University of Alberta

Exploring the Relationships Among Spirit at Work, Structural and Psychological Empowerment, Resonant Leadership, Job Satisfaction, and Organizational Commitment in the Health Care Workplace

by

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DEDICATION

To my husband, family, and friends for accepting and supporting me throughout the pursuit of my dream.

ABSTRACT

Health care workers are experiencing increasingly stressful work environments related to attempts to control escalating health care costs. Researchers (Kinjerski & Skrypnek, 2004) have developed a tool to identify the unique experience of individuals who are passionate about and energized by their work, also described as spirit at work (SAW). Identification and acknowledgement of these unique experiences by health care professionals and leaders will lead to collaboration in the development and maintenance of healthy workplaces. The objectives in this study were to (a) identify the relationship between the structural empowerment and psychological empowerment of practicing health professionals in both staff and management positions; (b) develop and test a theoretical model of the relationships among resonant leadership, the components of structural empowerment, psychological empowerment, and *SAW*, and the demographic variables of experience, education, rank, job satisfaction and organizational commitment for nurses (RNs), occupational therapists (OTs) and physical therapists (PTs); (c) identify what the practitioners in each health profession perceived as contributing to their personal *SAW* in the workplace; and (d) contribute to greater clarity in current and future discussions of *SAW.* A systematic review of the literature validated the relationship between structural empowerment and psychological empowerment. *SAW* and specified workplace concepts were identified and further elucidated through a province-wide survey followed by focus group discussions. Structural Equation Modeling (SEM)

analysis of the survey data demonstrated that the model originally postulated and tested fit the proposed theoretical relationships, after addition of modifications specific to each professional group. This research study makes significant contributions to existing health care workplace research that promises to create a healthier environment for staff and patients alike. Contributions include (a) the introduction of the construct of SAW and an indication of its role in the workplace, (b) an indication of the important role resonant leadership plays within the health care workplace and its multiple effects on other constructs within workplace theory, (c) further development of workplace theory through the use of real measures of concepts to support and strengthen previous research.

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I appreciate the support and assistance received from the three professional associations, ACOT, CPTA and CARNA, in the selection and distribution of the survey to occupational therapists, physical therapists, and registered nurses in the province. Finally, I would like to thank all those professionals who took time from their busy lives to answer the survey or participate in the focus groups.

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CHAPTER 1: INTRODUCTION

Searching for Solutions to Work-Life Issues

Health care workers are experiencing increasingly stressful work environments related to attempts to control rapidly escalating health care costs while continuing to provide quality service to consumers. Some registered nurses (RNs) have claimed that their ability to provide quality care has been affected by recent changes to the workplace (Canadian Institute for Health Information [CIHI], 2001). In describing the work overload of RNs in Alberta, Marck, Allen, and Phillipchuk (2001) stated that both nursing administrators and staff have reported feelings of "moral distress when they cannot find adequate numbers of qualified staff to deliver safe care" (p. 5). Recent discussions with RNs in Alberta revealed both "resource allocation and difficulties in professional and inter-professional relationships" (Webber, 2009, p. 1) as sources of moral distress. Research has repeatedly pointed out increasingly higher levels of burnout and job dissatisfaction for RNs throughout Canada, the US, and elsewhere (Thomson, Dunleavy, & Bruce, 2002).

My Search for Solutions

My search for solutions was initiated when I volunteered to be a "candy striper" in a rural Saskatchewan community hospital. This volunteer work was quickly followed by: a job as "nursing aide" at the age of sixteen; graduation from the University of Saskatchewan with a BScN; nursing practice in an assortment of health care environments, including medical, surgical, emergency, public health and home care; and work as a research assistant in the far north. My career was

marked by both highs and lows. Highs included opportunities to work with valued colleagues and senior RNs to provide patient care. The occasional lows were almost always associated with organizational structural issues and/or lack of support and coaching from senior management staff.

After many years as a care provider, I undertook the challenges of health care management. Much to my surprise, my entrance into the ranks of management did not eliminate these workplace highs and lows. Rather, they became more pronounced and I found it increasingly difficult to unearth the resources and organizational support that I believed to be essential for health care workers. I found myself unable to meet either my staff's expectations or my own expectations. Management of a staff composed of RNs, OTs, PTs and social workers brought me to the realization that practitioners within all health care disciplines were experiencing similar frustrations within the work environment and led me to intensify my search for answers. This search culminated with my entrance into graduate studies leading to a PhD in Rehabilitation Science.

My previous research (Wagner, 1991) on the job satisfaction of home care RNs uncovered a high level of job satisfaction for RNs in the rural areas surrounding Edmonton. However, following the completion of this research, restructuring by the government had placed severe stresses on the health care system and I was suspicious that the job satisfaction of health care providers had deteriorated. As I reflected upon the effects of restructuring, more questions arose: Has the job satisfaction of RNs changed since the restructuring? How has restructuring affected other health care professionals? What are the critical factors

that must be considered when restructuring the work environment? Why must we pay careful attention to these critical factors?

During this time of reflection, I stumbled onto the *Spirit at Work* research by Val Kinjerski (2004). She stressed the importance of spirit at work *(SAW)* for the individual within the workplace. *SAW* seemed to be the component missing in the health care workplace. As health care providers, we claim to provide mental, emotional psychological, physical and spiritual support to our patients/clients. However, despite claims by numerous authors that spiritual health is an essential component of overall health, many health care providers openly profess that they do not know how to provide spiritual support to either their patients or their colleagues. This obvious lack of spiritual support for health care providers and their patients suggested, to me, that identification of the health worker's spiritual needs and the associated provision of spiritual support might be a solution to my questions. I quickly concluded that if the provision of spiritual support to health care managers and staff could lead to healthier and more satisfied care providers, it could also lead to healthier patients. I examined published results from North American health care researchers who were also studying the workplace to discover other potential solutions to my questions before initiating research on the relationship between spirituality and the health care work environment.

North American Search for Solutions

Canadian RNs have attempted to resolve work-life issues by focusing on structural or process approaches such as relief staffing, workload measures, scheduling changes in the staff mix, technological innovations, strategic

cooperative initiatives, and participatory action research (Baumann & Underwood, 2002). A catalogue, developed by the Canadian Nursing Advisory Committee, provided employers with examples of specific strategies used across Canada to promote healthy workplaces that focused on "flexible work arrangements, family care initiatives, leave and compensation, legislation, health and wellness, physical work environment and safety practices, supportive organizational culture, and union and management support and initiatives" (Wagner, 2002, p. 2).

Health care researchers in the United States also pursued resolution of work-life issues that impact patient care and outcomes. An investigation of a group of US hospitals known as magnet hospitals that did not experience difficulties recruiting or retaining staff during the nursing shortage of the 1980s revealed significant relationships between nursing care, patient satisfaction levels and mortality levels (Scott, Sochalski, & Aiken, 1999). The implementation of deliberate changes related to well-defined organizational features such as nursing leadership, organizational structure, management style, personnel policies and programs, professional models of care, quality of care, quality improvement, consultation and resources, level of RN autonomy, relationships between the community and the hospital, RNs as teachers, image of nursing, RN-physician relationships, and professional development, placed these hospitals in a position to attract and retain nursing staff even in times of shortages (Monarch, 2003).

Research on magnet hospitals led to the creation of the American RN Credentialing Center Magnet Recognition Program, an "evidence-based model for

RN leaders interested in transforming the practice climate" (Stolzenberger, 2003, p. 523) that has been a catalyst for many changes in health care workplaces across the US. Related research conducted in Alberta, Canada, suggested that RN leaders who employ a resonant leadership style can mitigate the negative impact of hospital restructuring on RNs (Cummings, Hayduk, & Estabrooks, 2005).

Emerging research on spirituality in the workplace reported a relationship between positive workplace behaviours/attitudes and specific changes in workplace structure/processes (Cavanagh, 1999; Kinjerski, 2004; Marques, Dhiman & King, 2005; Mitroff & Denton, 1999). Acknowledgement of spirituality as a contributing factor in business success corroborated the results of Kinjerski's recent research on *SAW*. *SAW,* with its four components of *engaging work*, *sense of community*, *spiritual connection*, and *mystical experience*, appeared to express the experience of individuals who are passionate about and energized by their work (Kinjerski, 2004). Researchers and employers alike questioned how this new and emerging workplace construct could be linked with existing organizational workplace theories that are associated with employee success.

The growing body of research on work empowerment (Laschinger, 2008b) emphasized that employees should be given control over their circumstances—structural empowerment—if they are to reach their optimal performance (Kanter, 1977). This established body of research appears congruent with the *SAW* concepts of *engaging work*, *sense of community*, *spiritual connection*, and *mystical experience* (Kinjerski, 2004). Another variable, psychological

empowerment, which consists of competence, impact, meaning, and self-determination (Spreitzer, 1995), has been identified as an intervening variable between structural empowerment and work behaviour and attitudes (Laschinger, 2008b), revealing relationships to workplace behaviours/attitudes that are similar to those unveiled in the research on *SAW* (Cavanagh, 1999; Kinjerski, 2004).

SAW and Workplace Research

The recent emergence of *SAW* (Kinjerski, 2004) in the North American workplace research has been viewed with scepticism by many people. My review of established workplace research on structural empowerment (Kanter, 1977), the University of Western Ontario (UWO) workplace empowerment model (Appendix A) and psychological empowerment (Spreitzer, 1995) suggested an association with *SAW*, as an important aspect of the health care work environment.

Since leaders have a significant role to play in the implementation of workplace empowerment and the resultant *SAW* of health care workers, I felt it was important to investigate this potential relationship. Cummings (2004) described the significant impact on workplace performance resulting from the workplace RN-leader relationship, or resonant leadership. Organizational leadership, through its documented impact on behaviours and attitudes in the workplace, may be associated with *SAW*.

SAW and Workplace Teams

The twentieth and twenty-first centuries have constituted a time of rapid evolution of health care knowledge. Provision of comprehensive quality care to

clients requires experts to work within client centered teams. Health care teams are considered by many to be essential to the provision of care within complex health settings. The team may be: a multidisciplinary team composed of clerical office staff, office nurse and physician at a physician's clinic; an interdisciplinary team in the hospital consisting of social workers, nurses and physical therapists; or a transdisciplinary team in a home care setting composed of nurses, occupational therapists, physical therapists, social workers and mental health nurse consultants. Although team dynamics vary from team to team, depending on the team purpose and structure, the literature does not reveal any definite linkages between team types and specific work dynamics within the team. Researchers have identified the cognitive aspects of team potency, team orientation, team identity, and shared mental models as significant components of health care team dynamics (Millward, 2001). Since SAW is an essential ingredient in the client-staff helping relationship (Kinjersky, 2004), it is reasonable to assume that SAW is also associated with successful team performance.

In summary, my interest in SAW led to an examination of other individual and organizational variables that seemed congruent with SAW. I assumed that resonant leadership, structural empowerment, psychological empowerment, job satisfaction and organizational commitment were associated with SAW in some way, leading me to create and investigate a theoretical workplace model composed of these variables.

Purpose and Objectives of the Study

I undertook this study to examine the relationships among *SAW*, structural empowerment, psychological empowerment, job satisfaction, organizational commitment, and resonant leadership for RNs, OTs, and public and private PTs in Alberta. At the outset of the study I speculated that these variables had a relationship to each other as shown in Figure 1. The relationships pictured in the theoretical model were based on the assumption that resonant leadership had an effect on structural empowerment and SAW, while structural empowerment had a separate effect on psychological empowerment and psychological empowerment had an effect on SAW. Outcomes such as job satisfaction and organizational commitment might be predicted from these variables in relation to one another.

The study objectives were to (a) identify the relationship between the structural empowerment and psychological empowerment of practicing health professionals in both staff and management positions; (b) identify what the practitioners in each health profession perceived as contributing to their personal *SAW* in the workplace; (c) develop and test a theoretical model of the relationships among resonant leadership, the components of structural empowerment, psychological empowerment, and *SAW*, and the demographic variables of experience, education, and rank, and the outcome variables of job satisfaction and organizational commitment for each profession; and (d) contribute to greater clarity in current and future discussions of *SAW.*

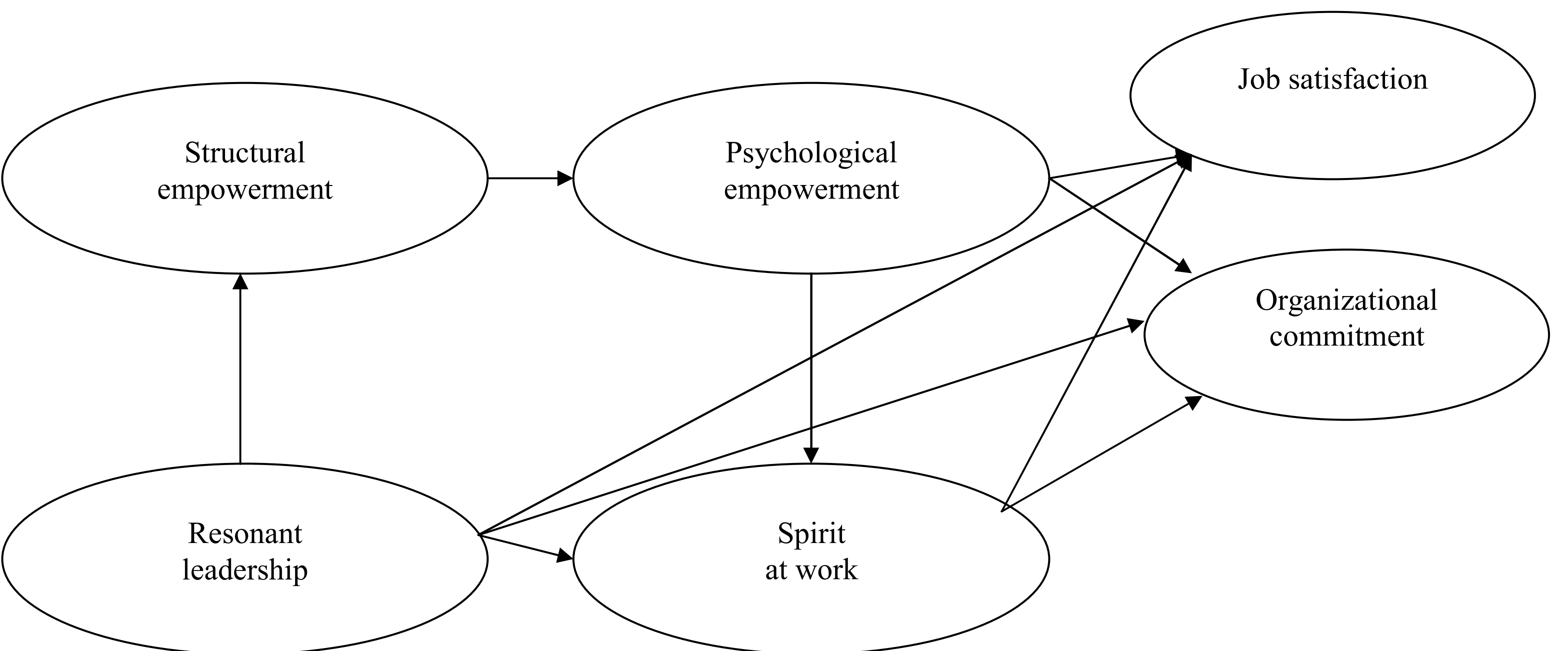

Figure 1. Proposed theoretical relationships between spirit at work (Kinjerski, 2004), workplace empowerment theory (Laschinger, 2008), and leadership (Cummings, 2007).

Synopsis of Research

My review of current studies on the relationship between structural empowerment and psychological empowerment (Laschinger, 2008b), suggested a direct positive effect of structural empowerment on psychological empowerment for RN managers and RN staff. The review also showed that increased structural empowerment and psychological empowerment not only increased RNs' innovation, but increased their job satisfaction and reduced burnout. Studies on SAW (Kinjerski, 2004) and resonant leadership (Cummings, 2004) pointed to further development of an inclusive workplace theory. Another solution to the increasing complexity of health caregiving, mentioned in the literature, was the development of interdisciplinary teams in which each team member contributed specialized expertise to the care of the complex client (McCallin, 2003; Temkin-Greener et al., 2004).

I combined a province-wide survey of RNs, OTs, PT public and PT private with focus group discussions in an attempt to provide further information about the workplace concepts previously identified through the literature review. SEM analysis of the survey data indicated significant relationships between the constructs of resonant leadership, structural empowerment, psychological empowerment, and *SAW* for RNs and PT public. Small sample sizes for OTs and PT private hindered the accurate identification of significant effects by LISREL 8.80 (Jöreskog, & Sörbom, 1996).

The triangulation of research methods, using a systematic review of the literature, surveys, and focus groups strengthens the results from previous studies

that report the contributions of workplace structures/processes to job satisfaction and organizational commitment (Cavanagh, 1999; Kinjerski, 2004, Laschinger, 2008b) and provide professionals and health care leaders with a rich body of information upon which to base future workplace decisions. Both positive and negative effects between theoretical concepts were identified within my research. These research outcomes will inform health care policy makers and managers and assist with the evaluation of existing health care workplaces and the design of future healthy work environments. This comprehensive research makes a valuable contribution to the substantive knowledge of the disciplines of nursing, occupational therapy, and physical therapy, particularly in the areas of leadership and organizational structure.

Overview of Thesis

In this chapter, I have provided an introduction to the research topic, explaining how and why the objectives and questions are important to the health care workplace. Chapter 2 includes a review of the literature on spirituality, *SAW*, workplace empowerment and leadership, including a systematic review of the research literature investigating the relationship between structural empowerment and psychological empowerment, for nurses, which provides a theoretical foundation for further research. The mixed method research approach is described in Chapter 3. The study was composed of a web-based survey, focus groups, and investigation of the causal relationships among the concepts and their indicators using LISREL 8.80 (Jöreskog & Sörbom, 1996). Results from the survey and focus groups are presented separately for each professional discipline of RN, OT

and PT in Chapter 4. Also, in Chapter 4, the structural equation models (SEM) that identify significant relationships among the concepts for RN, OT, public and private PT are portrayed. It is important to note that the small sample sizes for the OT and PT private models may misrepresent the effects in the larger population. In the concluding chapter, the research outcomes, and a discussion of the limitations of the different research processes for each professional discipline are expounded upon. The report concludes with recommendations for further research and proposed dissemination strategies.

CHAPTER 2: LITERATURE REVIEW

SAW

Spirituality in the workplace, or, more specifically, *SAW*, is a controversial construct that has recently emerged in the literature and seems to add a new dimension to research on health care workplaces. Kinjerski (2004) introduced the final section of her PhD dissertation on *SAW* with the following statement: “Enticed by the notion that the integration of spirituality and work leads to positive outcomes for both the individual and the organization, employers are looking for ways to cultivate spirit at work (Benefiel, 2003; Cacioppe, 2000; Groen, 2003; Krishnakumar & Neck, 2002)” (p.103). Krishnakumar and Neck contended that it is impossible to provide an authoritative description of workplace spirituality because of the extreme diversity of individuals within the workplace. A brief review of the multiple definitions of spirituality in the workplace and health sciences literature will help us to understand spirituality.

Spirituality and the Literature

Spirituality and the Workplace Literature

Spirituality at work has emerged as the new paradigm for successful businesses over the past 10 years. Marques, Dhiman and King (2005) described this awareness of spirituality as the desire for a humanistic work environment that not only has more meaning, but that also appears to be connected to something higher. They described work as an important component of most people’s lives which provided opportunities for spiritual, as well as financial growth. The role of

spirituality became even more evident in the American workplace after the September 11, 2001 terrorist acts (Marques et al.).

Marques et al.'s research indicated that spirituality in the workplace

> has nothing to do with ethereal experiences or performances, but everything with proper organizational behavior, involving humane approaches toward one another, and therefore with good organizational performance, and, in contradiction to what business executives fear, a better positioning of the organization overall, a better, more stable, more reliable workforce, and greater returns on investments as a logical consequence to increased organizational performance. (p. 87)

Mitroff and Denton (1999) conducted a study of Human Resource senior executives located primarily on the west coast of the United States. They discovered that there are five different ways organizations can be religious or spiritual (Appendix B). When the executive respondents were asked about their jobs they did not list money as the most important thing. Rather the "desire for self-actualization" as described by Maslow (1970) became prominent. Each of the models described in Appendix B began with a crisis or precipitating event and was implemented out of the desire to confront major crises. These business models, indicating principles other than pure economic ones for running their businesses, were supported by Krishnakumar and Neck's (2002) examination of recent research (1983-2001) indicating that "encouragement of spirituality in the workplace can lead to benefits in the areas of creativity, honesty and trust, personal fulfillment, and commitment, which will ultimately lead to increased organizational performance" (p.156). This literature described how profits follow directly from ethical practices. Not only did these businesses use the terms of

profit and loss, but they also used the terms "caring, heart, love and trust, without shame or self consciousness" (Mitroff and Denton, 1999, p. 91).

Many scholars and practitioners have argued that "the notion of organization as a machine" (Ciancutti & Steding, 2000, p. 105) is no longer applicable to the organizations of the 21st century. This machine-like organizational structure was hierarchical, with specific roles or "boxes" for individual employees, and operated through a system of command and control. "People working in these organizations were expected to employ compartmentalization, that is, to check in their feelings, emotions, discretion, curiosity, and creativity at the office's door" (Ashar & Lane-Maher, 2004, p. 251). Ashar and Lane-Maher described the evolution of this machine approach to management into a new business paradigm that was erected upon knowledge, intelligence, and innovation rather than planning, control, and obedience. Separate research conducted by Neal, Bergmann and Banner (1999) indicated that although most people were consciously integrating their spirituality with their work, they still felt very alone and had difficulty finding others to talk to about this process. To foster and rejuvenate employee qualities of commitment, responsibility, creativity and energy, Ashar and Lane-Maher stressed that the organization needed to "nurture relationships and cultivate the human spirit" (p. 251).

Spirituality in the Health Sciences Literature

The health sciences literature showed that spirituality has evolved as a "multidimensional concept affected primarily by humanistic and increasingly cultural influences" (Chiu, Emblen, Van Hofwegen, Sawatzky, & Meyerhoff,

2004, p. 422). Chiu et al., conducted a review of the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsychINFO, Medline, HealthStar, EMBASE, and Social Sciences Citation Index databases using the key words "spirituality, spiritual well-being, spiritual care, spiritual dimension, spiritual need, spiritual health, spiritual distress and spiritual support" (p. 407) between 1990 and 2000. Only nine of 73 identified articles included investigations of the construct of spirituality.

Although nursing authors have not cited a steadfast definition of spirituality, Chiu et al.'s (2004) thematic analysis of the definitions of spirituality that they found within the articles revealed four conceptual themes: (a) existential reality, which is "invented through meaning and purpose in life, which brings hope to our existence" (p. 410); (b) transcendence, which Chiu et al., described as "a rising above or going beyond the limits of material existence; . . . a developmental and evolutionary process of integration and inclusion into a greater wholeness" (pp. 413-414); (c) a sense of connectedness, which consists of a "relationship with Self, Others, Nature, and Higher Being. Love, Harmony, and Integrative Wholeness are cornerstones of these relationships" (p. 411); and (d) a power/force/energy, which includes "creative energy, motivation, guidance and a striving for inspiration; . . . a life-giving force giving a sense of wellness, a dynamic and integrative process, a unifying force, and the driving force behind religious practice" (p. 414). Although the concepts in the majority of articles that Chiu et al., selected for the literature review were not clear, they concluded that spirituality is a multidimensional construct composed of the elements of

existential reality, connectedness, transcendence and force/power/energy. Also, her comparison of the words used to describe spirituality revealed a gradual shift from a strong religious focus in 1991 to identification with the personal aspects of spirituality in more recent literature.

Miner-Williams (2006) reviewed the literature from the past two decades to construct a spiritually meaningful process for nursing practice using an *evolving theoretical framework* (Table 1). Although individual authors combined the concepts that influence the process of spiritual nursing practice in different ways, Miner-Williams' review highlighted commonalities amongst the concepts.

Table 1

Spirituality in the Health Sciences Literature

Authors	Terms used	The 'pieces'
Chiu et al. (2004)	Four themes with three attributes for the first theme, four attributes for the second, single attributes for the third and fourth themes	Existential (spiritual experience, meaning/purpose in life, hope) Connectedness (with self, others, nature and higher being) Transcendence Power/force/energy
Meraviglia (1999)	Two antecedents	Life, spirit
	Four attributes	Faith, connectedness, integration, unique and dynamic process
	12 outcomes	Meaning, purpose, hope, self-transcendence, spiritual well being, psychological well being, love, trust, creativity, religiousness, health and physical well being
	Eight related concepts	Religion, religiosity, spiritual dimension, spiritual aspect, spiritual perspective, spiritual component, spiritual subsystem, spiritual domain
Goldberg (1998)	Eight phenomena	Meaning, presenting, empathy/compassion, giving hope, love, religion/transcendence, touch, healing

(table continues)

Authors	Terms used	The 'pieces'
Dyson, Cobb, and Forman (1997)	Three key elements Five emerging themes articulated	Self, others and God Meaning, hope, relatedness, beliefs and expression of spirituality
La Pierre (1994)	Six factors	Journey, encounter with transcendence, community, religion, mystery of creation and transformation

Note. From Miner-Williams (2006). Adapted with permission of the author.

In an analysis of spiritual distress, Villagomeza (2005) identified seven distinct concepts within the construct of spirituality. Her description of the construct of spirituality supported the commonalities that Chiu et al. (2004, p. 287) identified: (a) connectedness, (b) sense of meaning and purpose in everyday life and amidst suffering (existential reality), (c) sense of self-transcendence, and (d) sense of inner strength and energy that is integrative and unifying beyond the physical realm (power/force/energy). However, her analysis added another three separate, but overlapping, concepts similar to those that Miner-Willams (2006) discovered in the literature (Table 1). Her construct of spirituality included (a) ”faith and belief system; . . . faith is belief in God or a power not necessarily identified as God” (Villagomeza, 2005, p. 287); (b) ”value system. A person's cherished standards: having to do with truth, beauty; and worth of thoughts objects or behaviors” (p. 287); and (c) ”sense of inner peace and harmony amidst the chaos of life and fear and uncertainty when experiencing life-altering or life-threatening illnesses” (p. 287).

Definition of SAW

The many definitions of spirituality in the literature and the “very strong personal nature of the word [spirituality]” (Krishnakumar & Neck, 2002, p. 154)

led Kinjerski and Skrypnek (2004) to distinguish between workplace/spirituality and the individual's spirituality in their research that resulted in the development of a tool to measure *SAW*. They defined *SAW* as the unique experience of individuals who are passionate about and energized by their work. *SAW* has the cognitive, spiritual, interpersonal, and mystical dimensions of:

> *engaging work* characterized by a profound feeling of well-being, a belief that one is engaged in meaningful work that has a higher purpose, an awareness of alignment between one's values and beliefs and one's work, and a sense of being authentic; *a spiritual connection* characterized by a sense of connection to something larger than self; *a sense of community* characterized by a feeling of connectedness to others and common purpose; . . . a *mystical or unitive experience* characterized by a positive state of energy or vitality, a sense of perfection, transcendence, and experiences of joy and bliss. (p. 20)

SAW showed strong commonalities with the construct of spirituality that other authors described, and clearly displayed themes of existential reality, transcendence, connectedness, and power/force/energy (Chiu et al., 2004; Miner-Williams, 2006; Villagomeza, 2005). This "individual" *SAW*, which focused on individuals' positive feelings about their work and the "desire of employees to express all aspects of their being at work and to be engaged in meaningful work" (Kinjerski, 2004, p. 104), was different from organizational spirit in the workplace, which generally referred to a positive workplace culture (Kinjerski, 2004).

Kinjerski (2004) clearly stated that *SAW* supports the need to change the structure of the work environment rather than changing the individual within the environment. These structural changes empower the individuals within the changed environment, who tend to experience a state of high *SAW*.

SAW and Work Outcomes

An emphasis on the health care provider as both a biological and a social organism interacting with the environment (Kinjerski, 2004) required an ecological approach to *SAW* to understand the varied interactions and resulting outcomes within health care. Additional research (Leigh, 1997; Milliman, Ferguson, & Czaplewski, 2003; Mitroff & Denton, 1999; Neck & Milliman, 1994) described a positive association between *SAW*, employee wellness, and organizational performance or success. The literature described the phenomenon of employer interest in nurturing this individual *SAW* because it led to positive outcomes, not only for the worker, but also for the organization (Benefiel, 2003; Cacioppe, 2000; Groen, 2003; Krishnakumar & Neck, 2002).

Kinjerski's grounded theory research (2004) reported that high employee *SAW* had effects on (a) individual well-being: Her research participants reported "improved physical health and mental stability, . . . feeling a lot better in general, . . . sense of wellbeing . . . that overflows into all of your life, . . . a sense of completion in my life, rather than segmentation" (p. 147); (b) relationships (a *sense of community* with fellow workers): Her participants spoke about a sense of "oneness" that they shared with others and an increased sense of team with team members when they said "The meeting is so much better when you are here" to the participant (p. 148); (c) improved customer service: Her participants believed that customers benefited from the *SAW* of individual staff. These benefits included students "being honored, heard and valued; . . . patients being treated well; . . . helping clients and doing extra things for them" (p. 148); and

(d) increased productivity: One participant stated, “Because I am so motivated and tend to be conscientious, [I] accomplish a lot” (p. 149). Another participant spoke about increased energy: “I can put in a 12 hour day. I will stay late. If I am having a busy day and someone wants to be fitted in, I will fit them in” (p. 149). Closer scrutiny and examination of the various attributes of *SAW* (an indication of how individuals experience their environment) will help us to identify ways to heal the workplace and, consequently, improve worker productivity/output.

Kinjerski and Skrypnek (2008) conducted workplace interventions focused on increasing *SAW* with staff from two different Canadian long term care centers. The quantitative results from this research showed a statistically significant increase in *SAW*, job satisfaction, organizational commitment, organizational culture, teamwork, and morale/climate from pre-test to post-test. The qualitative results from this study (2008) revealed an increase in overall morale, “personal growth and development, and . . . a more positive focus on the residents” (p. 22).

Work-Life Issues

Michie and Williams (2003) conducted a systematic literature review of the key work factors associated with psychological ill health and sickness absence among staff across all employment sectors (police, firefighters, blue-collar and white-collar workers, teachers, insurance workers, doctors, RNs, dentists, health care workers, residential care workers, social workers, public sector workers, public sector engineers). These researchers discovered literature that showed significant relationships between reduced psychological ill health and sickness and the implementation of planned workplace interventions that facilitated staff

empowerment. The planned interventions corresponded with the actions described in Rodwell's (1996) definition of empowerment and included "training and organizational approaches to increase participation in decision making and problem solving, increase support and feedback and improve communication" (p. 3). These intervention studies, retrieved from four electronic databases (Medline 1987-1999, PsychINFO 1987-1999, EMBASE 1991-1999, and the Cochrane Controlled Trials Register 1987-1999), revealed significantly successful reductions in psychological ill health and sickness absence within all types of employment in developed countries (Netherlands, UK, Sweden, Norway, US, Canada, Finland, France, Germany) as a direct result of staff empowerment interventions (Rodwell, 1996).

The importance of staff empowerment was emphasized by Fullam, Lando, Johansen, Reyes, and Szaloczy (1998), who stressed that creative solutions to problems and the corresponding customization of client care by empowered health care staff optimized client care. They also reported that overall empowerment of the individuals led to increased employee satisfaction and esteem, culminating in enhanced client care and reduced employee sick days and attrition.

Hausner (2002) alleged that empowering the personnel within the health care environment helped them to cope successfully with the stresses placed on the system. This research identified three beneficial outcomes of empowerment within the organizational setting: (a) the achievement of organizational goals,

(b) the ability of the organization to stay competitive, and (c) a reduction in management supervision (Hausner, 2002).

I found scant evidence of research in the literature on OT and PT workplace empowerment. An examination of CINAHL Plus with Full Text using the phrases *empowerment and physical therapy* and *empowerment and occupational therapy* revealed a single article by Suominen, Savikko, Kukkurainen, Kuokkanen, and Doran (2006) that referred to work-related empowerment in both PTs and OTs. I investigated articles that focused on *empowerment* in searches of the OTD database, Allied and Complementary Medicine database, Medline (R), and Medline database from 1966-2006; and only one of these articles focused on empowerment of the practicing PT and OT (Miller, Goddard, & Laschinger, 2001). Finally, an exploration of *empowerment and nursing* in CINAHL Plus with Full Text and Medline revealed 1,552 and 718 articles, respectively. The literature that I examined for the following systematic review of the literature was focused on nursing because of this scarcity of literature on empowerment within the rehabilitation disciplines of occupational therapy (OT) and physical therapy (PT) and the plethora of articles found within the nursing discipline.

The Relationship Between Structural Empowerment and Psychological Empowerment for RNs: A Systematic Review

Note: A version of this chapter has been accepted for publication. Wagner et al. (2010). *Journal of Nursing Management*.

Aim To describe the findings of a systematic review examining the relationship between structural empowerment and psychological empowerment for registered nurses (RNs).

Background Workplace empowerment research reveals a link between empowerment and positive work behaviours and attitudes. Research demonstrating the essential relationship between structural empowerment and psychological empowerment will provide direction for future interventions aimed at the development of a strong and effective health care sector.

Methods Published research articles examining structural empowerment and psychological empowerment for nurses were selected from computerized databases and selected websites. Data extraction and methodological quality assessment were completed for the included research articles.

Results Ten papers representing six studies revealed significant associations between structural empowerment and psychological empowerment for RNs.

Implications for Nursing Management Critical structural components of an empowered workplace can contribute to a healthy, productive and innovative registered nurse (RN) workforce with increased job satisfaction and retention.

Keywords: structural empowerment, psychological empowerment, workplace, systematic review

Background

The Canadian health care system is under constant stress from numerous environmental factors: an aging workforce, an increase in morbidity associated with an aging population, rapidly advancing technology, and exponential

advances in knowledge (Canadian Institute for Health Information, 2002). Recent studies report that RNs "are working with more complex patients, have fewer available resources, and have reduced opportunities to take time off for education, training and placements as a result of health restructuring" (Canadian Institute for Health Information, 2002, p. 90). The Canadian Institute for Health Information (2002) also reports that health care workers, including nurses, are more likely to have stress or job strain related absences from work than workers in other sectors. At the same time, Health Canada (2006) reports that one-third of Canadian RNs are aged 50 years or older, and many are considering early retirement. RN recruitment and retention issues have become a major concern for health care leaders.

Research on structural empowerment in health care settings (Laschinger, 2008a) indicates that changes in workplace structure can support healthier employees, reduce stress and increase employee commitment to organizational goals, culminating in improved organizational outcomes that include improved patient care. According to Kanter (1977, 1993), there are two systemic sources of power in organizations: *formal power*—associated with jobs that have high visibility, are essential to the organization, and require independent decision making; and *informal power*—derived from relationships or alliances with superiors, peers and subordinates (Miller et al., 2001). *Formal* and *informal power* facilitate access to job related empowerment structures of:

> *[support*—] feedback and guidance received from superiors, peers and subordinates . . . [*information*—] the data, technical knowledge and

> expertise required to function effectively in one's position..[*resources*—] the time, materials, money, supplies and equipment necessary to accomplish organizational goals . . . [and *opportunity*—] autonomy, growth, a sense of challenge and the chance to learn and grow (Laschinger & Havens, 1997, p. 16) .

The University of Western Ontario Workplace Empowerment research program is a program of research, based on Kanter's (1977) original theory, that emphasizes that staff need increased access to *opportunity, information, resources, support, formal power* and *informal power* if they are to be empowered. These six components of structural empowerment have been identified through extensive research as separate and distinct sources of organizational power (Kluska et al., 2004; Laschinger et al., 2001c; Miller et al., 2001; Laschinger et al., 2003a,b; Laschinger and Finegan, 2005b;). Research also reveals that the specific behaviours and attitudes of job satisfaction, commitment, trust and low burnout are influenced by all six components of structural empowerment (Beaulieu et al., 1997; Laschinger et al., 2001c; Sarmiento et al., 2004). Over 60 studies completed by Laschinger and colleagues point to the importance and relevance of structural empowerment theory in the health care workplace (Laschinger, 2008b).

Additional research conducted by Laschinger et al. (2001a, 2001b, 2001c) suggested an expanded workplace empowerment model where Spreitzer's (1995) model of psychological empowerment provided an intervening role between structural empowerment and job satisfaction. Psychological empowerment is an

essential component of workplace empowerment, representing intrinsic task motivation, or employee rewards that are inherent to empowering work conditions (Laschinger, Finegan, & Wilk, 2009). Components of this multi-faceted construct of psychological empowerment include: *meaning*—a fit between job requirements and beliefs, or the value of a work objective, compared to an individual's own ideals or standards; *competence*—an individual's confidence or belief in their abilities to perform activities with proficiency; *self-determination*—sense of choice or control over one's work/autonomy and in the commencement and maintenance of work activities in the workplace; and finally, *impact*—the sense of being able to influence important outcomes at work (Thomas & Velthouse, 1990). These authors stressed that the four dimensions reveal an orientation towards work reflecting the individual's desire and ability to influence his or her job and workplace (Thomas & Velthouse, 1990).

Significance

Identifying and understanding the relationship between structural empowerment and psychological empowerment will assist health care leaders to counteract the impact of environmental stress on the health care system and to improve the recruitment and retention of RNs. Structural empowerment, or the individual's awareness of empowering workplace surroundings (Laschinger et al., 2009) has been demonstrated to have significant measurable impact on health care personnel when psychological empowerment, or the "psychological state that employees must experience for empowerment interventions to be successful" (Laschinger et al., 2001c, p. 261), is also present. Research demonstrating this

essential relationship between structural empowerment and psychological empowerment will provide direction for future interventions aimed at the development and maintenance of a strong and effective health care sector. A health care sector that supports healthier employees, reduces stress and increases employee commitment will culminate in improved organizational outcomes, including improved patient care (Laschinger, 2008a).

Objective

The objective of this systematic review was to assess studies reporting a relationship between structural empowerment and psychological empowerment for practicing RNs. There is no evidence of this type of review in the literature. The research questions guiding this review were:

1. Is overall structural empowerment in a health care organization associated with overall psychological empowerment of practicing RNs in both staff and management positions?
2. What is the strength of the relationship between the four job related empowerment structure subscales of *opportunity, information, resources* and *support* and overall psychological empowerment?
3. What is the strength of the relationship between overall structural empowerment and the four psychological empowerment subscales of *meaning, competence, self-determination* and *impact*?

Methods

Search Strategy

The initial search included the following on-line bibliographic databases; ABI Inform, Eric, Health Star, Health Source: Nursing Academic Scholarly, AMED, PsycINFO, MEDLINE in-process, Scopus, EMBASE, CINAHL, and ProQuest Dissertations and Theses. The search included publications from inception to March 2009. Peer reviewed articles were sought. Searches were not limited to English. Two relevant research web sites were searched for additional articles: Gretchen Spreitzer, http://webuser.bus.umich.edu/spreitze/; and, Heather Laschinger, http://publish.uwo.ca/~hkl/learningpubs.html .

Inclusion Criteria

The following inclusion criteria guided the selection of published papers:

1. A study population consisting of practicing RNs;
2. Qualitative or quantitative peer-reviewed papers reporting primary research;
3. Studies investigating the relationship between structural empowerment and psychological empowerment, with structural empowerment and its components as the predictor variables, and psychological empowerment and its components as the outcome variables.

Data Search and Screening

Each database was searched using the following search terms: structural empowerment, workplace empowerment, psychological empowerment, structural empowerment AND psychological empowerment, workplace empowerment AND

psychological empowerment, professional autonomy, power, organizational climate, and organizational culture (Table 2). Autonomy, organizational climate and organizational culture were included as search terms to assist in the identification of articles that met our criteria but may not have used empowerment as a key word. A screening tool adapted from Wong and Cummings (2007) was used to examine the literature for this review.

Table 2

Literature Search: Electronic Databases

Database (Through March 2009)	No. of titles and abstracts reviewed
ABI inform (scholarly, including peer-reviewed)	229
Ovid Eric (journal article and peer reviewed)	40
Health Source: Nursing Academic Scholarly (peer reviewed)	7541
Ovid AMED	96
Ovid PsycINFO	926
Ovid MEDLINE (limited to human)	12003
Scopus (Health Science, Social Science Articles)	6231
Ovid EMBASE	545
CINAHL (peer-reviewed and research)	2458
ProQuest Dissertations and Theses	1313
Manual search of websites (Spreitzer and Laschinger)	76
Total minus duplicates	20,628
First selection	744
Second selection	85
Papers provided by expert	1
Total articles (studies) meeting specified criteria	10 (6)

The first author reviewed all titles and abstracts using the following exclusion criteria to delete articles: duplicates; articles not discussing one of the

three professions of RN, OT or PT; clinical patient care articles; articles on students; historical articles; legislation; interviews; and finally, editorials/letters/conference reports. To establish inter-rater reliability, a second reviewer evaluated a random sample of 100 articles, using the same exclusion criteria. The second reviewer suggested retention of an additional five papers. Discussion of this discrepancy led to a consensus on consistent application of the criteria and culminated in the exclusion of the five papers.

The first author reviewed the retained titles and abstracts again using the inclusion criteria. The second reviewer randomly selected and reviewed 10 titles and abstracts from this step of the screening process and recommended retention of an additional two papers. Once more this discrepancy was discussed and the two papers were excluded, thus ensuring the screening criteria were applied consistently between the reviewers.

Further discussion at this stage of the screening revealed that both reviewers had not required all three inclusion criteria to be present in the article when completing the screening tool. Consequently, the screening tool was revised to clearly state that the article must meet all three inclusion criteria. The first author applied the revised screening tool (Figure 2) to selected articles. The second reviewer screened 10 randomly selected articles using the revised screening tool and no discrepancies were identified between the two reviewers.

Quality Assessment

Studies were screened for quality using the Quality Assessment and Validity Tool for Correlational Studies adapted from previous published

The relationship between structural empowerment and psychological empowerment A systematic review (Modified 2008) Screening Tool for Inclusion/Exclusion		
Study: First Author: Publication Information: Date: Journal:		
Instructions for completion: 1. Circle Y or N for each criterion 2. Record inclusion decision: article must satisfy all three criteria 3. Record if additional references are to be retrieved		
Inclusion/exclusion criteria: 1. Does the study measure structural empowerment using CWEQ or CWEQ II (2): How measured? Specify: - Opportunity - Information - Support - Resources - Formal Power - Informal Power	Yes	No
2. Does the study measure psychological empowerment (Using Psychological Empowerment measuring tool): How measured? Specify: - Meaning - Competence - Self-determination - Impact	Yes	No
3. Is the relationship between structural empowerment and psychological empowerment in health care organizations evaluated?	Yes	No
a. Is there evidence of direction?	Yes	No
Text only:	Yes	No
b. Is there a P-value?	Yes	No
c. Is there a statistic identified? Which one(s)?	Yes	No
d. Is there an indication of magnitude?	Yes	No
a. Final decision: include in study (must fulfill all requirements of 1, 2 and 3): Comments:	Yes	No

Figure 2. Revised screening tool for inclusion/exclusion
(adapted from Wong & Cummings, 2007)

systematic reviews (Estabrooks et al., 2003, Cummings & Estabrooks, 2003, Meijers et al., 2006, Wong and Cummings, 2007, Cummings et al., 2008a). This tool used 15 questions to scrutinize and score the design, sample, measurement and statistical analysis of each study and has been found to be useful for classifying the research as low quality, medium quality or high quality.

Results

Search Results

The search strategy yielded 20,628 titles and abstracts. Of these, 744 articles remained after exclusion criteria were applied. The second screening using the inclusion criteria yielded 85 manuscripts that were retrieved and screened. One paper published in May, 2009, describing the relationship between structural empowerment at the unit level and psychological empowerment at the personal level (Laschinger et al., 2009), was provided to the author by an expert. A total of ten articles met the research and screening criteria and were considered to have an acceptable level of quality for further review.

Six studies, describing both structural empowerment and psychological empowerment but failing to discuss the relationship between them, were identified during the systematic review of the literature. The three Canadian studies revealed a relationship between structural empowerment and psychological empowerment in relation to: staff RNs' job strain, organizational commitment and job satisfaction (Laschinger et al., 2001a); RN managers' burnout, job satisfaction, energy level and frequency of physical symptoms of poor health and depressive symptomatology (Laschinger et al., 2004b); and, acute

care staff RNs' perceived respect (Faulkner & Laschinger, 2008). Three international studies revealed a relationship between structural empowerment and psychological empowerment in relation to: long term care staff RNs' work stress in Taipei city (Li, Chen & Kuo, 2008); public health staff RNs' job productivity in northern Taiwan (Chang & Liu, 2008); and, finally, effectiveness of an empowerment-based education program for public health staff RNs in Taiwan (Chang, Liu & Yen, 2008). However, none of the six studies elaborated upon the relationship between structural empowerment and psychological empowerment and therefore, these studies were not selected for the final review.

Characteristics of Selected Studies

Five of the ten selected papers composed the first study of staff nurses in Ontario tertiary care hospitals (Laschinger et al., 2001a; Laschinger et al., 2001c; Manojlovich & Laschinger, 2002; Laschinger et al., 2003b; Laschinger et al., 2004c). The second study (Laschinger et al., 2007) of nurse managers from Ontario acute care hospitals, revealed a higher percentage of managers with master's degrees in the random sample than in the national database. RNs working in two general hospitals located in the Netherlands were sampled in the third study (Knol & van Linge, 2009). The fourth study (DeCicco, Laschinger & Kerr, 2006) consisted of RNs and RPNs employed in nursing homes throughout Ontario. Kluska, Spence Laschinger and Kerr's (2004) survey of staff nurses working in critical care, medical-surgical or maternal child units within Ontario teaching hospitals, indicated more full time and younger nurses than the provincial average. The final study (Laschinger, Finegan, & Wilk, 2009)

examined nurses selected from inpatient units with more than 30 staff nurses that were located within Ontario hospitals with more than 300 beds. See Table 3 for characteristics of included studies.

Results of Quality Assessment

The study by Knol and van Linge (2009) and the multi-paper Ontario study (Laschinger et al., 2001a; Laschinger et al., 2001b; Manojlovich & Laschinger, 2002; Laschinger et al., 2003b; Laschinger et al., 2004c) were deemed to be high quality. The remaining four studies were rated medium quality. All six studies were retained in the review.

Strengths

Strengths of all the studies included the use of a prospective design; sampling more than one site; use of a reliable instrument for measurement of both structural empowerment and psychological empowerment; design based on Kanter's (1977, 1993) structural empowerment and Spreitzer's (1995) psychological empowerment theoretical models; and analysis of correlations for multiple effects. Laschinger et al. (2009) used a stratified cluster sampling design rather than probability sampling for their study of nurses in 21 Ontario hospitals.

Table 3

Characteristics of Six Studies Included in Systematic Review

Study	Article	Subjects	Measurement	Scoring	Reliability	Validity	Analysis
[a] #1A	Laschinger H.K.S., Finegan J.E., Shamian J. (2001a). Promoting nurses' health: Effect of empowerment on job strain and work satisfaction. *Nursing Economic$ 16*(2), 42-52	404 RNs (210 female, 194 male)	CWEQII (Conditions for Work Effectiveness Questionnaire) 6 subscales	Items summed and averaged for each of 6 subscales. Overall SE (structural empowerment) is calculated as sum of 4 subscales (3 items each) of opportunity, information, support and resources	a = 0.79 - 0.82	Content	Path Analysis of 4 major study variables: SE—exogenous; Job Sat, PE and Strain are endogenous
			PES (psychological empowerment scale) 4 subscales (3 items)	Items summed and averaged for each of 4 subscales. Overall PE (psychological empowerment) was sum and average of 12 items	a = 0.71 - 0.92	Content Convergent and divergent	
			Job satisfaction (job sat) (4-items)	Total score	a = 0.82	Content	
			Strain—modified job content questionnaire	Total score	a = 0.71	Content	
[a] #1B	Laschinger H.K.S., Finegan J.E., Shamian J. & Wilk P. (2001c). Impact of structural empowerment on job strain in nursing work	404 staff nurses (210 female, 194	CWEQ 4 subscales of opportunity, information, support and resources (3 items)	12 manifest variables	Not reported (NR)	Content & concurrent	SEM with maximum likelihood estimation with 2 second-order latent variables,
			Job Activities Scale (3 items)	3 manifest variables	NR	Content, concurrent	

(table continues)

Study	Article	Subjects	Measurement	Scoring	Reliability	Validity	Analysis
[a] #1B	settings. *Journal of Nursing Administration, 31*(5), 260-272.	male)	Organizational Relationships Scale (3 items)	3 manifest variables	NR	Content, concurrent	12 first-order latent variables and 35 manifest variables
			PES 12-item scale, 4 subscales with 3 items each	12 manifest variables	NR	Convergent, divergent, content & concurrent	.
			Job satisfaction 4-item	4 manifest variables	NR	Content & concurrent	
			Strain—modified job content questionnaire (psychological demand and decision latitude)	One manifest variable	NR	Content	
[a] #1C	Manojlovich M., Laschinger H.K.S. (2002). The relationship of empowerment and selected personality characteristics to nursing job satisfaction. *Journal of Nursing Administration 32*(11), 586-595.	347 RNs	CWEQ, 4 subscales (3 items)	Items summed and averaged for each of 4 subscales (O, I, S, & R). Overall SE was sum of 4 subscales.	a = 0.95	Content	Hierarchic regression for first hypothesis
			PES 12-item scale, 4 subscales	Items summed and averaged for each of 4 subscales. Overall PE was sum and average of 12 items.	a = 0.88	Convergent and divergent	Moderated regression models were used to test the second hypothesis
			Mastery 10-item scale	Total score	a = 0.80	Content	
			Jackson's Personality Research Form-Achievement Scale (modified)—16 items,	Total score	a = 0.61	Content	
			4-item Job Sat scale	Total score	a = 0.81	Content	
[a] #1D	Laschinger H.K.S., Finegan J.E., Shamian J., Wilk P. (2003b). Workplace	Time 1 First study: 412 RNs	CWEQII 6 subscales (5 subscales had 3 items each, 1 subscale had 4 items)	Latent variable SE had six indicators corresponding to subscales	a = 0.60 – 0.81	Construct	SEM: SE (Time1)-exogenous

(table continues)

Study	Article	Subjects	Measurement	Scoring	Reliability	Validity	Analysis
	empowerment as a predictor of Nurse burnout in restructured healthcare settings. *Hospital Quarterly* (64), 2-11.	Time 2 (3 years later) 239 RNs	PES 12-item scale 4 subscales (3 items each) Maslach Burnout Inventory—Emotional Exhaustion subscale	Latent variable PE had 4 indicators corresponding to subscales 5 indicators corresponding to items	a = 0.85 – 0.94 NR	Convergent & divergent Content	PE (Time1) and burnout (Time 2) were endogenous
[a] #1E	Laschinger H., Finegan J.E., Shamian J., Wilk P. (2004c). A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *Journal of Organizational Behavior* 25, 527-545.	Time 1 412 RNs Time 2 239 RNs with 185 useable returns	CWEQII 6 subscales (5 subscales had 3 items each, 1 subscale had 4 items) PES 12-item scale 4 subscales with 3 items Work satisfaction 4-item global measure	Factor scores for subscale total score. Latent variable of SE had 6 indicators Factor scores for subscale total score. Latent variable of PE had 4 indicators Total scores for items. Four indicators for latent variable.	A = 0.60 – 0.87 a = 0.85 – 0.94 a = 0.78-0.84	Construct, content, concurrent Convergent & divergent, concurrent Concurrent	Structural Equation Modeling: 2-wave-covariable SEM analytic approach
# 2	Laschinger H.K.S., Purdy N., Almost J. (2007). The impact of leader-member exchange quality, empowerment, and core self-evaluation on nurse manager's job satisfaction. *Journal of Nursing Administration*.37 (5), 221-229.	40 middle mgmt RNs 101 first-line mgmt RNs	CWEQ-II 6 subscales (each subscale was sum and average of items) PES 12-item scale LMX (Leader Member exchange) –MDM (multidimensional measure)	Items summed and averaged for each subscale. Total score created by summing 6 subscales Scores created by summing and averaging items Scores created by summing and averaging items	a = 0.62 – 0.80 a = 0.89 – 0.93 a = 0.72 – 0.97	Construct Confirmatory factor analysis (CFA) Exploratory factor analysis (EFA), CFA Content	SEM Core self-evaluation was exogenous; LMX Quality, SE, PE and Job Sat were endogenous

(table continues)

Study	Article	Subjects	Measurement	Scoring	Reliability	Validity	Analysis
#2			Job satisfaction	Scores created by summing and averaging items	a = 0.92	Optimal weighting of 4 specific core traits & incremental validity over 5 factor model	
			Core Self-evaluation Scale	Scores created by summing and averaging items	a = 0.56 – 0.77		
#3	Knol J. & van Linge R. (2009). Innovative behaviour: the effect of structural and psychological empowerment on nurses. *Journal of Advanced Nursing* 65(2), 359-370.	857 RNs with 519 returned surveys	CWEQ-II 6 subscales (each subscale was sum and average of items)	Items summed and averaged for each subscale. Total score created by summing 6 subscales	a = 0.88	Construct factor analysis of Dutch version revealed construct identical to the original CWEQII Content. Jansen et al. (1997) argued scale was reliable and valid	Pearson's correlation; Bivariate linear regression; Sobel test (Baron & Kelly, 1986) Hierarchical regression "Product variable approach" regression.
			PES 12-item scale	Scores created by summing and averaging items for each of 4 subscales	a = -0.87		

(table continues)

Study	Article	Subjects	Measurement	Scoring	Reliability	Validity	Analysis
#3			Innovative Behavior 16 item questionnaire	Four subscales—16 items	a = 0.96	Construct Factor analysis	
# 4	DeCicco J., Laschinger H.K.S., Kerr M. (2006). Perceptions of empowerment respect. Effect on nurses' organizational commitment in nursing homes. *Journal of Gerontological Nursing* 32(5), 49-56.	79 staff RNs	CWEQII 6 subscales	Items summed and averaged for each of 6 subscales. Total empowerment score calculated as sum of the means of six subscales	a = 0.86	Construct validity	Multiple regression analysis
			PES 4 subscales	Items summed and averaged for each of 4 subscales. Overall PE (psychological empowerment) was sum and average of 12 items	a = 0.83	Convergent and divergent validity	
			Effort-Reward Imbalance Questionnaire (3 questions)	Overall respect score obtained by summing and averaging the means of the 3 questions	a = 0.86	Content	
			Organizational Commitment (6 items)	6 items were summed and averaged to obtain scores	a = 0.82	Content	
#5	Kluska K.M., Laschinger H.K.S., Kerr M. (2004). Staff nurse empowerment and effort-reward imbalance. *Canadian Journal of Nursing Leadership* 17(1), 112-128.	112 staff nurses	CWEQII 6 subscales	Items summed and averaged for each of 6 subscales. Total empowerment score calculated by summing the means of the six subscales	a = 0.84	Construct validity	Path analysis using AMOS Correlational analyses
			PES 4 subscales	Items summed and averaged for each of 4 subscales. Overall PE (sum and average of 12 items)	a = 0.82 to 0.91	Construct validity	

(table continues)

Study	Article	Subjects	Measurement	Scoring	Reliability	Validity	Analysis
#5			Effort-Reward Imbalance (ERI) Questionnaire 3 subscales	Items summed to create subscale scores of extrinsic effort, reward and over commitment	a = 0.82 for effort	Content	
				ERI was a ratio between extrinsic effort and reversed reward score.	a = 0.74 for reward	EFA, CFA	
				Log of ERI and dichotomous ERI used. Over commitment measured by revised scale	a = 0.78 for overcom-mitment	Not stated Content	
#6	Laschinger H.K.S., Finegan J.E., Wilk P. (2009). Context Matters: The impact of unit leadership and empowerment on nurses' organizational commitment. *Journal of Nursing Administration* 39(5), 228-335	3,156 nurses from 21 Ontario hospital with more than 300 beds	LMX-MDM scale	12 item scale used to measure 4 dimensions. Scores created by summing and averaging items	a=0.94	Convergent & divergent validity. CFA	Multilevel structural equation modeling techniques
			CWEQ-II	19 items combined to create overall empowerment score	a = 0.87		
			Core Self-Evaluation Scale	12 item scale used	a = 0.69		
			PES	12 item scale used to measure 4 components of PE construct	a = 0.70 to 0.90		

[a] Papers #1A to #1E compose the first study discussed in the systematic review.

Weaknesses

Weaknesses revealed in one or more of the studies were failure to discuss the protection of anonymity or confidentiality of respondents; lack of evidence of probability sampling; no description of justification of sample size; response rates of less than 60%; absence of a description of the reliability of the measurement instruments; finally, the internal consistency of each measurement scale was not always ≥ 0.70.

Structural empowerment and psychological empowerment are based on the perceptions of the individual and can only be measured through self report, consequently none of the reported data in any of the studies was observational. However, as Laschinger et al. (2001c) stated, “given the demonstrated reliability and validity of the measures used . . . common method variance problems should be somewhat attenuated” (p. 265).

Relationship Between Structural Empowerment and Psychological Empowerment

All six studies measured the relationship between structural empowerment and psychological empowerment (Table 4) for practicing RNs. In addition, evidence regarding: the relationship between components of structural empowerment and overall psychological empowerment; and, the relationship between overall structural empowerment and components of psychological empowerment provided valuable insights into the Ontario nurses’ workplace. Different methods (path analysis, structural equation modeling [SEM], multilevel

Table 4

Relationship between Structural Empowerment (SE) and Psychological Empowerment (PE)

Study	Source	SE and PE relationship	Other significant relationships
#1A	Laschinger, H.K.S., Finegan, J., Shamian, J. (2001a). Promoting nurses' health: Effect of empowerment on job strain and work satisfaction. *Nursing Economic$ 16*(2), 42-52	Changes in SE had a direct positive effect on PE: $\beta = 0.46$ χ^2=17.9 df=1, Cumulative Fit Index (CFI)=0.95, Incremental Fit Index (IFI)=0.95	PE and job strain (direct negative effect of $\beta = -0.45$). PE and job satisfaction (direct positive effect of $\beta = 0.30$). SE and job satisfaction (direct positive effect of $\beta = 0.38$; indirect positive effective of $\beta = 0.15$). Once effects of PE are accounted for, job strain is not a factor in predicting work satisfaction. Variance accounted for--38%
#1B	Laschinger, H.K.S., Finegan, J., Shamian, J., Wilk, P. (2001c). Impact of structural empowerment on job strain in nursing work settings. *Journal of Nursing Administration 31*(5), 260-272	Changes in SE produced statistically significant changes in PE: $\beta = 0.85$; $\chi^2 = 1140$; df = 545; χ^2/df = 2.09; CFI = 0.986; IFI = 0.986; Root Mean Square Error of Approximation (RMSEA) = 0.052	PE had a direct positive effect on job satisfaction ($\beta = 0.79$). PE had a directive negative effect on job strain ($\beta = -0.57$). Once the effect of PE was controlled for, the strain/job satisfaction relationship disappeared. Variance accounted for--58%
#1C	Manojlovich, M., Laschinger, H.K.S. (2002). The relationship of empowerment and selected personality characteristics to nursing job satisfaction. *Journal of Nursing Administration 32*(11), 586-595	Correlation between SE and PE r = 0.53 Significant *(p for above not stated)	SE predicted 29.5% variance in job satisfaction. ($R^2 = 0.29$ $F(1,403) = 164.9$, $P = 0.001$) SE and PE, together, accounted for 38% of variance in job satisfaction. SE and PE were significant independent predictors of job satisfaction ($\beta = 0.39$, $p = 0.001$ and $\beta = 0.33$, $p = 0.001$ respectively). PE predicted additional 7.2% of variance in job satisfaction (F change = 45.39. df = 1,402, P = 0.001) All SE factors had significant correlations with PE opportunity (r = 0.45), information (r = 0.37), support (r = 0.47) and resources (r = 0.48) Three PE factors had a significant relationship to SE. autonomy (r = 0.42), impact (r = 0.45) and meaning (r = 0.26) significantly correlated with PE One PE factor did not have a significant relationship to SE. Competence (r = 0.07) *(p for factors not stated)

(table continues)

Study	Source	SE and PE relationship	Other significant relationships
#1D	Laschinger, H. K. S., Finegan, J., Shamian, J., Wilk, P. (2003b). Workplace empowerment as a predictor of Nurse burnout in restructured healthcare settings. *Hospital Quarterly* (64), 2-11	Time 1: Changes in SE produce statistically significant changes in PE: $\beta = 0.44$; $\chi^2 = 198.68$ (df = 85); IFI = 0.90; CHI = 0.90; RMSEA = 0.08. *(p for above not stated)	SE had direct effect on burnout at Time 1 of ($\beta = 0.44$) and an indirect effect at Time 1 on burnout through PE ($\beta = -0.11$) Influence of PE at Time 1 on burnout at Time 2 ($\beta = -0.28$). Nurses' feelings of empowerment in their work environment at Time 1 predicted a significant proportion of reported levels of burnout at Time 2 ($R^2 = 0.107$)
#1E	Laschinger, H.K.S., Finegan, J., Shamian, J., Wilk, P. (2004c). A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *Journal of Organizational Behavior 25,* 527-545	Changes in SE produce statistically significant changes in PE over time: $\beta = 0.38$ ($p \leq 0.05$) ($R^2 = 0.616$, χ^2 [significance not stated] =667.455, df = 342, IFI = 0.979, CFI = 0.979, RMSEA = 0.072)	Changes in SE over time produced significant changes in job satisfaction: $\beta = 0.70$ ($p \leq 0.05$) Changes in PE over time did not result in a significant change in job satisfaction (no indirect effect). B = -0.08 ($p \leq 0.05$) R^2 for Job Satisfaction–Time 2–66.6% (increased by 36.6% when the effects of SE and PE for Time 1 and Time 2 were added to the stability model)
#2	Laschinger, H.K.S., Purdy, N., Almost, J. (2007). The impact of leader-member exchange quality, empowerment, and core self-evaluation on nurse manager's job satisfaction. *Journal of Nursing Administration,.37* (5), 221-229	Changes in SE produce statistically significant changes in PE: $\beta = 0.43$; χ^2 (significance not stated) = 26.14; df = 3; CFI = 0.90; IFI = 0.90; RMSEA = 0.23	Leader Member Exchange (LMX) had positive direct effect on SE ($\beta = 0.42$) PE had direct positive direct effect on job satisfaction ($\beta = 0.35$) Core self-evaluation had significant direct effect on: job satisfaction ($\beta = 0.37$); LMX ($\beta = 0.18$); SE ($\beta = 0.32$); PE ($\beta = 0.39$)

(table continues)

Study	Source	SE and PE relationship	Other significant relationships
#3	Knol, J. & van Linge, R. (2009). Innovative behaviour: the effect of structural and psychological empowerment on nurses. *Journal of Advanced Nursing 65*(2), 359-370	Correlation between SE and PE ($r = 0.45$, $p < 0.01$) Bivariate regression analysis between SE and PE ($F[1,484]=124.022$, $p < 0.001$) revealed that SE explained 20.4% of variance of PE	Bivariate regression analysis between SE and innovative behavior revealed that SE accounted for 20.2% of the variance in innovation ($F[1,475]=120.323$, $p<0.001$). Separate regression of four dimensions revealed that informal power was most the most important of the 4SE dimensions in all cases (β=0.346-0.407, $p<0.001$), accounting for 25.5% of variance Bivariate regression between PE and innovative behaviour accounted for 27.8% of the variance in innovation ($F[1,504] = 193.808$, $p < 0.001$). Separate regression of the four dimensions of PE on innovative behaviour revealed impact was most important (β = 0.107-0.129, $p < 0.05$). Impact accounted for 40.7% of the variance. Regression of the effect of SE and PE on innovative behaviour led to determination coefficient $R^2 = 0.335$ confirming the mediator effect of PE on innovative behaviour Hierarchical regression for a "quadratic relationship between independent and dependent variables revealed no statistical significance ($t[471]=-0.217$, $p=0.828$), [therefore] the preposition that SE determines the extent to which PE leads to innovative behaviour" (p. 367) or the moderator effect, was not confirmed
# 4	DeCicco, J., Laschinger, H. & Kerr, M. (2006). Perceptions of empowerment respect. Effect on nurses' organizational commitment in nursing homes. *Journal of Gerontological Nursing 32*(5), 49-56	Correlation between total SE and total PE: for RNs $r = 0.50$ $p < 0.01$ (one-tailed significance) for RPNs $r = 0.53$ $p < 0.01$ (one-tailed significance) Relationship between components of SE and total PE for RNs and RPNs ($p<0.01$): Opportunity $r = 0.42$ $r = 0.32$ Information $r = 0.42$ $r = 0.39$ Support $r = 0.42$ $r = 0.38$ Resources $r = 0.26$ $r = 0.35$ Formal power $r = 0.44$ $r = 0.35$ Informal power $r = 0.50$ $r = 0.58$	For both RNs and Registered Psychiatric Nurses(RPNs) SE and PE explain 42% of the variance in respect ($p = 0.0001$). SE is the stronger predictor of respect for both RN and RPN For RNs SE, PE and respect explain 48% of the variance of affective commitment (p =0.0001). Both SE and respect were significant predictors of affective commitment ($\beta = 0.447$, $t = 4.133$, $p = 0.0001$ and $\beta = 0.265$, $t = 1.392$, $p = 0.019$) For RPNs ; SE, PE and respect explain 40% of the variance of affective commitment ($p = .0001$). SE was the only significant predictor of affective commitment ($\beta = .354$, $t = 1.388$, $p = .170$) Correlation between SE subscale components and respect for RNs and RPNs: Opportunity (RN) $r = 0.44$ ($p<0.01$) (RPN) $r = 0.26$ ($p<.05$) Information (RN) $r = 0.51$ ($p<0.01$) (RPN) $r = 0.44$) ($p<0.01$) Support (RN) $r = 0.58$ ($p<0.01$) (RPN) $r = 0.47$ ($p<0.01$) Resources (RN) $r = 0.15$ (NS) (RPN) $r = 0.57$ ($p<0.01$)

(table continues)

Study	Source	SE and PE relationship	Other significant relationships
#5	Kluska, K.M., Spence Laschinger, H.K. & Kerr, M.S. (2004). Staff nurse empowerment and effort-reward imbalance. *Canadian Journal of Nursing Leadership 17*(1), 112-128	Fit of revised model was GFI = 0.98, IFI = 0.97, NFI = 0.94, RMSEA = 0.09 SE has significant direct effects on PE ($\beta = 0.46$ $p < .05$)	SE has significant direct effects on Effort-Reward Imbalance (ERI) ($\beta = -0.31$ $p<0.05$) Over commitment had a significant effect on ERI ($\beta = 0.35$, $p < 0.05$) PE decreased to $\beta = -0.01$ (NS) after effects of SE on ERI were accounted for. Access to resources was most strongly related to extrinsic effort ($r = -0.47$, $p < 0.001$) and ERI ($r = -0.43$, $P < 0.001$). Perceived lack of access to resources related to over commitment ($r = -0.22$, $p = 0.02$) Perceived rewards related to all empowerment variables, strongest relationship with formal power ($r = 0.38$, $p < 0.001$) and autonomy ($r = 0.28$, $p = 0.001$). The revised model accounted for 22% of the variance in ERI. Diploma nurses significantly less empowered than degree nurses ($t(110) = 2.00$, $p = 0.049$)
# 6	Spence Laschinger, H.K., Finegan, J. Wilk, P. (2009). Context Matters The impact of unit leadership and empowerment on nurses' organizational commitment *Journal of Nursing Administration 39*(5), 228-335	χ^2 (significance not stated) = 31.734 CFI = 0.976, RMSEA = 0.041, Tucker Lewis Index = 0.922 At level 2 (unit level) SE had a significant direct effect on level 1 (individual-level) nurses' PE ($\beta = 0.672$) Correlation between SE and Level 1 (Nurses) PE = 0.39 (p value not given)	**Level 1 (Individual)** Core self-evaluation **(**CSE) had a significant positive effect on PE ($\beta = 0.333$). PE had significant positive influence on job commitment ($\beta = 0.386$). Correlation between job commitment and: PE = 0.41; CSE = 0.21; Years in nursing = 0.08; SE = 0.35; LMX = 0.37. Correlation between PE and: CSE = 0.33; Years in nursing = 0.13; SE = 0.39; LMX = 0.36; Correlation between CSE and: years in nursing = 0.05; SE = 0.12; LMX = 0.13. Correlation between years in nursing and: SE = -0.06; LMX = -0.04. Correlation between LMX and SE = 0.36. Level 1 predictors explained 15.6% of variance in job commitment (level 1) and 13.4% of variance in PE (level 1) **Level 2 (Unit)** LMX quality had significant direct effect on SE ($\beta = 0.292$). Correlation between LMX and unit empowerment = 0.29. SE had significant direct effect on level 1 (individual) nurses' job commitment (level 1) ($\beta = 0.392$) . LMX (level 2) had significant direct ($\beta = 0.412$) and indirect ($\beta =0.196$) effects on nurses PE (level 1) and significant direct ($\beta = 0.437$) and indirect ($\beta = 0.115$) effects on job commitment (level 1). Level 2 predictors explained 44.5% of variance in job commitment and 78.3% of variance in PE

structural equation modeling, hierarchic regression and ‘product variable approach’ regression) were used to analyze the data in the six studies.

Relationship Between Overall Structural Empowerment and Overall Psychological Empowerment

These studies reported a significant positive relationship between structural empowerment and psychological empowerment for staff RNs, RPNs and management RNs. Psychological empowerment functioned as a mediator, being partly responsible for the influence of structural empowerment on innovative behaviour in the Dutch study and on employee effectiveness and satisfaction in the multi-paper Ontario study. However, psychological empowerment did not explain additional variance for effort-reward imbalance after accounting for the effects of structural empowerment and over commitment in the study by Kluska et al. (2004). The study of Ontario staff nurses also revealed significant positive relationships between perceptions of structural empowerment over time and psychological empowerment. The multilevel study (Laschinger et al., 2009) revealed a causal relationship between structural empowerment at the group (hospital unit) level and psychological empowerment and organizational commitment at the individual level.

Relationship Between Job Related Empowerment Structure Subscales and Overall Psychological Empowerment

The four job related empowerment structure subscales of *opportunity, information, resources* and *support* had significant positive correlations with overall psychological empowerment for the staff nurses in the Ontario study. This

illustrated the important contribution each job related empowerment structural component makes to the psychological empowerment of RNs.

Relationship Between Overall Structural Empowerment and Psychological Empowerment Subscales

Measurement of the psychological empowerment subscales of *self determination, impact* and *meaning* revealed significant positive correlations with overall structural empowerment for the Ontario staff nurses. The psychological empowerment subscale of *competence* did not have a significant relationship with the perception of overall structural empowerment, suggesting that this sample of nurses felt competent, regardless of the presence or absence of structurally empowering conditions within the organization.

Discussion

The exploration of the relationship between social structure and overall empowerment, its components and proven outcomes, points to the importance of specific workplace interventions that provide structural empowerment to RNs. Research studies demonstrate that structural empowerment leads to psychological empowerment that culminates in measurable positive workplace outcomes such as: increased job satisfaction (Laschinger et al., 2001c; Laschinger et al., 2001a; Manojlovich & Laschinger, 2002; Laschinger et al., 2003b; Laschinger et al., 2004c; Laschinger, Purdy, & Almost, 2007) for both RN staff and RN management; increased perceptions of respect and affective commitment for RN staff (DeCicco et al., 2006); increased organizational commitment of the individual RN (Laschinger et al., 2009); increased RN innovation (Knol & Linge,

2009); reduced effort-reward imbalance for RN staff (Kluska et al., 2004); and finally, reduced burnout for RN staff (Laschinger et al., 2003b).

Since five of the six studies included in this review were published by Laschinger and associates, the review must be placed in context of the body of work centering on workplace empowerment completed by this researcher over the past 16 years, to acknowledge its theoretical strength. Examination of the studies encompassed by the UWO Workplace Empowerment Research Program (Laschinger, 2008b) reveals an extensive program of research (grouped by staff nurses, managers, staff nurses and managers, educators/students, nurse practitioners and physiotherapists) on workplace empowerment conducted in varied settings. As this body of research developed, additional workplace attributes such as burnout (Sarmiento et al., 2004), organizational trust and commitment (Laschinger et al., 2000), workplace health (Laschinger & Finegan, 2005a), nursing professional practice environment (Laschinger, 2008a), job satisfaction (Laschinger et al., 2001d; Laschinger et al., 2001a; Manojlovich & Laschinger; 2002; Laschinger, Finegan, Shamian & Wilk*,* 2004; Laschinger et al., 2007), respect (Laschinger & Finegan, 2005b), organizational justice (Laschinger, 2004), nursing leadership (Wong & Cummings, 2007; Laschinger et al., 2007) and others, were tested to determine their relationship to structural empowerment. This extensive body of work reveals an exploration of the relationship of various aspects of the workplace to Kanter's theory of structural empowerment. Each study builds upon the previous research, providing a strong foundation and future direction for additional work.

Most of the early studies focused on the individual, clearly delineating the relationship between structural empowerment and psychological empowerment of the RN staff at the "patient or client care" level of the organization. However there are many levels of decision making within the health care system, with all the layers interacting and ultimately having an impact on both health care providers and clients. A recent study by Laschinger et al. (2009) emphasized that structural empowerment at the group or nursing level positively influenced individual staff nurses' perceptions of psychological empowerment. In addition, recent studies highlighting the relationship between empowerment, professional practice environments and patient outcomes (Laschinger & Finegan, 2005a) further identified the need for multi-level research on workplace empowerment, not only at the unit level, but also at organizational, regional, provincial, national and international levels. Measurement of the relationship between different organizational levels provides the context required to further understand the causal relationship between structural empowerment and psychological empowerment.

Research at the individual manager level revealed a significant relationship between structural empowerment and psychological empowerment for managers (Laschinger et al., 2007). When *meaning, self determination* and *impact* increase amongst managers, it is anticipated that associated increases in outcomes, or leadership actions that lead to the structural empowerment of subordinates, will also occur.

Worldwide interest in improving both patient outcomes and nurse retention led to research on magnet hospitals in numerous countries. Although a study by Laschinger et al. (2003a) demonstrated that workplace empowerment research and magnet hospitals research have common features such as autonomy, control over practice environment and positive nurse-physician relationships that culminate in improved patient outcomes and increased nurse retention, international research on workplace empowerment is limited. Recent research conducted in the Netherlands shows psychological empowerment to be a mediator between structural empowerment and innovative behaviour (Knol & van Linge, 2009). The research points to the need for global investigation of this workplace phenomenon. Additional international research, similar to the study by Manojlovich and Laschinger (2007), that combines empowerment with components of magnet hospital research, and the study by Knol and van Linge (2009) may provide valuable information about the relationship between structural empowerment and psychological empowerment in health care facilities throughout Canada and other countries.

Limitations

This review was limited to those studies examining the relationship between structural empowerment as the predictor variable and psychological empowerment as the variable receiving the effects. Although the demonstration of this relationship is essential to link the perceptions of structural empowerment to psychological empowerment, this criterion also screens out qualitative research. The qualitative research may reveal valuable factors contributing to the

relationship such as the importance of the context and culture of the RN's environment.

Recommendations for Future Research

Several recommendations for future research arise from this review. Additional testing of the hypothesis with different and unique samples composed of different health care professionals selected from varied care settings and geographical locations, also more longitudinal studies will strengthen the relevance of this research to varied workplaces. Testing the fit of theory with additional workplace variables such as burnout and organizational commitment will provide clarification of the relationship between structural empowerment, psychological empowerment and workplace outcomes. The use of research tools that measure objective data i.e., an increase in RN retention, improved nurse sensitive outcomes such as fewer falls, pressure ulcers and medication errors, and a reduction in overall patient morbidity, rather than the perceptions of the individuals, will give health care leaders concrete evidence of the importance of this research. Further investigation of the relationship between structural empowerment, psychological empowerment and outcomes or leadership actions of managers would provide greater understanding of healthy workplace leadership. Finally, it is important to explore and measure the relational effect between structural empowerment and psychological empowerment within uncharted levels of the workplace such as the overall work site, organization, region or province/state and country.

Recommendations for Health Care Leaders

Health care leaders must consider the relationship of structural and psychological empowerment to organizational outcomes when they are designing changes for a health care system that is already under constant stress. Delegation or "decentralization" of formal power to individuals throughout the system, ranging from high level managers to patient/client caregivers, must occur for a successful change process to come to pass. Additional dissemination of information regarding the effectiveness and efficiency of potential interventions, along with the provision of resources and support required by change leaders at all levels of the health care system, should transpire prior to providing managers and staff with opportunities for involvement with modifications of the existing system. This allocation of formal power combined with the presence of structural components designed to support empowerment and change at all levels of the organization, will culminate in positive long-term workplace outcomes for both managers and staff, ultimately leading to improved patient outcomes.

Conclusion

Pressure imposed on our health care system by: aging national demographics, increasingly complex and expensive medical treatments, and consumers who are demanding access to expert health care, requires conscientious attention to the health care work environment. At the same time magnet hospital research from other countries demonstrates that changes in hospital work environments lead to increased nurse retention and reduced patient morbidity and mortality (Scott et al., 1999, Laschinger et al., 2003a; Middleton

et al., 2008). Although research exploring the relationship between structural empowerment and psychological empowerment is relatively recent (Laschinger, 2008b), the studies included in this review suggest a direct positive relationship between structural empowerment and psychological empowerment, and their subscales, for both nurse managers and staff nurses. These studies also reveal that increased structural empowerment and psychological empowerment are not only associated with increased nurse innovation, but lead to increased nurse job satisfaction and reduced burnout. Research has shown the way to the development and maintenance of a healthy and productive nursing force through health care leader attention to critical structural components in their work environments.

Structural Empowerment and SAW

This systematic review of the literature has clearly revealed a strong relationship between structural and psychological empowerment. However, it was essential that I review the literature further to defend additional proposed relationships in the model between structural empowerment, psychological empowerment, *SAW*, job satisfaction, organizational commitment, rank, experience, education, and resonant leadership (Figure 1). Upon a review and comparison of structural empowerment and *SAW*, I identified strong similarities between Kanter's (1977) six structural supports and Kinjerski's (2004) seven characteristics of the organization that foster *SAW* (Table 5). This resemblance suggests that Kanter's six structural supports influence not only the individual worker's behaviour, but also employees' *SAW* and "the positive feelings that individuals have about their work" (p. 2).

Table 5

Kanter's (1977) Structural Supports That Influence Empowerment Compared to Kinjerski's (2004) Organizational Characteristics That Foster SAW

Kanter (1977)	Kinjerski (2004)
Formal power	Strong organizational foundation
Informal power	Sense of community
Support	Appreciation and regard
	Positive workplace culture
	Inspiring leadership
Resources	Organizational integrity
Opportunity	Personal fulfillment, development
Information	Continuous learning

Kanter (1977, 1993) reported significant changes in outcomes when employees were given the information, support, opportunity, and resources to act on their own judgments. Most authors agreed that the freedom to contribute and the opportunity to have ideas heard facilitate increased business creativity and lead to increased productivity. Cuilla (2004) championed the process of worker empowerment and claimed that giving employees a voice in how they perform their work and how the jobs are designed culminates in high-quality output. In their popular book *In Search of Excellence*, Peters and Waterman (1982; as cited in Cuilla, 2004) espoused the view that creative individuals are essential to successful organizations: "Excellent organizations do not produce the conformist" (p. 67). The literature on workplace empowerment and spirituality affirmed that a workplace that has the structures in place to allow employees to be creative and heard while fostering their *SAW* is an empowered environment. This was evident in Kinjerski's (2004) description of *SAW*: "SAW reflects a distinct state that involves . . . a belief that one's work makes a contribution, a sense of connect to

others and common purpose, an awareness of a connection to something larger than self" (p. 2).

Psychological Empowerment and Spirituality

Recent developments within the "fourth force" of psychology, which involves the study of the transcendent or spiritual dimensions of humanity, have rippled outward from the discipline of psychology into the bordering professional human service domains of management and health care. This fourth force, more commonly referred to as *transpersonal* psychology, is "concerned with the study of humanity's highest potential, and with the recognition, understanding, and realization of unitive, spiritual, and transcendent states of consciousness" (Wikipedia, 2007, ¶ 2). Although Spreitzer (1995) did not describe a relationship between empowerment and spirituality in her existing model of psychological empowerment, it is important to investigate this dimension further, based on the work that has emerged from the studies on transpersonal psychology.

Maslow (1970), the philosophical father of the transpersonal theory of psychology, has been portrayed as one of the "greatest source[s] of historical management and organizational theory influence on the ideal of spirituality in the workplace" (Quatro, 2004, p. 233). McGraw (1992) equated empowerment to Maslow's concept of self-actualization, which Fullam, Lando, Johansen, Reyes, and Szaloczy (1998) equated to "the most sophisticated behavior that is expected of employees" (p. 255) and which is achieved only after the basic needs are satisfied. In 1968 Maslow added a higher level to his hierarchy of needs that consisted of transcenders and transcending self-actualizers who were "capable of

transcending the limitations of personal identity and thus [had] a deeper sense of eternity and the sacred" (Cowley, 1993, p. 530).

Emerging research on spirituality in the workplace (Alexander et al., 1993; Cavanagh, 1999; Frew, 1974; Kinjerski, 2004; Tischler, Biberman, & McKeage, 2002) revealed a relationship between specific changes in workplace structure/and positive workplace behaviours/similar to those unveiled in research on psychological empowerment. Maddox's (2002) definition of spirituality as a "belief system based on intangible elements that impart vitality and add meaning to life events" (p. 12) further stressed the importance of understanding the relationship between spirituality and psychological empowerment.

Leadership

Spiritual Leadership

Fairholm (2003) described spiritual leadership as a

> holistic approach that considers the full capacities, needs and interests of both leader and led: spiritual leaders see leadership as a contextual relationship in which all participants want to grow and help others in their self-development activities (p. 11).

Spiritual leaders not only promote others' spiritual growth, but they "create an environment where individuals can reflect on work experiences and find deeper meaning in experience, thereby both providing and promoting spiritual care" (Burkhart et al., 2008). The Waterwheel Model further illustrates this dynamic concept of spiritual leadership (Solari-Twadell, 2006). The model is built on eight assumptions that are grouped according to: the framework of the waterwheel; the driving force that makes the waterwheel function; spiritual leaders who actualize

sustaining capacities and finally, spiritual leaders who foster capacity building in others (Table 6).

Table 6

Solari-Twadell's Waterwheel Model of Spiritual Leadership

Description	Assumption
Framework of the Waterwheel	Spiritual leaders: 1. Have foundational life experiences that impact the development of their core beliefs and values 2. Have the capacity for self-awareness that may support or alter their core beliefs and values 3. Have core beliefs and values made visible through their actions and decisions 4. Build relationships and tell stories that transmit new ways of thinking, being, and doing 5. Have a connectedness with a power greater than themselves
Driving force that makes the Waterwheel function	6. Spiritual leaders are continuous, reflective learners
Spiritual leaders who actualize sustaining capacities: The buckets	7. Spiritual leaders actualize sustaining capacities (buckets) of: service-oriented, self-disciplined, ethical, intuitive, creative, open-minded, grateful, faith-filled, wisdom seeker, open to surrender, discerning, inquisitive
Spiritual leaders who foster capacity building in others: The ripples	8. Spiritual leaders foster capacity building characteristics in others of: inspiration, values, vitality, respect, integrity, trust, courage, wholeness, vision, honesty, communication, community, hope, prayer.

Resonant Leadership

Resonant leadership (Cummings, 2004) displays some similarities to the spiritual leadership described by Solari-Twadell (2006). Cummings (2004)

investigated the relationship between the recent hospital restructuring in Canada during the 1980s and 1990s and nursing workplace behaviours/attitudes and patient outcomes. In the process of questioning what factors mitigate the impact of hospital restructuring on RNs, researchers studied different RN leadership styles and their relationship to the ability of the nursing staff to deal with change (Cummings et al., 2005). The writings of Goleman, Boyatzis, and McKee (2002) on resonant leadership and the ability of leaders with high emotional intelligence to hear their workers' negative feelings and respond empathetically were applied to Alberta research on the impact of hospital restructuring by Estabrooks, Tourangeau, Humphrey, Hesketh, Giovanetti, and Thomson et al. (2002). This analysis of the Alberta RN Survey of Hospital Characteristics (Estabrooks et al., 2002) revealed that RNs reported fewer negative effects when they worked in an environment with resonant leadership (Cummings et al., 2005).

Goleman et al. (2002) claimed that this empathic or resonant leadership is essential during times of restructuring and change. Resonant leadership consists of the four leadership styles of (a) visionary leaders, who "move people towards shared dreams by sharing knowledge and influence that empower others to act and innovate" (Cummings, 2004, p. 77); (b) coaching leaders, who focus on developing others; (c) affiliative leaders, who build strong relationships with their employees; and (d) democratic leaders, who build consensus and promote innovation, teamwork, and collaboration (Cummings, 2004). The two dissonant leadership styles of pacesetting, in which the leader pushes the employees, at a high emotional cost to the employees, to achieve consistently high standards; and

commanding, in which the leaders are micro-managers and "more concerned about directing staff efforts than supporting them" (p. 78), result in costs to the organization such as "decreased productivity, an increase in missed deadlines, mistakes and an exodus of employees to more congenial settings" (Goleman, 1998, p. 37). Goleman emphasized that resonant leadership is 'the art of persuading people to work toward a common goal' (p. 37), not domination.

Two groupings of leadership styles based on Goleman et al.'s (2002) work emerged as having distinctly different influences on RNs' experience of change. Leaders with resonant leadership styles successfully mitigated the effects of hospital restructuring on RNs. RNs with dissonant leaders

> reported significantly more emotional exhaustion and psychosomatic symptoms, poorer levels of emotional health, decreased workgroup collaboration and teamwork with physicians, decreased satisfaction with supervision and their job, and greater unmet patient care needs. (Cummings, 2003, p. 11)

Cummings (2004) suggested that the difference between these two leadership styles is "the investment of relational energy by resonant nursing leadership to build relationships with RNs and manage emotion in the workplace" (p. 76).

Kinjerski and Skrypnek (2008) trialed a workplace intervention intended to increase *SAW* in the workplace by allowing supervisors and subordinates in a long term care facility to attend sessions together. The researchers reported increased teamwork, heightened morale, and improved staff relationships following completion of the intervention. These outcomes were consistent with the research of Strack, Fottler, and Kilpatrick (2008), who reported a moderately positive correlation between managers' spirituality and their perceived leadership

practices. Comparison of Goleman et al.'s (2002) resonant leadership model and Kinjerski's (2004) *SAW* for employees points to a strong relationship between the two constructs (Table 7).

Table 7

Relationship Between Resonant Leadership Style and Employees' SAW

Resonant leadership style	Employees' *SAW*
Visionary: shared dreams, sharing knowledge and influence, empowering others to act	*Engaging work*: a belief that one is engaged in meaningful work that has a higher purpose, a sense of being authentic
Affiliative: strong relationships, *sense of community*	*Sense of community*: a feeling of connectedness to others and common purpose
Coaching: developing others, seeing potential in others that they may not have identified	*Engaging work*: a sense of being authentic, a belief that one is engaged in meaningful work that has a higher purpose
Democratic: consensus, teamwork, collaboration, innovation	*Sense of community*: a feeling of connectedness to others and common purpose *Engaging work*: a belief that one is engaged in meaningful work that has a higher purpose, a sense of being authentic

Positive Work Behaviours and Attitudes

The work behaviours and attitudes of job satisfaction and affective organizational commitment are components of the UWO Workplace Empowerment Model that lead not only to work effectiveness attributes such as achievement and success, respect, and cooperation in the organization, but also, more important, to client satisfaction (Rosabeth Kanter; as cited in Laschinger,

Finegan, Shamian, & Wilk, 2001). Blegen (1993) reported a strong relationship between job satisfaction and organizational commitment. Tett and Meyer (1993) not only identified a negative relationship between both work behaviours/attitudes and turnover, but described how job satisfaction and organizational commitment each make unique contributions to turnover intentions. Although in additional research, Mosadeghrad, Ferlie, and Rosenberg (2008) did not clarify whether job satisfaction leads to organizational commitment or organizational commitment culminates in job satisfaction, the common view supports the causal precedence of satisfaction over commitment.

Job Satisfaction

The literature revealed multiple definitions of job satisfaction (Herzberg, 1966; Kuokkanen, Leino-Kilpi, & Katajisto, 2003; Maslow, 1998; Porter & Lawler, 1968). Health care researchers have summarized their recent findings on job satisfaction as “a discrepancy between how much a person wants or expects from the job and how much the person actually receives” (Laschinger, Shamian, & Thomson, 2001, p. 212).

One of the earliest writers on the subject of workers’ dissatisfaction in modern society was Karl Marx, who argued that the most serious consequence of the Industrial Revolution was the alienation of the worker from the product of his labour. Many sociologists have built upon the works of Marx and criticized the depersonalization of work with the resultant loss of the intrinsic rewards.

A parallel approach to work satisfaction developed in the field of psychology through an analysis of human needs. Herzberg (1966) isolated five

factors (motivators) that he believed are the most important determinants of job satisfaction: achievement, recognition, interesting work, responsibility, and advancement. He balanced them against the four factors (hygiene) of salary, working conditions, interpersonal relations, and the administrative approach of the organization and found that they are important only if they are absent from the workplace and do not necessarily motivate staff if they are increased, but would cause dissatisfaction if absent. Interactions between these factors result in a sense of satisfaction or dissatisfaction (Herzberg, 1966).

Many researchers have used Maslow's (1970) hierarchy of human needs, with the basic physiological necessities on the bottom and self-actualization on the top, to order the factors associated with work satisfaction. Wagner's (1991) study of home care RNs in Alberta revealed that most RNs were satisfied with their interpersonal interactions and were searching for opportunities to achieve the higher-level satisfaction of ego or self-actualization needs; for example, to "share in the determination of methods and procedures" and "share in the setting of goals" (p. 29). These results support Maslow's hypothesis that the satisfaction of self-esteem and self-actualizing needs are the greatest organizational concerns in North American society, because most of the lower needs have already been met.

The results of Wagner's (1991) Albertan job satisfaction research are strongly related to more recent research on magnet hospitals (Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger, Shamian, & Thomson, 2001) and restructured health care settings (Laschinger, Finegan, Shamian, & Almost, 2001). Laschinger, Shamian, and Thomson reported significant positive relationships between

autonomy and control over practice (self-esteem or ego needs) and RNs' job satisfaction. Janney, Horstman, and Bane (2001) reported that active implementation of shared decision-making processes decreased the RN vacancy rate and mandatory overtime in one year and increased RN job satisfaction in one organization. Researchers also reported a significant link between dissatisfaction with working conditions and the consequential departure of RNs from their profession (Laschinger, Finegan, Shamian, & Almost, 2001). Magnet hospital research showed the significant impact of nursing job satisfaction on the crucial outcome of quality patient care when the researchers reported a direct link between work satisfaction and the patient's experience of care from the nursing staff (Laschinger, Shamian, & Thomson, 2001).

Organizational Commitment

Organizational commitment is defined in the literature as a psychological state that "(a) characterizes the employee's relationship with the organization and (b) has implications for the decision to continue or discontinue membership in the organization" (Meyer, Allen, & Smith, 1993, p. 539). Three additional distinct themes that compose organizational commitment are also identified in the literature: an affective or emotional attachment to and involvement in the organization (affective), awareness of the costs of leaving the organization (continuance), and a sense of obligation to stay with the organization (normative) (Eisenberger, Fasolo, & Davis-LaMastro, 1990; Kuokkanen et al., 2003; Meyer et al., 1993). Factor-analytic studies of the three different commitment scales revealed that they measure distinctly different constructs (Allen & Meyer, 1996;

Shore & Tetrick, 1991). However, Meyer and Allen (1991) reported that one commitment scale, affective commitment, is positively related to job performance. Meyer et al., asserted that “affective commitment contributed most frequently to prediction, particularly in the case of the organization-relevant outcomes” (p. 546).

Affective organizational commitment is positively related to job satisfaction and negatively related to turnover, according to Janney et al. (2001). The analysis of a shared decision making process conducted in West Virginia University Hospitals that involved 32 three-week RN focus groups on every unit and every shift revealed that empowerment has a positive influence on affective organizational commitment. Janney et al.’s study did not demonstrate a predictive relationship between empowerment and the continuance commitment scale.

Laschinger, Finegan, Shamian, and Almost (2001) used the affective organizational commitment subscale to investigate the hypothesis that staff RNs who rate their jobs as having high levels of strain have lower perceptions of structural and psychological empowerment, less commitment to the organization, and lower work satisfaction. The analysis of the 300 male and 300 female RNs from tertiary care hospitals in Ontario revealed that staff RNs who experienced “high psychological stress at work with little control over their job were significantly less empowered, less committed to the organization and less satisfied with their jobs than those with lower levels of job strain” (p. 239). Laschinger, Finegan, Shamian, and Almost stressed that “employees with strong affective commitment work in the organization because ‘they want to’ and because the

workplace supports employee autonomy" (p. 240). They also "contribute more to the accomplishment of organizational goals and are less likely to leave the organization" (p. 240).

Population Demographics and Work Empowerment

Most of the workplace empowerment studies revealed very few demographic variables with a relationship to empowerment (Kluska et al., 2004; Laschinger & Havens, 1997). Finegan and Laschinger's (2001) gender analysis in which they used the work empowerment model to compare men and women demonstrated no significant differences in the responses for any of the measured variables according to gender.

Koberg, Boss, Senem, and Goodman (1999) reported that individuals with more tenure, who have learned through experience that continued effort leads to feelings of competence in their performance, display greater feelings of empowerment (Webb, 1992; Wilson & Laschinger, 1994). "Status in the hierarchy," or the organizational rank, is another variable that is strongly associated with increased empowerment, because it affords "sociopolitical support and perceived access to information, resources, and influential persons" (Koberg et al., 1999, p. 76).

Although the research revealed a relationship between age and empowerment in the work setting, the different studies showed conflicting results. Ettington (1997) concluded that older managers feel less empowered because they tend to be perceived as plateaued in the organization. Another study of a multidisciplinary team composed of RNs, practical RNs, OTs, PTs, masseurs,

health fitness RNs, X-ray assistants, laboratory assistants, and podiatrists in a Rheumatism Foundation Hospital in Finland revealed similar results: younger health care staff report more work-related empowerment than older staff do (Suominen et al., 2006). However, in Kuokkanen et al.'s (2003) research on critical care RNs, long term care RNs and public health RNs in southern Finland uncovered the dissatisfaction of younger RNs who were clearly considering leaving the profession or changing jobs.

Spreitzer, Kizilos, and Nason (1997) reported that individuals with higher levels of education feel more empowered, and Kluska et al. (2004) concurred. Spreitzer et al.'s examination of the relationship between RNs' empowerment and effort-reward imbalance in their research, that was conducted with a sample of 112 hospital staff in Ontario, showed that diploma RNs were significantly less empowered than degree RNs were. Kuokkanen et al. (2003) claimed that further education, career consciousness, and organizational activities are strongly related to empowerment, based on their survey of RNs in southern Finland.

Health Care Teams and the Health Care Workplace

Irvine, Kerridge, McPhee, and Freeman (2002) described a transition from generalist health care workers to "specialists" or "experts" that has occurred since the turn of the century. These experts "now have a more detailed understanding of, and information about, substantive issues they deal with than at any time in the past and so 'own' a socially defined body of 'core' knowledge that is central to their tasks" (Irvine et al., p. 201). However, more recently, professionals' failure to utilize the expertise of others in different health care fields (Huws Jones, 1971)

has become a significant concern. Patients have reported difficulty accessing comprehensive quality from a variety of disciplines in a coordinated manner and it has become evident that there is a need to develop a framework of practice that supports a wider use of knowledge and resources (Huws Jones, 1971). Other studies reported that improved team work and communication within health care teams resulted in substantial reduction of health care errors (Kaissi, Johnson, & Kirschbaum, 2003; Scott, Sochalski, & Aiken, 1999). Temkin-Greener, Gross, Kunitz, and Mukamel (2004) strongly supported the interdisciplinary team in the care of the frail elderly, stating "the complexity of these patients' needs demands highly effective coordination of resources across time, multiple settings of care, and diverse disciplines" (p. 475). Collaboration, through the establishment of teams of 'experts' from different disciplines, has been reported to be the answer to improved clinical management of complex, very sick clients (McCallin, 2003; Ooms, Rolland, Mintz, & Doppelt, 1995). Multidisciplinary, interdisciplinary and transdisciplinary health care teams evolved during the twentieth century as a direct result of the necessity for professional collaboration in the provision of quality client driven care (Eve, 2003) to vulnerable and complex clients.

The question "What are the characteristics or 'dynamics' of an effective health care team?" has been discussed by researchers for several decades. Researchers have described a variety of health provider groups that range from teams in name only with little evidence of shared goals or collaborative teamwork (Miller et al., 1999a cited in Millward, 2001) to teams of professionals who work at high levels of collaboration. Much of the research on teamwork aimed at

identifying and changing of individual behaviors of team members had little impact on the provision of health care (Tannenbaum, Beard, & Salas, 1992; as cited in Millward, 2001). *SAW* (Kinjerski, 2004). Research with its emphasis on *sense of community, spiritual connection, mystical experience* and *engaging work* has been identified as valuable workplace knowledge that will assist health care leaders to identify critical components of a dynamic health care team and workplace.

RN, OT, and PT are just three of the health care professional disciplines who provide the care required to restore clients to health and to maintain clients at their optimum health. Each discipline brings to the health care team a unique knowledge base and set of skills (Table 8, Appendix C). The differences in knowledge, skills, and employment displayed by members of various professional disciplines may have a significant impact on both their workplace culture and their empowerment.

Triangulation of Research Methods

Many authors (Bryman, 2006; Freeman, 2006; Morse, 2005; Ritchie, 1999) have recommended a mixed-method design or triangulation of research methods that combines surveys with qualitative processes. Tashakkori and Teddlie (1998) organized different types of mixed-method research into three major categories: (a) an equal-status mixed-method design with quantitative and qualitative surveys, (b) a dominant–less dominant mixed-method design in which one of the methods is dominant and "a small component of the overall study is drawn from an alternative design" (p. 44), (c) a design with a multilevel use of

Table 8

Highlights of Unique Knowledge Base and Skill Sets for OTs, PTs, and RNs

(OTs)	(PTs)	(RNs)
A health professional concerned with promoting health and well-being through occupation. Occupation refers to everything that people do during the course of everyday life. (CAOT, 2003, p. 1)	Physical Therapy is dedicated to: Improving and maintaining functional independence and physical performance; Preventing and managing pain, physical impairments, disabilities and limits to participation; and Promoting fitness, health and wellness. (CPA, 2006, p. 1)	Nursing practice is a synthesis of the interaction among the concepts of person, health, environment and nursing. It is a direct service provided to a variety of patient/client populations throughout the life cycle. . . . Caring is an integral part of this service. Nursing services are offered to individuals, groups, families and communities in the areas of practice, management, education, research and counselling. (CARNA, 2003, p. 2)

Note. See Appendix C for expanded descriptions.

approaches in which “data from more than one level of organizations or groups are used” (p. 48). The timeline for each of these three mixed-method approaches can be either sequential or simultaneous. Todd, Nerlich, McKeown, and Clarke (2004) further elaborated on the strengths of the different research approaches. Describing quantitative research as involving hard, reliable data and viewing the “social world as external to the observer” (p. 3), whereas qualitative methods tend to “use rich data and see the social world as being constructed by the observer” (p. 3).

I used a web-based quantitative survey method that increased the speed of response, decreased survey costs, and decreased the respondents’ burden because

they were able to access and complete the survey on their own time (Dillman & Bowker, 2000; Douglas, 2005; Klein, 2002). Focus groups allowed the participants in my study freedom to describe and explain their perceptions of structural empowerment, psychological empowerment, *SAW*, resonant leadership, job satisfaction, and organizational commitment in their workplaces (Morse & Field, 1995), and thus to clarify their responses. The triangulation of research methods by using focus groups to illuminate context, will impart further richness and validation to the quantitative data collected through the web-based survey method (Bryman, 2006).

Research Questions

I conducted a systematic review of the literature to answer question 1: What is the relationship between structural empowerment in a health care organization and the psychological empowerment of practicing health professionals in both staff and management positions?

i) Is overall structural empowerment in a health care organization associated with overall psychological empowerment of practicing RNs in both staff and management positions?

ii) What is the strength of the relationship between the four job-related empowerment structure subscales of *opportunity*, *information*, *resources*, and *support* and overall psychological empowerment?

iii) What is the strength of the relationship between overall structural empowerment and the four psychological empowerment subscales of *meaning*, *competence*, *self-determination*, and *impact*?

I used a survey method and SEM analysis to investigate the answers to question 2: How are resonant leadership; the demographic variables of experience, education, and rank; the structural empowerment components of support, information, resources, and opportunity; the psychological empowerment components of meaning, competence, self-determination, and impact; and the *SAW* components of *engaging work*, *sense of community*, *spiritual connection*, and *mystical experience* associated with job satisfaction and organizational commitment for (a) RNs, (b) OTs, (c) PTs (public practice), and (d) PTs (private practice) within the province of Alberta?

I conducted separate focus groups to answer question 3: What do health professionals (RNs, OTs, and PTs) perceive as contributing to their personal *SAW* in the workplace?

Significance of the Study

The construct of *SAW* is surfacing in the literature as an important component of healthy workplaces. This research sets apart *SAW* as a unique aspect of the work environment, which existing workplace empowerment research has not already captured. Demonstrating that *SAW* contributes unique attributes to an empowered and productive work environment will assist managers in creating a healthy work environment that facilitates improved patient outcomes.

One solution to increasing health caregiving complexity identified in the literature is the growing development of interdisciplinary teams in which each team member contributes specialized expertise to the care of the complex client (McCallin, 2003; Temkin-Greener, Gross, Kunitz, & Mukamel, 2004). Lessons

learned from research with nursing professionals such as in the UWO Workplace Empowerment Research Program can be applied to other members of the health care team such as PTs and OTs. The Work Empowerment Research Program (Laschinger, 2008b) has a well-validated record of identifying health care workplace concerns within many different settings. The current research is one important step towards uncovering the components of a healthy workplace for RNs, OTs, and PTs.

The reduction of illness and disability in the health care workplace is essential if quality and cost-efficient health care is to be provided to the consumer (CIHI, 2001). Previous health care restructuring has decreased the resources available to care providers during a period in which a corresponding complexity of client needs related to advancing technology and a rapidly aging population has occurred (CIHI, 2001). At the same time, magnet hospital research has revealed that RNs' burnout related to increasing workplace stresses have a significant relationship to patient outcomes (Scott et al., 1999). This research will help to fill the gap in research for RNs, OTs, and PTs within the health care environment in Alberta.

Finally, managers as leaders set an example for staff to follow. In evaluating and discussing *SAW*, health care managers are saying that spirit is a significant component of the health care workplace—whether it be related to clients, peers, supervisors, or subordinates. This is the first step towards increasing *SAW* in individual workplaces.

Operational Definitions

Structural empowerment: Six components that must be present in the organization to empower the staff. According to Kanter (1977, 1993), there are two systematic sources of power in organizations:

Formal power: Associated with jobs that are "visible and central to the purpose of the organization and allow for discretion in decision making" (Miller et al., 2001, p. 1882).

Informal power: Derived from relationships or alliances with superiors, peers, and subordinates (Miller et al., 2001, p. 1882).

Formal and informal power facilitate access to the following job-related empowerment structures:

Opportunity: Includes autonomy, growth, a sense of challenge, and the chance to learn and grow (Laschinger, 2004).

Information: The data, technical knowledge, and expertise required to function effectively in one's position (Laschinger, 2004).

Support: Feedback and guidance received from superiors, peers, and subordinates (Laschinger, 2004).

Resources: The materials, money, supplies, equipment, and time necessary to accomplish organizational goals (Laschinger, 2004).

Psychological empowerment: Composed of the following four cognitions that reveal an orientation towards work that reflects the individual's desire and ability to "shape his or her work role and context" (Spreitzer, 1995, p. 1444):

Meaning: A fit between job requirements and beliefs, or the value of a work objective compared to an individual's own ideals or standards.

Competence: An individual's confidence or belief in abilities to perform activities with proficiency.

Self-determination: A sense of choice or control over one's work/and the commencement and maintenance of work activities in the workplace.

Impact: The sense of being able to influence important outcomes at work. It is the reverse of learned helplessness (Spreitzer, 1995).

Spirit at work (*SAW*): The experience of individuals who are passionate about and energized by their work. It is composed of the following:

***Engaging work*:** Cognitive dimension characterized by a profound feeling of well-being (Kinjerski & Skrypnek, 2004, p. 20).

***Sense of community*:** Interpersonal dimension characterized by a feeling of connectedness to others and common purpose (Kinjerski & Skrypnek, 2004, p. 20).

***Spiritual connection*:** Spiritual dimension characterized by a sense of connection to something larger than self (Kinjerski & Skrypnek, 2004, p. 20).

***Mystical experience*:** Mystical dimension characterized by a positive state of energy or vitality, a sense of perfection, transcendence, and experiences of joy and bliss (Kinjerski & Skrypnek, 2004, p. 20).

Resonant leadership: Consists of four leadership styles that reflect leaders who build harmonious work environments and support staff success: (a) visionary

leaders, who "move people towards shared dreams by sharing knowledge and influence that empowers others to act and innovate" (Cummings, 2004, p. 77); (b) coaching leaders, who focus on developing others; (c) affiliative leaders, who build strong relationships with their employees; and (d) democratic leaders, who build consensus, promote innovation, teamwork and collaboration (Cummings, 2004).

Job satisfaction: Represents a summary of the favourableness of various aspects of the job, or "a discrepancy between how much a person wants or expects from the job and how much the person actually receives" (Laschinger, Shamian, & Thomson, 2001, p. 212).

Organizational commitment: An affective or emotional attachment to and involvement in the organization that "(a) characterizes the employee's relationship with the organization and (b) has implications for the decision to continue or discontinue membership in the organization" (Meyer et al., 1993, p. 539).

CHAPTER 3:

METHODS

Mixed-Methods Research Design

The data collection methods in this research consisted of a systematic review of the research literature; a descriptive, cross-sectional, multimodal design of postal and Web-based surveys distributed to a randomly selected sample of RNs, OTs, and PTs; and three focus groups consisting of RNs, OTs, and PTs. A systematic review of the research literature to investigate the relationship between structural and psychological empowerment provided essential theoretical strength to the ensuing quantitative and qualitative research. This explanatory mixed method approach (Cresswell & Clark, 2007) was highly weighted toward the quantitative survey (web-based and postal mail-out) of a large sampling of RNs, OTs, and PTs who were either practicing in the public system (PT public) or working in private practice (PT private) across Alberta. I integrated the quantitative/qualitative approach by using the information from an open-ended question at the end of the survey and from three discipline-specific focus groups to further clarify and confirm the results from the dominant quantitative survey method.

Survey

Sample Size Calculation

The sample size was calculated, based on the initial research question about the relationships between structural empowerment, psychological empowerment, the workplace outcomes of job satisfaction and organizational

commitment, and the variable *SAW* as well as the population demographic variables. Examination of the Workplace Empowerment Model, the *SAW* model, and the demographic variables revealed 14 variables to be investigated, which thus required a sample size of between 70 and 140 subjects. The 14 variables that I measured were *SAW*, structural empowerment, psychological empowerment, job satisfaction, organizational commitment, resonant leadership, impact, self-determination, meaning, competence, level of education, organizational rank, years at current position, and age of employee (Appendix D).

Warren (2003) recommended using the formula: $n = \underline{L/f^2} + k + 1$

Where $f^2 = R^2/1\text{-}R^2$, K = number of variables, and R^2 = variances declared to be significant.

$R^2 = 20\%$

$n = L/0.2/0.8 = L/0.25 = k = 1$

Where k = 14, Power = 0.8, L = 18.34, alpha = 0.05, Sample Size = 88.36

Norman and Streiner (2000) suggested that a sample size of 5 to 10 subjects per variable being measured is adequate. To ensure that I obtained an adequate sample size for the survey from accessible professionals, I required a minimum of 140 subjects (14 parameters x 10 subjects/ parameter = 140) to respond. However, a response rate of 30% for survey-type research is considered a good response (Baruch & Holtom, 2008; Portney & Watkins, 2000). Consequently, 467 (140 x 10/3) questionnaires were sent to randomly selected RNs, 467 were sent to randomly selected OTs, and an additional 467 were sent to randomly selected PTs in public practice and 467 to PTs in private practice in

Alberta. These numbers were aimed at an adequate final response rate of 140 subjects for each professional group (Appendix D).

Sample Criteria

Provincial professional associations within the province of Alberta approached randomly selected RNs, OTs, PTs (private and public) from those eligible for the study. Individuals were eligible for this study if they were OTs or PTs with a valid e-mail address and registered with their professional association or if they were RNs registered with their professional association with an up-to-date postal address. In 2007, 2,070 PTs (public and private practice) were registered with the College of Physical Therapists of Alberta (CPTA), and 75% had e-mail access. The Alberta College of Occupational Therapists (ACOT) reported that 90% of its 1,385 members had access to e-mail, and the College and Association of Registered Nurses of Alberta (CARNA) reported that approximately 60% of their 28,820 members had e-mail access. The surveys returned after the designated dates were excluded.

Limitations of Sampling Criteria

The OT and PT professional associations were unable to provide 100% of their members' e-mail addresses, which introduced a potential response bias into the final survey results. The professionals excluded from the selection of the random sample may have responded differently from the respondents with e-mail addresses.

Missing Data

Fifteen respondents (PTs) did not answer the questions on resonant leadership. Ten respondents described themselves as being in an out-of-scope position or in private practice and commented that they could not answer this question because it did not apply to them. I used pairwise deletion of missing data for the data analysis.

I did not use four RN surveys from the sample for the analysis. Three randomly skipped multiple questions (12%, 28%, and 39% of the total questions), and the fourth RN responded solely to the comments section (I included the comments in the analysis). I also did not use two PT responses. One missed randomly distributed questions (17% missing data), and the second responded only to the demographics. I removed two OT questionnaires from the survey because the respondents randomly skipped a large number of questions (16% and 57% missing data). Again all comments were included in the analysis.

Twenty-one RNs did not respond to the question on the number of years in professional practice on the paper questionnaire, which reveals an apparent lack of clarity in the construction of the mail-out paper questionnaire. Because this was only 14% of the total RN questionnaires—less than the 15% to 40% that Polit and Beck (2008) recommended as a guideline for deletion of the variable—I used pairwise deletion.

Survey Instruments/Measurement Tools

I conducted the survey by using a standard questionnaire (Appendix G) composed of the 19-item Conditions for Work Effectiveness Questionnaire II

(CWEQ) questionnaire (H. K. S. Laschinger, personal communication, May 1, 2006) that measures staff perceptions of their access to six workplace empowerment structures that Kanter (1977) identified: opportunity, information, support, resources, formal power, and informal power; a 12-item scale that measures Spreitzer's (1995) psychological empowerment dimensions of meaning, competence, self-determination, and impact; the 18-item *SAW* (Kinjerski, 2004) survey questionnaire with the four factors of *engaging work*, *sense of community*, *spiritual connection*, and *mystical experience*; the resonant leadership scale (Estabrooks, Squires, Cummings, Birdsell & Norton, 2009) with 10 questions that cover the components of openness, integrity, optimism, team achievement, self-control, empathic, developing others, conflict management, vision, and empowerment; and a short questionnaire on the employee's organizational rank, years of professional experience, education, and professional discipline—RN, OT, PT private, or PT public. The outcome variables were determined by a four-item scale that measures overall job satisfaction; and a six-item scale measured affective organizational commitment. See Table 9.

Survey Process

I received e-mails from Dr. H. Laschinger, Dr. G. Spreitzer, Dr. V. Kinjerski, and Dr. G. Cummings (Appendix E) granting permission to use the questionnaires in my proposed research.

Table 9

Psychometric Properties of Survey Tools

Tool	Measurement	Scoring	Reliability	Validity
CWEQ—II (Laschinger, 2008b)	19 items composing 6 subscales (opportunity, information, support, resources, formal power and informal power)	Scores summed to create total structural empowerment score Likert scale (1-5) for each item Items are summed and averaged to provide a score for each subscale ranging from 1-5	a = 0.78 – 0.93 over 12 separate studies Individual items α = 0.55 – 0.83 Subscales α = 0.71 – 0.95	Second order confirmatory factor analysis construct validity. X^2= 279, df = 129, CFI = 0.992, IFI = 0.992, RMSEA = 0. 054
Psycho-logical empower-ment (Spreitzer, 1995)	12 items composing four subscales of meaning, competence, self-determination and impact	Scores of subscales summed to create total score. Higher scores represent higher empowerment Likert scale (1-7) for each item. Items are summed and averaged for each subscale	Total psychological empowerment α = 0.62 – 0.72 Test-retest among subscales α = 0.79 – 0.85 ($p < .05$) with tests 5 months apart	Factor analysis (convergent and divergent validity) AGFI = 0.93 – 0.87, RMSR = 0.04 – 0.07, NCNFI = 0.9 7 – 0.98.
SAW (Kinjerski & Skrypnek, 2006)	18 items composing four subscales of *engaging work*, *sense of community*, *mystical experience* and *spiritual connection*	Scores of 4 subscales summed to create *SAW* score. Higher scores represent higher perceptions of *SAW* Likert scale (1 – 6) for each item	Total *SAW* α = 0.93 Four subscales α = 0.86 – 0.9.	Cross-validation comparison of two samples Factor loadings 0.56 – 0.99 Subscales and total scale significantly correlated Face/content validity

(table continues)

Tool	Measurement	Scoring	Reliability	Validity
Resonant leadership (Estabrooks, Squires, Cummings, Birdsell & Norton, 2009)	10 items measuring components of resonant leadership	Likert scale (1 – 6) for each item Means of those who answered (1) – (5) used as resonant leadership score	High internal consistency for total scale α = 0.95	Face/content validity Correlations between variables above 0.5, most above 0.6.
Job satisfaction (Quinn & Shepard, 1974)	Four items from job satisfaction index	Likert scale (1-7)	Internal consistency of items α = 0.72	
Organiza-tional commitment (Meyer et al., 1993)	Six item modified affective organiza-tional commitment scale	Likert scale (1-7)	Six item scale α = 0.74 – 0.85	Face and content validity

Pilot Study

I piloted the survey on a convenience sample of six human service professionals who were not members of the study samples and were computer literate. Three weeks were allowed for the distribution, return, and analysis of the pilot survey prior to starting the formal survey. I asked the participants to comment on the general format of the questionnaire and used the pilot survey to identify errors or concerns about the administration of the questionnaire, such as whether the instructions for filling out the questionnaire were clear. Piloting also assisted in testing the strategy for distributing the questionnaire to the respondents and back on the Web survey tool (Boynton, 2004).

The pilot study revealed a concern with the return of a complete set of responses to the Web-based questionnaire. I originally designed the questionnaire in two sections that required the respondents to make a choice to exit or continue after the first section. If they chose to submit the first section and exit, the questionnaire was closed and stored in the server. The respondent would then be unable to re-enter and complete the questionnaire. I removed the choice to exit after the first section, and the final version of the revised Web-based questionnaire required the respondents to complete the entire survey before submitting the questionnaire and exiting the Web site, eliminating the afore-mentioned concern.

Sampling Method

I decided to stratify all four professional groups according to place of residence (urban or rural) based on recommendations from provincial professional associations. Urban falls within the boundaries designated by the professional association for Calgary and Edmonton, and rural refers to the remainder of the designated professional population within Alberta. CARNA randomly selected a stratified urban/rural sample of 467 RNs from the 28,820 RNs in Alberta. The Alberta College of Occupational Therapists (ACOT) randomly selected a stratified sample of 467 OTs from 1,385 OTs in Alberta. CPTA randomly selected a stratified urban/rural sample of 467 PTs private from the 736 PTs private across Alberta and a stratified urban/rural sample of 467 PTs public from the 1,334 PTs public across Alberta.

I was unable to obtain e-mail access to the RNs; thus CARNA sent a postal mail-out introductory letter (Appendix F) to the RN sample during the first week of September 2007. ACOT and CPTA sent the e-mail introductory letter to the OT, PT private, and PT public samples during the second week of September 2007 and requested that the participants complete the Web-based survey within six weeks. I placed a reminder, instructions for access, and a thank you note in the CARNA and ACOT newsletters within two weeks of the initial information distribution. Approximately two weeks after the initial information distribution CPTA sent an e-mail reminder (Appendix F) to both PT sample populations because the distribution timetable of their professional newsletter did not coincide with the survey distribution. CARNA, ACOT, and CPTA sent a second mail-out postcard to RNs and an e-mail to OTs and PTs (private and public) approximately four weeks after the initial distribution of the survey questionnaires.

The inadequate number of responses to this initial distribution to the RN and OT samples required a second distribution of the questionnaires six months later. CARNA sent an identical RN sample a postal mail-out in the second week of May 2008, with a copy of the original introductory letter, a copy of the questionnaire (Appendix G), and a return envelope. In the third week of May 2008, ACOT sent the e-mail introductory letter to the Web-based survey to the identical sample of OTs, who completed the second OT survey through e-mail because I did not have access to the postal addresses of the initial OT sample. CARNA mailed reminder postcards (Appendix F) to RNs one week after the initial mail-out, and ACOT send reminder e-mails (Appendix F) to OTs two

weeks after the initial e-mail. The initial response to the survey from the PTs was adequate, and there was no second e-mail distribution to the PTs.

I used the following methods to increase the response rates: The university sponsorship lent credibility to the research, the individually printed and signed cover letter focused on the importance of the study and the respondent's reply, I informed the respondents that I would protect their confidentiality, and the use of a survey tool, Survey Gold, with professionally designed graphics and questionnaires, ensured greater ease and timely responses to the survey.

Data Inclusion and Data Entry

I set the completion date for the initial survey at October 26, 2007, although I accepted the completed questionnaires until November 12, 2007, from all four professional groups. Although the completion date for the second distribution was June 12, 2008, I accepted the questionnaires until June 25, 2008, from both RNs and OTs to allow for potential postal delays.

Survey Gold stored the response data on their server, located in the United States, and collated it into a database, from which I removed the data on a daily basis and located it in my database. Once I had removed the data, it was deleted from the server permanently, and I converted the data into SPSS. Numerous organizations throughout the world, including the University of New Brunswick, University of Regina, University of Saskatchewan, and University of British Columbia have purchased the Survey Gold tool, which Golden Hills Software (2006) has licensed for use.

Expected Response Rate for the Survey

The expected response rate of 30% was based on research showing that the return rate of computer-based surveys is similar to that of a mail-out questionnaire of between 30% and 60% (Portney & Watkins, 2000). This expected response rate is further supported by an analysis of 1,607 studies published between 2000 and 2005 in 17 refereed academic journals that displayed a response rate mean of 44.7%, with an SD of 21.8 for mail surveys; a response rate mean of 54.7% for e-mail surveys, with an SD of 23.9; and a response rate mean of 38.9%, with an SD of 15.1 for Web surveys (Baruch & Holtom, 2008).

Biases frequently associated with Web-based surveys include variability in the respondents' technical skills that can interfere with uniform responses to the survey and loss of responses if the instrument is not submitted properly or the internet connection is lost (Best & Krueger, 2004).

Statistical Analysis

I analysed the data, using descriptive statistics, to determine the extent of missing data and whether they were missing at random. The first step was to determine the frequency of missing values on a variable-by-variable basis. I performed pairwise deletion of the missing variables for causal modeling to ensure accurate representation of the results. Because an investigation of the survey data revealed no variables with 15% or more missing data, I retained all variables from the questionnaire (Polit & Beck, 2008).

I used the following methods to answer research question 2:

i) Descriptive statistics were calculated to characterize the sample in terms of the professional discipline of RN, OT, and PT within the public health care system or PT in a private practice setting; organizational rank; years at current position; age; and educational level. The survey demographics were compared with the provincial demographic data and Pearson's chi-square tests were used to determine whether the survey sample was representative of the data from the professional association and CIHI (2007a) that described the provincial population.

ii) LISREL 8.80 (Jöreskog & Sörbom, 1996) was used to test the theoretical model of relationships among resonant leadership (Cummings 2004): experience, rank and education, structural empowerment (Laschinger, 2008b); psychological empowerment (Spreitzer, 1995); SAW (Kinjerski, 2004); job satisfaction (Eisenberger, Cummings, Armeli, & Lynch, 1997); and organizational commitment (Allen & Meyer, 1996; Meyer, Irving, & Allen, 1998).

Focus Groups

I assembled three focus groups that consisted of separate and distinct gatherings of RNs, OTs, and PTs (equal numbers of public and private practitioners within this group) to discuss research question 3. The meetings consisted of a discussion about workplace empowerment and *SAW* with a group of five to eight health professionals who shared their personal experiences related to the research questions (Woodring, Foley, Santoro Rado, Brown, & Hammer, 2006). The conversations were audiotaped to ensure an accurate representation of

the discussion and I recorded the participants' comments on flipcharts to ensure integrity (accurate representation of the participants' contributions to the discussion). During the research documentation I stressed the need for transparency by checking with the participants to ensure that the focus group transcript and my analysis represented what they had said.

Sample

I asked professional associations to recommend a purposeful sample of professionals who were actively practicing within their profession and whom they felt could provide information characterizing their profession. I selected these group members for their discipline-specific knowledge and personal workplace experiences (as determined by the professional association). Because a limited sample was obtained through consultation with the professional association, e-mails were sent to managers of selected private and public health care organizations (recommended by professional associations) with an attached poster to recruit volunteers for the focus group. As Ritchie (1999) explained, "This form of research seeks the specific and the unique, and samples where it can learn most, rather than for representativeness or generalizability" (p. 255).

The selection of professionals who were actively practicing within their designated profession within Alberta resulted in a group with similar shared professional experiences, as the focus group literature recommended (Woodring et al., 2006). Morse and Field (1995) supported the establishment of three separate discipline-specific focus groups because of the need for a relatively

homogenous group, since the goal is "to encourage individuals to share their ideas and perceptions" (p. 32).

Eight volunteers participated in the OT focus group, and the RN and PT group each consisted of five volunteers. The group size of five to eight was small enough for everyone to participate in discussions, but still large enough to allow the sharing of diverse ideas and opinions (Morgan, Krueger, & King, 1998).

Preparation of the Participants

I contacted all of the participants by phone or e-mail to explain the research project, gave them the dates and times of the focus group, and then I sent all participants a follow-up e-mail reminder of the focus group meeting, stating the location, time, and purpose.

Group Environment

The RN, OT, and PT focus groups were held between November 2007 and May 2008. I had advised the participants to set aside two hours for the meeting, and I provided snacks and drinks. A quiet room with minimal outside interference within Corbett Hall at the University of Alberta was secured for the meetings. The group was seated around a table to encourage the open participation of all members in the discussion. Before asking the group members to sign an informed consent form, I discussed maintenance of their anonymity, their voluntary participation in the group discussion, and their freedom to leave at any time without penalty. The participants were asked to print their first names on blank name tags and to turn off their cell phones prior to the commencement of the group.

Group Process

I facilitated and centered the focus group discussion on clearly formulated research questions and a previously developed interview guide. Themes from the survey were used to guide the development of structured questions that introduced the topics for discussion and secondary questions that were used for probing (Stewart, Shamdasani, & Rook, 2007):

1. Tell us your name and where you live.
2. Could you describe a healthy workplace?
3. When you think of leadership, what comes to mind?
4. When you think of workplace empowerment, what comes to mind?
5. Think back to your most memorable job, or last job. What made it memorable?

Potential probes included (a) challenging work; chance to gain new skills and knowledge, opportunity to use all your own skills and knowledge; (b) access to information about current state of the hospital, values and goals of top management; (c) access to support; for example, information about things you do well, comments about things you could improve, helpful hints, or problem-solving advice; (d) access to adequate resources; for example, time adequate to do necessary paperwork and/or job requirements and temporary help when needed; (e) collaboration on patient care with physicians; (f) being sought out by management/peers for help with problems; and (g) seeking out ideas from other professionals.

6. How did you feel when you worked there?

Potential probes included (a) confidence about your ability to do your work, (b) your work was important to you, (c) autonomy in determining how the job is done, (d) large impact on department, (e) found meaning or purpose at work, (f) experience a real sense of trust and personal connection with your co-workers, (g) experience an energy or vitality at work that is difficult to describe at times, and (h) experience a connection with a greater source that has a positive effect on your work.

7. Were there work conditions present in this organization which could have been changed to make it a healthier place to work? If so, what were they and why would you change them?
8. Most of us spend about 1/3 of our adult lives in work-related activities. I'm trying to identify the relationship between an employee who is happy and productive at work and the actual workplace environment. What advice would you have for me?

Although fostering group interaction on the questions and the related topics described within the quantitative research was my primary goal, I was also prepared to allow the participants to approach topics that were related to the research questions, but not anticipated or reflected in the protocol (Morgan et al., 1998).

The group members were informed at the beginning of the session that the proceedings of the group would be audiotaped. The outcomes of the discussions were posted on the walls and reviewed with the participants as we completed each discussion topic to verify that they accurately reflected the discussion. At the end

of the group discussion I asked all participants whether they had anything more to add (Donalek, 2005).

Data Analysis

Transcript Preparation

Following the focus group, I transcribed the audiotapes and reviewed the transcripts to fill in gaps and missing words, as well as to correct spelling and typographical errors. I limited the editing of the transcripts in order to maintain the character of the responses. Each transcript was e-mailed to the pertinent focus group member for member checking (Loiselle, Profetto-McGrath, Polit, & Beck, 2007) to ensure accuracy and the credibility of the data, and the group members were asked to submit their feedback by e-mail. Each member's feedback on gaps and missing words was incorporated into the data after consultation with that individual.

Scissor-and-Sort Technique

I reviewed, compared, and categorized the transcript material using N-Vivo (qualitative research software with purpose-built tools for classifying, sorting, and arranging information) according to the constructs identified in the literature of structural empowerment (Laschinger, 2004), psychological empowerment (Spreitzer, 1995), *SAW* (Kinjerski, 2004), leadership (Cummings, 2004; Upenieks, 2003), job satisfaction (Eisenberger et al., 1997), and affective organizational commitment (Allen & Meyer, 1996; Meyer et al., 1998). Coded material consisted of "phrases, sentences, or long exchanges between individual respondents. The only requirement [was] that the material [was] relevant to the

particular category with which it [was] identified" (Stewart et al., 2007, p. 116). This sorted text was then incorporated into an overarching interpretive analysis of each topic discussed in the focus group process by using the transcribed text as supporting evidence (Stewart et al., 2007).

Finally, I identified issues and categories within the analyzed focus group transcript material and linked them with the related survey data according to each research question. A professor in the Faculty of Rehabilitation Medicine reviewed and compared the transcripts and the sorted text. This independent colleague check of the key constructs identified within the focus group transcripts lent additional reliability to my interpretation of the group themes. A final member check meeting with the focus group participants was scheduled to share the final sorted text from the focus group and ensure that the completed documentation represented the participants' views. I integrated the transcribed and sorted text from the focus group with the quantitative research results to give additional context and depth to the final documentation.

Ethical Considerations

The Health Research Ethics Board, University of Alberta (HREB), reviewed and approved the project before the study commenced. I offered the respondents a summary of the results of the finished research if they forwarded their request and e-mail/postal address to me. Copies of the final research will be placed in the CARNA, CPTA, and ACOT libraries.

Survey

The questionnaire was accompanied by a cover letter (Appendix F) in which I assured the participants' confidentiality and anonymity and informed them that their participation in the study was voluntary. The letter also introduced me as the researcher, the research project, the anticipated results of the research, the research process, and the timelines. My phone number, the Associate Dean of Graduate Studies for Rehabilitation Medicine phone number, and the HREB phone numbers for any questions about the research were included in the letter.

I maintained the confidentiality and anonymity of the respondents throughout the survey process, and I did not identify ownership of the individual responses to the Web-based survey, thus ensuring anonymity. The Survey Gold software includes processes to ensure that the respondents are not identified, all data are kept confidential, and anonymity is maintained. I will keep the SPSS data retrieved from Survey Gold and the completed questionnaires in a locked file for seven years. The participant consent form (Appendix F) described the steps that were taken to ensure confidentiality.

Focus Group

The participants signed the informed consent form (Appendix F) prior to the focus group commencement, and I have maintained their anonymity. The form described the steps that I have taken to ensure confidentiality. Only I had access to the recruitment information, including names, e-mail addresses, and phone numbers; and I destroyed this information at the conclusion of the project (Morgan et al., 1998). The identities of the participants were hidden and I did not

use their names in the transcription and final documentation. Only I had access to the tapes after the transcription was completed, and I will keep the tapes for seven years after the conclusion of the project. I either removed or modified names and other potentially identifying information in the transcripts.

I reiterated the voluntary nature of the participation both prior to and throughout the focus group, and no one was obligated to answer any of the questions that were asked. The participants were informed that they could take a break at any time if they felt uncomfortable and that they did not need to offer an explanation (Morgan et al., 1998). The final report for the focus group contained as few identifiers as possible to ensure the respondents' anonymity. For example, only aggregate information on the demographics of the group was presented. The participants were identified at the end of each quotation by an assigned number. I explained fully to the participants prior to the commencement of the focus group that in qualitative research confidentiality cannot be assured if the participants' words are quoted, and the consent forms informed them that I might use some of their words in the final reports (Morse & Field, 1995).

Structural Equation Model and Theory Development

LISREL 8.80 (Jöreskog & Sörbom, 1996) was used to test the theoretical model of relationships among resonant leadership (Cummings 2004): experience, rank and education, structural empowerment (Laschinger, 2008b); psychological empowerment (Spreitzer, 1995); job satisfaction (Eisenberger, Cummings, Armeli, & Lynch, 1997); organizational commitment (Allen & Meyer, 1996; Meyer, Irving, & Allen, 1998); and *SAW* (Kinjerski, 2004). The development of

the initial model was based on the review of the literature and my experience of over three decades in health care.

I theorized that resonant leadership has a direct influence on structural empowerment, which consists of opportunity, information, support, and resources; and *SAW*, which consists of *engaging work*, *sense of community*, *spiritual connection*, and *mystical experience*. Experience, rank, and education have direct effects on the psychological empowerment components of self-determination, impact, competence, and meaning. I also theorized that the components of structural empowerment have a direct effect on the components of psychological empowerment, which, in turn, have a direct influence on the components of *SAW*. Furthermore, I theorized that resonant leadership, the components of psychological empowerment, and the components of *SAW* have a direct effect on both job satisfaction and organizational commitment.

Separate causal modeling was used to apply the initial theoretical model in Figure 3 to each of the three separate groups of RN, OT, and PT public. Since PT private are frequently in private practice, resonant leadership and rank were removed from Figure 3 and the resultant model was applied to the PT private sample data. Separate modeling was used for each discipline to account for the differences in professional history, culture and practices between the respective disciplines. Although all of the variables had three or more indicators, I used a single indicator for each of the 18 variables included in the study, because of the limited sample size. I chose an indicator to represent each variable based on item clarity and a match with the theoretical understanding.

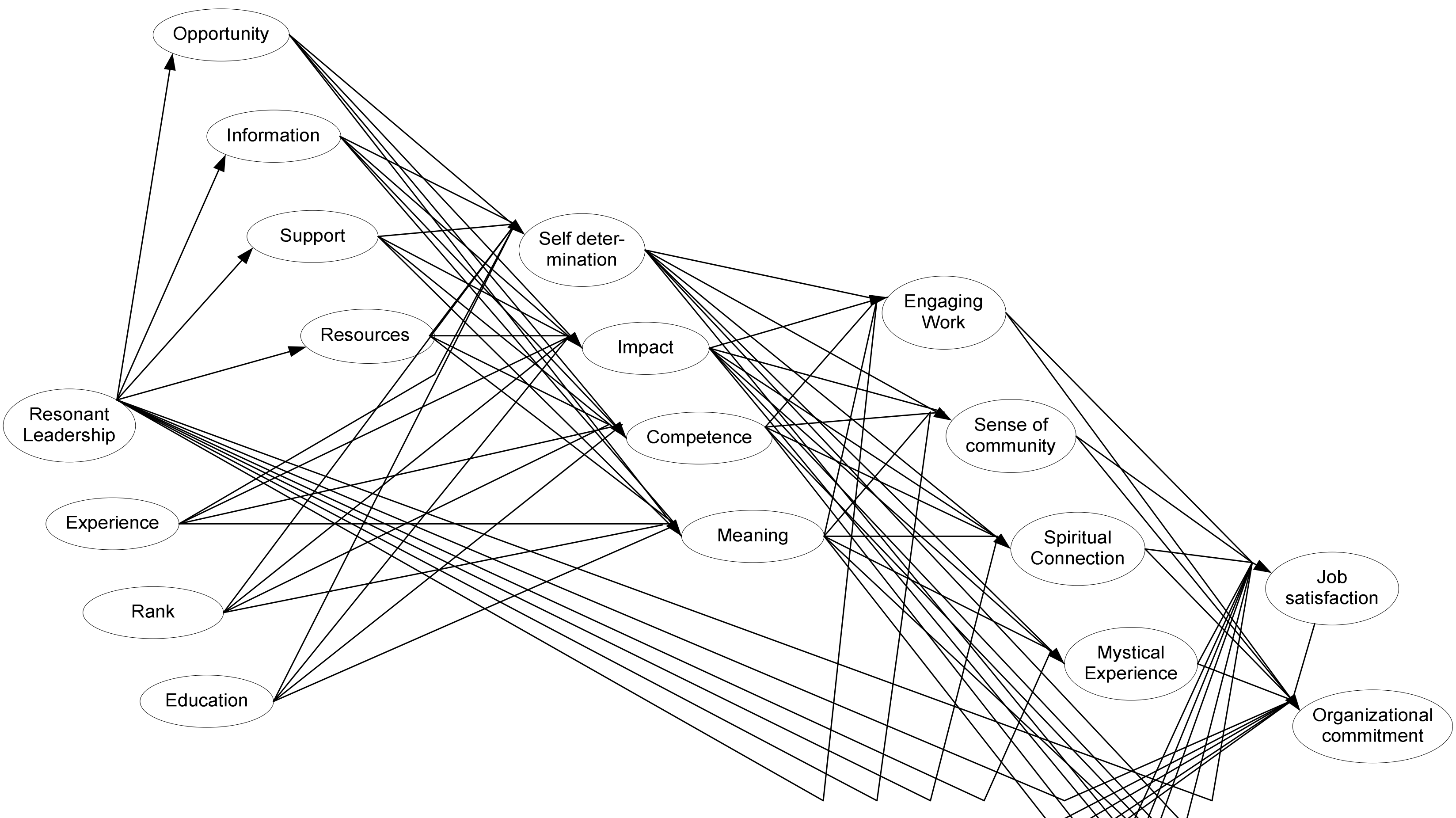

Figure 3. Theoretical model.

I specified and scaled the latent variables using a fixed 1.0 loading and the fixed measurement error variance shown in Table 10. A resonant leadership error variance of 20% was used to investigate the RN sample in contrast to the error variance of 35% that was used with the OT and PT public sample. The smaller error variance was used for RNs because the resonant leadership construct arose from research conducted on Canadian RNs (Cummings et al., 2008), while there has been no documented research on resonant leadership for OTs or PT public.

Model Development

Testing the Model

I used LISREL 8.80 (Jöreskog & Sörbom, 1996) to calculate a chi-square for the structural equation model for:

a. RNs of 348.61 ($p < 0.00$, $df = 76$),
b. OTs of 152.05 ($p < 0.00$, $df = 76$),
c. PT public of 261.2 ($p < 0.00$, $df = 76$) and ,
d. PT private of 268.05 ($p < 0.00$, $df = 69$).

These calculations indicated that the model did not fit the data. Review of the initial model revealed that it did not account for interactions between each of the separate concepts within the constructs of structural empowerment, psychological empowerment, and *SAW*. I had not sufficiently integrated the existing theory into my model and further extensive revisions were required.

Model Modifications

I used a standard protocol to determine what modifications to make to the final model. This protocol involved an initial look at the overall theory guiding

Table 10

Measurement Error Specification for the Latent Variables in the SEM for RNs, OTs, PT (Public), and PT (Private)

Latent variable	Survey item	Measure-ment error	Variance (Error variance)			
			RN	OT	PT pub	PT priv
Resonant leadership (OT and PT)	The leader in my clinical program or unit actively listens, acknowledges, and then acts on requests and concerns.	35%		1.292 (0.452)	1.281 (0.448)	
Resonant 1eadership (RN)	The leader in my clinical program or unit actively listens, acknowledges, and then acts on requests and concerns	20%	1.585 (0.317)			
Experience	Total number of years in professional practice.	15%	1.271 (0.191)	1.042 (0.156)	1.224 (0.184)	1.355 (0.204)
Rank	Your position in the organization.	25%	0.103 (0.026)	0.166 (0.042)	0.125 (0.031)	
Education	Highest level of education you have completed.	5%	0.429 (0.021)	0.126 (0.006)	0.310 (0.016	1.005 (0.053)
Opportunity	How much opportunity do you have in your present job to gain new skills and knowledge.	10%	0.974 (0.097)	0.867 (0.087)	0.877 (0.088)	0.872 (0.087)
Information	How much access to information do you have in your present job? The values of top management.	10%	1.469 (0.147)	1.493 (0.149)	1.470 (0.147)	1.90 (0.190)
Support	How much access to support do you have in your present job? Helpful hints or problem solving.	5%	1.079 (0.054)	1.113 (0.056)	1.229 (0.062)	1.493 (0.075)

(table continues)

Latent variable	Survey item	Measurement error	Variance (Error variance)			
			RN	OT	PT pub	PT priv
Resources	How much access to resources do you have in your present job? Acquiring temporary help when needed.	5%	0.921 (0.046)	1.259 (0.063)	1.241 (0.062)	1.526 (0.076)
Self-determination	I can decide on my own how to go about doing my own work.	5%	1.782 (0.089)	1.159 (0.058)	1.016 (0.051)	0.941 (0.051)
Impact	I have significant influence over what happens in my department.	5%	1.991 (0.100)	2.450 (0.123)	1.955 (0.098)	2.139 (0.107)
Competence	I have mastered the skills necessary for my job.	5%	1.375 (0.069)	1.007 (0.050)	1.254 (0.063)	1.102 (0.055)
Meaning	My job activities are personally meaningful to me.	5%	1.352 (0.068)	0.822 (0.041)	1.155 (0.058)	1.154 (0.058)
Engaging work	I am able to find meaning or purpose at work.	5%	0.846 (0.042)	0.485 (0.024)	0.695 (0.035)	0.689 (0.035)
Sense of community	I experience a real sense of trust and personal connection with my co-workers.	5%	0.846 (0.042)	0.822 (0.041)	0.944 (0.047)	0.730 (0.037)
Spiritual connection	I experience a connection with a greater source that has a positive effect on my work.	5%	1.790 (0.090)	1.668 (0.083)	1.783 (0.089)	1.695 (0.085)
Mystical experience	At times, I experience an energy or vitality at work that is difficult to describe.	5%	1.551 (0.078)	1.018 (0.509)	1.126 (0.113)	1.412 (0.071)
Job satisfaction	If a good friend of mine told me that he/she was interested in working a job like mine I would strongly recommend it.	10%	2.034 (0.203)	1.272 (0.127)	1.530 (0.153)	1.893 (0.189)
Organizational commitment	This organization has a great deal of personal meaning for me.	10%	2.179 (0.218)	2.249 (0.225)	1.725 (0.173)	2.746 (0.275)

Pub = public; priv = private

this research study and identifying important modifications that matched with theory.

After I was convinced that my model accounted for the important theoretical relationships within the model, I investigated each discipline separately. Selection of the discipline specific modification indices proceeded in the following order:

1. Identified the highest modification index revealed in the LISREL data analysis;
2. Compared the revision suggested by each index against my theory to ensure that it was theoretically sound;
3. A maximum of four modification indices were added to each discipline;
4. Z score of values of plus or minus 2 were considered to be significant because the sample size for each group was small and the available published research upon which to base results was limited. Any modification indices included in the model with Z scores between 1.96 and 2 were identified.

Modifications to the Overall Theoretical Model

After further careful study of the theory describing relationship among the latents, I made 14 sequential modifications, and the chi-square decreased to 99.01 ($p = 0.00196$, $df = 62$) for RNs, 91.85 ($p = 0.01494$, $df = 62$) for OTs, 109.48 ($p = 0.00019$, $df = 62$) for PT public and 76.56 ($p = 0.0311$, $df = 46$) for PT private. The fit for the model improved but was still not adequate.

My review of the literature revealed a relationship between rank and structural empowerment (Kanter, 1977, 1993), which suggested that rank may facilitate direct access to the structural empowerment components of opportunity, information, support, and resources. Sequential inclusion of these additional relationships increased the model fit for RNs (chi-square =72.76, df = 58, p = 0.089) for OTs (chi-square = 53.04, df = 58, p = 0.303) and for PT public (chi-square = 85.88, df = 58, p = 0.010). Although the fit for this revised model was considerably improved, this was still not a good fit. I decided to review the model and modification indices for each professional group separately.

A maximum of four modification indices were added to each model. Due to the small sample sizes, the complexity of the models, and the concern about the accuracy of additional effects, additional significant modifications were recorded for future investigation and excluded from the final model. Significant modification indices that indicated a relationship between the exogenous variables and SAW were not included in the final models since there was no theoretical support for these relationships in the literature.

Modifications to the Theoretical Model for RNs

Two additional relationships between resonant leadership and self-determination and information and job satisfaction were identified by the modification indices for RNs. Adding the modifications to the model in a sequential manner resulted in a good fit (chi-square =58.61, df = 56, p = 0.380). However, the estimate for information to job satisfaction suggested that increased information led to reduced job satisfaction. This did not make theoretical sense

and was contrary to the facts in the existing literature (Laschinger et al., 2004); therefore, I investigated one more modification index with a value over 4.0.

I investigated the estimated effect from rank to job satisfaction next. This effect implied that when staff move into management positions, their job satisfaction decreases. I turned to the literature to find answers for this puzzling potential relationship between rank and job satisfaction. A study of Ontario RN managers' health (Laschinger et al., 2004) reported that structural empowerment has an impact not only on psychological empowerment and RN manager health, but also on job satisfaction. This Ontario study described an environment with staffing shortages and rapid and overwhelming change, which made expectations and deadlines very difficult for managers to meet during a time of increased workload as a result of the SARS crisis (Laschinger, Finegan, Shamian, & Wilk, 2004). Other authors (Stengrevics, Kirby, & Ollis, 1991) claimed that staffing issues impeded performance of the managers' role, while a review of the health care environment in Alberta during my survey revealed nursing staffing shortages that undoubtedly had an impact on RN managers' job satisfaction. The large representation of management staff in this research sample suggested that this was an accurate representation of the impact of rank on job satisfaction; therefore, I maintained this relationship in the model.

Further study of the model showed a pre-existing significant causal effect leading from rank to information suggesting that the direct effect of information on job satisfaction prior to the addition of the causal effect between rank and job satisfaction was actually measuring the effect of rank on job satisfaction. Thus I

removed the proposed relationship between information and job satisfaction from the model, and these modifications resulted in a good fit (chi-square = 56.22, df = 56, p = 0.466). One modification index with a value over 4.0 (effect from experience to sense of community) remained after the analysis was completed.

Modifications to the Theoretical Model for OTs

The modification indices called for a strong significant relationship from impact to meaning, both components of psychological empowerment. This relationship, not included in the original theoretical model, suggested that OTs who have significant influence over what happens in their department consider their job activities personally meaningful. I considered this additional causal effect theoretically sound and added it to the model for OT.

The second significant relationship that was not included in the original model consisted of a significant relationship from resources to *mystical experience*. The suggestion that "the ability to acquire temporary help when needed" increased the OTs' perception of energy or vitality coincided with theory (Table 6), and was added to the model.

Another modification index pointed to a significant relationship from information to organizational commitment. This suggested that OTs with more information about the values and goals of top management and the current state of the organization felt a stronger commitment to the organization. This relationship appeared to be theoretically sound and was included in the final model.

The remaining modification index with a value over 4.0 pointed to a significant relationship from opportunity, or chance to gain new skills and

knowledge on the job, to *mystical experience*. This relationship appeared to be theoretically sound (Table 6), and was also integrated into the final model.

All of the preceding modifications made theoretical sense, and were added to the model sequentially, which resulted in a good fit (chi-square = 39.73, p-value = 0.927, df = 54). None of the remaining modification indices that described the intervening relationships between the exogenous variables and the outcome variables exceeded 4.0. This indicated that the addition of further coefficients to the model would not improve the model fit significantly. I considered the warning from LISREL about the small sample size for this analysis that resulted in unreliable parameter estimates and decided that this model may misrepresent the effects in a larger population. This study should be repeated with a larger sample size. However, since the model is similar to other health discipline models and the OT focus group discussion revealed similar concepts, I will continue to discuss this model as representing available OT data.

Modifications to the Theoretical Model for PT public

PT focus group results supported the addition of a significant modification index that indicated a direct relationship between information and the outcome variable of organizational commitment. Three strong, significant relationships from the variables measuring structural empowerment to the variables measuring *SAW* of opportunity and *engaging work*, resources and *spiritual connection*, and support and *engaging work*, confirmed the relationships that I previously identified through comparison of Kanter's (1977, 1993) structural supports that influence empowerment to Kinjerski's (2004) organizational characteristics that

foster *SAW* (Table 6). The analysis of the data from the study of PT public in Alberta gave further credence to the existence of a significant causal relationship between structural empowerment and *SAW*. All of these modifications made theoretical sense, and I added them to the model in a sequential manner, which resulted in a good fit (chi-square = 58.52, p = 0.313, df = 56). Seven additional modification indices with values over 4.0 remained in the LISREL analysis of the model for PT public in Alberta.

Application of Theoretical Model to PT Private Survey Data

Many PT private are in solo practice. I removed resonant leadership and rank from the theoretical model that I used to analyze the PT private responses because the PT private demographics revealed that 32.6% of the respondents were in management or out-of-scope positions.

Modifications to the Theoretical Model for PT Private

This study should be repeated with a larger sample size. However, since the model is similar to other health discipline models and the PT private focus group discussion revealed similar concepts, I will continue to discuss this model as representing available PT private data. The modification indices for the SEM analysis of the survey data indicated that support led to a *sense of community*, and the presence of organizational resources led to a feeling of support by PT private. The presence of information in the organization was perceived to lead to organizational commitment. Finally the PT private stated that sense of community was related to mystical experience. All of these modifications were statistically significant and made theoretical sense, consequently I added them sequentially to

the model, which resulted in a good fit (chi-square = 54.58, df = 44, p = 0.132). Four additional modification indices with significant values over 4.0 remained in the LISREL analysis of the survey data after I completed these modifications.

CHAPTER 4:

PRESENTATION OF FINDINGS

This chapter is divided into five sections and is focused on the presentation of the findings from questions 2 and 3. Section A describes the RN survey demographics, the survey group results, and the focus group results. Section B includes the OT survey demographics, survey results and the focus group results. Section C discusses the PT public and PT private survey demographics, and the focus group results. Section D presents a summary of the triangulation of research methods. Section E shows the SEM analysis of the RN, OT, PT public and PT private results. A summary of research results are provided in Section F.

Section A: RN Results

Survey

Demographics

The RNs returned 144 useable surveys, for a return rate of 31%. Comparison of RN survey demographics to the provincial demographics may be found in Table 11. Two by two Pearson's chi-square analysis of the demographic data for work location of the RN and age did not indicate significant differences between the survey and provincial data. However, analysis specified a significantly greater number of RNs in management for the survey sample than shown in the provincial data. Analysis of the education data also revealed a significantly larger proportion of RNs with master's or doctoral preparation (Table 11) for the survey sample.

Table 11

Comparison of RN Survey Demographics to Provincial Demographics

	Survey		Provincial		Significant chi squares	
Descriptor	%	N	%	N	Variable	Chi square
Work location						
Home care	10.8	16	14.1	3,646		
Acute care/hospital	59.5	88	65.1	16,845		
Long term care	10.1	15	7.8	2,005		
Rehab facility	2.0	3	--	--		
Community	7.4	11	12.9	[a]3,349		
Private practice	2.0	3	0.1	36		
Other [b]	9.5	14				
Organizational Position						
Staff	87.8	130	93.2	24,142	Staff by management	17.71***
Management	11.5	17	4.3	1,110		
Missing values	0.7	1	2.4	629		
Age						
< 30	8.8	13	11.5	2,983		
30-44	33.1	49	35.3	9,146		
45-55	31.8	47	33.7	8,701		
Over 55	26.4	39	19.5	5,051		
Highest level of education					Master's by diploma	15.41***
Diploma	55.4	82	56.9	14,739		
Baccalaureate	35.8	53	40.1	10,372		
Master's [c]	8.8	13	2.9	761	Master's by baccalaureate	16.87***
Missing data	0	0	.03	9		

[a] Listed under home care. [b] Includes direct care, education, research. [c] Includes doctoral degree.
Note. Home care data and community data were combined for RN.
*p ≤ .05; **p ≤ .01; ***p ≤ .001.

Responses to Likert-Style Questions

The means, standard deviations, and Cronbach's alpha calculated on the responses to the questions, classified according to the individuals and their subscale components, are displayed in Table 12. Cronbach's alphas calculated in Table 12 were similar to those in the literature (0.858 to 0.999).

Responses to Open-Ended Survey Question

Additional comments on *SAW*, workplace empowerment, or resonant leadership by *s*eventy-seven RNs (52%) were analyzed and grouped into categories that paralleled the survey questions: structural empowerment, psychological empowerment, *SAW*, resonant leadership, job satisfaction, and organizational commitment (Table 12). These comments gave me a greater depth of understanding of the responses to the Likert-type questions on the survey. Appendix H displays the content analysis of the responses.

Table 12

RN Mean, Standard Deviation, Reliability of Variables and Components and Survey Comments

Scales/subscales	Minimum-Maximum	Means (standard deviations)	Cronbach's alpha	Survey Comments	
				N	%
Structural Empowerment	**22.00-57.00**	**37.49 (7.69)**	**0.86**	**22**	**23**
Opportunity	4.00-15.00	11.85 (2.30)	0.78		
Information	3.00-15.00	8.56 (3.06)	0.87		
Support	3.00-15.00	8.66 (2.77)	0.83		
Resources	3.00-15.00	8.47 (2.23)	0.73		
Psychological empowerment	**30.00-82.00**	**61.41 (9.64)**	**0.88**	**9**	**10**
Competence	3.00-21.00	16.84 (2.87)	0.81		
Meaning	3.00-21.00	17.36 (3.27)	0.91		
Self-determination	3.00-21.00	14.70 (3.55)	0.74		
Impact	3.00-21.00	12.23 (3.74)	0.90		
SAW	**20.00-108.00**	**75.94 (15.14)**	**0.93**	**34**	**36**
Engaging work	8.00-42.00	31.68 (6.22)	0.87		
Sense of community	4.00-18.00	13.32 (2.61)	0.79		
Mystical experience	5.00-30.00	18.41 (5.12)	0.79		
Spiritual connection	3.00-18.00	12.41 (4.05)	0.88		
Organizational commitment	**6.00-42.00**	**22.98 (3.18)**	**0.86**	**8**	**9**
Job satisfaction	**4.00-28.00**	**20.18 (5.14)**	**0.93**	**4**	**4**
Resonant leadership	**10.00-59.00**	**37.67 (11.55)**	**0.96**	**17**	**18**

RN Focus Group

Appendix I contains the content analysis of the focus group discussion.

Demographics

This group of five RNs was a highly homogenous gathering of senior RN practitioners with greater than 20 years of experience in nursing. Two participants, between the ages of 45 and 55, had more than 20 to 30 years of experience. Two participants, between the ages of 45 and 55, had more than 30 years of experience. A single senior RN over the age of 55 with more than 30 years of experience also participated in the focus group.

One RN was an educator, another worked in long term care, two were in administrative roles, and one was a senior clinician in mental health. Their educational backgrounds included a diploma in nursing, a baccalaureate in nursing, two master’s degrees, and one doctoral degree.

Summary of Findings

The focus group results support and offer greater insight into the understanding of work-life issues. All of the participants referred to a variety of positive and negative workplace experiences throughout their careers, and considerable discussion focussed on the health care cutbacks of the mid 1990s. This cohort of RNs was well established in practice during the cutbacks in Alberta. Discussion of the impact of the cutbacks was very intense, and one RN reported that she had been “bumped” nine times and forced to seek professional counselling to help her to deal with the ensuing trauma. This dialogue on bumping in the workplace led to a related discussion on the prevalence of horizontal

violence in the current health care workforce, which forced a couple of RNs to seek alternate employment. Several participants cried when they related their personal experiences of experiencing conflict and negative relationships with their peer.

The group members agreed that all of the aspects included in the survey contribute to a healthy workplace environment. The RNs displayed a deep knowledge of and interest in spirituality and health care and linked the theme of spirit throughout their discussions of the workplace, mentioning the four components of *SAW* many times. All participants referred to a variety of positive and negative workplace experiences throughout their careers, but were satisfied with their current employment. This study demonstrates that the UWO workplace empowerment model (Laschinger & Finegan, 2005a, 2005b), with the inclusion of *SAW* (Kinjerski, 2004) and resonant leadership (Cummings, 2004), measures important aspects of the RN workplace.

Section B: OT Results

OT Survey

Demographics

The OTs returned 100 useable surveys, for a return rate of 21.5%. Comparison of OT survey demographics to the provincial demographics may be found in Table 13. Two by two Pearson's chi-square tests (Table 13) revealed a significant difference between acute care and home care, acute care and community, and acute care and "other" in the survey data for OTs. The survey data revealed a smaller percentage OT respondents in acute care and more OT in

home care, community, and “other” when compared to the provincial demographic data.

Although Pearson’s chi-square analysis of the OT demographic data on organizational position did not reveal a significant difference in the organizational position of the OT, it is important to note that CIHI’s (2007b) data included only 540 listings for respondents, with the remaining 853, or 60.8%, listed as missing values under the category of organizational position. This absence of respondents may have biased the research results.

Investigation of the data, using Pearson’s chi-square revealed a greater percentage of OTs in the younger than 30 age group and proportionately more OTs in the 30 to 44 age group and the 44 to 55 age group and fewer in the older than 55 age group than did the provincial demographic data (Table 13).

Pearson’s chi-square analysis of the OT educational data revealed a significant difference in the education of the OTs between the survey data and provincial data (Table 13). The survey data revealed a larger percentage of OTs with master’s or doctoral preparation than did the provincial data This resulted in a biased sample.

Table 13

Comparison of OT Survey Respondents to Provincial Demographics

	Survey		Provincial		Significant chi squares	
Descriptor	%	N	%	N	Variable	Chi-square
Work location						
Home care	20.8	15	11.0	153	Acute by home care	4.86*
Acute care/hospital	23.6	17	24.8	346	Acute by community	10.71**
Long term care	11.1	8	5.2	73		
Rehabilitation	6.9	5	6.8	95	Acute by other	6.99**
Community	13.9	10	5.1	71		
Private practice	4.0	4	35.3	492	Community by rehab	6.16*
Other[a]	22.2	16	11.8	165		
Organizational position						
Staff	75	54	32.7	456		
Management/ out of scope	25	18	6.0	84		
Missing values			61.2	853		
Age						
< 30 (< 35)[b]	13.9	10	42.0	627	< 30 by >30-44	33.28***
30-44 (35-44)[b]	48.6	35	31.4	469		
45-55 (45-54)[b]	30.6	22	18.2	272		
Over 55 (55 and up)[b]	6.9	5	8.4	126	< 30 by >44-55	27.75***
					< 30 by >55	6.16*
Years in professional practice[c]						
< 1	4.2	3				
>1-10	41.7	30				
>10-20	23.6	17				
>20-30	20.8	15				
>30	9.7	7				
Highest level of education						
Diploma	1.4	1				
Baccalaureate	84.7	61	99.2	1,328	Baccalaureate by master's	83.25***
Master's[d]	13.9	10	0.8	11		

[a]Includes direct care, education, research. [b]Provincial data for age range varied from survey data. [c]Province did not report on this item. [d]Includes doctoral degree.

Note. Sixty (4.3%) "missing values" were revealed in the provincial demographic data for OT education. Diploma is included with baccalaureate. *$p \leq .05$; **$p \leq .01$; ***$p \leq .001$; 2-sided.

Responses to Likert-Style Questions

The means, standard deviations, and Cronbach's alpha calculated on the responses to the questions, classified according to the individual concepts and their subscale components, are displayed in Table 14. The reliabilities for the subscales or indicators of the concepts revealed a greater variance (0.73 to 0.95) than the reliabilities for the overall constructs of structural empowerment, psychological empowerment, and *SAW*.

Responses to Open-Ended Survey Question

Additional comments on *SAW*, workplace empowerment, or resonant leadership by 57 OTs (56%), were analyzed and grouped into categories that paralleled the survey questions (Table 14). Appendix H displays the content analysis of the responses.

Table 14

OT Mean, Standard Deviation, Reliability of Variables and Components and Survey Comments

Scales/subscales	Minimum-maximum	Means (standard deviations)	Cronbach Alpha	Survey comments	
				N	%
Structural Empowerment	**21.00-55.00**	**38.09 (7.70)**	**0.86**	**23**	**14**
Opportunity	7.00-15.00	11.90 (2.30)	0.80		
Information	3.00-15.00	8.81 (3.00)	0.83		
Support	3.00-15.00	8.75 (2.77)	0.86		
Resources	4.00-15.00	8.65 (2.41)	0.73		
Psychological empowerment	**42.00-83.00**	**65.49 (9.42)**	**0.88**	**9**	**15**
Competence	6.00-21.00	16.51 (2.59)	0.82		
Meaning	12.00-21.00	17.69 (2.27	0.84		
Self-determination	4.00-21.00	17.13 (3.24)	0.89		
Impact	3.00-21.00	14.22 (4.49)	0.93		

(table continues)

Scales/subscales	Minimum-maximum	Means (standard deviations)	Cronbach Alpha	Survey comments	
				N	%
SAW	**52.00-105.00**	**76.72 (12.14)**	**0.91**	**18**	**30**
Engaging work	20.00-42.00	32.34 (4.78)	0.84		
Sense of community	6.00-18.00	13.58 (2.56)	0.83		
Mystical experience	6.00-30.00	19.30 (4.43)	0.80		
Spiritual connection	3.00-18.00	12.77 (2.77)	0.84		
Organizational commitment	**8.00-43.00**	**22.88 (2.74)**	**0.91**	**3**	**5**
Job satisfaction	**8.00-28.00**	**21.45 (4.38)**	**0.94**	**6**	**10**
Resonant leadership	**10.00-60.00**	**41.36 (10.69)**	**0.95**	**10**	**17**

OT Focus Group

The OT focus group discussion centered on discovering the factors that health professionals (OTs) perceive as contributing to their personal *SAW* in the workplace. The content analysis of the focus group discussion is found in Appendix I.

Demographics

Eight OTs participated in the focus group. Three were under 30 years of age, with more than 1 year but less than 10 years in professional practice. Two participants between the ages of 30 and 45 and one between the ages of 45 and 55 had more than 10 years and less than 20 years of experience. Another OT who was older than 45 but younger than 55 years of age had more than 20 years and less than 30 years of experience. Finally, one senior OT was over 55 and had more than 30 years of experience.

Three OTs worked in home care, another three worked in long term care, one taught at the university, and the final OT worked in rehabilitation. All OTs had a minimum of a baccalaureate degree, and one had a master's degree.

Summary of Findings

The findings revealed noticeable differences between the participants who were recent graduates and those with more than 10 years' experience. These OT professionals were both excited by their professional practice and concerned about their working environment The recent graduates spoke with great enthusiasm about their work environment and described the development of a support group and their ongoing effort to set boundaries within their work environment. The more mature graduates made both positive and negative comments about their work experiences. Two OTs had left workplaces that had become unhealthy for them. The senior member of the group also described positive and negative personal work experiences and using her personal experiences to illustrate experiences that are common to OTs in their workplaces.

The participants described all of the components that I investigated in this research study as contributing to job satisfaction and organizational commitment. It is important to note that *SAW*, with its emphasis on *engaging work* and *sense of community*, was an integral aspect of all of the focus group discussions. This study demonstrates that the UWO workplace empowerment model (Laschinger, 2008b) with the inclusion of *SAW* (Kinjerski, 2004) and resonant leadership (Cummings, 2004), measure important components of the OT workplace.

Section C: PT Public and PT Private

Survey

Demographics

The PT public returned 169 useable surveys, for a return rate of 36%; and the PT private, 92 useable surveys, for a return rate of 21%. Comparison of PT survey demographics to the provincial demographics may be found in Table 15. Pearson's chi-square analysis of the PT work location data revealed significant differences between the survey demographics and the provincial data for acute care and community, acute care and rehabilitation, community and long term care, community and private, community and "other," private and "other," and private and rehabilitation (Table 16). Pearson's chi-square analysis revealed a larger percentage of PTs in management and significantly more PTs prepared at the diploma level than at the baccalaureate level in the survey data (Table 15).

Responses to Likert-Style Questions

The means, standard deviations, and Cronbach's alpha calculated on the responses to the questions, classified according to the individual constructs and their latent concepts, are displayed in Table 16. The reliabilities for the subscales or indicators of the concepts revealed a greater variance (0.67-0.99) than the reliabilities for the overall constructs of structural empowerment, psychological empowerment and SAW.

Table 15

Demographics of PT (Public and Private) Survey Respondents and Provincial Demographics

Descriptor	Survey		Provincial		Significant chi-squares	
	%	(N)	%	(N)	Variables	Chi-squares
Work location						
Home care	5.3	14	4.2	82	Acute by community	11.22*
Acute care/hospital	25.4	67	28.6	559	Acute by rehabilitation	5.68*
Long term care	4.9	13	5.1	100		
Rehab facility	7.2	19	4.9	81	Community by long term care	5.56*
Community	6.1	16	3.6	48		
Private practice	31.4	83	25.2	713	Community by private	13.00***
Other[a]	19.7	52	16.6	325		
					Community by other	4.41*
					Private by other	4.6*
					Private by rehabilitation	6.96**
Organizational position						
Staff	79.2	206	92.0	1,755	Staff by management	78.78***
Management	20.8	54	5.2	99		
Age						
< 30	14.0	37	13.3	275		
30-44	43.6	115	49.3	1,020		
45-55	26.5	70	25.8	534		
Over 55	15.5	41	11.6	241		
Missing	0.4	1				
Years in professional practice[b]						
< 1	2.3	6				
>1-10	32.6	83				
>10-20	27.3	72				
>20-30	24.2	64				
>30	14.2	38				
Missing	0.4	1				
Highest level of education	13.3	35	9.0	187		
Professional diploma	73.1	193	77.0	1,593	Baccalaureate by diploma	4.83*
Baccalaureate degree	12.1	32	13.0	270		
Master's degree[c]	1.5	4	1.0	20		
Missing data						

[a] Includes Direct Care, Education, Research. [b] Province did not report on this item. [c] Includes doctoral degree.
Note. The missing values category for organizational position included 48 or 2.5% of the total population of PTs.
*p ≤ .05; **p ≤ .01; ***p ≤ .001; 2-sided.

Table 16

PT Public and PT Private Mean, Standard Deviation, Reliability of Variables and Components and Survey Comments

	Minimum-maximum		Means (standard deviation)		Cronbach alpha		Survey comments	
Scales/subscales	Public	Private	Public	Private	Public	Private	Public	Private
Structural Empowerment	**18.00-57.00**	**17.00-60.00**	**37.33 (7.45)**	**39.08 (8.58)**	**0.85**	**0.89**	**43**	**31**
Opportunity	3.00-15.00	4.00-15.00	11.51 (2.21)	12.02 (2.14)	0.72	0.75		
Information	3.00-15.00	3.00-15.00	8.68 (3.07)	9.34 (3.83)	0.88	0.88		
Support	3.00-15.00	3.00-15.00	8.58 (2.79)	8.59 (3.21)	0.83	0.85		
Resources	3.00-15.00	4.00-15.00	8.39 (2.49)	9.14 (2.44)	0.76	0.67		
Psychological empowerment	**20.00-84.00**	**20.00-84.00**	**63.52 (9.68)**	**69.40 (9.61)**	**0.90**	**0.91**	**15**	**11**
Competence	3.00-21.00	5.00-21.00	16.29 (2.69)	17.45 (2.41)	0.84	0.83		
Meaning	3.00-21.00	4.00-21.00	17.46 (3.00)	18.24 (2.74)	0.93	0.92		
Self-determination	5.00-21.00	5.00-21.00	16.68 (2.98)	18.27 (2.67)	0.90	0.90		
Impact	3.00-21.00	3.00-21.00	13.20 (4.02)	15.73 (4.11)	0.95	0.92		
SAW	**40.00-103.00**	26.00-109.00	**74.78 (13.65)**	**77.47 (14.84)**	**0.92**	**0.96**	**42**	**30**
Engaging work	16.00-42.00	20.00-42.00	31.78 (5.33)	33.03 (6.17)	0.85	0.91		
Sense of community	5.00-18.00	5.00-19.00	13.56 (2.51)	13.53 (2.61)	0.78	0.80		
Mystical experience	6.00-30.00	6.00-30.00	19.26 (4.15)	19.69 (4.86)	0.77	0.80		
Spiritual connection	3.00-18.00	3.00-19.00	10.98 (3.95)	11.64 (4.25)	0.85	0.89		
Organizational commitment	**8.00-42.00**	**6.00-42.00**	**26.12 (6.74)**	**28.44 (8.19)**	**0.88**	**0.99**	**6**	**4**
Job satisfaction	**8.00-28.00**	**4.00-28.00**	**20.55 (4.72)**	**21.57 (4.73)**	**0.95**	**0.93**	**13**	**9**
Resonant leadership	**14.00-51.00**	**12.00-50.00**	**39.56 (9.83)**	**41.86 (10.54)**	**0.95**	**0.96**	**21**	**15**

Responses to Open-Ended Survey Questions

Twenty three PT private (26%), and 57 PT public (33%) offered comments. The comments were analyzed and grouped into categories that paralleled the survey questions: structural empowerment, psychological empowerment, *SAW*, resonant leadership, job satisfaction, and organizational commitment (Table 16). Appendix H displays the content analysis of the responses.

PT Focus Group

Content analysis of the focus group discussion is found in Appendix I.

Demographics

Five PTs participated in the focus group. Four between the ages of 30 and 45 had more than 10 years and less than 20 years of experience. One senior PT over the age of 55 who had more than 30 years of experience also participated in the focus group.

One PT worked in home care, another worked in long term care, two were in private practice, and the final PT was a graduate student with experience in pediatric PT in the public system. One participant had the minimum of a diploma, three PTs had a baccalaureate degree, and one participant had a master's degree.

Summary of Findings

This group of PTs was enthusiastic, positive, and 'high energy.' This group of PT professionals reflected very positively upon their professional practice; and were delighted to have the opportunity to share their experiences with their fellow participants and myself. All group members spoke highly of their current

workplaces. One participant stated that it had taken her some time to find a workplace that was a good fit. Another described a previous workplace as rewarding despite having had a constraining hierarchical structure. No significant differences in the perceptions of the PTs in private practice and the PTs in public practice were apparent.

The participants mentioned all of the components of leadership, SAW, psychological and structural empowerment investigated in this research study, and described them as contributing to job satisfaction and organizational commitment. It is important to note that SAW, with its emphasis on engaging work and sense of community, was an integral aspect of all of the focus group discussions. This study demonstrates that the UWO Workplace Empowerment Model (Laschinger, 2008b) with the inclusion of SAW (Kinjerski, 2004) and resonant leadership (Cummings, 2004) measures important components of the PT workplace.

Section D: Triangulation of Research Methods

The comments from the survey and the focus group revealed themes consistent with both theory and the results from the Likert-style questions (Table 17). I found slight differences in the frequency of comments between the different professionals included in this research project; however, the three different research methods, which consisted of Likert-style survey questions, an open-ended survey question, and focus group discussions, uncovered similar workplace components for all four professional groupings.

Table 17

Frequency of RN, OT, PT Public, and PT Private Survey and Focus Group Comments

Variables measured in Likert-style questionnaire	Survey comments				Focus group comments		
	RN	OT	PT public	PT private	RN	OT	PT
Leadership	17	10	21	1	32	43	37
Information	3	1	2		2	4	3
Resources	8	1	14	3	1	11	5
Support	10	3	16	5	22	37	24
Opportunity	2	2	7	8	2	3	9
Informal power	7	4	5			3	8
Formal power	1	2	4			8	3
Impact	3	5	4	2	7	14	11
Self-determination	2	7	5	2	7	16	17
Competence			1		1		3
Meaning	3	1	4	3	12	4	8
Engaging work	15	2	7	5	34	17	30
Sense of community	20	9	13	5	16	41	23
Spiritual connection	4	3	7	4	2	1	1
Mystical experience	6	2	8	6	8	10	6
Job satisfaction	4	6	13	5	5	4	9
Organizational commitment	8	3	6	1	9	8	1

Section E: SEM Analysis of RN, OT, PT Public and PT Private Survey Results

The strong theoretical relationships uncovered through the systematic review of the literature, content analysis of focus groups and the consequential triangulation of research methods provided support to my further investigation of the research data using LISREL 8.80 (Jöreskog & Sörbom, 1996) to identify the causal relationships between the different latent concepts for each of the professional disciplines.

Application of Theoretical SEM to Survey Results

I used LISREL 8.80 (Jöreskog & Sörbom, 1996) to obtain the maximum likelihood estimates shown in Tables 18 for RN, Table 19 for OT, Table 20 for PT public, and Table 21 for PT private. Effects of variables with a coefficient exceeding twice its standard error (two tailed $p < .05$) are specified in these tables. Since the sample size is small, effects with a coefficient between 1.96 and 2 located in the tables must be regarded with caution. The squared multiple correlations of the variables (R^2) are displayed in these tables. Discipline specific models were developed for RN (Figure 4), OTs (Figure 5), PT public (Figure 6) and PT private (Figure 7).

SEM Residuals

Examination of the residuals for the final models (Appendix K)indicated: no residuals with a standardized value of greater than two for RNs; a single residual with a standardized value greater than two from resonant leadership to support for OTs; four residuals with a standardized value of greater than two, from competence to impact, from experience to spiritual connection, from rank to engaging work and from rank to sense of community for PT public; and a single residual with a standardized value of greater than two from support to information for PT private. These residuals are within an acceptable range, indicating that the models are a good representation of the survey data for the different disciplines.

Table 18

Estimated Effects in the Final Causal Model for RNs

Outcome variables \ Causal variables	Opportunity	Information	Support	Resources	Self determination	Impact	Competence	Meaning	Engaging work	Sense of community	Spiritual connection	Mystical experience	Job satisfaction	Resonant leadership	Experience	Rank	Education	R^2
Opportunity		0.10	0.28‡											0.07		0.45		0.24
Information			0.48‡	0.23‡										0.00		1.55‡		0.41
Support														0.43‡		0.68‡		0.25
Resources														0.27‡		-0.50		0.13
Self determination	0.29‡	0.29‡	-0.24	-0.04										0.37‡	0.03	0.12	0.14	0.23
Impact	0.28‡	0.13	0.19	0.11	0.43‡		-0.05								0.40‡	0.63	-0.12	0.56
Competence	-0.04	0.07	-0.15	-0.02	0.42‡										0.19‡	-0.38	-0.03	0.26
Meaning	0.13	0.07	0.08	-0.07	0.11		0.42‡								0.05	-0.25	-0.22	0.32
Engaging work					0.07	0.05	0.01	0.28‡		0.32‡	0.00	0.28‡		0.9				0.61
Sense of community					-0.04	0.18‡	0.10	0.07			0.14‡			0.04				0.19
Spiritual connection					-0.04	-0.00	-0.12	0.43‡						0.29‡				0.19
Mystical experience					0.12	0.12	0.04	0.06			0.42‡			-0.05				0.31
Job satisfaction					0.17	0.33‡	0.14	-0.07	0.34‡	-0.15	0.16	0.10		0.21‡		-1.19‡		0.55
Organizational commitment					0.01	0.34‡	0.11	0.06	-0.08	0.04	0.32‡	0.11	-0.02	0.32‡				0.47

R^2 Proportion of explained variance in the endogenous variables.
‡Coefficients exceed twice its standard error, two-tailed $p < .05$.

Table 19

Estimated Effects in the Final Causal Model for OTs

Outcome variables \ Causal variables	Opportunity	Information	Support	Resources	Self determination	Impact	Competence	Meaning	Engaging work	Sense of community	Spiritual connection	Mystical experience	Job satisfaction	Resonant leadership	Experience	Rank	Education	R^2
Opportunity		0.19	0.28											0.11		-0.15		0.31
Information			0.33‡	0.09										0.12		1.83‡		0.55
Support														0.83‡		-0.19		0.41
Resources														0.44‡		0.57		0.19
Self determination	0.40‡	-0.13	0.32‡	-0.07											-0.11	1.00‡	-0.17	0.32
Impact	0.30	-0.20	0.03	0.16	0.70‡		0.06								0.08	1.78‡	-0.25	0.58
Competence	0.03	-0.09	-0.02	0.13	0.06										0.26‡	0.25	-0.26	0.11
Meaning	0.18	0.09	0.11	-0.08	0.16	0.20‡	-0.02								0.18	-0.58	-0.39	0.42
Engaging work					0.02	-0.03	0.08	0.33‡		0.05	0.00	0.36‡		0.11				0.57
Sense of community					-0.03	-0.01	0.32‡	0.14			0.09			0.41‡				0.41
Spiritual connection					-0.05	0.02	0.13	0.31						0.24				0.10
Mystical experience	0.27‡			0.23‡	0.15	0.05	0.06	0.13			0.12			-0.21				0.60
Job satisfaction					0.40‡	-0.16	0.08	0.27	-0.17	0.10	-0.03	0.56		0.34‡				0.59
Organizational commitment		0.34‡			-0.06	0.03	0.34‡	0.47‡	0.58	0.12	-0.05	-0.45	0.26	0.02				0.56

R^2 Proportion of explained variance in the endogenous variables.
‡Coefficients exceed twice its standard error, two-tailed $p < .05$.

Table 20

Estimated Effects in the Final Causal Model for PT Public

Outcome Variables \ Causal Variables	Opportunity	Information	Support	Resources	Self determination	Impact	Competence	Meaning	Engaging work	Sense of community	Spiritual connection	Mystical experience	Job satisfaction	Resonant leadership	Experience	Rank	Education	R^2
Opportunity		0.10	0.16											0.09		-0.05		0.11
Information			0.06	0.16										0.45‡		1.51‡		0.43
Support														0.72‡		0.04		0.36
Resources														0.48‡		-0.15		0.12
Self determination	0.23‡	0.10	0.10	0.11											0.11	0.50	-0.07	0.22
Impact	0.05	0.43‡	0.12	-0.06	0.49‡		0.10								-0.08	0.82‡	-0.48‡	0.55
Competence	-0.28‡	0.19‡	-0.06	-0.05	0.30‡										0.45‡	-0.70	0.19	0.27
Meaning	0.38‡	0.12	0.05	0.10	0.19‡		0.32‡								0.031	-0.37	-0.23	0.40
Engaging work	0.16‡		0.13‡		-0.01	0.05	-0.03	0.26‡		0.23‡	-0.03	0.19‡		0.01				0.66
Sense of community					0.13	0.09	0.06	0.11			0.06			0.30‡	0.30‡			0.29
Spiritual connection				-0.24‡	0.05	0.04	-0.15	0.30‡						0.50‡	0.50‡			0.22
Mystical experience					0.11	-0.01	-0.05	0.28‡			0.35‡				0.09			0.44
Job satisfaction					0.20‡	-0.09	-0.06	0.26‡	0.63‡	-0.01	0.031	-0.13		0.34‡	0.34‡			0.53
Organizational commitment		0.40‡			0.08	-0.07	-0.06	0.28‡	-0.13	-0.11	-0.02	0.33‡	0.18		0.11			0.46

R^2 Proportion of explained variance in the endogenous variables.

‡Coefficients exceed twice its standard error, two-tailed p < 05.

Table 21

Estimated Effects in the Final Causal Model for PT Private

Outcome variables \ Causal variables	Opportunity	Information	Support	Resources	Self determination	Impact	Competence	Meaning	Engaging work	Sense of community	Spiritual connection	Mystical experience	Job satisfaction	Experience	Education	R^2
Opportunity		0.13	0.25‡													0.21
Information			0.42‡	0.06												0.15
Support				0.39‡												0.01
Resources																----
Self determination	0.07	0.16	0.19	-0.02										0.03	0.03	0.18
Impact	0.15	0.40‡	0.06	0.04	0.52‡		0.35‡							-0.12	0.15	0.52
Competence	0.01	-0.06	-0.02	0.16	0.29‡									0.44‡	***-0.19‡***	0.41
Meaning	0.32‡	0.06	-0.08	0.04	0.31‡		0.40‡							-0.07	-0.07	0.39
Engaging work					-0.03	0.10	-0.15	0.38‡		0.47‡	-0.04	0.09				0.71
Sense of community			0.25‡		0.11	-0.04	0.36‡	0.02			0.09					0.52
Spiritual connection					0.05	0.19	-0.04	0.13								0.08
Mystical experience					-0.02	0.14	-0.15	0.45‡		0.52‡	0.24‡					0.58
Job satisfaction					0.06	0.01	-0.03	0.36	0.15	0.30	0.17	0.09				0.36
Organizational commitment		0.39‡			-0.34‡	0.38‡	-0.22	0.39	-0.09	0.10	-0.02	0.12	0.39‡			0.65

R^2 Proportion of explained variance in the endogenous variables.
‡Coefficients exceed twice its standard error, two-tailed p < .05. Coefficients in bold italics are between 1.96 and 2.00 times standard error, two-tailed t(p < .05)

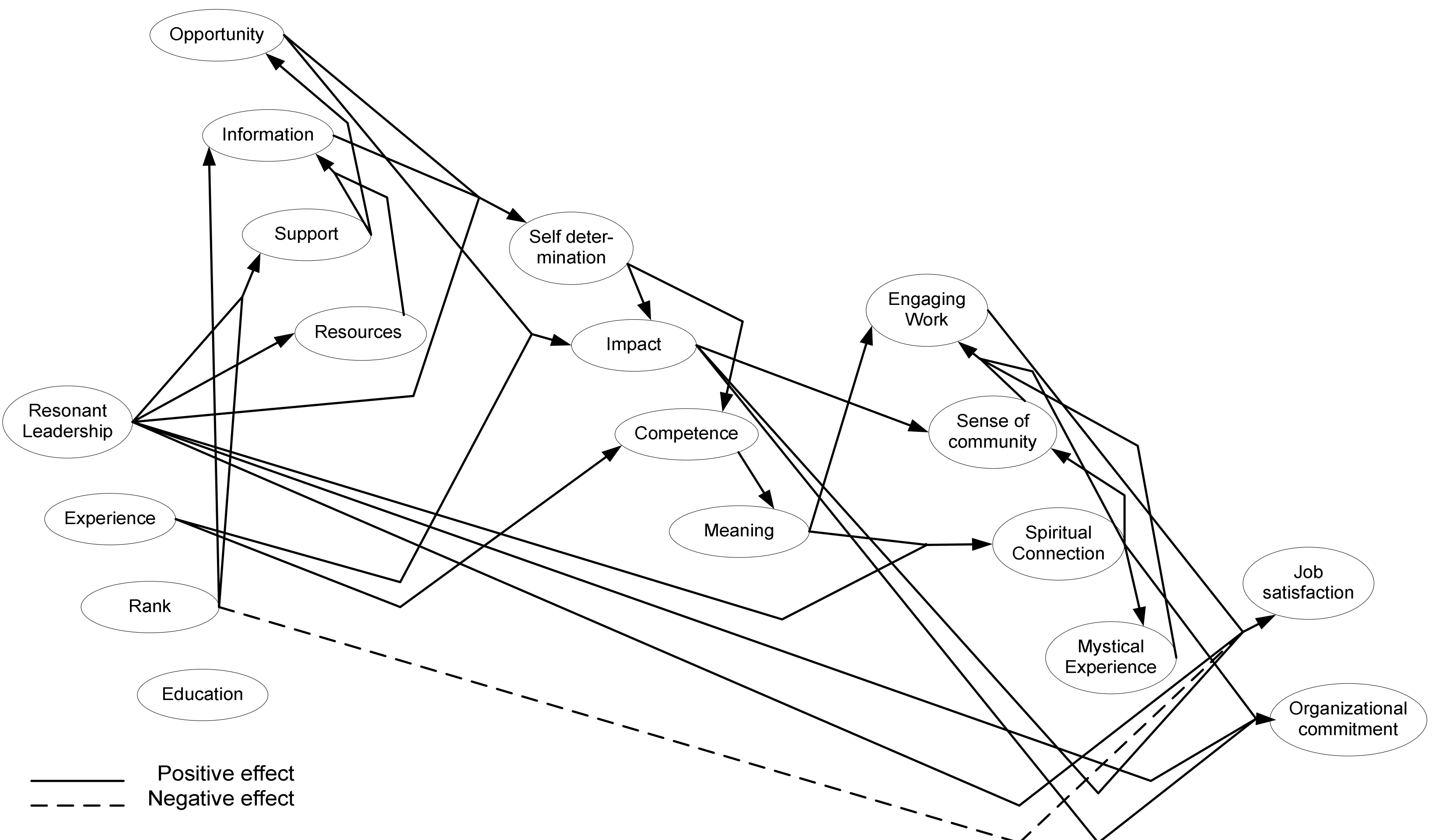

Figure 4. RN SEM with significant findings.

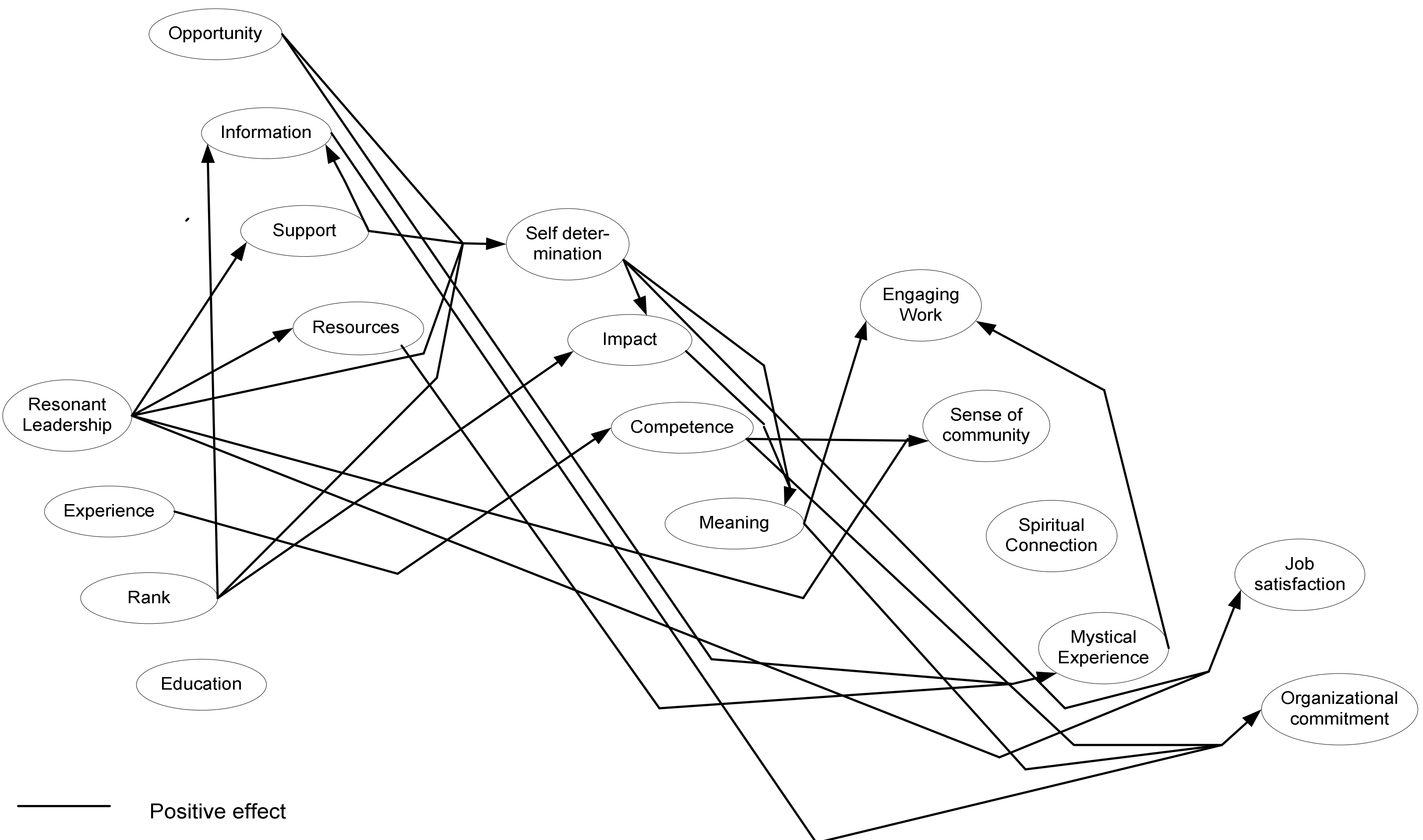

Figure 5. OT SEM with significant findings.

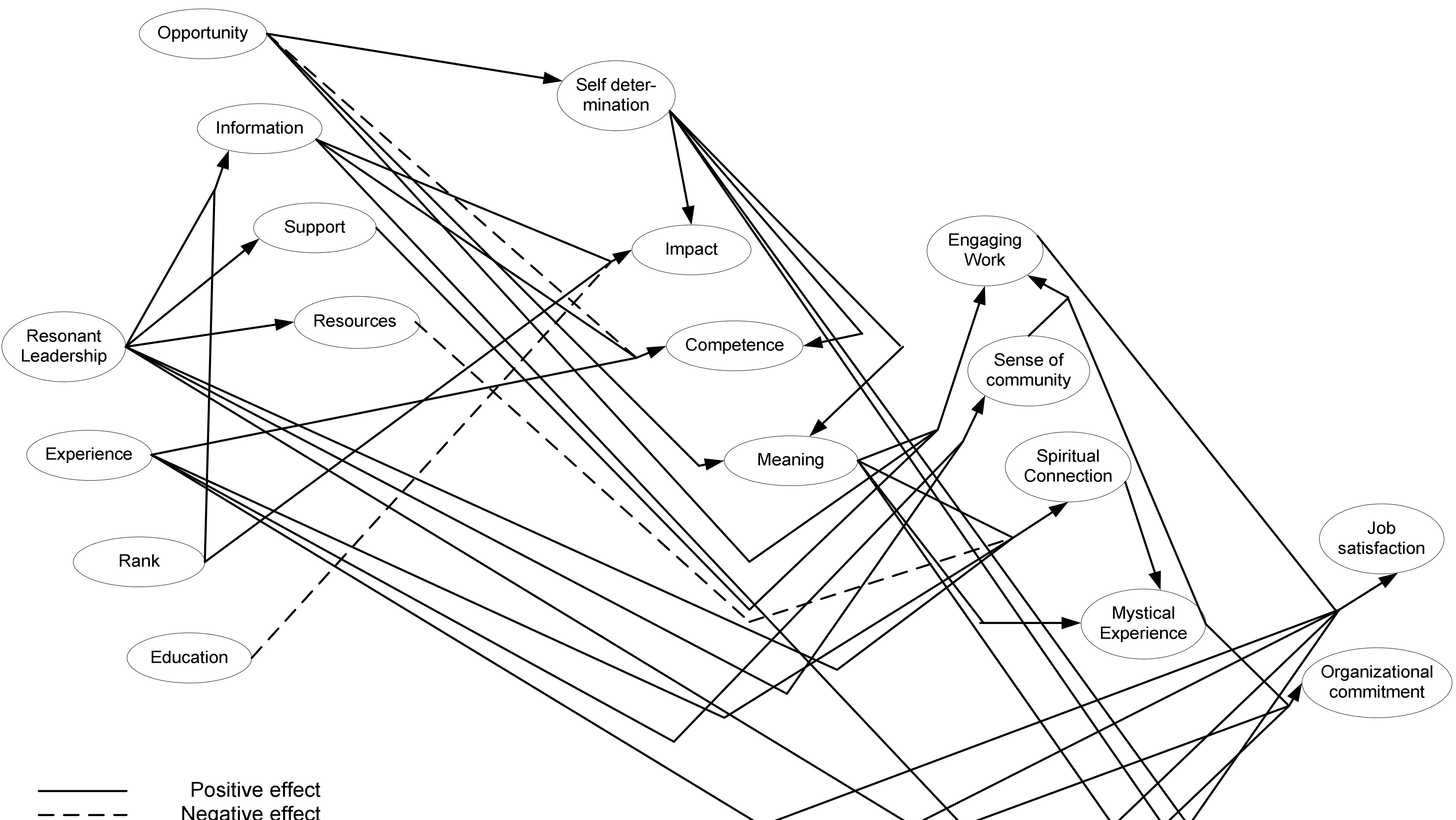

Figure 6. PT Public SEM with significant findings.

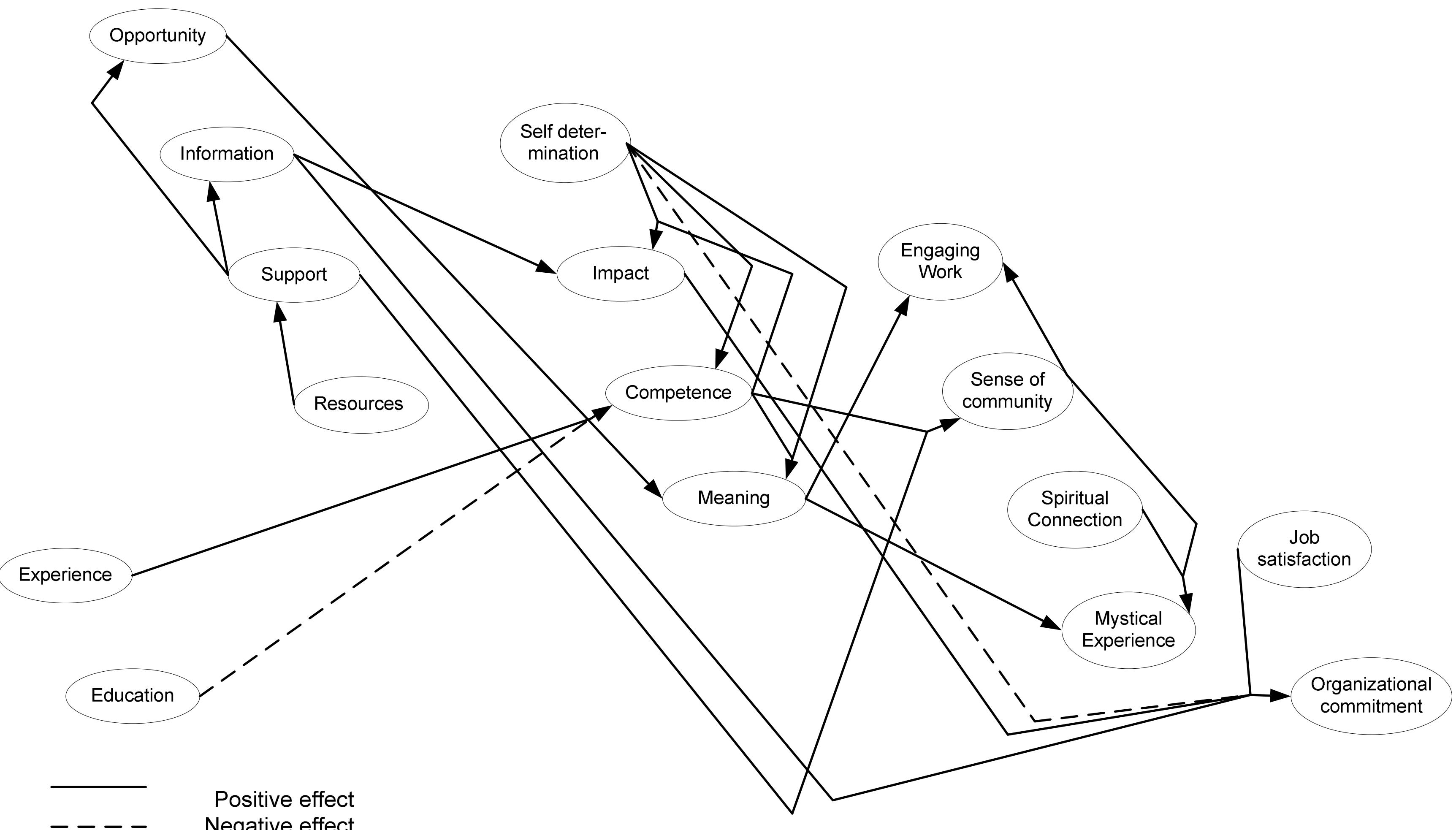

Figure 7. PT Private SEM with significant findings.

Section F: Summary of Research Results

Tables 22 and 23 display the significant positive and negative relationships within the population samples for all four professional models. A comprehensive discussion of the results from the development of the SEM models for RNs, OTs, PT public and PT private may be found in Appendix K. Both the SEM analysis of the Likert-style questions and the content analysis of the responses to the open-ended question (Appendix H) provided valuable insight into the relationships between the study variables for these sample populations.

RNs

The survey data revealed a significantly greater number of RNs in management and a greater number of RNs prepared at the master's or doctoral level than the provincial demographic data indicated and these differences must be taken into account when generalizing the results from the survey data to the provincial population.

Resonant leadership, rank and experience exhibited significant direct or indirect effects on the outcome variables of job satisfaction and organizational commitment for all sample groups. SEM analysis did not indicate significant relationships between education and any of the other variables within this model for RNs.

All of the remaining variables received significant effects and had a significant direct or indirect effect on one of the outcome variables of job satisfaction or organizational commitment. The components of *SAW* were shown to be an integral part of this RN model. *Spiritual connection* played a pivotal role

Table 22

Significant Relationships Within Different Professional Models

Relationships	RNs	OTs	PT public	PT private
Resonant Leadership to Information			Positive	N/A
Resonant Leadership to Self Determination	Positive	Positive		N/A
Resonant Leadership to Organizational Commitment	Positive			N/A
Resonant Leadership to Sense of Community			Positive	N/A
Experience to Impact	Positive			
Experience to Sense of Community			Positive	
Experience to Spiritual Connection			Positive	
Experience to Job Satisfaction			Positive	
Rank to Support	Positive			N/A
Rank to Self Determination		Positive		N/A
Rank to Impact		Positive	Positive	N/A
Rank to Job Satisfaction	Negative			N/A
Education to Impact			Negative	
Education to Competence				Negative
Opportunity to Self Determination	Positive	Positive	Positive	
Opportunity to Impact	Positive			
Opportunity to Competence			Negative	
Opportunity to Meaning			Positive	Positive
Opportunity to Engaging Work			Positive	
Opportunity to Mystical Experience		Positive		
Information to Self Determination	Positive			
Information to Impact			Positive	Positive
Information to Competence			Positive	
Information to Organizational Commitment		Positive	Positive	Positive
Support to Opportunity	Positive			Positive
Support to Self Determination				Positive
Support to Sense of Community				Positive
Support to Engaging Work			Positive	
Resources to Information	Positive		Positive	
Resources to Support				Positive
Resources to Spiritual Connection			Negative	
Resources to Mystical Experience		Positive		
Self Determination to Competence	Positive		Positive	Positive
Self Determination to Meaning		Positive	Positive	Positive
Self Determination to Job Satisfaction		Positive	Positive	
Self Determination to Organizational Commitment				Negative
Impact to Meaning		Positive		
Impact to Sense of Community	Positive			
Impact to Organizational Commitment				Positive
Competence to Meaning	Positive		Positive	Positive
Competence to Sense of Community		Positive		Positive
Competence to Organizational Commitment		Positive		
Meaning to Spiritual Connection	Positive		Positive	
Meaning to Mystical Experience			Positive	Positive
Meaning to Organizational Commitment		Positive	Positive	
Meaning to Job Satisfaction			Positive	

(table continues)

Relationships	RNs	OTs	PT public	PT private
Engaging Work to Job Satisfaction	Positive		Positive	
Sense of Community to Engaging Work	Positive		Positive	Positive
Spiritual Connection to Mystical Experience	Positive		Positive	Positive
Mystical Experience to Engaging Work	Positive	Positive	Positive	
Mystical Experience to Organizational Commitment	Positive		Positive	
Job Satisfaction to Organizational Commitment				Positive

Note: Significant relationships are listed as positive or negative. Non-significant relationships are not listed. N/A is not applicable.

Table 23

Significant Relationships Common to the Models

Relationships	RNs	OTs	PT public	PT private
Resonant Leadership to Spiritual Connection	Positive	Positive	Positive	N/A
Resonant Leadership to Job Satisfaction	Positive	Positive	Positive	N/A
Experience to Competence	Positive	Positive	Positive	Positive
Rank to Information	Positive	Positive	Positive	N/A
Support to Information	Positive	Positive	Positive	Positive
Self Determination to Impact	Positive	Positive	Positive	Positive
Meaning to Engaging Work	Positive	Positive	Positive	Positive

Note: Significant relationships are listed as positive or negative. Non-significant relationships are not listed. N/A is not applicable.

in this model, not only receiving significant causal effects from meaning and resonant leadership, but also exerting significant effects on *sense of community* and *mystical experience*, and on both job satisfaction and organizational commitment. The following survey comment further elaborated on these relationships:

> I think maybe that nursing has burned me out. My spirit for nursing and its work is gone—too many years of abuse from the system—overwork—underappreciated and tired of trying. Now it is just a job and pays the bills—maybe it is time to leave nursing.

Engaging work received significant effects from meaning, resonant leadership, *sense of community*, and *mystical experience*. *Engaging work* also exerted a significant influence upon job satisfaction. *Sense of community* received

significant effects from impact, resonant leadership, and *spiritual connection*, while exerting a single significant effect on *engaging work*. *Mystical experience*, or the experience of energy or vitality in the workplace, received a single significant effect from *spiritual connection* and, in turn, exerted a significant effect on *engaging work*. The following comments from two respondents clearly depicted the relationships between *sense of community*, *mystical experience*, and *engaging work*: “I work in a very small teaching unit of ten RNs. We are close and work together in harmony, but also efficiently” and “I strongly believe that this can be a healing atmosphere when the client senses that the staff get along with each other.”

It is also important to note the negative relationship between rank and job satisfaction, which indicated that RNs in management positions reported lower job satisfaction than did RNs in staff positions. This is explained by the RN focus group members, who pointed out that the managers also need support from their leaders, to reduce their moral distress, and to enable them to provide healthy leadership to the staff:

> Because I think we have to remember that managers are staff too and they are managed..And depending on the direction that you might be getting from up top and what support there is for you, can really make a difference how everything flows, how everything works out and its ahhhhh. . . . Like I said, it’s moral distress.

SEM analysis of this survey of the Alberta RNs revealed a single significant negative relationship in the model between rank and job satisfaction. This significant relationship indicated workplace characteristics that were representative of the specific sample of RNs in Alberta at the time of the survey

(fall 2007 to early summer 2008). In addition, since education did not display a significant relationship with any other variables in this model, it is possible that education could be eliminated from the model for RNs.

OTs

The survey data indicated a smaller percentage of OT respondents in acute care and more OT respondents in home care, community, and "other"; and, a greater percentage of OTs in the more than 30 age group, the 30 to 44 age group, the 44 to 55 age groups and fewer in the more than 55 age group, when compared to the provincial data. The survey sample data was highly skewed, with a larger percentage of OTs with master's or doctoral preparation, thus creating a bias in all the responses and limiting my ability to apply the data from this research to the general population of OTs in Alberta.

Because of the large number of parameters, my discussion of the results must take into account the warning from LISREL (Jöreskog & Sörbom, 1996): "Total sample size is smaller than the number of parameters. Parameter estimates are unreliable."

Resonant leadership, experience and rank exhibited significant direct or indirect effects on the outcome variables of job satisfaction and organizational commitment. Analysis of the survey data did not indicate that education had significant effects on any variables. All of the remaining variables except competence received significant effects from other variables in the equation and all of the variables, except *engaging work, sense of community, spiritual*

connection and mystical experience, had a direct or indirect effect on one of the outcome variables of job satisfaction or organizational commitment.

None of the *SAW* variables were directly related to the outcome variables of job satisfaction and organizational commitment despite the OT survey comments that suggested they were important. OT commented on the relationship between *mystical experience, engaging* work and job satisfaction, stating they had a lack of energy or vitality in the workplace from a loss of pride in the job. *Sense of community* did not have an effect on any other variable. However, several OT respondents spoke very highly of a *sense of community*: "Staying in the present moment and working with the team who is with you right then creates opportunities for staff and clients that no one would have predicted!" Again, the SEM analysis of the survey responses showed that *spiritual connection* did not have a significant effect on other variables. In spite of this, several OTs referred to a connection with a greater source that has a positive effect on work as "a higher being or something [that] enables us all to move forward if each of us makes that choice."

Since education did not display a significant relationship with any other variables in this model, it is possible that education could be eliminated from the model for OTs.

PT Public and Private

The demographic survey data from PT public and PT private was combined to assist in comparing it to the provincial demographic data that was not broken up into PT public and PT private. Analysis of this data revealed a

significantly greater number of PTs in community and rehabilitation than in acute care; more PTs in long term care, private, and "other" than in community; and more participants in rehabilitation than in private. Further analysis revealed a larger percentage of PTs in management than indicated by provincial demographic data. The analysis also showed significantly more PTs prepared at the diploma level than at the baccalaureate level. I took these significant differences into account in generalizing the results from the survey data to the provincial population.

PT Public SEM Discussion

Resonant leadership, experience, and rank exhibited significant direct or indirect effects on the outcome variables of job satisfaction and organizational commitment. PT public data indicated a significant negative effect from education to impact, which represented the PTs' perception of reduced influence over what happens in the department when they have more education. I had theorized that a relationship existed; however, I had not anticipated a negative relationship. The focus group members did not speak about education, rather they stressed that experience in the workplace is essential to success: "If the role that you are in place for allows you to succeed, to advance, to become successful—that's empowerment in the workplace."

All the remaining variables received significant effects in the model, although three of the relationships were negative. All the variables except impact had a direct or indirect causal effect on one of the outcome variables of job satisfaction or organizational commitment.

I did not anticipate the significant negative relationship between opportunity and competence. This negative relationship followed from the PT public perception that increased “chances to gain new skills and knowledge on the job” were associated with decreased “mastery of the skills necessary for the job.” I also identified a significant negative relationship between resources and *spiritual connection* that suggested that when “temporary help is acquired as needed,” there was an associated perception that “the connection with a greater source that has a positive effect on work” was reduced.

Theory supported the significant effects that knowledge of the values of top management (information) had on organizational commitment, which the original model did not predict. This effect was clarified further by one PT who was quite vocal about a lack of information about the organization stating that leadership personnel who listened to what staff said and explained why a course of action occurred were not present in her workplace.

Two of the four components of SAW were shown to be significantly related to either job satisfaction or organizational commitment**.** *Engaging work* had a significant effect upon job satisfaction, and the PT public respondents commented that they enjoyed the work, were happy in the direct care provider role, and were “blessed” to be PTs. *Mystical experience* had a significant effect upon organizational commitment, but the remaining two components of *SAW* did not display a significant relationship with either job satisfaction or organizational commitment. Rather, *sense of community* had an effect on *engaging work,* and *spiritual connection* had an effect on *mystical experience.*

My SEM analysis showed three unexpectedly negative relationships among the variables. PT public perceived that increased opportunity resulted in decreased competence, increased resources resulted in decreased *spiritual connection,* and finally, increased education led to a decreased perception of impact. These significant relationships indicated workplace characteristics that were representative of the specific sample of PT public in Alberta at the time of the survey (fall 2007 to early summer 2008).

PT Private SEM Discussion

Because of the large number of parameters, my discussion of the PT private results must take into account the warning from LISREL (Jöreskog & Sörbom, 1996) indicating that the sample size is small and may hinder the accurate identification of significant effects between different concepts.

Experience and education both had direct effects on competence, but they did not have any effects on organizational commitment. Literature supported the effect of education on competence (Spreitzer, Kizilos, & Nason, 1997). However, my analysis of the data revealed an unanticipated negative effect from education to competence, suggesting that when PT private had more education they perceived themselves as having less competence. The correlation of education with perception of the individual PT's own competence requires further investigation.

All of the endogenous variables, or variables predicted to receive effects from other variables in the model, except self-determination, *spiritual connection* and job satisfaction, were significantly effected by other endogenous variables.

All of the latent concepts except meaning and the four components of *SAW* had a direct or indirect effect on the outcome variable of organizational commitment. Although job satisfaction did not receive significant effects from other variables in the model, it had a significant effect on organizational commitment, as confirmed in the literature (Mosadeghrad, Ferlie & Rosenberg, 2008). This relationship denoted an important difference between my other survey samples and PT private.

The SEM analysis showed a significant negative effect from self-determination to organizational commitment. This result indicated that PT private were actively working to succeed in solo practice by deciding “on their own how to go about doing their work” and did not have a strong commitment to a specific workplace.

My application of this theoretical model to the PT private sample revealed significant negative effects between variables that represented important differences between this sample population of Alberta PT private (fall 2007 to early summer 2008) and other sample populations. A significant negative relationship from self-determination to organizational commitment was revealed, which may have represented the PT private’s desire to practice independently of organizational controls. However, theory and logic did not predict, nor explain, the significant negative causal effect directed from education to the perception of competence.

CHAPTER 5:

DISCUSSION, RECOMMENDATIONS, LIMITATIONS, DISSEMINATION STRATEGIES AND CONCLUSION

The final chapter of this thesis is divided into three sections. The first section provides a discussion of key research findings and related recommendations. The second section identifies limitations connected with each research method and is subdivided by study population where appropriate. The next section provides dissemination strategies for the research findings. The chapter concludes with a discussion of the contributions this research has made to knowledge about healthy work environments for staff and thus for patients for whom they provide care.

Discussion and Recommendations

The pressure imposed on our health care system by aging national demographics, increasingly complex and expensive medical treatments, and consumers who are demanding access to expert health care, requires us to pay conscientious attention to the health care work environment. The reduction of illness and disability of health care providers in the workplace is essential if consumers are to receive quality and cost-efficient health care (CIHI, 2001). Magnet hospital research conducted around the world highlights hospital work environments that lead to reduced RN burnout, increased RN retention, and reduced patient morbidity and mortality and supports the need for changes in the health care workplace (Laschinger, Almost, & Tuer Hodes, 2003; Middleton et al., 2008; Scott et al., 1999). My research identifies workplace components that

promote a healthier environment for RNs, OTs and PTs and expand the Magnet hospital research.

SAW

> Who has seen the wind? Neither you nor I, but the trees bow their heads when the wind passes by. (Christina Rosetti, 1830-1894)

Wind, as described by Christina Rosetti, can be compared to “spirit.” We cannot see it, but we can see the powerful effect “spirit” has on the people who are touched by it, similar to how the trees “bow their heads when the wind passes by.” Over the years, many researchers have attempted to define “spirit.” Although they are beginning to agree on common elements (Table 1), a concise definition remains elusive. Despite this apparent ambiguity, employers are becoming increasingly interested in nurturing individual “spirit” in the workplace because such effort leads to positive outcomes, not only for the worker, but also for the organization (Leigh, 1997; Milliman, Ferguson, & Czaplewski, 2003; Mitroff & Denton, 1999; Neck & Milliman, 1994).

SAW refers to the unique experience of individuals who are both passionate about their work and energized by it (Kinjerski, 2004). My review of the management literature singled out *SAW* to be an important component of a healthy workplace (Benefiel, 2003; Cacioppe, 2000; Groen, 2003; Kinjerski, 2004; Krishnakumar & Neck, 2002). Individuals with high SAW find purpose at work and feel trust and personal connection with their co-workers, while experiencing both a link to a greater source that has a positive effect on their work, and an energy or vitality at work (Kinjerski, 2004). These are the

employees that all managers and leaders desire to have in their workplace. They are usually healthy, have good relationships with their fellow workers, provide outstanding "customer service" and contribute to increased workplace productivity (Kinjerski, 2004).

Close scrutiny and examination of the relationships between *SAW* and other constructs found in workplace theory, using SEM analysis, indicated that SAW specifies important attributes of the RN, and PT public workplaces that lead to individual job satisfaction. My analysis also showed that resonant leadership and the demographic variable of experience, individual concepts within structural empowerment and individual concepts within psychological empowerment, lead to SAW (Table 22 & Table 23). Participants within the focus groups stressed that SAW was essential to a healthy working environment, reinforcing that SAW is a discreet construct that receives effects from other constructs within health care workplace theory. I recommend that health care leaders be educated and supported to incorporate resonant leadership traits within their personal leadership approach and to cultivate structural empowerment components within the workplace. This research indicates that combining education and support while facilitating experienced staff to provide a positive role model for less experienced staff through education and formal and informal leadership roles will lead to healthier workplaces with increased SAW.

I also recommend that further studies, with larger sample sizes, be conducted with all four professional groups to investigate the causal relationships among resonant leadership, two of the three demographic variables of rank and

experience and the constructs of structural empowerment, psychological empowerment, *SAW*, and workplace outcomes. Further investigation and application of the proposed models on larger samples are required for all four professional groups to provide a more comprehensive definition of the factors that contribute to *SAW*. My research indicates that this knowledge will assist us to plan interventions that not only increase SAW, but also contribute to the quality of work life for health care professionals. This is similar to how our knowledge of factors that contribute to the wind assists us to plan for related weather changes.

Structural Empowerment and Psychological Empowerment Research

Laschinger (2008b) completed substantial research on structural empowerment and psychological empowerment over the past 15 years. LISREL 8.80 (Jöreskog & Sörbom, 1996) was used to identify the relationships between structural empowerment, psychological empowerment, job satisfaction and organizational commitment within many of these studies. Structural empowerment scores were calculated in these studies by summing the subscales or latent concepts which had been calculated by averaging measurements of three to four separate indicators (Laschinger, 2008b). Overall psychological empowerment was calculated as a sum and average of the 12 indicators (Laschinger, 2008b). My use of the actual score for the single indicator representing each latent concept contributing to the constructs of structural empowerment and psychological empowerment supported this earlier research. My analysis revealed causal effects going from two or more of the concepts within structural empowerment to two or more of the concepts within

psychological empowerment for all of the professional groups. The occurrence of these effects in groups of health care professionals other than RNs, further validates earlier research on workplace empowerment.

SEM analysis of this Alberta data indicated that the effects between the individual concepts within structural empowerment and psychological empowerment vary according to the sample population, as demonstrated in an Ontario study of RNs (Manojlovich & Laschinger, 2002). However, despite these variations, my research indicates that structural empowerment concepts have significant effects on other components of a health workplace. I recommend that health care leaders strive to increase the professional's perception of all four components of structural empowerment of support, resources, information and opportunity within each workplace through implementation and communication of targeted interventions i.e., regular and frequent informal and formal performance feedback, increased staffing during peak work periods, oral and written presentations on high level goals values that are tied to organizational decisions and changes, and finally, encouragement of education, innovation and flexibility in the professional health care workplace. Since the small sample size may have hindered the accurate identification of significant effects between different concepts, I recommend that additional research, with increased sample sizes be conducted. This research will lead to a more accurate measurement of the relationship between the individual concepts comprising the constructs of structural empowerment and psychological empowerment.

Resonant Leadership

Goleman (1998) defined resonant leadership as the "art of persuading people to work toward a common goal" (p. 37). Cummings' (2004) description of the leader who "actively listens, acknowledges and then acts on requests and concerns" was used to represent the construct of resonant leadership throughout SEM analysis of the survey data. The effect of resonant leadership upon individual concepts within structural empowerment, psychological empowerment and SAW was evident throughout data analysis for all four professional groups. Evidence also indicated that resonant leadership had significant effects on job satisfaction and organizational commitment for RNs, OTs, and PT public. All the professional focus groups had extensive discussions about their leadership needs, further emphasizing the importance of leadership in their workplaces. A study by Lee and Cummings (2008), supported by my research indicating the important effect of resonant leadership on SAW, job satisfaction and organizational commitment, indicates that education and support of health care leaders in the provision of resonant leadership is conducive to a healthy work environment (Lee & Cummings, 2008) and will lead to increased organizational commitment and the consequential retention of talented leaders.

Four Distinct Professional Models

Review of the literature led me to propose the relationships between resonant leadership, structural empowerment, psychological empowerment, SAW, job satisfaction and organizational commitment depicted in Figure 1. Further study of the concepts comprising these constructs and demographic data guided

the development of a theoretical model (Figure 3) that could be tested using LISREL 8.80 (Jöreskog & Sörbom, 1996) and data from samples of the populations. Each professional group is represented by a model designed to describe discipline-specific perceptions of significant effects between model concepts (Figure 4, Figure 5, Figure 6, Figure 7). The professional models were built upon an identical theoretical foundation; however significant modifications representing the separate profession-specific ethos or fundamental character and values of each professional group (Table 8, Appendix C) were required to accurately represent the RN, OT, PT public and PT private samples of these populations.

Recommendations for RNs

My research indicates that resonant leadership, the demographic variables of experience and rank, the concepts composing structural empowerment, the concepts composing psychological empowerment, and the concepts composing SAW all have a significant causal relationship with either job satisfaction or organizational commitment within the theoretical model for RNs (Figure 4). These findings are similar to previous research (Laschinger, 2008b). I recommend that leaders develop an awareness and understanding of all the components of a healthy workplace. This awareness will contribute to the implementation of health-promoting changes within their organizations, as suggested in the literature, for both staff (Laschinger, Finegan, Shamian, & Wilk, 2003) and patients (Laschinger, Almost, & Tuer Hodes, 2003; Middleton et al., 2008; Scott et al., 1999).

Leaders must strive to provide resonant leadership, opportunity, and information to their RN staff, since this research model indicates that these leadership behaviours encourage self-determination, which, in turn, increases RN job satisfaction and organizational commitment (DeCicco et al., 2006; Laschinger et al., 2007; Laschinger et al., 2009; Laschinger, Finegan, & Shamian, 2001; Laschinger, Finegan, Shamian, & Wilk, 2001; Laschinger, Finegan, Shamian, & Wilk, 2003; Laschinger, Finegan, Shamian & Wilk, 2004; Manojlovich & Laschinger, 2002). In addition, increasing support to RNs will augment the self-determination of RN staff in each organization. Although a systematic review of the literature by Lee and Cummings (2008) indicated that front line nurse managers generally had a higher level of satisfaction than either nurse executives or staff, my research indicated a reduced level of job satisfaction associated with RN management positions. Both my research and recent literature (Laschinger, Purdy & Almost; Lee & Cummings, 2008) indicate that when health care policy makers and senior executives ensure that structural empowerment components such as organizational and social support, opportunity for education, adequate resources, and information are present in the RN manager workplace RN manager job satisfaction will increase. Finally, although the effect of experience on *SAW* was not included in the final RN model, I recommend that this effect be investigated in future research, my data analysis indicated that it may be an important relationship for RNs.

Recommendations for OTs

I recommend that leaders expand their awareness and understanding of the components of a healthy workplace. This awareness, combined with the results from my research may lead them to tailor health-promoting changes within their organizations. My model indicates that development of resonant leaders through coaching, and organizational and social support is important for OTs. The model also indicated that opportunity for challenging work and the development and use of new skills, provision of information about the goals and values of senior management; regular performance feedback; and, the presence of sufficient staff to allow them to complete their job (including paperwork), will increase SAW, job satisfaction and organizational commitment of OTs. I recommend that special attention be directed to OTs in solitary practice, whether in large urban or isolated rural locations, as several OTs mentioned a concern related to isolation in both the open-ended survey question and the focus groups. Although the focus group members suggested that components of structural empowerment contributed to OT competence in the workplace, the SEM analysis did not show significant effects between structural empowerment and competence, and these contradictory results require further investigation. Also, further research on related workplace empowerment outcome variables such as reduced burnout and increased trust may reveal additional significant effects between concepts composing *SAW* and positive workplace outcomes for OTs in Alberta.

Recommendations for PTs

I recommend that leaders study and implement the recommendations for PT public and PT private separately. Although both groups have identical professional backgrounds, it is probable that unique aspects of private practice had significant effects on the variables that contributed to SAW and workplace empowerment.

Leaders of PT public must become aware of the issues associated with the negative effects displayed in the model (Table 20), explore their presence in the workplace, and pursue potential solutions. Provision of stability in the work environment and reduction of perceived workplace challenges may lead to a perception of competence for PT public, reducing the negative relationship between opportunity and competence identified in the model. Recognition of the expertise of PT public with advanced education by encouraging them to be involved with innovative projects and providing them with greater flexibility in their work will reduce the negative relationship between education and impact. Finally, the puzzling negative relationship between resources and spiritual connection, suggesting that when PTs have more resources they no longer rely on their spiritual connections, requires further study.

Health care leaders should continue to look for methods to increase the job satisfaction of PT in private practice (Figure 7), since this model shows that job satisfaction does not receive effects from any of the model components, indicating that PT private receive their job satisfaction from workplace components not included in the model. Two negative relationships identified within the PT private

model (Table 21) require special attention from health care leaders and employers. The first negative effect between self determination and organizational commitment appeared to refer to the individual's desire for independent employment in private practice with increased self-determination leading to decreased organizational commitment. The more surprising significant negative effect from education to competence suggested that PT private with more education were perceived by themselves and other PT private as less competent.

It is possible that SAW may have effects on outcome variables such as reduced burnout and increased trust found within the UWO Workplace Empowerment Model (Laschinger, 2008b) that were not included in this study. Future studies on PT private in the workplace should explore the outcome variables of reduced burnout and increased trust and further clarify the relationship between my proposed model and the theoretical outcomes that have been proposed by Laschinger (2008b).

Recommendation for Discipline-Specific Research

Because of the dearth of studies on OT and PT empowerment, I recommend further research compare the significant relationships of OTs, PT public and PT private to results from other disciplines. These comparisons will indicate whether planned interventions based on the UWO Workplace Empowerment Model, including *SAW* and resonant leadership, require substantial modifications before being applied to the OT, PT public and PT private professional workplaces. However, the models within this research indicate workplace components that require further investigation and possible change.

Limitations

Systematic Review of the Literature

The review was limited to studies that examined the relationship between structural empowerment as the predictor variable and psychological empowerment as the variable receiving the effects for RNs, or studies where structural empowerment effects psychological empowerment. This criterion screened out qualitative research that could reveal valuable contributons to the relationship, such as the importance of the context and culture of the work environment. I informed the readers of this limitation within the study to ensure they took it into account when reviewing the article. I did not include OT and PT literature in the systematic review because an initial review of the literature revealed only two articles describing research on the relationship between structural empowerment and psychological empowerment for OTs and PTs. Since review of the English abstracts for articles written in other languages did not reveal additional relevant articles, there were no non-English articles included in this study.

Survey

RNs

The professional college (CARNA) used an identical distribution list to distribute both the web-based survey and follow-up postal survey. The college was unable to track address changes to the distribution list over the eight months between the surveys, which meant that potential respondents may have been missed.

The significant differences between the RNs who responded to the survey and the provincial population of RNs on the two separate variables of organizational position and education placed another limitation upon the research. The survey sample consisted of a higher number of responses from RNs in management positions and RNs at the master's or doctoral level, thus the cumulative results had a slightly higher representation of the RNs in management positions and RNs with a higher educational preparation than what is actually present within the RN population in Alberta.

OTs

The professional college (ACOT) distributed the web-based survey to OTs electronically. Those who had limited computer access or who were uncomfortable with the computer-based approach might not have replied to the survey. The college stated that most of their business with members was conducted through the internet and e-mail and this limitation would have minimal impact on application of the results of the survey to the general population.

The chi-square analysis of the survey respondents and provincial population of OTs revealed significant differences in work location, age, and education between the survey data and the provincial data. The data on education indicated more individuals in the sample population possessing a higher education. Leaders and policy makers must consider the generalizability of these research results to their specific population i.e., what are the specific needs of professionals working in different locations, younger professionals, and professionals with less education.

PT (Public and Private)

The professional college (CPTA) distributed this web-based survey to PTs electronically. Those with limited computer access or who were uncomfortable with the computer-based approach might not have replied to the survey. The CPTA stated that most of their business with members was conducted through the internet and e-mail and this limitation would have minimal impact on application of the results of the survey to the general population of PTs.

Comparison and chi-square analysis of the survey respondents and provincial population of PTs revealed additional limitations related to work location, rank, and education in applying the survey data to the general population of PTs in Alberta. Leaders and policy makers must consider the generalizability of the research results to their specific population i.e., what are the specific needs of professionals working in different locations, professionals not holding a management or leadership position, and professionals with less education.

Focus Groups

I held three separate focus groups for RNs, OTs, and PT (public and private) at the University of Alberta in Edmonton. This location limited the participation of professionals from other areas of the province whose responses might have been directly related to their location.

Recruitment strategies that consisted of a combination of non-random sampling techniques constituted the second focus group limitation. These techniques limited the range of participants recruited to specific individuals who were contacted through the non-random sampling technique.

The timing of the focus group was a third limiting factor. I held the focus groups after work, when many professionals are fatigued or have other commitments. Individuals who participate in after-hour focus groups must be highly motivated, which has the potential to bias the results.

SEM Analysis

Sample Size

LISREL 8.80 (Jöreskog & Sörbom, 1996) identified a Critical N for each of the samples that was higher than the actual sample size: the RN CN = 206 (sample size = 144); the OT CN = 193 (sample size =100); the PT public CN = 226 (sample size = 169); and, the PT private CN = 109 (sample size = 92). The software also warned that the parameters might be unreliable for both the OT and the PT private because the sample sizes were too small for the number of parameters that were being investigated within the model. Samples that are smaller than the Critical N have reduced power and may misrepresent the effects present in the larger population. This must be considered when we generalize the results to the larger population.

Modifications

Eighteen modifications were made to the original model before it was applied to the survey data from each of the professional groups. The additional modifications were based on theory from the RN literature and provided a good theoretical model for the RNs. Although the modifications led to a good model fit for the remaining three professional groups, many of the suggested effects were not significant, indicating that theory is different for these groups. My research

must be regarded as initial descriptive exploratory research and the results used as guidelines for ongoing inquiry into the health care workplace.

Dissemination Strategies

The results of this study have significance for RNs, OTs, and PTs, their managers, leadership educators, and, finally and possibly most important, health care policy and decision makers. I will report these contributions to the substantive knowledge about health care leadership for RNs, OTs, and PTs, at leadership and academic conferences and in scholarly and research journals.

I will mail the research participants who requested copies of the results of the study a summary following its completion. I will also provide the provincial professional associations (CARNA, ACOT, CPTA) a copy of the dissertation for their libraries, and I will submit brief articles on the completed research to their provincial magazines. In addition, I will submit manuscripts that highlight important aspects of the research to professional practice journals that are read by most health care practitioners, leaders and educators. I will offer presentations to health care leaders at provincial, national, and international levels regarding the valuable contributions of resonant leadership, workplace empowerment, and *SAW* to healthy and productive workplace environments that have been structured to improve patient outcomes.

Conclusion

This research study makes significant contributions to existing health care workplace research that promise to create a healthier environment for staff and patients alike. Contributions include (a) the introduction of the construct of SAW

and indication of its role in the workplace for RNs, OTs, PT public and PT private, (b) an indication of the important role resonant leadership plays within the health care workplace and its multiple effects on other constructs within workplace theory, and (c) further development of workplace theory through the use of real measures of concepts to support and strengthen previous research.

The triangulation of research methods provides professionals and health care leaders with a rich body of information upon which to base future workplace decisions. My research indicates that *SAW* represents unique attributes of an empowered and productive workplace that will lead to improved patient outcomes. This research strengthens the arguments of previous researchers who supported the important contributions of workplace structures/processes to job satisfaction and organizational commitment (Cavanagh, 1999; Kinjerski, 2004) while emphasizing the important role played by resonant leadership in work settings in which professionals function as employees (Cummings, 2004). Positive and negative relationships between the model components will inform health care policy makers and managers and assist with the evaluation of existing health care workplaces and the design of future healthy work environments. This comprehensive research makes a valuable contribution to the substantive knowledge of the disciplines of nursing, occupational therapy, and physical therapy, particularly in the areas of leadership, workplace structural organization and specific indicators of healthy work environments such as SAW, job satisfaction and organizational commitment.

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APPENDIX A: TENETS OF WORKPLACE EMPOWERMENT

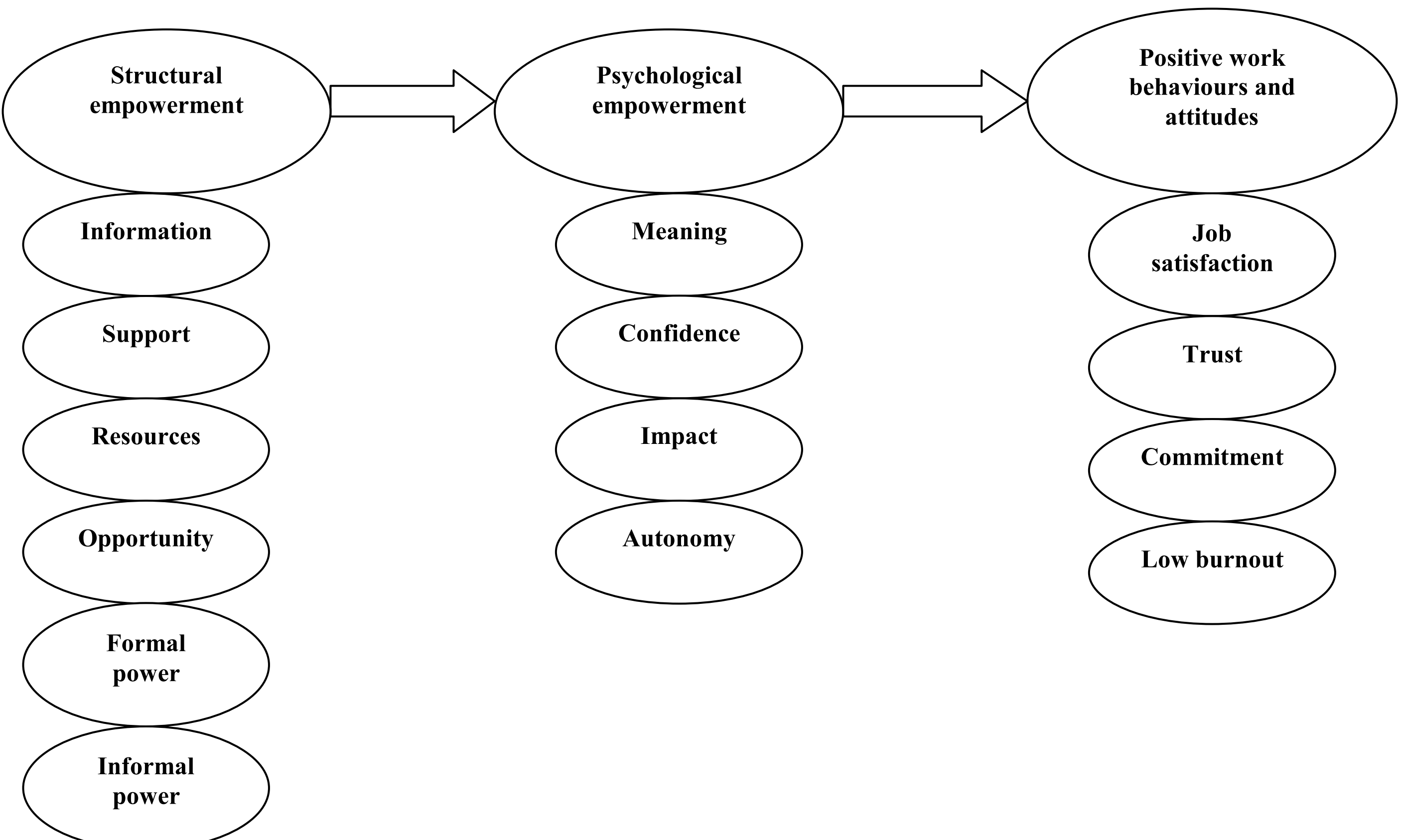

Figure A. Tenets of workplace empowerment (Laschinger, 2008b).

APPENDIX B: FOUR ORIENTATIONS TOWARD RELIGION AND SPIRITUALITY

		Spirituality	
		Positive	***Negative***
		Spiritual Based Organizations	**Spiritual Based Organizations**
Religion	***Positive***	“Religion and spirituality are synonymous and inseparable, both are examples of basic beliefs or intrinsic values” (Mitroff & Denton, 1999, p. 89) i.e., *Mormon-based and run businesses, Good Samaritan Society*	“Religion dominates spirituality and is a source of basic beliefs or values” (Mitroff & Denton, 1999, p. 89) i.e., *Hutterite farmers*
	Negative	**Evolutionary Organization** Starts as religious and evolves to ecumenical position i.e., *YMCA* **Recovering Organization** Organization that “adopts the principles of *Alcoholics Anonymous* as a way to foster spirituality” (Mitroff & Denton, 1999, p. 90) **Socially Responsible Organization** “Founders guided by strong spiritual principles that are applied directly to their business for the betterment of society” (Mitroff & Denton, 1999, p. 90) i.e., *The Body Shop, Mountain Equipment Co-op, Harley Davidson*	**Values-Based Organization** “Founders guided by basic philosophical principles that are not aligned with a religion , or even with spirituality” (Mitroff & Denton, 1999, p. 90) i.e. *Bank of Montreal, Exxon*

APPENDIX C: RN, OT, AND PT PROFESSIONAL DESCRIPTIONS AND INTERDISCIPLINARY SCENARIOS

Nursing

RNs make up the largest group of care providers in Health Care. The nursing practice standards published by the College and Association of Registered Nurses of Alberta stated that

> nursing practice is a synthesis of the interaction among theconcepts of person, health, environment and nursing. It is a direct service provided to a variety of patient/client populations throughout the life cycle, as well as groups and communities. The nursing practice context is any setting where a RN-client relationship occurs with the intention of responding to the needs or requests for nursing service. Caring is an integral part of this service. In the event that patients/clients are unable to respond to the RN on their own behalf, the term patient/client shall refer to the family or significant others. (p. 1, CARNA, 2003)

Occupational Therapy

OTs are an essential component of the interdisciplinary health care team. The Canadian Association of Occupational Therapy (CAOT) defines occupational therapy as:

> a health profession concerned with promoting health and well-being through the individual's occupation. Occupation refers to everything that people do during the course of everyday life. The primary goal of occupational therapy is to enable people to participate in the occupations which give meaning and purpose to their lives. OTs have a broad education that provides them with skills and knowledge to work collaboratively with people of all ages and abilities that experience obstacles to participation. These obstacles may result from a change in function (thinking, doing, feeling) because of illness or disability, and/or barriers in the social, institutional or and physical environment. (CAOT, 2003)

Physical Therapy

PTs on the health care team assist the client to attain and maintain their optimal level of physical. The Canadian Physiotherapy Association (CPA) gives the following description of the profession of physiotherapy in their consumer brochure:

> Physiotherapy is the primary health care profession that promotes wellness, mobility and independent function.
>
> Physiotherapists have advanced understanding of how the body moves, what keeps it from moving well and how to restore mobility..
>
> Physiotherapists manage and prevent many physical problems caused by illness, disability and disease, sport and work related injuries, aging and long periods of inactivity.
> Physiotherapist are skilled in the assessment and hands-on management of a broad range of conditions that affect the musculoskeletal, circulatory, respiratory and nervous systems. (CPA, 2009)

Interdisciplinary Scenarios

An example of the consultation role of RNs and PTs is revealed in the area of skin care. This has become a significant issue in many long term care settings since it is a “high-risk, high-volume, cost containment issue with potential for improvement” (Richardson, Prentice, & Rivers, 2001, p. 198). One long term care center in southern Ontario developed an interdisciplinary evidenced clinical pathway to work on this problem. The initial development group consisted of a clinical RN specialist, a clinical educator, a program director and two physicians. Consultation with the interdisciplinary team members such as physical therapy and occupational therapy did not occur until after the draft pathway had been developed. This additional consultation provided information on mobility management and types of mattresses, bed overlays and seating cushions that would reduce skin breakdowns (Richardson et al., 2001).

A fall reduction team in Montana led by the director of nursing and consisting of representatives from all the in-house services in the long term center provided discipline-specific evaluations. Nursing evaluated orthostatic hypotension, toileting, restraints; occupational therapy evaluated visual/perceptual skill level, positioning, environment, ADL functional level; while physical therapy evaluated balance, transfers, gait, environment. The team worked together to develop recommendations consisting of the four classes of clinical, environmental, restraint-free alarms and psychosocial interventions. Prior to proceeding with assessment, recommendation and interventions for the residents, the physician was informed of the resident’s status and asked for orders for fall team intervention (Eakman et al., 2002).

Patient safety and the appropriate use of restraints was the subject of a project involving all providers of care at an acute care center in Virginia, USA. Although there was administrative support for team members to participate in the project, it was difficult for disciplines such as occupational therapy and physical therapy to spend time in meetings because they were required to have a minimum number of direct treatment hours (Hancock et al., 2001).

An interdisciplinary committee was formed in Piedmont Hospital in Atlanta Georgia to oversee the redesigning of acute hospital care for older adults. Members included the clinical RN specialist (CNS) in geriatrics and managers and staff from different clinical departments (including rehabilitation services). An interdisciplinary team of front line staff composed of the CNS, pharmacist, nutritionist, volunteers, recreational therapist, patient care coordinator, chaplain, geriatric case manager providing post discharge follow-up, and finally, physical, occupational and speech therapists was brought together. The CNS not only conducted a geriatric assessment determining what rehabilitation services were required, but also ordered them. Nursing staff were trained to do parts of the geriatric assessment, thus decreasing lost time and enabling staff RNs to make rehabilitation referrals upon admission. Each team member was given autonomy to work with client issues within their scope of practice, putting interventions into place, as required. There was a significant increase in referrals to PTs, probably due to the early identification and ordering of services by the CNS. The physician's consent was required for inclusion of a patient in this pilot project, which could result in a delay for referral to the project if the physician chose to evaluate their patients before referring them. Nursing staff actively recruited patient participants in this program and contacted physicians for an order for patient participation (Tucker et al., 2006).

A Kansas hospital established an acute care of the elderly (ACE) unit that admits patients age 70 or older. A clinical RN specialist (CNS) provided leadership to the ACE team which consisted of a gerontologist, a pharmacist, physical and s, a social worker, a nutritional consultant and a resident chaplain. Team members worked with patient's primary RN to review the patient's baseline and current status. All ACE unit patients at risk for functional decline were screened within the first 24 hours by physical and s. Recommendations for physical and occupational therapy were then ordered by the physician (Cochran, 2005).

A collaborative effort of the interdisciplinary team was focused on improving the outcomes of care for the fragile population of patients with hip fractures in Wake Forest University Baptist Medical Center, North Carolina. The members of the working team consist of physicians from internal medicine and orthopedics, the CNS, case management, PTs, RNs and nutritionists.

> Evidence-based order sets, starting at the point of care entry for the patient reduce the misunderstandings between the physician and the RN regarding care implementation. . . . RNs and physicians discuss issues of care and

> are focused toward the discharge goal at a much earlier stage care. RNs have become proud of their contribution toward meeting goals and progress with the plan. (Watters & Moran, 2006, p. 164)

The daily multidisciplinary rounds on the units allow open exchange of innovative ideas and reinforcement of a consistent plan for individual patients. The CNS knows the entire plan of care for each patient, monitors it, intervenes when required and communicates important information with all team members as required or requested (Watters & Moran, 2006).

The John Hopkins Bayview Medical Center in Baltimore, Maryland has a multidisciplinary team working with homebound patients. Since home care is provided to patients in their homes and all disciplines are seldom represented in the patient's home at the same time, regular conferences present a special challenge. However an emphasis is placed on weekly multidisciplinary meetings which are led by a geriatric fellow, supervised by a geriatric physician specialist with additional representation from the disciplines of nursing, physical and occupational therapy, social work, and home health care. The case manager for the client, usually a RN or PT, provides updates on the patient, with each team member who has seen the patient contributing to the discussion. Since the state of Maryland requires all home care orders to be signed by a physician, treatment orders are changed, as required, by the geriatric fellow. A brief summary of the typical work scenario of a multidisciplinary team follows:

> A patient who has had several recent medication changes, including Coumadin requires the RN to educate him or her and the family members regarding possible interactions and side effects, the to reinforce medication management with a planner and to reinforce anticoagulant precautions and safety while using a knife or a razor, the PT to improve balance and prevent falls, and perhaps the social worker to obtain pharmacy assistance to pay for the medications. (Frock & Barnes, 2003, p. 203)

APPENDIX D: MODIFICATIONS TO INITIAL RESEARCH QUESTION AND IMPACT ON SAMPLE SIZE

Further exploration of the theory grounding this research and structural equation modeling (SEM) led to several changes in the variables measured in this research. The demographic variables of age and experience appeared to measure similar properties of the sample population. Consequently age was removed from the equation, while the demographic variable of experience was retained.

Previous research by Laschinger (2008b) used a measurement of the overall construct of structural empowerment. The overall construct of structural empowerment consisted of the sum of the scores of the four concepts composing this concept. Upon review of previous research and the strengths of SEM, the decision was made to include the twelve concepts of; information, opportunity, support, resources, impact, competence, meaning, self-determination, engaging work, sense of community, spiritual connection and mystical experience. The measurements of the overall constructs of structural empowerment, psychological empowerment and SAW were not included in the model. This allowed us to create a more detailed model of the relationships between concepts. However, this decision also led to the inclusion of 18 variables in the model, rather than 14. Consequently our sample size was underestimated.

APPENDIX E: CORRESPONDENCE WITH AUTHORS

Dr. Heather Laschinger:

	Jennifer Elaine Murphy <jemurphy@uwo.ca>
Sent	Thursday, February 2, 2006 7:53 am
To	jijwagner@shaw.ca
Cc	javascript:parent.addSender(%22%22)
Bcc	javascript:parent.addSender(%22%22)
Subject	Re: Empowerment Questionnaire Request Form
Attachments	CWEQforrequests.doc 40 K; CWEQ-IIforrequests.doc 58 K; CWEQ-IIuserguideAugust2004.doc 61 K; Signed Request Form -Joan Wagner.pdf 38 K

Dear Joan,
Thank you for your interest in my work. Attached are the signed request form and questionaires. If you have any questions please do not hesitate to contact me.
Good luck with your study. Heather
Dr. Heather K. Spence Laschinger, Professor
School of Nursing, University of Western Ontario
London, Ontario, Canada N6A 5C1
Tel:519-661-4065 Fax: 519-661-3410
E-mail: hkl@uwo.ca

----- Original Message -----
From: jijwagner@shaw.ca
Date: Wednesday, February 1, 2006 11:26 pm
Subject: Empowerment Questionnaire Request Form
To: hkl@uwo.ca
Cc: jmalmost@uwo.ca, jemurphy@uwo.ca, jensmurph@hotmail.com

> NURSING WORK EMPOWERMENT SCALE
> Request Form
>
> I request permission to copy the Nursing Work Empowerment Scale
> as developed by Dr. G. Chandler and Dr. Heather K.
> Spence Laschinger. Upon completion of the research, I will
> provide Dr. Laschinger with a brief summary of the results,
> including information related to the use of the Nursing Work

> Empowerment Scale used in my study.
>
> > Questionnaires Requested:
> Conditions of Work Effectiveness-I (includes JAS and ORS): Yes
>
> Conditions of Work Effectiveness-II: Yes
>
> Job Activity Scale only:
>
> Organizational Relationship Scale only:
>
> Organizational Development Opinionnaire
> or Manager Activity Scale:
>
> Other Instruments:
>
> Please complete the following information:
>
> Date: February 1, 2005
> Name: Joan Wagner
>
> > Permission is hereby granted to copy and use the Nursing Work
> Empowerment Scale.
>
> Date:
>
> Signature:
>
> Dr. Heather K. Spence Laschinger, Professor
> School of Nursing, University of Western Ontario
> London, Ontario, Canada N6A 5C1
> Tel:519-661-4065 Fax: 519-661-3410
> E-mail: hkl@uwo.ca

Dr. Gretchen Spreitzer:

Hi Joan,

What a fascinating research question. I am happy to have you use my instrument in your research. I do ask that you share your findings with me so that I can learn from you!

Gretchen M. Spreitzer
Professor of Management and Organizations
Ross School of Business
University of Michigan

From: Joan Wagner [mailto:jijwagner@shaw.ca]
Sent: Mon 4/24/2006 5:42 PM
To: spreitze@umich.edu
Subject: Psychological empowerment questionnaire
Greetings
My name is Joan Wagner. I am a PhD student at the University of Alberta, Canada, Faculty of Rehabilitation Medicine. I am hoping to complete my research on empowerment using Laschinger's workplace empowerment model which includes Kanter's structural empowerment and your psychological empowerment model. I hope to determine if the Spirit at Work questionnaire developed by Kinjerski (2004) reveals additional components of empowerment, not revealed in structural and psychological empowerment.

I would like to request permission to use your questionnaire, as posted on your web site, as a measurement of psychological empowerment in my research.

Thanking you in advance for your assistance.

Yours truly,
Joan Wagner

Dr. Val Kinjerski:

	Val Kinjerski <valkinjerski@telus.net>			
Sent	Friday, January 27, 2006 5:45 pm			
To	Joan Wagner <jijwagner@shaw.ca>			
Cc	javascript:parent.addSender(%22%22)			
Bcc	javascript:parent.addSender(%22%22)			
Subject	Re: Construct validity of Spirit at Work measurement scale			
Attachments	The Spirit at Work Scale Manuscript Jan 23.06 JMP.doc	164K	Final 18 item Spirit at Work Scale.doc	47K

Happy New Year Joan,

Good to hear from you. It sounds like you are progressing well. Just to let you know, we have done further data analysis on the SAWS (Spirit at Work Scale) and were able to reduce it to 18 items. We have a manuscript describing the process and detailing the results under review with the Academy of Management (Conference in August) and a journal. I've attached it for your information. Hopefully it will answer all the questions you might have. Now that we have reduced it to 18 items, we will have to update the manual (but the info you require is in the manuscript). I'll be sure to get you a copy once it is ready, but in the meantime, I've attached a copy of the new scale. My schedule is quite full for the next two months, so it may take some time before it is ready.

Just to let you know that we have also done some work to validate the SAWS. This manuscript is also in preparation and once completed, I'll send you a copy. Just for your info, the instruments we used to determine convergent and discriminant validity include: Job satisfaction, Organizational commitment, organizational culture, Vitality, Satisfaction with Life Scale, Gratitude, Short Index of Self-Actualization, Authenticity (I think),Five Factor of Personality Mini- Markers, ASPIRES (spirituality), and Mysticism. We thought that we had a group with both high and low spirit at work, but it seemed that mostly the high *SAW* folks responded (or at least their mean spirit at work was higher than our developmental sample). Getting folks with low spirit at work to respond is a challenge - I hope that you are more successful than I was.

Keep me posted. This is very exciting.

Val

Dr. Denise Miner-Williams:

From	Denise Miner-Williams <dminerwilliams@satx.rr.com>
Sent	Friday, February 2, 2007 5:53 am
To	Joan Wagner <jijwagner@shaw.ca>
Cc	javascript:parent.addSender(%22%22)
Bcc	javascript:parent.addSender(%22%22)
Subject	Re: permission to use a table

Hi, Joan-
Glad you found the "Puzzle" manuscript helpful. It took me two years in my doctoral program to get some kind of understanding of spirituality - which resulted in this framework. It has proved invaluable in my research - which, of course, is the purpose of mid-level theory!

There should be no problem with using the properly referenced table. I'll check with Blackwell Publications, but will only let you know if there's anything they stipulate. I would ask you a favor, however, of sending me a copy of the abstract of your dissertation - and the manuscript that hopefully results from the study!

Many blessings on your work!
~Denise

----- Original Message -----
From: "Joan Wagner" <jijwagner@shaw.ca>
To: <dminerwilliams@satx.rr.com>
Sent: Wednesday, January 31, 2007 11:48 AM
Subject: permission to use a table

> Dear Ms. Miner-Williams,
> My name is Joan Wagner. I am a PhD student at the University of Alberta,
> Faculty of Rehabilitation Medicine. I am presently writing my research
> proposal on Spirit at Work and Workplace Empowerment. I appreciated your
> article "Putting a puzzle together: making spirituality meaningful for
> nursing using an evolving theoretical framework." I found it to be very
> valuable in the discussion of a definition of spirituality.
> I would like to ask your permission to use your Table 1 Select definitions
> of spirituality within my proposal. I will ensure that full recognition
> of your work is given. The table is a valuable summary of previous work
> in this area.
>
> Thanking you in advance for your assistance.

Dr. Greta Cummings

From	Greta Cummings <greta.cummings@ualberta.ca>
Sent	Saturday, March 17, 2007 7:56 pm
To	Joan Wagner <jijwagner@shaw.ca>
Cc	Sharon Warren <sharon.warren@ualberta.ca>
Bcc	javascript:parent.addSender(%22%22)
Subject	RE: Leadership study
Attachments	Cummings Resonant Leadership Scale dec 12 2006.doc 62 K

Hi Joan;

I have attached the Resonant Leadership Scale. I am just now going through the preliminary psychometrics and they look good. If I need to make some changes, I'll let you know before you actually send out your survey. Perhaps you could check with me. I have planned on using the mean of the items as a resonant leadership score but will let you know if that changes once I have done some factor analysis.

I would like a copy of the data from this instrument plus the demographics in order to continue testing and refining the scale, and of course a reference to the source. I should have it published by the time you'll be publishing.

Best wishes! You've got a very good study.

greta

APPENDIX F: CORRESPONDENCE WITH SURVEY AND FOCUS GROUP PARTICIPANTS

Information Sheet to Accompany Web-Based Questionnaire

Spirit at Work, Workplace Empowerment and Resonant Leadership Survey

Information Sheet

Investigators:

Joan Wagner, PhD Candidate, Faculty of Rehabilitation Medicine, University of Alberta

Phone: 461-2691 E-mail: jijwagner@shaw.ca

Dr. Sharon Warren, Professor, Faculty of Rehabilitation Medicine, University of Alberta

What is the purpose of the study?

To discover how spirit at work, workplace empowerment and leadership are linked to each other for RN's, OT's and PT's in Alberta.

If you responded to this survey previously, thank you for your interest and please do not respond again to this survey.

Who is being asked to take part in the study and what do you have to do?

Random samples of registered RNs, s and PTs are being asked to take part in this survey. Please type in http://members.shaw.ca/jijwagner to open the survey and advice on how to fill out the survey. The survey should take about 10-20 minutes. You can choose not to answer any question you do not want to answer. We realize that your time is precious so we have done our best to make the survey easy to fill out.

Who will know the answers that you give on the survey?

There will be no markers placed on your response that will link you to your answer. Data will be stored on a flash drive/memory stick in a locked filing cabinet at the university. Only the investigators will have access to the data. Survey Gold will be used to conduct the web-based survey. The e-mail invitation to this research has been randomly distributed by ACOT to OT's across Alberta. The researcher will never know the names or addresses of selected individuals. Data can be removed on a regular basis from the Survey Gold server database and

it is gone from the server permanently. The Survey Gold software company (GHS) does not have access to the information obtained from cookies. GHS will not use IP addresses to identify personal information. “Traffic data” collected by GHS will not identify the users.

What are some of the possible benefits of the study?

We believe that the findings of this study will increase knowledge of the link between leadership, workplace empowerment and spirit at work. Showing that spirit at work helps to make an empowered and productive workplace, will help managers to make a healthy workplace for health care workers. This will also promote patient health. Research reports will be placed at all professional colleges for those who are interested. If you want your own copy of the summary of the study you may reach Joan Wagner by e-mail or at the phone number listed above.

What are some of the possible risks of participation in the study?

We are unaware of any possible risks for you as a result of participation in this study.

Deadline for survey completion is June 12, 2008.

If you have any questions, please contact Joan Wagner whose phone number and e-mail is listed above. If you have any questions about how the study is being carried out you can contact Dr. Paul Hagler, Associate Dean for Graduate Studies and Research, Faculty of Rehabilitation Medicine at 492-9674.

If you have concerns about your rights as a participant you may contact the Health Research Ethics Board at 492-0302.

Consent to participate in the study

Hitting the “send” button on the survey implies your consent to participate in the survey.

Please click on the following link to proceed with the study:

http://members.shaw.ca/jijwagner

E-Mail Reminder

Spirit at Work, Workplace Empowerment and Resonant Leadership

Please help us to discover the link between leadership, work place empowerment and spirit at work. Let’s work towards creating a healthy work place for health care workers. Go to: http://members.shaw.ca/jijwagner and fill out the survey by (date to be determined).

If you have already completed this survey, please accept our thank you.

Joan Wagner (Primary Investigator)
(780) 461-2691
e-mail – jijwagner@shaw.ca

Information Sheet to Accompany Postal Survey

Spirit at Work, Workplace Empowerment and Resonant Leadership Survey

Investigators:

Joan Wagner, PhD Candidate, Faculty of Rehabilitation Medicine, University of Alberta

Phone: (780) 461-2691 E-mail: jijwagner@shaw.ca

Dr. Sharon Warren, Professor, Faculty of Rehabilitation Medicine, University of Alberta

What is the purpose of the study?

To discover how spirit at work, workplace empowerment and leadership are linked to each other for RN's, OT's and PT's in Alberta.

If you have responded to this survey previously, thank you for your interest and please do not respond again to this survey.

Who is being asked to take part in the study and what do you have to do?

Random samples of registered RNs, s and PTs are being asked to take part in this survey. Your participation in this survey is voluntary. Please complete the attached survey and return it in the enclosed envelope. The survey should take about 10 – 20 minutes to complete. You can choose not answer any question you do not want to. We realize that your time is precious so we have done our best to make the survey easy to fill out.

Who will know the answers that you give on the survey?

There will be no markers placed on your response that will link you to your answer. Only the investigators will have access to the data from the study. CARNA has randomly distributed this survey to RN's across Alberta. The investigators do not have access to the names or addresses of selected RN's. Returned and completed questionnaires will be kept in a locked filing cabinet at the University of Alberta.

What are some of the possible benefits of the study?

We believe that the findings of this study will increase knowledge of the link between leadership, workplace empowerment and spirit at work. Showing that spirit at work helps to make an empowered and productive workplace, will help managers to make a healthy workplace for health care workers. This will also promote patient health. Research reports will be placed at all professional colleges

for those who are interested. If you want your own copy of the summary of the study you may reach Joan Wagner by e-mail or at the phone number listed above.

What are some of the possible risks of participation in the study?

We are unaware of any possible risks for you as a result of participation in this study.

Deadline for survey completion is June 12, 2008.

Return of the survey implies one's consent to participate. If you have any questions, please contact Joan Wagner whose phone number and e-mail is listed above. If you have any questions about how the study is being carried out you can contact Dr. Paul Hagler, Associate Dean for Graduate Studies and Research, Faculty of Rehabilitation Medicine at 492-9674.

If you have concerns about your rights as a participant you may contact the Health Research Ethics Board at 492-0302.

Yours truly,

Joan Wagner

Postal Reminder

Spirit at Work, Workplace Empowerment and Resonant Leadership

Please help us to discover the link between leadership, work place empowerment and spirit at work. Let's work towards creating a healthy work place for health care workers. If you have not already completed this survey, please complete and return it in the enclosed envelope by June 12 , 2008. If you have already completed this survey, please accept our thank you.

Joan Wagner (Primary Investigator)
(780) 461-2691 e-mail – jijwagner@shaw.ca

Information Form for Focus Group to Be Attached to Consent

Spirit at Work, Workplace Empowerment and Resonant Leadership

Focus Group

Information Sheet

Investigators:

Joan Wagner, PHD Candidate, Faculty of Rehabilitation Medicine, University of Alberta, Phone: 461-2691 E-mail: jijwagner@shaw.ca

Dr. Sharon Warren, Professor, Faculty of Rehabilitation Medicine, University of Alberta

What is the purpose of the study?

To study how spirit at work, workplace empowerment and resonant leadership are related to each other for RN's, OT's and PT's in Alberta.

Who is being asked to take part in the research and what do you have to do?

Volunteers from RN, OT or PT are being asked to take part in this focus group. You will be asked to spend two hours taking part in group meetings. The session will be voice-taped.

Your input in this study is voluntary, and if you wish to pull out from the study or leave, you may do so at any time, and you do not need to give any reasons for doing so. If you do withdraw from the study, this will have no effect on your link with the University of Alberta or any other agency.

Who will know the answers that you give?

Once group members have been picked, only the researcher will have access to their information and these records will be kept in a locked filing cabinet on the university campus for seven years. The names of all the people in the study will be kept private. Group members will be called only by first names.

There could be problems with your privacy during this study. To prevent problems with your own or others' privacy, you are asked not to talk about any of your own or other's private experiences that you would consider too personal or revealing.

You are asked to respect the privacy of the other members of the group by not talking about any personal facts that they share during the meeting.

To make sure that key discussions are clear to researchers, exact wording may be quoted in the final paper.

Once the results from the meeting have been copied onto paper, only the researchers will have access to the tapes that will be made. These tapes will be kept in a locked filing cabinet at the University of Alberta. For any copies that are made, not only names but any other facts that will link you to the tapes, will be either removed or changed.

How will the study help us?

We believe that the findings of this study will increase our knowledge of the link between leadership, workplace empowerment and spirit at work. Showing that spirit at work helps to make an empowered and productive workplace, will help managers to make a healthy workplace for health care workers. This will also promote patient health. Research reports will be placed at all professional colleges for those who are interested. If you want your own copy of the summary of the study you may reach Joan Wagner by e-mail or at the phone number listed above.

What are some of the possible risks of participation in the study?

We are unaware of any possible risks for you as a result of participation in this study.

What if you have other questions?

If you have any questions, please contact Joan Wagner whose phone number and e-mail is listed above.

If you have any questions about how the study is being carried out you can contact Dr. Paul Hagler, Associate Dean for Graduate Studies and Research, Faculty of Rehabilitation Medicine at 492-9674.

If you have concerns about your rights as a participant you may contact the Health Research Ethics Board at 492-0302.

Consent Form for Focus Groups

Part 1 :

Title of Project: Spirit at Work, Workplace Empowerment and Resonant Leadership

Principal Investigator: Dr. Sharon Warren, Professor, Faculty of Rehabilitation Medicine, University of Alberta
Co-Investigator: Joan Wagner , PHD Candidate, Faculty of Rehabilitation Medicine, University of Alberta
Contact Names: Joan Wagner, PHD Candidate, Faculty of Rehabilitation Medicine, University of Alberta, Phone Number: (780) 461-2691
Dr. Paul Hagler, Associate Dean for Graduate Studies and Research, Faculty of Rehabilitation Medicine, University of Alberta Phone Number: (780) 492-9674
Health Research Ethics Board: 492-0302

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you give permission to be audio-taped during the focus group session?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and with no effects on your relationship with the University of Alberta or any other organization or agency?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐

Who explained this study to you? ___________________________________

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject ___________________________________

(Printed Name) ___________________________________
Date___________________________________

Signature of Witness: ___________________________________
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.
Signature of Investigator or Designee ________________ Date ____________

APPENDIX G: SURVEY INSTRUMENT AND FOCUS GROUP LEADING QUESTIONS

A Survey of Spirit at Work, Work Empowerment and Resonant Leadership for RNs, s, and PTs

You are invited to participate in a research project that is examining attributes of the workplace that contribute to increased Spirit at Work (*SAW*) of the RN's, PT's and OT's providing care to individuals within that workplace. This study will also examine the relationship of *SAW*, empowerment, and resonant leadership to the individual professional's job satisfaction and commitment to the organization.

General Instructions:

The survey is organized into 7 sections as follows:

1. You will be asked questions about your working environment.
2. This will be followed by a number of self-orientations that people may have with regard to their work role. You will be asked to indicate the extent to which you agree or disagree with each one. This will measure your psychological empowerment within your specific working environment.
3. The survey then moves on to measure your experiences of Spirit at Work.
4. A short section follows will help to identify your satisfaction with your present job.
5. This following section will ask you about your commitment to the organization.
6. Leadership may play an important role on how you feel about your work. The next section will look at the type of leadership present within your work unit.
7. The final section will ask specific questions about your personal background and your practice, role and setting.

Comments on the last page of the survey are welcome.

Please note that you will be asked to rate your answers on scales ranging from 1-5, 1-6 or 1-7, and that answering formats vary throughout the survey.

SECTION 1: Conditions of Work Effectiveness

Please rate each item on how true the statement is for you. Select the number that best fits your experience.

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

1. Challenging work

- ☐ None (1)
- ☐ Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

2. The chance to gain new skills and knowledge on the job

- ☐ None (1)
- ☐ Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

3. Tasks that use all of your own skills and knowledge

- ☐ None (1)
- ☐ Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?

4. The current state of the hospital

- ☐ No Knowledge (1)
- ☐ A Little Knowledge (2)
- ☐ Some Knowledge (3)
- ☐ More Knowledge (4)
- ☐ Know a Lot (5)

5. The values of top management.

- ☐ No Knowledge (1)
- ☐ A Little Knowledge (2)
- ☐ Some Knowledge (3)
- ☐ More Knowledge (4)
- ☐ Know a Lot (5)

6. The goals of top management.

- ☐ No Knowledge (1)
- ☐ A Little Knowledge (2)
- ☐ Some Knowledge (3)
- ☐ More Knowledge (4)
- ☐ Know a Lot (5)

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

7. Specific information about things you do well.

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

8. Specific comments about things you could improve.

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

9. Helpful hints or problem solving advice.

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

10. Time available to do necessary paperwork.

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

11. Time available to accomplish job requirements.

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

12. Acquiring temporary help when needed.

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

IN MY WORK SETTING/JOB:

13. The rewards for innovation on the job are

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

14. The amount of flexibility in my job is

- ☐ None (1)
- ☐ A Little (2)
- ☐ Some (3)
- ☐ More (4)
- ☐ A Lot (5)

15. The amount of visibility of my work-related activities within the institution is

- ☐ None (1)
- ☐ More (4)
- ☐ A Little (2)
- ☐ A Lot (5)
- ☐ Some (3)

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

16. Collaborating on patient care with physicians

- ☐ None (1)
- ☐ More (4)
- ☐ A Little (2)
- ☐ A Lot (5)
- ☐ Some (3)

17. Being sought out by peers for help with problems.

- ☐ None (1)
- ☐ More (4)
- ☐ A Little (2)
- ☐ A Lot (5)
- ☐ Some (3)

18. Being sought out by managers for help with problems.

- ☐ None (1)
- ☐ More (4)
- ☐ A Little (2)
- ☐ A Lot (5)
- ☐ Some (3)

19. Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, s, Registered RNs, Dieticians.

- ☐ None (1)
- ☐ More (4)
- ☐ A Little (2)
- ☐ A Lot (5)
- ☐ Some (3)

OVERALL IMPRESSION

20. Overall, my current work environment empowers me to accomplish my work in an effective manner.

- ☐ Strongly Disagree (1)
- ☐ Disagree (2)
- ☐ Neutral (3)
- ☐ Agree (4)
- ☐ Strongly Agree (5)

21. Overall, I consider my workplace to be an empowering environment.

- ☐ Strongly Disagree (1)
- ☐ Disagree (2)
- ☐ Neutral (3)
- ☐ Agree (4)
- ☐ Strongly Agree (5)

SECTION 2: Psychological Empowerment

Using the following scale, please indicate the extent to which you agree or disagree that each one describes your self-orientation by marking it with an "X" in the box. Select only one.

Very Strongly Disagree (1)
Strongly Disagree (2)
Disagree (3)
Neutral (4)
Agree (5)
Strongly Agree (6)
Very Strongly Agree (7)

1. I am confident about my ability to do my work

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

2. The work that I do is important to me.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

3. I have significant autonomy in determining how I do my job.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

4. My impact on what happens in my department is large.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

5. My job activities are personally meaningful to me.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

6. I have a great deal of control over what happens in my department.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

7. I can decide on my own how to go about doing my own work.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

8. I have considerable opportunity for independence and freedom in how I do my job.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

9. I have mastered the skills necessary for my job.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

10. The work I do is meaningful to me.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

11. I have significant influence over what happens in my department.

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree (6)
- ☐ Very strongly agree (7)

12. I am self-assured about my capabilities to perform my work activities.

☐ Very strongly disagree (1)
☐ Strongly disagree (2)
☐ Disagree (3)
☐ Neutral (4)
☐ Agree (5)
☐ Strongly agree (6)
☐ Very strongly agree (7)

SECTION 3: Spirit at Work

This questionnaire includes 18 statements about experiences at work. Please rate each item on how true the statement is for you. Select the number that best fits your experience. For example, if you "completely agree" with the statement, choose 6; or if you "mostly disagree" with a statement, choose 2.

1	2	3	4	5	6
Completely disagree	Mostly disagree	Somewhat disagree	Somewhat agree	Mostly agree	Completely agree

How true is this statement?

1. I experience a match between the requirements of my work and my values, beliefs, and behaviours.	1 2 3 4 5 6
2. At times, I experience a "high" at my work.	1 2 3 4 5 6
3. I experience a real sense of trust and personal connection with my coworkers.	1 2 3 4 5 6
4. I am able to find meaning or purpose at work.	1 2 3 4 5 6
5. At moments, I experience complete joy and ecstasy at work.	1 2 3 4 5 6
6. I experience a connection with a greater source that has a positive effect on my work.	1 2 3 4 5 6
7. I am passionate about my work.	1 2 3 4 5 6
8. At times, I experience an energy or vitality at work that is difficult to describe.	1 2 3 4 5 6
9. I am fulfilling my calling through my work.	1 2 3 4 5 6
10. My spiritual beliefs play an important role in everyday decisions that I make at work.	1 2 3 4 5 6
11. I have a sense of personal mission in life, which my work helps me to fulfill.	1 2 3 4 5 6
12. I have moments at work in which I have no sense of time or space.	1 2 3 4 5 6

1	2	3	4	5	6
Completely disagree	Mostly disagree	Somewhat disagree	Somewhat agree	Mostly agree	Completely agree

How true is this statement?

13. I share a strong sense of purpose and meaning with my coworkers about our work.	1 2 3 4 5 6
14. I feel grateful to be involved in work like mine.	1 2 3 4 5 6
15. I receive inspiration or guidance from a Higher Power about my work.	1 2 3 4 5 6
16. I experience moments at work where everything is blissful.	1 2 3 4 5 6
17. I feel like I am part of "a community" at work.	1 2 3 4 5 6
18. At the moment, I am right where I want to be at work.	1 2 3 4 5 6

SECTION 4: Job Satisfaction

Using the following scale, please indicate the extent to which you agree or disagree that each one describes your job satisfaction by marking it with an "X" in the box. Select only one.

Very Strongly Disagree (1)

Strongly Disagree (2)

Disagree (3)

Neutral (4)

Agree (5)

Strongly Agree (6)

Very Strongly Agree (7)

1. If a good friend of mine told me that he/she was interested in working a job like mine I would strongly recommend it:

☐ Very strongly disagree (1)

☐ Strongly disagree (2)

☐ Disagree (3)

☐ Neutral (4)

☐ Agree (5)

☐ Strongly agree(6)

☐ Very strongly agree (7)

2. All in all, I am very satisfied with my current job:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

3. In general, my job measures up to the sort of job I wanted when I took it:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

4. Knowing what I know now if I had to decide all over again whether to take my job, I would:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

SECTION 5: Organizational Commitment

1. I would be very happy to spend the rest of my career with this organization:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

2. I really feel as if this organization's problems are my own:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

3. I do not feel a strong sense of "belonging" to my organization:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

4. I do not feel "emotionally attached" to this organization:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

5. I do not feel like "part of the family" at my organization:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

6. This organization has a great deal of personal meaning for me:

- ☐ Very strongly disagree (1)
- ☐ Strongly disagree (2)
- ☐ Disagree (3)
- ☐ Neutral (4)
- ☐ Agree (5)
- ☐ Strongly agree(6)
- ☐ Very strongly agree (7)

SECTION 6: Resonant Leadership

In answering the following, please focus on the formal leader of the *clinical program or unit where you work the majority of your time.*

Please indicate your level of agreement with the following statements by circling the number of your choice.

1 Strongly disagree	2 Disagree	3 Sometimes disagree	4 Agree	5 Strongly agree	6 Unable to determine

The leader in my clinical program or unit . . .						
1. Looks for feedback to ideas and initiatives even when it is difficult to hear.	1	2	3	4	5	6
2. Acts on values even if it is at a personal cost.	1	2	3	4	5	6
3. Focuses on successes and potential rather than failures.	1	2	3	4	5	6
4. Supports teamwork to achieve goals and outcomes.	1	2	3	4	5	6
5. Calmly handles stressful situations.	1	2	3	4	5	6
6. Actively listens, acknowledges, and then acts on requests and concerns.	1	2	3	4	5	6
7. Actively mentors and coaches individual and team performance.	1	2	3	4	5	6
8. Effectively resolves conflicts that arise.	1	2	3	4	5	6
9. Engages me in working toward a shared vision.	1	2	3	4	5	6
10. Allows me freedom to make important decisions in my work.	1	2	3	4	5	6

SECTION 7: Background Information

To assist us to describe the health professionals who have responded to this questionnaire we are going to ask you some additional questions. Please provide information concerning yourself and your work environment by marking thus [X] the appropriate category.

1. Your professional discipline:

☐ Nursing ☐ Physical therapy

☐ Occupational Therapy

2. Your work location:

(Select only one.)

☐ Home Care ☐ Private Practice

☐ Acute Care (Hospital) ☐ Other:

☐ Long term care

3. Your position in the organization:

☐ Staff ☐ Management

4. Total number of years in professional practice: (Count present year as a complete year.)______________

5. Age:

☐ Under 30 ☐ 45-55

☐ Over 50 ☐ 30-45

6. Highest level of education you have completed:

☐ Professional diploma ☐ Master's degree

☐ Doctorate degree ☐ Baccalaureate degree

7. Do you work in a setting where RNs, s and PTs interact?

☐ Yes ☐ No

8. Comments:

APPENDIX H: CONTENT ANALYSIS OF OPEN-ENDED QUESTION FROM SURVEY

RN Responses to Open-Ended Question

Structural empowerment. Twenty two comments on structural empowerment were written by RNs. The presence of opportunity and access to information were each mentioned by one RN, while another RN stated she had informal empowerment due to flexibility and the need to be innovative and creative in her job.

Six RNs described an absence of support in their workplace with comments such as “every day I am faced with an environment that is high paced and critical with little reward.” One RN optimistically described what happens when staff are supported: “the sky is the limit to what creative programs and super patient care people in helping professions can come up with when they feel valued and empowered.”

Absence of needed resources such as adequate staffing, time for patient care, resources for staff wellness and overall budget were described as impacting seven RNs work environment. Three of the seven RNs made comments similar to the following “Time constraints and staffing shortages are huge barriers to ‘being there’ for clients when they need you.”

One RN described formal workplace empowerment which allowed for flexibility, innovation and creativity. Three RNs described the presence of informal empowerment in their workplaces making comments such as “we consult frequently and are very open to suggestions as to what works most efficiently and are always willing to review successes and failures.” However another RN stated that “when it comes to issues that arise that need to be addressed with management regarding patient safety, new ideas for the betterment of our unit and so on we (the staff) are feeling ignored and bothersome.”

Psychological empowerment. Psychological empowerment was referred to by nine RNs in the comment section of the survey. One RN talked about psychological empowerment, stating: “I believe strongly in empowering people, and emanating a passion to work in such a challenging department.” Autonomy or self determination was an issue for three respondents with two respondents expressing concerns about the lack of autonomy, while another RN described how she had made her own choices with regards to her career path and the jobs she undertook. Two RNs questioned what the organization meant to them, stating “I feel less satisfied with the entire organization and at times question the values that are acted upon (not the ones in writing).” Three RNs wondered about the impact they were having on the workplace when they expressed concerns about treatment received from managers “I worked with my manager for over a year before she

learnt my name," while another excited staff RN described an organization using a health care prototype that stresses care for the caregiver.

SAW. RN submitted 34 comments about *SAW*. *Sense of community* was commented on by 18 RNs as they described how each team member is a valued part of the team. Eight RNs discussed the important personal qualities brought to the workplace by each team member that influence the dynamics of the team. " I work in a very small teaching unit of ten RNs. We are close and work together in harmony, but also efficiently." The presence of a positive and "upbeat" atmosphere that benefits the clients was commented on by five RNs, "I strongly believe that this can be a healing atmosphere when the client senses that the staff get along with each other." Six RN stated they were worried because staff concerns are not heard, staff do not feel empowered or valued, or they are short staffed and overworked, resulting in a loss of *sense of community* and culminating in loss of staff. "As a result, some of the really good staff are starting to feel undervalued and are seeking and gaining employment elsewhere. This is a sad loss to the clients as well as to peers." A couple of respondents described the negative impact of organizational politics on their sense of being an important part of the larger health care community: "organizationally, the majority of dollars go to acute care and the hospitals, thus it is my feeling that public health and community care remain a pebble in the shoe of this health region."

Engaging work was commented on by seven RNs. The theme of caring for patients was voiced by six RNs, with one respondent stating that we "teach others how to treat us." Five expressed concerns about difficulties providing the care in the manner they felt they should, "I am feeling very frustrated as I love my job and what I do for my patients as well as how they make me feel."

A failure to feel a connection to their work (*mystical experience*) was voiced by seven RNs. One voiced this sentiment by simply stating "So . . . I am bitter and I mostly hate being a RN." Another stated "I find myself just praying to tolerate the next shift at times." One RN discussed her unhappiness with her work stating "I work in this job because I have a mortgage and I like to eat. I would quit in a heartbeat if I had enough money."

Two RNs discussed *spiritual connection* and how openness to spiritual beliefs is important for client care and for the workplace.

Leadership. RNs made 17 separate comments on leadership. Eleven RNs expressed concerns regarding the leadership in their organization emphasizing that "leaders are 100% accountable for the teams they create" and they may not be "building the spirit of the unit but seem to be detrimental to the breaking of the spirit." Six RN commented that work environment is positive despite worries about management "the environment is mostly positive when discussing co-workers, however we are not being managed in a positive or empowering way." The presence of acting nursing managers or leaders was described by two

respondents who believed this influenced their answers, with one stating "we haven't had a formal leader (permanent) in place for over a year now."

Job satisfaction. Job satisfaction was mentioned by four RNs in their comments. Three of the RNs expressed satisfaction with their jobs and the work they get to do. "I am very content in my position as a RN and satisfied in my career choice!" The single remaining RN stated that her satisfaction levels are constantly changing, due to the changing nature of her profession.

Organizational commitment. Eight RNs described lack of organizational commitment within their comments. One respondent described her casual position, stating : "The casual work that I do now is why my answers reflect a more neutral view, and why I don't feel or experience a sense of connection to my workplace." The remaining seven respondents described RNs who are either leaving or seriously thinking of leaving the organization. "I think maybe that nursing has burned me out. My spirit for nursing and its work is gone—too many years of abuse from the system—overwork—underappreciated and tired of trying. Now it is just a job and pays the bills—maybe it is time to leave nursing."

OT Responses to Open-Ended Question

The respondents were asked if they had any additional comments on spirit at work, workplace empowerment or leadership. Fifty seven OTs (56% of OT respondents) offered comments.

Structural empowerment. Fourteen OTs documented comments on structural empowerment. Opportunity in the present job was described by two OTs who talked about a desire to learn more and to develop new skills. Three OTs talked about access to support with two OTs stating that they have "freedom and autonomy," but very little constructive feedback, while the other describes how the support of the team working together can create opportunities for staff and clients alike. One OT expressed concern about access to resources stating "I am at the point of breaking with the work load. I go home every day knowing that I have left things incomplete and having made choices of who is most needy of my response."

Formal power was mentioned by four OTs with one stating that the "limitations of what I can achieve would be my own personal limitations." Another stated that the flexibility to work casual had "greatly enhanced my professional satisfaction." However two respondents described inequities, lack of consistency, disjointed and repetitive services and resistance to change, with one respondent concluding "for someone that is an innovator it is very draining to be within a region that is so resistant to innovation."

Informal power was mentioned by two OTs. One described the presence of informal power when she stated "our reports are shared with whatever groups or services are working with the students, and we will participate in any meeting,"

while the remaining OTs described reduced informal power "I am never sure if any of the ideas we share in surveys at work make it to the top and are truly considered. . . . I am not sure my team always know what I can do either and than I am listened to because my workplace is mostly comprised of RNs."

Psychological empowerment. Psychological empowerment was mentioned by nine OTs. Four respondents described freedom and autonomy in their positions but three complained of a lack of feedback which they could use "constructively to enhance [their] skills." Another three expressed concerns about the controlling nature of the employer "it has so many rules and regulations that you feel that big brother is always looking over your shoulder." One OT described the presence of a higher being, that enables them to make a personal choice to move forward and change. While another explained that "staying in the present moment and working with the team who is with them right then creates opportunities for staff and clients that no one would have predicted!"

SAW. OTs wrote in eighteen comments on *SAW*. Ten OTs referred to *sense of community* in their responses. Five of the respondents centered on collaboration and team building. In one OT's words "In each of the sites we work as a team with collaboration and integration of our goals in the classroom day. Well functioning teams are one of the most important aspects of enjoying my job." One OT reflected further on the relationship between teamwork and client care stating "Staying in the present moment and working with the team who is with you right then creates opportunities for staff and clients that no one would have predicted!" Two OTs mentioned the interdisciplinary aspect of communication in teams with one OT stating "I now feel empowered because I am a leader and am excited to bring a different perspective to our organization, which has been appreciated by my fellow RN managers." Two OTs discussed the presence of an "adult bully" in the worksite. While yet another unhappy OT vented "Our leader has coworkers spying on us and we are now riddled with make work projects and forms which hamper productivity and stifle creativity."

Spiritual connection was mentioned by three OTs. One respondent stated "A higher being or something enables us all to move forward if each of us makes that choice. . . . It is up to me to change and not those around me, I am who I have control over." Another OT talked about the *spiritual connection*, stating that "clients are at times more able to reflect and communicate their feelings than my colleagues." A final respondent stated that she did not have spiritual satisfaction in her career until she "was able to have independence in making decisions (that were not under a RN manager).

One OT mentioned a lack of *mystical experience* in the workplace when describing loss of pride in the job.

Leadership. Leadership was mentioned by ten OTs in the comment section. The importance of knowledgeable and effective management and team leadership was stressed by five OT respondents. Three OTs discussed the loss of

morale in the department as a result of leader actions: "[L]ack of commitment to the overall program and a loss of trust in management, as well as a loss of pride in the job I do" were consequences of switch form a collaborative style of leadership to a "dictatorial/authoritative" style. Two OTs commenting on lack of formal management training with one stating "as dual trained degree in management and OT I find shortfalls in management purely based on training and lack of experience in managing complex human resources." One OT described her new "RN" manager as making her feel that "unless I am closely monitored I won't be professional." An OT leader states "I now feel empowered because I am a leader and am excited to bring a different perspective to our organization, which has been appreciated by my fellow managers, although it is not always easy, but the overall achievement is rewarding, even in the difficult times."

Job Satisfaction. Six OTs mentioned job satisfaction. Three OTs described dissatisfaction with their jobs. Another commented that smaller caseloads would be more satisfying causing her to "feel more energized at work." One expressed an enhancement of job satisfaction through the ability to work casual. A final OT discussed the relationship between happiness in the personal life and satisfaction at work.

Organizational commitment. Three OT discuss a lack of organizational commitment and how the stress of the workplace will in time "kill the spirit of healer and health care workers."

PT Public Responses to Open-Ended Question

Fifty seven, or 33% of the PT public respondents wrote in additional comments on the survey. Content analysis indicated that the PT public identified with all the variables examined within the Likert style questions. These comments provided greater depth and understanding of the importance of the survey variables within their workplace

Structural Empowerment. Forty three PT public provide comments addressing structural empowerment. Six mentioned opportunity for learning in their responses. Three described their work as satisfying and challenging. Another two described steep learning curves, while a third responded with a concern about inability to have group meetings for education due to scattered geographical locations.

One PT public was quite vocal about a lack of information about the organization stating that leadership personnel who listened to what staff said and explained why a course of action occurred were not present at this workplace.

Twelve public PT mentioned the absence of support in the workplace throughout their comments. Six felt that they were not being "'cared for' in the manner that we previously were." Another three expressed concern that their manager is a RN and does not know, or understand rehab principles. Other

concerns expressed were isolation and lack of performance appraisals. One manager discussed her struggle to keep a positive attitude and to support the staff "both in their successes and when they make the mistakes."

Sixteen PT public referred to resources in their comments. Lack of staff was mentioned by six respondents as having significant effect on them; "it is very difficult to maintain a positive spirit in the workplace when you feel you run from one crisis to the next." Another five respondents mentioned lack of time: "you are running full tilt with patient care. At times just surviving the day is the goal and hoping you saw the top priority patients!." Two respondents described a conflict between the requirements of work and home life. Lack of coverage for holiday and sick leaves was described as placing stress on the staff. One respondent stated that a lack of money budgeted for prevention was responsible for falls in the elderly and inadequate wound care.

Four PT public addressed informal power. Flexibility and ability to do the job as they wished were commented on by two respondents. Another stressed that there is no point in putting extra energy and time into the worksite, since the only reward is personal satisfaction. A fourth PT stressed that "empowerment may happen if you fight for it."

Another four PT public addressed the presence of formal power in their organization. Easy access to knowledgeable and capable colleagues was mentioned by three respondents. A fourth expressed concerns about "frustration in trying to achieve goals . . . when communication/professional approach and continuity of care become issues over which I have very little control."

Psychological Empowerment. Psychological empowerment was mentioned by 15 PT public with five respondents discussed meaning in their work. Two stated that they like their jobs and their clients are their #1 concern. Two PTs were in management positions and stated they are happiest when providing resident care. The final PT public stated that she is grateful for her work, but presently having a "difficult time seeing positive results of [her] work."

One respondent stated that she had no impact on the work place. She claimed "at the management and program development level I/we feel ignored."

Two PT public described concerns with their feelings of competence at work: "I had to deal with a difficult situation. . . . My confidence got a huge dent and I may leave my profession in the near future."

Seven PTs discussed self determination. Three stated "there is little inclusion of rehab staff to problem solve [their] situation." Another expressed concern regarding lack of control when it comes to achieving goals as part of an interdisciplinary team. One PT public claimed to have lots of autonomy on the job, however time constraints limited what could be done. One manager stated that "the great amount of autonomy" makes up for other issues. Finally a PT

described work as “fulfilling to have the opportunity to do my job as I wish [and] as I have the experience to do it.”

SAW. PT public made 42 comments about *SAW*. Fourteen PT public mentioned *engaging work* in their comments. Comments included; an appreciation of organization’s philosophy, goals and ideals, enjoying the work, being “blessed” to be a physio, happiness in the direct care provider role and the importance of the leader in the spirit, empowerment and quality of work for all. Frustration was expressed over the lack of control of their work environment by several PT public. Work load was also a significant concern for several respondents. Two management respondents commented on their personal happiness when providing direct resident care. One experienced PT public stated she did not want to continue to feel unhappiness with staffing shortages and the resulting changes that have occurred over the past year.

Thirteen comments were made about *sense of community*. Two PT public stressed that management and interdisciplinary team members supported them with lots of positive feedback. Three professionals described the importance of the team in giving them “some of the attitudes [they] need to be fulfilled at work,” when the leader cannot provide spirit, empowerment or quality of work for all. Several discussed the importance of spending time together as a team and supporting each other: “It is only because I work with an awesome team that supports each other that we manage to survive. We always try to take our lunch and have some laughs and not talk about work at lunchtime which is a critical break for us.” However, another professional described geographical distances and shortages of staff which prevented PTs from getting together for meetings. Finally, cultural differences between workers was described as source of friction which one PT public felt was compensated for by her success with patient care. A couple of PT public summarized the comments stating that the spirit had ups and downs “dependent upon the level of team unity, the support felt from management and the daily caseload/events.”

Eight PT public discussed *spiritual connection* when working. Six of them described helping people on their journey of healing, “it is in this work setting, which is largely controlled by myself, . . . that I would say my interactions with clients is guided by a higher spiritual power.” Another stated that she doesn’t approach her work “as guided by a higher power. Sometimes thinking like that [would] make dealing with coworkers easier.” One PT public stressed that she would “prefer more concrete items instead of the questions referencing a higher power.”

Four PT public commented on *mystical experience*. Two spoke about the lowering of morale in the workplace and difficulties with management. A third professional spoke to her recent “attitude adjustment” and her present efforts to “redevelop excitement about my work.” A final respondent expressed concern about the strong wording in the *SAW* section, stating “I do not feel ecstasy or bliss whether in or out of work. I always have a sense of time and space.”

Leadership. Twenty one PT public commented on leadership. Concerns about a RN leader managing the physiotherapy section were expressed by four PTs. Another four expressed trepidation about the manager's attitude towards the professionals: "When you hear your managers say that they just wish your area of program would just go away, it doesn't instill a lot of confidence in the team. It runs by default rather than leadership." Three professionals described how changes in leaders are associated with changes in management style: "You have to comply with the leadership of the day." "The immediate supervisor is more important in one's job satisfaction than is the organization" was claimed by another three PTs. Failure to listen to staff and explain actions; a lack of the sense of "being cared for" by the leader; disciplining staff rather than helping; and reorganization resulting in an emphasis on upper management were additional leadership concerns mentioned by individual PT public. One PT public manager described how the autonomy she was given to run her department has provided her with recognition from her peers throughout the region.

Job Satisfaction. Job satisfaction was discussed by 13 PT public. A couple of PT stated they were satisfied with their work in the physiotherapy department, but experienced frustration with interdisciplinary work. Again, competition between family and work reduced satisfaction for two PT public. Another two PT described a reduction in satisfaction due to increased job demands, while two more PT stated that the "immediate supervisor is more important in one's job satisfaction than is the organization. One new graduate expressed dissatisfaction with her role as "sole charge peds physio." Emphasis on upper management was described as a factor that did not allow for "cohesiveness nor satisfaction" by one PT public. The opportunity for "hands on" with patients and interaction with the team were sources of satisfaction for one PT public. A volunteer PT stated her volunteer experience had been the most rewarding experience of her career. Another respondent stated that *SAW* is a hugely important factor, saying: "Good for you for identifying this as a motivational factor and in the area of job satisfaction."

Organizational Commitment. Six PT public gave responses describing organizational commitment. Two discussed how a change in managers impacted their desire to continue with the job. Changes in health care, finances, and overwhelming caseloads were described by three separate PTs as affecting their commitment. Finally, a PT public stated that "one's time is valuable and spending it on your family , friends, life outside of work is far more important that what you do at work.

PT Private Comments

SAW

Twenty comments on *SAW* were documented in the comment section by PT private. Four PT private commented on *SAW*. Unrealistic expectation about client cures, professional growth, changing physical health and a focus on

finances are described as having a significant impact on individual practitioner's engagement with their work.

Sense of community was commented on by five PT private. One PT private claimed that multidisciplinary teams build enthusiasm, clarify beliefs and help create a feeling of involvement in the profession. The other two expressed a concern about loss of their community practice because of the multidisciplinary teams. The remaining two PT private vouched for the importance of engagement and empowerment of staff in the retention of quality health care workers.

Four PT private mentioned *spiritual connection* and concerns about the mention of a 'higher power' in their responses to the comments question. One respondent stated "I think that the 'spirit' of a workplace obviously develops as a direct result of the qualities of the workers within that workplace, though I do not feel that a higher power or divine inspiration necessarily drives that spirit."

Mystical experience was referred to by six PT private. Two PT spoke about how lack of empowerment has reduced their enjoyment of their work. One PT private described her approach to work: "I have to force myself to leave my home each morning. I cannot wait for the work day to end. I have not joy in my workplace." Another two PT express claim that program management has destroyed the community of practice. Concern about chances for advancement in the profession and top down communication are describing as create low morale.

Structural Empowerment

Fourteen PT private decided to comment further upon structural empowerment. Eight PT private commented on opportunity within the health care environment. Six respondents spoke highly of the flexibility in hours and type of practice and commented on the ability to "develop and utilize our skills to the best benefit for our clients is very satisfying. . . . We still have many opportunities to consult with other professionals to develop a complete program for the patient." One PT stressed that the employer in a small workplace must value the knowledge and experience of their staff and actively engage them in decision making. Another PT stressed that failure of the job to change along with the PT's changing needs limits the opportunity for a rewarding experience at work.

Access to support was mentioned by 5 PT private. Two specified that mentors are important and "not enough active guidance is taken in this role." Another PT stressed that owners not only listen to their comments and ideas but also act on them. One owner of a small private PT practice stated that staff can only be empowered "so far with limits" and it is difficult to cultivate leadership in support staff. Failure to provide support or guidance when organizational and administrative activities are assigned concerned another PT.

Access to resources was mentioned by three PTs private as a source of frustration. Understaffing, 3rd party decisions and lack of opportunity for advancement were mentioned as resource issues.

Leadership

One PT Private mentioned leadership as caring only about the bottom line with communication being top down.

Psychological Empowerment

Psychological empowerment was commented on by seven PT private. Two PT private commented on impact. One PT described how being a co-owner of a clinic is challenging and requires the learning of new skills. The other PT stressed that since frontline workers have no control over their environment, morale is low.

Three PT private mentioned meaning. One PT described working in a "nurturing/helping profession to assist each individual, for no other rewards e.g., spiritual/personal. Ensuring that new graduates have a realistic expectation for their careers was deemed to be important for another PT. Finally, another PT states that only reason for staying at this location is the larger-than-average payout.

Autonomy was mentioned by two PT private. "My leader is not involving or empowering me, when she asks me to do more organizational admin activities without providing adequate support or guidance. Leaving a lot of extra work in addition to patient care." As a co-owner of a clinic, the other respondent had autonomy.

Job Satisfaction

Five PT private discussed job satisfaction in their comments. Two would recommend their job to a good friend. Another three expressed satisfaction with their private practice stating "Being able to develop and utilize our skills to the best benefit for our clients is very satisfying."

Organizational Commitment

One PT described loss of organizational commitment: "I feel totally disempowered. . . . It is an endless struggle to continue. Therefore at great personal expense, I have decided to leave this profession."

APPENDIX I: CONTENT ANALYSIS OF FOCUS GROUPS

RN Focus Group

Structural empowerment. Structural empowerment refers to Kanter's (1977, 1993) theory of structural power in organizations which emphasizes that power is a "structural determinant affecting organizational behaviours and attitudes" (Laschinger, 2004, p. 1), composed of formal power, informal power, opportunity, information, support and resources, which leads to positive workplace attitudes and behaviours such as job satisfaction and organizational commitment.

1. Support

RN participants stressed the importance of structural empowerment in a healthy and empowered workplace, with the predominant theme being the need for support by all members of the health care team. They also indicated that all members of the team, from the director to the front line staff, must support each other if the workplace is to be a positive and productive environment. Initially, the group discussed the type of support they would like to receive from the management:

> I think it's important to get acknowledgement from your, from your supervisors and your directors in your department and your managers. So some kind of acknowledgement and appreciation.
>
> I prefer that the management [talks to] you [about]what you have done right, instead of [talking to] you [about]what you have done wrong.
>
> Yeah, to add to that is, that there is an atmosphere of inclusiveness instead of exclusiveness. I think that one of the things that I deal with is the struggle of there are too many secrets around.
>
> I think I still prefer the 50 year old manager at work. They're learning to have more soul, more spirit, more understanding. Thirty years old, you're learning about your job, you're learning to accommodate the owner of the building, facility, instead of really working with your staff, appreciating them.

Several of the group members pointed out that the managers also need support from their leaders, to reduce their moral distress, and to enable them to provide healthy leadership to the staff:

> You said it depends on what kind of support there is for you. Because I think we have to remember that managers are staff too and they are managed.

> I had no place—I had no safe environment to talk to anybody about what I was trying to really truly say about what was going on. You need that trusting environment, that support, because of confidentiality, you know, from the up above, to help direct you with what you are doing.
>
> And depending on the direction that you might be getting from up top and what support there is for you, can really make a difference how everything flows, how everything works out and its ahhhhh. . . . Like I said, it's moral distress.

Members of the group who had leadership experience (past or present) suggested methods for supporting others:

> My boss said something to me once and it's something that I try and remember—is to set them up for success. So the people underneath, that you're supposedly leading and managing—set them up for success. Because as you say—it's not about you, it's about them and how do you engage them and how do you help them be successful.
>
> Now it is true, that in order to be healthy, a worker needs to have some sort of support. That the primary operandi is not that the person comes to work to get their needs met. They don't come for therapy. But as a leader, we can, we can support them through that and we can, if they perhaps need therapy or something, we can help them and direct them and maybe facilitate that to happen.

Support from colleagues is essential for a healthy working environment. New staff who have not received adequate support from management in the form of orientation and training to the requirements of a specialized health care environment are especially "needy" and require support from their colleagues. This theme came through when the group members discussed their experiences during the cutbacks of the early '90's' in Alberta health care:

> It was a wonderful unit, we were all RNs and everyone worked really well together. And then of course, the bumping started happening. . . . So she had no operating room experience at all. And she didn't go through the three month orientation and all of that learning process. And she came onto our unit. She was a lovely person, she was quite bright. But of course it takes time took to get up to speed. She was treated quite poorly by . . . a lot of the RNs on the unit. I was appalled by how other RNs—because they were hurting so much, and because we had people who had been bumped out and there was a sense of loss, and I think a sense of grieving that was going on. But the way they treated this new person. . . . I still think back to that because I can't believe that we—that that could be done to each other at a time when we should have been supporting each other.

One group member responded to the preceding description of the cutbacks, simply stating: “And I was on the receiving end of that. And it was—it was just awful. It really was.”

Support and mentoring from colleagues can make a difference to an individual’s entire professional career, as described by two RN participants:

> There were a couple of people on the unit that took me under their wing and mentored me. And particularly one individual I remember, and I highly, highly respected her. To this day I still think of her. I looked forward to going to work every day. I felt that I was making a difference.
>
> I remember writing to her [a nursing friend] at that time and saying “You know I feel just so awful, I don’t know if I can ever be a RN again.” And she wrote back to me and she said “You are having a blessing of the most important thing that you will ever go through to learn to be a RN. And it will benefit all the rest of the patients and clients that you ever have in your whole career.” She was 100% right. . . . So that experience that you had that was bad, was also your best.

The RNs in the focus group then elaborated on the importance of supporting their colleagues:

> If you think about the models that we work with in nursing—I’m looking at the McGill model, how we’re supposed to go and work with families and draw on their strengths. You know, why are we not using those models with our staff and our co-workers and our students in the same way—setting them up for success, looking for their strengths and then helping them to work through the areas that may be would help them.

One group member summarized the discussion on support for the RN within the workplace by emphasizing the individual’s need for recognition:

> I think, in order for someone to be happy at work, they must be recognized as a person. And not just as a means to get something out of them. That they bring a whole lot more than their knowledge, their skill, and their ability to perform a job. They bring so much more than that to the place. I think you have to recognize that.

2. Presence of formal power

RNs described the impact of a lack of formal organizational power on the RN in the workplace by describing the failure of the organization to recognize the contribution of the individual and the suggestion that the RN is regarded as the physician’s handmaiden:

> And how long do you, as an individual, bang your head sort of against a brick wall. Like at what cost? . . . I know I go into a place thinking I want

> to help if there's a problem, I want to be part of the solution. But so often, if there's no chance of moving, then all it does is destroy you.

> Structurally in our health care organization we have taken that group of workers—the physician—and set them aside completely. They are funded differently, they have different organizational, they have a different stovepipe than all the rest of us do. And it's a product of a medical model and the roles of the other workers being the handmaidens. And its changing, not changing very fast in. . . . It's like there are two parallel pyramids. Its not even a pyramid. I don't know if I could draw it. But you know there's the management hierarchy and then there's the physicians.

3. Access to information

Access to information about the values and goals of top management helps the staff to meet expectations. One group member stressed that staff internalization of the organizational vision made a difference to the working environment for individuals at the front line:

> Truthfully, it should be an organizational vision and you were talking about the . . . one being "Love at work," or something like that.

Another RN stressed that communication of important information through all levels of the health care system is essential:

> So being able to have the information that you need to be able to anticipate what the needs are. That's a healthy work environment, as far as I am concerned. Communication is another bit, it's a huge, huge struggle and challenge. Communication between all of those areas that I mentioned, all of the partners.

Psychological empowerment. Psychological empowerment (Spreitzer, 1995) has been shown to be the intervening variable between structural empowerment and behavioural and attitude variables in the University of Western Ontario's (UWO) workplace empowerment model (Laschinger, 2004). The components of self-determination, meaningfulness of job activities, impact on the organization and belief in ability to do a good job (competence) were all described as being important.

1. Meaning

One RN described how the provision of care to the residents provides meaning for her on a daily basis in the health care workplace:

> It's not the facility, it's not my boss, but it is my residents that keep me gong back. They are waiting for me and I enjoy their company. I enjoy working with them, and I enjoy helping them. It becomes my life. Whatever happens when I get really burnt out. I go there, management is

> whatever, I go there for the sake of my residents, not because of management. Sometimes not even because of my peers, but it is just for my residents. It keeps me going. They are waiting for me. They need me, to give them their medicines every day, to help them, to talk to them; and that makes me, that gives me a positive goal, somebody's waiting for me. That is beautiful. Somebody's waiting for me.

Discussion also ensued on how the profession of caring nursing can lose its meaning for the individual RN:

> And I got to the point that I was so totally where I shouldn't be in nursing—in the operating room and recovery room—that I was going to quit nursing. And again, I say, my lamp was low, my light was low. But it was the spirit. It was because I didn't feel that I was giving to nursing what I wanted to give. But . . . I was providing spiritual care to patients. . . . But I just didn't recognize it.

The participants also spoke about RNs who may not be able provide the necessary care to patients/clients because of loss of meaning due to personal traumatization experienced in an unhealthy workplace:

> We end up having a lot of walking wounded around, instead of wounded healers. . . . So whether you're in management, whether you're a bedside RN, whether you're whatever. To cope with what you're dealing with, you close down, and then we see trauma happening. And just imagine, if its happening to each other, what are our patients experiencing?

Finally the group described how they can give value and meaning to themselves and others by honouring people:

> Honouring is something that kind of resonates with me and that's something that we don't do enough of. Honouring other people and their truth. And being able to honour your own self and your own truth and what's right for you.

2. Self-determination

Self-determination was described as an essential characteristic of a desirable workplace, which may not always be present:

> In the terms of management/leadership, there's a hierarchy that I have been exposed to whereby management would defer to the physicians. And the physicians would then make decisions about the staffing and things. And to me that is just so wrong, wrong, wrong!
>
> Horizontal violence and bumping are pretty strategical at times.

> You know what—if I can't go and work in a place and stand in my own truth, have a voice, and be able to walk in that truth, then I can't stay.
>
> I'm thinking—someone's going to tell me that I can't listen to someone. Excuse me.
>
> I feel empowered to stand in my own truth. I am able to practice from a place of--I won't say health--I don't want to be put in a place of moral distress. Free of moral distress.
>
> We're all walking around and there's that peeking soul coming out of each one of us—looking—is it safe? Is it safe to be authentic, who I am, and to have that authentic voice and being who I am, here in the present? Whether it be in my job, in my workplace, whether it be at coffee with someone--is it safe? So I leave that image of that peeking soul, coming out of each and every individual, looking to see.

3. Sense of impact on the workplace

Concerns were expressed by the participants that they had little impact on the workplace, especially since it is so difficult, and sometimes dangerous, to have a voice:

> It can be very difficult to speak your truth. It really can be [resounding yes in agreement from the rest of the group].
>
> Well, I like to give my opinion, but they don't listen [laughter]. I just like to say " you know you should approach this person differently." But you know, they don't listen. I don't know, dictatorship state—no soul.
>
> Particularly in the whole political sense of the organization. Because you do stand at risk to put yourself on the line. To saying "No, I don't agree with that."

4. Sense of competence

Health care has many specialized fields that require caregivers with unique skills. This group described the devastating effect on a RN when that RN did not have competency in the required skills:

> During the bumping time when I was on the receiving end and I had been bumped nine times, I ended up in a place that I didn't really want to be, job wise, but needed a job. I had some interest in the area, but it was very small. There were only five staff and it was a very small little area. And you needed expert skills to work in there. And I didn't realize how much expertise, you know, at the time. But it came very evident to me and I felt like I was drowning. And then, I was ostracized, and, not well received at all, because they had lost someone that had those skills. . . . I have trouble

> understanding how RNs can be like that to RNs. And I think it was so traumatic. . . . Well it spiralled me into seeking some professional counselling.

SAW. *SAW* has the cognitive, spiritual, interpersonal and mystical dimensions of

> *engaging work* characterized by a profound feeling of well-being, a belief that one is engaged in meaningful work that has a higher purpose, an awareness of alignment between one's values and beliefs and one's work, and a sense of being authentic; a *spiritual connection* characterized by a sense of connection to something larger than self; a *sense of community* characterized by a feeling of connectedness to others and common purpose, . . . a mystical or unitive experience characterized by a positive state of energy or vitality, a sense of perfection, transcendence, and experiences of joy and bliss. (Kinjerski & Skrypnek, 2004, p. 20)

This group of RNs had a deep knowledge and interest in spirituality and health care. Consequently, the theme of spirit was linked to all the discussions. The four components of *SAW* were mentioned many times throughout the focus group discussion.

1. *Engaging work*

Engaging work refers to the ability to find meaning and purpose in the work they are doing in the present moment. Two of the participants had completed graduate theses work on spirituality and one of them described this experience:

> And for me, probably the most wonderful thing that I had an opportunity to do in my career was when I wrote my master's. I was looking at what was the of spirituality in the context of nursing. And the year that I did that was the pinnacle of my life. . . . So that being engaged with something that is so powerful and meaningful to me and trying to understand what that is. And then learning about that from the lens of nursing and health care was for me, probably the most memorable thing that I've done in my life, in my career.

Discussion ensued regarding the significance of being a wounded healer and being able to work with others on a meaningful soul-to-soul level:

> And you—what you've done is you've worked through your hurt. You've gone on that journey and you've worked through it. . . . And you can be with someone else at that soul-to-soul level. . . . And you are bringing all of who you are—all of your experiences and you are able to focus on them and their pain.

Engaging work requires the individual RN to be fully present throughout her work day:

> We are human beings and . . . we come to our position/job as a human being holistically all of what we are emotionally, physically, spiritually as a whole person and professional. You can't separate the RN who comes to work as just a professional person; . . . there is a wholeness of that person, that individual, and that sense of being wholly present, fully present and engaging whenever you are involved with another human being. And to be authentic. Because spirit time is present time. When we are here, fully present, that is spirit time.

> There are patients that are so sick, sometimes. . . . The residents are always waiting. . . . Then you finish late.

Group members also mentioned that when the requirements of work and the individual's values are in conflict moral distress occurred, and the work was no longer engaging:

> I know from my experience of being in middle management it's the fact that you've got the management above and its pulling you this way and you've got your staff or students, or whoever you have down here, pulling you this way and you're sitting there. My experience was that I could listen to both sides. I could see both sides. Both the positive and the negative of both sides. And being morally distressed very often because of the position I was put in. And a horrible, horrible place to be. I never felt like I was doing a good job, or that I was making a difference. So I wasn't finding any encouragement in the work that I was doing. It was just a huge stress.

Another RN mentioned that she had left bedside nursing because of changes which interfered with her ability to be engaged with her work:

> I just couldn't be that kind of RN that I wanted to be and was trained to be. And I hear of that a lot from us older RNs. . . . You know, back when we used to give backrubs. You know about touching your patient, . . . and you'd sit on the bed and you'd touch them, for God's sake. Without gloves!

2. *Mystical experience*

A *mystical experience* is described as those times when everything is blissful and the worker is full of energy and vitality and experiences a high at work. This group of experienced professionals did describe such moments, however they also described moments of extreme despair and depression in the workplace:

> I looked forward to going to work every day. I felt that I was making a difference. I mean maybe that was just youthful innocence. . . . I don't know—it was just different.

> When I did my masters, I was looking at what was the of spirituality in the context of nursing. And, that year that I did, that was the pinnacle of my life.

> That is beautiful. Somebody's waiting for me.

> I have trouble understanding how RNs can be like that to RNs. . . . Well it spiralled me into seeking some professional counselling and that ultimately changed my entire life and career—for the better. . . . But it certainly killed my spirit. And I sank into a depression and I think it was because I felt my spirit die, or, it didn't die, I lost sight of it.

> Chaos, disorganization, labelling, disrespect. It becomes very difficult to put words to it. I think for me, personally, it was very disempowering, very dispiriting. I had no voice. I had no spirit. . . . And I took that position because I wanted to share my skills and expertise. . . . I never felt I had an opportunity to do that.

3. *Sense of community*

The highs and lows of the focus group members' experiences of their health care/nursing community gave us some insights into the RN's journeys through their professional life:

> You know what really surprises me is that my most memorable job is my first year out of nursing training. That was 32 years ago. I guess I look back on it—it was—we had good staff—we all got along together. We felt supported, we worked as a team. We laughed together, we cried together when things went on that were tough. We often socialized together outside of work. And we debriefed together.

> Another one of the things that is really prominent and important for me is a sense of collaboration and not competition. And truthfully, that's what I struggle with all the time is competition.

> I think RNs are tough on each other. So it comes back to that competition that you were talking about.

> If you're new and you're wanting to commit and you're wanting to fit in and you're trying to make those connections. . . . Like you go into the coffee room or whatever and people are gossiping, it goes against what you believe in and how you feel. Its really hard then to get connected and feel that connectedness which is certainly, is something that is a spiritual need that we have.

> You have that—you know Glaser's needs—you have that need to belong. And you're new in a group and they're all gossiping. I have said that I'm really not comfortable with this conversation. And boy, if you want to set yourself out there as an outlier, you just did it, sweetheart. And its more uncomfortable.
>
> There's a lot of horizontal violence, actually.
>
> Drop a bomb on the place and blow it up and start fresh with everybody. Because you know what—In those kinds of environments, there is a culture. . . . That is a toxic culture. And until you get rid of everybody, it will just keep perpetuating itself.
>
> And I think that any of us have potential. So why would we not want to be helping each other find that potential, wherever that potential can take you.

4. *Spiritual connection*

The sense of *spiritual connection* was an underlying theme throughout most of the discussion with this group of RNs. Brief comments about the "intentional creation of a life-giving force" in the workplace were made:

> But that has to be created by the organization that you work with and a bunch of individuals working together.
>
> It needs to flow both ways. Up and down and sideways.

Leadership. When asked what came to their mind when they thought of leadership, group participants presented a description of their ideal leader:

> An awareness of the people, or the issues, of the history, the directions, you the future directions and goals, and just that people are so individual. You can't lead them all the same way. They don't respond. And that goes back to getting
>
> to know the people that you lead.
>
> There's leaders who have authority to lead—so your directors and so on, but there is, I think . . . much more important, there are leaders that are within a group of workers. . . . I really feel that to lead a group of people through a process, you have to help them find their truth. So it's not like you know the answer, always. It's like you have to help your group find their truth. And move forward and that's the way you lead.
>
> If you think about encourage--its about helping people find the courage to move forward, to build on their strengths. So leadership, having good leaders. I like to use the word leaders instead of management, . . . but

> also there's informal leaders that are really strong within the group that help that sort of do the same thing, that help to keep it moving in the direction towards the goal, or whatever. It's so important, because if you don't have that, you end up with people going all their different ways and kind of mish mosh.
>
> You know truthfully, I really think that the only place for followers is in crisis. . . . In a crisis, that's when you need somebody to get in the driver's seat.
>
> [When] I think of leadership, the of self awareness is really big for me. Because I think if you are going to be an efficient and effective leader, you really need to have a lot of self-awareness of who you are, what your values are. You have to have a sense of the big picture—like where are we going, where do I want my group to go, and how are we going to go there together. I think that's a really important part of that. Knowing what your own strengths are and, how you can engage your group to move forward on a particular project or plan or whatever that might be.
>
> It's like working with students. You want to set them up for success, not to fail. I think that certainly goes for the people we work with. You want people to be successful.
>
> You have to role model. Like I think you know what you're expecting or what you're wanting to expect from other people. No one's perfect. You have to have that sense of humility. That you know we're all human. No one's perfect.

As the discussion progressed, group members began to vocalize that, in the role of RN, all RNs are leaders (especially leaders of new RNs).

Job Satisfaction. A second demonstrated outcome of workplace empowerment is job satisfaction. RN focus group participants described job satisfaction in their present employment:

> I have moved on, and I am very fortunate to be working in a really great environment where I am valued and appreciated and all of those good things that we talked about what a healthy environment is.

Organizational commitment. Organizational commitment is described as an attitude and behavioural outcome of the UWO workplace empowerment model. The focus group members discussed reasons for their commitment, or lack of commitment, to the health care work place and their profession:

> If I can't stand in my own truth and have a voice and speak, then I can't stay.

> And sometimes there are some very good things within . . . that are healthy and that you enjoy. And yet, there's something over top, that's unhealthy and you're not going to change it and, that's a struggle that I'm having right now in my current job. And thinking when is enough, enough? I need to know when to get out to save myself.

> I had no voice. I had no spirit. I almost cracked up, actually. And took time off work to recuperate and to regenerate and to rediscover my voice. . . . Very, very traumatic, because I had never been exposed to such cruelty, and such inhumaneness in my career of 37 years. . . . And I have now no desire to go back into working one to one with patients.

> But it was one of the reasons that I left bedside nursing. I just couldn't be that kind of RN that I wanted to be and was trained to be.

One group member suggested a very simple sounding solution to the lack of organizational commitment:

> If you listen, there will be lots of people that will tell you how to approach staff or how to help them, and how to make people feel dedicated to work. And the facility will be functioning, will function better and everybody will be working well.

OT Focus Group

Structural empowerment. Structural empowerment refers to Kanter's (1977, 1993) theory of structural power in organizations which emphasizes that power is a "structural determinant affecting organizational behaviours and attitudes" (Laschinger, 2004, p. 1), composed of formal power, informal power, opportunity, information, support and resources, which leads to positive workplace attitudes and behaviours such as job satisfaction and organizational commitment. The OT participants emphasized the importance of structural empowerment in a healthy and empowered workplace throughout their discussion during the focus group.

1. Support

Access to support was mentioned by all the OTs. The participants described many different sources of support which contribute to a healthy and empowered workplace. The importance of support from the organizational leadership or management team was mentioned early in the discussion:

> You've met that cutback and you've taken on more cases and you've done something. There's gotta be something in it for you. In some intrinsic or some other way. Because you don't—you don't feel recognized. Everybody else got the pay raise—up there because they brought it in on budget or under budget—But it doesn't filter down in terms of where it is really implemented.

Another OT elaborated further on management support:

> But nobody tells you that your caseload went up or that your outcomes are improved. Until its about a year down the road and you see the annual report. . . . I think to keep feeling empowered and to keep going you need the old behavioural, the remedial immediate feedback every now and then. I mean there's only so many times you can say I'm doing a good job.

Several OTs stressed that lack of support from management can be very harmful to the OT's working environment:

> If a consumer takes an issue over your head, the management has the authority to make a decision that's contrary to----the mandate you've been asked to work under. They're not backing you up. And often there's not even a conversation about what needs to happen. So, it's very disempowering in your relationship with your clients.

Support may also be generated within the external team the OT is working with:

> So . . . you form it [the team] with the immediate group of employers that happen to be in that environment. And sometimes, you know, that's more powerful. They say you—I like the way you've done that. That was really interesting. While the rest of us, that you have been working with all the time—we just take it for granted that you're gonna do that. And the external people commenting on it, I think becomes a really powerful stimulus for you to do it again, or to keep on trucking.

Support from colleagues was also described as significant source of support for OTs:

> It was the support and leadership that we created internally that made that work out. We all felt like we were doing important work and we supported each other and despite all of the systemic chaos and craziness, that kept a core group of people there for 10 years. And when that group finally disintegrated, for myself personally, and for some of the other people that were in the core group, it really was that we no longer felt that were valued as individuals. . . . Would you be loyal to them when they are not loyal to you?

Meetings with other professional OTs was described as an external way to find support and empowerment from colleagues:

> We have an OT group meeting once a month and I find that really empowering because you're seeing these things wrong, you want to fix them, you have some ideas. But going to these meetings, sort of empowers you as a professional and gives you confidence to say 'Hey I was fighting about that. I can make change. And even, or if you are having more problems, you can sort of brainstorm. . . . Because of the isolation you

> often can't bounce ideas off of ahhh professionals with the maybe same outlook or perspective as you. . . . Hammering the issue out and then coming back to the facility and really having lots of ideas in your toolbox.

OTs are educated to assist with the development of healthy workplaces. As a consequence of this occupational role, each individual OT feels a responsibility, which appears to be unique to this professional group, for their own workplace health and empowerment:

> You know—we come out with all these individualized treatment plans with individualized everything for clients, but the work system doesn't individualize for us. Back to the original feeling of not walking the talk when it relates to us. . . . As OTs we're supposed to know how to support that and change workloads and adapt and do all these things—but.

Finally, the need for this multi-faceted support was summarized by a group member:

> When you think of all the extenuating circumstances and all the contributing factors that would make you stay and lots of them are really simple and basic-- like getting your light bulbs replaced, the odd pat on your back from your boss once in a while—its not like your performance appraisal.

2. Resources

Resources which include the presence or absence of: adequate numbers of professional staff, appropriate working spaces and time were another important structural component of an empowering workplace for OTs:

> So you know—we're not being able to build the teams as selectively as people were in the past, either. It sounds horrible, but sometimes you're taking what you can get. . . . So you just need the warm body on your teams. And you know, sometimes we're just so thankful to have a warm body on our teams. Whether it's a high functioning warm body or not . . . .

> How valued do you feel if your desk is part of how you see the company valuing you. I'm not even worth a square inch of space . . . .

> I think you need down time, too. As lame as this sounds. You need to organize your desk, or organize your bag or organize your toolkit, whatever you're bringing out. I think that's important, because some days you hit the ground running and you don't stop until you're done. . . . I didn't even eat today.

3. Presence of informal power

Several participants described the importance of collaborating with physicians and other professionals on patient care and, being sought out by managers and peers for help with problems:

> If you are consulted on something and the person consulting you wants to know your opinion and wants to know what you think about that situation. That's just—you feel, I don't know, you feel needed, wanted—like you are important to the entire runnings of the group, the team. . . . It's hard to describe what that feels like.

4. Access to information

Respondents expressed a few concerns that they were not being given an accurate picture of what was happening with the organization:

> I'm thinking—a level of honesty. So often lately—like we get almost propaganda—this is going to be good for you—when it is the bottom line. . . . If they'd say out front—its for the accountants—I would be a whole deal—it would make it so much easier to deal with—that this is somehow good for me.

5. Presence of opportunity

Opportunity to gain new skills and knowledge through continuing education was described as an important component of the workplace by several OTs:

> There is some recognition of the individual need for health or the continued development in the unit. That's the next step. You know continuing professional development. Recognizing that people need to be fed professionally.

6. Presence of formal power

Several participants mentioned what happens when they do not have formal power:

> [T]here are these restrictions on it that are external structural things and so we express our creativity and our innovation in the environments that we have some control over. So you get these microcosms. Which in some cases may be quite contrary to policy.

Psychological empowerment. Psychological empowerment has been shown to be the intervening variable between structural empowerment and behavioural and attitude variables in the University of Western Ontario's workplace empowerment model (Laschinger, 2004). The OTs participating in this discussion group conversed about the relationship between empowerment and the four components of; self-determination, meaningfulness of job activities, the

impact they have on what happens in their department, and their belief in their ability to do a good job, otherwise called competence.

1. Self-determination

The focus group participants spoke strongly about the need for self-determination, which is one of the components of psychological empowerment. One individual linked self-determination to positive organizational outcomes:

> You get the most out of people when you give them the responsibilities and give them the tools or the autonomy (a component of psychological empowerment) to accomplish that at whatever level is appropriate.

Another OT chose to describe self-determination in her workplace by describing the opposite:

> For me, the opposite is when you are expected to operate within a certain mandate and when things go over your head, its not supported. Management makes a decision that's contrary to the mandate and that definitely leads to the front line workers feeling no sense of empowerment at all.

The OT focus group participants also stressed the importance of self-determination in fostering a link between empowerment and *SAW*:

> I think, in my practice, if I'm working on something, and I need to finish it and its 4:30, I'll finish that—so that I feel good about it. . . . And I know that's not in every area, but in my area its allowed. Then I can find better balance at home because when I find that I'm not finishing those little tiny things, I get home and I think about it. And if you can finish it off maybe it takes five minutes, then I take five minutes off on Friday.

2. Impact

Participants described the ability to make a difference, or to have an impact, as being influenced by the presence of structural empowerment:

> You know—we come out with all these individualized treatment plans with individualized everything for clients, but the work system doesn't individualize for us. Back to the original feeling of not walking the talk when it relates to us (sounds of agreement). As OTs we're supposed to know how to support that and change workloads and adapt and do all these things—but.

3. Meaning

Group members believed that work that has meaning to the individual professional as an important motivating factor:

> I think it always helps to be able to work and focus on areas where you feel your strengths are. You know what you are interested in. Because that helps you feel like you are accomplishing something. And it has that—you know it is an intrinsic motivating factor, I guess.

4. Competence.

Competence was described by focus group members as being a natural consequence of structural empowerment:

> Because you are going to be better at your job if you are bringing information and stuff that is more pertinent to you. I think you do a better job.

SAW. *SAW* was an underlying theme throughout the focus group. The four components of *SAW* of; *sense of community*, *engaging work*, *mystical experience* and *spiritual connection* were mentioned by participants at least once.

1. *Sense of community*

Comments about a sense of trust and personal connection with co-workers and a *sense of community*, were mentioned much more frequently than any of the other components of *SAW*:

> I think of positive energy, with like, kind of a healthy camaraderie. Where you can laugh and as well as care about your colleagues on a personal level, as well as a professional level.

> It was about the whole work environment. I had a phenomenal leader. Everyone had a strong work ethic and shared a common vision. It just drives you to really want to do the very best you can. And if you're sick a day, you feel bad that you're missing on that experience. It's about the whole package. You can have a great leader, but if you don't have a good cohort to work with it still falls apart, even with a great leader.

> But when you're out there in the front, you're not working in this collective environment and often, if you're in private practice, there's no team out there. Because nobody is paying for it. So I wonder how, then we achieve that collective feedback. I mean, if we believe what we say about the OT literature. We go back and we tell stories about our clients or whatever, you know, the narrative over the coffee, or something. And through that we get some validation.

2. *Engaging work*

Several group members discussed a match between the requirements of their work and their values:

> And it's also being able to sort of internalize your role and find the personal meaning for you in that. It didn't matter that I wasn't at the top. I still *SAW* what I was doing as important and needed, and I was validated a lot. I mean I had a saying on this project.
>
> Yeah, you're working hard. I think when you are in that type of role, you are working as hard as you can because you want to be working in that role. You want to succeed and do your best in that role.

3. *Mystical experience*

Several staff also described experiencing a "high" at work, or an energy or vitality that is difficult to describe:

> Maybe it was a period of time where we all were in never-never land. But it was a period of time where all those positive characteristics that you said, coalesced and the outcomes speak for themselves. At that point I said I had the best job in the country.
>
> I think I felt a sense of creativity. Celebrating the small successes were huge gains, like not everybody could see those. But for me I was like "Oh we made a difference!" Even if your client behaviours happened like five times less. It's the little things I think that you celebrate. For me—I made sure that I took stock of that, because, obviously you get a lot of push back.
>
> I would say it was existential. You know there was a sense that [laugh] you could just keep flying. You just kept rolling and there really wasn't anything that you couldn't do. There was no sense of containment. Just your own energy and resources.

4. *Spiritual connection*

Sense of *spiritual connection* was only mentioned once during the focus group. However, it was described as a method of dealing with a "toxic" work environment where the OT *SAW* "criminal dysfunction in professional staff." She learned to look at the workplace from a different viewpoint: "That's how I cope. I find those important moments, those connections with clients, with myself and work from that kind of space."

Her comments led to additional discussion with another OT after the meeting was over on how to integrate spirit into the work of the OTs.

Leadership. Group participants had a lot to say about leadership. In answer to the question on leadership, single words and phrases describing what they wanted from a leader initially emerged from individual participants: "accessibility, accountability, trust relationship, fairness, consistency, enthusiasm creating an atmosphere of excitement, a level of honesty, leaders find rewards."

Leadership appeared to be a key component that was connected with all of the other model components being investigated in this study. Participants elaborated on leadership throughout the focus group:

> That especially goes to the leadership. . . . The employees need to feel the respect—need to feel that they can respect the leadership to create a well—healthy workplace.
>
> And a good leader finds or is curtailed by the same forces, but will find those opportunities internally to keep people interested—initiative going, and will recognize them in whatever ways that are available for them. They have to be a little deviant [chuckle].
>
> But when I think of examples of people who I think have been great leaders they inspire the people around them. They—by example and by the things that they are doing. They inspire you to want to do better, as well.
>
> I think the distinction between a manager and a leader is really important. When I think of examples of people who I think have been great leaders, they inspire the people around them.
>
> I think of having a leader who has a really clear vision of where they want to go.
>
> But I've had jobs within the job. I can say that I had the ideal experience. I had an experience where there was leadership that gave you the distance, the responsibility and the authority.
>
> Leaders have to have credibility. It's not enough to just walk the walk, they've got to have the talk to go with it. If you want me to trust you and believe in you, then do that.
>
> I guess that I feel empowered when I know that my team, my leadership, that they will stand behind me and that I don't have to rationalize my decisions. . . . I know that they trust me.
>
> I think you also have to feel that your leader will, and I will use the word, fight for you. Your position, or the unit's, however they exist, will be put forward in the strongest case. And they will do that, because they believe in you and they believe in the system.

Job satisfaction. Another outcome of workplace empowerment has been shown to be job satisfaction. OT focus group participants mentioned job satisfaction several times:

> "Job satisfaction can come together as a construct and can pull a lot of things together. And if you don't have it, it can be devastating."

Organizational commitment. Organizational commitment is one of the attitude and behavioural outcomes of the UWO workplace empowerment model. The importance of organizational commitment was mentioned several times during the focus group:

> I think that's why this is so important because ideally you would stay at a job for personal fulfillment. You would stay if you felt you were getting something from it and you had a great team, like you already mentioned. If life is about living and you spend a good chunk of your day at work--why would you go somewhere where you are dragging your feet every day? Life's too short, right? It think you go. I can see both sides of the fence—right.
>
> Nobody asks that question "What do we have to do to get you to stay?" That's hugely important.

PT Focus Group

Structural empowerment. The presence of structural empowerment and the related components described in the UWO workplace empowerment model (Laschinger, 2008b) that facilitate the empowerment of the professional within the organization, were mentioned by all the PT within the focus group.

1. Access to support

All the PTs praised the support they received in their workplace from their management team and their colleagues:

> My rules in the job are—If I am the least bit uncomfortable, I need to chat with my boss about it.
>
> It was the respect and the confidence and the trust that I received, and the mentorship that I got. Despite the fact that at that point I was quite young. And one of the most remarkable things about our team was that even as a relatively new therapist, we were—I never felt vulnerable asking for help—And I guess it was a very constructive atmosphere—we actually did do a lot of peer mentoring. . . . So, we would go out, as two PT's and then we would give each other feedback. And the remarkable thing was--I never felt vulnerable, I always felt supported.

However, one PT did express concern about lack of support for her from the organizational structure:

> Well, I think there were a lot aspects of my first job that were very rewarding. But I think, I just remember feeling a little constrained by the hierarchical structure.

Varying types of support for the individual in the workplace were described as being present for one participant:

> Your co-workers and your work environment are looking out for your best interest in a variety of ways—emotionally, as well as more professionally. We were in the process of trying to start a family. And I was in the process of trying to find my balance between my professional self and my home self. And they were very open to working with me on that, and making sure that I was finding that balance.

Support was described as coming from different aspects of the organization:

> I would like to work in the environment which is supportive, with trust among all the disciplines and co-workers.

> The performance review is a structured time to sit down and talk about where they see themselves. Where they see themselves within our clinic and where do they want to go with that role--because there's some things that we weren't aware of that they wanted to work on, that they *SAW* they needed.

2. Presence of formal power

The PTs spoke about the importance of individual power to initiate change and take on new roles in their workplace:

> I think it's important to feel like you are able to initiate change. You do have the power to change, no matter where you are in that organization. And you can impact it.

> And the fact that they were okay letting me take on the roles that I was, despite the lack of experience. And they were okay working with me in that role. I think also it was the flexibility that they gave.

Workplaces allowing for flexibility and innovation were also described as desirable:

> Paradigm shift thinking, outside the box thinking. Not going with just the conventional wisdom. We want to have a work location, workplace that is constantly growing and changing with the times. Progressive and not

> getting stuck with "we did it this way before and so we might as well stay with that way."
>
> Open to that change, because change is constant.
>
> I don't want myself to become just like that other person. I don't want to clone out. I want to continue to enrich myself and then add back because of the things that I know.

3. Opportunity

Gaining new skills and knowledge on the job, and being given the opportunity to use these new skills and knowledge through challenging work were mentioned by several participants as contributing to a healthy workplace:

> You feel that you are developing, that you're growing. You look forward to going to work. You're progressing, you're developing, you're doing something for your environment.
>
> What about tools—giving the individual the tools and maybe it's the educational tools, or it might be the physical tools. As a therapist going out and not having or a RN not having a dressing, in that rough example, but giving them the tools to succeed.
>
> So, I had the opportunity to work with disciplines that I wasn't used to working with. So it was more in the education and psychology field which I really learnt a lot from. And I really felt like that gave me the opportunity to develop my skills as a PT.

4. Access to resources

A good physical working environment, working equipment and adequate financial compensation were mentioned as part of a positive work environment:

> I think just having the equipment that you need. So that you feel like, you can be efficient and effective. Sometimes I find if I am having computer glitches, or I just don't have something that I need to do something simple. It can be so frustrating. I think that makes a difference.
>
> Well maybe we could put down adequate budget for empowerment [laughter].
>
> Well I think people's achievements and certainly their experience and extra achievements in terms of courses and certifications should be recognized financially. And I think, if that's done well, it does empower other people to improve themselves, if they know it's going to be recognized.

5. Access to information

Information about the current state of the organization and the values and goals of top management may empower staff was mentioned several times:

> Well there were a lot of aspects of my first job that were very rewarding. But I think, I just remember feeling a little constrained by the hierarchical structure.

6. Access to informal power

Activities such as being sought by others for ideas and help were mentioned as sources of informal power:

> And in every job, I've had the opportunity to also be a bit of a leader, as well. And so, taking that information that I've ingested and passing it on to somebody else. At different levels, sometimes it was in a very beginner level. I enjoy the job that I am currently in.

Psychological empowerment. Psychological empowerment, an intervening variable between structural empowerment and the outcomes of attitude and behaviour was also mentioned by the PTs.

1. Self determination

Participants emphasized the need for self determination or autonomy in their role as a PT within their working environment:

> I think, from the clinical perspective, as a physio—I think its very important to be able to work independently and not be dictated to in terms of recipes, or canned approaches to treatment. I would find that, very, very unempowering as a clinician, if I was told that this is the way I would have to do thus and so. Not being given clinical freedom.
>
> I guess it depends on the area that you are working in. I don't think any of us should ever succumb to recipes of treatment.
>
> The head of the school would have an idea—Like let's build a clinic within the physiotherapy program, and let's partner with the university hospital. And she would run with it. She would think it was a good idea and then he and I would put it together.
>
> And letting me challenge myself. Letting me go out there and take on some difficult things. And just believing in me that I could do it.
>
> I was very, very involved in our professional association in my last year of employment there and they gave me so much freedom to travel across the

> country, . . . such that, when I left that hospital, I said that I would never be able to work in another public institution again.

> Knowing the degree of autonomy that will be required and sometimes you might want to give somebody more independence and autonomy. And at other times you might need to maybe have more of—you might not be able to allow them as much freedom, depending on the situation.

> We had a lot of autonomy on that job. So I felt like I could be creative and have some freedom to do my own thing.

2. Impact

Having significant influence over what happens in their department was described by all the PTs in the focus group:

> I don't want to clone out. I want to continue to enrich myself and then add back because of things that I know. And that is how I will contribute back in. I know that I did a lot of good things so I feel good.

A PT private business owner mentioned how she listens to her staff and encourages them to contribute to organizational decisions:

> You know, at the end of the day, they all know, if they have any ideas, we're not the be-all and end-all, and that we're open to anything, however bizarre, to consider it. Because our goal is to, every month, to have a better place. And I'm not going to have all those ideas. . . . We could have made the decision and said this is the direction we are going, but instead we involved everyone in the discussion and said "Here's the problem, what are your ideas for the solution?" The solution that came out of that was completely different than what I thought we have to go . It was them committing to it. Part of that I think was the fact that we gave them the ability to direct that. I don't think that if I had come with that idea, I don't think that they would have been as receptive to it, because, it wasn't from them.

3. Meaning

Doing work that was personally meaningful to the individual PT was embedded within many of the comments:

> The last thing that I thought about was just the variety. And I guess that part fit with my personality. I like to have a—to be in a position where something happens every day; you are meeting new people. I guess its dynamic and just sort of a good fit for my own personality. I found that to be rewarding itself.

> Although we've talked about it here, I also don't want to lose myself. I want to make sure that I'm enhanced and that I grow and I'm developed by my surrounding, by my environment, by my peers, by my leadership individuals. But I use all that and it enhances me to become more and better and stronger and able to provide that service.

4. Competence

Participants spoke about having competence and about developing the competence of their peers:

> It was a very decentralized organization. It had very few layers of management. I was given just a tremendous opportunity to build leaders within my department. So that specialized unit was like its own little department. So that each of my supervisors should have been able to take my job one day, and, one of them did.

> If the workplace offers you a position that you can succeed within. It its something that you're bound to fail at, its not really going to empower you in the workplace. If the role that you are in place for allows you to succeed, to advance, to become successful—that's empowerment in the workplace.

SAW. *SAW*, an emerging in management literature which refers to care providers who continue to find their work meaningful and purposeful and who remain passionate about and energized by their work (Kinjerski, 2004), was an integral aspect of the focus group discussions.

1. *Engaging work*

Finding a meaning or purpose at work which matches with their personal mission in life was an important for the participants:

> I think that its also important to be able to work at something that is really fulfilling to you. Its rewarding because you're getting something personal back out of it, I guess.

> I think also, within workplace empowerment—its creating that deep understanding that everyone can make significant changes in their clients. And that they can change these clients and that they can help them move forward with whatever goal is appropriate. Looking sometimes at the newer grads, they sometimes feel so helpless. And being able to instil in them that belief, that knowledge that they can make a difference.

> I was working with hemiplegia, and the job itself was great, I liked working with them. Then they were walking. It was really good and it was being recognized [by others].

> I think the people that the clinicians are dealing with on a day to day basis, mainly their patients, give them tremendous empowerment. I mean, a good clinician, gets a great performance appraisal, several times a day. That to me, is very empowering.
>
> Sometimes with new grads, they don't realize that they made a change. Like they don't know how much they did for a client. Like they prescribe an orthotic, or they just "Oh I did that"—but they don't know in the long run, how much they are helping a person. It's acknowledging that.
>
> I think the actual work to me was really rewarding and I just felt like I made a difference—for kids and for teachers.
>
> At the end of the day, in a nut shell—I love what I do, I love where I do it. And I think it makes me a better person. I have taken the odd little [maternity] leave here and there, but I never stay long, because I miss it, its part of me. I love it.

2. *Sense of community*.

PTs emphasized the importance of a sense community with shared sense of purpose and meaning in the workplace:

> Again the workplace has an eclectic, wide range of staff individuals, of which bring a myriad of information and wealth that you can draw upon and you, yourself as an individual working in that particular location is one of those. You bring a certain set of skills that are valued. So you've got an opportunity to work in a place that has a very dynamic group of people that you enjoy and that add to and get from.
>
> And part of that I think comes down to sharing a like-minded—I finally found that I was on a team with people that just *SAW* things the same way that I did. So I think that was also important. Because I had been in other places that I felt very different in—just in the way that I approached my clients. So it was nice to be in a place where we shared that same passion, in the same way.
>
> It is empowering to walk in and be proud of the place you are working in. And be proud of the way it looks. Even more so, is the atmosphere that is there can be uplifting and positive. Versus you wale into other places where there is just kind of a cloud sitting over everything.
>
> It was a shared passion, because I brought passion. But everybody goes down where you just don't have as much. That was when there was always someone else on that team that would pick you up and invigorate you and you would do the same. Irrespective if it was boss or not, you knew that you cold also do that when you *SAW* them struggling. The fact that it was reciprocal in that way. And it's nice when it goes both ways.

> Because its one thing to be the one that's always getting picked up. But it's also a very powerful thing to be able to pick the other person up once in awhile.

3. *Mystical experience*

Several participants described a feeling of a sense of high at work:

> You know, if you gave me five million dollars tomorrow, would I change my life? And I really wouldn't, at this point. I really like—yeah I know there's the financial rewards. But I couldn't live without it. And that's what I'm hoping I can create as much for everyone that comes into the team—that they can have a place that they love as well.

> I would probably still be there if someone hadn't corralled me into applying for the job at university hospital. But I loved it. I just absolutely loved with the combination of clinical practice and administration. The rehab disciplines are just so appreciated in those environments. It was good.

4. Sense of *spiritual connection*

The focus group members did not directly discuss a *spiritual connection* in their workplace. However, one PT inferred a *spiritual connection* through her choice of language:

> That was the first clinic in that city, actually at that time, that I started in the clinic as a new grad and I was very blessed and supported. It was a really great opportunity. I never had that feeling, ever again, in any other job.

Leadership. The group was asked to describe leadership. The following words and phrases were shared:

> Strong business ethics, commitment to promises, open positive conflict resolution, horizontal leadership, consistent, open door, leading by example, integrity, participatory leadership, supportive, energizing, inspiring, empowering, respecting opinions, effective communicator, good interpersonal skills, commitment to learning and improving.

Additional comments that arose in the discussion:

> I want to use the word succeeding. And by that I mean allowing people or putting people in that workplace in a position that they can succeed.

> It's not just top down, but a real encouragement to listen to everyone's opinions in terms of not only the planning process, by problem solving.

> Knowing the degree of autonomy that will be required and sometimes you might want to give somebody more independence and autonomy. And other times you might need to maybe have more of—you might not be able to allow them as much freedom, depending on the situation.
>
> Confident commitment to succession planning. Not being afraid of the young new dynamo on the block aspiring to their job. You know, you groom . . . .
>
> Knowing your limitations and your weaknesses. I think that's important to your staff that they see you as someone that isn't perfect and that does make mistakes. And that you acknowledge when you do make a mistake.
>
> How about good corporate citizenship. Somebody that contributes to the community. Obviously in a business there's a spin-off from that—in terms of recognition of the business. It's that you're doing it with a true commitment to improving a situation and doing good work.
>
> It reminds me of a saying that I really liked about how an effective leader can plant the seed, but doesn't need to take responsibility for what comes of it. So its again exactly what you are saying. Empowering the group to come up with their own solution. And then not need to own it as your own. Even if it's what you would have done in the first place.
>
> But that empowerment in the workplace can come from that leader who has the skills and the subtleties to lead that person, sometimes without the person knowing that they're being led, towards maybe the right decisions that lead them into positions of success.
>
> That's a wonderful way of putting it. Because you're empowering, but its an invisible kind of empowerment. It's almost like people don't realize what's happening. You've made a change.
>
> That individual who was saying that they *SAW* something in me that I didn't see in myself and through their leadership, they were able to draw that out of me. And I became more through that job than I was when I came into that job.

Job satisfaction. The participants agreed that job satisfaction, also described as an outcome of the UWO workplace empowerment model, was important for them in their workplace:

> There's some things I wouldn't care how much money I was making. . . . No matter how many hundreds and thousands of dollars I might be able to make, I just couldn't do it. I wouldn't like the environment. There's some things that it doesn't matter how much money you make, its just not worth it.

Organizational commitment. Organizational commitment, another outcome of the workplace empowerment model was described by one PT:

> I am going to share our new corporate values with you—and that's why I enjoy going to work. And I'll speak in the first person: I have fun and I love what I do. I work with integrity and compassion, and I am committed to results. That's what gets me to work every day.

APPENDIX J: RESIDUALS FOR RNs, OTs,

PTs PUBLIC AND PTs PRIVATE

RN Residuals

	SE_Opp	SE_Inf	SE_Sup	SE_Res	PE_Det	PE_Imp
SE_Opp	0.001					
SE_Inf	0.004	0.012				
SE_Sup	0.002	0.014	0.000			
SE_Res	0.037	0.028	0.064	0.000		
PE_Det	-0.002	0.005	0.007	-0.001	-0.001	
PE_Imp	-0.023	0.007	0.026	-0.013	-0.013	-0.014
PE_Comp	-0.014	-0.002	0.014	-0.026	-0.005	-0.013
PE_Mean	-0.011	-0.007	0.002	-0.008	-0.002	0.016
SAW_Eng	0.040	-0.029	0.031	0.024	0.000	0.010
SAW_Com	0.027	-0.041	0.039	-0.097	0.001	-0.002
SAW_Spi	-0.116	-0.085	-0.069	-0.002	0.003	0.037
SAW_Mys	0.054	-0.137	-0.080	0.117	-0.002	0.009
JS	0.029	-0.129	-0.019	-0.066	-0.004	0.021
OC	-0.084	0.084	0.059	-0.073	-0.002	0.029
RES_LEA	0.007	-0.017	-0.036	0.008	-0.004	0.138
EXPER	-0.071	-0.001	0.075	-0.121	-0.028	-0.039
RANK	0.002	-0.004	-0.001	-0.004	0.000	0.000
EDUC	0.003	0.028	0.027	0.008	0.001	0.012

	PE_Comp	PE_Mean	SAW_Eng	SAW_Com	SAW_Spi	SAW_Mys
PE_Comp	-0.007					
PE_Mean	-0.002	-0.003				
SAW_Eng	-0.010	-0.012	-0.004			
SAW_Com	-0.008	-0.007	0.002	0.000		
SAW_Spi	-0.015	-0.026	-0.010	-0.002	-0.017	
SAW_Mys	-0.005	-0.005	0.001	0.010	-0.004	-0.001
JS	-0.020	-0.023	-0.006	-0.003	0.033	-0.001
OC	-0.025	-0.033	-0.007	0.002	-0.009	-0.003
RES_LEA	-0.070	-0.129	-0.059	-0.004	-0.032	-0.010
EXPER	-0.021	-0.014	0.121	0.197	0.069	-0.075
RANK	-0.001	0.000	0.003	0.005	-0.040	0.008
EDUC	-0.003	0.003	0.017	0.004	-0.102	-0.081

	JS	OC	RES_LEA	EXPER	RANK	EDUC
JS	0.014					
OC	0.018	0.005				
RES_LEA	0.029	0.000	0.020			
EXPER	-0.003	0.084	-0.063	0.000		
RANK	-0.003	-0.001	0.000	-0.002	0.000	
EDUC	-0.057	-0.074	0.005	0.000	-0.002	0.00

Summary Statistics for Fitted Residuals
Smallest Fitted Residual = -0.137
Median Fitted Residual = -0.002
Largest Fitted Residual = 0.197

OT Residuals

	SE_Opp	SE_Inf	SE_Sup	SE_Res	PE_Det	PE_Imp
	--------	--------	--------	--------	--------	--------
SE_Opp	0.000					
SE_Inf	0.000	0.001				
SE_Sup	0.000	-0.003	0.000			
SE_Res	0.037	-0.001	0.018	0.000		
PE_Det	0.003	-0.007	-0.014	0.018	-0.001	
PE_Imp	0.011	-0.005	-0.012	0.020	0.003	0.009
PE_Comp	0.007	0.005	-0.003	0.003	0.002	0.002
PE_Mean	0.008	-0.001	-0.013	0.015	-0.002	0.002
SAW_Eng	-0.002	0.038	0.004	0.055	0.003	0.007
SAW_Com	-0.003	0.014	0.016	-0.023	0.012	0.035
SAW_Spi	-0.064	0.080	0.051	0.082	0.008	0.025
SAW_Mys	-0.006	0.093	-0.015	0.022	0.001	-0.006
JS	0.000	0.014	0.079	-0.042	0.007	0.025
OC	-0.086	0.006	0.101	0.087	0.004	0.018
RES_LEA	0.011	0.006	-0.052	-0.007	0.079	0.163
EXPER	-0.031	0.037	0.026	0.008	-0.009	-0.014
RANK	0.002	-0.002	-0.004	0.000	-0.001	0.000
EDUC	-0.022	0.010	0.030	-0.002	0.001	-0.008

	PE_Comp	PE_Mean	SAW_Eng	SAW_Com	SAW_Spi	SAW_Mys
	--------	--------	--------	--------	--------	--------
PE_Comp	0.000					
PE_Mean	0.002	-0.002				
SAW_Eng	0.002	0.000	0.002			
SAW_Com	0.003	-0.012	0.004	-0.003		
SAW_Spi	0.001	-0.009	0.000	-0.005	-0.003	
SAW_Mys	-0.003	0.007	-0.011	0.083	0.005	0.021
JS	0.002	-0.010	0.001	0.008	-0.001	0.046
OC	0.003	-0.009	0.010	-0.008	0.012	0.056
RES_LEA	0.012	-0.059	-0.027	-0.002	-0.025	-0.009
EXPER	-0.002	-0.003	-0.026	-0.055	-0.003	0.166
RANK	0.000	0.000	0.006	-0.033	-0.053	0.023
EDUC	-0.001	0.002	-0.020	-0.003	-0.058	-0.022

	JS	OC	RES_LEA	EXPER	RANK	EDUC
	--------	--------	--------	--------	--------	--------
JS	0.004					
OC	0.002	-0.004				
RES_LEA	-0.021	-0.092	0.038			
EXPER	0.065	0.045	0.023	0.000		
RANK	-0.006	-0.002	0.002	-0.003	0.000	
EDUC	-0.026	-0.011	-0.009	0.000	0.000	0.000

Summary Statistics for Fitted Residuals
Smallest Fitted Residual = -0.092
Median Fitted Residual = 0.000
Largest Fitted Residual = 0.166

PT Public Residuals

	SE_Opp	SE_Inf	SE_Sup	SE_Res	PE_Det	PE_Imp
SE_Opp	0.003					
SE_Inf	0.003	-0.007				
SE_Sup	0.009	-0.005	0.000			
SE_Res	0.057	-0.018	0.048	0.000		
PE_Det	0.004	-0.006	-0.004	0.001	-0.003	
PE_Imp	-0.007	-0.016	-0.018	-0.008	-0.009	-0.015
PE_Comp	-0.011	-0.010	-0.034	-0.052	-0.012	-0.014
PE_Mean	0.002	-0.018	-0.016	-0.008	-0.009	0.098
SAW_Eng	0.011	-0.012	-0.010	-0.012	-0.001	0.029
SAW_Com	0.075	-0.018	-0.005	-0.025	-0.001	0.010
SAW_Spi	-0.036	0.063	-0.084	0.000	0.003	0.025
SAW_Mys	-0.046	0.060	-0.034	0.116	-0.002	0.032
JS	0.024	-0.081	0.027	0.038	-0.001	0.043
OC	-0.018	-0.003	-0.005	0.069	0.000	0.036
RES_LEA	-0.027	0.008	-0.012	-0.046	0.016	0.009
EXPER	-0.027	-0.023	-0.086	-0.106	-0.028	-0.028
RANK	0.003	-0.001	0.005	0.003	0.001	0.004
EDUC	0.008	0.019	0.036	0.027	0.010	0.016

	PE_Comp	PE_Mean	SAW_Eng	SAW_Com	SAW_Spi	SAW_Mys
PE_Comp	0.003					
PE_Mean	-0.013	-0.010				
SAW_Eng	-0.010	0.000	0.009			
SAW_Com	0.004	0.003	0.025	0.003		
SAW_Spi	0.009	0.007	-0.012	0.001	0.000	
SAW_Mys	-0.003	-0.001	0.008	0.079	0.003	0.001
JS	-0.004	-0.008	0.003	0.010	-0.008	0.003
OC	0.004	-0.008	-0.003	0.016	0.040	0.017
RES_LEA	0.057	0.026	0.011	0.009	0.042	-0.021
EXPER	0.006	-0.031	-0.009	-0.016	0.210	0.110
RANK	0.000	0.000	-0.034	-0.045	0.017	0.013
EDUC	0.001	0.014	-0.029	-0.030	-0.056	0.003

	JS	OC	RES_LEA	EXPER	RANK	EDUC
JS	-0.001					
OC	-0.034	-0.004				
RES_LEA	0.004	-0.007	0.016			
EXPER	-0.041	0.022	0.028	0.000		
RANK	-0.035	0.016	0.006	-0.001	0.000	
EDUC	-0.003	-0.013	-0.008	0.000	0.000	0.000

Summary Statistics for Fitted Residuals
Smallest Fitted Residual = -0.106
Median Fitted Residual = 0.000
Largest Fitted Residual = 0.210

PT Private Residuals

	SE_Opp	SE_Inf	SE_Sup	SE_Res	PE_Det	PE_Imp
SE_Opp	0.000					
SE_Inf	0.000	0.001				
SE_Sup	0.004	-0.019	0.000			
SE_Res	0.007	-0.002	-0.006	0.000		
PE_Det	0.000	0.000	0.003	-0.009	0.001	
PE_Imp	0.003	0.003	-0.005	-0.024	0.001	0.001
PE_Comp	-0.054	0.016	0.035	0.001	0.005	0.002
PE_Mean	-0.031	0.004	0.007	0.023	0.001	0.003
SAW_Eng	0.004	0.084	0.011	0.014	0.001	-0.003
SAW_Com	-0.015	0.118	0.007	0.129	0.003	0.000
SAW_Spi	0.108	-0.056	-0.003	-0.039	0.001	0.001
SAW_Myst	0.132	0.011	-0.046	0.116	0.002	-0.003
JS	0.160	0.039	0.072	-0.007	0.001	-0.004
OC	0.081	0.012	0.164	0.044	-0.001	-0.004
EXPER	-0.086	0.048	0.068	-0.101	0.017	0.008
EDUC	0.109	-0.009	-0.020	-0.219	0.006	-0.018

	PE_Comp	PE_Mean	SAW_Eng	SAW_Com	SAW_Spi	SAW_Myst
PE_Comp	0.002					
PE_Mean	-0.012	-0.010				
SAW_Eng	-0.002	-0.003	-0.001			
SAW_Com	0.002	-0.003	0.001	0.006		
SAW_Spi	-0.003	-0.002	0.000	-0.001	0.000	
SAW_Myst	-0.002	-0.006	-0.001	0.002	-0.001	-0.001
JS	0.003	-0.007	-0.001	-0.001	0.000	-0.001
OC	0.017	0.008	0.029	0.045	-0.051	-0.035
EXPER	-0.017	-0.035	0.060	0.113	0.149	0.081
EDUC	-0.019	-0.005	0.054	-0.135	0.115	0.183

	JS	OC	EXPER	EDUC
JS	-0.002			
OC	-0.033	-0.036		
EXPER	-0.021	0.105	0.000	
EDUC	0.102	0.074	0.000	0.000

Summary Statistics for Fitted Residuals

Smallest Fitted Residual = -0.219
Median Fitted Residual = 0.001
Largest Fitted Residual = 0.183

APPENDIX K: DISCUSSION OF RESEARCH RESULTS

RNs

The survey data revealed a significantly greater number of RNs in management and a greater number of RNs prepared at the master's or doctoral level than the provincial demographic data indicated and these differences must be taken into account when generalizing the results from the survey data to the provincial population. Both the SEM analysis of the Likert-style questions and the content analysis of the responses to the open-ended question (Appendix G) provided valuable insight into the relationships between the study variables for this sample population.

All of the exogenous variables, except education, exhibited significant direct or indirect effects on the outcome variables of job satisfaction and organizational commitment.

Resonant leadership. SEM analysis of the survey data revealed that resonant leadership had a significant relationship with the structural empowerment components of support and resources, which was further emphasized by the survey comment, "Leaders are 100% accountable for the teams they create." Resonant leadership also had a significant effect leading to *spiritual connection*, and the RNs stated that leaders were not "building the spirit of the unit, but seem to be detrimental to the [building] of the spirit." Finally, the survey data confirmed a significant direct effect leading to the two outcome variables of job satisfaction and organizational commitment.

The RN survey data did not reveal a direct relationship between resonant leadership and information and opportunity or *engaging work, sense of community* and *mystical experience*, as the theoretical model proposed. However, upon closer examination of the model, I discovered that resonant leadership had an indirect effect on these same variables.

Experience. SEM analysis revealed that experience was related to the two components of psychological empowerment of impact and competence, as the original theoretical model suggested. Experience failed to show a significant relationship leading to self-determination and meaning, the remaining components of psychological empowerment. However, a significant effect from competence to meaning suggested an indirect effect between experience and the personal meaningfulness of job activities.

Rank. Rank was significantly related to support and information and had a direct significant negative effect leading to the outcome variable of job satisfaction. Rank was not related to any of the psychological empowerment variables, contrary to the initial theoretical model.

Education. SEM analysis did not reveal significant relationship between education and any of the other variables within this model.

All of the endogenous variables received significant effects from other variables in the model and also had a significant direct or indirect causal effect on one of the outcome variables of job satisfaction or organizational commitment.

Structural empowerment. Opportunity, information, and support, three of the four components of structural empowerment, were significantly related to the

two components of psychological empowerment of self-determination and impact.

Support was related to self-determination, which suggested that when support increased, self-determination decreased. This negative relationship was contrary to the survey comments that suggested that more support on client-related issues would result in a positive impact: “When it comes to issues that arise that need to be addressed with management regarding patient safety, new ideas for the betterment of our unit and so on, we (the staff) are feeling ignored and bothersome.” Instead, the respondents to the nursing survey interpreted the survey question on support as an attempt to control RNs’ self-determination rather than encourage self-determination. The negative relationship between support and self-determination represented a significant concern for this group of Alberta RNs, whose results deviated from those of previous UWO Workplace Empowerment research (Laschinger, 2008b).

Resources, did not exert a significant effect on the components of psychological empowerment; rather, it displayed a significant relationship with information. RNs’ comments in the survey described an absence of needed resources such as adequate staffing, time for patient care, resources for staff wellness, and overall budget and suggested that absence of these resources resulted in a lack of time or energy within the workplace to investigate and understand the values of top management.

Psychological empowerment. Self-determination did not have a direct effect on components of *SAW*, job satisfaction, or organizational commitment; rather, it had a significant effect on the psychological empowerment components of impact, and competence.

Impact had a significant causal effect on *sense of community* and organizational commitment. The following statement from a RN who expressed concern about the treatment from managers implied this relationship: “I worked with my manager for over a year before she learnt my name.”

Competence had a single significant effect on meaning, while meaning, the final component of psychological empowerment, demonstrated significant causal effects on *engaging work* and *spiritual connection*. The following comment illustrated the strong relationship between meaning and *engaging work*,: “I feel less satisfied with the entire organization and at times question the values that are acted upon (not the ones in writing).”

SAW. *Spiritual connection* played a pivotal role in this nursing model, not only receiving significant causal effects from meaning and resonant leadership, but also exerting significant effects on *sense of community* and *mystical experience*, and on both job satisfaction and organizational commitment. The following comment further elaborated on these relationships:

I think maybe that nursing has burned me out. My spirit for nursing and its work is gone—too many years of abuse from the system—overwork—underappreciated and tired of trying. Now it is just a job and pays the bills—maybe it is time to leave nursing.

Engaging work received significant causal effects from meaning, *sense of community*, and *mystical experience*. *Engaging work* also exerted a significant

causal influence upon job satisfaction. *Sense of community* received significant effects from impact, resonant leadership, and *spiritual connection*, while exerting a single significant effect on *engaging work*. *Mystical experience*, or the experience of energy or vitality in the workplace, received a single significant causal effect from *spiritual connection* and, in turn, exerted a significant causal effect on *engaging work*. The following comments from two respondents clearly depicted the relationships between *sense of community*, *mystical experience*, and *engaging work*: "I work in a very small teaching unit of ten RNs. We are close and work together in harmony, but also efficiently" and "I strongly believe that this can be a healing atmosphere when the client senses that the staff get along with each other.

Job satisfaction. Job satisfaction received significant causal effects from *engaging work,* impact, and the two exogenous variables of resonant leadership and rank. It is important to note the negative relationship between rank and job satisfaction, which indicated that RNs in management positions reported lower job satisfaction than did RNs in staff positions.

Organizational commitment. Organizational commitment received significant causal effects from *spiritual connection*, impact, and the exogenous variable of resonant leadership.

SEM analysis of this survey of the Alberta RNs revealed an unexpected significant negative relationship in the model: between rank and job satisfaction. This significant relationship indicated workplace characteristics that were representative of the specific sample of RNs in Alberta at the time of the survey (fall 2007 to early summer 2008). In addition since education did not display a significant relationship with any other variables in this model, it is possible that education could be eliminated from the model for RNs. Further testing of this model would reveal if these unexpected results are specific to this sample population, or can be generalized to the larger population of RNs.

OTs

The survey data revealed a smaller percentage OT respondents in acute care and more OT respondents in home care, community, and "other"; a greater percentage of OTs in the more than 30 age group and proportionately more OTs in the more than 30 to 44 and more than 44 to 55 age groups and fewer in the more than 55 age group. The survey sample data was highly skewed, with a larger percentage of OTs with master's or doctoral preparation, creating a bias in all the responses and limiting my ability to apply the data from this research to the general population of OTs in Alberta.

Both the content analysis of the responses to the open-ended question (Appendix G) and the SEM analysis of the Likert-style questions supported theory and provided valuable insight into the relationships between the study variables for this sample population.

Resonant leadership, experience and rank exhibited significant direct or indirect effects on the outcome variables of job satisfaction and organization commitment. Education did effect any other variables in the model.

Resonant leadership. SEM analysis of the survey data revealed a significant relationship between resonant leadership and support and resources. The OT respondents' comments emphasized the importance of knowledgeable and effective management and team leadership within the workplace. The significant relationships between resonant leadership and *sense of community* and job satisfaction were supported by comments regarding the loss of morale in the department as a result of the switch from a collaborative style of leadership to a "dictatorial/authoritative style." The participants also expressed loss of morale in statements such as "lack of commitment to the overall program and a loss of trust in management, as well as a loss of pride in the job I do."

Experience. *E*xperience was significantly related to competence.

Rank. Rank was related to information, self-determination and impact.

Education. The survey data did not indicate significant relationships between education and the endogenous variables within the model.

All of the endogenous variables received significant effects from other variables in the model. All of the endogenous variables except the four *SAW* variables also had a direct or indirect effect on one of the outcome variables of job satisfaction and organizational commitment.

Structural empowerment. Two of the four components of structural empowerment of opportunity and support were related to self-determination, a component of psychological empowerment. The OT respondents made several comments about a desire for the opportunity to learn more and to develop new skills. They also complained of a lack of feedback that they could use "constructively to enhance skills." An OT also thought that supporting teamwork could create opportunities for staff and clients alike and team support led to self-determination.

Information and resources did not have significant effect on any of the components of psychological empowerment.

Opportunity and resources had a significant effect on *mystical experience.* An OT expressed concern about the lack of resources: "I am at the point of breaking with the work load. I go home every day knowing that I have left things incomplete and having made choices of who is most needy of my response." Information, the final component of structural empowerment, had a significant effect on the outcome variable of organizational commitment.

Psychological empowerment. Self-determination was significantly related to impact. Impact was significantly related to meaning.

Opportunity and support (components of structural empowerment) also had an indirect effect on impact and meaning through their significant relationship with self-determination. Three different OT respondents were concerned about the controlling nature of the employer and commented on the significant effect of self-determination on job satisfaction: "So many rules and regulations that you feel that big brother is always looking over your shoulder."

Competence, the fourth component of psychological empowerment, did not have a significant relationship with any components of structural empowerment or psychological empowerment.

Competence was significantly related to both *sense of community* and organizational commitment.

Meaning played a central role for this sample population and displayed significant relationships with *engaging work*, and the outcome variables of job satisfaction and organizational commitment Meaning also received significant effects from self-determination and impact.

SAW. *Mystical experience* showed a significant effect on *engaging work.* This was supported by the OT comment regarding a lack of energy or vitality in the workplace from a loss of pride in the job.

Sense of community did not have an effect on any other variable. However, several OT respondents spoke very highly of a *sense of community*: "Staying in the present moment and working with the team who is with you right then creates opportunities for staff and clients that no one would have predicted!"

Again, the SEM analysis of the survey responses showed that *spiritual connection* did not have a significant effect on other variables. However, several OT referred to a connection with a greater source that has a positive effect on work as "a higher being or something [that] enables us all to move forward if each of us makes that choice."

Job satisfaction. Job satisfaction received significant effects from resonant leadership; and self-determination.."

Organizational commitment. Organizational commitment was significantly related to information, competence and meaning.

SEM analysis of the data revealed that job satisfaction was not related to organizational commitment for OT.

Since education did not display a significant relationship with any other variables in this model, it is possible that education could be eliminated from the model for OTs. Further testing of this model would reveal if these unexpected results are specific to this sample population, or can be generalized to the larger population of OTs.

PT Public and Private

I combined the survey data from PT public and PT private, which revealed a significantly greater number of PTs in community and rehabilitation than in acute care; more PTs in LONG TERM CARE, private, and "other" than in community; and more participants in rehabilitation than in private. Further analysis revealed a larger percentage of PTs in management than indicated by provincial demographic data . The analysis also showed significantly more PTs prepared at the diploma level than at the baccalaureate level. I took these significant differences into account in generalizing the results from the survey data to the provincial population. Both the SEM analysis of the Likert-style questions and the content analysis of the responses to the open-ended question (Appendix G) provided valuable insight into the relationships between the study variables for this sample population.

PT Public SEM Discussion

Resonant leadership, experience and rank exhibited significant direct or indirect effects on the outcome variables of job satisfaction and organization commitment.

Resonant leadership. SEM analysis of the survey data showed that resonant leadership had significant effects on information, support, and resources. The PT focus group participants verified this finding when they stressed that they all provided leadership for others, whether as managers or in a more informal manner as senior PTs to junior PTs.

Resonant leadership was significantly related to *sense of community* and *spiritual connection.* However, there were no significant effects from resonant leadership to *engaging work* or *mystical experience*. Job satisfaction received a significant effect from resonant leadership.

Experience. The SEM analysis of the survey data revealed a significant causal relationship from experience to competence. This relationship indicated that experienced PTs have a greater mastery of the skills necessary for the job than do PTs with less experience.

Rank. Rank had a significant effect on information, which suggested that the participants perceived managers as having the additional information and knowledge required to manage the organization. Rank also had a significant effect on impact, which indicated the PTs' perception that PTs in management positions had significant influence over what happened in their department.

Education. PT public perceived a significant negative effect from education to impact, which represented the PTs' perception of reduced influence over what happens in the department when they have more education. I theorized that a relationship existed; however, I did not anticipate a negative relationship.

All the endogenous variables received significant effects in the model, although two of the relationships were negative. All the endogenous variables except impact, had a direct or indirect causal effect on one of the outcome variables of job satisfaction and organizational commitment.

Structural empowerment. I did not anticipate the significant negative effect of opportunity on competence. This negative relationship followed from the PT public perception that increased "chances to gain new skills and knowledge on the job" were associated with decreased "mastery of the skills necessary for the job."

SEM analysis showed opportunity was significantly related to self-determination, competence, meaning, and *engaging work.* Comments by six PT public elaborated on the importance of learning opportunities in the workplace. Information had significant effect on impact and competence. The SEM analysis revealed that support had a significant effect on *engaging work*, and is supported by the 12 PT public who commented on the absence of support in the workplace. The original model did not predict the significant relationships between these components of structural empowerment and *SAW.*

The negative relationship between opportunity and competence indicated that increased opportunities for challenging work and increased education resulted in decreased competence. Many comments were made about isolation and the

difficulties experienced with work overload by the PT public. I also identified an unanticipated significant negative effect of resources on *spiritual connection* that suggested that when "temporary help is acquired as needed," there was an associated perception that "the connection with a greater source that has a positive effect on work" was reduced.

Theory supported the significant effect that knowledge of the values of top management (information) had on organizational commitment, which the original model did not predict.

Psychological empowerment. Meaning was significantly related to *engaging work*, *spiritual connection*, and *mystical experience*; with two PT public commenting that they liked their jobs and their clients were their number-one concern. None of the other components of psychological empowerment had a significant effect on the *SAW* components. However, self-determination was significantly related to impact, competence, and meaning; and one PT commented that it was "fulfilling to have the opportunity to do my job as I wish[ed and] as I [had] the experience to do it." SEM also revealed that competence was significantly related to meaning. Self-determination had a significant effect on organizational commitment, while meaning had a significant effect on organizational commitment.

SAW. *Engaging work* was significantly related to job satisfaction, and the PT public respondents commented that they enjoyed the work, were happy in the direct care provider role, and were "blessed" to be PTs. *Mystical experience* was significantly related to organizational commitment, but the remaining two components of *SAW* displayed no direct significant relationship with either job satisfaction or organizational commitment. Rather, *sense of community* was related to *engaging work,* and *spiritual connection* was related to *mystical experience*

Job satisfaction and organizational commitment. The SEM analysis of the PT public data showed that job satisfaction was not significantly related to organizational commitment.

My SEM analysis of this survey of the Alberta PT public revealed three unexpectedly negative relationships. PT public perceived that the increase in opportunity resulted in decreased competence, when resources increased, the perception of a *spiritual connection*, decreased, and finally impact decreased when education increased. These significant relationships indicated workplace characteristics that were representative of the specific sample of PT public in Alberta at the time of the survey (fall 2007 to early summer 2008).

PT Private SEM Discussion

Because of the large number of parameters that I investigated using the proposed theoretical model, my discussion must take into account the warning from LISREL (Jöreskog & Sörbom, 1996): "Total sample size is smaller than the number of parameters. Parameter estimates are unreliable." Both the SEM analysis of the Likert-style questions and the content analysis of the responses to the open-ended questions (Appendix G) provided valuable insight into the relationships between the study variables for this sample population.

Both exogenous variables had a significant effect on competence. The exogenous variables of education and experience did not have significant effects on the outcome variables of job satisfaction and organizational commitment.

Experience. Years of experience for the PT private were related to competence, which indicated that individuals with more experience had a greater mastery of the skills necessary for the job than did PTs with less experience.

Education. The SEM analysis also revealed that education was related to competence and the literature supported this relationship (Kuokkanen et al., 2003; Spreitzer et al., 1997). However, my analysis of the data revealed an unanticipated negative relationship between education and competence, suggesting PT private with higher education were perceived as less competent. It is important that a high percentage of the respondents to the survey were diploma-prepared.

All of the endogenous variables except *spiritual connection* and job satisfaction received significant effects from other variables in the model. All of the endogenous variables except meaning and the four components of *SAW* had a direct or indirect causal effect on the outcome variable of organizational commitment. Although job satisfaction did not receive significant effects from other variables in the model, it was significantly related to organizational commitment.

Structural empowerment. All four components of structural empowerment had direct or indirect effects on all four components of psychological empowerment. Opportunity had a significant effect on meaning, and one respondent pointed out that being a co-owner of a clinic is challenging and required the learning of new skills. Information had a significant effect on impact, and two PTs stressed that mentors were important and that "not enough active guidance is taken in this role." Another PT observed that owners not only listen to their comments and ideas, but also act on them. Information also had a significant effect on the outcome variable of organizational commitment.

The components of structural empowerment were also significantly related to each other; resources had a significant effect on support, and support was significantly related to both information and opportunity. The focus group members described components of structural empowerment that they regarded as important in the workplace, which also supports these relationships.

Psychological empowerment. Analysis of the data from PT private revealed that two of the four components of psychological empowerment had significant effects on three of the four *SAW* components: Competence had a significant effect on *sense of community*, and meaning had significant effects on *engaging work* and *mystical experience*. Self-determination and impact had no significant effects on any of the components of *SAW*.

Two of the four components of psychological empowerment of self-determination and impact had significant effects on the outcome variable of organizational commitment.

The SEM analysis showed a significant negative effect from self-determination to organizational commitment. PT private perceived an increased ability to "decide on their own how to go about doing their work" as related to a decreased commitment to the organization. These results suggested that PT

private were actively working to succeed in solo practice and did not have a strong commitment to a specific workplace.

The analysis also revealed significant relationships between the different components of psychological empowerment: Self-determination had significant effect on impact, competence and meaning. Competence had significant effect on impact and meaning. Spreitzer (1995) suggested these relationships in her discussion of the *gestalt* of psychological empowerment.

SAW. The SEM analysis of the PT private data revealed no significant relationships between the components of *SAW* and the outcome variables of job satisfaction and organizational commitment. However, the analysis indicated several significant relationships between the individual components of *SAW*. *Sense of community* had significant effects on both *engaging work* and *mystical experience*, and one PT private noted that multidisciplinary teams built enthusiasm, clarify beliefs, and created a feeling of involvement in the profession. Two different PT expressed the concern that multidisciplinary teams have caused the loss of their community practice. *Spiritual connection* had a significant causal effect on *mystical experience*. One respondent commented that "the 'spirit' of a workplace obviously develops as a direct result of the qualities of the workers within that workplace, though I do not feel that a higher power or divine inspiration necessarily drives that spirit."

Job satisfaction and organizational commitment. Job satisfaction had a significant effect on organizational commitment, as the literature confirmed (Blegan, 1993; Mosadeghrad et al., 2008). However, none of the variables in the model exerted a significant effect upon job satisfaction. This suggested that sources of job satisfaction for PTs in private practice did not arise from the components of structural empowerment, psychological empowerment, or *SAW*, and another source of job satisfaction, that the model did not identify, must exist for PT private.

Application of this theoretical model to the PT private sample revealed significant negative effects that represented important differences between this sample population of Alberta PT private (fall 2007 to early summer 2008) and other sample populations. A significant negative effect from self-determination to organizational commitment was revealed, which possibly represented the PT privates' desire to practice independently of organizational controls. However, theory and logic did not predict or explain the significant negative effect from education to competence. Further testing of this model would reveal if these unexpected results are specific to this sample population, or can be generalized to the larger population of PT private.