

Seeking Connectivity in Nurses' Work Environments: Advancing Nurse Empowerment Theory

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The purpose of this study was to investigate how staff nurses and their managers exercise power in a hospital setting in order to better understand what fosters or constrains staff nurses' empowerment and to extend nurse empowerment theory. Power is integral to empowerment, and attention to the challenges in nurses' work environment and nurse outcomes by administrators, researchers, and policy-makers has created an imperative to advance a theoretical understanding of power in the nurse–manager relationship. A sample of 26 staff nurses on 3 units of a tertiary hospital in western Canada were observed and interviewed about how the manager affected their ability to do their work. Grounded theory methodology was used. The process of seeking connectivity was the basic social process, indicating that the manager plays a critical role in the work environment and nurses need the manager to share power with them in the provision of safe, quality patient care.

Keywords: nurse, nurse manager, empowerment, power, leadership

Résumé

**La quête de liens dans les milieux
de travail des infirmières et infirmiers :
une contribution à la théorie
de l'autonomisation du personnel infirmier**

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L'objectif de cette étude était d'examiner comment s'exerce le pouvoir par les gestionnaires et le personnel infirmier en milieu hospitalier afin d'une part de mieux comprendre ce qui favorise ou contraint l'autonomisation des infirmières et infirmiers et d'autre part de contribuer au développement de la théorie de l'autonomisation du personnel infirmier. Le pouvoir d'action faisant partie intégrante de la notion d'autonomisation, l'attention portée par les administrateurs, les chercheurs et les décideurs aux résultats du personnel infirmier ainsi qu'aux difficultés avec lesquelles celui-ci doit composer dans son milieu de travail a rendu nécessaire le développement d'une compréhension théorique plus approfondie de l'exercice du pouvoir au sein de la relation qui lie les gestionnaires aux infirmières et infirmiers. Un échantillon composé de 26 membres du personnel infirmier de 3 unités d'un hôpital de soins tertiaires de l'ouest du Canada a été observé et soumis à des entretiens portant sur la façon dont les gestionnaires influencent la capacité des infirmières et infirmiers à effectuer leur travail. Une méthodologie favorisant le développement d'une théorie enracinée dans les données empiriques a été employée. L'étude a permis de constater que la quête de liens est le processus social fondamental à l'œuvre, ce qui indique que les gestionnaires jouent un rôle essentiel dans le milieu de travail et que le personnel infirmier a besoin que ceux-ci partagent avec lui l'exercice du pouvoir pour assurer la prestation aux patients de soins sécuritaires et de qualité.

Mots-clés : infirmières et infirmiers, gestionnaires du personnel infirmier, autonomisation, pouvoir, exercice du pouvoir

Introduction

The central idea of empowerment theory is the power that individuals need in order to do their work in a meaningful manner (Kanter, 1977, 1993). A key responsibility of nurse leaders is to create conditions that empower nurses to provide the best possible care in a healthy work environment that fosters professional practices and effective working relationships (Laschinger, Finegan, & Wilk, 2009; Laschinger, Gilbert, Smith, & Leslie, 2010). The increased attention to the challenges in nurses' work environments and nurse outcomes has created an imperative to investigate nurse empowerment in greater depth and breadth (Udod, 2011).

Background

Power, according to Kanter's (1977, 1993) theory of structural power, is associated with the ability to mobilize resources to get things done. Accordingly, work environments that provide access to resources, support, and information empower nurses to do their work in meaningful ways (Kanter, 1977, 1993). From this perspective, power is associated with granting power and is shared for everyone's benefit. Kanter argues that managers play a key role in assuring nurses access to sources of empowerment in work settings, a position that is confirmed by Laschinger's research (Greco, Laschinger, & Wong, 2006; Laschinger, 1996; Laschinger, Wong, McMahon, & Kaufman, 1999). Empowerment is a tool used to motivate nurses and is manifested by a degree of clinical judgement within one's scope of practice in caring for patients to achieve organizational goals. Access to empowering structures is heightened by specific job characteristics and interpersonal relationships that foster communication through formal and informal power. Relationships have been found between empowerment and decreased levels of job stress and emotional exhaustion/burnout (Kluska, Laschinger, & Kerr, 2004; Laschinger, Finegan, & Shamian, 2001; Laschinger, Finegan, Shamian, & Wilk, 2003).

In contrast, Conger and Kanungo (1988) and Spreitzer (1995) highlight the key role of leadership behaviour in shaping nurses' work experiences. The motivational approach to empowerment involves sharing power and information to increase nurses' confidence in their own effectiveness and thus improve productivity. By enabling nurses to develop a sense of ownership in their work and the organization, empowerment is thought to increase nurses' commitment and involvement, ability to cope with adversity, and willingness to function independently (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). Spreitzer (1995) developed a scale to measure four cognitive domains: *meaning* (the fit between a given activity and one's belief, attitudes, and behaviours); *competence* (belief

in one's ability to perform a task); *impact* (belief that one can influence organizational outcomes); and *self-determination* (sense of control over how one performs one's job).

Nurse researchers have found that involvement in unit decisions, supportive management, trust in management, and job satisfaction have been positively linked to staff empowerment (Laschinger & Finegan, 2005; Laschinger, Finegan, Shamian, & Wilk, 2001; Laschinger & Havens, 1996). From a psychosocial perspective, employees who are psychologically empowered value a manager who creates conditions for enhancing their motivation by removing disempowering organizational structures.

Critical social perspectives deconstruct the way that power is embedded in nursing practice (Forbes et al., 1999). Since the early 1990s there has been increasing interest in using critical approaches to inform nursing research (Ceci, 2003; Cheek, 1999; Cheek & Gibson, 1996; Cheek & Porter, 1997; Fahy, 2002; Fulton, 1997; Manias & Street, 2000). These approaches challenge the status quo, highlight marginal voices in dominant discourses, and explore issues of power and knowledge in nursing. For nursing, critical social theory offers a research perspective that may help "uncover the nature of enabling and/or restrictive practices, and thereby create space for potential change and, ultimately, a better quality of care for patients" (Wells, 1995, p. 52). Collectively, the results of these studies suggest that, in conjunction with staff nurses' tenuous relationships with their supervisors (Laschinger & Finegan, 2005), building trust between nurses and their managers is critical to patterns of nurse empowerment within relations of power that contribute to a positive work environment (Hardy & Leiba-O'Sullivan, 1998; Laschinger & Finegan, 2005; Moye & Henkin, 2006).

The purpose of this study was to extend empowerment theory to explain how staff nurses and their managers exercise power in a hospital setting, and thus to better understand what fosters or constrains staff nurses' empowerment. The study was guided by two questions: 1. *How are staff nurses and their managers situated in social relations of power?* 2. *What is the context in which these interactions occur?*

Research Method

A grounded theory method (Strauss & Corbin, 1998) was used to theorize the process of how nurses and their managers exercise power in their relationships. It was anticipated that this inquiry would provide the foundation for "the elaboration of existing theory" (Suddaby, 2006, p. 635) to produce a better understanding of how nurses exercise power, thus influencing empowerment practices.

Sample

The sample comprised registered nurses chosen on the basis of their experiences with the social process under investigation (Corbin & Strauss, 2008; Strauss & Corbin, 1998). As the study got underway, theoretical sampling involved gathering data driven by concepts derived from an emerging theory and then determining what people, events, or places would maximize opportunities to discover variation among concepts (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Twenty-six registered nurses were recruited from three units in a tertiary hospital in western Canada. They ranged in age from 20 to over 50, with 40% being between 26 and 30. The majority of nurses were female (88%) and the majority (64%) had a nursing degree or a nursing degree in progress. The length of time the nurses had worked on their current units ranged from 7 months to 24.5 years, with a mean of 7.5 years. The total number of years as an RN ranged from less than 1 to 30, with a mean of 10. One nurse transferred to another unit after her observation and despite repeated attempts the researcher was unable to contact her for a follow-up interview. Nurse managers were not part of the study.

Data Collection and Analysis

In this grounded theory study, data were collected during 2008–09 and are “grounded” in the interactions nurses had with their manager (Chenitz & Swanson, 1986; Creswell, 1998; Morse & Field, 1995). Grounded theorists have the tools to examine and analyze contradictions by focusing on words and actions that may reveal crucial priorities that are key to improving practice (Charmaz, 2005; Corbin & Strauss, 2008). Grounded theory’s potential for developing theory remains untapped, as does its potential for studying power (Charmaz, 2005). It is the method of choice for investigating the exercise of power between nurses and their managers.

Power was explored in the hospital as the context in which staff nurses work and observational fieldwork helped capture how power was exercised. The researcher observed staff nurses on all three shifts (days, evenings, and nights) over a period of 3 to 4 hours at various times of day and on different days of the week. The goal during these observations was to pay close attention to the design of the unit, the social relationships in the work environment, and the practices that shaped nurses conduct in terms of how staff nurses and their manager exercised power. The ways of thinking and behaviours that were produced surrounding nurses’ ability to do their work illustrated the workings of power. The researcher attended to the purpose and frequency of staff nurses’ informal discussions with managers, the extent to which staff nurses participated

in decision-making affecting their professional practice, and management behaviours and practices that affirmed or negated staff nurse involvement. The researcher spent 11 mornings, 9 afternoons, and 6 evenings/nights on the units, for a total of 26 episodes of fieldwork. In total, 90 hours were spent in the field making observations. Spradley's (1980) framework was used for documenting field notes containing the researcher's impressions, insights, and interpretations of what was observed in the field and served as an analysis of social relations of power integral to staff nurse empowerment.

Semi-structured interviews lasting from 40 to 60 minutes were conducted with the participants in a quiet room in the hospital or in the researcher's office connected to the hospital. An interview guide consisting of questions gleaned from the literature on organizational empowerment became more focused as a result of participant observations.

The study received ethical approval by the university and the regional health authority.

In keeping with the guidelines for grounded theory, data collection and analysis were conducted concurrently using constant comparative techniques (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Opie (1992) suggests that focusing on the differences in observing and interviewing participants is comparable to Glaser and Strauss's (1967) constant comparative method. Therefore, in open coding, interview transcripts and observations were analyzed line by line and generated several categories, such as *working without an anchor and stepping up of power*, and descriptive codes were written in the margins. By keeping codes active, the researcher was able to preserve the process and differentiate later sequences following multiple observations and interviews. In the second level of coding, categories were related to subcategories along the lines of properties and dimensions to form more precise and comprehensive explanations of phenomena (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Finally, the core category that emerged was *seeking connectivity*, and it was systematically related to other categories until a pattern of relationships was conceptualized (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Data saturation was achieved when there were no significant additions to the data and the theory "made sense" (Morse & Field, 1995).

Findings

Seeking connectivity was the basic social process in which nurses strived to connect with their manager to build a workable partnership in the provision of good patient care while responding to organizational demands. Conditions, actions, and consequences formed the theory of seeking connectivity as an extension of nurse empowerment theory. First, five

contextual factors represented the conditions in the organization that influenced nurses' relationships with their manager. Second, five themes related to how nurses and their managers exercised power in their relationships: (a) *working without an anchor*, (b) *silencing forms of communication*, (c) *stepping up of power*, (d) *positioning to resist*, and (e) *experiencing the potentiality of enabling*. The last two of these — (d) and (e) — concern nurse responses to the relationship of power. Through encounters with contextual factors (conditions), and as a result of nurse–manager actions and interactions, nurses responded to and shaped the situations in which they found themselves in order to provide patient care in satisfying ways.

Organizational Context

Five key contextual factors in the hospital influenced nurses' relationships with their manager. First, the budget was incorporated into nurses' everyday language; their care had become a cost-conscious activity driven by economic efficiency and resource constraints. Second, "working short" was defined as a lack of nursing personnel; sick days were not filled for budgetary reasons, which influenced how nurses managed their workloads. When nurses experienced a shortage of professional nursing staff, their work activities became less controllable. Third, all nurses expressed concern about the frequency with which they were being "pulled away" by competing organizational priorities; they had to temporarily stop direct patient activities and respond immediately to overcapacity alerts, provide documentation, and dispense medications at the designated time, while also responding to myriad non-nursing duties. Fourth, the nature of policies was an organizing and dominant feature of nurses' work. Institutional policy decisions re-organized nurses' judgement and actions in line with managerial priorities, and occasionally affected nurses' ability to provide good care because they had to juggle patient care with meeting organizational demands. Finally, organizational priorities increased the scope of nurses' workloads, and they perceived that their actions could jeopardize patient safety and their professional licences.

Nurse and Nurse Manager Relations

Working without an anchor. In this category, nurses described engaging in their work without the consistent support of their manager. However, the extent to which this occurred varied with each nurse. Nurses characterized the manager as subordinating nursing and patient care practices to organizational priorities.

The manager's lack of visibility and nurses' inability to interact with the manager in a regular and consistent manner exacerbated their perception of working in isolation. The lack of visibility adversely affected their access to knowledge and engagement in decision-making, and they

believed that this limited the manager's understanding of patient needs and time constraints. Nurses perceived the manager's lack of awareness of what was happening on the unit as a dissonance between the needs of patients and the manageability of nurses' work:

There's a lot of questions. If you did ask for a sitter to come . . . she'd really grill you about why are you doing this: "Is this really appropriate?" She was looking at the dollar figure more than how stressed we were at work or what our work environment was . . . it really puts a lot of stress on you to hear that.

In the views of the nurses, managers had limited clinical knowledge and experience, which constrained their ability to understand the complexities of nurses' work and to advocate in the best interests of nurses and patients:

She [the manager] needs to be involved in [the] day-to-day . . . she goes to meetings, [is] not really on the ward; she doesn't have a very broad knowledge base [in] nursing.

She was . . . almost never accessible to anyone on the floor, for any reason, whether it was to do with staffing issues, workload issues, with the basic needs . . . it seemed like there was always something more pressing.

In general, working without an anchor accentuated the tension that nurses experienced in meeting organizational demands while providing patient care, without the consistent and active engagement of the manager in facilitating and guiding professional responsibilities.

Silencing forms of communication. Silencing forms of communication refers to how communication patterns were circumscribed between managers and nurses, reinforcing the isolation that nurses experienced. Nurses perceived themselves as "having to go along" with the manager and/or management's policy changes without dialogue to elicit their viewpoints. Nurses described input into policy changes regarding staffing levels, the patient delivery model, and documentation as either circumscribed or non-existent. The manner in which the policies were communicated by the manager gave the impression of a non-negotiable edict, according to one nurse: "She says we'll use it as a guideline, but everything seems to be kind of set in stone." Another nurse described the lack of input into the changes to the patient care delivery model: "It kind of came out of left field and just kind of landed and we were told to scurry away and do it."

Rather than assuming a leadership role in executing a change process by preparing and meeting with staff, one manager let the educator assume the role of "pushing" the policies:

From what I see, [manager] has a very silent role . . . through this whole thing I've never actually heard her discuss any of the changes with any of the staff. If you approach her she'll explain the reasoning, but she's not one to hold staff meetings.

In general, promoting one-way communication with minimal ability to exchange ideas may have been a way for managers to minimize conflict and retain power while responding to organizational mandates over which they had little control. It may have been a way for them to handle a polarized situation as each struggled for control over how contextual factors would influence nurses' work.

Stepping up of power. This was categorized by the nurses as the manager's supportive attitudes, guidance, and behaviours in enhancing nurses' control over their work despite the contextual demands of the workplace. The manager acted as a liaison to support nurses and/or resolve conflict between nurses and patients, families, or other health professionals, especially when there was a power differential. One nurse described the manager as someone who could advocate for and support nurses in ways that facilitated their patient care activities:

Often on this unit we've had troubles with the physicians . . . you kind of need someone at a higher source of power because there's too much of a power space between the nurses and physicians.

Nurses suggested that when the manager engaged with nurses, solicited feedback, and was receptive to their opinions and professional judgement on decisions affecting their work, nurses responded favourably:

When she [nurse manager] started I was really impressed that she came around every day and introduced herself. She grabbed you for maybe 15 minutes and would ask what you would do to improve the place — she really wanted to know what was going on.

In general, stepping up of power was characterized by the manager's accessibility on the unit, seeking a close-up view of the demands of nurses' work and redirecting her activities to actively support nurses in their provision of patient care. This raised nurses' comfort level in interacting with the manager and contributed to nurses' trust in their manager.

Nurse Responses

Positioning to resist. Nurses' resistance strategies were intermittent and were deployed at multiple points along a continuum to challenge the power imbalances between themselves and their managers. Nurses did

not take an “all or nothing” approach to resistance towards their managers and role responsibilities. A close reading of the data suggests that there were deep-rooted resistances at play that were not always apparent or easily discernible. Yet at other times the resistance demonstrated by nurses was overt and readily apparent.

An aspect of positioning to resist was characterized as the means by which nurses allowed their manager a trial period to ascertain her fitness for the role of manager. Nurses dropped hints about a manager’s trial period, but it was never clear exactly what she needed to demonstrate and when the learning curve expired:

[Manager] is still new so we’re still giving her a year or two grace, kind of thing. We sometimes wish she would give the ward a whirl to see what it’s like.

Nurses used subtle and not so subtle strategies to get the manager to conform to how they perceived a manager should function. In informal meetings with one manager, nurses used a variety of suggestions to persuade the manager to change her behaviour:

I think there was maybe a handful of senior staff who’d had 20-plus years’ experience [and] just felt they had a lot to teach her. I said, “If you had come to report, you’d kind of know what the floor looks like — if we’re over-census, who we can take and who our pre-books are.”

Nurses demonstrated more overt forms of resistance when workloads became unmanageable. This was particularly evident in the actions related to policies, such as not consistently adhering to the new patient care delivery model and not documenting immediately. Doing the bare minimum was one way nurses coped with “doing more with less”:

You need to sometimes just step away for a few minutes . . . patients not getting washed; you kind of have to weigh . . . what’s the most important and prioritize things, so maybe someone will not get washed up before they go home.

Occasionally, nurses engaged in unproductive acts of resistance, yet the most successful acts of resistance were the result of their collective decision to act as patient advocates. A more detailed analysis of resistance related to the exercise of power between nurses and their manager will be outlined in a future publication.

Experiencing the potentiality of enabling. Nurses experienced the potentiality of enabling as advocating for good-quality patient care when the manager was supportive of nurses in their practice environments. When the manager minimized the demands of the organization, this enabled nurses to believe in the manager’s reliability and dependability

and increased nurses' sense of control over their work. Nurses were then able to provide the quality of care they believed necessary to promote and enhance patients' health and well-being, thus making a difference to the trajectory of the patient's recovery.

Nurses described the paralyzing fears that patients faced as they underwent advanced medical therapies or life-threatening surgeries: "You go in there and hang the chemotherapy and they're like deer caught in the headlights and they're absolutely frightened." Nurses described patients as being attentive and as having confidence that the nurse was making a difference to their recovery and well-being:

I've always done my medicine [nursing care] in totality. I'm able to talk [to patients]. I've had some patients tell me [that] because they had time to talk with me they felt better even though they had been feeling down.

Nurses believed they were able to focus on direct patient care when the manager intervened to regulate organizational processes and practices. Nurses were then able to use their knowledge and expertise to engage with the patient for the purpose of promoting good health behaviours and health outcomes.

Discussion

The basic social process that emerged was *seeking connectivity*, defined as nurses' striving to connect with their manager to build a workable partnership for the provision of quality care while responding to organizational demands. This theorization is an extension of empowerment theory and explains how nurses and their managers exercised power in their relationships and how seeking connectivity either hindered or fostered their ability to feel empowered in the work setting. The overarching finding is that the manager plays a critical role in modifying the work environment for nurses and therefore nurses seek connection with their manager.

In an organizational context, budgetary priorities, policies, and efficiency-oriented interruptions combined in various ways to influence nurses' thinking and shape their actions. The hospital sought to maintain power through a series of mechanisms affecting the way that nurses' work was structured and circumscribed to align with centrally determined policies and practices that downplayed nurses' professional judgement about patient care. According to the critical social perspective, nurses' work is situated in institutional structures where policies represent a sophisticated form of power over nurses and their work (Rankin & Campbell, 2006). Other studies report similar findings in that hospitals are providing an increased intensity of care with fewer nurses striving to

meet patient needs (O'Brien-Pallas et al., 2005; Priest, 2006). Cost containment and efficiencies have served to limit the range of services; when hospitals wish to save money they cut back on nursing personnel, creating a stressful work environment and potentially compromising the quality of care (O'Brien-Pallas et al., 2005; Priest, 2006; Rankin & Campbell, 2006). The present study reveals, from a structural perspective, that reasonable workloads and time (Kanter, 1993) are essential for nurse empowerment.

The first theme, *working without an anchor*, is congruent with the findings of other nursing studies. New governance models have found that nurse managers have increased spans of control (Laschinger et al., 2008; McCutcheon, Doran, Evans, McGillis Hall, & Pringle, 2009) and decreased visibility and availability for mentoring and support (Canadian Nursing Advisory Committee, 2002). However, the literature on magnet hospitals confirms that a supportive manager is one who is available, responsive, and approachable (Kramer et al., 2007). From a motivational empowerment perspective, Laschinger and Finegan (2005) note the importance placed on autonomy by professional nurses, yet nurses in the present study reported deficits in autonomy. Rankin and Campbell (2006) report that nurse leaders learn to apply text-based methods of managing nurses, which include assessing workload and ensuring documentation standards in response to their lack of accessibility on the unit. Without the active engagement of the manager, nurses experience the added pressure of having to address organizational priorities while also providing patient care. Without the manager's availability to navigate complex institutional bureaucracies, nurses lack a sense of involvement in their work (Conger & Kanungo, 1988; Thomas & Velthouse, 1990).

The second theme, *silencing forms of communication*, is congruent with the findings of other studies describing nurses' limited ability to negotiate or contribute to decisions affecting their practice. Daiski (2004) found that nurse disempowerment resulted from nursing leadership aligning with hospital administrators, nurses receiving little respect from managers, and nurses being excluded from decision-making processes. Other researchers suggest that nurses' exclusion from decisions that affect their work results from a failure to acknowledge nurses' professional judgement based on their close contact with and observation of patients (Cheek & Rudge, 1994; Peter, Lunardi, & Macfarlane, 2004). Critical social empowerment demands that nurses have an equal voice in decision-making and collaborate with their manager in recognition of their potential contributions to the organization (Casey, Saunders, & O'Hara, 2010). In the present study, nurses found value and power in the nurse-patient relationship but did not always believe that their knowledge and expertise were being recognized.

The third theme, *stepping up of power*, is interpreted as supportive leadership behaviour: being accessible to communicate and exchange information, exhibiting a positive management style, providing feedback, and offering expressions of caring (Corbally, Scott, Matthews, Gabhann, & Murphy, 2007; Faulkner & Laschinger, 2008; Kuokkanen & Leoni-Kilpi, 2001). These findings align with those of Laschinger and Shamian (1994) suggesting that when managers have access to information, resources, and support they are able to influence nurses' access to similar empowerment structures. In the present study, as with Spreitzer's (1995) concept of psychological empowerment, stepping up of power characterized nurses as able to practise autonomously and exercise control over their work despite the demands of the organizational environment.

The fourth theme, *positioning to resist*, is congruent with the findings of an ethnographic study by Street (1992) suggesting that nurses are most articulate when speaking about their relationship with the nursing administration. Studies report that "speaking up" is an act of resistance and that nurses speak up in response to moral distress and ethical concerns (Peter et al., 2004; Sundin-Huard & Fahy, 1999; Wurzbach, 1999). Indirect forms of resistance are those in which nurses' actions are aimed at stalling or pretending not to notice events in order to advocate for the patient (Hutchinson, 1990). Nurses' most assertive acts of resistance rely on their professional knowledge of patient care and include providing documentation and going to a higher authority (Peter et al., 2004; Schroeter, 1999). Consistent with a critical social perspective, where the redistribution of power often involves conflict and resistance to the dominant nature of bureaucratic processes and structures, the present study adds to these findings, as nurses manipulated their practice as a way to exercise power and control over their work.

The final theme, *experiencing the potentiality of enabling*, illustrates how nurses feel more empowered when their manager promotes professional behaviours and supportive relationships, which ultimately has an impact on safety, the quality of care, and the quality of the work environment (Boyle & Kochinda, 2004; Laschinger, Finegan, Shamian, & Wilk, 2004; Ulrich, Buerhaus, Donelan, & Dittus, 2005). The present findings demonstrate that structurally empowered work environments are the outcome of leadership practices that foster employee feelings of respect and organizational trust (Laschinger & Finegan, 2005; Laschinger et al., 2004). Similar to Spreitzer's (1995) construct of competence, experiencing the potentiality of enabling was characterized as nurses' ability to practise according to professional standards.

Limitations

Although the sample size was limited, the intention of this qualitative study was not to generalize the findings but to extend the theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Including both nurses and their managers in the study might have resulted in a more balanced perspective, especially in light of the high turnover of managers encountered on one of the units. There was a sense that some participants wanted “to get back at” their manager. Fendt and Sachs (2008) argue that the “first requirement of qualitative research is faithfulness to the phenomena under study” (p. 450). In response, the researcher demonstrated sensitivity to the phenomena and sought to capture the essence of participants’ narratives (Corbin & Strauss, 2008).

Conclusion

The findings reveal that the manager plays a critical role in modifying the work environment. The findings highlight the way in which power is mobilized by nurses and managers in the context of structural empowerment, psychosocial empowerment, and critical social empowerment, and they clarify how the theory of seeking connectivity advances nurse empowerment theory. Okhuysen and Bonardi (2011) argue that management issues often require explanations developed from a combination of perspectives to provide answers to complex questions. Most revealing is that the critical perspective of empowerment discloses power relations that perpetuate hierarchical structures in nursing practice and the ways that these power relations affect the daily lives of clinical nurses. In a future publication the author will analyze how nurses’ resistance can introduce alternative discourses to dominant organizational and managerial discourses through critical social empowerment.

References

- Boyle, D. K., & Kochinda, C. (2004). Enhancing collaborative communication of nurse and physician leadership in two intensive care units. *Journal of Nursing Administration, 34*(2), 60–70.
- Canadian Nursing Advisory Committee. (2002). *Our health, our future: Creating quality workplaces for Canadian nurses*. Ottawa: Health Canada. Retrieved August 26, 2014, from <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2002-cnac-cccsi-final/index-eng.php>.
- Casey, M., Saunders, J., & O’Hara, T. (2010). Impact of critical social empowerment on psychological empowerment and job satisfaction in nursing and midwifery settings. *Journal of Nursing Management, 18*(1), 24–34.
- Ceci, C. (2003). Midnight reckonings: On a question of knowledge and nursing. *Nursing Philosophy, 4*(1), 61–76.

- Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed.) (pp. 507–535). Thousand Oaks, CA: Sage.
- Cheek, J. (1999). Influencing practice or simply esoteric? Researching health care using postmodern approaches. *Qualitative Health Research*, 9(3), 383–392.
- Cheek, J., & Gibson, T. (1996). The discursive construction of the role of the nurse in medication administration: An exploration of the literature. *Nursing Inquiry*, 3(2), 83–90.
- Cheek, J., & Porter, S. (1997). Reviewing Foucault: Possibilities and problems for nursing and health care. *Nursing Inquiry*, 4(2), 108–119.
- Cheek, J., & Rudge, T. (1994). The panopticon re-visited? An exploration of the social and political dimensions of contemporary health care and nursing practice. *International Journal of Nursing Studies*, 31(6), 583–591.
- Chenitz, W. C., & Swanson, J. M. (1986). *From practice to grounded theory: Qualitative research in nursing*. Menlo Park, CA: Addison-Wesley.
- Conger, J. A., & Kanungo, R. N. (1988). The empowerment process: Integrating theory and practice. *Academy of Management Review*, 13(3), 471–482.
- Corbally, M. A., Scott, P. A., Matthews, A., Gabhann, L. M., & Murphy, C. (2007). Irish nurses' and midwives' understanding and experiences of empowerment. *Journal of Nursing Management*, 15(2), 169–179.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing*, 48(1), 43–50.
- Fahy, K. (2002). Reflecting on practice to theorise empowerment for women: Using Foucault's concepts. *Australian Journal of Midwifery*, 15(1), 5–13.
- Faulkner, J., & Laschinger, H. K. S. (2008). The effects of structural and psychological empowerment on perceived respect in acute care nurses. *Journal of Nursing Management*, 16(2), 214–221.
- Fendt, J., & Sachs, W. (2008). Grounded theory method in management research: Users' perspectives. *Organizational Research Methods*, 11(3), 430–455.
- Forbes, D. A., King, K. M., Eastlick Kushner, K., Letourneau, N. L., Myrick, A. F., & Profetto-McGrath, J. (1999). Warrantable evidence in nursing science. *Journal of Advanced Nursing*, 29(2), 373–379.
- Fulton, Y. (1997). Nurses' views on empowerment: A critical social theory perspective. *Journal of Advanced Nursing*, 26(3), 529–536.
- Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Greco, P., Laschinger, H. K. S., & Wong, C. A. (2006). Leader empowering behaviours, staff nurse empowerment and work engagement/burnout. *Nursing Leadership*, 19(4), 41–56.
- Hardy, C., & Leiba-O'Sullivan, S. (1998). The power behind empowerment: Implications for research and practice. *Human Relations*, 51(4), 451–483.

- Hutchinson, S. A. (1990). Responsible subversion: A study of rule-bending among nurses. *Scholarly Inquiry for Nursing Practice*, 4(1), 3–17.
- Kanter, R. (1977). *Men and women of the corporation*. New York: Basic Books.
- Kanter, R. (1993). *Men and women of the corporation* (2nd ed.). New York: Basic Books.
- Kluska, K. M., Laschinger, H. K. S., & Kerr, M. S. (2004). Staff nurse empowerment and effort–reward imbalance. *Canadian Journal of Nursing Leadership*, 17(1), 112–128.
- Kramer, M., Maguire, P., Schmalenberg, C., Brewer, B., Burke, R., Chmielewski, L., . . . Waldo, M. (2007). Nurse manager support: What is it? Structures and practices that promote it. *Nursing Administration Quarterly*, 31(4), 325–340.
- Kuokkanen, L., & Leino-Kilpi, H. (2001). The qualities of an empowered nurse and the factors involved. *Journal of Nursing Management*, 9(5), 273–280.
- Laschinger, H. K. S. (1996). A theoretical approach to studying work empowerment in nursing: A review of studies testing Kanter’s theory of structural power in organizations. *Nursing Administration Quarterly*, 20(2), 25–41.
- Laschinger, H. K. S., & Finegan, J. (2005). Using empowerment to build trust and respect in the workplace: A strategy for addressing the nursing shortage. *Nursing Economics*, 23(1), 6–13.
- Laschinger, H. K. S., Finegan, J., & Shamian, J. (2001). Promoting nurses’ health: Effect of empowerment on job strain and work satisfaction. *Nursing Economics*, 19(2), 42–52.
- Laschinger, H. K. S., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter’s model. *Journal of Nursing Administration*, 31(5), 260–272.
- Laschinger, H. K. S., Finegan, J., Shamian, J., & Wilk, P. (2003). Workplace empowerment as a predictor of nurse burnout in restructured healthcare settings. *Longwoods Review*, 1(3), 2–11.
- Laschinger, H. K. S., Finegan, J., Shamian, J., & Wilk, P. (2004). A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *Journal of Organizational Behavior*, 25(4), 527–545.
- Laschinger, H. K. S., Finegan, J., & Wilk, P. (2009). Context matters: The impact of unit leadership and empowerment on nurses’ organizational commitment. *Journal of Nursing Administration*, 39(5), 228–235.
- Laschinger, H. K. S., Gilbert, S., Smith, L. M., & Leslie, K. (2010). Towards a comprehensive theory of nurse/patient empowerment: Applying Kanter’s empowerment theory to patient care. *Journal of Nursing Management*, 18(1), 4–13.
- Laschinger, H. K. S., & Havens, D. (1996). Staff nurse work empowerment and perceived control over nursing practice. *Journal of Nursing Administration*, 26(9), 27–35.
- Laschinger, H. K. S., & Shamian, J. (1994). Staff nurses’ and nurse managers’ perceptions of job-related empowerment and managerial self-efficacy. *Journal of Nursing Administration*, 24(10), 38–47.
- Laschinger, H. K. S., Wong, C. A., McMahon, L., & Kaufmann, C. (1999). Leader behavior impact on staff nurse empowerment, job tension, and work effectiveness. *Journal of Nursing Administration*, 29(5), 28–39.

- Laschinger, H. K. S., Wong, C. A., Ritchie, J., D'Amour, D., Vincent, L., Wilk, P., . . . Almost, J. (2008). A profile of the structure and impact of nursing management in Canadian hospitals. *Healthcare Quarterly*, 11(2), 85–94.
- Manias, E., & Street, A. (2000). Legimitation of nurses' knowledge through policies and protocols in clinical practice. *Journal of Advanced Nursing*, 32(6), 1467–1475.
- McCutcheon, A. S., Doran, D., Evans, M., McGillis Hall, L., & Pringle, D. (2009). Effects of leadership and span of control on nurses' job satisfaction and patient satisfaction. *Nursing Leadership*, 22(3), 48–67.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.
- Moye, M. J., & Henkin, A. B. (2006). Exploring associations between employee empowerment and interpersonal trust in managers. *Journal of Management Development*, 25(2), 101–117.
- O'Brien-Pallas, L., Tomblin-Murphy, G., White, S., Hayes, L., Baumann, A., Higgin, A., . . . Wang, S. (2005). *Building the future: An integrated strategy for nursing human resources in Canada. Research synthesis report*. Ottawa: Nursing Sector Study Corporation. Retrieved June 3, 2005, from <http://www.buildingthefuture.ca/e/study/phase1/reports/Rresearch-Synthesis-Report.pdf>.
- Okhuysen, G., & Bonardi, J. P. (2011). Editors' comments: The challenges of building theory by combining lenses. *Academy of Management Review*, 36(1), 6–11.
- Opie, A. (1992). Qualitative research, appropriation of “other” and empowerment. *Feminist Review*, 40, 52–69.
- Peter, E., Lunardi, V. L., & Macfarlane, A. (2004). Nursing resistance as ethical action: Literature review. *Journal of Advanced Nursing*, 46(4), 403–416.
- Priest, A. (2006). *What's ailing our nurses? A discussion of the major issues affecting nursing human resources in Canada*. Ottawa: Canadian Health Services Research Foundation. Retrieved August 26, 2014, from http://www.cfhi-fcass.ca/Migrated/PDF/What_sailingourNurses-e.pdf.
- Rankin, J. M., & Campbell, M. L. (2006). *Managing to nurse: Inside Canada's health care reform*. Toronto: University of Toronto Press.
- Schroeter, K. (1999). Ethical perception and resulting action in peri-operative nurses. *AORN Online*, 69(5), 997–1002.
- Spradley, J. P. (1980). *Participant observation*. New York: Holt, Rinehart & Winston.
- Spreitzer, G. M. (1995). Psychological empowerment in the workplace: Dimensions, measurement, and validation. *Academy of Management Journal*, 38(5), 1442–1465.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Street, A. (1992). *Inside nursing: A critical ethnography of clinical nursing practice*. Albany: State University of New York Press.
- Suddaby, R. (2006). From the editors: What grounded theory is not. *Academy of Management Journal*, 49(4), 633–642.
- Sundin-Huard, D., & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorising the relationships. *International Journal of Nursing Practice*, 5(1), 8–13.

- Thomas, K. W., & Velthouse, B. A. (1990). Cognitive elements of empowerment: An “interpretive” model of intrinsic task motivation. *Academy of Management Review, 15*(4), 666–681.
- Udod, S. A. (2011). *Seeking connectivity: An analysis of relationships of power from staff nurses’ perspectives*. Unpublished doctoral dissertation, University of Toronto.
- Ulrich, B. T., Buerhaus, P. I., Donelan, K., & Dittus, R. (2005). How RNs view the work environment: Results of a national survey of registered nurses. *Journal of Nursing Administration, 35*(9), 389–396.
- Wells, D. L. (1995). The importance of critical theory to nursing: A description using research concerning discharge decision-making. *Canadian Journal of Nursing Research, 27*(2), 45–58.
- Wurzbach, M. E. (1999). Acute care nurses’ experiences of moral certainty. *Journal of Advanced Nursing, 30*(2), 287–293.

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