

July 2014

The Influence of Resonant Leadership and Structural Empowerment on the Job Satisfaction of Registered Nurses

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Graduate Program in Nursing

A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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THE INFLUENCE OF RESONANT LEADERSHIP AND STRUCTURAL
EMPOWERMENT ON THE JOB SATISFACTION OF REGISTERED NURSES

(Thesis format: Monograph)

by

Eunice Bawafaa

Graduate Program in Nursing

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Nursing

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Abstract

There are longstanding and growing concerns about the demanding nature of work environments that affect nurses' health, job satisfaction and provision of quality care. Specifically in healthcare settings, there is the need for leaders to create supportive work environments to avert these negative trends and increase nurse job satisfaction. The purpose of this study was to examine the influence of managers' resonant leadership and nurses' structural empowerment on their job satisfaction. A secondary analysis of data collected from a non-experimental survey design using a sample of 1216 registered nurses from nine provinces in Canada was conducted. Structural empowerment partially mediated the relationship between resonant leadership and job satisfaction. In addition, resonant leadership and structural empowerment explained a total of 32% whilst controlling for age, education and work setting of the variance in job satisfaction ($F_{(5, 1169)}=131.78, p<.001, R^2=0.36$). The findings of this study suggested that resonant leaders are instrumental in creating structurally empowering environments that contribute to nurse job satisfaction. Therefore, a focus on developing resonant leadership skills among nurse leaders in healthcare organizations will advance the creation of healthy work environments that promote job satisfaction and retention of nurses.

Key words: resonant leadership, structural empowerment, job satisfaction, mediate, registered nurses

Dedication

I dedicate this thesis to my husband, Bertrand B. Zielley and son, Winston A. Zielley

Acknowledgements

I am lost for words for an anonymous person who made my graduate studies possible in the University of Western Ontario, Canada. My family and I will forever be grateful to you. I also wish to acknowledge Dr Catherine Ward- Griffin, Micheal S. Kerr, Oona St Amant, Myriam Delgado, and all who made this dream possible.

My sincere and most profound gratitude goes to my Supervisor (Dr Carol A. Wong) and advisory committee (Dr Heather K.S. Laschinger), who worked tirelessly with me throughout this thesis. Dr Carol A. Wong has been a real coach and mentor who sacrificed a lot of her time and was dedicated in guiding and directing this thesis. Your area of expertise (authentic leadership) reflected in the encouragement, patience and understanding that you gave me during this research. The knowledge and support acquired from you will forever be remembered and cherished.

To my husband (Bertrand B. Zielley) and son (Winston A. Zielley), your sacrifices and love gave me the strength to move on during very trying times in school. To my parents (Naa, & Mrs Bawafaa), siblings (Edward, Frederick, Sylvia, and Juliet), your prayers and support are much appreciated.

I believe that it is God who makes everything possible and I thank Him for how far He has brought me and for the lives of all those who contributed in one way or the other in making my graduate education a possibility.

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Chapter one

Introduction

In a time when there are looming shortages of nurses both locally and internationally, the future of the healthcare system becomes critical not just for the public and decision makers, but for the nurses who are faced with the stresses of current work complexity and role overload created by these shortages (Berry & Curry, 2012). The situation has deteriorated so much that 62% of nurses reported working through their breaks and 18% indicated a lack of respect and support from supervisors (Berry & Curry, 2012; Morrow, 2009; Shields, 2006). One outcome is high turnover which has cost implications for healthcare organizations of about \$25,000 per nurse annually to recruit, orientate, compensate for bed closures and pay for overtime when positions are vacant (Berry & Curry, 2012). The turnover and shortages have been associated with lower nurse job satisfaction attributed to poor work environment conditions (O'Brien-Pallas, Tomblin Murphy, Shamian, Li, & Hayes, 2010). In a 2005 National Survey of the work and health of nurses in Canada, and the 2012 report from the Canadian Federation of Nurses Union (CFNU), some of the challenges identified by nurses that contribute to reduced job satisfaction included inadequate staffing, medication errors, role overload, job strain, inexperienced staff, lack of shared decision making, poor communication, heavy workloads, and lack of supportive leadership (Berry & Curry, 2012; Shields, 2006).

This worsening situation is a threat to healthcare not just in Canada, but globally and left unchecked, the nation's quality of care may deteriorate (Canadian Nursing Advisory Committee, 2002). Statistical records indicate that there is an increasingly

ageing nurse workforce in Canada (Canadian Institute for Health Information [CIHI], 2011). In 2010, the average age of the Canadian nurse was 45.4 years, with 25.5% and 11.4% of the total nurse workforce above the ages of 55 and 60 years respectively (CIHI, 2011). As of 2011, those above 60 years still remained at 11.3% with those younger than 30 years at 13.8% (CIHI, 2011). Between 2003 and 2011, CIHI recorded an annual growth rate of only 1.6% of registered nurses.

In spite of the fact that nurses comprise the majority of workers in the healthcare sector, 8% of nurses are reported absent from work weekly as a result of ill health and in 2010, CFNU recorded that 19,200 nurses were absent from work due to illness and disability of registered nurses (CFNU, 2010; CIHI, 2011). The nursing shortage is however masked by overtime workloads and delayed retirements of the ageing workforce (CFNU, 2010). To worsen the nursing plight in the face of absenteeism, shortages and an ageing workforce, nurses are experiencing job dissatisfaction with their work roles and work environments (Berry & Curry, 2012). Recently, downsizing in the healthcare sector, restructuring, changes in health policies, budget cuts, and reductions in financing for continuing nurse education have all contributed to job stress, insecurity, and job dissatisfaction among nurses (Berry & Curry, 2012; Greco, Laschinger, & Wong, 2006). There is a need therefore, to create empowering and healthy work environments to enhance the job satisfaction of nurses who play a key role in patient outcomes (Wong & Laschinger, 2012).

Job satisfaction generally, is the affective orientation held by employees towards their work (Price, 2001). Research has demonstrated that job satisfaction is attained when employees experience a feeling of happiness about their work (Whitley & Putzier, 1994).

In essence, situational factors (work environment, work conditions, work relationships), and personal factors (self-esteem and emotional stability) play major roles in nurse job satisfaction (Laschinger, 2012). Ritter (2010) stated that the quality and type of nursing leadership, the level of active participation in decision making, positive practice in work environments, nurse autonomy, and collegial relationships, were all crucial for job satisfaction and increased retention of nurses. Most studies have also identified a positive work environment as key to attaining job satisfaction and retention (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Cicolini, Comparcini, & Simonetti, 2013; Laschinger, 2008).

Through empowering structures such as the availability of opportunities, resources, information and support in workplaces, healthcare institutions and leaders can enhance job satisfaction, support commitment, reduce stress levels, and improve the general well-being of nurses (Cicolini et al., 2013). More specifically, structural empowerment which has been defined as having access to opportunities, needed resources, information and support has been reported to predict job satisfaction in work settings (Greco et al., 2006; Kanter, 1993; Laschinger, 2008; Laschinger, Finegan, & Wilk, 2009; Patrick & Laschinger, 2006; Sarmiento, Laschinger, & Iwasiw, 2004). Evidence supporting a positive relationship between empowerment and job satisfaction has been reported in a number of nursing studies (Anderson, 2000; Baker, Fitzpatrick, & Griffen, 2013; Fock, Hui, Au, & Bond, 2013; Greco et al., 2006; Laschinger, 2008; Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger, Finegan, & Shamian, 2001a, 2001b; Lashinger, Finegan, Shamian, & Wilk, 2004; Patrick & Laschinger, 2006).

Kanter's (1993) structural empowerment theory, provides an effective theoretical framework for examining the process through which resonant leaders can promote job satisfaction among registered nurses. This theory postulates that an individual's position and prevailing work conditions shapes the way in which they respond to work circumstances in an organization (Kanter, 1993). Power, which is the ability to utilize organizational resources is core in Kanter's theory and is derived from the employee's ability to gain effective support, information and needed resources (Kanter, 1979). Inevitably, leaders in organizations foster empowered behaviours through engagement of employees in decision making, feedback, giving employee's autonomy and enhancing goal attainment and accomplishment (Greco et al., 2006; Kanter, 1977). Specifically, resonant leaders are known to demonstrate empathy (ability to understand and share in another person's feelings) which is a principal attribute in resonant leadership (RL), commitment and exhibit a passionate vision for the goals of the organization (Boyatzis & McKee, 2005).

Leadership is defined as "a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2013, p.5). Leaders also perform a variety of managerial functions including strategic planning, decision making, human resource management and negotiation, fiscal management, resource mobilization, and quality care analysis (Cummings, 2004). However, attention to the significance of leadership in the healthcare sector has also highlighted how achieving these functions requires the use of emotional intelligence (Cummings, 2004; Goleman et al., 2002). Emotional intelligence is defined by Mayer and Salovey (1993), as the "ability to monitor

one's own and other's feelings and emotions to discriminate among them, and to use this information to guide one's thinking and actions" (p.433).

Resonant leadership (RL) is a type of relational leadership style rooted in emotional intelligence (EI) and research has demonstrated that in the midst of challenges, emotionally intelligent leaders remain effective and efficient through the emotional components of mindfulness, hope, and compassion which are attributes of RL (Boyatzis & McKee, 2005). These leaders draw on resonance which involves the use of positive emotions to motivate followers to bring out their best in every situation and to always aspire to higher goals (Goleman et al., 2002; Squires et al., 2010). The use of EI to genuinely and empathically connect with others, as well as maintaining meaningful interpersonal relationships is resonance (Cummings, MacGregor, et al., 2010). Emotional intelligence has four main domains (self-awareness, self-management, social awareness, relationship management) and nineteen related behavioural learned competencies (Boyatzis & McKee, 2005; Goleman, 1998a; Goleman et al., 2002). According to Goleman et al. (2002), *self-awareness* is the ability to understand one's own emotions and their impacts, and use mental awareness and not impulse to guide one's actions; *self-management* constitutes one's emotional self-control, transparency, adaptability, achievement, initiative, and optimism; *social awareness* refers to the demonstration of empathy, organizational awareness, and services to yourself, staff, and needs of clients; *relationship management* involves using inspiration, influence, ability to develop others, initiating, being a change catalyst, maintaining and building strong bonds, and most importantly fostering collaboration, team work and team spirit (Boyatzis & McKee, 2005; Goleman et al., 2002).

There are four leadership styles of the resonant leader that support staff development and successes; 1) *visionary* (ability to influence others through shared dreams and knowledge); 2) *coaching* (focusing on the development of others); 3) *affiliative* (building strong positive relationships with followers); and 4) *democratic leaders* (consensus building through collaboration, team work and innovation) (Cummings, 2004). Goleman (1998a, 1998b) saw resonant leadership as a way of persuading people towards achieving a common goal. Research has shown that about 85-90% of the exceptional difference in leadership skills between leaders of the same category is accounted for by EI (Boyatzis & McKee, 2005). Resonant leadership has been reported to increase positive work outcomes such as job satisfaction (Cummings, MacGregor et al., 2010). In the absence of EI, leaders find it challenging to maintain and sustain their proactiveness, resonance, and effectiveness over time (Boyatzis & McKee, 2005).

Inability to achieve resonance leads to dissonance, that is, distress, crisis, internal disquiet, volatile emotions and unrest in organizations and among staff (Boyatzis & McKee, 2005). Leaders who sustain resonance have the ability to consciously renew themselves through mind, body, heart, and spirit in a holistic process (Boyatzis & McKee, 2005). Thus, resonant leaders show concern, resolve conflicts, are easily accessible, and enable staff growth and development, and these behaviours contribute to positive nurse work and patient outcomes (Cummings, 2004). Nurses who work under resonant leaders feel valued, recognized, appreciated, connected, and supported in their work environments and in meeting patient and client needs (Cummings, 2004). Additionally, resonant leaders inspire, develop, and coach others to attain desired

outcomes such as job satisfaction and this has been viewed by researchers as a needed effective competence for nurse leaders (Boyatzis, Smith, Oosten, & Woolford, 2013; Cummings, 2012).

There is a critical need to improve nurse job satisfaction by creating work environments where nurses feel empowered, less stressed, and more respected and valued. Leaders have a central role to play in the creation of such empowering work environments (Cropanzano & Mitchell, 2005). Kanter's theory (1979) offers a framework for understanding how RL of nurse managers might influence the job satisfaction of nurses by facilitating access to the four empowerment structures in organizations. Few studies have empirically tested the theoretical link between resonant leadership and structural empowerment within the healthcare setting. Given the significant focus on the critical role of the nurse manager in building and supporting quality healthcare work environments (Cummings, MacGregor, et al., 2010), it is important to identify nurses' perceptions of managers' resonant leadership and how this relates to work attitudes such as job satisfaction. The purpose of this study was to examine the influence of managers' resonant leadership and nurses' structural empowerment on the job satisfaction of a sample of Canadian direct care nurses working in hospital and community settings. Investigating these relationships may uncover some of the mechanisms or processes by which nursing leaders influence nurses' job satisfaction and contribute to the development of strategies to improve workplace conditions for nurses.

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Chapter Two

Manuscript

Job satisfaction is a key indicator of the quality of work environments and is linked to potential increased turnover intentions leading to nurse shortages (Greco, Laschinger, & Wong, 2006). There are longstanding and growing concerns about the demanding nature of nurse work environments in terms of rapid changes in healthcare organizations and policies, mounting workload pressures, high physical demands, burnout and increasing acuity of patients all of which influences quality care and outcomes (Canadian Nurses Association [CNA] and Registered Nurses' Association of Ontario [RNAO], 2010; Shields, 2006). These work environment issues have a tremendous impact on the job satisfaction of nurses and raise fears about potential turnover and shortages of nurses (Berry & Curry, 2012; Lucas, Laschinger, & Wong, 2008). Moreover, supportive work environments that promote nurses' job satisfaction play an important role in the retention of nurses, ultimately supporting the delivery of quality healthcare (Duffield et al., 2011; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

Globally, there is the anticipation of a 29% nursing shortage by 2020 if these current trends continue unabated (Andrews & Dziegielewski, 2005; Royal College of Nursing Policy and International Department, 2012). In Canada, it has been projected that by 2022, the country will experience a full time registered nurse shortage of 60,000 nurses (Canadian Federation of Nurses Unions [CFNS], 2012; CNA, 2009). A shortfall of nurses may exacerbate poor working conditions which will also contribute to decreased nurses' job satisfaction. Low job satisfaction could be related to quality of care in that for

every extra patient that is added to nurses' workload, there is a 7% increase in the probability of patient mortality (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Since nurses are the largest group of professionals in the healthcare sector, there is the need for more attention to nurse job satisfaction by healthcare organizations and managers as this has a significant impact on quality of care, turnover, productivity, and patient outcomes (Aiken et al., 2001; Berry & Curry, 2012; Wong, Laschinger, & Cummings, 2010).

Job satisfaction is defined as the feelings an individual has about his/her job (Price, 2001). However, job satisfaction depends not only on an individual's experiences of various aspects of a job, but also on the expectations that he/she has of what their job should provide (Lu, Barriball, Zhang, & While, 2012; Price, 2001). Thus, job satisfaction among nurses has been attributed to interpersonal relationships among staff, physical conditions at work, autonomy, empowerment, good wages, roles, and quality care (Laschinger, 2012; Lu et al., 2012; Pretorious & Klopper, 2011; Utriainen & Kyngas, 2009).

Kanter's theory of structural empowerment (1993) describes that in organizations where there is access to opportunities, needed resources, information and support, there are avenues for growth and development and workers in such organizations feel empowered to do their work (Greco et al., 2006; Kanter, 1979; Laschinger, Finegan, & Wilk, 2009). Empowerment is an attribute of a quality work environment and has been linked to a range of positive work attitudes including job satisfaction (Lucas et al., 2008; Young-Ritchie, Laschinger, & Wong, 2009). This theory provides a helpful framework which leaders can use to create empowering work environments because it emphasizes how effective communication patterns, participation, emotional and social considerations

in organizations, are necessary for effective and desired organizational outcomes (Kanter, 1993).

In addition, studies have also identified that effective nursing leadership is central to nurses' job satisfaction (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Cummings, 2004; Klopper, Coetzee, Pretorius, & Bester, 2012; Ritter, 2010). Nurse managers are usually ideally positioned within healthcare organizations to promote nurses' work life due to their direct contact with nursing staff and their knowledge of unit concerns (Anthony et al., 2005; Thompson et al, 2011). Given the current challenges such as, increasing complexity of organizations, pressures to reduce costs, higher expectations for optimal quality outcomes, projected nurse shortages, and stressful work environments, nurse managers struggle to make relationship-building a key priority in their roles (Berry & Curry, 2012; Erickson, 2013).

Research has demonstrated that one needs special skills in order to lead effectively in the midst of challenges and high leadership expectations (Boyatzis & McKee, 2005). There has therefore been a call for stronger relational leadership skills for nurse leaders specifically, skills that entail high levels of emotional intelligence (EI) known as resonant leadership (RL) (Boyatziz, Smith, Oosten, & Woolford, 2013; Cummings, Hayduk, & Estabrooks, 2005; Evans & Allen, 2002; Squires, Tourangeau, Laschinger, & Doran, 2010). These skills include team support, mentorship, positive relationship-building, and ability to engage others in organizational goals which are major attributes of resonant leaders (Boyatzis, Smith, & Blaize, 2006; Cummings et al., 2008). Resonant leaders are known to be empathetic and able to inspire others to achieve positive work results (Cummings, 2004; Cummings et al., 2008; Cummings et al., 2010).

These leaders are able to create empowering work environments that facilitate and foster goal attainment and job satisfaction through mindfulness, hope and compassion (Cummings et al., 2010; Goleman, Boyatzis, & McKee, 2002).

Since the work environment has a crucial role to play in nurses' job satisfaction, positive environmental features such as empowerment and resonant leadership require further examination (Laschinger, Finegan, & Wilk, 2010; Pretorious & Klopper, 2011; Wagner, 2010). However, as a new and emerging concept, very few studies have examined RL especially in healthcare (Cummings et al., 2008; Cummings et al., 2010). As far as we know, no studies have specifically examined the combined effect of RL and structural empowerment on the job satisfaction of registered nurses using Kanter's structural empowerment theory. The purpose of this study is to examine the influence of managers' resonant leadership and nurses' structural empowerment on the job satisfaction of Canadian registered nurses in direct care roles. It is anticipated that examining this relationship will contribute to knowledge of strategies that organizations and nurse leaders can adopt to influence nurse job satisfaction.

Theoretical Framework

Kanter's structural empowerment theory (1993, 1977), provides a valuable theoretical framework for examining the relationships among RL, empowerment and job satisfaction. The structural empowerment theory by Kanter incorporates the notion that behaviours and attitudes of employees are influenced more by the prevailing work characteristics than the individual's personal characteristics (Kanter, 1993). Kanter suggested that power is not a means of oppression or dominance but rather, is defined as "the ability to mobilize resources to get things done" (Kanter, 1979, p. 210). Power in an

organization is derived from the employee's ability to gain access to effective support, information, opportunity, and needed resources (Kanter, 1993). Thus, in a work environment where there are available structures to enhance effective completion of work, power evolves and becomes central to the achievement of organizational goals (Kanter, 1993; Laschinger, 2008). Access to power in an organization is largely dependent on the position and relationship held by a person in the organization (Kanter, 1993).

Organizational power can be formal or informal which are related to one's position and relationship in the organization. Formal power is specific to role characteristics such as, visibility, recognition, relevance, and discretion, whilst informal power arises from personal relations, associations, and connections among employees in a work setting (Kanter, 1977, 1993). Formal power is visible to others and creates opportunities for employees in problem solving. Kanter indicates that access to information, support, opportunity and resources are the four sources through which power is obtained.

Individuals in organizations display varying behaviours and attitudes depending on their degree of access to structural supports established in work environments (Kanter, 1993; Laschinger, 2008). According to Kanter (1993), those with power, have autonomy and tend to be creative which contributes towards their development and personal growth. On the contrary, employees who perceive themselves as having less access to opportunities demonstrate disengagement, low self-esteem, and are less inspired to work (Sarmiento, Laschinger, & Iwasiw, 2004). This theory further emphasized effective communication patterns, participation, emotional and social considerations thus, an

affirmation of the human ideology in organizations for effective and desired outcomes. Kanter's theory (1977, 1993) placed emphasis on perceived actual conditions in work environments by employees as opposed to their psychological interpretation of these conditions (Laschinger, Finegan, & Shamian, 2001).

The four components of structural empowerment are access to: *opportunity*, the availability of chances to develop and grow in skills and knowledge; *resources*, the ability to get the needed supplies, personnel, equipment, materials, time, and money to do one's job; *information*, technical knowledge, policies and data required for work accomplishment; and *support*, which is the motivation, guidance, direction, help, and feedback from those you work with for successful and effective work completion and job outcomes (Kanter, 1993; Laschinger, 2008; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010). Employees who lack access to these structures of empowerment in their organizations may experience a sense of powerlessness and may be less motivated, committed and productive (Kanter, 1993; Laschinger & Finegan, 2005).

Kanter's structural empowerment theory offers a useful guide for nurse leaders in that leaders can adapt and incorporate these empowering structures in their roles as well as the work environments. Thus, leaders can foster empowerment by facilitating staff access to opportunities for development, transparent and regular information on relevant organizational goals and activities, mentoring and support, and adequate resources in terms of staffing, equipment and supplies (Kanter, 1977; Lashinger et al., 2001a, 2001b). Empowerment is seen both as a process and an outcome that can arise from individual or group competence (Gibson, 1991; Kanter, 1993). Without empowerment, employees

cannot respond, and cope positively with organizational challenges (Laschinger, Finegan, Shamian, & Wilk, 2004).

Related Research

In this literature review theoretical and empirical studies of resonant leadership, structural empowerment, and job satisfaction including documented relationships among these concepts are discussed.

Resonant Leadership

Resonant leadership is a positive relational leadership style and existing literature supports the importance of relational leadership for effective work outcomes (Cummings, 2004; Cummings et al., 2010; Wong, Cummings, & Ducharme, 2013). Relational leadership is a leadership perspective that focuses on the individual and their perceptions, intentions, and behaviours relative to their relationships with others in order to achieve common goals (Cummings et al., 2010; Wong et al., 2013). According to Goleman et al. (2002), the primary task of the leader is the emotional or relational component. Leaders who are able to motivate their followers through positive emotions for best results is known as resonance (Goleman et al., 2002; Squires et al., 2010). Resonance is a concept that entails the use of emotional, financial, environmental, social, and cultural intelligence to motivate and encourage followers to aspire and bring out their best in all situations for desired results (Boyatzis & McKee, 2005; Cummings 2004).

Boyatzis and McKee (2005), also contend that resonant leadership styles are based primarily on the emotional intelligence of these leaders. As a type of relational leadership style rooted in emotional intelligence, Squires et al. (2010), defined RL as the “behaviour of leaders who demonstrate a high level of emotional intelligence (EI), are in

tune with the emotions of those around them, use empathy and manage their own emotions effectively to build strong, trusting relationships and create a climate of optimism that inspires commitment” (Squires et al., 2010. p. 916). Similarly, emotional intelligence is defined as the ability to manage one’s own emotions and those of others (Goleman et al., 2002). Emotional intelligence has four main domains: *self-awareness*, *self-management*, *social awareness*, *relationship management* and nineteen related behavioural learned competencies (Boyatzis & McKee, 2005; Goleman, 1998a, 1998b; Goleman et al., 2002).

According to Goleman et al. (2002), *self-awareness* is the ability to understand one’s own emotions and their impacts, and use mental awareness and not impulse to guide one’s actions; *self-management* constitutes one’s emotional self-control, transparency, adaptability, achievement, initiative, and optimism; *social awareness* refers to the demonstration of empathy, organizational awareness, and services to yourself, staff, and needs of clients; and *relationship management* involves using inspiration, influence, ability to develop others, initiating, being a change catalyst, maintaining and building strong bonds, and most importantly fostering collaboration, team work and team spirit (Boyatzis & McKee, 2005; Goleman et al., 2002).

These competencies have been reframed to reflect leadership competencies, which Goleman et al. (2002) used to distinguish six leadership styles or behaviours that are interchanged seamlessly and in different amounts depending on the situation. Four of these styles: visionary, coaching, affiliative (relationship management), and democratic create resonance with followers and boost performance (Cummings, 2004; Cummings, Hayduk, & Estabrooks, 2005). The other two styles, pacesetter and commanding, should

only be used judiciously and in specific circumstances or they fail to demonstrate EI and result in dissonance or discord (Goleman et al., 2002). Goleman (1998a) saw resonant leadership as a way of persuading people towards achieving a common goal.

Boyatzis and McKee (2005) stated that organizational goals are achieved through leaders who demonstrate RL skills. Resonant leadership has been studied in other disciplines such as education, business, and organizational psychology. Craig's (2008) research findings demonstrated a strong positive correlation between EI competencies (optimism, empathy, achievement orientation, and emotional self-awareness) of principals and the job satisfaction of teachers (Craig, 2008). In general, leaders who are able to create resonance are reported to be successful in their organizations partly because it increases the satisfaction levels of the workers (Craig, 2008; Cummings et al., 2008; Squires et al., 2010). Cummings (2004), proposed that nurses who work under resonant leaders feel valued, recognized, appreciated, connected, and supported in their work environments. This may be attributed to the fact that positive emotions in human relationships enhance performance and thereby improve employees' satisfaction with work (Boyatzis & McKee, 2005).

Cummings et al.'s (2010) systematic review of 53 studies examining relationships between leadership styles and outcome patterns for the nursing workforce and work environments, showed that higher job satisfaction among nurses was associated with resonant, transformational, and supportive leadership styles in 24 studies. Furthermore, in 10 studies lower job satisfaction among nurses was associated with task-oriented and dissonant leadership styles. The study emphasized that task-focused leadership styles were not sufficient to achieve desired, optimum effects on the staff

nurse workforce (Boyatzis et al., 2012; Boyatzis et al., 2013; Cummings, et al., 2010; Duckworth, 2011; Squires et al., 2010).

Additionally, Cummings et al. (2005) examined the extent to which emotionally intelligent nursing leadership styles influenced nurse outcomes during hospital restructuring. In a secondary analysis of the Alberta Nurse Survey data (Giovannetti, Estabrooks, & Hesketh, 2002), seven data sets reflecting different leadership styles were created from nurse work environment data reflecting 13 leadership competencies based on emotional intelligence. These seven leadership styles were: four resonant, two dissonant and one mixed leadership styles (Cummings et al., 2005). A causal relationship was established between hospital restructuring and the effects on nurses when a theoretical model using the seven created data sets was tested using structural equation modelling. Cummings et al. (2005) found that there were significantly fewer negative effects on nurses who worked under resonant leadership as compared to those who worked under dissonant or mixed leadership styles (Cummings, 2004; Cummings et al., 2005). Nurses who worked with resonant leaders, reported lower stress and emotional exhaustion and greater collaboration, teamwork, and job satisfaction. Thus, Cummings et al. (2005) suggested that RL alleviated the effect of hospital restructuring on the general well-being of nurses whilst dissonant leadership compounded nurses' emotional distress.

Wagner, Warren, Cummings, Smith, and Olson (2013) in an exploratory descriptive cross-sectional study, assessed the relationships among resonant leadership, workplace empowerment, "spirit at work", job satisfaction and organizational commitment. A total of 148 randomly selected registered nurses in Alberta responded to a web-based survey and a follow-up mail survey. The results showed a significant

positive effect of resonant leadership on job satisfaction ($\beta = 0.26, p < 0.05$). There was also a positive effect between resonant leadership and the empowerment dimensions of access to support ($\beta = 0.28, p < 0.05$) and resources ($\beta = 0.51, p < 0.05$). The study supported the notion that RL and structural empowerment components are important concepts positively associated with job satisfaction (Laschinger, Almost, & Tuer-Hodes, 2003; Wagner, 2010; Wagner et al., 2013). Wagner (2010) also suggested that increases in commitment, creativity and innovation of staff occurred when there is a sense of community among staff that empowered them in their work.

Similarly, in a cross sectional survey of 600 Ontario registered nurses, Squires et al. (2010) examined the link between leadership, nurse work environment, and nurse and patient outcomes in hospitals. The results of the study demonstrated that RL was positively associated with the quality of nurse-leader relationships which in turn contributed to positive perceptions of the work environment and patient safety climate, decreased medication errors, intentions to leave and emotional exhaustion (Squires et al., 2010). Squires suggested that a leader's empathy played a central role in the creation of positive work environments and safe climates. At the core of RL competencies is empathy, that is, the ability to understand and share in another person's feelings and this attribute is used by resonant leaders to show support and compassion to their followers which consequently enhance positive relationships and job satisfaction (Cummings, 2004).

There is one other study examining the relationship among resonant leadership, empowerment and job satisfaction (Laschinger, Wong, Cummings, & Grau, 2014). Using path analysis in a sample of 1241 Canadian direct care nurses, Laschinger et al. tested a

model connecting resonant leadership and empowerment to workplace incivility, burnout, and job satisfaction. However, in this study the two-item measure of global empowerment was used instead of the 12-item *Conditions for Work Effectiveness Questionnaire-II (CWEQ-II)* to measure the four dimensions of structural empowerment. Resonant leadership was measured using Cummings et al. (2010) 10-item *Resonant Leadership Scale* that reflects four resonant leadership styles and associated behaviours. Findings showed a strong relationship between RL and global empowerment ($\beta=.47, p <.05$) and both direct ($\beta=.16, p <.05$) and indirect effects of RL on job satisfaction through global empowerment ($\beta=.49, p <.05$). This suggests the mediating effect of empowerment. Empowerment had a significant negative effect on co-worker incivility ($\beta= -0.25, p <.05$) which in turn had a significant direct effect on emotional exhaustion ($\beta=0.14, p <.05$) and a subsequent negative effect on job satisfaction ($\beta= -0.20, p <.05$). This study adds support for the concept of RL and the growing body of knowledge providing evidence for the essential role of positive leadership practices in creating healthy work environments that promote satisfaction and retention of nurses.

In summary, resonant leadership is reported to promote emotional maturity in followers (Squires et al., 2010). When nurse managers use their emotional skills of empathy, relating, listening and responding to concerns to understand what their followers are feeling during challenging times, they build trust and high quality relationships with staff. Outcomes such as job satisfaction have been associated with positive relational leadership styles such as resonant leadership (Cummings et al., 2010). The importance of job satisfaction to potential turnover and an increasing nursing

shortage signify the need for research examining nursing leader EI behaviours specifically, RL (Feather, 2009).

Empowerment

There is considerable nursing research in which Kanter's (1977, 1993) structural empowerment theory has been tested. Organizational empowerment was described by Kanter (1993), as necessary for achieving optimal effectiveness from the staff. In any organization or work setting, the process of empowerment starts with the elimination of barriers that prevent staff from attaining desired work goals (Regan & Rodricmez, 2011). Thus, taking initiative and responding to job challenges creatively without barriers is empowerment (Quinn & Spreitzer, 1997). Inevitably, people feel empowered when they have access to opportunities, information, support, and resources that enhance their growth and development known as structural empowerment (Kanter, 1977). Employees who lack access to these structures of empowerment in their organizations may experience a sense of powerlessness and may be less motivated, committed and productive (Kanter, 1977; Laschinger & Finegan, 2005).

A number of nursing studies have linked relational leadership styles to structural empowerment such as: *leader-member exchange* (Dansereau, Graen, & Haga, 1975) which had a direct positive effect on workplace empowerment and the outcomes of the individual nurse (Laschinger et al., 2009); and *authentic leadership* (Avolio, Gardner, Walumbwa, Luthans, & May, 2004) which influenced nurses' job satisfaction and performance directly and indirectly through structural empowerment in a sample of 280 Ontario acute care nurses (Wong & Laschinger, 2012). However, the association of

resonant leadership, another relationally oriented leadership style, with empowerment has received relatively little examination.

Two studies examining nurses' perceptions of emotionally intelligent leadership styles of their managers lend some support to the relationship between resonant leadership and empowerment. Using a descriptive correlational survey design in a sample of 203 acute care nurses in two Ontario community hospitals Lucas et al. (2008) demonstrated that EI of nurse leaders was positively related ($r=0.62, p< 0.01$) to staff nurses' structural empowerment. Similarly, Young-Ritchie et al. (2009), in a study of 300 Ontario emergency staff nurses found a strong direct effect of emotionally intelligent leadership on structural empowerment ($\beta =.54, p< 0.01$) which in turn was strongly related to nurses' organizational commitment. Both studies demonstrated that emotional intelligence was a positive antecedent to the empowerment of registered nurses. Emotionally intelligent leaders may increase empowerment in that they foster empowered behaviours through engagement of employees in decision making, offering constructive feedback, giving employee's autonomy and enhancing goal accomplishment (Greco et al., 2006; Kanter, 1977).

A positive connection between workplace empowerment and nurse's job satisfaction was identified in a recent systematic review of studies examining the relationship between nurse empowerment and job satisfaction (Cicolini, Comparcini, & Simoneti, 2013). In 12 studies significant relationships were found between empowerment and job satisfaction. For example, Laschinger et al.'s (2003) secondary data analysis of three studies of Ontario nurses (two with staff nurses and one with nurse practitioners), examined workplace empowerment, magnet hospital characteristics and

job satisfaction and reported that empowerment was significantly related to job satisfaction ($r = .42, p < .01$). Findings also showed that higher perceptions of autonomy, and control over one's work resulted in higher job satisfaction. Without empowerment, employees cannot respond, and cope positively with organizational challenges (Laschinger et al., 2004). Thus, to ensure job satisfaction among nurses, empowerment has a significant role to play (Anderson, 2000; Laschinger et al., 2004; Laschinger et al., 2003; Patrick & Laschinger, 2006; Sarmiento et al., 2004). In these studies, the commonality in study findings was that empowerment had direct effects on the job satisfaction of nurses.

Job Satisfaction

Job satisfaction is defined as the affective or positive emotional orientation toward work held by employees (Mueller & MCloskey, 1990; Price, 2001). The extent to which employees like their job is satisfaction and on the contrary, the extent to which they dislike their jobs is dissatisfaction (Spector, 1997). Some of the commonly found antecedents of job satisfaction in nursing research include support of leaders or supervisors, recognition or appreciation for contributions, communication, staff relationships with work, working conditions, staff productivity and effectiveness, and staff health and well-being (Brady & Cummings, 2010; Cummings et al., 2008; Lu et al., 2012). Since the work environment has a crucial role to play in nurse job satisfaction, positive environmental features such as empowerment, supportive leaders, adequate staffing, mutual respect, and collaborative working relationships which have also been linked to increased nurse satisfaction must be optimal (Laschinger et al., 2010; Pretorius & Klopper, 2011; Wagner, 2010).

Research has demonstrated that job satisfaction is an important factor in the recruitment as well as the retention of nurses but interestingly, an exhaustive understanding of this concept continues to be elusive in that job satisfaction has close relations with individual expectations, nature of the organization, and professional commitment (De Milt, Filtzpatrick, & McNulty, 2010; Lu et al., 2012). In general, not only do these factors impact job satisfaction, but they also affect the physical and mental health of nurses. In the national survey of 18,000 Canadian nurses in 2005, job dissatisfaction was more prevalent among nurses (12%) than employed individuals (8%) overall (Shields, 2006). Job dissatisfaction was associated with ratings of fair or poor health among nurses which was attributed to work stress including high job strain, low support from coworkers or supervisors, high role overload and low autonomy. The odds of being absent 20 or more days for health-related reasons were high for nurses reporting the aforementioned conditions (Shields, 2006). These findings signal the importance of job satisfaction as a key indicator of workplace conditions including leadership support.

Lu et al.'s (2012) recent systematic review of 100 published articles on job satisfaction among registered nurses working in hospital settings, explored some of the sources of nurse job satisfaction. The study identified working conditions, role conflict and ambiguity, organizational environment, role perception, job stress, and professional commitment as closely associated with job satisfaction of nurses (Lu et al., 2012). Although most reviews of nurses' job satisfaction studies have identified the importance of positive leadership, Hayes et al. (2010) noted that the support and respect of leaders, supervisors, and the organization were particularly important to nurses at the patient care unit level. These research have not only reported the significant sources of nurses' job

satisfaction but have also shown that job satisfaction is a key factor in nurses' organizational commitment, turnover intentions, burnout, and absenteeism (Aiken et al., 2008; Hayes et al., 2010; Lu et al., 2012).

Laschinger (2012) examined the job and career satisfaction and turnover intentions of 342 of newly graduated nurses in their first two years in the workplace and found that 31-60% of the variance in job, career satisfaction, and turnover intentions was due to structural empowerment factors. Structural empowerment was positively and significantly related to nurse job satisfaction ($\beta= 0.39$ in year one, and $\beta= 0.24$ in year two, $p =0.05$) (Laschinger, 2012). Tourangeau, Cranley, Laschinger, and Pachis (2010), also showed that empowerment was strongly associated with job satisfaction and turnover intentions of 675 nursing staff and other allied health professionals in 26 Ontario long term care facilities. Similarly, a multi-site, multi-level cross-sectional study of 679 acute care nurses conducted by Purdy et al., (2010), showed that structural empowerment had significant direct effects on nurses' job satisfaction and perceived care quality. All these studies provide support for the positive effect of empowering work environments on nurses' job satisfaction.

Summary of the Literature

In this literature review, there is an indication that relational leadership styles are strongly associated with positive outcomes such as job satisfaction (Cummings et al., 2010). Though RL is a type of relational leadership style, very little is known of its impact on nurse job satisfaction. Cummings (2004) suggests that nurses who work under resonant leaders feel valued, recognized, appreciated, connected, and supported in their work environments (Cummings, 2004) and a few studies have linked RL to nurse job

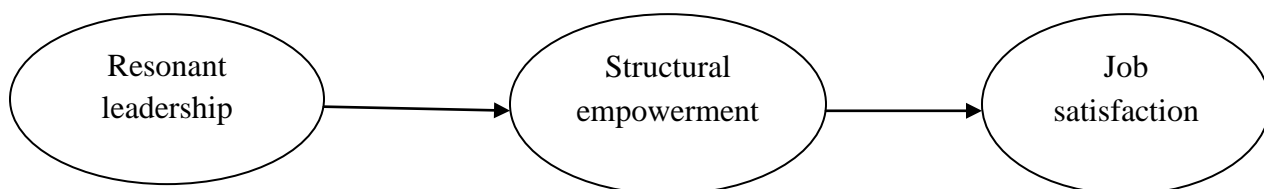
satisfaction (Cummings et al., 2005; Laschinger et al., 2014; Wagner, 2010).

Additionally, findings from several studies have supported a positive relationship between empowerment and nurse job satisfaction (Anderson, 2000; Laschinger et al., 2003; Patrick & Laschinger, 2006; Purdy et al., 2010; Wagner et al., 2013; Wong & Laschinger, 2012). However, there is a gap in the literature in that there has been no specific study specifically examining the influence of managers' RL and nurses' structural empowerment on the job satisfaction of registered nurses in direct care roles.

Hypothesis and Rationale

Based on Kanter's structural empowerment theory (1977, 1993) and the literature reviewed, the model in Figure 1 was examined and the following hypothesis developed.

Figure 1. Hypothesized model



Hypothesis: Structural empowerment mediates the relationship between resonant leadership and job satisfaction.

Kanter's structural empowerment theory which is the framework guiding this study postulates that power in an organization is derived from employee's access to support, information, opportunity for growth and development, and needed resources in completing one's job (Kanter, 1993). Access to these structures facilitates structural empowerment in the work setting which positively influences job satisfaction and

effectiveness at work (Laschinger et al., 2003; Laschinger et al., 2001a, 2001b). Resonant leaders demonstrate empathy, commitment, and have the ability to engage others in developing positive work environments (Boyatziz et al., 2013; Boyatziz & McKee, 2005; Cummings et al., 2008, 2010). Research findings have shown positive relationships between resonant leadership practices, well-being of nurses and work outcomes (Cummings, 2004; Cummings et al., 2010). It is hypothesized that nurses' perceptions of their immediate supervisor's resonant leadership behaviours would be positively related to the extent to which they considered their work environments to be structurally empowering. In addition, it is proposed that structural empowerment is the process through which (or mediator) resonant leaders influence nurses' job satisfaction as shown in other studies of relational leadership and empowerment (Laschinger et al., 2014; Wong & Laschinger, 2012).

Methods

Design and Sample

A secondary analysis of data from a study by Laschinger et al. (2013) entitled, *Nurses' Career Aspirations to Management Roles: Identifying the Next Generation of Nursing Leaders*, was conducted. This study used a nonexperimental survey design. Ethical approval was obtained from the University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) in 2009 (Appendix A).

Nurses from nine provinces in Canada were surveyed (all provinces but Prince Edward Island). The provincial regulatory bodies' registry lists were used to generate samples of registered nurses working in direct patient care positions in hospital and

community settings. Nurses who were not staff nurses such as those employed in advanced practice, clinical nurse specialist, nurse practitioner, resource nurse, charge nurse, nurse educator, team leader, or manager positions were excluded. A disproportional stratified sampling method was used to ensure that nurses from each province were adequately represented in the sample and 3,600 nurses (400 per province) received a mail survey in the fall of 2010. There was a 35% response rate achieved as 1241 nurses participated out of the 3600 that were mailed the survey. For purposes of this secondary data analysis, some non-direct care nurse respondents were removed from the data set reducing the number from 1241 to 1216 with all other details remaining unchanged.

The demographic characteristics of the participants in this study are presented in Table 1. The study sample was made up of nine provinces; the highest proportion was from Alberta (14.2%) and the lowest from New Brunswick (7.2%). The mean age of participating nurses was 41.54 ($SD = 11.08$) years with females being the majority (93.5%). More than half were baccalaureate degree holders (51.9%). The majority also worked in hospital settings (88.5%). For unit specialty, the majority worked in medical-surgical units (51.6%), and were also employed full time (58.2%). Nurses on average, reported 16.80 ($SD=11.71$) years as registered nurses, 12.00 ($SD= 10.11$) years in their current organizations, and 7.58 ($SD= 6.65$) years in their current units.

Instruments

Three different instruments were used to measure the major study variables (Appendix B). Resonant leadership in this study was measured using the *Resonant*

Table 1

Demographic Characteristics of Sample (N=1216)

Demographics		Frequency (n)	Percentage (%)
Province:	Alberta	173	14.2
	British Columbia	120	9.9
	Manitoba	131	10.8
	New Brunswick	88	7.2
	Newfoundland	163	13.4
	Nova Scotia	131	10.8
	Ontario	142	11.7
	Quebec	128	10.5
	Saskatchewan	140	11.5
Gender:	Female	1137	93.5
	Male	79	6.5
Highest Education:	Degree	631	51.9
	No degree	585	48.1
Work Setting:	Hospital	1072	88.5
	Community	103	8.5
	Both	36	3
Unit Specialty:	Medical–surgical	627	51.6
	Critical care	272	22.4
	Maternal-child	137	11.3
	Mental health	51	4.2
	Community	76	6.3
	Long-term care	53	4.4
Employment Status:	Full time	708	58.2
	Part time and casual	489	40.2
Demographics	N	M	SD
Age	1216	41.54	11.08
Years as a registered nurse	1216	16.80	11.71
Years in current organization	1109	12.00	10.11
Years on current unit	1085	7.58	6.65

Leadership Scale (Cummings, Yurtseven, et al., 2010) which assesses an individual's overall emotional intelligent leadership skills as perceived by an observer. Based on Goleman's model of emotional intelligence, the 10-items are congruent with the domains of self-awareness, social awareness, self-management, and relationship management. The items are divided into 10 interconnected but distinct concepts: (1) openness, (2) integrity, (3) optimism, (4) team achievement, (5) self-control, (6) empathy, (7) developing others, (8) conflict management, (9) visionary/inspiring, and empowering (Cummings et al., 2010). Each item is rated on a five point Likert scale of 1.0 (strongly disagree) to 5.0 (strongly agree). In a sample of 600 registered acute care registered nurses, the scale demonstrated a high reliability coefficient of 0.94 (Squires et al., 2010).

More recently, the scale was used as a sub-scale in the creation of a larger survey designed to measure organizational context (Estabrooks, Squires, Adachi, Kong, & Norton, 2008). Six items of the 10-item resonant leadership scale were used as the leadership subscale. Psychometrics of the subscale were reported as a single factor with a high internal reliability coefficient of 0.91 (Estabrooks et al., 2008). Content validity is evidenced by each statement aligning with the behaviours of Goleman et al.'s (2002) four resonant leadership styles: visionary (e.g. "engages me in working toward a shared vision"), coaching (e.g. "actively mentors and coaches individual and team performance") affiliative (e.g. "actively listens, acknowledges, and then acts on requests and concerns"), and democratic (e.g. "allows me freedom to make important decisions in my work") (Cummings et al., 2008). The alpha reliability coefficient for the total scale was 0.94 in this study.

The *Conditions for Work Effectiveness Questionnaire-II (CWEQ-II)* which was developed by Laschinger et al. (2001), was used to measure the four main dimensions of structural empowerment (Laschinger et al., 2001a). The CWEQ-II has 12 items each of which is rated on a 5-point Likert scale ranging from a low of 1 (= none) to a high of 5 (= a lot). The four structural empowerment subscales measured include access to opportunities, support, resources and information. Each subscale includes three-items per subscale and an example item for the opportunity subscale is “the chance to gain new skills and knowledge on the job” (Laschinger et al., 2001a). The total empowerment score was attained by totaling the mean scores of the subscales of CWEQ-II, which usually ranges from 4-20 (Laschinger et al., 2001). Perceived structural empowerment is indicated with a higher score. Cronbach alpha reliability scores have ranged between 0.71- 0.95 in previous studies (Laschinger et al., 2001). In this secondary analysis, the Cronbach alpha scores of the subscales ranged between 0.79 and 0.88 with a total scale alpha of 0.85. Construct validity was substantiated by a strong correlation with the measure of global empowerment reported as $r=0.56$ (Laschinger et al., 2001b) and in this study, there was evidence of construct validity since workplace empowerment scale was significantly and positively correlated with the global empowerment scale ($r=.52$, $p<.001$). Additionally, construct validity was supported by a confirmatory factor analysis that validated the overall factor structure of empowerment (Laschinger et al., 2001a).

Job satisfaction was measured using four items from the five-item general satisfaction subscale of the Job Diagnostic Survey by Hackman and Oldham (1975). The items are rated on a 5-point Likert scale of strongly disagree (=1) to strongly agree (=5) and an example is, “satisfied with my job”. An average of the four items is calculated for

the overall job satisfaction. Alpha reliability has been reported as ranging from 0.67- 0.85 (Hackman & Oldham, 1975). A confirmatory factor analysis has supported the validity of the Job Diagnostic Survey tool (Laschinger et al., 2004). The reliability coefficient for this study supported the scale with an alpha coefficient of 0.79.

Additionally, a demographic questionnaire was used in the study to collect data about the participant's age, gender, educational level (degree or no degree), unit of specialty, employment status, number of years of experience, work setting, and the province of respondents.

Data Collection Procedures

Following ethical approval mailed surveys were distributed in the fall of 2010 using the Dillman Total Design Methodology (2007). Thus, each participant was first mailed the survey questionnaire (Appendix B) and a letter of information (Appendix C). Non-responders were mailed a reminder letter a month after the first one was mailed and, four weeks later, a second reminder letter was mailed to non-responders. Participant's consent to participate in the study was demonstrated if he/she returned a completed questionnaire (Polit & Beck, 2011). Confidentiality was ensured with the use of code numbers for each non respondent for follow ups that was only known by researchers.

Data Analysis

Statistical analysis of data was completed using the Statistical Package for Social Sciences (SPSS) program, version 20.0 (SPSS Inc., 2012). Descriptive statistics were calculated including the means and standard deviations of all scores for the study variables (Table 2). Consistent with the assumptions outlined in Munro (2005), data were

normally distributed and linear relationships existed among the independent variable (resonant leadership), mediator variable (structural empowerment) and dependent variable (job satisfaction). To determine the relationships among the three study variables (resonant leadership, empowerment, job satisfaction) and demographic data, age, years as a registered nurse, years in the organization, and years in current unit, Pearson correlations were computed. T-tests (independent samples test) and analysis of variance (ANOVA) were performed to analyze for differences in major study variables by the demographics, gender, province, work setting, employment status, educational level (degree/no degree), and unit specialty. Hierarchical multiple linear regression was used to test the influence of resonant leadership and empowerment on the job satisfaction of registered nurses. The level of statistical significance for all analyses was set at $p \leq 0.05$.

A mediator is defined as “a variable that specifies how the association occurs between an independent and an outcome variable” (Bennet, 2000, p.416). Mediators are variables that further explain the strong association between two variables and they tend to influence the relationship between an independent and dependent variable. The mediation model was tested using the method articulated by Baron and Kenny (1986). Four conditions are necessary to establish mediation: (1) the independent and dependent variables must be significantly related; (2) the independent and mediator variables must be significantly related; (3) the mediator and dependent variables must be significantly related; (4) the relationship between the independent and dependent variables must be reduced (partial mediation) or removed and nonsignificant (full mediation) when the mediator is added. In addition, the Sobel test based on Preacher and Leonardelli’s (2001) procedure was conducted to confirm the significance of the mediation model.

Results

Descriptive Results

The means and standard deviations of the major study variables are shown in Table 2. The nurses sampled in this study perceived their leaders to have a moderate degree of resonant leadership ($M=3.23$, $SD=0.94$). Of the 10 resonant leadership items the “supports teamwork” item was rated highest ($M=3.54$, $SD=1.12$) while “acts on values” was rated lowest ($M=2.99$, $SD=1.13$).

Nurses’ perceptions of structural empowerment were moderate ($M=2.66$, $SD=0.97$). Access to opportunity ($M=4.00$, $SD=.83$) was rated highest by nurses while access to information was rated lowest ($M=2.66$, $SD=.97$). These findings are consistent with previous studies of structural empowerment (Greco et al., 2006; Laschinger, 2012). Nurses in this study reported moderate job satisfaction ($M=3.18$, $SD=.92$).

Relationship of Demographic Variables to Major Study Variables

Nurses’ job satisfaction varied by education ($t_{(1214)}=2.66$, $p=.008$). Nurses with no degree were significantly more satisfied with their job ($M=3.25$, $SD=.93$) than those with a degree ($M=3.11$, $SD=.91$). However, there were no differences in workplace empowerment or resonant leadership based on education. Nurses’ ratings of job satisfaction varied by work setting ($t_{(1208)}=5.88$, $p=.003$). Those in the community setting

Table 2

Mean, Standard Deviations, Reliability Analysis and Correlation Matrix of Study Variables

Variable	<i>M</i>	<i>SD</i>	Items	Score Range	α	1	2	3	4	5	6	7
1. Resonant Leadership	3.23	0.94	10	1-5	0.94							
2. Total Empowerment	12.15	2.66	12	4-20	0.85	.51						
3. Opportunity	4.00	0.86	3	1-5	0.83	.32	.66					
4. Information	2.66	0.97	3	1-5	0.88	.33	.75	.34				
5. Support	2.71	0.98	3	1-5	0.84	.44	.80	.39	.49			
6. Resources	2.78	0.92	3	1-5	0.79	.34	.64	.18	.27	.37		
7. Job Satisfaction	3.18	0.92	3	1-5	0.7	.43	.53	.32	.35	.42	.42	
8. Global Empowerment	3.22	0.95	2	1-5	-	.47	.52	.27	.32	.42	.47	.61

All correlations were significant at the 0.001 level (1-tailed). α is Cronbach's alpha

were more satisfied with their jobs ($M=3.45$, $SD=.92$) than those in hospital settings ($M=3.15$, $SD=.92$). Also, nurses in the community were significantly ($t_{(1208)}=2.14$, $p=.032$) more empowered ($M=12.69$, $SD=2.66$) than those in hospitals ($M=12.11$, $SD=2.65$). Further, nurses in the community rated their managers to be significantly higher ($t_{(1208)}=2.00$, $p=.045$) on resonant leadership ($M=3.41$, $SD=.97$) than those in hospitals ($M=3.21$, $SD=.94$). In addition, job satisfaction correlated positively and significantly with age ($r=.18$, $p<.001$), years as a registered nurse ($r=.18$, $p<.001$), years in organization ($r=.12$, $p<.001$), and years on current unit ($r=.08$, $p<.001$). No significant differences in the major study variables based on employment status, gender, unit specialty were found.

Correlation Analysis

Pearson correlation analysis was conducted to examine the relationships among the three major study variables including their subscales as shown in Table 2. Nurses' perceptions of their leader's RL was significantly and positively related to workplace empowerment ($r=.51$, $p<.001$), and job satisfaction ($r=.43$, $p<.001$). Resonant leadership was also positively correlated with all the subscales of workplace empowerment with access to support correlating highest ($r=.44$, $p<.001$) and opportunity lowest ($r=.32$, $p<.001$). The four subscales of workplace empowerment correlated positively with each other. Access to support correlated highest with information ($r=.49$, $p<.001$) and lowest with resources ($r=.37$, $p<.001$). Among the four subscales of structural empowerment, the lowest correlations were between access to opportunity and resources ($r=.18$, $p<.001$) and the highest being between access to support and information ($r=.49$, $p<.001$). Finally, job satisfaction was positively and significantly related to total structural empowerment

($r=.53, p<.001$) and all four dimensions of workplace empowerment with the strongest being access to resources ($r=.42, p<.001$) and support ($r=.42, p<.001$) and the lowest was opportunity ($r=.32, p<.001$).

Test of Hypothesis

The study hypothesis stated that structural empowerment mediates the relationship between RL and job satisfaction. In meeting the conditions stipulated by Baron and Kenny (1986) for mediation, four regressions were conducted. Age, education (no degree, degree), and work setting (hospital, community) were used as control variables since they showed significant relationships with or differences in major study variables (Table 3). In the first equation, age ($\beta=.185, t=5.49, p<.001$), education ($\beta=.015, t=0.46, p=.645$), and work setting ($\beta=.072, t=2.48, p=.013$) explained 4% of the variance ($F_{(3,1171)}=16.11, p<.001$) in job satisfaction but only age and work setting were significantly associated with job satisfaction. In the second equation, RL ($\beta=.447, t=17.44, p<.001$) was added and was significantly associated with job satisfaction (Condition 1 for mediation) and resonant leadership explained a further 19.8% of the variance ($F_{(4, 1170)}=19.26, p<.001$) in job satisfaction. In a previous equation, the second condition for mediation was met in that the control variables age ($\beta=.063, t= 2.122, p=.034$), education ($\beta=.062, t=2.118, p=.034$) and RL ($\beta=.506, p<.001$) but not work setting ($\beta=.025, t=.988, p=.323$) were significantly associated with the mediator, workplace empowerment (Condition 2 for mediation). In the final equation, control variables, RL, followed by empowerment explained a total of 35.8% of the variance ($F_{(5,1169)}=131.78, p<.001$) in job satisfaction but only age ($\beta=.189, t=6.86, p<.001$), RL ($\beta=.241, t=8.85, p<.001$), and empowerment ($\beta=.407, t=14.98, p<.001$), were significantly associated with

job satisfaction. Empowerment explained another 12.2% of the variance in job satisfaction.

Table 3

Coefficients of Final Model for Study Hypothesis

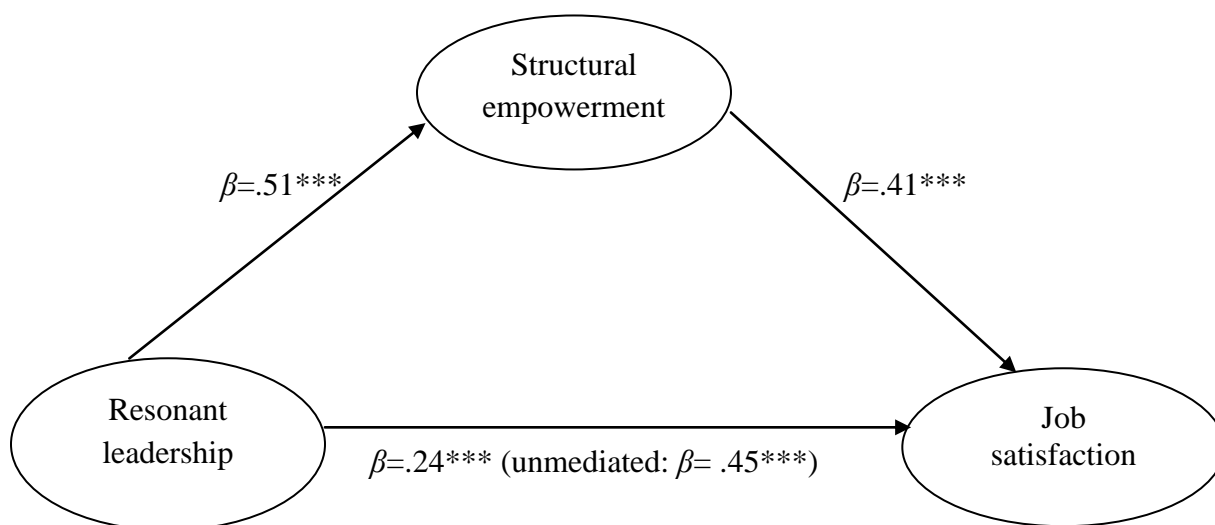
Model	Variables	<i>N</i>	<i>R</i> ²	Adjusted <i>R</i> ²	β	<i>T</i>	<i>p</i>
Model 1	Age	1171	0.040	.037	.185	5.49	<.001
	Degree-Degree/ no degree				.015	0.46	.645
	Work setting				.072	2.48	.013
Model 2	Age	1170	0.238	.235	.215	7.15	<.001
	Degree-Degree/ no degree				.008	0.25	.800
	Work setting				.042	1.63	.103
	Resonant Leadership				.447	17.44	<.001
Model 3	Age	1169	0.36	.358	.189	6.86	<.001
	Degree-Degree/ no degree				-.018	-.065	.516
	Work setting				.032	1.35	.178
	Resonant Leadership				.241	8.85	<.001
	Workplace Empowerment Scale				.407	14.98	<.001

Dependent Variable: Job Satisfaction.
All Betas reported are Standardized

The final equation met the two remaining requirements for partial mediation: the hypothesized mediator, empowerment ($\beta=.407, p<.001$), was a significant predictor of job satisfaction while controlling for RL (Condition 3) and the effect of RL ($\beta=.241, p<.001$) on job satisfaction was reduced almost by half but still significant when empowerment was entered into the model (Condition 4). To further assess the significance of the mediation, the Sobel (1982) test was applied. Results indicated that the mediation effect of empowerment between RL and job satisfaction was significant

($z=7.17, p<0.05$). Therefore, the hypothesized model was partly supported, whereby empowerment partially mediated the relationship between nurses' perceptions of their managers' RL and nurses' job satisfaction (Figure 2).

Figure 2. Final model



Note. *** is $p < .001$

Discussion

The purpose of this study was to test the influence of managers' resonant leadership style and nurses' structural empowerment on their job satisfaction. The results of the study showed partial support for the hypothesis that structural empowerment mediates the relationship between resonant leadership and the job satisfaction of nurses because a partial versus full mediation effect was found. This means that resonant leaders influence nurses' job satisfaction both directly and indirectly through their influence on nurses' access to empowerment structures in the workplace. In the final mediation model,

resonant leadership and structural empowerment explained 32% of the variance in job satisfaction whilst controlling for age, education, and work setting.

The positive association between RL and structural empowerment is consistent with Wagner et al.'s (2013) findings. If nurses see their managers as demonstrating the behaviours of RL they are more likely to have greater access to information, opportunity, support and resources to accomplish their work. The positive link between structural empowerment and job satisfaction provides further support to the considerable number of studies linking structural empowerment with job satisfaction (Laschinger et al., 2003; Patrick et al., 2006; Sarmiento et al., 2004). Furthermore, if nurses are happy in their work overall they are less likely to contemplate leaving their jobs (Andrews & Dziegielewski, 2005; De Milt et al., 2011; Duffield et al., 2011; Lu et al. 2012). As far as we know, this is the first study that has examined the mediating role of structural empowerment between RL and job satisfaction in nursing. Therefore, cultivating and developing resonant leaders who facilitate nurses' access to empowerment in the workplace play a crucial role in nurses' job satisfaction and ultimately improving retention.

The sampled nurses rated their managers as having moderate levels of resonant leadership ($M=3.23$, $SD=0.98$) compared to the study by Squires et al. (2010) who found a slightly higher mean score for resonant leadership ($M=3.50$, $SD=.86$) in a sample of 266 Ontario acute care nurses survey. This difference may be a result of having a much larger and cross national sample. Among the 10 items reflecting RL behaviours tested in this study, nurses perceived their managers "*act on values*" as the lowest rating which could mean nurses perceive that their managers are either not open about their values or nurses

do not see that their managers act on their true values. Nurse managers often have to implement actions determined by the overall organization which may not be consistent with their personal values (Boyatzis & McKee, 2005; Cummings et al., 2010). The highest rated RL behaviour was “*supports teamwork*” which may mean that nurses see this as a key leadership behaviour consistent with their perception of their manager’s resonant leadership skills. Support is manifested when nurses feel there is guidance, direction, help, and feedback from managers and this contributes to successful and effective work completion and outcomes like job satisfaction (Kanter, 1993; Laschinger, 2008; Laschinger & Finegan, 2005). This also lends support to the findings of Cummings et al. (2005) and Squires et al. (2010) in which resonant leadership was positively associated with increased satisfaction with leader-nurse relationship and job satisfaction. The expectation is that leaders who demonstrate support for teamwork enhance group relationships, and promote positive emotions in the workplace which increases nurses’ work effectiveness and consequently, improves job satisfaction (Boyatzis & McKee, 2005; Boyatzis et al., 2013)

Interestingly, except for work setting there were no significant associations between the study demographic variables and resonant leadership. This could be an indication that nurses’ perceptions of their managers’ resonant leadership attributes and skills are not dependent on age, levels of education, unit specialty, or years as a registered nurse among others because personal situation variables may not influence their leadership perceptions (Boyatzis et al, 2012). However, nurses’ perceptions of their manager’s resonant leadership skills, structural empowerment and job satisfaction did vary by work setting. This could be an indication that the work setting in which one

works (community/hospital) has a significant role to play in job satisfaction and those in hospital settings are less satisfied because of the constant daily high patient load on nurses and the rapid turnover and short staffing which negatively affects satisfaction (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Shaver & Lacey, 2003).

Consistent with other studies, job satisfaction is related to prevailing work conditions and environment, and the individual expectations on the provisions of the job (Aiken et al., 2008; Klopper et al., 2012; Laschinger, 2012; Laschinger et al., 2010).

Structural empowerment strongly predicted job satisfaction. The tested relationship supports Kanter's theory which postulates that structural empowerment influences employees' work attitudes such as the level of job satisfaction. This study's findings are consistent with other studies showing that structural empowerment directly influences nurses' job satisfaction (Fock, Hui, Au, & Bond, 2013; Laschinger et al., 2003; Laschinger et al., 2010; Wagner, 2010). Moreover, these findings reinforce those of other recent studies in which structural empowerment mediated the relationship between other positive leadership styles and work outcomes such as leader empowering behaviours and burnout (Greco et al., 2006), authentic leadership and job satisfaction and performance (Wong & Laschinger, 2012) and leader-member exchange and organizational commitment (Laschinger et al., 2009). It is therefore expected that in a work environment where components of structural empowerment flourish, nurses will effectively accomplish their work and feel satisfied with their jobs.

In addition, the study finding provide additional support for Kanter's theory by substantiating that leaders and in this case resonant leaders are instrumental in creating work environments that empower employees in growth, ability, knowledge, and guidance

towards effective and satisfactory work completion. Among the components of structural empowerment, access to support also had the strongest association with job satisfaction as did resources. This is consistent with other study findings (Laschinger et al., 2004; Laschinger et al., 2009; Sarmiento et al., 2004) which also found support to be the highest and strongest component in relation to job satisfaction. However, nurses' perceptions of their actual access to information and support were rated the lowest. This may be a reflection of the fast-paced and demanding nature of nursing work environments and the wide scope of manager roles which challenge their ability to be present and available on their units to offer ongoing communication and support (Lucas et al., 2008; Young-Ritchie et al., 2009). The implication may be that there are organizational policies around information and opportunities for support that may not be under the decisional domain of the nurse manager or these may be minimal or non-existent. However, it may also be that there is much more managers could be doing in these areas to provide access to these empowering structures.

Limitations

The cross-sectional design in the primary data used here limits interpretations of causality to the evidence of co-variation in the study variables and the foundational theoretical associations (Taris, 2000). Although the sample included nurses from nine of the ten Canadian provinces the return rate was low, limiting the generalizability of the findings. However, the demographic profile of nurses in our sample was not noticeably different on most variables from the national database (Canadian Institute for Health Information 2010), including age (41.54 years vs. a national average of 45.9 years), gender (93.5% female vs. a national average of 93.8% female) and employment status

(58.2% full-time vs. a national average of 58.6% full-time). The one exception was the higher proportion of nurses with baccalaureate degrees in our sample (51.9% vs. a national average of 40%). In addition, there is potential for response bias due to the use of self-report surveys (Polit & Beck, 2008).

Conclusion

The study findings provide support for the integration of the concept of resonant leadership and Kanter's structural empowerment theory which leads to positive outcomes such as job satisfaction. The findings demonstrated that resonant leadership of nurse managers had a significant direct and an indirect effect on the job satisfaction of registered nurses through structural empowerment. Additionally, the results supported the mediating role of structural empowerment between resonant leadership and job satisfaction of nurses. Healthcare administrators and senior nurse leaders who foster the development of resonant leadership and structural empowerment in their organizations may see an increase in the retention and recruitment of nurses through increased job satisfaction in an era of nurse shortages. Focused attention on nurse's job satisfaction may also yield benefits in terms of increased productivity and improved quality care.

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Chapter Three

Discussion

The purpose of this study was to test Kanter's (1977, 1993) theory of organizational empowerment in a sample of direct care nurses working in hospitals and community settings in nine provinces across Canada. In this study, perceived resonant leadership of managers had both a direct and an indirect effect on job satisfaction through structural empowerment resulting in a partially mediated model. Findings of this study highlight how resonant leadership can influence the creation of empowering work environments where nurses feel satisfied in their jobs. In a time of a pending nursing shortage, successful organizations will be those with managers skilled in leadership competencies to work with nurses in creating workplaces that foster nurses' job satisfaction and ultimately, commitment to their organizations and retention in their roles.

Effective leaders are key to the foundation for creating positive work structures, motivating staff, fostering team-building, promoting participation, and facilitating care processes (Wong, Cummings, & Ducharme, 2013). In organizational contexts, leaders are expected by followers to be supportive in helping staff meet both personal and organizational goals (Greco et al., 2006; Kanter, 1993). Additionally, positive nurse leadership behaviours have been shown to improve communication, quality care, nurse work climates, effective teamwork, staff performance and patient outcomes (Cummings, MacGregor, et al., 2010; Wong et al, 2013). In the midst of recent nurse shortages and increasingly challenging workloads, it is essential to create work environments in which both nurses and leaders can feel empowered to effectively perform their duties and thus, promote nurse job satisfaction (Greco et al., 2006; Wong & Laschinger, 2012).

Implications for Theory

This study examined RL which has been shown in a few nursing studies to be associated with structural empowerment and/or job satisfaction among registered nurses. The findings in this study add to the theoretical basis for resonant leadership and job satisfaction with structural empowerment as a mediating variable in the nursing literature. As far as we know, this is the first study linking resonant leadership, structural empowerment and job satisfaction. The study supports previous studies (Cummings et al., 2005; Squires et al., 2010; Wagner, 2010; Wagner et al., 2013) that concluded that resonant leadership which is rooted in emotional intelligence is instrumental in influencing nurse outcomes such as job satisfaction.

Secondly, the results of this study further contribute to the body of work documenting the importance of Kanter's theory to organizational outcomes and supports the fact that access to support, information, opportunity, and resources create the platform for the potential success of management interventions based on this theory (Laschinger et al., 2001). It further validates Kanter's theory and the role of structural empowerment as a mediating variable between resonant leadership and job satisfaction. The study findings demonstrated that an integration of resonant leadership and structural empowerment theory may yield positive outcomes for healthcare organizations and leaders who aim to promote positive worklife conditions for nurses. Findings also confirmed the fact that structural empowerment is a strong predictor of job satisfaction at the individual level (Laschinger, 2008; Laschinger et al., 2004; Laschinger, Wong, Cummings, & Grau, 2014; Patrick & Laschinger, 2006; Wagner, 2010).

Further, study findings add to a series of studies testing nurse relational leadership styles and outcomes in hospital settings (Cummings, Midodzi, et al., 2010; Wong & Laschinger, 2012; Wong et al., 2010) by examining direct care nurses' perception of their manager's resonant leadership skills and the job satisfaction of nurses working in hospital and community settings across Canada.

Implications for Practice

Study results suggest implications for hospital administrators to consider in how frontline nurse managers can contribute to positive work conditions as a strategy to increase job satisfaction and ultimately retention of nurses in healthcare organizations. According to Kanter (1979), the manager plays a pivotal role in the employee's relationship to work. Cummings (2004) contends that the leader-nurse relationship is at the core of a resonant leader's everyday practice based on refined skills reflective of emotional intelligence. In addition access to opportunity, information, support, and resources are important determinants of employee empowerment that influence effective outcomes for organizations (Kanter, 1977, 1993). As shortages of nurses continue, healthcare administrators need to plan for the competencies needed by leaders to create and maintain work environments where nurses feel satisfied with their work and choose to stay in their jobs. This secondary analysis aimed to examine the importance of nurse manager leadership by exploring the relationships between resonant leadership, structural empowerment, and job satisfaction.

The study findings demonstrated that the development of resonant leadership competencies in nurse leaders may be essential in creating access to empowerment structures and job satisfaction (Cicolini et al., 2013; Squires et al., 2010). Nursing

practice thrives when relationships between managers and nurses in the work setting are collaborative and managers demonstrate the emotional intelligence components of self-awareness, self-management, social awareness, and relationship management (Wagner et al., 2013; Young-Ritchie, Laschinger & Wong, 2009). This means that resonant leaders are able to empathize with the concerns of other nurses and thus, signal to staff that their concerns are acknowledged and valued (Cummings, 2004; Cummings et al., 2008; Goleman et al., 2002). Through these signals, nurses gain confidence in their skills and contributions to patient care which they can apply in future situations (Cummings, 2004).

In this study, nurses rated only moderate access to support but support was most strongly associated with resonant leadership of the manager. According to Kanter (1977, 1993) employees perceive they have access to support when they receive constructive feedback and coaching regarding their work from those within the organization. Nurse managers who aim to have high visibility and presence in their units are able to build positive relationships with nurses conveying performance standards and work expectations as well as providing immediate feedback that reinforces positive work behaviours (Cummings, 2004; Laschinger, 2008). In turn, when nurses experience adequate support, they have more confidence in their decision-making which promotes initiative and innovation (Kanter, 1993; Laschinger et al., 2013). The current challenges and pace of change in healthcare organizations and larger spans of control for unit managers mean that frontline leaders have less time available for face-to-face interactions with nurses (Laschinger et al., 2008; Squires, et al., 2010; Wong & Laschinger, 2012). However, organizational leaders who recognize the value of relationship-building and time spent with staff should acknowledge that value in their organizations and ensure

frontline managers have job flexibility and reasonable spans of control to maintain and enhance relationship development with frontline staff.

The emotional competencies of resonant leaders create empowering and enabling work environments for staff which can aid in lowering workplace stress, facilitate staff growth, contribute to a supportive team climate, and promote positive outcomes such as job satisfaction and quality care (Cummings, 2004). When nurse leadership is strengthened, there is a positive effect on the nurses which brings out the best in them as well as reduces the emotional exhaustion, medication errors, and decreased quality of care of patients (Squires et al., 2010). Resonant leaders will therefore, be instrumental in continuous fostering of a trusting relationship in nurse work environments in order to enhance and maintain satisfaction levels. Thus, in the presence of a resonant leader in a work setting, there is the solid establishment of a transparent communication system and a supportive, participatory, and collaborative culture among leaders and staff which are necessary for positive work outcomes (Cummings, Midodzi, et al., 2010). This will also facilitate clarity of roles, well defined policies and guiding principles, and the initiation of effective management structures such as teamwork and collaboration (Cummings, Midodzi, et al., 2010). In the face of challenges and the increasing demands in nursing recently, resonant leaders may be a preferred choice for organizations in dealing with the job dissatisfaction of nurses and potential nurse shortages.

Implications for Education

Findings from the study suggested that resonant leaders may be instrumental in creating positive empowering work environments. Nurse managers should therefore be educated on the critical role that they play as leaders and how their leadership styles

impact staff and their outcomes. Furthermore, in addition to clinical competencies of managers, further emphasis should be focused on developing leaders who have competencies in emotional intelligence. Leaders who are skilled in emotional intelligence have the ability to lead and influence the overall emotional tone within themselves and others. Results of this study highlight the value nurses perceive in the relationship of the frontline leader to their own perceptions of empowerment in the work settings. When frontline leaders are supported to spend time with staff enhancing empowering structures within work units, nurses experience greater job satisfaction. Periodic workshops and training programs should be organized for nurse leaders on resonant leadership to train nurse leaders on relational leadership skills specifically, RL skills. This has become necessary in that leadership skills can be learned and emotional intelligence competencies can be acquired through training programs (Boyatzis, & McKee, 2005; Cummings et al., 2005; Goleman et al., 2002; Northouse, 2013).

Leadership education in undergraduate education should include some focus on EI and RL to serve as a foundation for effective leadership to equip students with the competencies of emotional intelligence to enable them to become effective practitioners and potential future leaders. Bulmer Smith, Profetto-McGrath and Cummings (2009) suggested that developing the EI skills of students could potentially increase how they cope with learning stress, improve future decision-making, and might possibly facilitate new graduate nurses' transition into practice and improve future nurse retention in the workplace. Educating and training students and new graduate nurses to be equipped with EI competencies should be a priority in nursing education so that knowledge can be translated into the development of future healthcare leaders (Cummings et al., 2005;

Laschinger et al., 2008; Laschinger et al., 2013). With the inclusion of EI in nursing education curriculum, nursing students may be prepared with strong emotional intelligence competencies to meet the demands of increasingly complex work environments (Evan & Allen, 2002; Goleman et al., 2002). Stronger EI and RL skill sets among nurses in the workplace may influence patient outcomes when emotionally laden situations are managed more effectively at personal and team levels (Bulmer Smith et al., 2009).

Recommendation for Future Research

Few studies have examined the relationship between nurse leadership and patient outcomes; nurse job satisfaction and patient outcomes; and resonant leadership and patient outcomes (Cummings, 2013; Wong et al., 2013). There is a need for research to examine the influence of resonant leadership on outcomes such as nurse absenteeism and turnover and patient outcomes such as adverse events and patient satisfaction. This is necessary because patient outcomes and absenteeism are objective outcomes which have significant financial implications for organizations. This research would also widen the network of empirical support for the connection between RL and these outcomes. Longitudinal studies should be done to examine the causal relationship among resonant leadership and structural empowerment and job satisfaction as well as observable nurse outcomes such as turnover, and absenteeism among nurses.

There is also the need for future research to explore the relationship between empowerment, nurse job satisfaction and patient outcomes in diverse settings (Cicolini et al., 2013). With the inclusion of diversity from multiple work settings (hospital, community) and countries (developed, developing and less developed countries), validity

of findings may be increased allowing for greater generalizability (Cummings, MacGregor, et al., 2010). In terms of developing countries, future research on resonant leadership in developing countries is necessary but may be challenging since they are more under-resourced in both human and material resources. Empowerment has been extensively studied in Canada and in hospital settings but very little is known about empowerment in clinics, health outpost, community, and public health settings warranting further studies. Finally, there is a need for intervention studies to test the effectiveness of developmental programs to advance the resonant leadership (emotionally intelligent) competencies of frontline managers in clinical settings.

Conclusion

The study findings provide support for the integration of the concept of resonant leadership and Kanter's structural empowerment theory which leads to positive outcomes such as job satisfaction. The findings demonstrated that resonant leadership of nurse managers had both a significant direct and an indirect effect on the job satisfaction of registered nurses through structural empowerment. It was also evidenced that the structural empowerment theory by Kanter (1993), is an effective guideline for nurse leaders in the creation of supporting structures for employees in accessing resources, support, information, and opportunities that are needed in accomplishing work goals (Laschinger et al., 2001). Specifically, a focus on the development of resonant leadership and structural empowerment in healthcare organizations has the potential to enhance the job satisfaction level of registered nurses.

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empowerment and organizational commitment. *Nursing Leadership*, 22 (1), 70-85.

APPENDIX A

A. 01 Ethical Approval Form



Office of Research Ethics

The University of Western Ontario
 Room 4180 Support Services Building, London, ON, Canada N6A 5C1
 Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
 Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. H.K.S. Laschinger
Review Number: 15790E **Review Level:** Expedited
Review Date: December 23, 2008
Protocol Title: Nurses' Career Aspirations to Management Roles: Identifying the Next Generation of Nursing Leaders
Department and Institution: Nursing, University of Western Ontario
Sponsor: CIHR-CANADIAN INSTITUTE OF HEALTH RESEARCH
Ethics Approval Date: January 20, 2009 **Expiry Date:** May 31, 2011
Documents Reviewed and Approved: UWO Protocol, Letters of Information and Consent For Focus Groups (3) - Staff Nurses, Formal Leaders, Unit Leaders; Letters (2) of information and Consent - Interviews, Survey; Advertisement; Invitation Letters.

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

- changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- all adverse and unexpected experiences or events that are both serious and unexpected;
- new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert

Ethics Officer to Contact for Further Information			
<input type="checkbox"/> Janice Sutherland (jsuther@uwo.ca)	<input type="checkbox"/> Elizabeth Wambolt (ewambolt@uwo.ca)	<input type="checkbox"/> Grace Kelly (grace.kelly@uwo.ca)	<input checked="" type="checkbox"/> Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

cc: ORE File
LHR

APPENDIX B

Study Instruments

- B. 01 Conditions for Work Effectiveness Questionnaire-II
- B. 02 Resonant Leadership Scale
- B. 03 Job Diagnostic Survey: General Satisfaction Subscale
- B. 04 Demographic Questionnaire

Conditions for Work Effectiveness Questionnaire-II (Laschinger 2001)

To what extent is each of the following present in your current job?

	1= None	2	3= Some	4	5= A Lot
1. Opportunity for challenging work.				1	2 3 4 5
2. The chance to gain new skills and knowledge on the job.				1	2 3 4 5
3. Tasks that use all of your own skills and knowledge.				1	2 3 4 5
4. Information about the current state of the organization.				1	2 3 4 5
5. Information regarding the values of top management.				1	2 3 4 5
6. Information regarding the goals of top management.				1	2 3 4 5
7. Specific information about things you do well.				1	2 3 4 5
8. Specific comments about things you could improve.				1	2 3 4 5
9. Helpful hints or problem solving advice.				1	2 3 4 5
10. Time available to do necessary paperwork.				1	2 3 4 5
11. Time available to accomplish job requirements.				1	2 3 4 5
12. Acquiring temporary help when needed.				1	2 3 4 5

Note: Items 1-3 relates to opportunity subscale; 4-6 information subscale; 7-9 support subscale; and 10-12, resources subscale.

Resonant Leadership Scale (Cummings et al., 2010)

Focusing on your IMMEDIATE SUPERVISOR'S behaviours at work please indicate the extent to which you agree or disagree with each statement.

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

Job Diagnostic Survey: General Satisfaction Subscale (Hackman & Oldham, 1975)

Please indicate the extent to which you agree or disagree with each statement.

	1= Strongly Disagree	2	3	4	5= Strongly Agree
1. I feel very satisfied with my job.					1 2 3 4 5
2. I feel that my co-workers are satisfied with their jobs.					1 2 3 4 5
3. I feel I would be happy to work here until I retire.					1 2 3 4 5
4. I feel my organization provides a supportive work environment in which to work.					1 2 3 4 5

As an RN: _____ Years _____ Months

As an RN at your current organization _____ Years _____ Months

As an RN on your current unit _____ Years _____ Months

10. Average hours worked per week? less than 20 hours 20-39 hours
 40 hours and over

11. In the past year, has the amount of overtime required of you:

Increased Decreased Remained the Same
 Not Applicable

12. In the past year, how many days have you missed work due to illness/disability? _____
of days

APPENDIX C

Letter of Information

C. 01 Letter of Information

“Nurses’ Career Aspirations to Management Roles: Identifying the Next Generation of
Nursing Leaders”

Survey Letter of Information for Staff Nurses

Co-Principal Researchers:

Heather K. Laschinger, RN, PhD, The University of Western Ontario

Carol A. Wong, RN, PhD, The University of Western Ontario

Funding: Partnerships for Health Systems Improvement (PHSI)

Introduction

We are inviting you to take part in our research study named above. This form provides information about the study. You do not have to take part in this study. Taking part is entirely voluntary (your choice). A staff member of our research team will be available to answer any questions you have. You may decide not to take part or you may withdraw from the study at any time. This will not affect your employment status in any way.

Purpose of the Study

Recent research has shown that the age of nurse managers in Canada averaged 52 years of age, raising concerns of a nursing leadership shortage in the coming years. Recent reports indicate the importance of strong nursing leadership in retaining nurses and the need for stronger leadership skill development among nurses. Despite much anecdotal evidence from staff nurses indicating disinterest in management positions and difficulties recruiting first line managers, there is no data available about what influences staff nurses’ interests in aspiring to become a nurse manager. The purpose of this study is to investigate factors influencing direct care nurses’ career aspirations to management roles within today’s complex healthcare settings.

Procedures for this Study

The proposed project is a dual-phased project spanning a period of 3 years and consisting of three elements: **focus groups, interviews, and surveys.**

The survey component of the study consists of a comprehensive questionnaire assessing direct care nurses’ interests in taking on leadership roles and factors influencing these career expectations. We will obtain a random sample of 200 nurses

from each of 10 provinces from their respective College of Nurses. If you are not a direct care nurse, you should not participate in this study.

What You Will Be Asked to Do

You will be asked to complete a **survey**, which should take approximately 30 minutes of your time. You may decide whether to complete the survey on your own time or at work. Survey questions may ask about your conception of the manager role, your experiences with succession planning, your current work environment, and perceptions about your supervisor. Once you have completed your survey, please place it in the self-addressed envelope provided and put it in the mail. You may keep the enclosed \$2 Tim Horton's card whether or not you choose to complete the survey.

All data will automatically be sent to the research site - the Nursing Research Unit at The University of Western Ontario. Only members of our research team will be able to access the data. All data will be stored in a locked cabinet in a secure room. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Risks and Discomforts to You if You Participate in the Study

There are no anticipated burdens, harms or potential harms for participation in this study. There is a chance that you may feel uncomfortable answering questions about aspiring to be a nurse manager on the survey. Care will be taken to ensure confidentiality of survey data and we will respect your privacy. Also, you will not have to answer any questions if you feel uncomfortable. You may refer to your Employee Assistance Plan representative if you need to talk to someone further about these issues.

Benefits to You if You Participate in the Study

Nurses will not be guaranteed any direct benefits as a result of their participation in this study. However, this study will indicate reasons why fewer nurses are interested in management positions. This information can be used to improve the workplace in such a way that nurses would like to become managers, thus alleviating the manager shortage.

In addition, further knowledge can be acquired that will begin to identify the factors affecting direct care nurse's aspirations to assume first line managerial roles. As a result, this information can be used to inform policy and organizational initiatives that will make these roles attractive to future nurse leaders.

Voluntary Participation and Withdrawing from the Study

Before deciding to participate, you should know that you do not have to take part in the study. Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your employment status. If, during the course of this study, new information becomes available that may relate to your willingness to continue to participate, this information will be provided to you by the investigator.

Costs Associated with the Study

Participation in this study will not result in any expenses to you.

Information About Study Results

If you would like a copy of the research results, please indicate so in the area provided on the survey. The results of the study will also be given at conferences held in 2010 and 2011.

Confidentiality and Privacy

For the surveys, no identifying information of participants will be linked to the data. Only grouped data will be reported during the dissemination of our findings. Individual responses will not be reported. If the results of the study are reported in a publication, this document will not contain any information that would identify you. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Each participant will be given a personal identification number (PIN) in order to link individual data across timeframes for the survey. The Research Assistants at The University of Western Ontario will link study PINs to your name only for the purposes of distributing information letters and surveys to you. Data will be sent directly to Western with only the PIN as the identifier. All participant names and assigned PINs will be destroyed as soon as the data collection is complete. The survey distribution will consist of the survey as well as a reminder letter, and finally a second distribution of the survey asking non-respondents to complete the survey if they haven't yet done so.

Contacts for Study Questions or Problems

If you have any further questions about this study, please feel free to contact Dr. Heather Laschinger or Dr. Carol Wong at the contact below. We would very much appreciate your participation in this research project. We would very much appreciate your participation in this research project. If you choose to participate in the survey, please use the pre-addressed, stamped envelope enclosed to return your completed written questionnaire to the research office. If you choose not to participate, please return the

blank questionnaire, after which you will not be contacted further. Thank you very much for considering our request.

What are my research rights?

You indicate your voluntary agreement to participate by completing and returning this questionnaire. You do not waive any legal rights by signing the consent form. You will be given a copy of this letter of information and consent form once it has been signed. If you have any questions about your rights as a research participant or the conduct of the study, you may contact Dr. David Hill, Scientific Director, Lawson Health Research Institute, or The Office of Research Ethics.

Sincerely,

Heather Laschinger, RN, PhD
Professor, Co-Principal Investigator
School of Nursing
University of Western Ontario

Carol Wong, RN, PhD
Professor, Co-Principal Investigator
School of Nursing
University of Western Ontario

Curriculum Vitae

Name	Eunice Bawafaa
Post -Secondary Education and Degrees:	The University of Western Ontario London, ON, Canada 2012-2014 MScN University of Ghana Legon, Accra, Ghana 2002-2006, B.A.Nursing with Psychology
Honours and Awards	First Class Honors B.A.Nursing with Psychology, 2006 Academic Excellence Award, Legon Hall, University of Ghana, 2006 Best Nurse of the Year Award, Nyaho Medical Center, 2008 Global Health and Interprofessional Practice Certificate
Related Work Experience:	Arthur Labatt Family School of Nursing, London, Canada Research Assistant, October 2013-April 2014 University of Western Ontario, London, Canada Teaching Assistant, September 2012-April 2014 Teaching Support Center, University of Western Ontario Advanced Teaching Program Teaching Mentor Program Global Intellectual Exchange Program (University of Ghana & University of Michigan). Representative and Research Member 2005 Ridge Hospital, Ghana Nursing Officer, October 2009-August 2012 Nyaho Medical Center, Ghana Nursing Officer, December 2006-September 2009
Professional Memberships:	Sigma Theta Tau International Honor Society of Nursing (STTI) Ghana Registered Nurses Association (GRNA) Ghana Nurses and Midwives Council (GNMC) Ghana Health Service (GHS)