04011/Staff_Nurse_Perception_of_Job_Empowerment_and.7.aspx

Wong, C. A., Cummings, G. G., & Ducharme, L. (2013). The relationship between nursing leadership and patient outcomes: A systematic review update. *Journal of Nursing Management*, *21*(5), 709–724. https://doi.org/10.1111/jonm.12116

World Health Organization. (2021). *WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas*. World Health Organization. https://www-ncbi-nlm-nih-gov.uml.idm.oclc.org/books/NBK570763/

World Health Organization. (2023). *Health Workforce Development*. https://www.who.int/teams/health-workforce/health-workforce-development

Yasin, Y. M., Kerr, M. S., Wong, C. A., & Bélanger, C. H. (2020). Factors affecting job satisfaction among acute care nurses working in rural and urban settings. *Journal of Advanced Nursing*, *76*(9), 2359–2368. https://doi.org/10.1111/jan.14449

Yesilbas, H., & Kantek, F. (2024). Relationship between structural empowerment and job satisfaction among nurses: A meta-analysis. *International Nursing Review*, *71*(3), 484–491. https://doi.org/10.1111/inr.12968

Zimmer, L. V., Banner, D., Aldiabat, K., Keeler, G., Klepetar, A., Ouellette, H., Wilson, E., & MacLeod, M. (2014). Nursing education for rural and northern practice in Canada. *Journal of Nursing Education and Practice*, *4*(8),162. https://doi.org/10.5430/jnep.v4n8p162

Appendix A: Research Question/Theory Concept Chart

Research Questions

Concepts	Question 1	Question 2	Question 3
Access to Resources	✓	✓	✓
Access to Opportunities	✓	✓	✓
Access to Support	✓	✓	✓
Access to Information	✓	✓	✓

Appendix B: Study Description Email for Access

To Whom it May Concern,

My name is Ariel Wilcox, and I am a graduate student at the University of Manitoba, College of Nursing. For the thesis portion of my master's program, I will be conducting a research investigation entitled "Rural Manitoba Nurse Leader Perceptions of Practice Environment Empowerment Structures." The pertinent questions guiding this study are:

1) How do nurse leaders describe and understand structural empowerment?
2) What organizational structures do nurse leaders identify as essential to empowered environments? (i.e., support, resources, information, opportunity),
3) How do nurse leaders create structures supporting empowered environments?

This study aims to study rural nurse leaders' understanding and creation of organizational structures which support empowerment.

I plan to recruit rural nurse leaders (hoping for about 10 participants) in the Southern Health-Santé Sud region of Manitoba to participate in a research study designed to learn more about rural nurse leaders' understanding of structural empowerment regarding rural nurse recruitment and retention. I am asking (if possible) for you and your administrative team to share this information via your internal e mail. I would also like to ask permission in displaying advertisement posters in your premises.

Rural nurse leaders will be asked to participate in a one-on-one audio (in person) or audio/video (via zoom) recorded interview expected to last 60-75 minutes. Interviewees will be placed by coded number into random generator and three participants will be randomly chosen to participate in a review of the post analysis findings to confirm findings and provide their feedback. This will be added to the analysis portion of study. Information collected during the interview will be used only for the purposes of research at the University of Manitoba, College of Nursing. All information collected in this study will be kept confidential. Only the primary investigator and the academic advisor will know the participants' identity.

This study poses minimal risk to the participants and is completely voluntary. The results of the study will be disseminated through presentations, peer reviewed journal articles, conferences, and my master's thesis.

Thank you for consideration of this research request. I hope to be able to proceed with this research in Southern Health-Santé Sud region to shine light on the importance of structurally empowered nurse leaders in rural nurse recruitment and retention.

Sincerely,

[redacted]

Ariel Wilcox, RN, BN, MN(c)

Appendix C: Letter of Invitation to Participants

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

Dear Rural Nurse Leaders

I am a graduate nursing student at the University of Manitoba. Part of my master' s program consists of conducting a research investigation entitled "Rural Manitoba Nurse Leader Perceptions of Practice Environment Empowerment Structures." The questions guiding this study are:

1) How do nurse leaders describe and understand structural empowerment?

2) What organizational structures do nurse leaders identify as essential to empowered environments? (i.e., support, resources, information, opportunity), and

3) How do nurse leaders create structures supporting empowered environments?

The rural nurse leader role is essential to health care functioning. Recruitment and retention strategies are crucial and worse in rural areas due to geographical location. Empowered nurse leaders are a strategy to develop successful recruitment and retention strategies via increased job satisfaction. Therefore, understanding our current rural nurse leaders' perceptions of empowerment is essential to inform how nurse leaders can be empowered, and therefore facilitate increased job satisfaction, recruitment and retention of staff. The aim of this study is to learn more regarding rural nurse leaders' understanding and creation of organizational structures which support empowerment.

You are being asked to participate as a registered nurse leader in rural Manitoba Southern Health-Santé Sud region. Inclusion criteria include: 1) occupy/employed in a designated leadership position (such as client services manager (CSM), clinical resource nurse (CRN), chief nursing officer (CNO), chief nursing executive (CNE), nurse manager, or nurse administrator, 2) in your position for more than 6 months, 3) work in Southern Health-Santé Sud region in Manitoba, and 4) are fluent in English. If you decide to participate in this study, you will be asked to complete a demographic questionnaire (with the interviewer at the beginning of the interview), which will be used to describe the study population. Participation in the study involves one in person or virtual interview that will take 60-75 minutes. During the interview, the researcher will ask you questions to explore the participants' understanding of structural empowerment. Interviewees will be placed by

coded number and 1, 4 and 10 (last) will be asked to review the post analysis findings to confirm findings and provide their feedback. This will be added to the analysis portion of the study.

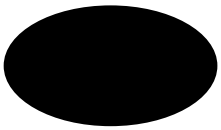
Participation in this study has minimal risks and participation is voluntary. Participants will receive a $50 Visa electronic gift card via email as a token of appreciation.

All information you provide as part of this study is confidential. My academic advisor and myself will be the only individuals with access to any identifying data. The study findings will be shared through journal publications, presentations in relevant academic fields, and in my master's thesis. A summary of the study findings will be sent to interested participants.

If you have any questions, you can contact the primary investigator, Ariel Wilcox, by email at: [redacted], or you may contact the faculty advisor for this research study, Dr. Judith Scanlan at [redacted]. If you agree to participate, please contact the primary investigator by email and we will set a mutually convenient time and place for the interview. At that time, you will sign a consent form and receive a copy for your reference. Prior to the interview, each participant and I will go over and ensure consent form completion and comprehension. This study has been reviewed and approved by The University of Manitoba's Research Ethics Board 1.

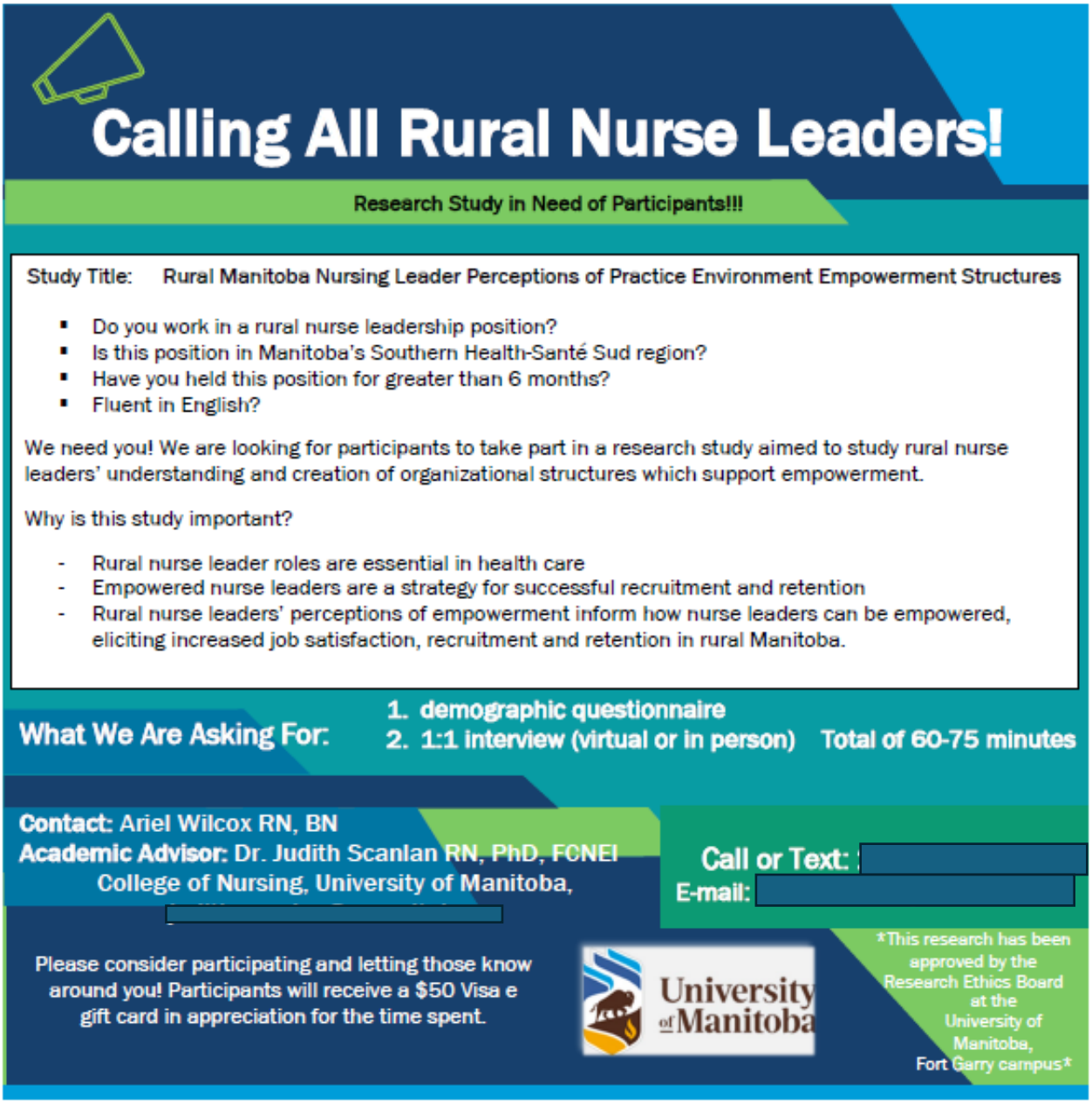
Thank you for considering this request, I look forward to meeting and talking with you.

Best,



Ariel Wilcox RN, BN, MN(c)

Appendix D: Study Advertisement



Appendix E: Participant Informed Consent Form

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

Study Title: Rural Manitoba Nurse Leader Perceptions of Practice Environment Empowerment Structures

Principal Investigator:

Ariel Wilcox, RN, BN, MN(c), Graduate Student, College of Nursing, [redacted]

Academic Advisor:

Judith Scanlan, RN, PhD, FCNEI, Associate Professor, College of Nursing, [redacted]

Committee Members:

Sonia Udod, RN, PhD, Associate Professor, College of Nursing [redacted]

Malcolm Doupe, PhD, Professor, Max Rady College of Medicine Community Health Science, [redacted]

Funder: TBA

This consent form, a copy of which you can download or print, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, feel free to ask any of the people named above. Please take the time to read this document and any accompanying information carefully. It is very important that you understand: what is being asked of you, what the risks and benefits of participation are, and how the information you provide will be used and stored.

Purpose of the Study: The purpose of this study is to investigate how rural nurse leaders understand and create empowered practice environments

Participant Selection: You are being asked to participate as a registered nurse leader in rural Manitoba Southern Health-Santé Sud region who is 1) employed in a designated leadership position (such as client services manager (CSM), clinical resource nurse (CRN), chief nursing officer (CNO), chief nursing executive (CNE), nurse manager, or nurse

administrator, 2) worked in this position for more than 6 months, 3) work in Southern Health-Santé Sud region in Manitoba and 4) can conduct study process(s) in English.

Study Procedures: If you decide to participate in this study, you will be asked to complete a demographic questionnaire (with the interviewer at the beginning of the interview), which will be used to describe the study population. Participation in the study involves one in-person or virtual interview that will take approximately 60-75 minutes. During the interview, I will ask you questions to explore your understanding of structural empowerment.

If the interview will be conducted virtually, it will be done by using University of Manitoba Zoom software and will be audio and video recorded and simultaneously transcribed with this software. You may turn your camera off during the interview if you prefer, although I would appreciate it if you could leave the camera on to facilitate the interview process. Your name on the Zoom software will be replaced with a code number at the beginning of the interview. If interview is in person, only an audio recording will be utilized by means of a handheld recorder. Handheld recordings will be immediately moved to a UM secured platform post interview and permanently deleted from the handheld recording device.

Interviewees 1, 4 and the last participant interviewed will be asked to participate in a review of the post analysis findings to confirm findings and provide their feedback. This will be added to the analysis portion of study and last approximately 30 minutes.

Study Risks: Participation in this study has minimal risks, that is risks that are no greater than what you might encounter in your daily life.

Study Benefits: Being a participant in this study may not help you directly, but information learned from you and other participants may help us understand how rural nurse leaders understand structural empowerment and the benefits of such in recruitment and retention to rural nursing. By taking an active role in this study, you will have the opportunity to reflect on your own leadership aspirations and development.

Compensation: Participants will receive a $50 Visa electronic gift card via email as a token of appreciation. At the beginning of the interview, the researcher will confirm your email address to send the gift card. You may keep the gift card even if you choose to withdraw from the study. I will collect additional personal information from you to record your receipt of the honorarium. I will keep this information separate from any other research information in a secure location for 7 years (August 2032) in case the University of Manitoba has to account for the money during a financial audit.

Storage and Use of Data: All the information you provide as a participant in this study is confidential which means we as the research team must keep it safe. The academic advisor and principal investigator will be the only individuals with access to any identifiable data. Your information will be kept on a UM approved secure platform. Paper copies of

electronic transcripts as well as any additional notes taken at the time of the interview will be securely stored in a separate locked filing cabinet of the researcher on campus at the University of Manitoba or at their home office. Your name will not appear on the recordings or transcripts of the interview that is conducted with you. Your interview data will be labelled with an assigned numeric code. A separate file will be maintained that contains the participant numeric codes and their names (master list). This file will be kept in a separate location from the study data on a secure University of Manitoba network drive. We may wish to quote your words directly in reports and publications resulting from this study; however, your name will not be used if a quote by you is used. All identifiable data including the master list, consent forms, any recordings, interview transcripts, recordings, and demographic questionnaires will be destroyed 7 years after completion of the study, August 2032.

I will do my best to keep your personal information safe. However, it is not possible to guarantee confidentiality. I will only share your personal information if the law requires us to. Your research information may be shared outside of the University of Manitoba with researchers, other organizations, and/or made publicly available. The information is being shared for further analysis or testing, as part of the research study, and/or because it is required by a funder or journal. It will not include your name or any information that could identify you. The study findings will be shared through my master's thesis, journal publications and presentations in relevant academic fields and a summary of the study finding will be sent to interested participants.

Withdrawing: Your participation in this research study is voluntary. You can choose to do only the activities and/or answer only the questions that you are comfortable with. You may withdraw from the study for any reason. You do not have to explain why. You will not be penalized in any way. You will keep your honorarium. Should you withdraw partway through the study, all of your information will be destroyed unless you have consented to allowing us to keep it. You may withdraw from the study until two weeks after the interview. After this date, we will start our analysis so it may not be possible to withdraw your information as it will not be linked to your name. To withdraw, please contact Ariel Wilcox at the phone number or email above.

Questions or Concerns: A designated University of Manitoba auditor may check that this study is being done safely and properly. To do this, they may visit the study site or review the research records. I will tell you if someone outside the research team will be there while you are participating. If this makes you uncomfortable, please tell the Principal Investigator, who will ask the auditor to return at another time. This study has been reviewed and approved by Research Ethics Board 1. However, this does not mean that participation is risk-free. If you have any questions, concerns, or complaints about this study, you may contact any members of the research team listed on the first page or the Office of Human Research Ethics at humanethics@umanitoba.ca or (204) 474-7122.

Consent: By signing this document, I agree that:
• I have read the above information or had it read to me.
• I have had the opportunity to ask and have answered all of my questions.
• I understand what is being asked of me.
• I will be taking part in a research study.
• I may freely stop or leave the research study activities at any time.
• My information may be shared outside the University of Manitoba.
• I do not waive my legal rights by participating in the study.

Please review the following statement. For each statement, please circle if you agree or do not agree:

I agree to participate in this study.	Yes	No
I agree to be audio-recorded in this study.	Yes	No
I agree to be video recorded in this study *(virtual only)*.	Yes	No
I agree to the use of a numeric code when study findings are shared	Yes	No

You may create an image by scanning the document with a document scanner or taking a picture of it with a digital camera or your phone. The principal investigator or research assistant will contact you in the near future to arrange a time to conduct the interview.

_____

Name of Participant Participant Signature Date

If you wish to receive a summary of the study results, please provide your email address below and an electronic copy of the report will be emailed to you in approximately Fall/Winter 2025/2026.

Email: _____

Notice Regarding Collection, Use, and Disclosure of Personal Information
Your personal information is being collected under the authority of *The University of Manitoba Act*. The University of Manitoba is committed to preserving your right to privacy. The information you provide will be used by the University to support our research. Your personal information will not be used or disclosed for other purposes, unless permitted by *The Freedom of Information and Protection of Privacy Act* or *The Personal Health Information Act*. If you have any questions about the collection of personal information: Ph: 204-474-9462 or Email: fippa@umanitoba.ca

Appendix F: Demographic Questionnaire

Please answer the following questions to reflect the best of your present-day situation:

1. Please indicate your age category:
   ☐ 18-25 years old
   ☐ 26-30 years old
   ☐ 31-40 years old
   ☐ 41-50 years old
   ☐ 51-60 years old
   ☐ greater than 61 years old

2. Do you identify as:
   ☐ male
   ☐ female
   ☐ non-binary
   ☐ transgender
   ☐ agender
   ☐ prefer not to declare
   ☐ other: _____

3. Select your highest achieved educational level:
   ☐ nursing diploma
   ☐ undergraduate degree
      ☐ nursing ☐ other (please specify) _____
   ☐ graduate degree (masters)
   ☐ doctoral degree
   ☐ other: _____

4. How many years total have you been a nurse? _____

5. Please indicate the number of years you have occupied a nurse leader position:
   ☐ less than a year
   ☐ 1-5 years
   ☐ 6-10 years
   ☐ 11-15 years
   ☐ 16-20 years
   ☐ greater than 21 years

6. Please indicate the area or sector where you currently hold your leadership position:
   ☐ acute care
   ☐ long term care
   ☐ community care
   ☐ education
   ☐ public health
   ☐ other: _____

7. As a nurse leader I am currently employed:
   ☐ in a full-time position/EFT 1.0
   ☐ in a part time position, please specify EFT _____

8. Please list any specific relevant leadership/management courses/workshops which you have completed to date which compliments your current education in your leadership role:

_____
_____
_____
_____
_____

Appendix G: Interview Guided Research Questions

The research question posed is: How do rural nurse leaders understand and create empowered practice environments?

1. Can you talk to me about your work environment (access to support)
    a. From your perspective what contributes to this environment
    b. Who in your organization mentors you and your thinking about how you can contribute to your workplace environment? Prompt with some of the individuals you identify above superiors peers subordinates
    c. How do you provide support to your staff? Prompt: specific to working short staffed? General: With personal/professional life balance? In their jobs/tasks?
    d. How do you facilitate/foster trust and safety in your working environment?

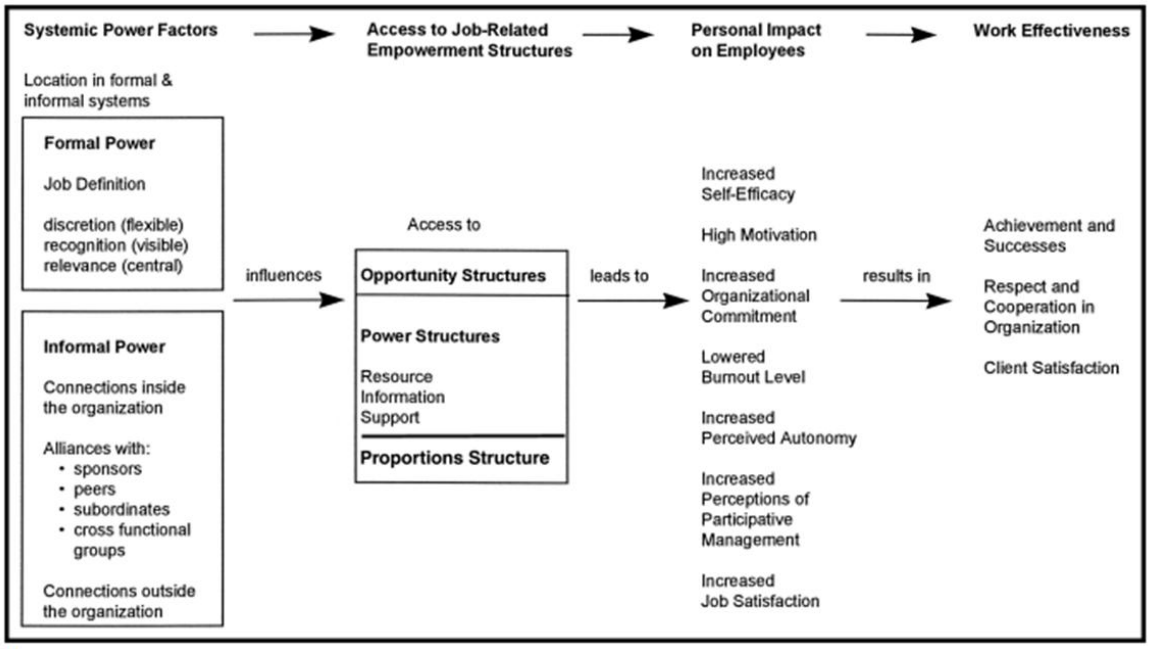
2. Can you explain how and when access to knowledge is pertinent to provide effective leadership to your staff (access to information)
    a. How is employee feedback received?
    b. What forms of orientation are offered upon hire? Are all new hires put through the same types of orientation? Can you describe key features of orientation in your workplace. Are there aspects of the orientation that you would change or add?
    c. Does your staff have access to organizational policies and procedures to make informed decisions? How and in what circumstances do your staff access and use organizational policies and procedures?
    d. How are staff kept informed of information pertinent to their work as a nurse?

3. What resources do you give your staff for their ability to do their job to the best of their means (access to resources)
    a. How do you build employee confidence?
    b. How do you encourage safe and effective choices in the workplace?
    c. How do nurses describe their ability to access the resources essential to their ability to provide nursing care?

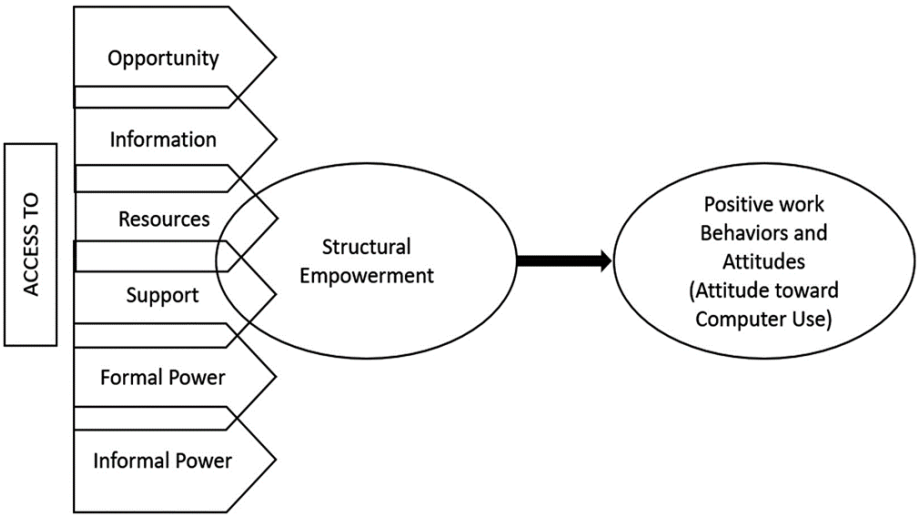
4. Can you describe the opportunities you and your staff have for growth and movement (access to opportunity)
    a. What supports are there for professional development?
    b. How do your staff increase knowledge and skills pertaining to their job?
    c. How were you prepared to be a leader? Can you describe this preparation? Are there aspects of your work as a leader that you think you are well prepared for? Aspects that you would like more preparation/information?

Appendix H: Conceptual Framework

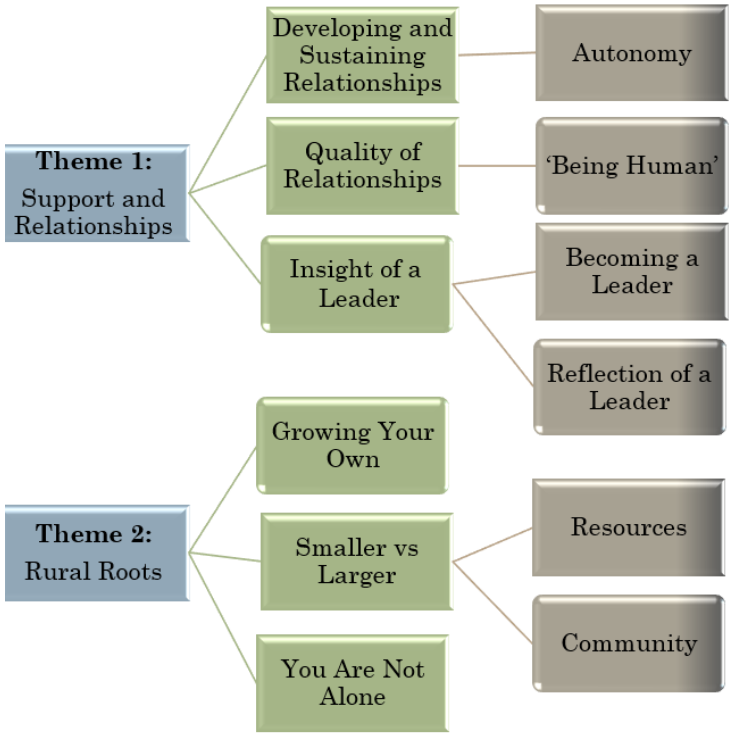
A general representation of the relationships among concepts of Kanter's (1979) structural theory of power in organizations, depicted by Laschinger et al.'s work in 1997 (Laschinger et al., 1997; Miller et al., 2001).



Proposed concepts and their corresponding relationships within Kanter's Structural Theory illustrated by (Ta'an et al., 2020).



Appendix I: Findings' Themes and Subthemes



Appendix J: Table 1- Demographic Questionnaire Participant Results

Age	
31-40 years	1
41-50 years	8
51-60 years	1
Gender	
Male	1
Female	9
Highest Educational Degree	
Diploma	1
Bachelor's Degree	8
Graduate Degree	1
Years Worked as Nurse	
11-20 years	8
21-30 years	1
31-40 years	1
Years Worked as a Rural Nurse Leader	
1-5 years	5
6-10 years	3
11-15 years	2
Area of Employment	
Acute Care	5
Long Term Care	4
Other	1
Employment	
Full Time	8
Part Time	2
Extra/Additional Managerial Education	
Yes	10