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

By

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

A Thesis

Submitted to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements

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Abstract

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

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

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Table of Contents

List of Figures

List of Tables

Chapter One: Introduction

Introduction

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

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

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

Background to the Study

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statement of the Problem

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

Purpose of the Study

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

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

Research Hypothesis

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

Definition of Terms

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

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

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

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

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

Summary of Chapter

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

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

involvement in decision making (Kanter).

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

Chapter Two: Conceptual Framework

Introduction

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

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

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

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

Theory of Structural Power in Organizations

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

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

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

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

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

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

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

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

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