

Empowerment of Nurses During the COVID-19 Pandemic: Insights from Nurses'

Experiences

by

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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

Rady Faculty of Health Sciences

University of Manitoba

Winnipeg

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Acknowledgements

I want to express my sincere appreciation to my advisor, Dr. Sonia Udod, for her invaluable guidance and support throughout my graduate education. Your commitment to my success will be forever appreciated. To my thesis committee members, Dr. Geneveive Thompson and Dr. Sean MacDonald, thank you for your expertise, encouragement and support. This work was also supported by the Kathleen and Winnifred Raune Graduate Research Grant.

To the team at LEAD Outcome Research lab, Komal, Saba, Simer, and Alycia, thank you for your love, patience and insightful feedback throughout my research.

I have also been incredibly lucky to have a supportive and understanding mother. Thank you, Florence Amponsah, you are my inspiration. To my precious boys, Othniel, Joel and Israel, I love you and did this for you.

And finally, thank you to the nurses who participated in this study. Your willingness to share your experiences with me has positively contributed to the future of crisis leadership in nursing and healthcare.....yes, we made it!

Abstract

Background: The quality of registered nurses' work environment is essential to working effectively in a crisis such as pandemics. Organizational empowerment shapes nurses' psychological experiences and how they can provide quality patient care. Despite significant evidence for nurse empowerment, the COVID-19 pandemic significantly impacted nurses' empowerment in the work environment in Manitoba, Canada. Nurses experienced heavy workloads, mandated overtime shifts, staffing shortages and limited resources that led to exhaustion and job dissatisfaction.

Purpose: This qualitative descriptive study examined how the structural elements of organizational empowerment and psychological empowerment influenced nurses' experiences during the COVID-19 pandemic.

Methods: Semi-structured individual virtual interviews were used to collect data from nurses in two tertiary hospitals. Framework analysis (FA) by Ritchie and Spencer (1994) were used to analyze data guided by Kanter's (1977) Theory of Structural Empowerment and Spreitzer's Psychological Empowerment Framework (1995).

Findings: Four major themes emerged with subthemes: 1) organizational support and capacity response, 2) resilient adaptation and constrained agency, 3) work environment constraints, and 4) continuum of nurse distress and wellbeing. Overall, nurses found structural elements challenging, negatively impacting their work, wellbeing and outcomes. To better manage crises, organizational empowerment that includes in-person communication, senior leader support, crisis training, enhanced resource allocation, and mental health programs can facilitate nurses' psychological empowerment and workforce sustainability.

Conclusion: Organizations need to create workplace conditions that strengthen nurses' empowerment during health crises. This study supports and may extend the use of Kanter's theory from traditional work environments to challenging times such as pandemics for workforce sustainability, retention, and wellbeing.

Keywords: Nurses, structural empowerment, psychological empowerment, COVID-19 pandemic

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Chapter 1

Introduction

The critical role nurses play in managing health emergencies and crises over the decades remain apparent. Crisis management in nursing includes procedures, skills, and approaches used by nurses to anticipate, effectively manage, and reduce the impact of possible crisis scenarios such as an abrupt decline in patient health to large-scale catastrophes including pandemics (Bundy et al., 2017; Edmonson et al., 2016). The abrupt and rapid nature of infectious disease outbreaks highlights the importance of the capacity of the healthcare system to respond to impending crises through developing management plans, procedures, and policies to meet the challenges of potential health emergencies.

Additionally, the readiness and preparedness of frontline healthcare workers in responding to a possible infectious disease outbreak are essential. With the predominant healthcare workforce being nurses, empowering nurses to respond to health emergencies and crises may serve as an effective strategy for handling crises, enabling nurses to utilize their skills and abilities to control their work (Al Sabei et al., 2022a; Albasal et al., 2022a; Aliakbari et al., 2023a; Braithwaite, 2023; Ojikutu et al., 2022; Taleb et al., 2024). Moreover, over the years, the nursing literature has repeatedly proven a positive connection between structural and psychological empowerment, and a reduction in burnout, emotional exhaustion, attrition, absenteeism, and an increase in nurses' job satisfaction, retention, organizational commitment, resilience, and overall wellbeing (Albasal et al., 2022a; Al-Hussein, 2020; Aliakbari et al., 2023a; De Almeida & Orgambidez, 2019; Ding & Wu, 2023; Fragkos et al., 2020; Laschinger et al., 2001a; Sarmiento et al., 2004).

The World Health Organization (WHO) declared the coronavirus disease (COVID-19), caused by the SARS-CoV-2 virus, a global pandemic due to the significant levels of spread and severity observed following its outbreak from China (WHO Director-General, 2020). The COVID-19

pandemic significantly impacted healthcare, putting immense and unprecedented pressure on health workers, especially frontline nurses. Given the numerous waves and remarkable duration of the COVID-19 pandemic, evaluating nurses' experiences and exploring how policymakers can support nurses in future crises through effective strategies that focus on nurses' empowerment for enhanced efficacy is relevant.

This study investigated registered nurses' sense of empowerment during the COVID-19 pandemic within a Canadian healthcare setting. Similar to other countries such as the United States and Italy, Canada faced significant ramifications of the pandemic including lockdown and restrictions, prolonged use of personal protective equipment (PPE), resource constraints, surge in mental health issues, backlog surgeries, increased health expenditure, long-term care crisis, and nursing workforce issues, making prominent loopholes in the health systems' readiness, preparedness, and response to crises (Canadian Nurses Association, 2020; Government of Canada, 2022; Health Canada, 2024; McMahon et al., 2020; Stelnicki et al., 2020).

Nurses who constitute most of Canada's healthcare professionals were significantly impacted as they stood at the frontline caring for the high numbers of infected people in addition to mitigating the spread of the Coronavirus to the communities using limited resources and support (Health Canada, 2024). This weakened the nurses' defense wall resulting in high levels of burnout, stress, attrition, mental and physical health issues, COVID-19 infections, poor work-life balance, deaths, impoverished care, intention to leave, and career change further impacting nurses' retention (Bourgeault, 2022; CFNU, 2020; CIHI, 2024; Health Canada, 2024; Murphy et al., 2022). It was imperative to comprehend frontline nurses' perceived sense of empowerment to inform better procedures, structures, and policies for future crises.

Additionally, the study aimed to bridge existing knowledge gaps and contribute valuable insights that can guide leadership development initiatives tailored to the specific needs of Canada's healthcare institutions. Furthermore, this research provides empirically supported empowerment suggestions that might guide leadership behaviors when managing crises in Canada's healthcare industry. This thesis is structured into five chapters: the first chapter comprises background information, problem statement, objectives, and research questions. The second chapter is the literature review providing context for this study. The third chapter describes the study methodology. The fourth chapter presents the findings. Lastly, the fifth chapter discusses the findings.

Background

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 virus), initially referred to as the 2019 novel coronavirus, is reported to have genetic similarities with the virus responsible for the 2003 SARS outbreak (WHO, 2020). Transmission of the virus occurs through close contact between people when small liquid particles are expelled from the mouth or nose of an infected individual when coughing, sneezing, speaking, singing, or breathing, and alternatively, if the infectious particles directly contact the eyes, nose or mouth (WHO, 2021). The first cases were found in Wuhan, China, in December 2019, and later an alarming spread of the disease inside and outside of China with high death cases leading to a pandemic declaration of disease (WHO Director-General, 2020).

Geerts et al. (2021) describe comprehending world crises and pandemics with a new paradigm of four interrelated continuous phases: escalation, emergency, recovery, and resolution. The escalation stage is described as the recognition that an external threat is advancing mostly due to limited, chaotic, or unverified information and the imperative of making rapid

preparations (Geerts et al., 2021). In this first stage, the Public Health Agency of Canada (PHAC) initiated its emergency operations center after confirmation of an outbreak in China and the World Health Organization's pandemic declaration on March 11, 2020 (Detsky & Bogoch, 2020; McMahon et al., 2020; Razak et al., 2022). Additionally, resources were gathered, education of the public and training of frontline health workers as well as incidence command systems were established.

The emergency stage highlights leadership when a threat or crisis is urgent, direct, and localized, requiring rapid response (Geerts et al., 2021). Canada recorded the first case of COVID-19 in January 2020 in Toronto (CIHI, 2022; Razak et al., 2022) and in a flash, the entire nation lived through the consequences. To mitigate and contain the spread, Canada's government limited outside household gatherings to 5 to 10 people, imposed travel restrictions, and increased COVID-19 testing and tracing capacity throughout the country by June 2020 (Government of Canada, 2021) and subsequently, mandated masks in July 2020 initially in Quebec, Nova Scotia, and parts of Ontario (Detsky & Bogoch, 2020).

The number of COVID-19 related deaths in Canada was confirmed to be about 80% and linked to long-term care residents with Ontario and Quebec provinces with highest records (Detsky & Bogoch, 2020, 2021). Educational institutions were shut down and classes converted to online learning; numerous enterprises temporarily collapsed, resulting in unemployment, while others swiftly adapted to remote work arrangements (Detsky & Bogoch, 2020; Razak et al., 2022; Statistics Canada, 2022). Individuals engaged in home isolation, enacted physical distancing measures while stepping outside, and adapted to a new way of life which consequently had an impact on their psychological well-being. With the advent of each

successive wave of COVID-19, public health measures were modified, either loosened or strengthened.

Geerts et al. (2021) further described the third stage – the recovery phase, as when there is reduced threat but persistent risks and tiredness of all involved. This makes the recovery stage unstable requiring cautious leadership to avoid relapse. After the initial wave transpired with a worldwide spread of the COVID virus, successive waves influenced by the Delta and Omicron variants hit Canadians with each inciting renewed surge. Canadians had rest periods in between the waves with loosened restrictions on travel and precautionary measures allowing a breather and a state of normalcy; however, a high record of mental health issues and burnout. The experience for Canadians was that of fear and panic, and high regard for leadership actions to stop this nightmare; however, leaders themselves were also experiencing the pandemic.

According to Government of Canada one-year and two-year COVID-19 update, nearly 50% of Canadians reported increased stress levels during the pandemic higher than before the outbreak with prevalence higher among women, those aged 35-44, LGBTQ+ individuals, and those with children under 15 years old (Government of Canada, 2021, 2022). COVID-19 vaccinations began in Canada on 14 December 2020 (Health Infobase Canada, 2021; Statistic Canada, 2021) though there was high resistance stemming from safety issues, side effects of drugs, religious beliefs, and conspiracy theories around the pandemic.

Canada's nursing workforce of about 459,005 in 2021 and 450,000 in 2022 (CNA, 2021; Murphy et al., 2022) as well as the overall healthcare delivery system faced unpredictable challenges during the early stages of the COVID-19 pandemic. The novelty, high infectivity and pandemic potential of the virus as well as lengthy acute phase led to most of the challenges associated with managing COVID-19 infected patients. Additionally, witnessing high number of

deaths, prolonged use of PPE's, lockdown, and restrictions all affected nurses' physical, social, and mental well-being disrupting their work-life balance and professional prospects (Canadian Nurses Association, 2020; Government of Canada, 2021, 2022; Health Canada, 2024; Murphy et al., 2022; Razak et al., 2022; Statistics Canada, 2022; Stelnicki et al., 2020). These challenges resulted in increased workload and overtime for nurses with high reports of feelings of stress, frustration, and exhaustion and an overall decline in levels of motivation, empowerment, and confidence (Canadian Nurses Association, 2020; CIHI, 2024b; Detsky & Bogoch, 2020, 2021; Government of Canada, 2021, 2022b; Murphy et al., 2022; Razak et al., 2022; Udod, 2023; Udod et al., 2021). CIHI (2022) reports the double increase of 120,140 healthcare vacancies seen in Canada from the beginning of the pandemic to 2022-2023.

Nurses found COVID-19 situations stressful because they often were not able to provide safe quality care which led to increased level of burnout, depression, anxiety, post-traumatic stress disorders (PTSD,) and other mental health issues than the general public (Al Sabei et al., 2022a; Jun et al., 2021; Kilroy et al., 2022; McVicar, 2003; Stelnicki et al., 2020). The Manitoba Nurses Union (2014) and Stelnicki et al. (2020) pre-pandemic studies on Canadian nurses revealed high PTSD rates, symptoms of burnout, increased stress and anxiety levels, and about 1 in 3 nurses needed medical treatment for clinical burnout. The pandemic added to these challenges with nurses exhibiting heightened exhaustion as patients' illnesses worsened, resources were scarce, protocols kept changing, workload increased, as well as the meticulousness in PPE gowning (CFNU, 2020).

Moreover, limited fore-knowledge about COVID-19 also led to significant concern for nurses' health and safety as well as that of their loved ones due to the unpredictable trajectory of the pandemic and the obligations associated with additional duties in infection control (WHO,

2020b; WHO Director-General, 2020). Murphy et al. (2022) add that nurses feared dying, spreading the virus to their homes, and becoming sick as they worked around the clock amid the early stages of the pandemic. Murphy et al. (2022) further described that, COVID-19 pandemic caused resentment among nursing students pursuing the program and a high intention to quit after school. Several studies also confirm resource scarcity, nurses' redeployment, high patient volume, increased ICU admissions, high acuity, rapid COVID-19 protocol changes and infection with COVID-19 led to job dissatisfaction, high turnover rates, high physical and mental health issues consequently affect the quality of patient care (Alsulimani et al., 2021; Aydin & Bulut, 2022; Castaldo et al., 2022; Chan et al., 2021; Ding & Wu, 2023; Kloutsiniotis et al., 2022; McMahon et al., 2020).

Statistics Canada (2023) reported most nurses worked overtime during the first year of the pandemic leading to an increase in nurses' absences from work due to illness and disabilities. A total of 459,005 registered nurses were qualified to work in Canada in the year 2021 (CNA, 2021); however, in the fourth quarter of 2021, job vacancy rates for registered nurses increased by about 117%, reaching 22,955 as compared to the same quarter in 2019 before the pandemic. Similarly, the first four months of 2023 saw the highest percentage of employment vacancies for registered nurses and registered psychiatric nurses by 5,475 positions almost 24.0% to 28,335 compared to the same period in 2022.

The Canadian Federation of Nurses Union (*CFNU- Member Survey*, 2022) report revealed that early-career nurses (59%) and mid-career nurses (56%) are more likely to leave their jobs than late-career nurses (20%) with exhaustion or burnout (57%) as the main reason nurses resign. Other factors contributing to early retirement and resignation according to the report include inability to give proper care (45%), inadequate personnel numbers (43%),

inadequate administration/management support (36%), random staffing, scheduling, and redistribution (21%), and insufficient acknowledgment or communication (21%).

The personal and family life of nurses was impacted greatly by the pandemic. A web-based cross-sectional study on Quebec registered nurses (RN) and licensed practice nurses (LPN) to assess the impacts the pandemic had on their personal and occupation dimensions showed that managing changes in leisure activities such as traveling and care of young children who were at home due to lockdown and constraints was difficult for nurses as well as spending quality family time (Marceau et al., 2022). Additionally, Adil and Mahmood (2023) assessed the personal life of frontline nurses and found the majority left home responsibilities solely to their spouses and were unavailable emotionally though physically present when in the house with their families.

Likewise, most nurses lacked physical connection and support from loved ones and family as well as colleagues at work due to restrictions and resorted to communication via social media further causing feelings of loneliness (Arnetz et al., 2020). Arnetz et al. further point how single-parent nurses had a tough time dealing with their schedules and finding people to take care of their children. The rage, anger, and insults from family members who could not be with their loved ones in the hospital, especially dying patients due to hospital visiting mandates added to frontline nurses/managers' emotional toll (Arnetz et al., 2020; Castaldo et al., 2022).

Research on nursing empowerment has consistently shown positive outcomes including high job satisfaction, organizational commitment, higher nurse retention rates, less burnout and stress, and improved well-being (Al Sabei et al., 2022a; Albasal et al., 2022a; Al-Hussein, 2020; Aliakbari et al., 2023a; Boudrias et al., 2012; Cicolini et al., 2014; DeVivo et al., 2013; Doré, 2019; Fragkos et al., 2020; Permarupan et al., 2019; Saleh et al., 2022; Sarmiento et al., 2004; Taleb et al., 2024). Empowered nurses are also more likely to demonstrate resilience, creativity,

and leadership, benefiting both patients and their fellow healthcare professionals (Albasal et al., 2022a; Faulkner & Laschinger, 2008; Laschinger & Fida, 2014; Saleh et al., 2022). Study findings by Aghaei et al. (2020) and Aliakbari et al. (2023) confirm the significant role empowerment educational programs play in enhancing nurses' capacity, self-efficacy, and competence to deal with crises.

Jafarian-amiri et al. (2023) cross-sectional study assessing the relationship between empowerment and compassion fatigue among 247 nurses working in COVID-19 inpatient unit revealed that structural empowerment such as access to resources, information, training and support positively correlated with compassion satisfaction and inversely correlated with compassion fatigue. In addition to structural empowerment initiatives, Rega et al. (2017) highlight the significance of a personal sense of empowerment characterized by autonomy, trust, and meaning, and the ability to establish one's role and have an impact on the organization which imperatively reduce anxiety, stress, burnout, and enhance job satisfaction. This includes appreciating the inherent value and professionalism of nurses, seeking and investing in nurses' professional growth, allowing active participation in organizational activities as well as freedom of expression and execution of responsibilities (Albasal et al., 2022a; Aliakbari et al., 2023b; Boudrias et al., 2012; Cicolini et al., 2014; Jafarian_amiri et al., 2023; Permarupan et al., 2019; Rega et al., 2017).

Presently, leaders and organizations are transitioning from handling the immediate impacts of the crisis to confronting its enduring consequences (Geerts et al., 2021). At this phase, Canada seeks to evaluate the deeper repercussions of the pandemic on persons and systems, discern lessons learned, to execute strategies for reconstruction of the country. Malagón et al. (2022) assessed the long-term implications caused by the break in cancer treatment during the pandemic

on cancer mortality in Canada using the microsimulation model and anticipated a 2.0% increase in cancer death rates in Canada from 2020 to 2030, calling for quick diagnostic and treatment capacities to reduce the backlog. Similarly, Cost et al. (2022) cross-sectional study findings on the effects of COVID-19 emergency precautions on children/adolescents aged 6-18 mental health irrespective of a previous psychiatric illness revealed 67-70% of these children experienced deterioration in one of these mental health domains: depression, anxiety, irritability, attention, hyperactivity, and obsessions/compulsions with high incidence recorded in the first wave.

Murray and Piot (2021) also predicted a future with COVID-19 becoming seasonal or endemic with peak periods in the winter periods. The high vaccination rates, improved understanding of COVID-19 transmission and preventive measures projected an end to the pandemic nightmare; however, recurrent outbreaks continue to pose a threat and constant reminder of the pandemic experience (Murray & Piot, 2021). The Canadian respiratory virus surveillance in August 2024, reports a typical weekly COVID-19 admission rate of 3.0 out of 100,000 people and 34% of outbreaks in long-term care facilities (Canada, 2024). The study aligned with this stage, seeking not only to rectify damage but to capitalize on the potential to enhance systems, structures, and outcomes for future crises (Geerts et al., 2021).

Problem Statement

Nurses, as frontline healthcare providers, faced unique challenges in their roles during the early stages of the COVID-19 pandemic navigating high-pressure situations, complex patient care, and evolving healthcare policies (Canadian Nurses Association, 2020; CFNU, 2020; Chan et al., 2021; Detsky & Bogoch, 2021; McMahon et al., 2020; Razak et al., 2022). Moreover, the nature of the work environment for nurses during the early stages of the COVID-19 pandemic significantly influenced their job satisfaction, with implications for both individual well-being

and the quality of patient care (Abrams et al., 2023; Arnetz et al., 2020; CFNU, 2020; Chan et al., 2021; Ding & Wu, 2023). Empowering nurses during crises reduces burnout, improves quality of care, job satisfaction and nurses retention (Al-Dweik et al., 2016b; Boudrias et al., 2012; Jafarian_amiri et al., 2023; Saleh et al., 2022).

While there are extensive studies on the deep-seated changes in nurses' personal and occupational lives in the early stages of the COVID-19 pandemic, there is a lack of thorough research on nurses' sense of empowerment. With the gradual reduction of the acute phase of the pandemic, assessing the perceived sense of empowerment of nurses is essential to inform better structures, policies, and procedures in future crises. The Institute of Medicine guidance for establishing crisis standards of care for use in disaster situations (Institute of Medicine, 2009) recommends learning from and improving crisis standards of care response situations by integrating the views of the public and healthcare providers in the development and implementation of disaster guidelines and policies.

Objectives

This exploration examined nurses' perceived sense of empowerment during the COVID-19 pandemic and 2) recommend effective empowerment strategies for use in future health crises.

Research Questions

1. What structural and psychological empowerment strategies were used to support nurses during the pandemic? 2. How do nurses perceive these strategies improved their well-being and outcomes? 3. How best do nurses perceive they could have been empowered in the COVID-19 pandemic?

Conceptual Framework

This study was by guided by two theories: Kanter's theory of structural empowerment (SE) developed by Rosabeth Moss Kanter (1977) and Gretchen M. Spreitzer (1995) refined concepts of psychological empowerment (PE). The central tenet of SE is premised on the organizational structure playing a critical role in determining an individual's ability to accomplish their work. These include access to resources, information, opportunities and support through formal and informal power. Kanter (1977) posits that individuals possessing both formal and informal power can utilize work empowerment structures that facilitate their ability to do their tasks in meaningful ways. *Formal power* is perceived as the visible roles within an organization, which enables individuals to exercise creativity and independent decision-making. On the other hand, *informal power* arises from work relationships, social ties, affiliations, and alliances formed by networking with colleagues, supervisors, and subordinates within and beyond the organization. *Resources* are the available materials, equipment, time and staffing to carry out work effectively. *Support* comprises employees receiving feedback, guidance, and encouragement from supervisors, peers, and other team members. *Information* is the provision of relevant knowledge about organizational goals, decisions, policies, and technical information needed to function effectively. Lastly, *opportunity* describes the employees having prospects for growth, learning, and career advancement.

Spreitzer (1995) proposes a more subjective form of empowerment denoting how an individual feels about their work. PE reflects a personal sense of competence, self-determination, meaning, and impact regarding their work. According to Spreitzer (1995), *meaning* refers to the alignment between an individual's values, beliefs, and their work role; *competence* is one's belief in their ability to perform their work with skills; self-determination denotes the sense of control

and *autonomy* over one's work; and *impact* is the degree to which individuals feel their work influences organizational outcomes. There is evidence in the nursing literature that SE and PE reduce burnout, stress, mental health issues, increase engagement, retention rates, organizational commitment, and job satisfaction.

Conceptually, both SE and PE are connected or interrelated as SE fosters PE (Laschinger et al., 2001a). Kanter's SE and Spreitzer's PE were chosen for this study because of the substantial groundwork and empirical backing in reducing burnout, mental health issues and increasing job satisfaction, performance, and improving nurses' overall well-being. Both frameworks helped in informing the research objectives and the methodology for this study.

Health Emergencies

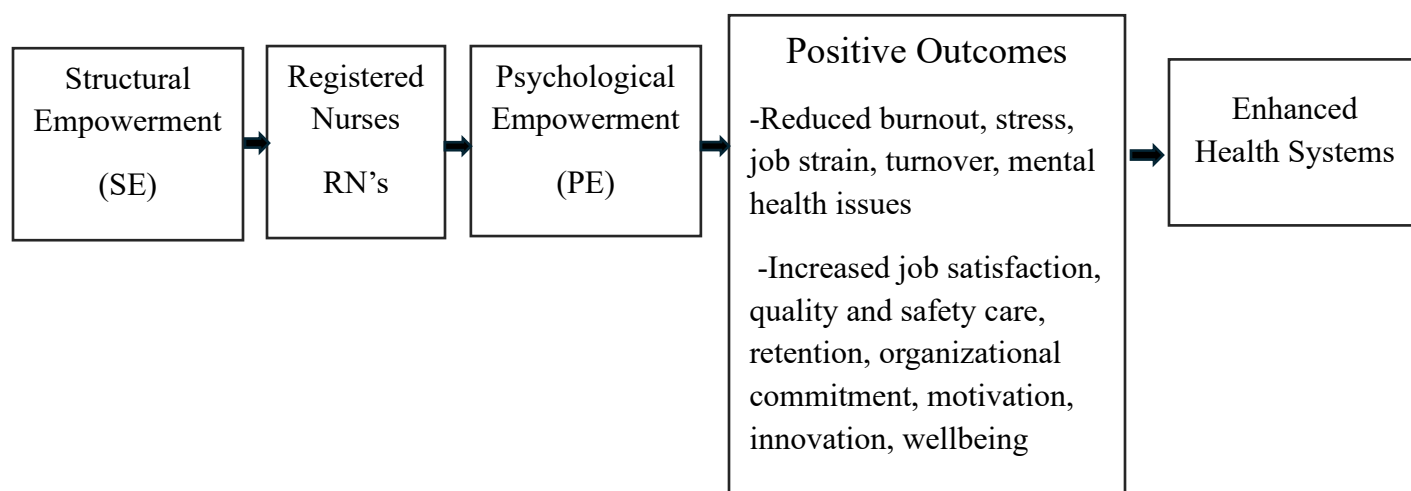


Figure 1: Proposed conceptual framework

Significance of Study

The information and knowledge gained from this study is timely to meet the urgent need for strategies to enhance nurse empowerment for nurse retention and workforce sustainability in the

post-pandemic context. By focusing on nurse empowerment, this study offers pragmatic ideas to improve leader practices to better support frontline workers and foster long-term staff retention.

Conceptual Definitions

Nurses: A person whose job is to care for people who are ill or injured, especially in a hospital (Cambridge Dictionary | English Dictionary, Translations & Thesaurus, n.d.). In this study, the term "nurses" refers to registered nurses (RNs) who were actively involved in COVID-19 patient care. The inclusion criteria specify the level of nursing education, certification, and the nature of their clinical responsibilities.

Structural Empowerment (SE): Structural empowerment is defined as empowering employees or individuals through organizational processes and structures such as resources, information, support and opportunities (Laschinger et al., 2001a). Structural empowerment in this study denotes the organizational structures that were made available for nurses during the COVID-19 pandemic.

Psychological empowerment (PE): Psychological empowerment refers to an individual's orientation or awareness toward their work (Gong et al., 2020; Permarupan et al., 2019). In this study, psychological empowerment describes nurses' feelings about their work during the COVID-19 pandemic.

COVID-19: A disease caused by the SARS-CoV-2 coronavirus which spread between people in close contact (World Health Organization, WHO, 2024).

Pandemic: This occurs when a new disease or a new strain of an existing disease- often viral respiratory disease, spreads rapidly across a large region, affecting a significant number of people (Kelly, 2011). Pandemic in this study refers to the recent COVID-19 pandemic which was

declared in March 2020 (World Health Organization-WHO Director-General, 2020) and ended in May 2023 (*WHO Chief Declares End to COVID-19 as a Global Health Emergency* | UN News, 2023).

Summary

There is a dearth of literature exploring the perceived sense of empowerment of nurses during the COVID-19 pandemic. Empowering nurses is shown to reduce stress and burnout, improve job satisfaction, quality of care, and nurse retention (Agnew, 2022; Atmospera-Walch, 2017; Fragkos et al., 2020). The concept of empowerment is highlighted in literature as an ideal way for nurses to handle a health crisis; however, the urgency noted in the literature on nurses' high levels of stress and burnout leading to low job satisfaction, and consequently high attrition and early retirements rates during the COVID-19 pandemic indicate that research focusing on nurses' sense of empowerment is required. Without a commitment to empowerment strategies, nurses may not have the skills, capacity or desire to work in future health crisis.

Chapter Two

Literature Review

The COVID-19 pandemic imposed severe working circumstances on nurses, characterized by personnel shortages, elevated infection risks, and significant emotional distress stemming from patient suffering. These settings highlighted the significance of structural and psychological empowerment to mitigate burnout and bolster resilience as well as preserve nurse well-being. This chapter reviews the existing body of knowledge on structural empowerment (SE) and psychological empowerment (PE) in nursing, focusing on the COVID-19 pandemic. It identifies nurses perceived SE and PE during the COVID-19 pandemic and highlights gaps that the study aims to address. Guided by the question below, this review highlights the significance of employing successful empowerment strategies to assist nurses during health crises and provides insight for cultivating a resilient nurses' workforce. The research question is: How do nurses perceive their structural and psychological empowerment during the COVID-19 pandemic?

As part of this review, literature from peer-reviewed journal articles, surveys, and self-report questionnaires from nurses in different healthcare environments forms a significant imperative. Search terms used include “psychological empowerment”, “Spreitzer’s psychological empowerment theory”, “structural empowerment”, “Kanter’s structural empowerment theory” “nurses”, “nurs*”, “nursing”, “COVID-19”, “pandemics”, “empowerment” “empower*”, with Boolean operators “AND”, and “OR”. Databases searched include Google Scholar, Scopus, CINAHL and formal nurses’ websites. This chapter is organized as follows. First, a look into structural and psychological empowerment and its application in nursing. Next, a delve into health crises such as pandemics and the impact it has on nurses as healthcare workers. And then,

nurses perceived structural and psychological empowerment during the recent COVID-19 pandemic will be examined, and gaps in literature identified.

Introduction to Empowerment

In the late 1960s and early 1970s, the self-help and political awareness movements that were taking place at the time gave rise to the notion of empowerment grounded in social action (Ryles, 1999). Empowerment was linked to community interests and efforts to augment the power and influence of marginalized groups, including workers, women, and ethnic minorities (Chandler, 1992). Subsequently, there became a growing acceptance of the significance of actions and traits of the individuals in an organization influenced by structures in the organization.

Defining empowerment can be challenging because empowerment is described in different forms in different contexts (Bradbury-Jones et al., 2007). According to the Oxford English Dictionary, *empowerment* is the act of giving somebody more control over their own life or the situation they are in. The focus of these definitions is on power which is described as “possession of control, authority, or influence over others”: “ability to act or produce an effect (*Cambridge Dictionary | English Dictionary, Translations & Thesaurus*, n.d.). However, power is a hefty term and it may suggest a more negative than positive feel (Conger & Kanungo, 1988) and is not the same as hierarchical power. Power and empowerment, though sometimes used interchangeably, have diverse meanings, especially in specific fields.

Power is defined in various ways in nursing. *Power* is described as the possession of control, influence, or dominance over an entity or individual (Chandler, 1992). According to Benner, an internationally acclaimed author, educator, and nursing theorist whose work shapes the nursing skill acquisition debate, power encompasses the caring techniques employed by nurses to empower patients (Benner, 2001). Benner further describes that the transforming and healing

qualities of power contribute to nursing's essence of caring (Benner, 2001). On the other hand, Kubsch (1996) also argued that expert power- the ability to influence others through the possession of knowledge or skills that are useful to others- is more relevant to nursing than other types of power, such as legal, coercive, remunerative, normative described by other researchers (Conger & Kanungo, 1988). Power may also be seen as the endless force that helps people overcome oppression (Ryles, 1999). When it comes to the process of empowerment, power is an essential component.

However, empowerment does not take place in a vacuum; rather, it takes place within the larger dynamics of power relationships (Al-Dweik et al., 2016a; Udod, 2008). Chandler (1992) was one of the pioneers in articulating the concept of empowerment within the nursing profession and distinguished between power and empowerment, indicating that empowerment facilitates a person's action, whereas power implies control, influence, or dominance (Chandler, 1992). Empowerment provides individuals or organizations with the ability to get access to and make use of power (such as knowledge, resources, or influence) to change their situations (Rega et al., 2017). Chandler (1992) contends that the distribution of control, authority, and influence is not the only factor that contributes to empowerment; rather, it is relationships that are the source of empowerment. Empowerment involves sharing power from leaders and institutions to underprivileged groups, patients, and employees. Shifting power dynamics can reduce inequities and give people agency and control.

Empowerment is highly used in the nursing field, highlighting nurses' ability to influence their field, form independent opinions, and advocate for patients and themselves. Empowerment, or the state of being empowered, is viewed as a motivational construct, which means to enable rather than just delegate work. Conger and Kanungo (1988) describe empowerment as an

individual's conviction in their own sense of self-efficacy being strengthened. Other scholars also describe empowerment as boosting a person's capacity to make decisions, take action and bring about change, and to carry out their work in a manner that is meaningful (Kuokkanen et al., 2007; Laschinger et al., 1997). According to Kuokkanen and Katajisto (2003), the notion of empowerment has been modeled from a wide variety of perspectives. For instance, Ryles (1999) describes empowerment as either a subjective experience or a collective one. Others see empowerment arise from the working environment (Kanter, 1993) or within one's own mindset (Conger & Kanungo, 1988) and as either a process or a consequence, depending on the context (Gibson, 1991).

In recent years, the idea of empowerment has emerged as a prominent topic of discussion in the context of workplace relations, notably in nursing and healthcare contexts. There is a widespread consensus that empowerment is an essential component in achieving higher levels of work satisfaction, stimulating creativity, improving mental health and boosting organizational performance (Boamah, 2022; Chandler, 1986; Conger & Kanungo, 1988; Gibson, 1991; Laschinger et al., 1997; Ryles, 1999; Spreitzer, 1996). Both Kanter's Structural Empowerment Theory and Spreitzer's Psychological Empowerment Theory, which are both highly used unduly theoretical frameworks, offer viewpoints that are complimentary to one another regarding the conceptualization and implementation of empowerment in the workplace as explained in the following sections.

Overview of Kanter's Structural Empowerment Theory

Kanter's theory of structural empowerment forms the basis for implementing empowerment in nursing (Laschinger et al., 1997). Kanter's theory of structural empowerment has been utilized unduly in nursing. This theory is not originally a nursing theory but rather one of sociology and

was conducted from a business discipline viewpoint in an ethnographic study. Developed by Rosabeth Moss Kanter in the 1970s, the structural empowerment theory, also known as Kanter's hypothesis or theory, was initially applied to management and organizational behavior, but has since found extensive use across various sectors, including nursing. Kanter posits that individuals respond rationally to their prevailing circumstances and describes that it is a mandate for management to establish conditions conducive to work efficiency. Kanter's structural empowerment theory provides a framework for understanding how nurses' organizational procedures and structures can support employees perform their duties effectively, thereby enhancing outcomes. From a structural viewpoint, Kanter describes employees should have access to the information, support, and resources necessary to accomplish work and opportunities for development.

According to Kanter, empowerment entails the ability to accomplish tasks and mobilize resources (Kanter, 1977), with a focus on creating empowering work conditions within organizations. In Kanter's theory (1977) the term "structural empowerment" refers to the procedures and organizational structures that enable individuals to perform their roles effectively (Kanter, 1977). Kanter adds that both formal mechanisms within an organization, such as an employee's position, and informal systems, such as social relationships within and outside the organization, serve as sources of power. In this context, the concept of power denotes the ability to influence and achieve desired outcomes. Kanter's structural empowerment encompasses several aspects including:

Access to resources: this emphasizes the importance of providing employees with the necessary tools and resources, including knowledge, training, and tangible materials, to perform their duties effectively. This ensures that employees have access to equipment, adequate time and

supplies, technology, staffing levels, and other essential resources required to make them function in their roles (Kanter, 1977).

Access to information underscores the significance of granting employees' access to the relevant information needed to fulfill their roles competently. This includes access to data, organizational goals, policies, procedures, and decision-making processes within the organization. Informing employees allows them to understand expectations and contribute meaningfully to patient care and organizational goals.

Access to support denotes organizations enabling employees to excel by offering them the physical and emotional support, guidance, and encouragement they need from various sources such as colleagues, managers, mentors, and professional networks. A supportive environment fosters trust, a sense of belonging, and camaraderie, which are essential for job satisfaction and retention.

Access to opportunities describes the need to provide opportunities for professional growth, development, and advancement. These opportunities may include specialization, leadership roles, promotions, career progression, as well as access to educational programs, workshops, and conferences to enhance knowledge and skills.

Application in Nursing

Throughout the nursing profession, Laschinger expansion of Kanter's theory has been extensively utilized to investigate ways in which the structural elements of an organization influence nurse satisfaction, performance, patient outcomes and retention. Kanter's theory of structural empowerment forms the basis for implementing empowerment in nursing (Laschinger et al., 1997). The first time Kanter's paradigm was applied in a nursing environment was by Chandler (1986, 1991), who researched the views of power in employment held by 268 staff

nurses. Through her research, she discovered that the staff nurses working at two hospitals in the United States of America saw access to opportunities and power structures, as described by Kanter, as critically important empowering traits. Overall, the findings revealed nurses had poor scores on assessments of Kanter's constructs, which suggests that there was a limited degree of empowerment in these hospitals. Laschinger et al. (1997) secondary studies examining the relationships among variables in Kanter's theory and two different facets of work decisional involvement (control over the content and context of nursing practice) revealed formal power and work empowerment mechanisms were mediated by informal power. Formal and informal power and access to empowerment structures were important determinants of nursing practice content and context engagement. The findings confirm Kanter's theory and inform theory-based management approaches to increase nurses' professional and organizational decision-making.

Other studies in nursing using empowerment theory have outlined positive nurse and organizational outcomes (Agnew, 2022; Al Sabei et al., 2022; Gilbert et al., 2010; Harwood et al., 2010; Hayes et al., 2014; Laschinger et al., 2001a; Orgambidez & Almeida, 2019; Xu et al., 2024; Zhang et al., 2018). For instance, cross-sectional studies by Hayes et al. (2014) and Xu et al. (2024) found structural empowerment has a strong direct negative effect on burnout. Harwood et al. (2010) and Orgambidez & Almeida (2019) findings further indicate constructs of structural empowerment such as access to resources, opportunities, informal and formal power reduce nurses' burnout. The consequence of persistent stress in the workplace not well managed leads to burnout and manifest as a decrease in professional competence, sentiments of negativity or cynicism relating to one's employment, feelings of energy depletion or fatigue, and greater mental distance (World Health Organization, WHO, 2019). Nursing is demanding, comprising long shift hours, high patient-nurse ratios, high workload, quick decision-making, inadequate

resources- both man and materials and the strain of caring for patients who may have bad outcomes (Dulko & Kohal, 2022; Gibson, 1991; Laschinger et al., 1997, 2001a). High burnout rates are recorded in nursing worldwide and evidence suggests nurses have lowered levels of burnout when structurally empowered (Boamah & Laschinger, 2016; Guo et al., 2016).

A significant association between structural empowerment and nurses job satisfaction has been found (Ahmad & Oranye, 2010; Cai & Zhou, 2009; Chen et al., 2022; De Almeida & Orgambidez, 2019; García-Sierra & Fernández-Castro, 2018; Hauck et al., 2011; Hu & Liu, 2004; Kelly et al., 2022; Ning et al., 2009). Other studies further assessing the impact of structural empowerment on nurses' job satisfaction, turnover rate and engagement found structural empowerment positively influences engagement and job satisfaction as well as a reduction in turnover intentions of nurses (Cai & Zhou, 2009; Hauck et al., 2011; Kelly et al., 2022; Yürümezoğlu & Kocaman, 2019). Studies show nurses structural empowerment increase organizational commitment (Ahmad & Oranye, 2010; Albasal et al., 2022a; Fragkos et al., 2020; McDermott et al., 1996; Wilson & Spence Laschinger, 1994) and improve patient safety and care quality (Armellino et al., 2010; Asif et al., 2019; Atmospera-Walch, 2017; Demir et al., 2023; Goedhart et al., 2017; Horwitz & Horwitz, 2017; Johnson, 2015; Lundin et al., 2024). In summary, in the evolving healthcare system, the role of structurally empowering nurses needs to be prioritized for well-being, improving patient quality of care, job satisfaction as well as reducing turnover intentions.

Overview of Spreitzer's Psychological Empowerment Theory

The psychological empowerment theory was first talked about by Conger and Kanungo (1988) and Thomas and Velthouse (1990). Gretchen Spreitzer in the 1990s built on these earlier works, moving the attention away from organizational structures toward the individual's feeling

of empowerment in the workplace. Spreitzer indicates psychological empowerment arises when a work environment interacts with one's personality, which develops the four empowerment cognitions and inspires human activity (Spreitzer, 1995). A psychologically empowered individual is one who not only wants to but can influence their work position and context. This type of empowerment shows an active rather than a passive perspective on work. Spreitzer describes *psychological empowerment* as a motivating construct that is manifested in four cognitive dimensions: meaning, competence, self-determination, and impact (Spreitzer, 1995). According to Spreitzer, empowerment is a psychological condition that occurs when an individual has the perception that they can exert influence over their working organization and accomplish goals that are significant to them (Spreitzer, 1995). Spreitzer's description of the four cognitions is:

Meaning: Involves perceiving one's work as important and purposeful, that contributes to broader objectives and societal benefits while assuring congruence between a nurse's beliefs, values, and actions, and the demands of the profession (Spreitzer, 1995).

Competence: Refers to an individual's belief in their abilities and skills to perform job functions effectively.

Self-determination: Involves having a sense of control and autonomy over one's professional responsibilities and decisions.

Impact: The sense or recognition of one's work on organizational goals and outcomes, contributing to a sense of purpose and job satisfaction.

Application in Nursing

Spreitzer conducted the earliest studies on psychological empowerment first developing and validating the multidimensional measure of psychological empowerment in the workplace (Spreitzer, 1995). Spreitzer et al. (1997) tested the relationship between the four dimensions of psychological empowerment (meaning, competence, self-determination, and impact) on three outcomes that are anticipated to result from empowerment: effectiveness, work satisfaction, and job-related strain on two groups of nurse managers. Findings consistent across both groups reveal each construct is associated with different outcomes and that no one construct can accurately predict all three outcomes as such employees must experience each of the dimensions of psychological empowerment to be able to accomplish all the anticipated outcomes of empowerment. Another study by Spreitzer on the relationship between psychological empowerment and leadership showed supervisors who reported higher empowerment levels were perceived by their subordinates as being upward influencing, and inspirational (Spreitzer et al., 1999).

Other researchers investigated the impact psychological empowerment has on nurses' job satisfaction. Nurses' job satisfaction is highly prioritized as they form most of healthcare workforce and play a significant role in providing around the clock patient care (Al-Hussein, 2020; Boamah, 2018; Gu et al., 2022; Ning et al., 2009). The global shortage of nurses calls for urgent strategies to recruit and retain nurses to meet the dynamic healthcare system. Ahmad and Oranye (2010) empirical study among 556 nurses in England and Malaysia found a significant relationship between psychological empowerment and job satisfaction with meaning, self-determination and impact being constructs with the most significant effect on job satisfaction. The findings are consistent with other studies (Al-Hussein, 2020; Baker et al., 2011; Gu et al., 2022; Li et al., 2018;

Saif, 2013; Wang & Lee, 2009) highlighting the positive effect of psychological empowerment on nurses' job satisfaction.

Psychological empowerment is shown to reduce emotional strain or burnout (Al Sabei et al., 2022a; Boudrias et al., 2012; Faulkner & Laschinger, 2008; Gilbert et al., 2010; Harwood et al., 2010; Laschinger et al., 2001b) increase organizational commitment (Ahmad & Oranye, 2010; Albasal et al., 2022a; Al-Hussein, 2020; Chang et al., 2010; Li et al., 2018), increase retention and engagement rates (Conroy et al., 2023; Faulkner & Laschinger, 2008; Hampton & Rayens, 2019; Meng et al., 2016; Otaibi et al., 2022) and increase quality patient care (Bonias et al., 2010; Karimi et al., 2021; Kostiwa & Meeks, 2009; Malak & Abu Safieh, 2022).

Relevance of Structural and Psychological Empowerment in Health Crises/ Pandemic Management

Pandemics are described as health conditions that spread globally (World Health Organization, WHO, 2024) causing significant loss of human life, disruption to homes and communities, and negatively impacting development in countries. The world has seen pandemics such as severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), influenza (H1N1), Swine flu (H1N1/09), and Ebola. The high infectivity, rapid incidence and sequel of these pandemics place a significant strain on health systems capacity and healthcare workers (Schneider et al., 2022)). Intensified levels of work-related stress, burnout and psychological ill-health experiences are reported among healthcare professionals who play a key role in such health emergencies and nurses consistently are the most impacted (Matsuishi et al., 2012). These experiences are mostly characterized by an increase in workload and/or work hours, inadequate personal protective equipment (PPE), negative reports in the media, high rate of infection, inadequate support from employer or leadership, fear of being infected and

transmission to others. Sentiments of isolation and separation from loved ones all lead to high prevalence of stress, anxiety, depression, burnout, physical pains, insomnia, high turnover rates, and post-traumatic disorder (PTSD) after years of the outbreak among nurses across pandemics (Alsubaie et al., 2019; Bai et al., 2004; Koh et al., 2005; Matsuishi et al., 2012; Park et al., 2018; Schneider et al., 2022; Styra et al., 2008; Su et al., 2007; Wong et al., 2007).

Empowerment is even more relevant during pandemics when healthcare workers, particularly nurses, are confronted with difficult circumstances including redeployment, staff shortages, high patient volumes and workloads, burnout and mental health issues and insufficient resources. For example, as frontline health professionals, nurses are mostly redeployed during healthcare crises or emergencies to meet patient care needs, reduce workload from the surge in patients, and for healthcare workforce optimization (Bundy et al., 2017; Setzer, 2021). Though a sense of duty and responsibility is felt by nurses to respond to patient care during health crises, high records of psychological pressure from redeployment have been documented in the literature (Maunder et al., 2008; Schneider et al., 2022; Shiao et al., 2007). White et al. (2024) descriptive qualitative study on ICU nurses' experiences of redeployment in Australia during the COVID-19 pandemic highlights how the lack of choice of nurses, lack of orientation and unfamiliar surroundings resulted in stress, anxiety, absenteeism, feelings of undervalue and insecurity.

Similarly, Lukewich et al. (2024) studies on primary healthcare nurses across four provinces in Canada (British Columbia, Ontario, Nova Scotia, Newfoundland and Labrador) indicated 15.8% were mandated for redeployment as the pandemic progressed. These nurses report a lack of involvement in decision-making and being redeployed without information on the location and job description further causing anxiety, panic and stress (Lukewich et al., 2024). A study in England on nurses' experiences of redeployment similarly indicates 66% of nurses did not have a choice

regarding their redeployment as well as adequate training for the new role causing high levels of emotional exhaustion and feelings of incompetence (Taylor et al., 2023). Notably, such challenges have been encountered in previous pandemics (Alsubaie et al., 2019; Mashino et al., 2022; Schneider et al., 2022; Shiao et al., 2007) calling attention to the significance of training, clear communication, involvement in decision-making, and flexible strategies or an operational redeployment plan in health crises (Hartley et al., 2024; Juan et al., 2021; Lukewich et al., 2024; Taylor et al., 2023).

Parallel to the stress of the magnitude of work that health personnel faced during the H1N1 pandemic in 2009 (Matsuishi et al., 2012) and severe acute respiratory syndrome (SARS) in 2003 (Koh et al., 2005; Shiao et al., 2007), nurses' workloads increased dramatically amid the COVID-19 pandemic exacerbating the pressures faced pre-pandemic (Zhang et al., 2021). Lim et al. (2023) explored the psychological experiences of nurses in Iran, USA, China, Turkey, and Canada giving direct care to COVID patients. Findings reveal that critically ill COVID-19 patients required procedures that were specialized and complex such as mechanical ventilation, continuous renal replacement therapy and extracorporeal membrane oxygenation, which was challenging for nurses to quickly master and learn these skills. Another study identified that the different COVID variants and waves necessitated new skills and demands in patient care that further burdened nurses in addition to the stress of donning and doffing personal protective equipment (PPE). Findings from several studies among ICU nurses in Spain, Singapore, Italy, United Nations, and USA during the pandemic indicate that increases in workload during the pandemic result from employees engaging in activities that they do not typically conduct (Bellanti et al., 2021; Fernandez-Castillo et al., 2021; Gomez et al., 2020; Koh et al., 2005; Zhang et al., 2021).

The report on nurses in Africa during the pandemic indicates the massive surge in COVID-19 patients led to high workloads that impaired nurses' decision-making abilities and the quality of patient interactions (Nchasi et al., 2022). Other studies in Ghana and Uganda found that nurses worked long hours on the frontline, saving patients' lives to the detriment of their own health (Aziato et al., 2021; Kabunga & Okalo, 2021). Nurses' workload was impacted by the COVID-19 pandemic worldwide causing severe strain on nurses and negatively affecting their well-being.

COVID-19 gave rise to intense emotional and mental health challenges among nurses. In a Canadian study, Havaei et al. (2021) examined nurses' anxiety and depression trends over time: before (time 1), 1 month (time 2) and 3 months (time 3) after the COVID-19 pandemic declaration and found a 10% to 15% increase in anxiety and depression in time 1 and 2 and levels higher in time 3 than time 1. Castaldo et al. (2022) found high emotional stress for nurses caring for dying COVID-19 patients due to visitor restrictions. Varghese et al. (2021) studies on mental health issues among nurses during the COVID-19 pandemic in Asia, Europe, the Eastern Mediterranean Region and America reveal anxiety rates of 32%, stress 46%, depression 32%, insomnia 38.3% and PTSD 18.6%. Risk factors identified for these mental health issues include direct care for COVID-19 patients, lack of PPE, low self-efficacy and resilience, being female and poor social support (Varghese et al., 2021). These assessments depict the psychological impacts of the COVID-19 pandemic on nurses worldwide which is consistent with previous pandemics (Matsuishi et al., 2012; Maunder et al., 2008; Shiao et al., 2007) and the triggering factor for most nurses leaving their jobs (Kelly et al., 2022).

Managing health crises requires the provision of adequate human and material resources; however, such resources are usually insufficient or lacking, posing substantial risks to patients receiving care and frontline healthcare workers' health and well-being (Bundy et al., 2017; Institute

of Medicine, 2009; Wooten & James, 2008). Previous pandemic reports reveal a consistent trend of limited resources (Akintujoye, 2020; Maunder et al., 2008), creating professional and ethical problems regarding health workers' obligation to care for patients and the limits they should go. Cho et al. (2021) cross-sectional study on resources provided to nurses in the US during the COVID-19 pandemic recounts nurses' reports of being given one N95 mask and one surgical mask per week due to inadequate PPE and being permitted to wear N95 mask only when doing a procedure. Studies by Yusefi et al. (2022) and Liu et al. (2020) highlight how the lack of prediction and proactive planning for public health emergencies in Iran and China respectively resulted in inadequate or lack of human and material resources during the COVID-19 outbreak.

This exacerbated battle with resources during the pandemic forced nurses to prioritize caring for patients with urgent needs to meet the scarce resources such as PPE, beds in ICU, ventilators, and extracorporeal membrane oxygenation (Gebreheat & Teame, 2021). Morley et al. (2020) further elaborate on nurses assuming non-nursing roles because inadequate PPE limited other providers to enter patients' rooms. These insufficient resources coupled with strict adherence to precautionary guidelines such as donning and doffing led to delays in patient care and high concerns about the quality of care provided, consequently resulting in high moral distress, burnout and depression in nurses (Morley et al., 2020; Sperling, 2021; Turale et al., 2020). Overall, resource constraints are still a major challenge in managing health crises or emergencies all over the world. Definite measures and plans must be established in preparation and managing future occurrences to protect the well-being of both patients and health workers, especially nurses. Hartley et al. (2024) recommends strategic allocation of resources, clear communication and involvement of health workers in decision-making processes for better outcomes in future pandemics and crises.

Kanter's structural empowerment and psychological empowerment underscore the significance of organizational support systems and individual sense of competence and autonomy respectively (Laschinger et al., 2001) to handle pandemic uncertainties. Reyes et al. (2024) confirm the significance of empowerment during healthcare emergencies especially, for new nurses with less than 10 years of experience, those in the young adult group, those in lower positions or ranks and nurses who are single as they tend to exhibit lower levels of empowerment. Reyes et al. argue that nurses with more than 10 years of experience, those in the middle-age and older adult group as well as those in higher positions and ranks, have higher levels of empowerment and more access to resources, information, power, opportunity and support (Reyes et al., 2024).

A meta-analysis of eighty-two studies on 210,669 healthcare providers on the relationship between burnout and quality and safety of care found burnout is associated with poorer quality healthcare and reduced patient safety (Salyers et al., 2017). The risk for burnout is high among healthcare workers during health crises thus the need for effective burnout interventions is crucial (Akintujoye, 2020). Both structural and psychological empowerment provide evidence that reducing burnout across contexts (Al Sabei et al., 2022a; Belji Kangarlou et al., 2022; Bosak et al., 2021; Boudrias et al., 2012; Gilbert et al., 2010; Guo et al., 2016; Meng et al., 2015) must be employed during health crises for quality and safety care, and overall nurses' wellbeing (Akintujoye, 2020; Khrais & Nashwan, 2023; Reyes et al., 2024).

However, nurses did not perceive a high sense of empowerment during the COVID-19 pandemic. Using search terms, only two studies were found assessing both SE and PE among nurses (Khrais et al., 2023; Travers et al., 2020). The instruments used in measuring structural and psychological empowerment were the psychological empowerment scale (PES) and the conditions of work effectiveness questionnaire-11 (CWEQ-11). The theoretical basis for all studies found

were Kanter's structural empowerment and Spreitzer's psychological empowerment frameworks. Most of the studies were cross-sectional quantitative surveys (Al Sabei et al., 2022a; Arshadi Bostanabad et al., 2022; Dimitrios et al., 2023; Ertem et al., 2021; Khrais et al., 2023; Taleb et al., 2024), two qualitative studies (Braithwaite, 2023; Travers et al., 2020) and one random control trial (RCT) (Üstün, 2023). The majority of the studies assessed the perceived structural or psychological empowerment and the relationship between other variables such as professional quality of life, clinical leadership practices, type of leadership, clinical competency, burnout, stress and support programs.

Most of the studies found nurses' perceived level of structural empowerment as low to moderate during the pandemic (Al Sabei et al., 2022; Braithwaite, 2023; Khrais et al., 2023; Taleb et al., 2024; Travers et al., 2020). For instance, regarding measures on the domains or subscales of structural empowerment, most of the studies found low scores in access to information for nurses (Al Sabei et al., 2022; Braithwaite, 2023; Dimitrios et al., 2023; Khrais et al., 2023; Taleb et al., 2024; Travers et al., 2020). Information regarding practice guidelines and precautionary measures was described as unavailable, inconsistent, bulky or loaded, not streamlined, lacked contextual significance, conflicting with nurses' values with inadequate practical training and orientation. According to Travers et al. (2020), challenges in information impacted nurses understanding, knowledge, autonomy and competence to care for COVID-19 patients.

Considering access to resources, nurses report an overall lack of resources such as PPE, staffing, ventilators and beds (Al Sabei et al., 2022; Dimitrios et al., 2023; Khrais et al., 2023; Taleb et al., 2024; Travers et al., 2020) as well as challenges with the distribution of resources between nursing assistants, registered nurses, physicians and non-COVID-19 healthcare workers (Travers et al., 2020). Resources were described as inadequate, untimely and limited during the pandemic.

However, Braithwaite (2023) studies on CNO's experiences found resources to be adequate or available but unequally distributed.

Access to support was very challenging as nurses emphasized how inadequate support from nurse managers and senior leadership was a precursor to burnout. Nurses described how flexible scheduling and redeployment strategies, training in crisis management or orientation in redeployment roles, frequent check-ins and compassionate leadership could have kept them grounded and safe (Al Sabei et al., 2022a; Khrais et al., 2023; Travers et al., 2020). Additionally, nurses wanted backup plans for quarantine or exposure situations, and recognition of their efforts and sacrifices. Nurses resorted to support from family, frontline staff and peers during the COVID-19 pandemic rather than their leaders (Al Sabei et al., 2022; Braithwaite, 2023; Khrais et al., 2023; Taleb et al., 2024; Travers et al., 2020).

Most of the nurses in this review reveal working with COVID-19 patients was an opportunity for growth, creativity and innovation (Dimitrios et al., 2023; Khrais et al., 2023; Taleb et al., 2024; Travers et al., 2020) though the CNO's did not perceive as such but only grasping the experience. Nurses revealed that using new machines and equipment as well as working in other units enhanced their knowledge, skills and capabilities.

The psychological empowerment levels of nurses recorded during the pandemic were low to moderate (Arshadi Bostanabad et al., 2022; Travers et al., 2020). Nurses working with COVID-19 patients express how lack of support, resources and information impacted their competence, autonomy and meaning to their work even though they felt they were making impact on patient lives as well as the organization (Travers et al., 2020). Arshadi Bostanabad et al. (2022) found high records of confidence and self-determination whereas competence and meaningfulness to work were very low among Iran nurses working with COVID-19 patients.

Highlighting the significance of social work structures in fostering psychological empowerment, Üstün (2023) found higher levels of psychological empowerment, lower compassion fatigue and burnout in the intervention group after eight weeks of online support sessions than nurses in the control group who were working with COVID-19 patients. Ertem et al. (2021) found nurses with longer clinical and occupational experience had higher psychological empowerment and found their work meaningful, experienced a sense of competence and control over what they were doing as well as believed in their abilities affecting organizational outcomes.

Consequences on the Nursing Workforce

The COVID-19 pandemic significantly affected global healthcare systems, with nurses facing most of the challenges at the frontlines. Pre-existing workplace stressors such as high workload, inadequate resources, staffing shortages, long shift hours and demanding tasks made the nursing workforce more vulnerable when the COVID-19 pandemic hit. These disempowered nurses experienced low job satisfaction and consequently, the mass exodus of nurses, change of job positions and roles and early retirements, depleting the already strained nursing workforce.

In Canada, the different waves, high infectivity and death rates, inadequate human and material resources, inconsistent precautionary measures and demanding tasks caused high emotional, mental and physical exhaustion, chronic fatigue, depression, and post-traumatic stress disorder (PTSD) among nurses (Murphy et al., 2022; Statistics Canada, 2023). This strain greatly impacted on the quality of patient care and nurses' outcomes with an overall low job satisfaction leading to high attrition and turnover among nurses in the critical care, intensive care unit (ICU), long-term care, psychiatric and community units (Bourgeault & Ahmed, 2022).

Studies across Canada during the pandemic found higher attrition rates and turnover intentions among nurses in Saskatchewan (Mehta et al., 2022), Quebec (Lavoie-Tremblay et al.,

2022), Ontario (Nelson et al., 2021), Alberta (Gamble et al., 2022), British Columbia (Havaei et al., 2021) and rural Manitoba (Ramsey et al., 2024). Nurses chose to move within their own organizations to keep their salary and benefits (if eligible), while others decided to leave their organizations or the nursing profession altogether. Burnout, poor work-life balance, not getting enough help or training, a bad work culture, lack of autonomy, and nurses' perspectives not being respected by management were all factors leading to the high attrition.

Other studies highlighted how the years of nursing experience, age/cohort, specialty, region, and rural versus urban also impacted nurses' decision to leave (Murphy et al., 2022; Udod, 2023). Provincial media news reported 95,800 healthcare job vacancies in the fourth quarter of 2022 and two-thirds of these vacancies were for nurses (Dove, 2023). In Quebec, approximately 4000 nurses were reported to have quit their roles during the pandemic, which was a 43% increase from 2019 (Varner, 2021). Similarly, the Canadian Press (May 13, 2024), revealed Ontario, had 6,000 nurses job vacancies in 2022, which rose to 10,110 in 2023 and 13,200 in 2024 (Jones, 2024). In Manitoba, a record of almost 3,000 vacant nursing positions were seen in June 2023 (Winnipeg Free Press, 2024) and Southern Health, a health region in the province, reported 52% vacancy rate in February 2024 (Kitching, 2024). Younger nurses currently choose to work as travel or agency nurses because of the flexibility with work hours, less stress, autonomy over length of their contract, exploring different parts of Canada as well as getting paid well (Dove, 2023; Kitching, 2024). These shortages and vacancies have resulted in increased overtime hours and workloads, longer shifts, interrupted or minimal break time, and low morale for nurses (Ramsey et al., 2024). Strategies need to be found to decrease nurses' stress and burnout so nurses can be retained to provide patient care.

Gaps in the Literature

Most of the studies were quantitative (Al Sabei et al., 2022; Arshadi Bostanabad et al., 2022; Dimitrios et al., 2023; Ertem et al., 2021; Khrais et al., 2023; Taleb et al., 2024), one RCT (Üstün, 2023) and two qualitative studies (Braithwaite, 2023; Travers et al., 2020) that examined nursing assistants and CNO's leaving a large gap in literature on registered nurses' experiences. Contextually, studies were conducted in United States, Iran, Oman, Turkey, Jordan and Greece but not in Canada. More studies across the globe are necessary to inform better policies and strategies for nurses in future pandemics. Additionally, the studies address the emergency or peak phase of the pandemic creating a gap in nurses perceived structural and psychological empowerment during the later stages of the COVID-19 pandemic.

Summary

Healthcare workers, especially nurses, face heightened ramifications during health crises or emergencies. The COVID-19 pandemic was a significant and negative work experience for nurses characterized by high workloads, redeployments, lack of resources, limited knowledge and prolonged waves. This review found nurses structurally disempowered through the limited support, resources, information and opportunity, consequently, psychologically disempowering nurses with diminished meaning to their role and work, competence, autonomy and feelings of not impacting their organizational goals. This study will address registered nurses' overall experiences of structural and psychological empowerment during the COVID-19 pandemic to inform better policies and strategies for the wellbeing of nurses in future health crises.

Chapter Three

Methodology

This chapter outlines the research design, sampling plan, method of recruitment, setting, data collection and data analysis plan that was used for this study exploring nurses' experiences of SE and PE during COVID-19 pandemic. Ethical considerations and trustworthiness are also discussed.

Study Design

A descriptive qualitative research design was used to investigate the research questions of this study. Qualitative research is used when examining the perspectives of study participants on a comprehensive knowledge of a problem, including contextual factors and human interactions (Creswell et al., 2007). A qualitative method was appropriate for this study to capture personal narratives, nuanced understanding and perspectives (Creswell & Poth, 2018) of nurses' SE and PE during the pandemic from the perspectives of frontline nurses. The descriptive qualitative research method is known for its flexible approach and is highly utilized in nursing and healthcare research across various contexts to explore experiences as lived and daily life (Doyle et al., 2020). Acknowledging that nurses' realities are influenced by their unique context (French, 2005; Phillippi & Lauderdale, 2018) including the challenges of the COVID-19 pandemic and their work environment, I constructed knowledge from their individual perspectives and lived experiences. Lastly, a qualitative descriptive method supported the conceptual framework analysis, providing a rich description and deep appreciation of the framework (Creswell & Poth, 2018).

Study Participants

Eight registered nurses in two tertiary hospitals participated in the study after further recruitment yielded no response. This group of nurses were selected from the population of registered nurses in acute care settings in the province of Manitoba. Omona (2013) highlights the significance of sampling in qualitative research as it improves the quality of the research outcomes. Given this, a purposive sampling strategy was used in the selection of participants for this study. Purposive sampling is the most efficient method when there is a need for the exploration of a specific problem or cultural domain with experts from the field (Campbell, 2020). Using purposive sampling in this study ensured the selection of participants that provided rich diverse perspectives and insights about the problem under study (Campbell et al., 2020; Creswell et al., 2007).

Inclusion criteria were: 1) acute care registered nurses (RNs) who provided care to COVID-19 patients; and 2) nurses who worked full time. These groups of nurses are often the first point of call-in patient care in medical emergencies, and such settings are high-stress environments with diverse patient populations and strict protocols for patient care. These nurses were selected for the study because they can provide rich and nuanced accounts of their experiences and appreciate the impact of the pandemic on their professional lives. *Excluded* were: 1) nurses on leave of absence (LOA) during the pandemic and 2) nurses who changed their roles or transferred to a different unit during the pandemic.

Setting

Acute care nurses in the Grace Hospital of the Winnipeg Regional Health Authority (WRHA) and Health Science Centre (HSC), a Shared Health facility in the province of Manitoba, Canada were selected for this study. These hospitals were selected because of proximity to the researcher

and the high need for retention and recruitment of nurses after the pandemic (Kitching, 2024).

The WRHA is the largest health authority in the province of Manitoba, Canada, and serves more than 750,000 people in Winnipeg city, northern community of Churchill and the rural municipalities of East and West St. Paul (WRHA, 2025). WRHA, which has not including HSC, five major hospitals, thirty-nine long-term care facilities, access centers, six health centers, ten community health offices and five walk-in connected care, offers a variety of programs and services to their residents (WRHA, 2025).

The HSC is also the largest health facility in Manitoba, providing emergency and specialized services. As a Shared Health facility, it is mainly responsible for providing provincial planning, health services and operational support for Manitoba's health system. Most of the COVID patients were cared for in this facility with many nurses working at the frontline during the pandemic (Shared Services, 2020). Hearing firsthand accounts of nurses working within HSC and the Grace Hospital provided insights into their unique pandemic experiences and work satisfaction within the Canadian health system.

Recruitment

After ethics approval from the Committee for Harmonized Health Impact, Privacy, and Ethics Review (CHIPER board) and Research Improvements through Harmonization in Manitoba (RITHIM), institutional access approval from the Grace and HSC was initiated. In collaboration with Dr. Udod, we connected with the Chief Nursing Officers of the two selected hospitals. Information about the study's goals, possible risks and benefits, methods and significance were shared to gain permission to conduct the study (Appendix A). The student researcher then shared the email invitation letters to the RN's (Appendix B) and a flyer about the study including eligibility criteria, benefits and contact information, to be circulated with the Chief Nursing

Officers who then had their Administrative Assistants share the email with participants. This allowed the participants to make informed decisions about whether to take part in the research and that they provide their consent voluntarily without coercion or undue influence (Nijhawan et al., 2013).

Nurses who were interested in participating reached out to myself as the student researcher through emails. Upon contact with the student researcher, further explanation about the study, participant role and ethical considerations were discussed and written informed consent obtained (Appendix C). A copy of the signed consent was given to participants for future reference. Demographic information was collected to contextualize participants' experiences and enhance understanding of the findings (Appendix D). As per the participants' convenience, virtual interviews were scheduled.

Data Collection

According to Creswell et al. (2007) interviewing participants promotes an accurate description of an experience as felt. The primary source of data for this study was semi-structured individual virtual interviews with open-ended questions for structure and spontaneity of responses (Kallio et al., 2016). The interview guide (Appendix E) was developed in consideration of the SE Theory (Kanter, 1997) and PE Theory (Spreitzer, 1995). Semi-structured interviews suited this study because the researcher can clarify confusing responses, seek examples or ask follow-up questions (Guest et al., 2006). This ensures the production of authentic data garnered from participants' own words and the reflection of experiences.

Microsoft Teams was used for these interviews. The feasibility, cost-effectiveness, data management options as well as safeguards has promoted the acceptance and wide use of Microsoft -Teams as a tool in qualitative research data collection (Archibald et al., 2019). This

study used Microsoft Teams for its accurate data collection through recording and transcribing (Baym et al., 2021). In addition, field notes were taken to enhance reflexivity, capture contextual data and support data analysis (Phillippi & Lauderdale, 2018). Considering the evidence of the stressful impact of the COVID-19 pandemic on nurses globally (Arnetz et al., 2020; Ballantyne & Achour, 2023), strategies to provide psychological safety to participants were ensured as recalling such experiences can trigger emotions (McCosker et al., 2001). The student researcher showed empathy and sensitivity to participants emotions during the interview (McCosker et al., 2001). Participants were given time to cry or express their emotions without any interruption to promote their wellbeing. Additionally, the researcher allowed the termination or rescheduling of the interview if participants were distressed. Participants in very distressing states were to be provided with a name and contact number for counseling sessions in the University of Manitoba for support.

Overall, eight one-to-one individual interviews lasting 40-60 minutes were conducted, audio-recorded and transcribed via MS-Teams. The responses were in depth; however, it was noted in field notes that nurses still have grievances with how things evolved during the COVID-19 pandemic. Thus, participants were very expressive with some drifting of question occasionally. None of the participants were seen in emotional distress such as crying to warrant termination or rescheduling of the interview or counseling need. One participant was noted to have language issues and more reserved, so answers were short and straight forward. Data saturation was reached in the eighth interview as statements became repetitive and no new data was seen when compared to previous interviews. The student researcher reviewed audio recordings and cleaned transcripts to enhance flow, ensure accuracy of text, and that all nuances were reflected in the

transcriptions. All identifiers were removed and replaced with codes to promote confidentiality to participants.

To ensure privacy, confidentiality and compliance with ethical standards, the identified data were stored digitally using pseudonyms and interview code numbers to protect participant's information. Data are stored digitally using password-protected files in OneDrive, an online cloud storage service and a memory stick. Consistent with the ethics guidelines, data will be stored for five years and then destroyed. For safety, physical notes will be kept in waterproof and fireproof storage boxes in Dr. Udod's office. Computer qualitative data analysis software (CAQDAS) such as MAXQDA, which aids in annotating coding decisions and retrieving text sections was used in the deductive coding of all transcripts.

Data Analysis

This study used the Framework Analysis (FA) method developed by Ritchie and Spencer (Ritchie & Lewis, 2003; Ritchie & Spencer, 1994). FA is a systematic and flexible approach that operates within the theme-based analysis (Gale et al., 2013; Ritchie & Spencer, 1994; Ward et al., 2013). FA was chosen for this study because of its flexibility in facilitating simultaneous or sequential data gathering and analysis and for offering a systematic method for transcript analysis as well as a clear audit trail (Ward et al., 2013). The following steps as described by Ritchie and Spencer (1994) were followed.

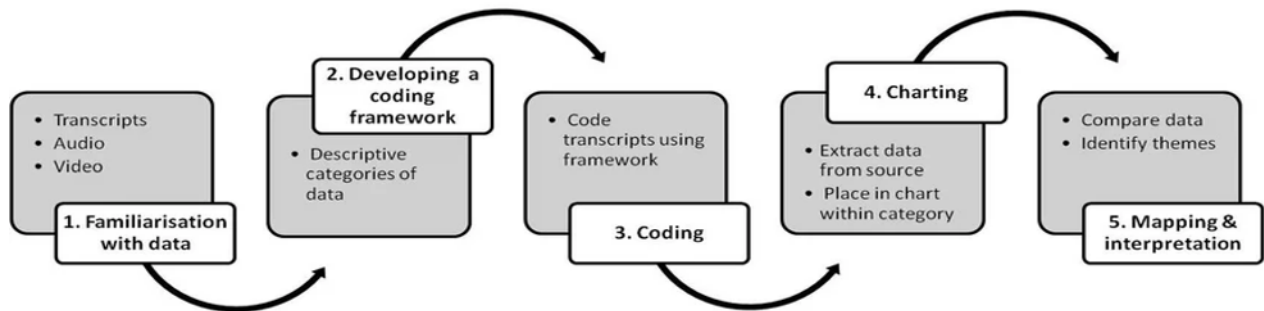


Figure 1: Five-step process in Framework Analysis, based on Ritchie and Spencer (1994)

1) *Familiarization through immersion in the data*- The transcripts and field notes were read multiple times to immerse in the data, enhance understanding and familiarity, ensure accurate coding, identify patterns, and strengthen the rigor and credibility of the analysis (Ward et al., 2013).

2) *Developing coding framework*: Kanter's structural empowerment theory and Spreitzer's psychological empowerment theory models were the frameworks for this study. The domains of SE include access to resources, access to information, access to support, access to opportunities, formal and informal power. PE, on the other hand, key tenets are meaning, confidence, autonomy, and impact. A code system was developed based on the three research questions:

1. What structural and psychological empowerment strategies were used to support nurses during the pandemic?

2. How do nurses perceive these strategies improved their well-being and outcomes?

3. How best do nurses perceive they could have been empowered in the COVID-19 pandemic?

Open coding of two transcripts was done to not miss important data and allow for unbiased data exploration. Using SE and PE domains as subthemes for questions one and three, while codes were grouped according to similarities under subthemes wellbeing and outcomes for question two. For instance, one participant's response highlights the positive influences the organizational strategies had on nurses.

“It was smart to open up a purely COVID unit apart from because we had still a regular unit for people who did not have COVID. So I think that strategy ended up working well. We all liked having it because up until then, we would just keep them either in our isolation rooms or we use that 4 bed space and it was a bit tough going in and out constantly, whereas in the COVID unit, we had all the charts, everything inside the dirty space and so you could just do your job”.
(0007: 62 – 62).

3) *Coding*: Review with advisor was done and a decision was made to refine or expand the pre-defined codes. For example, initially, all participants assumed charge nurse roles at a point during the pandemic, and this was coded as a formal power (Appendix E). However, in consultation with advisor, it was refined and agreed as not. This is inherent to ensuring accurate interpretation of participants' experiences and perceptions of empowerment during the pandemic (Lincoln & Guba, 1985). Using MAXQDA, the remaining transcripts were deductively coded according to the coding system developed.

4) *Charting*: A spreadsheet was used to create a matrix to organize data. Each column being themes/subthemes and each row a transcript. Summary of each theme/subtheme per participant or interview document was charted in the summary grid in MAXQDA.

5) *Mapping and Interpretation*: The final step in framework analysis was achieved by developing a matrix showing how final themes were developed after refining categories into higher-order topologies and finding patterns between categories (Appendix G).

Establishing Trustworthiness

Establishing and maintaining the highest quality and integrity is inherent to qualitative studies (Cope, 2014; Lincoln & Guba, 1985). According to Lincoln and Guba (1985), the key components of rigor that researchers must pay attention to in qualitative research include credibility, transferability, dependability, and confirmability. *Credibility* is accurately describing participants' experiences or perspectives and the researcher's interpretations and depiction of them (Lincoln & Guba, 1985; Sandelowski, 2010). In this study, credibility was supported through the rich description of participant perceptions and the use of illustrative quotes. Additionally, Dr. Udod reviewed the transcripts and the preliminary findings to enhance the interpretation of findings. *Dependability* is the consistency of data collected over time in similar settings (Lincoln & Guba, 1985). To support this, a thematic matrix was created to promote extensive documentation of how data was coded, categorized and interpreted, making it easy for others to audit and verify findings. *Confirmability* refers to whereby the researcher ensures that the data analysis are shaped purely by the participants' experiences and ideas rather than the researcher's personal preconceptions and biases (Lincoln & Guba, 1985). I kept a reflexive journal to document potential biases to facilitate interpretation of nurses' experiences in their own voice. Additionally, detailed accounts of activities and decisions were kept throughout the

study for readers to assess the research process and support transparency. *Transferability* describes the extent to which a study's findings can be applied to another context (Lincoln & Guba, 1985). In this study, transferability is supported by the purposeful sampling of participants from settings aligning with the objectives of the study. Additionally, the transparent documentation and explanation of the research process- data collection, analysis and interpretations will allow future researchers to build upon the established insights across different demographics and locations contributing to a broader body of literature.

Ethical Considerations

The following are some of the ethical considerations utilized for this study and how I managed them. First, as a student researcher, I gained participants' informed consent. Participants (nurses) were fully informed about the goals, methods, potential hazards, and benefits of the study. Additionally, this was also managed by providing a detailed consent form written in a language accessible to participants, emphasizing voluntary participation and the right to withdraw at any time (Polit & Beck, 2024).

It was also crucial to safeguard participants' confidentiality, privacy, and anonymity to promote candid and open communication and to protect respondents from fear of reprisal due to their participation. Privacy and anonymity were managed using coding systems to anonymize data, store data securely, and only report aggregated results to prevent the identification of individual participants. Additionally, participants were provided with the autonomy to skip questions or withdraw at any time.

Another significant consideration was avoiding non-maleficence described as decreasing participants' risks or discomfort while maximizing the study's potential benefits (Ledford et al.,

2024). This was managed by assessing two initial interviews to determine any possible problems with discomfort or risk, but no issues were found.

The autonomy of participants was protected by assuring participants that they have the right to withdraw from the study without facing negative consequences (Gelling, 2016). I emphasized in the consent that the nurses' position and duties would not be affected by their refusal to continue in the study, and that participation is completely voluntary. This upheld participants' autonomy by guaranteeing their choice to leave the study at any time without repercussions.

Moreover, I was prepared to facilitate debriefing sessions to talk about any possible psychological or emotional effects of the study. More importantly, participants were to be provided with appropriate resources or referrals for support if needed. However, no emotional distress was noted. Lastly, I committed to transparent reporting, clearly indicating any limitations to the study and conflicts of interest or potential biases in publications.

Summary

The methodology and research design used for this study were described in this chapter. A qualitative descriptive study was chosen for this study to examine nurses' perception of SE and PE during COVID-19 pandemic. The details of the study design, recruiting strategy, sample, setting, data collection and ethical considerations have all been described as well as the trustworthiness was also described.

Chapter Four

Results/Findings

The purpose of this study is to investigate how the structural elements of organizational empowerment (SE) and psychological empowerment (PE) influenced nurses' experiences during the COVID-19 pandemic. This qualitative descriptive study highlights the significance of empowerment in a crisis work environment by representing the perspectives of nurses during the COVID-19 pandemic using Kanter's (1977) theory of structural empowerment and Spreitzer's (1995) theory of psychological empowerment. This chapter describes participants' perspectives of structural and psychological empowerment during COVID-19 pandemic in two tertiary hospitals in Winnipeg, Manitoba, Canada.

Participant Demographics

Although a sample size of 10-12 participants was estimated, a total of eight participants were recruited utilizing purposive sampling. Data was collected over a three-month period. In consultation with Dr. Udod and Dr. Thompson, we agreed that eight participants were adequate for the study after two further email recruitment yielded no responses. The participants were recruited from two tertiary hospitals involved in caring for patients during the COVID-19 pandemic.

Participants represented diverse nursing roles, years of experience, and practice areas, which provided a broad range of perspectives regarding structural and psychological empowerment during the pandemic. All participants were registered nurses working in acute care settings, including intensive care units, emergency departments, and COVID-19 designated units. Participants' years of nursing experience were between 10 to 40 years and above, except for one with less than 10 years of experience, allowing the study to capture both early-career and

experienced nurses' perspectives. Most of the participants had full-time employment status, and a few reported working in redeployed nurse roles during the pandemic (Table 1).

Participants Codes	Age	Sex	Educational Background	Unit	Years of Experience	Employment Status
0001	40-49	M	Bachelor's Degree in Nursing	Emergency	>20	Full-time
0002	50-59	F	Bachelor's Degree in Nursing	ICU/Emerge/IPTC	>30	Full-time
0003	30-39	M	Master's Degree	ICU	<10	Full-time
0004	30-39	F	Bachelor's Degree in Nursing	ICU	>10	Full-time
0005	50-59	F	Bachelor's Degree in Nursing	Post Kidney Transplant Clinic	>40	Full-time
0006	30-39	M	Bachelor's Degree in Nursing	ICU	>10	Part-time
0007	30-39	F	Bachelor's Degree in Nursing	ICU	>10	Full-time
0008	40-49	F	Bachelor's Degree in Nursing	ICU	>20	Full-time

Table 1: Participant Demographic Characteristics

Findings

The findings are organized into the four emerging themes with subthemes and supported with participant quotations. The four themes identified include (1) organizational support and capacity response, (2) resilient adaptation and constrained agency, (3) work environment constraints, and (4) continuum of nurse distress and wellbeing.

Theme 1: Organizational Support and Capacity Response

This theme describes how the organizations responded to the COVID-19 pandemic work demands through staff and resource allocation, effective communication, training, and fostering supportive environments. This included redeployments of nurses, provision of needed equipment such as ventilators, PPE and space, keeping staff informed, and upskilling staff through mock codes and in-service training. The theme is further categorized into four subthemes to encompass both the structural and relational strategies employed (Figure 2). Subthemes include 1) workforce and resource mobilization, 2) communication and information clarity, 3) collaborative and social support systems, and 4) capacity-building and skill development.



Figure 2: Illustrates the four subthemes identified in theme 1

Subtheme 1: Workforce and Resource Mobilization

This category delineates the tangible and intangible resources employees need to function effectively (Kanter, 1977) including allocation of staff, provision of equipment, personal protective equipment (PPE), along with space and time provided to mitigate the urgent demands of the pandemic. Participants describe being reassigned to different units, along with nurses from

other units being transferred to their home unit to help with the workload. Some of the nurses redeployed as extenders or float nurses were operating room nurses (OR), retired intensive care unit (ICU) nurses, recovery nurses and medicine nurses.

“And then also during that time in our ICU, we have received nurses from other areas of nursing. Let's just say, OR nurses, recovery nurses, because during that time there had been a slow intake for OR patients, so we collaborated with those nurses, they were redeployed to us and then they were helping accomplish nursing tasks. They were not there as ICU nurses because they were not trained with ventilators and high alert drugs and stuff like that, but they were beside us, ready to take on small nursing tasks.” (Nurse 3, 7 – 7)

Several nurses indicated there was adequate equipment but faced challenges due to staffing shortages.

“As far as being able to do our job, I think we had the equipment we needed in our setting, but we were short-staffed. That made it tough because many of our staff were redeployed; ambulatory care is always seen as not needing to exist when these things happen.” (Nurse 5, 27 – 29)

As a means to alleviate the nursing shortage, some respondents emphasized that the organizations recruited more nurses without following the normally accepted or standard pathways such as limiting the amount of experience a nurse needs to work in a critical care area.

“During COVID, they lessen that standard all of a sudden. Now you don't need two years of medicine or two years of emergency nursing. You just graduated six months ago, and

for sure, it's ok. There was no critical thinking background because we were desperate.”

(Nurse 8, 93 – 93)

Several participants highlighted the reduced bureaucratic layers during the pandemic period, facilitated quick change processes which were typically drawn out and challenging pre-pandemic.

“So, one of the nice things about COVID was that it did probably push for things to get done. But now when there's no real push to get things done, things take forever, right?”

(Nurse 1, 78 – 78)

Subtheme 2: Communication and Information Clarity

This subtheme describes how participants accessed the needed information and their ability to effectively use the knowledge during the pandemic. Participants enumerated the multiple channels in which information was received including command centers, emails, memos, in-person meetings such as morning huddles or rounds to keep staff updated.

“It's usually through huddles. We usually have huddle around 9:00. There's also communication via e-mail, but we weren't really using that type of communication to disseminate information. We have a communication binder but that is for more the charge nurses versus from manager to charge nurse.” (Nurse 6, 8 – 8)

Several participants described in-person meetings, updates from colleagues and streamlined information as the best ways of communication that enhanced clarity of the information being shared.

“What I did find effective was they had the physicians, and I guess there were charge nurses that belonged to the command center for hospital, so I would say that the verbal reports that we received were more effective than the emails.” (Nurse 2, 10 – 10)

“And if there was e-mail communication brought out, it was echoed by management in the huddle, just as a reminder. So, they kind of helped summarize for us and kind of helped with the communication that way.” (0001: 7 – 7)

Subtheme 3: Collaborative and Social Support Systems

This subtheme describes how participants received emotional support to function effectively throughout their work experiences in the pandemic. All participants stated that team and peer solidarity were their main source of strength that encouraged them to persevere and navigate the crisis.

“Well, it definitely helped to have friends in the unit. It just kind of made it bearable. It made the experience less stressful. We could be having codes after codes, you're intubating, extubating, transferring. But if you have people that you can rely on and they're just happy, and its let's do it together, I'm going to help you. It just made you feel a little lighter. For sure, that's the biggest support that we felt, was from each other, from peers.” (Nurse 8, 47 – 47)

Some of the participants also reported that unit managers were present and visible, working in the units, ensuring adequate staffing, providing verbal appreciation, coaching and leading the way. These managers also listened to their concerns, boosted their morale and helped them manage stress.

“My nurse manager has been really supportive. She was our ICU educator for a long time. She was an ICU nurse before becoming an ICU educator and an ICU manager, so she knows how to be an ICU nurse. She knows how we feel and she was selfless. That is her personality. So I think I got lucky. We got lucky as a team that we have her during that time because she was so supportive. She would even work as a bedside nurse, take off her manager's hat and be a bedside nurse if we're really, really short. She would stay up late until like 9:00 or 10:00 PM during the pandemic to just really make sure we got the PPE, we got enough people and stuff like that. She would mix medications for us. She was not only thinking about staffing issues, but even the smallest things, she carried on.”

(Nurse 3, 9 - 9)

Subtheme 4: Capacity-Building and Skill Development

This category details the training opportunities participants had to leverage to manage the complexities of skills and knowledge needed to care for patients. Some of the participants were involved in mock codes, PPE audits, in-service training, and using acquired skills from new positions to help them build competencies in patient care.

“We had to use a different IV pump at that time, I remember. And there were in-service training and learning management system (LMS) that we had to do, so that will tell me how to do it.” (Nurse 6, 18 – 18)

“In the XXX health region, there were many efforts made because XXX town was the receiving facility. I would say that there were many opportunities for mock codes, we ran PPE audits, we tried to train the trainer, we did a lot of that, and it was in the moment. I can't speak to other units, but I can say that the unit was super supportive.” (Nurse 2, 19 - 19)

Others described receiving practical guidance from educators and managers on the revised protocols.

“They would do just in time teaching. The educator would kind of roll out this is how we're doing things. They mentioned it in our huddles and then, I think there just were constant on the floor reminders as well. So that's how they reinforced and then kind of kept things consistent during that time” (Nurse 1, 25 - 25)

Overall, the subthemes of Theme 1 illustrate the organizational response measures, extending beyond operational adjustments to include the relational and developmental strategies employed to enable staff to manage the work demands of the pandemic.

Theme 2: Resilient Adaptation and Constrained Agency

This theme describes participants' psychological perspectives about their role, influenced by the structural elements provided during the pandemic. The theme relates to participants' ability to do their best work when they feel that what they do matters, when they believe they are capable, their ability to have some control over how they do their work, and when they see that their actions make a difference on patient and organizational outcomes. Theme 2 is further grouped into four subthemes highlighting both participants' positive and negative perspectives about role. This includes a) dedication and tenacity, b) low confidence and agile learning, c) restrained agency, and d) Feeling Seen (Figure 3).

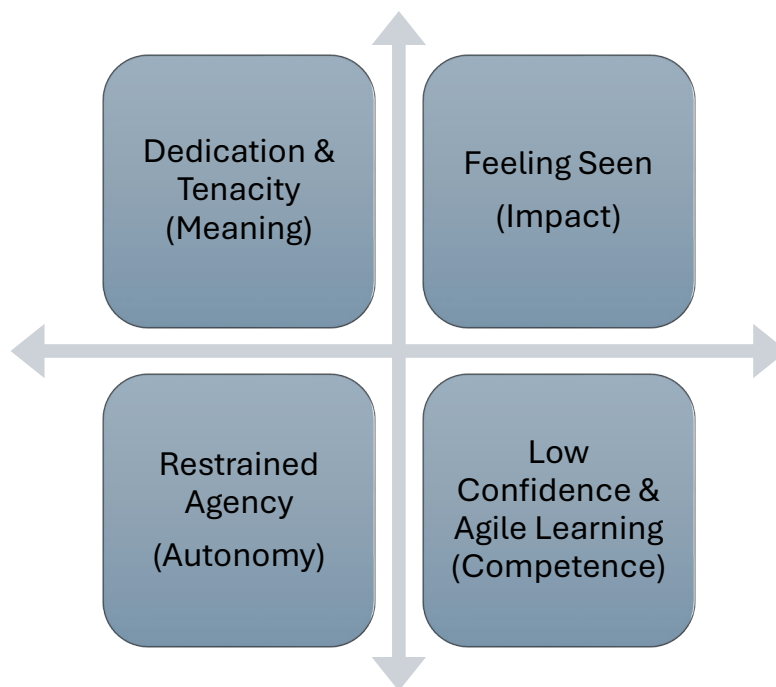


Figure 3: The four subthemes in theme 2

Subtheme 1: Dedication and Tenacity

All participants reported having an unwavering commitment to continue supporting colleagues and caring for patients despite the challenges they encountered in their daily work during their pandemic experience. Participants linked their dedication to supporting patients in such a crisis, to the desire to grow while aligning with their personal and professional values.

“I remember one of my inspirations to get into nursing was reading this book about a nurse that was nursing during a SARS epidemic. So that nurses book kind of inspired me to get into nursing, and I realized that there were a lot of parallels to what we were facing during COVID. And I kind of felt the same way, like there was another epidemic when I was a younger nurse, I think it was in 2010, it was the H1N1 epidemic that was a big part that put a lot of stress on the hospitals. So, I realized it was like that but the next level, plus recognizing through the news and the media what was happening around the world

with COVID, especially during Wave 2 during pre-vaccines era, there was a lot of high mortality, a lot of stress on people. My role is to kind of help out. So I felt useful as being a frontline worker.” (Nurses 1, 34 - 34)

“I've been a nurse since 2007 and I felt that being a nurse it's not just about a profession, but it is a calling. I think it is fulfilling to know that as an ICU nurse, you were able to help that patient during life and death situation. And I always just think about the family members waiting for that patient to come home because that patient is not a single entity, that patient is a member of a family, that patient is a member of a society. That patient could be an accountant or a healthcare aid or something. We all have a role to play in society. So sharing my skills and my knowledge as a nurse and putting it into practice has saved many lives and I feel that really made my nursing role meaningful. That to me is giving back because I think of nursing not just a profession, but it is a calling. Not everyone has that gift.” (Nurse 3, 27 - 27)

“So, I think what really made me stay is because well, it was more of my own personal drive to stay. I mean, nursing is very flexible and there's lots of opportunities to go other places in terms of nursing, but just that was my area of interest, and I still feel kind of that passion to care at the frontline. I feel I belong there because of my skill set and my confidence and my capabilities to work there. I mean, if I was constantly stressed and overwhelmed, then I would probably have maybe felt differently, but I was able to kind of like adapt.” (Nurse 1, 54 - 54)

Subtheme 2: Low Confidence and Agile Learning

Participants described their low confidence, especially in early part of the pandemic, during waves 1 and 2 due to changing protocols, high anxiety levels and limited support. Some of the

participants reported reliance on prior experience, core nursing skills and knowledge, and colleagues to manage their role. Participants modified or adjusted approaches based on the demands presented by COVID-19 illness and improved their care with their competence as the pandemic progressed.

“Yeah, and it's because I think you only know what you know. And I felt I knew what I needed to know at sort of every stage and that knowledge grew and developed.” (Nurse 5: 45 – 45)

“So the first wave, yes, was challenging, of course. 2nd wave and 3rd wave, I feel like over time then we started to just build on that knowledge that we already had. So it's definitely, I don't know if I would say less stressful because it was high level stress throughout the entire thing, but I feel it was more manageable in a sense like the resilience of the staff had grown as a result of COVID, but it was still stressful. I guess we were more resilient and adaptable to the change.” (Nurse 4: 17 - 17)

Subtheme 3: Restricted Agency

Most of the participants reported a lack of control over their work role due to top-down or centralized decision-making process during the pandemic. However, some participants described their unit manager asking for their feedback and input though many nurses were not included in the decision-making affecting their work. A few participants highlighted having the ability to advocate and some level of control over tasks in later waves when they could anticipate the care patients needed.

“I didn't feel I was really heard. It was more, I was kind of the doer or doing the tasks and just kind of had to follow direction. There was no real collaboration at all with the

frontline nurses. It was all leadership, infection control, nursing, kind of dictating how things are going to be rolled out and enforced during the pandemic.” (Nurse 1, 27 - 27)

“I think the rules were clear, such as how to enter the centre and what we were allowed or not allowed to do. However, were we involved in the decision-making? No. It was very top-down type of decision-making.” (Nurse 5, 33 - 33)

“So, a lot of the decisions didn't seem they've been thought through because they were coming from people who did not have actual hands-on experience. But I don't think I was directly involved with much decision-making.” (Nurse 7, 22 - 22)

“..... but there was autonomy and being able to advocate for your patients so in that sense, we still had that power of course.” (Nurse 4, 38 – 38)

Subtheme 4: Feeling Seen

Participants described evidence of their role in improving patient and organizational outcomes. For instance, such as improving death rate and patient satisfaction metrics, optimizing policies, e.g. visitor restrictions and supporting redeployed nurses through mentorship and guidance.

“I felt at that point that perhaps management were hearing what we had to say and our concerns and we'd had a lot of evidence to support that we can't have three patients each. I think we're trying to do better for our patients, and we did know that if we had staff so that if your assignment had some positive patients and some negative patients, we'd done the groundwork to show that just wasn't effective and we had a quite high rate of patient deaths. So, I think at that point the attention turned to nursing and that we were being listened to.” (Nurse 2, 23 – 23)

“After the 2nd wave, we had more evidence to support patient harm. And again, none of it was intentional, obviously, and that's a really important part that nobody hurt someone on purpose, but patients were injured. Then we had a very controlled unit, so we had some pretty good evidence to support that we open these curtains, and we had ICU nurses taking care of three patients now they're all sick. So with that data, we were able to get additional support. Like nurse support, they weren't ICU nurses, but they were trained. They weren't ICU trained, but they would come and offer support. So we just had additional resources and at that point there was also the uncertified healthcare aid. So we just had more, more staff.” (Nurse 2, 26 - 28)

“So, I did have a lot of opportunity to train like other nurses, because during that time they were redeployed to us and some of them showed real interest in being an ICU nurse during that time and so I was able to just be there for them. If they have questions, specific questions and things like that.” (Nurse 3, 14 – 14)

Some of the participants further described recognition from the community, health leaders, patients and family in the form of appreciative gestures including food, thank you cards and encouraging words affirming their feelings of significance and belief of making an impact.

“Honestly, we received a lot of “thank yous” by food. In the community, we would have people banging, honking their horns. Some people even created some signs for us outside of the hospital or different restaurants would give us food or would deliver food for us to show their appreciation, like that's from sergeant Sunday to different restaurants. Basically, they would come in surprises, with bringing us free food for the day. And it was like that throughout the whole region, not just XXX hospital.” (Nurse 8, 64 – 64)

“Our manager always verbally like just in person would talk about how she valued us. The doctors would sometimes buy us food or if we had a really rough shift, they would just express their gratitude for how the team had rolled with it.” (Nurse 7, 60 – 60)

“There are also volunteers. I remember at one point they were giving away caps like nursing surgical caps, and people were like those little 3D printed ties for your masks so that they weren't digging into your ears. Things like that. So felt appreciated that way too. Like with these little tokens of appreciation that kind of helped with boosting morale as well. I thought so, little things like that, I think helped.” (Nurse 1, 52 – 52)

To summarize, results highlight both positive and negative feelings of participants in their role during the pandemic. This includes the interplay of constrained agency and confidence, and the high feelings of influencing goals and dedication to role.

Theme 3: Work Environment Constraints

This theme reports on the identified challenges participants experienced in their role during the pandemic. These work constraints include communication barriers, competency gaps, inadequate resources, limited emotional support from senior leaders, and limiting nurse engagement in decision-making (Figure 4).

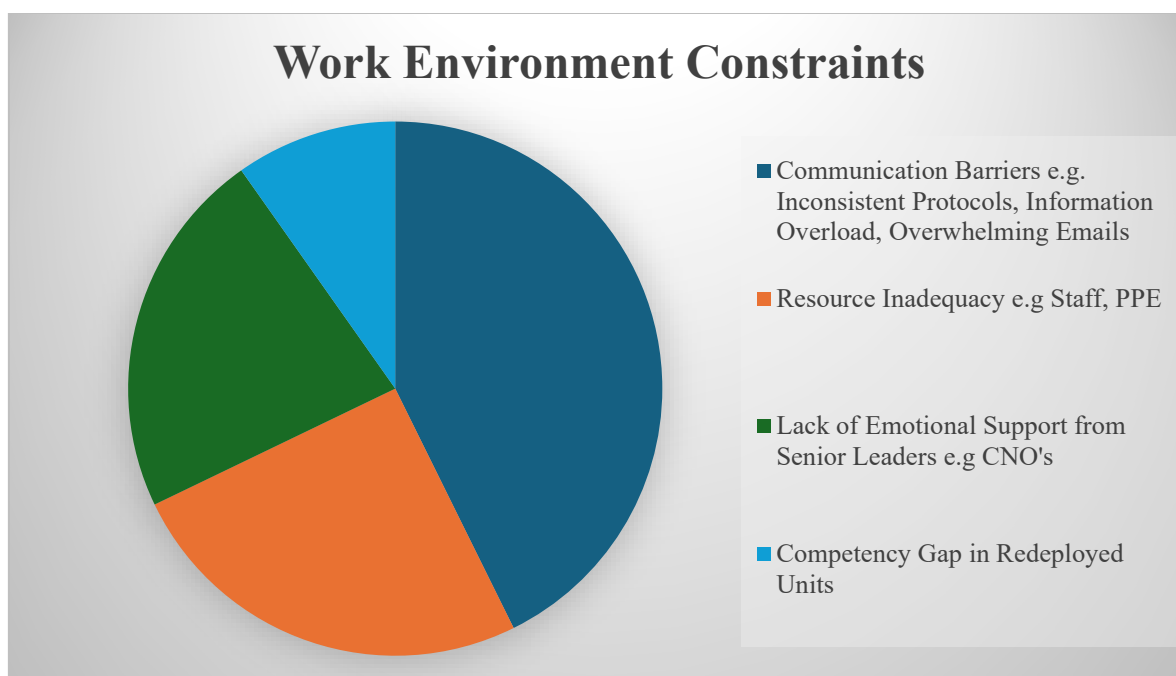


Figure 4: Illustrating the subthemes in theme 3

Subtheme 1: Communication barriers is the most significant structural deficit participants described. Most of the participants described how the changing protocols, overwhelming emails, and information overload negatively impacted their work roles. Additionally, participants highlighted that there was limited time to read written information as a result of high workload.

“....and a lot of policy changes. For instance, for COVID now Aerosol-Generating Medical Procedure (AGMP) means this, OK, now we're changing it because we're running out of isolation rooms now, OK, now we don't have to isolate AGMP, only this part. It kept changing from week to week. So you definitely had to try to keep up at that time.” (Nurse 8, 38 – 38)

“That was stressful, especially if you were off for a few days and then you come back and it's like, oh, no, that's changed. Oh, no, that's different.” (Nurse 7, 64 – 64)

Subtheme 2: Inadequate resources are the second challenge participants described. Most of the participants connected this deficit in both human and material resources e.g. staff, PPE and equipment, to patient surges, high acuity, and high workload. Additionally, participants noted high absences such as sick leave and nurses quitting, unequal allocation and distribution, limited access and supply of tangible resources, and backlog of supplies as contributing factors to inadequate resources.

“.... there’s extra staff that’s being pulled from other areas to support the critical care units, but then you have our actual nursing critical care trained nursing staff who would in turn have COVID themselves. So that was really challenging for staff shortage, and we had an increased number of patients that we normally would take and admit in critical care units.” (Nurse 4, 15 – 15)

Subtheme 3: Limited emotional support from senior leaders is the third area participants struggled with. Some of the participants described their feeling of abandonment stemming from senior leaders such chief nursing officers (CNO’s) and facility managers, disregard for their concerns, lack of empathy, and involvement in decisions. Participants felt disrespected that they had no voice, and their emotional needs were neglected.

“We had one lady, she was the chief clinical operations officer (CCOO), the one right above our boss, came in and she said she was going to provide all the support; she was going to talk to us. She came into the COVID unit for 15 minutes and left, and that was it, doesn’t really feel supportive. Didn’t listen to questions, didn’t ask how we were doing. Nothing like that just gave a speech and that was it.” (Nurse 7, 12 – 12).

Subtheme 4: Competency gap was the last structural deficit participants described. Some of the participants reported not receiving any training in COVID management. This further highlighted the negative impacts changing protocols had on their confidence. Some of the participants who received training described it as rushed, unstructured, and lacked depth to make meaningful impact on their knowledge and skills needed to care for patients. Hence, most of the participants resorted to their peers for help and their prior experience. Many described the limited skills they had in the units they were redeployed to as well as their encounters working with redeployed nurses in their own home unit.

“The red zone was something that people did not necessarily receive a lot of training in.

And we knew quite quickly that it wasn't the right or the safest environment. It was just the environment that was available.” (Nurse 2, 19 – 19)

And another participant reported the following:

“So, staffing was an issue for sure. But we did get a lot of extenders from other places, which was really nice, they varied a lot in skill level and comfort level. Some were retired ICU nurses or had some ICU experiences, where some didn't know how to check the blood sugar or were community nurses, but most were pretty eager to help in whatever way they could. So we really appreciated that and it did usually help for sure.” (Nurse 7, 15 – 15)

To sum up, this theme presented the structural barriers nurses experienced in their role including inadequate resources, competency issues, emotional neglect and struggles with information received which negatively impacted their psychological empowerment and optimal function in their pandemic roles.

Theme 4: Continuum of Nurse Distress and Wellbeing

This theme represents the impact that the structural measures implemented had on participants' wellbeing and how participants were impacted by their work. Findings reveal both negative and positive effects leading to further categorization and development of four subthemes to include: 1) the distress and disengagement, 2) resilience and adaptive capabilities, 3) being valued, and 4) professional fulfillment experiences of nurses (Figure 5).

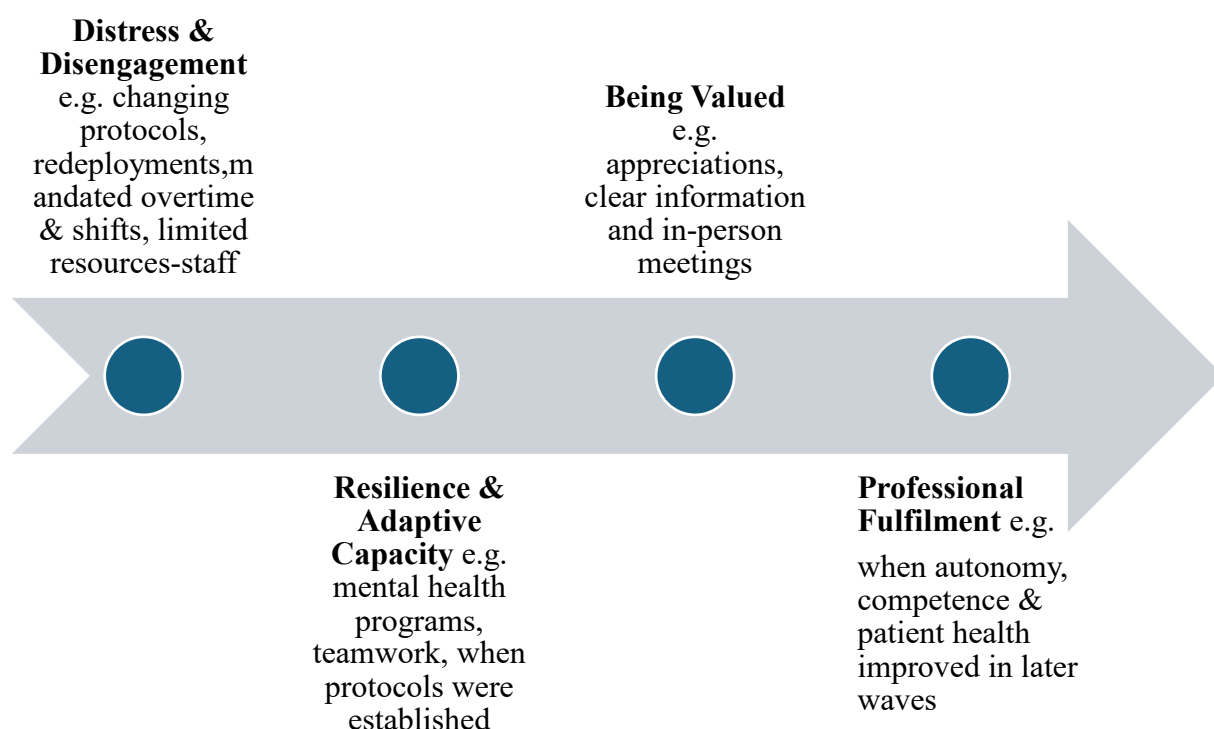


Figure 5: Illustrates the subthemes in theme 4

Subtheme 1: Distress and Disengagement

Participants described the moral distress they experienced in their work environment which led to anxiety, frustration and confusion that was experienced by nurses during this time. Most participants linked these experiences as the reason for nurses' leaving their positions. Further,

increased workload, fear of the unknown, changing protocols, overtime and extra shifts, and redeployment were identified as the major causes of this distress and mental health issues.

“I'm assuming people left because they either didn't want to expose themselves to something that was kind of an unknown pathogen or an unknown ailment. There was definitely a high demand for work, there was a lot of forced overtime and a lot of mandating to work extra hours on top of your shift. So then you got burnout scenarios from that.” (Nurse 1, 63 - 63)

Others described their lack of motivation and feelings of powerlessness from the limited autonomy and a lack of confidence they experienced as a result of redeployment and changing protocols.

“How would I approach patient care because of the unknown, that hesitancy, that fear of your own health, contributed to that feeling. And then also the inconsistencies of the information being laid to us also contributed to that. So that have led me to like, OK, am I competent to protect this patient and to protect myself and to protect others around me because of the inconsistency of the information being disseminated.” (Nurse 3, 37 - 37)

Several participants also described the harm or complications patients had due to the substandard care resulting from limited resources and high workload.

“So, when we don't have enough ICU nurses because of the floating, because of the mandating and stuff like that, it was evident that, we have been missing a lot of our ICU routines. We have been skipping it, let's just say in the ICU, in a perfect situation, in a perfect staffing model, we would be turning patients every two to three hours to prevent pressure ulcers. We will be doing every four-hour oral care to prevent ventilator

associated pneumonia, but when you are short of resources. You will only focus on the immediate needs of the patient, medications, ventilator needs, this and that. So, we can only do so much if we have two to three patients to take care of critically ill patients. We have been missing oral care, we have been missing turning, all those little things that would really in the long-term affect patients' overall health because now you're not only dealing with one system issue, but then now there's a compounding pneumonia, there's a compounding wound care that you have to do.” (Nurse 3, 48 – 48)

“We knew it wasn't safe and not being able to provide safe care was that was just wasn't worth it.” (Nurse 2, 21 – 21)

Subtheme 2: Resilience and Adaptive Capacity

Some of the participants emphasized that the mental health programs and assessment reminders that were sent out were helpful in sustaining them through the pandemic. However, there was a suggestion that an increase in the number of sessions and an onsite therapist would have been much appreciated.

“I did. I accessed it. Then I think for the first time, I found it somewhat helpful. I find it really depends on your therapist and how you click, because later on I tried it again and I had a terrible one. And I left and then the next time I tried, I had just the best therapist ever and it was fantastic. So it just really depended on the therapist they had available. But the one I had at that time was OK and I actually also got a recommendation for a somatic therapist, which is more like body therapy stuff, breathing and movement and stuff like relaxation music, things like that. I found that really helpful for me.” (Nurses 7, 45 – 45)

Others described when policies were more established, they had much control and that enhanced their wellbeing.

“But when things were somewhat established and set up, then you kind of felt more supportive for well-being.” (Nurse 1, 59 – 59)

Participants further described team solidarity and peer support as major reasons why they stayed and worked in their roles throughout the pandemic.

“I’ve always felt our unit has always been great, it’s very much a team approach, and everyone kind of trusts each other and respects each other and treats each other well. So, I’ve always felt I have the freedom to make decisions. And have the support to go to people if I don’t know what decision to make. I’ve never felt I don’t have a reasonable level of independence there.” (Nurse7, 54 – 54)

Subtheme 3: Being Valued

Participants described that recognition and appreciation such as thank you cards, food, monetary incentives from the community, managers, friends, patients and family, validated the significance of their role and boosted their self-esteem.

“The public actually provided us with a lot of meals, like free meals. There were specific places that would just regularly send us free meals. That was really nice because still to this day, it’s nice not to worry about what to pack and what to cook when you’re already drained and you’re working all the time. So the meals, we always felt really valued by those and we’re really appreciative of that. It’s such a nice way to just show that you value someone. Our manager always verbally in person would talk about how she valued

us. The doctors would sometimes buy us food or if we had a really rough shift, they would just express their gratitude for how the team had rolled with it.” (Nurses 7, 59 – 60)

Others described experiences of psychological safety, being respected and reduced cognitive load when information was streamlined, shared timely, and in-person, which ultimately fostered connections.

“And if there was e-mail communication brought out, it was echoed by management in the huddle, just as a reminder. So, they kind of helped summarize for us and kind of helped with the communication that way.” (Nurse 1, 7 – 7)

“..... but our manager was always pretty good at getting our feedback and conversing with us and talking to us.” (Nurse 7, 22 – 22)

Subtheme 4: Professional Fulfillment

Some of the participants expressed their experiences of job satisfaction when they gained autonomy and control over their work in the later waves of the pandemic and when patient care improved.

“Kind of outside of my scope [of practice], but I knew that the doctors would have ordered it, so I had that autonomy to do that. And I felt that helped to contribute to a little bit of efficiency in the patient's care because now they're not waiting for tests, things are kind of laid out. Everything is laid out for internal medicine consults and things like that.” (Nurses 1, 47 – 48)

Several participants identified that the COVID-19 protocols or guidelines that were received despite inconsistencies clarified nurses work and reduced death rates and enhanced the quality of life of patients.

“I think these support that they provided to me, helped with patient care and the outcome as well, because if we didn't get the support that we received or I received, then we probably would have more people dying from the side effects of COVID or COVID itself.” (Nurse 6, 56 – 56)

“I think a lot of the things that were carried out was always based off the newest evidence or evidence to support, because I know studies were being done while we were going through the pandemic. And again, we were just really listening to the processes that were shared through a given direction. And I think we were all learning together, so when it comes to how did this improve our care, I'd like to think it of course improved our care because it was based off of either evidence or other areas. I guess following the process help us get ourselves organized.”

(Nurse 4, 49 - 49)

Overall, this theme enumerated the effects of the implemented structures on participants' wellbeing including feelings of incapable, moral distress, powerlessness, improved patient health status and contentment with work.

Summary of Findings

Overall, the findings highlight the organizational response measures implemented during the COVID-19 pandemic in two tertiary hospitals in Manitoba, Canada. Additionally, the results described participants' feelings about roles, the challenges they encountered and the impacts the implemented strategies had on their wellbeing and patient care throughout the pandemic. The findings shed light on how organizational structural elements as described by Kanter (1997) influenced participants' pandemic work and role experiences.

Chapter 5

Discussion of the Findings

The purpose of this study was to examine registered nurses' (RNs) perceptions of structural empowerment (SE) and psychological empowerment (PE) during the COVID-19 pandemic in acute care facilities. Guided by Kanter's (1977) structural empowerment theory and Spreitzer's (1995) psychological empowerment theory, the findings demonstrate how organizational structures influenced nurses' ability to function in their roles during the COVID-19 pandemic. Four major themes emerged from the data analysis with subthemes: 1) organizational support and capacity response, 2) resilient adaptation and constrained agency, 3) work environment constraints, and 4) continuum of occupational wellbeing and distress.

This chapter provides an interpretation of the study findings, and each theme is discussed in relation to the research questions and objectives, existing literature, and Kanter's (1977) theory of structural empowerment and Spreitzer's (1995) theory of psychological empowerment. The findings revealed how organizations responded to the COVID-19 pandemic, nurses' perceptions about their role, the challenges experienced, the impact on their wellbeing and patient outcomes, as well as learnings for future crisis management.

Discussion of Major Findings

Theme 1: Organizational Support and Capacity Response

The first theme describes the elements of information, resources, training opportunities, and relational support participants received to enable them to work in their role during the COVID-19 pandemic. All participants described drawing upon the social support systems, resources, communication, and skills development to navigate their pandemic experiences. The finding

suggests that the organizational structural elements of resources, information and support dictate how employees can function in their role.

Workforce and resource mobilization emerged as a particularly significant positive element. Nurses found the physical, but limited resources including PPE, staff, and equipment essential in their experiences. These resources were particularly important in helping nurses respond to challenging situations such as patient surges, high acuity and mortality rates, high workloads, and emotional demands. This supports recent studies which emphasize the significance of tangible and intangible resources needed during a crisis and in the standard of care (Cho et al., 2021; Eley & Hassmen, 2023; Y. Liu et al., 2020; Romney et al., 2020).

This finding aligns closely with Kanter's (1977) concept of access to resources. Kanter argues that human and material resources are essential components of an empowering work environment. When employees have the requisite PPE, equipment, and adequate staffing readily available as well as the needed time, they can do their jobs effectively and efficiently, and without strain (Laschinger et al., 2001). Participants who reported access to additional staff and material resources such as PPE, mental health programs, and equipment, stated they were better able to respond to the demands of their work role. Conversely, Kanter posits that a lack of resources creates bottlenecks, forcing nurses to work overtime with high workloads which may lead to unsafe and poor quality of care as well as mental health issues.

The study findings also shed light on the value of communication and information clarity. Participants relied on the data, policies, and guidelines on COVID-19 virus and decisions managers and leaders made by others to assist them to function in their roles. Information formed the foundational structural element on which other structures were maximized. Nurses found the timeliness, streamlining of information and in-person communication helpful in their

experiences. This resonates with studies in the United States, Australia and Finland, where nurses perceived timely updates, content of information, and in-person communication very effective in enhancing patient care practices and outcomes, especially, during wave one of the COVID-19 pandemic (Kämäräinen et al., 2022; Lord et al., 2021; Simonovich et al., 2021).

Kanter's (1977) theory highlights the significance of informing employees to ensure decisions are based on the company's broader goals, vision and facts to reduce costly errors. Participants found themselves relying on COVID-19 information to align their individual day-to-day efforts within the overarching strategy of the organization, ensuring staff are focused on the same goals. Furthermore, Kanter (1977) emphasizes that when transparent communication and relevant information is readily accessible, it builds a culture of psychological safety and employees can execute tasks quickly and autonomously. On the other hand, Kanter describes information as the basis of any organization that, without it, breeds anxiety, poor decision, lack of accountability and a lack of trust.

The findings also suggest collaboration and social support as an important element in nurses' roles during the pandemic. Participants found teamwork and peers supportive in their experiences. Godfrey and Scott (2021) suggest peer support as an essential component in crisis response to sustain wellbeing. Similarly, a study exploring Australians nurses' perception and experiences of work environment in a decentralized intensive care unit (ICU) found the need for implementing nursing care with team-building exercises and a pod model- where staff are permanently grouped to work together to positively impact social cohesion and teamwork which can influence nurses job satisfaction (Loveday et al., 2021). Findings revealed some of the participants found unit managers engaging, compassionate, flexible with schedules, sharing responsibility, and showing appreciation, motivating and encouraging in their experiences. This

is supported in recent studies, which found open communication, active interaction, lighter workloads, encouraging words, social support, and a respectful atmosphere can positively impact nurses' resilience (Jeffs et al., 2020; Leng et al., 2021; Markey et al., 2021; McKinley et al., 2019; Sihvola et al., 2022).

This also aligns with Kanter's (1977) assertion on employee access to support and informal power. Kanter describes informal power is derived mainly from relationships, networks, and alliances. She highlights building strong collaborative relationships with peers, subordinates, and superiors can offer assistance, champion your cause, support your ideas, and facilitate your access to significant opportunities (Kanter, 1977). Kanter perceives informal power as a fundamental means by which employees may obtain access to other structural elements, such as information and resources. In terms of access to support, Kanter emphasizes employees receiving regular constructive feedback and emotional backing from leadership and colleagues to do their job confidently. According to Kanter, when employees have high levels of support and informal power, they experience less burnout, have higher job satisfaction, and can mobilize the necessary resources to achieve organizational goals.

The last organizational element revealed in this study findings is capacity and skill development. Some of the participants describe receiving in-service training, experience in mock codes and preceptor or educator assistance to enhance their skills in managing complex COVID-19 patients. This is consistent with studies in Iran and Slovenia, deemed areas with high records of natural disasters, but found nurses were limited in crisis clinical skills and underscoring additional clinical and practical skill training for nurses before and during crises situations (King et al., 2019; Ličen & Prosen, 2025; Shahabi et al., 2016). This also aligns with Kanter's (1977) position that employees should have access to opportunities for growth, advancement, and skills

development within an organization. Kanter asserts that growth and skill development isn't just about moving up the corporate ladder but expanding capabilities such as access to challenging assignments, specialized training programs, and the chance to learn new technologies or methodologies. In Kanter's view, an absence of opportunity for growth and skill development systematically drains employees of their motivation, turns productive workers into rigid bureaucrats, and fosters a culture of stagnation and cynicism.

Findings from this study support and add to the literature on the relevance of organizational structural elements as described by Kanter in nurses' work environment, especially during a crisis. However, the findings show that participants struggled more with formal power with speaking up to institutional policies and decisions. Participants had the responsibility of managing COVID-19 patients but had limited authority to influence decision-making in their organization. Kanter notes that when structural formal power is constrained, employees spend more time navigating bureaucracies than solving problems. Findings in this theme suggest formal power is aligned with senior leadership and Kanter highlights that formal power should be highest in jobs that are central to the organization's core strategy.

Theme 2: Resilient Adaptation and Constrained Agency

The findings reveal a higher level of role commitment but limited control over work. Participants had the willingness and personal drive to work in their roles during the pandemic, but various elements such as limited resources, changing protocols and lack of leadership support with the organizational structures restricted their ability to make choices and take action.

The study findings suggest dedication and tenacity as a significant factor to participants' resilience during the pandemic. Participants revealed feeling valued because of their skills and years of experience in critical and intensive care and motivated to work in their roles through

compassion and the connections with patients and their team. This finding is consistent with the results of a study that explored the structural and psychological empowerment of nurse practitioners (NPs) in the United States, indicating that the NPs valued their work and found meaning in their roles (Stewart et al., 2010).

Nonetheless, the finding also brings to light participants' sentiments of constrained agency that led to experiencing lack of competence. Nurses found their autonomy and confidence in their roles limited, especially during the early waves of the COVID-19 pandemic. Nurses described being the 'doers' with limited input into decisions and tasks they were asked to do, and not being adequately trained, rendering them powerless and struggling in caring for patients. Similarly, professional autonomy was found to be low among nurses in Japan and Brazil during the pandemic due to limited knowledge of the COVID virus, communication issues, and limited resources (Costa et al., 2023; Ganchuluun et al., 2023). Several studies also found enhancing ICU and emergency nurses' clinical skills during the pandemic may be key in contributing to their wellbeing, commitment and care quality (Albasal et al., 2022b; Arshadi Bostanabad et al., 2022; Connolly et al., 2018).

Lastly, the findings unveiled some of the participants' experiences of feeling seen in their roles during the pandemic. According to Spreitzer (1995), even if structural elements are provided to empower individuals, the psychological element of impact is relevant since people must believe their actions have a significant outcome. Participants described some of the positive influences they made on patient health outcomes, positive experiences of redeployed nurses such as extenders and float nurses, and organizational practices through their recommendations. Similarly, Travers et al. (2020) found nurses rather than leaders were reported as the main support systems for the nursing assistants during the pandemic.

This finding supports Spreitzer's (1995) framework that ineffective structural empowerment negatively influences individual psychological empowerment. Participants noted the impact limited resources, support, training, and fragile communication had on their experiences during the pandemic. The findings also support Spreitzer's (1995) argument that, for an individual to be fully empowered, all four components- meaning, competence, autonomy, and impact must be present simultaneously. The absence of even a single component may result in the disintegration of the psychological framework of empowerment, resulting in specific, predictable performance issues. Spreitzer highlights that these four dimensions combine to form an overall construct and do not substitute for one another.

According to Spreitzer (1995), participants in this study may be described as the "handcuffed experts" or "the paralyzed enthusiast." They are skilled, committed, care about the mission, and see the possible outcomes, but they had limited choice or agency over how they execute their daily work as well as lacked confidence in their technical skills or training respectively. Spreitzer (1995) projects that, fragmentation in psychological empowerment breeds profound anxiety, self-doubt, risk aversion, frustration, dissatisfaction, lack of motivation, employee attrition, and turnover rates. Lastly, the findings also add to the need to support novice nurses to retain and build resilience in challenging times to strengthen practical skills and confidence (Lavoie-Tremblay et al., 2016).

Theme 3: Work Environment Constraints

The study findings revealed challenges in the implementation of organizational structures during the pandemic. This finding highlights the implementation gap or difference between the efficacy of Kanter's theory and its effectiveness in the real world.

Finding revealed that information and communication were inefficient. Participants described challenges such as information overload, frequently changing protocols, and an overwhelming number of emails. This is similar to the doctors and nurses' concerns including changing protocols, too much information, lack of clarity, and different sources of information during the H1N1 pandemic (Baker, 2010; Caley et al., 2010; Wong et al., 2012). Recent studies during the COVID-19 pandemic also describe challenges with information received as not nursing-specific, limited clarity, and data ambiguity (Cha & Park, 2021; Heather et al., 2021).

This finding also reveals that both human and material resources provided to nurses in this study did not meet the work demands during the pandemic. All participants describe 'limited staff' as their main problem. Others also cited unequal distribution of resources, allocation and supply chain issues, limited mental health programs with inadequate sessions and lack of onsite therapists, inadequate PPE's and limited space for patients. This is consistent with findings from other studies highlighting resource allocation and supply issues (Liu et al., 2020; Morley et al., 2020), and inadequate staff, beds and PPE (Al-Thobaity & Alshammari, 2020; Azimi & Momeni, 2025; Cho et al., 2021; Gebreheat & Teame, 2021; Grinspun et al., 2022; Ulrich et al., 2020). Challenges with staff, equipment and supplies were also noted in the H1N1 pandemic in China (Wong et al., 2012), Manitoba, Canada (Funk et al., 2010.) and the United States (Cannava et al., 2010).

This finding shows a competency gap with respect to the deficiency in knowledge and skills nurses required to function in their roles in managing COVID patients. Some of the participants described receiving "no training", 'rapid training' and being "redeployed" to inexperienced units and the negative impact it had on them such as anxiety, frustrations and dissatisfaction. Similarly, the study by Shahabi et al. (2016) found nurses had moderate clinical skills in crisis and required

additional training and skills in crisis situations. This study finding is contradictory to the studies by Peiró et al. (2020), which showed nurses with more years of experience tend to have decreased perception of work overload, decreased feelings of being underprepared, and less fear of infection when compared with less experienced nurses in Spain during the peak of the pandemic.

Participants found themselves poorly supported by senior leaders. Participants described feelings of abandonment stemming from the limited presence of senior leaders, lack of empathy and disregard for concerns. However, nurses found some of the direct unit managers engaging, visible and flexible in scheduling, reassuring and supportive. This finding is similar to the study of clinical nurses in Spain, who perceived a health system failure because of senior leaders' poor management and lack of support (Huerta-González et al., 2024). The study also found nurse managers demonstrated better management as a result of their proximity, empathy, and accessibility to nurses than the hospital's senior leaders. Nurses relied on their peers more than senior leaders as seen in this study finding. Additionally, a study of 5000 nurses in the United States found unhealthy work environments characterized by uncertainty, low morale, limited psychological safety and role ambiguity, when frontline nurses were separated from their managers and directors (Raso et al., 2021). The study findings support and add to the literature regarding nurses' perceptions of limited support of senior leaders or managers, especially during a crisis.

Theme 4: Continuum of Nurse Distress and Wellbeing

The analysis of the findings revealed the consequence of nurses' distress during the early stages of the pandemic to comfort or satisfaction in the later stages. This suggests that organizations struggled or were incapable of responding to the COVID-19 pandemic effectively

in the early stages, and nurses as frontline providers were negatively affected. However, as the pandemic progressed and organizations gained stability, nurses' wellbeing and patient outcomes improved. This highlights that organizations were unprepared for a health crisis as significant as the COVID-19 pandemic.

Distress and Disengagement

This finding revealed nurses' experiences of physical exhaustion, emotional distress, high mental health issues and feelings of powerlessness during waves 1 and 2. Participants described problems with their mental, emotional, and physical health during the pandemic. Nurses described instances where they provided less than ideal care due to limited resources and the subsequent injury or harm to patients such as compounding a patient's pneumonia or wound. This finding is consistent with records of emotional distress and mental health issues in previous pandemics such as H1N1 and SARS that care was not optimal and contributed to nurses distress (Bai et al., 2004; Maunder et al., 2008; Naushad et al., 2019). However, the COVID-19 pandemic suggests the highest recorded level of emotional distress. There is extensive evidence on COVID-19 pandemic showing the high records of nurses' burnout, mental health issues including stress, frustrations, depression, anxiety and physical discomfort e.g. missing breaks and meals, insomnia, scarring, visual and auditory obstructions as a result fogging googles and muffled speech from prolonged PPE (Al Sabei et al., 2022b; Crowe et al., 2022; Kulkarni et al., 2021; Maben & Bridges, 2020; Norful et al., 2021; Nowicki et al., 2020; Sato et al., 2022). Few studies have explored frontline nurses' view on the impacts of COVID-19 on patient safety. The finding in this study add to Schulson et al. (2024) report of central line infections, patient falls and medication errors due to poor quality of care imposed by the constrained resources during the pandemic.

Resilience and Adaptive Capacity

This subtheme revealed the resources nurses used to adjust to these stressful situations. A few participants found the mental health programs helpful, though limited. All nurses appreciated the support they received from colleagues and how working as a team helped them maintain their resilience. This aligns with a study on health systems adaptive, absorptive and transformative capacities of the health workforce during the first wave of the COVID-19 pandemic in Europe- Austria, Denmark, Germany, Italy, the Netherlands and the UK (Burau et al., 2022). The study found upscaling ICU care with new teams and acute COVID-19 teams, initiating new mental health services (online consultations, free hotlines), increasing therapy sessions and building collaboration between staff enhanced resilience. Similarly, healthcare personnel linked teamwork and supporting each other during the pandemic to individual resilience (Glette et al., 2023). This finding supports mental health programs, teamwork and peer support as a strategy to promote resilience, especially in challenging situations.

Being Valued

Participants described feeling valued and emotionally strengthened by their peers, leaders and community which promoted their mental wellbeing. Nurses described receiving recognition and appreciation from the community, family, and hospital leaders in the form of food, allowances and incentives, thank you cards, as well as priority access in shops. Some of the nurses also found mental health boosts in the form of face-to-face in-person communications and flexible schedules contributing to their work-life balance. Borzuchowska et al. (2023) suggest good governance which ensures access to resources without constraints, a free and transparent flow of information and provision of incentives or well-motivated resource elements, promotes resilience in ICU nurses. Glette et al. (2023) further add that access to unit managers and leaders enhanced

resilience during the pandemic. This finding supports the appreciation and recognition, leaders' visibility, open communication and schedule flexibility were strategies nurses experienced that fostered resilience.

In summary, findings support registered nurses experienced structural and psychological empowerment during the COVID-19 pandemic. Most specifically, nurses felt that resources, information, support and skill training received were relevant in helping them function in their roles, this lead to their psychological empowerment when adequate. Laschinger et al. (2001) asserts that nurses with sufficient access to resources, information, support and opportunities tend to trust their leaders. Consequently, nurses will be satisfied with their work and more committed to accomplishing organizational goals. However, registered nurses also experienced working with limited resources, support, training and challenging information that led to feelings of constrained agency and low confidence, which increased their emotional distress and may have negatively influenced patient outcomes. Together, these themes highlight how nurses' experiences during the COVID-19 pandemic were shaped not only by the workplace structures such as resources, information, support and training but the workplace conditions and personal resilience influenced nurses' sense of empowerment, their ability to adapt to challenges, and their overall wellbeing during the pandemic.

Strengths and Limitation

There are strengths and limitations in this study. First, structural and psychological empowerment of nurses is a timely topic, especially, after the unprecedented pandemic impact. The study uncovered rich, nuanced qualitative data, capturing experiences of nurses' empowerment and disempowerment during the pandemic. Limitations identified in this study are the small sample size and self-reported perceptions that may be influenced by emotions and

recall bias. An additional limitation of this study is a potential lack of transferability. Since participants were only recruited from two hospitals in Winnipeg, Manitoba, results may not reflect the experiences of all nurses in the acute care setting.

Implications for Nursing Leadership

The findings in this study may provide encouraging guidance for nurse leaders in a future crisis. Nurses would benefit from both human and material resources. Provision of mental health programs, an onsite therapist(s) and increasing Employee Assistance Programs (EAP) sessions would also enhance nurses' wellbeing and resilience. Competency preparation is also acknowledged that would prepare nurses for a crisis and include crisis patient management knowledge and skills. The finding revealed nurses would benefit from a structured pandemic guide outlining the expectations and how to respond during health emergencies— to organize care, minimize decision-making fatigue, promote wellbeing and ultimately improve patient outcomes. Nurses' preference for in-person communication is also noted in this study.

The finding also suggests structured mentorship programs to support novice nurses to promote skill development, retention and wellbeing. Nurses' desire for a supportive work environment where leaders, especially senior leaders are visible, engaging, empathetic, flexible, and include their input into decision-making and create psychologically safe spaces. Findings also support building teams and enhancing interprofessional collaboration to foster adaptability and resilience.

Overall, this study findings strongly support the use of resources, information, support, informal networks and crisis competency development during health emergencies. Health organizations initiatives in response to the pandemic align with Kanter's position on organizational structural empowerment of employees. However, nurses encountered challenges

in these elements such as information inconsistencies, limited resources, support, formal power and training, which impacted their wellbeing and ability to function in their roles.

Future Research

The findings in this study indicate the COVID-19 pandemic negatively impacted nurses' work and well-being. Future research could focus on a larger sample and examine the long-term outcomes to explore how structural and psychological empowerment may influence nurses' job satisfaction, burnout, retention, and overall wellbeing beyond the COVID-19 pandemic. This study provides a foundation for future research investigating nurses' well-being and work environment during crises.

Conclusion

The purpose of this study was to explore how organizational structural elements influenced nurses' psychological empowerment during COVID-19 pandemic through the lens of Kanter (1977) and Spreitzer (1995). Findings revealed the elements of Kanter's theory such as workforce and resource mobilization, information and communication, social support, influenced skill development, autonomy and competence contribute to nurses' sense of psychological empowerment. Nonetheless, some drawbacks were noted in the implementation of these structures including a lack of support from senior leaders, communication barriers, inadequate resources and competency gaps which negatively affected nurses' psychological empowerment and ultimately, their wellbeing and outcomes. This study supports and may extend the use of Kanter's theory from traditional work environments to challenging times such as pandemics for workforce sustainability, retention, and wellbeing.

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Appendix A



Letter Requesting Access to Organization

Dear Sir/Madam (CNO),

I am writing this letter to request access to your organization for research purposes. I am a graduate student in the Master of Nursing program at the University of Manitoba in nursing administration stream.

The title of the study is “Empowerment of Nurses During the COVID-19 Pandemic: Insights from Nurses Experiences”. The purpose of the study is to examine registered nurses’ perceptions of structural and psychological empowerment during the COVID-19 pandemic and to investigate how these strategies influenced nurses’ outcomes and wellbeing. This study aims to inform policies and leader practices in supporting frontline nurses during future health crises. The data collected will be used to complete the thesis requirement of the Master of Nursing program. I plan to disseminate the results of the completed study through presentations and publications to highlight the significance of structural and psychological empowerment in nurses’ work environment, most especially, during challenging times such as pandemics. The data collected will also contribute to the nursing leadership literature.

Demographic information and audiotaped interviews will be collected and transcribed for the purpose of data analysis. All audiotapes and demographic data will be coded to ensure confidentiality and anonymity. Data will be stored in the University of Manitoba secured cloud storage system and hard copies locked in a filing cabinet in Dr. Udod’s office for up to 5 years as per university policy and then confidentially destroyed.

I am requesting permission for you to distribute the recruitment script and email invitation to registered nurses (RN’s) who cared for COVID-19 patients within your organization through your internal email, staff bulletin boards, or during staff meetings. I will also be available for a 10-minute power-point presentation should your staff request, to clarify any questions or explain the study including the theoretical framework that will guide this study, as well as a brief overview of the current literature. Voluntary participation will be highlighted not only during the presentation, but also on distributed flyers and study invitations, and during recruitment as well as when obtaining informed consent.

The study is supervised by a thesis committee consisting of Dr. Sonia Udod, College of Nursing, University of Manitoba (Thesis chair and advisor); Dr. Genevieve Thompson, College of Nursing, University of Manitoba (internal member); and Dr. Sean MacDonald, Asper School of Business, University of Manitoba (external member). This study has been approved by the Research Ethics Board at the Committee for Harmonized Health Impact, Privacy, and Ethics Review (CHIPER). A copy of the approval is attached.

Data collection is planned to begin in September/October of 2025. A summary of the completed study will be provided to you, if requested.

Please contact me if you wish for further information regarding this study. I look forward to your response. Thank you.

Sincerely,

Vera Amponsah RN, BN

Appendix B



Letter of Invitation to Registered Nurses

Research Project Title: Empowerment of Nurses During the COVID-19 Pandemic: Insights from Nurses Experiences

Researcher: Vera Anokyewaa Amponsah

Research Supervisor: Dr. Sonia Udod

I would like to invite you to participate in this study, which aims to explore registered nurses (RN's) perceptions of empowerment during the COVID-19 pandemic. If you decide to participate in the study, your participation will include an audio taped interview that will take no longer than 45-60 minutes at a time that is convenient for the both of us.

Before the interview, I will ask you to complete a form that asks a few questions that describe yourself. As part of the interview, I will ask participants about the organizational structures that were put in place such as resources, support, information and training opportunities used to help frontline nurses care for COVID-19 patients as well as nurses' individual feelings about their work or roles during the pandemic. Every attempt will be made to maintain your confidentiality before and after this study. A coding system will be used to maintain confidentiality and your name will not appear in any potential publication of the results.

The results of this study will be used to meet thesis requirements to complete my Masters of Nursing degree and may be submitted for publication in an appropriate journal. Your name will not be used in any documents or presentations that may occur as a result of this study. You personally, may not benefit from this study at this time, however, results of this study may enhance leader practices to support frontline nurses in future crises and day-to-day empowering practices in nurses work environment. There will be a compensation for your time participating in this study, and you will receive a \$25 E-gift card that will be emailed to once you consent to participation.

Remember that you are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without any prejudice or consequence. This study has received approval from the Ethical Review Board, Nursing and Education University of Manitoba.

If you are interested in participating in this study, please contact me at the number and emails identified below.

Vera Anokyewaa Amponsah RN, BN
Graduate Nursing Student, Master of Nursing Program
Faculty of Nursing
University of Manitoba
Winnipeg, Manitoba

Appendix C

Informed Consent

Empowerment of Nurses During the COVID-19 Pandemic: Insights and Recommendations from Nurses Experiences

Vera Anokyewaa Amponsah

Master's student

College of Nursing, University of Manitoba

Student Advisor: Sonia A. Udod, RN, PhD

Associate Professor

College of Nursing, University of Manitoba

Consent for Nurses

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

Purpose of the Study

I am doing this research for a thesis under the supervision of Dr. Sonia Udod. This research study is to explore nurses' experiences of structural and psychological empowerment during the COVID-19 pandemic. We are hoping to create actionable recommendations on structural and psychological empowerment for future health crises to improve nurses' outcomes and retention.

Study Procedures

If you decide to take part in the study, we will meet for a 45–60-minute interview with Microsoft Teams. With your consent, I will audio and video record our meeting. After your interview, you will have the chance to withdraw from study until February 2026, after which data analysis will commence. I will email you a copy of the summary of the study result if requested.

Risk and Benefits

This study has minimal risks, a potential risk is that you may experience strong emotions as people sometimes do when they talk about their work experiences. If you feel sad or depressed, you can call the counseling support team in the University to talk to someone.

There are no direct benefits to you by participating in this study, however, this study could benefit nurses, managers and healthcare leaders in improving nurses' outcomes and wellbeing during future health crisis.

You will be given a \$25 gift card to compensate you for the time and expenses for participating in this study.

Confidentiality

All the information you provide as a participant in this study is confidential which means we as the research team must keep it safe. We will do our best; however, it is not possible to guarantee absolute confidentiality. We will only share your personal information if required through court order or law (e.g., suspected child or elder abuse).

Use and Storage of Information

Your information will be stored on a secure platform approved by the University of Manitoba. We will have a file that links your name to your information using a code. We will keep the file with your name, contact information, and code separate from the research information you share with us. When we share the results of this study, we will combine everybody's responses. This means no one will see your answers, name, or contact information. We may share some of your information as quotes. The quotes will not include your name or information that may identify you.

We will destroy any identifiable information like your [name, recordings, contact information] by February 2026. The rest of your information will be destroyed by June 2031.

Dissemination

The study results will be shared through 1) the publication of a master's thesis; 2) journal publications and presentations in relevant academic fields; and/or 3) a summarized report of the study results to 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 February 2026. 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 at the phone number or email above.

Questions or Concerns

Designated University of Manitoba personnel (and/or Funder) 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. We will tell you if someone outside the research team will be there while you are participating. If this makes you uncomfortable, please tell a member of the research team who will ask the personnel to return at another time.

This study has been reviewed and approved by a Research Ethics Board at the University of Manitoba. However, this does not mean that participation is risk-free. If you have questions about your rights as a research participant, you may contact the Office of Human Research Ethics.

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.

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.

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.

Name of Participant

Participant's Signature

Date

Summary of Results

Please provide an email address below if you would like to be sent a summary of the study results and/or my individual results.

Email address: _____

Appendix D

Demographic Form

Date: Code number.....

Participant Information (Please tick all that apply)

1. Age: 20-29years ☐ 30-39years ☐ 40-49years ☐ 50-59years ☐ 60-69years ☐

2. Gender: Male ☐ Female ☐ Others

Please specify

3. Educational Background: Bachelor's Degree ☐ Master's Degree ☐

4. Years of Experience in Role: Below 10 years ☐ Above 10 years ☐

5. Working Unit During the Pandemic: ICU ☐ Emerg ☐ General ☐ Others

Please specify.....

6. Status of Employment During the Pandemic: Full-time ☐ or Part-time ☐

Appendix E

Interview Guide

Objective

To explore the experiences of structural and psychological empowerment among nurses in Canada.

Introduction

Welcome, and thank you for agreeing to participate in this interview. I am Vera Anokyewaa Amponsah, a final year Master of Nursing Administration (Thesis) student, and I am conducting a study on the topic “Empowerment of Nurses During the COVID-19 Pandemic: Insights and Recommendations from Nurses Experiences” This will be a 45-to-60-minute interview at your convenience. Please feel free to decline any questions you do not wish to answer and withdraw your consent at any time during the interview. All answers and information shared remain confidential. The interview will be recorded as in the consent form, and I will keep a field note to help capture every detail. The questions will be in under four (4) main sections with 2 to 3 questions, and I will alert you during each section to enhance flow. Do you please have any questions or concerns before I proceed with the interview?

Yes/ No.

Please tell me a little about yourself and your general experience during the COVID-19 pandemic?

Core Interview Questions

Structural Empowerment

1. How were you able to do your work in your role as RN in your unit or organization during the pandemic, specifically regarding
 - Access to information,
 - Support,
 - Resources
 - Opportunities to train or cross-train?
2. How did your organization provide clear role expectations, involve you in decision-making or policy development and acknowledge your role or contributions?
3. How did you find your workplace informal networks, were they supportive or motivating during the pandemic?

Psychological Empowerment

1. What motivated you to work in the pandemic or how was your work/role meaningful to you?
2. How do you describe your competence level in your role as a registered nurse?
3. How will you describe your control or autonomy to make independent decisions in your role?
4. How do you feel your voice, input or role was valued in the unit or organization?

Effectiveness of Strategies

1. How did you perceive these organizational provisions or strategies improved your well-being and patient outcomes?
2. How do you feel these subjective perceptions or feelings about your work during the pandemic impacted your well-being and performance?

Lessons/ Recommendations for Future Health Crises

1. How best do you think your organization could have enabled you to work during the COVID-19 pandemic?
2. If you could go back to your role during the pandemic, what would you change to make you feel more enabled to care for COVID-19 patients?
3. Do you have additional thoughts or recommendations on how nurses can be enabled to work in future crises?

Ending Questions (5-10 minutes)

1. Is there anything else you'd like to share about your experiences?
2. Do you have any questions for me or feedback about this conversation?

Thank you very much for your participation; your time and invaluable insights are highly appreciated!

Appendix F

Samples of Initial Codes

Participants Quotes	Initial Codes
"I had experience as a charge nurse" (0002, Pos. 23) "I'm working in emergency, right? The very frontlines with people coming in sick and whatever" (0001, Pos. 47)	Formal Power Charge nurse role Frontline identity
"And recognizing that the people that surrounded you were also there for the very same reasons" (0002, Pos. 32) " So everyone from the physician group to nursing to healthcare aids and Allied health, we all kind of did our part. And I think there was a lot of maybe even interdepartmental help as well. So I think we all kind of pitched in to kind of fit that need because we're seeing through the media and with the news what was happening especially during like Wave 2, our ICU pretty much tripled in capacity at one time. So there were shifts where I was picking up as in the ICU even though I'm not ICU trained like to work in that kind of a setting" (0001, Pos. 38),	Informal Power Team cohesion/solidarity
"I think the longer you've been in the profession, it just kind of seems like a sense of not obligation, but you're just kind of committed to it. So being old, I think that was a long way of saying I was old and it was easier to stick around" (0002, Pos. 71) "And it's probably like in my 22 years now of nursing, it was probably the most proud I've ever been to be a nurse" (0002, Pos. 32)	Meaning Role commitment passion for job/job satisfaction
	Autonomy:

"I think that the lack of autonomy really was that maybe we just didn't know what was happening. So if you're the physician in charge of a COVID ICU and you don't know what that looks like or what that could look like, you're playing your cards pretty close to your chest" (0002, Pos. 45) "But for sure there was a time where I was able to initiate and was thanked for initiating a lot of the work, so having that autonomy, was recognized by the physician group when I was in my roles at doing initial care with patients at the front" (0001, Pos. 62),	lack of autonomy due to uncertainty made independent decisions/had autonomy later on
"But I think that at that point the seniority was really beneficial" (0002, Pos. 40) "I just kind of went with one direction and with what I have learnt and then if it's a, oh no, I can't do it that way and that we're doing something different, then I just kind of adapted" (0001, Pos. 51)	Competence: felt years of experience were helpful adapted to role
"You work a night shift in xxx hospital, there's three of you. And you're like, where are the people?" (0002, Pos. 41) "We have to work with what we have. For instance, well, we don't have supply, we are limited in supply with forced overtime or forced shifts. We need to fill these vacancies, so we expect you to help fill it out, do your all for your role, right?" (0001, Pos. 36)	Resources: inadequate staff limited resources
"So unfortunately, the information we received, I would say by email wasn't consistent. I don't feel that it was properly set up from a bedside nurse perspective" (0002, Pos. 10) "Like one minute we're allowed to wear surgical masks, and everyone has to wear a	Information: inconsistent emails changing protocols

surgical mask when they're in the room. And then it was N95 masks, but you're only allowed to have an allotment of masks per shift, and then they got away from the N95 mask and encouraged respirator use. And then we went back to surgical masks and so it was just kind of very inconsistency" (0001, Pos. 34),	
"Well, obviously they were kind of helped to reinforce what was best practices in the moment" (0001, Pos. 29) "It just wasn't balanced, it wasn't safe. We knew it wasn't safe and not being able to provide safe care just wasn't worth it" (0002, Pos. 21) "I would say that there is a huge knowledge gap between how we could protect ourselves and it just the inconsistency from facility to facility was a little bit overwhelming sometimes" (0002, Pos. 15)	Patient outcomes: training strengthened best practices initially poor/unsafe patient care Nurses Well-being frustration/exhaustion from inconsistent information
"I definitely feel like the workplace should have better allocation of supplies and equipment. There seemed to always be a shortage of supplies and equipment, and so there was always that. So I felt like the workplace should have had better access to supply instead of last-minute ordering, I think it was an issue across Canada essentially, and then there was times where they would get last-minute supplies. But I think it compromised on quality of equipment" (0001, Pos. 85) "I just feel a physical presence would have been nicer, more appreciated and worth a million times" (0002, Pos. 77)	Learnings/Recommendations for future better resource allocation visible leadership/physical presence

Appendix G

Final Themes Developed

Initial Themes	Initial Categories	Refined Categories	Core Concepts	Final Theme
Structural Empowerment	Resources • Redeployment/allocation of staff, recruitment • Provision of PPE, space & beds, and equipment • EAP or mental health programs • Removal/reducing bureaucracies or red tapes for quick change processes • Mandated overtime and extra shifts to fill vacancies	Tangible resources	Provision of human, material and time resources to meet work demand	Theme 1: Organizational Support and Capacity Response
	Intangible resources			
	Information • Use of organizational communication tools e.g. command centers, emails, memos, in-person • Timely/frequent updates • Streamlining information • Referrals to online Websites for additional information	Multiple channels of communication	Improving communication through diverse modalities	
		Clarification		

	Informal power - Feeling competent due to knowledge and skills acquired over the years - Peers/networking power - Teamwork/Team Solidarity	Expertise in intensive unit Cohesive support environment	Skilled and knowledgeable in intensive care Shared responsibility	
	Formal power - Legitimate/official power given e.g. nurse educator role - Ability to make decisions	Authority based on position Top-down decisions	Formal authority granted to an individual	
Psychological Empowerment	Meaning - Personal fulfilment - Personal growth & development - Alignment of personal values - Connection and community - Sense of purpose & significance - Job and financial security	Strong meaning or dedication and tenacity	Unwavering commitment to purpose	Theme 2: Resilient adaptation and constrained agency
	Autonomy - Lack of involvement in decisions - Limited right to make decisions - Lack of control over tasks - Protocol changes/limited resources/ affected decisions	Restricted agency	Reduced capacity for self-governance and limited power or opportunity to act on choices	

	Impact • Influence & mentorship of extenders • Improving metrics e.g patient/family satisfaction, revenue • Strengthening patient advocacy/rights • Optimization of policies e.g. visitors' restrictions • Received incentives and rewards e.g money/materials/food/thank you cards • Recognition/appreciation by leaders/community	Tangible validation of role or hard work Individual perception of influence and significance	Proof or objective results and positive impression of input from leaders and community	
Challenges of implemented structural elements	• Emails were bulky and inconsistent • Limited time to read emails • Overload of information led to indecision • Email information lacked clarity • Confusion about changing protocols	Communication barriers	Limitations to effective communication	Theme 3: Work Environment Constraints
	• Lack of depth/rapid training reduced confidence • Limited experience or skills in redeployed units	Competency gap	Difference in skills and knowledge, and the job/role requirement	

	• Limited resources to meet patient surges and acuity e.g. staff, PPE, space • Unequal resource distribution • Limited mental health support e.g. restricted EAP sessions, lack of onsite therapist and time to access • Increased workload from mandated shifts and overtime	Inadequate access and supply of resources	Resource scarcity or insufficiency to meet the demands	
	• High feelings of abandonment due to less senior leadership presence and support in later waves • Apathy/disregard for concerns • Lack of empathy by senior leaders • Felt not listened to/respected • Top-down decisions and dictatorship	Lack of emotional support from Senior leaders e.g. CNO's, facility managers Limited voice and engagement	Limited connection, autonomy and safety Lack of opportunity to share ideas	

Impact on nurses' well-being and patient outcomes	• Confusion/frustration/anxiety due to changing protocols • High experiences of burnout/frustration from high workload, overtime and extra shifts • Changing protocols was stressful for nurses to keep up to date • More responsibilities/poor work-life balance for female nurses • Nurses leaving/quitting due to stress from being floated/redeployed • Frequent protocol changes and redeployment impacted autonomy and confidence • Felt valued and appreciated by manager, family, patients, friends, and community from received verbal appreciation, food and thank you cards • Nurses appreciate mental health programs and assessment reminders sent out • Established policies and work control promoted safety/wellbeing	High mental health issues or emotional distress leading to high attrition rates Lack of motivation Validation and self-worth Emotional resilience Clear information and social	Powerlessness and moral injury leading to quitting Feelings of incapability and no agency leading to diminished interest or energy Being seen and knowing you matter Ability to adapt to stressful situations Psychological safety and	Theme 4: Continuum of Nurse Distress and Wellbeing
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	- Streamlined information, timely updates, and in-person meetings maximized communication and care - Guidelines/protocols improved patient care and outcomes - iPads promote family connections/patient wellbeing - Inconsistencies/incompatibilities in policies negatively affected patient care - Unsafe care and injury to patients due to high workload and limited resources - Patient care efficiency when autonomy is gained - Patient outcomes improved later in wave 3 & 4 when nurses had control over things	connection reduced cognitive load Organized care increased patient quality of life and longevity Avoidable patient harm and substandard care Higher job satisfaction	deep human connection Improved patient health status Complication of not providing needed care Contentment with work	
Learnings for future Crisis	- Developing/establishing solid pandemic protocols - Streamlined information/timely updates/ morning huddles or in-person meetings maximized communication	Well-structured pandemic plan Appropriate and clarity of information e.g. in-	Comprehensive framework to guide crisis Sharing information as needed and through effective mode	Recommendations for leadership

	• Crisis training • Rotation or exposure to acute units • Leadership training	person meetings Competency building	Developing skills, knowledge and attitude to perform role effectively	
	• Better resource allocation and equal distribution • Timely/quality/adequate supply of resources • Mental health support • Organizations removing bureaucratic processes to facilitate change even after pandemic • Recruitment with standards • Better nurse-patient ratios • Space for patient surges	Allocation and equal distribution, and supply of tangible and intangible resources	Ensuring resources are available, accessible to all and adequate	
	• Mentorship and support for new nurses • Building resilience in schools to prepare new nurses • Team building/motivation	Creating cohesive groups, adaptive strategies and intentional guidance	Foundational structure for nurses to overcome adversity or situational changes	
	• Open dialogue/in-person communication/transparency • Leaders being present/visible • Leaders being flexible and having empathy/compassion	Emotional support	Providing a safe space	

	• Involving nurses in decision-making • Better time management/work-life balance • Self-care/kindness to self • Nurses speaking/standing up for themselves	Deliberate care of mental, emotional, physical and social health and voicing needs	Taking care of personal health and wellbeing	
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