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# Structural Empowerment: A Qualitative Inquiry Into the Work Life of the Oncology Nurse

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# Structural Empowerment: A Qualitative Inquiry Into the Work Life of the Oncology Nurse

## **Abstract**

Through the lens of Kanter's theory of structural empowerment, this study sought to explore oncology nurses' perceptions of structural empowerment and their insights on how existing structures provide support, opportunities, information, and resources needed to get their work accomplished and impact the delivery of safe quality care. The research sought to examine the extent to which oncology nurses believe they are working within this prescribed environment. Through qualitative research methods, this study used in-depth interviews to explore seven oncology nurses' perceptions of structural empowerment. The research questions were: (a) What are oncology nurses' perceptions of structural empowerment? and (b) How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done? The findings showed that: (a) shared governance structures were highlighted as existing and empowering, (b) promotion of continued professional development and growth exists, (c) autonomy is encouraged at the direct-care level and welcomed by many, (d) a presence of effective communication and receipt of information was noted, but opportunities for improvement were made, and (e) participation in the delivery of oncology care is very rewarding but emotionally challenging. Recommendations were made to improve the inter-connectedness between the unit-based and departmental councils; evaluate to see if professional development and growth structures are meeting organizational and individual needs; create a more situational leadership approach to supervising staff to increase staff competency level; and further investigate the concepts of empathy, setting emotional boundaries, and building resiliency as they relate to structure of empowerment for oncology nurses.

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Carleen Evans

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Structural Empowerment:  
A Qualitative Inquiry Into the Work Life of the Oncology Nurse

By

Altagracia Mota

Submitted in partial fulfillment  
of the requirements for the degree  
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Supervised by

Dr. Claudia L. Edwards

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## **Dedication**

I would like to start with a dedication and a big thank you to my Dearest Susan for your love, patience, and understanding throughout this journey. You were there for every laughter, every tear, every milestone, with camera in hand and pride in your heart. You have kept me grounded. This degree belongs to you as much as it does me.

A deep appreciation to my Chair, Dr. Claudia Edwards, and Committee Member, Dr. Carlene Evans. Your continued scholarship, faith, support, and reminders to “trust the process” were invaluable.

This journey would not have been possible without the tremendous support of all my family and friends. I would like to thank my mother. Throughout my life you have given me the strength, guidance, and love to meet any challenge, and you have encouraged me to follow my heart, always stressing the importance of education. You have influenced the woman that I am today. Te adoro mama.

A special thank you to my brothers and sisters for always believing in and encouraging me to follow my dreams. Much appreciation goes to my second family, John S. & the Capellans, for all the games and laughter. A thank you to Laura and Celeste for your friendship and continued support. A special acknowledgement to my SJFC CNR Cohort #4 and my buddies “The Sig Sigmas” for the great insights, discussions, and lively debates. A final thank you to all my formal and informal mentors along the way.

### **Biographical Sketch**

Altagracia Mota has over 25 years of experience in oncology nursing dedicated to the delivery and promotion of quality care in the roles of staff nurse, clinical nurse specialist, adjunct faculty, nursing staff development specialist, and nurse residency program coordinator. Dr. Mota received her Bachelor of Science degree in nursing in 1987 and her Master of Science in nursing education from the College of New Rochelle. Ms. Mota entered St. John Fisher College in pursuit of her doctoral degree in the Ed.D. Program in Executive Leadership. Ms. Mota pursued her research in structural empowerment: a qualitative inquiry into the work life of the oncology nurse under the direction of Dr. Claudia Edwards and Dr. Carleen Evans and received the Ed.D. degree in 2015.

## **Abstract**

Through the lens of Kanter's theory of structural empowerment, this study sought to explore oncology nurses' perceptions of structural empowerment and their insights on how existing structures provide support, opportunities, information, and resources needed to get their work accomplished and impact the delivery of safe quality care.

The research sought to examine the extent to which oncology nurses believe they are working within this prescribed environment. Through qualitative research methods, this study used in-depth interviews to explore seven oncology nurses' perceptions of structural empowerment. The research questions were: (a) What are oncology nurses' perceptions of structural empowerment? and (b) How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done?

The findings showed that: (a) shared governance structures were highlighted as existing and empowering, (b) promotion of continued professional development and growth exists, (c) autonomy is encouraged at the direct-care level and welcomed by many, (d) a presence of effective communication and receipt of information was noted, but opportunities for improvement were made, and (e) participation in the delivery of oncology care is very rewarding but emotionally challenging.

Recommendations were made to improve the inter-connectedness between the unit-based and departmental councils; evaluate to see if professional development and growth structures are meeting organizational and individual needs; create a more

situational leadership approach to supervising staff to increase staff competency level; and further investigate the concepts of empathy, setting emotional boundaries, and building resiliency as they relate to structure of empowerment for oncology nurses.

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## **Chapter 1: Introduction**

### **Introduction**

Nurses are the largest segment of the United States health care workforce comprising over 3 million (Institute of Medicine (IOM), 2011). The findings from a 2008 national sample survey of registered nurses, by the United States Health Resources and Services Administration (HRSA), estimated that 3,063,162 licensed registered nurses (RNs) were living in the United States. At time of the survey, an estimated 444,668 had received their first U.S license within the last 7-10 years. Half of the RN population had a bachelor's or higher degree in nursing or a nursing-related field; while the other half of the RN population's highest education level was a diploma or an associate degree (HRSA, 2010).

More than 21% of RNs earned an academic degree prior to their initial nursing degree. Fewer than half of nurses with master's degrees worked in hospitals, more than 18% worked in ambulatory care settings, and nearly 12% were employed in academic education. The most common job title of RNs in the United States is "staff nurse," or its equivalent (66.3%). Between 2004 and 2008, the proportion of staff RNs increased by 2.2%. Fewer than 20% of RNs with graduate degrees are staff RNs, compared to 72.8% of staff nurses without a graduate degree. The next-most -common (12.5%) job title in 2008 included management and administration titles (HRSA, 2010).

Nearly two-thirds of RNs reported working in a health occupation prior to their initial nursing education. At its highest since 1977, an estimated 2,596,399 RNs were

employed in nursing in 2008, representing 84.8% of licensed RNs. Full-time employment had increased from 58.4% in 2004 to 63.2% in 2008.

The average age of RNs was found to be rising. Among nurses under 50 years old, 90% or more were employed in nursing positions; this percentage dropped to less than half of RNs over age 65. In 2008, 62.2% worked in hospital settings (92% < age 25, 53% > age 55 y/o), compared to 57.4 % in 2004 who worked in hospital settings (HRSA, 2010). These statistics are significant in the discussion of nurses' impact on health care quality outcomes.

The nurse's role in the delivery of patient care and its influence on patient care outcomes is a topic that has come to the forefront of many health care and nursing organizations. "Rapid and dynamic changes in health care delivery and policy environments have placed the issues of patient safety and quality of care at the center of health care and the nursing profession" (American Nurses Association (ANA), 2015, p. 1).

The past several decades have influenced the role and scope of the practice of oncology nurses (Quinn-Rosenzweig, 2012). "As the health care delivery system changes and new scientific discoveries are integrated into cancer care, the role of the oncology nurse will continue to evolve" (Reiger & Yarbrow, 2003, para. 2). Oncology nurses are working in many roles/settings that were not common years ago. From the frontline of health care delivery, oncology nurses are expected to demonstrate expertise in patient assessment, symptom management, patient education, and coordination of care. In advanced practice roles, nurses can also be seen leading ambulatory nurse-run clinics, providing long-term follow-up, genetic counseling, and assuming many leadership

positions. Nurses are in a position to influence patient outcomes through advocacy, safe delivery of patient care, and team work and collaboration (Reiger & Yarbrow, 2003).

The American Nurses Association is a professional organization that represents the nation's entire population of registered nurses. It is dedicated to ensuring quality of care delivery and high standards of nursing practice. It is at the forefront of policy initiatives relating to health care reforms (ANA, 2015). The American Nurses Credentialing Center (ANCC) is a subsidiary of the ANA. The ANCC's mission is to promote excellence in nursing and health care globally through credentialing programs. These programs recognize health care organizations that promote nursing excellence and quality patient outcomes, while providing safe, positive work environments (ANCC, 2015). The Magnet Recognition Program® is one of its programs.

The ANCC model for the Magnet Recognition Program serves as a guide for structural reorganization for institutions seeking magnet status. ANCC magnet-recognized organizations serve as international resources of nursing knowledge and expertise. The magnet model consists of 14 forces of magnetism that are categorized within the model's five components: transformational leadership, structural empowerment, exemplary professional practice, new knowledge and innovations, and improvements and empirical outcomes. Organizational structure, professional engagement, shared decision making, quality of care delivery, and professional development are five of the 14 forces that are identified as "magnetic" and, therefore, attractive to the nurses who are the subject of this research. The structural empowerment component of the Magnet model addresses institutional support for professional engagement, commitment to professional development, teaching role development,

commitment to community, and recognition and contribution of nurses (Kercher & Harris, 2011).

This research seeks to understand nurses' perceptions of structural empowerment. It seeks to explore their perceptions of the impact of their current work structure on their ability to get their work done. A qualitative approach will be used to gain insight into the oncology nurses' perceptions of structural empowerment and the work environment needed in order to practice their profession as collaborative partners in the pursuit of high quality care. Findings have the potential to inform policy makers and practitioners in the field of nursing by contributing to the literature on structural empowerment among oncology health care providers. Results also have the potential to assist leaders in designing structures and processes that are best suited to the nurses' expectations of an empowering environment for the safe delivery of care.

Such an environment is provided by leadership that is transformative, has power and is supportive of employee needs and provides the structures that promote empowerment (Kanter, 1993). The need for understanding the nurses' perceptions of structural empowerment and its role in helping nurses feel that they are partners in care delivery is an important area for further research and exploration.

A qualitative, advocacy/participatory worldview will be the foundation for this research. Using a descriptive qualitative approach, through semi-structured one-on-one interviews, this study will seek to describe organizational structural empowerment and its impact on the work life of oncology nurses as defined by oncology nurses. Themes from their responses will be compared to what current evidence suggests as best practice indicative of the need for a structurally empowered environment.

**Empowerment structures.** According to Johnson, Billingsley, May, Costa, & Hanson (2004), the health care industry of the late 1970s and '80s struggled to find a solution to the immense public health threat of an inadequate supply of quality professional nurses. In order to determine how to provide this needed supply, efforts led to research focused on finding why certain institutions were not being impacted by nursing turnover. The original Magnet research study looked at organizations, which during the nursing shortage of the '70s and '80s were able to retain nurses (McClure, Poulin, Slovie, & Wandelt, 1983).

The Magnet study sought to explore two things:

1. What are the important variables in hospital organizations and their nursing services that create a magnetism that attracts and retains professional nurses on its staff?
2. What particular combination of variables produce model(s) of hospital nursing practice in which nurses receive professional and personal satisfaction to the degree that recruitment and retention of qualified staff are achieved?

(McClure et al., 1983).

The goal was set to explore the factors associated with success in attracting and retaining professional nurses. Forty-one hospitals from across the country were selected to participate in the study based upon perceptions of great work environments and low retention rates. Focus-group interviews were held with RN and Chief Nursing Officer (CNO) representatives from each nominated hospital. The RN and CNO interviews were held in different geographical areas, according to the regional location of the institutions, on the same day, and the RN and CNO focus groups were separated. The findings helped

facilitate the identification of a set of hospital characteristics that appeared to account for attracting and retaining nurses at select institutions at a time when other hospitals were not able to do so. They found that these hospitals all shared similar characteristics.

These “best practice” environments for nurses provide: (a) quality nursing leadership; (b) opportunities for education, development, and advancement; (c) adequate numbers of human resources, such as staffing and flexible scheduling; (d) flat, decentralized shared decision making; (e) collaborative interdisciplinary relationships and team work; (f) competitive benefits and career advancement; (g) quality improvement infrastructures based on evidence-based practice and research; and (h) meaningful recognition of nurses’ valuable contribution to care, including pay/reward for performance (Kramer, Schmalenberg, & Maguire, 2010).

There has been continued research comparing Magnet and soon-to-be Magnet hospitals with non-Magnet hospitals. Most studies are supportive of the Magnet influence, but others have not found significant differences in outcomes (Armstrong & Laschinger, 2006; Hess, DesRoches, Donelan, Norman, & Buerhaus, 2011; Laschinger, Almost, & Tuer-Hodes, 2003). Laschinger et al., (2003) performed a secondary analysis of three studies, two surveyed staff nurses and one surveyed nurse practitioners (NPs). Findings revealed that nurses were most satisfied with an environment that provided a combination of access to empowering work conditions, such as information, support, and resources, along with Magnet hospital characteristics such as autonomy, control over practice, and positive nurse-physician relationships.

Armstrong & Laschinger’s 2006 study utilized questionnaires and survey instruments to test for environmental and Magnet characteristics. Findings showed that

Magnet-like characteristics such as structures of empowerment (access to information, resources, and support) and strong nursing leadership, were significant predictors of staff nurses' positive perception of a patient-safety climate. "These conditions encourage a patient-centered care approach, which would support a strong patient-safety culture" (Armstrong & Laschinger, 2006, p.126).

Hess et al. (2011) surveyed Magnet, Magnet in process, and non-Magnet hospital nurses using data from the 2010 National Survey of Registered Nurses. Nurses in Magnet hospitals and those in the process of applying for Magnet status rated higher in their ability to: influence the workplace organization, participate in shared governance, and gain support for continuing education. Minimal impact of Magnet-status hospitals was found in nurses' satisfaction with their role, their view of their work environment, and relationships with physicians and nurses. There were also no statistical differences in how they viewed their opportunities to influence decisions about patient care (Hess et al., 2011).

The number of hospitals with Magnet status has been rapidly growing from 18 in 2000 to 370 in 2010 (Abraham, Jerome-D'Emilia, & Begun, 2011). The initial Magnet application can cost up to approximately \$70,000, and significant financial resources are also needed to put required structures into place. Hospitals that seek Magnet status tend to have extra resources, both human and financial, which allow for major structural and process changes (Abraham et al., 2011). There are few or no regulatory incentives or barriers to hospitals that choose to adopt Magnet status (Abraham et al, 2011). However, market forces, such as population growth and the increased demand for care, result in an increased demand for nurses. Magnet designation may improve an organizations'

attractiveness as an employer. Adoption of the Magnet status is influenced by a need to compete for patients and/or nurses (Abraham et al., 2011). In order to qualify for Magnet designation, organizations need to show evidence that the described “magnetic” structures are in place. The organizations are assessed through an evaluation of supportive documentation and a site visit by external Magnet consultants (ANCC, 2015).

**The nursing workforce and health care.** The Institute of Medicine (IOM) was established in 1970 as a branch of the National Academies of Sciences. As an independent non-biased authority, it advises decision makers and the public on issues relating to health care. Congress, federal agencies, and some independent organizations utilize the IOM as a channel for research studies (IOM, 2013). For example, the IOM’s Quality of Health Care in America Committee was formed in June 1998. Its goal was to develop a strategy that would result in improvement in quality health care by 2008 (IOM, 1999; IOM, 2001). Its first report, *To ERR is Human*, focused on patient safety, error rates, nurse-physician communication, and quality of care delivery (IOM, 1999). The report found that lack of collaboration and communication in health care has led to medical errors resulting in injuries and deaths (IOM, 1999). In this landmark report, the IOM highlighted studies on medical errors, reporting 44,000-98,000 deaths per year. Errors highlighted in the review included deaths from drug errors, chemotherapy overdoses, and wrong-site surgery (IOM, 1999). Two studies using large samples of hospital admissions, one in New York, and one in Colorado and Utah, reported a rate of preventable adverse events at 58% in New York and 53% in Colorado and Utah (Thomas, Studdert, Newhouse, Zbar, Howard, Williams, & Brennan, 1999). The IOM, based on the findings from this report, encouraged individuals in charge of the delivery

and oversight of care in hospitals to establish a national focus to enhance a knowledge base about safety.

A recommended national agenda for reducing errors in health care and improving patient safety was laid out (IOM, 1999). Recommendations were made for using reporting systems to identify and learn from errors. Raising standards and expectations for improvement in safety was emphasized. These actions were aimed at creating safe systems through the implementation of safe practices at the point of care (IOM, 2001).

The IOM's (2001) second report, *Crossing the Quality Chasm*, states that health care harms patients too frequently. Changes in public health care needs, demographics, health care delivery systems, and technology has produced not only a gap, but a chasm, between the health care system we now have and the health care system we could have. It emphasized that all health care entities should pursue six goals. Health care should be safe, effective, patient centered, timely, efficient, and equitable. The report reinforced the need for collaboration and communication between organizations and clinicians. It promoted a free flow of information, effective communication, and information sharing among patients and clinicians (IOM, 2001).

The IOM (2001) proposed 10 rules for health care redesign:

1. care is based on continuous healing relationships,
2. care is customized to individual patient needs and values,
3. the patient is the source of control,
4. knowledge is shared and information should flow freely,
5. decision making is evidence based,
6. health care system should take ownership of safety,

7. transparency among caregivers and patients is needed,
8. patient needs should be anticipated,
9. waste is continuously decreased,
10. cooperation among clinicians is a priority.

The 21<sup>st</sup> century health care environment is experiencing a multitude of changes. These changes include increases in regulations (Buerhaus, DesRoches, Applebaum, Hess, Norman, & Donelan, 2012; IOM, 2011), technology (IOM, 2012, 2013a), and patient acuity (AHRQ, 2004). Challenges to health care delivery also include an aging and diverse patient population (IOM, 2011), a retiring workforce, and ongoing nursing shortages (IOM, 2011). Cancer care is also impacted by similar barriers. There are 14 million cancer survivors in the United States, and 1.6 million people are diagnosed with cancer each year. Despite recommendations and initiatives from the IOM, barriers to quality and efficient cancer care still exist (IOM, 2013a). These barriers include an aging patient population, work force shortages, fragmented and poorly coordinated care, rising cancer care costs, increased complexities of treatments, and few tools for improving quality of cancer care. Tools that are lacking include quality metrics, practice guidelines, and adequate availability or use of information technology (IOM, 2013a).

**Regulatory impacts.** The Affordable Care Act (ACA) was passed by Congress in 2010 and upheld by the Supreme Court in 2012. Many changes to the structure and function of health care delivery are expected. These changes to the health care system will impact the nursing profession and the role of the nurse in the delivery of quality care (Buerhaus et al., 2012). The ACA is expected to implement initiatives that will have an impact on current workflows within organizations. These hopes to enhance the alignment

of goals of care, improve coordination of care, and facilitate patient's journey through the care continuum (Buerhaus et al., 2012). The need to strengthen nurses, to become partners and leaders in improving the delivery of care and the health care system as a whole inspired a partnership between the IOM and the Robert Wood Johnson Foundation (RWJF).

The United States is at an important crossroads as health care reforms are being carried out and the system begins to change. Nurses are vital to the realization of the goals set by the 2010 Affordable Care Act (IOM, 2011). The Robert Wood Johnson Foundation (RWJF) is the largest philanthropic institute in the United States dedicated to health care initiatives. In the last 40 years, the RWJF has devoted itself to the improvement of health and health care. The IOM and the Robert Wood Johnson Foundation (RWJF) noted that in addition to previously mentioned barriers, poor nurse-physician collaboration and RN educational levels may also impact the nurses' abilities to be agents for change. The RWJF was a co-creator of the IOM. The IOM and RWJF were in agreement that accessible, high-quality care could not be achieved without exceptional nursing care and leadership. In 2008, the IOM and RWJF launched a two-year initiative in response to the need to assess and transform the nursing profession. The partnership between these two organizations sought to bring more credibility and visibility to the topic. The organizations merged staff and resources in order to explore the challenges that are central to the future of the nursing profession. (IOM, 2011).

The key recommendations that have come from this initiative are: (a) nurses should be able to practice within the full extent of their education and licensure; (b) nurses should achieve higher levels of education and training and develop skills in

leadership, health care policy system improvement, evidence-based practice, and teamwork and collaboration; (c) nurses should be full partners with physicians and other health care professionals in redesigning US health care by participating in problem identification, development and implementation of improvement measures, and engaging in shared decision making; and (4) systems need to be put into place to improve data gathering and data communications relating to workforce and workforce needs (IOM, 2011).

**Information technology (IT).** IT plays an important role in improving the quality of cancer care delivery, patient health, cancer research, quality measurements, and performance improvement. “Health IT positively influences the dissemination of information for patient education, care decision making by health care personnel, data collection and usage in research, and offers a venue for clinicians to monitor and utilize health care outcomes data” (IOM, 2013a, p. 235). The collection of outcome data serves as a tool for implementing changes in patient care delivery and organizational structures that will result in performance improvement (IOM, 2013a). The need for the increased use of health information technology has been recommended through the years. Health information technology, when used appropriately, can positively impact patient outcomes. When it is not used appropriately, it can have an adverse effect on patient safety. Nurses and other health care professionals have the greatest responsibility for the daily use of these health care technologies. They are expected to have the knowledge base in its utilization, and they are expected to safely incorporate it into their practice. The users’ input on design and implementation is vital (IOM, 2012).

**Patient acuity.** New medical advances and technologies, combined with a declining average length of stay, have led to increases in the amount of care required by patients who are in the hospital. These technologies have shifted immediate post-surgical care to the outpatient setting. Less seriously ill patients are being sent home sooner. Patients who, in the past, would have recovered in the hospital, are discharged today to skilled nursing facilities or to their homes. During the period 1980-2000, the average length of an in-patient hospital stay fell from 7.5 days to 4.9 days. This results in a higher overall concentration of sick people in hospitals who need more care and exhibit higher patient acuity levels (AHRQ, 2004). This type of care needs to be provided by skilled nurses who give input into the plan of patient care. According to Aiken, Cimiotti, Sloane, Smith, Flynn, & Neff, (2011), every 10% increase in the number of bachelor degree or higher prepared nurses, there is an associated 5% decline in mortality and failure to rescue following common surgical procedures.

**Aging and diversity.** The U.S population aged 65 and older is expected to rise from 12.7% in 2008 to 19.3% in 2030. With it will come increased chronic conditions such as diabetes, hypertension, and cardiovascular disease. Minority groups are projected to be in the majority by 2042, and by 2050 today's minority populations will comprise 54% of the total population. Aiken (2005) found a 30% difference in mortality rates when nurse/patient ratios were doubled from 1:4 to 1:8. With 900,000 nurses over the age of 50, there are concerns about whether there will be enough nurses and diverse types of nurses available to meet the demand of the growing patient population (IOM, 2011).

**Quality of care delivery and environment.** Buerhaus et al. (2012) reported on the 2010 National Survey of Registered Nurses. The survey was conducted by mail from

May through August 2010. The survey, which was sent to a random sample of 1500 nurses, sought to see how well nurses were positioned and prepared to face the challenges of the 21<sup>st</sup> century reforms and initiatives. Comparing these results with previous surveys, which had been administered two years earlier, they hoped to demonstrate either deterioration or improvements in the nursing workforce. Workforce characteristics explored included the quality of the health care environment, staffing, nurses' views of payment policies (pay for outcomes), and health reform. "Results of this program of survey research offer a picture of registered nurses' capacity to practice successfully in a care delivery environment that, over the current decade, is expected to emphasize teams, care coordination, and which has become driven increasingly by payment incentives that reward quality, safety and efficiency" (Buerhaus et al, 2012, p. 319).

The Buerhaus et al. (2012) National Survey of Registered Nurses 2010 results indicated that 80% of the nurses felt that their hospital frequently or often provided patient-centered care that was equitable, safe, effective, and efficient. Twenty-five percent of the nurses surveyed felt their work place environment offered opportunities to influence organizational decisions. Thirty-three percent of the nurses reported that their environment offered opportunities for participation in decisions about patient care. These results were noted as significant increases in ratings from prior years. There were no reported improvements in RN relationships with physicians in the studies in the past 10 years. Only about one in 10 nurses rated their relationship with physicians as either very good or excellent. Career satisfaction was rated significantly higher in 2010, at 57%, compared to 35% in 2002. Job satisfaction tripled from 13% to 40%. Two-thirds of nurses felt that staffing ratios would have a positive impact on care. One-half of the

nurses supported mandated staffing ratios. Of the RNs surveyed 40% perceived increases in education and training opportunities, 69% saw increased in their workload, and eight in 10 RNs (79%) noted an increase in quality improvement initiatives designed to prevent what are now being called “hospital-acquired never conditions”, or adverse events that should never happen .

**Collaborative partnerships.** The role interactions of nurses and doctors have been studied were studied by Stein (1967). The infamous “doctor-nurse game” was first coined by Stein in 1967. The game entails a nurse making recommendations for care or medical decisions, while at the same time, allowing the recommendation to appear as if it was initiated by the physician (Stein, 1967). “The nurse must communicate her recommendations without appearing to be making a recommendation statement; the physician, in requesting a recommendation from the nurse, must not appear to be asking for it” (Stein, 1967, p. 699). This game was taught early in schools of medicine and nursing; the physician was taught he was in control, the nurse was taught to be subservient and to follow orders. The nurse’s knowledge of what these patients required had to be disguised, so as not to insult the physician (Stein, 1967). Undergraduate socialization in schools of medicine and nursing promoted these hierarchal behaviors and divisions among professions (Stein, 1967; Stein, Watts, & Howell, 1990).

Stein et al. (1990) revisited the nurse-doctor game theory and found that social changes had modified this phenomenon. Toward the end of the 20<sup>th</sup> century, nurses viewed themselves as professionals in their own right and were now looking for autonomy and respect for their expertise. The current media was portraying nurses as strong role models and resources to physicians in television series such as *St. Elsewhere*

and China Beach. Gender issues were evolving with women entering the medical field and men entering nursing. However, health care professionals continued to engage in activities that maintained traditional hierarchal models and controlled or challenged boundaries to maintain or obtain power (Stein et al., 1990).

Witz (1992) explored the concept of power and its relation to professional closure. When exploring patriarchal practices in the workforce, and the concepts of exclusion, inclusion, demarcation, and dual closure; Witz noted that professions engaged in activities that maintain traditional hierarchal models. These activities tended to control or challenge boundaries in order for individuals to maintain or obtain power. In these instances, individual knowledge and skills are protected by boundaries, they are not shared, and they diminish collaborative practices (Witz, 1992). The promotion of collaboration and mutual decision making was non-existent.

Much of these power struggles still exist today. Care inefficiencies and power struggles result from nurses lacking the needed power and autonomy over their practice (Blanchfield & Biordi, 1996). Pronovost and Vohr (2011) discussed the circumstances surrounding the death of Josie King in 2001, an 18-month old victim of medical errors:

The nurses said they tried to voice their concerns up the chain of command, but no action was taken. The way communication was organized . . . during that time did not make it easy. Nurses would have to talk to residents, who then passed the message on to chief residents or fellows, who then would have to talk to the attending surgeons. It is common for the opinions of lower levels of hierarchy to be discounted and often ignored by higher ups . . . if someone jumps rank, or seeks approval . . . outside of the chain or in any way circumvents this hierarchy;

the penalty is often public humiliation and reprimand. In these ways a critical message can get tangled and lost in a complex archaic culture that puts patients at risk (Pronovos & Vohr, 2011, p. xv).

Josie's death illustrates that the lack of collaboration and communication in health care leads to medical errors, resulting in injuries and deaths.

Improving collaboration and communication among health care providers requires organizational changes that would support collaborative practices and promote interdisciplinary communication and education (Conway, Little, McMillan & Fitzgerald, 2011). Collaborative practice entails nurses and doctors impacting patient-care outcomes through a team-based approach, which utilizes shared knowledge and skills. A supported interdisciplinary approach to health care delivery may result in improved care coordination, less duplication of services, and improved patient outcomes (Conway et al., 2011). Failure to change current organizational structures results in interprofessional jealousies and boundaries (Conway et al.).

Conway et al. (2011), through a consultancy project, developed a framework for ongoing professional development and identified core competencies for collaborative learning. They examined a health care delivery system in Australia, known as the Community, Aged care, Rehabilitation, and Education Network (CARE Network). The staff of the CARE Network consisted of an interdisciplinary group of representatives from medicine, nursing, occupational therapy, social work, and physiotherapy. There were two phases to their project, the first was to gather data from the staff to explore structures, roles, and functions of the care teams and examine participants' perceptions of educational needs related to the clinical service care delivery. Workshops, interviews and

six focus groups were conducted comprising a variety of representations from each role category. The data sets led to a consensus on emergent themes. The stakeholders sought a framework that would enhance person-centered clinical practice, support-staff clinical competence, establish standards and guidelines for education and training, and ensure that service delivery matches the philosophy and values of the CARE Network. The second phase consisted of developing core competencies. The staff identified these as providing person-focused care, having a multi-professional client management approach, using an evidence-based approach to care, engaging in creative problem solving, engaging in ongoing professional development, and accepting shared responsibility for the CARE Network (Conway et al., 2011).

Improvements in collaborative practice have depicted nurses and doctors working together and using shared knowledge and skills to positively impact patient care outcomes and staff satisfaction (Clark, 2009; Kramer & Schmalenberg, 2003). Shared governance structures are one of a few nursing care models that provide a forum for nurse empowerment (Barden, Griffin, Donahue, & Fitzpatrick, 2011, Houston, Leveille, Luquire, Fike, Ogola, Ogola, & Chando, 2012).

In 1998, the ANA established the National Database of Nurse Quality Indicators (NDNQI). The goal of the NDNQI is to promote and facilitate the standardization of information submitted by hospitals across the United States on nursing quality and patient outcomes (ANA, 2013). It serves as a repository for data, and it is a resource for hospitals to measure and benchmark their levels of nursing-sensitive indicators with other similar institutions. NDNQI reports are provided at the unit level and hospitals can benchmark with units that are of similar specialty and size. Comparing their own outcomes with

peers motivates staff to improve their outcomes (Luquire & Strong, 2011). Examples of this include a decrease in hospital-acquired pressure ulcers from 40% to 11% within 90 days at a hospital's ICU (Morehead, as cited in Luquire & Strong, 2011), and reported increases in patient satisfaction from the 9<sup>th</sup> to the 99<sup>th</sup> percentile in an emergency department (Powell, as cited in Luquire & Strong, 2011).

Nursing-sensitive indicators reflect the structure, process, and outcomes of nursing care (ANA, 2013). The structure is defined by the number, the skill set, and the education and certification levels of the nursing staff. Nursing care, such as assessment, intervention, and RN job satisfaction, are indicative of the process of nursing care.

Nursing-sensitive indicators also measure nurses' perceptions of the resources available to them, which impact patient care delivery and job satisfaction. The indicators explore professional relationships and nurses' access to information, shared decision making, autonomy, and supportive leadership. Hospitals may utilize the surveys developed by the NDNQI to assess gaps in care delivery or organizational structure. Many institutions looking to improve their outcomes, and institutions striving for Magnet recognition, participate in the NDNQI (ANA, 2013).

The Magnet model provides a framework for the future of nursing practice and research. Within the Magnet model, the transformational leader is seen as the one who provides a structurally empowering environment that allows for nurses to practice autonomously and to the best of their capabilities using the newest evidence, technology, and resources to deliver quality, measurable patient care, which leads to better patient outcomes (ANCC, 2015). Transformational leaders facilitate changes to organizational values, beliefs, and behaviors in order to optimize organizational success. They can

envision where the organization needs to be and can even engage reluctant followers. The leader and the follower relationships evolve to a point where they share in mutual learning opportunities and establish shared values and beliefs (Drenkard, Wolf, & Morgan, 2011).

A collaborative and effective team-work environment, where the roles and contributions of all are appreciated, promotes safe patient care and more satisfied employees. An environment that promotes a sharing of resources allows team members to accomplish mutual goals. Clark (2009) stated that “team work thrives when teams can share their knowledge, skills, expertise, and information, develop interpersonal relationships, and address team issues” (p. 223). This requires a leader who would promote equity, communication, and shared decision making among its members (Clark, 2009, Kramer & Schmalenberg, 2003).

Unlike yesterday’s leadership requirement for stabilization and growth, today’s leaders must transform their organization’s values, beliefs, and behaviors. “It is relatively easy to lead people where they want to go; the transformational leader must lead people where they need to be, in order to meet the demands of the future” (ANCC, 2015, Transformational leadership, para. 1).

### **Problem Statement**

Nurses’ proximity to patients, and their scientific knowledge and understanding of the process across the continuum of care, gives them the opportunity to act as full partners with other health care professionals. It is imperative that they assume a leadership role in the improvement and redesign of the health care system and its practice environment (IOM, 2011).

New health care legislation will bring access and health care coverage to millions of Americans. This new access will place an increased demand on the current health care system. The increased access to health care and an aging patient population will result in an increasing demand for growth in health care services (IOM, 2011).

The current nursing shortage is a global issue that affects many nations (Brennan & Daly, 2009; Twigg & McCullough, 2013). Twigg and McCullough (2013) reported a global estimated shortage of 4.3 million doctors, midwives, nurses, and support personnel. In the United States, a deficit of 285,000 nurses is expected by 2020, and 500,000 by 2025. This deficit will be due, in part, to a retiring workforce whose current average age is 43.4, and a decrease in younger women choosing nursing as a profession (Buerhaus, Staiger, & Auerbach 2008). Nurse leaders are faced with the challenge of ensuring adequate nurse staffing, in order to provide high quality care to patients, within the constraints of an aging population, a nursing shortage, and rising health care costs (Brennan & Daly, 2009).

Nursing practice, according to the IOM (2011), encompasses health promotion, disease prevention, and care coordination toward a goal of cure or end of life. The role of nursing is matched to the needs of the future consumer of health care. Nurses have a direct effect on patient care and are on the front line to ensure that this care is delivered in a safe, effective, and compassionate manner (IOM, 2011).

Aiken et al. (2011) looked at outcomes from 665 hospitals in four large states. They linked the data from hospital discharge notes, randomly selected nurses' feedback, and American Hospital Association data. Findings showed that patient deaths were lower in organizations that not only provided low nurse-to-patient ratios, but also provided

good work environments and employed nurses with higher levels of education. The low nurse-to-patient ratios, alone, did not improve outcomes. Aiken et al. supported that these “good” work environments were reflective of Magnet-like structures. The Aiken et al. study outcomes support recent IOM recommendation for increasing the number of baccalaureate nurses from 50 to 80% by 2020 and also support the ANCC and IOM’s recommendations for good work environments (ANNC, year; IOM, year).

All nurses recognize their work as stressful and emotional, yet they feel that, overall, it is satisfying, rewarding, and meaningful. The work of nursing requires addressing many relationships. These can be therapeutic, collegial, and professional in nature. Bakker et al. (2013) looked at the context of the oncology nursing practice. Its uniqueness was determined to be due to the complexity of cancer control and the therapeutic relationships these nurses formed with their patients and families. As with all nursing workplaces, oncology environments have been impacted by health care restructuring. The nature of oncology nursing includes daily exposure to pain, suffering, and loss. In their systematic review, Bakker et al found that oncology nurses reported that their relationships with the patients and families were strong and rewarding. Oncology nurses’ relationships with physicians scored higher when compared to relationships between nurses and physicians who work in non-oncology settings. Clarity with what the nurse’s role is within the interdisciplinary relationship was still challenging.

The development of a healthy and empowering work environment has been shown to require strong nursing leadership at all levels within an organization, in particular, at the point of care or unit level where patient care is delivered (Sherman & Pross, 2010). Transformational leaders need to have the vision, influence, clinical

knowledge, and strong expertise relating to the professional nursing practice. A transformational leader needs to seek innovative approaches to transform an environment during times of change and turmoil. “They must enlighten the organization as to why change is necessary, and communicate each department’s part in achieving that change. They must listen, challenge, influence, and affirm as the organization makes its way into the future” (ANCC, 2015, Transformational leadership, para. 3).

### **Theoretical Rationale**

Nurses need power to effectively work collaboratively with colleagues, patients, and physicians and to influence improvements in health care delivery (Manojlovic, 2007; Manojlovic & Laschinger, 2002). Manojlovich (2007) mentioned three types of power that are needed by nurses in order for them to contribute to their work. These needs stem from three domains: control over content of practice, control over context of practice, and control over competence. Empowered nurses demonstrate increased effectiveness in the delivery of care and in their role. This sense of empowerment is enhanced when nurses are given the recognition and opportunity to have a shared sense of voice and decision making when it comes to their practice environment.

**Kanter’s theory of organizational structural empowerment.** Kanter’s (1977) organizational structural empowerment theory will form the conceptual framework for this study. The concept of organizational structural empowerment was first introduced over 30 years ago after a five-year study, which was reported in Kanter’s seminal work, *Men and Women of the Corporation* (Kanter, 1977). The five-year study took place at a large industrial corporation and speaks to organizational behavior and empowerment. Kanter’s theory proposes that a leader’s effectiveness on the job is influenced by the

structural aspects of a work environment that provides access to formal and informal power. A structurally empowered work environment offers access to information, support, resources, and opportunity to all employees (Kanter, 1993).

Kanter's ethnographic case study of an organization, which was anonymously referred to as "Indsco," sought to not only to report empirical data but also to search for an explanation and a theory (Kanter, 1977, 1993). "I was interested in understanding a complex social reality and its impact on the people who experienced it. I wanted to develop concepts that would make sense out of actions of people located in different parts of organizational worlds" (Kanter, 1993, p. 418). Kanter gathered quantitative and qualitative data through surveys, interviews, focus groups, observations, document reviews, and one-on-one conversations with participants, to examine organizational structures.

Kanter (1977, 1993) found that the empowerment-structured organization leads to increased autonomy, job satisfaction, and commitment among employees. Kanter identified three variables of structural behavior in organizations: (a) the structure of opportunity, (b) the structure of power, and (c) the relative number of people based on their size and social composition. Most people are found to work in hierarchal systems that define who or which roles have the capacity for mobility and opportunity for growth or change. These systems also define a network of power relationships. This is individual power that goes beyond the power allocated to a particular position or title. The distributions of social types or characteristics define population the make-up of the workforce (Kanter, 1977, 1993).

*Sources of power.* According to Kanter (1997, 1993), organizations that empower are those that can supply the access to information (decisions, data, technology), support (feedback, guidance), resources (money, supplies, time) and opportunities (mobility, growth, participation on committees) to get the work done. Kanter's theory of structural empowerment speaks to power as developing because of access to an organizational structure of power (Kanter, 1993). People need to have the right position and the right responsibilities. Power is gained by participating in activities that meet three criteria: extraordinary, visible, and relevant (Kanter, 1993). Kanter's theory encouraged employees to go beyond the norm and to do the unexpected. It encouraged them to participate in opportunities that exhibit the credibility, importance, and the value of their work. Effectiveness of and accountability for outcomes is increased when people feel ownership of the work (Kanter, 1993).

Kanter's views on structural empowerment have been supported and tested within the nursing and health care literature (Manojlovic, 2007; Manojlovic & Laschinger, 2002, Upenieks, 2002). Kanter's theory of structural empowerment helps to inform the exploration of health care organizations, the organization's influence on nurse empowerment, and its impact on nurses' and organizational outcomes. His work has informed major works on power and the power of nurses (Manojlovich, 2005, 2007; Laschinger, Gilbert, Smith, & Leslie, 2010). It has influenced studies linking structural empowerment to leadership effectiveness (Upenieks, 2002, 2003). It has served as a foundation for studies in nursing education and leadership program development (Ledwell, Andrusyszyn & Iwasiw, 2006; MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2011). Kanter's theory has been tested to link workplace empowerment to

Magnet hospital characteristics and job satisfaction (Laschinger et al., 2003). It has also impacted studies relating to patient safety (Armstrong & Laschinger, 2006; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

Stemming from Kanter's theory is the role of the transformational leader who facilitates this empowered structure (ANCC, 2015; Kanter, 1993; Upenieks, 2003). It takes a transformational leader to lead an environment that is structurally empowering (ANCC, 2015). This study will concurrently address the concept of transformational leadership and how it relates to structural empowerment.

***Transformational leadership.*** Kanter emphasizes that a leader must empower the organization and its employees. A leader with power, promotes power (Kanter, 1993). Nursing research has integrated the theories of structural empowerment and transformational leadership (Laschinger & Smith, 2013; Patrick, Laschinger, Wong, & Finegan, 2011).

Laschinger and Smith (2013) integrated Avolio's (2011) authentic leadership theory and Kanter's (1977) theory to examine new graduate nurses' perception of the influence of transformational and authentic leadership and structural empowerment on the quality of interprofessional collaboration in health care environments. Their study suggested that authentic transformational leadership and empowerment may be fundamental resources that influence interprofessional collaboration. Authentic leaders are positioned to integrate new graduate nurses into the interprofessional team and to promote their work and voice in decision making as it relates to patient care delivery. They indicated that positive collaborative experiences may lead to higher quality and less fragmented care.

Patrick et al. (2011), integrating Kouzes & Posner's 2007 model of transformational leadership and Kanter's 1977 theory, hypothesized that staff nurses' use of clinical leadership behaviors could be positively related to their nurse managers' use of Kouzes & Posner's five transformational leadership practices, which are modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart (Kouzes & Posner, 2007). An indirect impact of nursing leadership on staff nurses' clinical behavior was found by Patrick et al (2011). Staff nurses' clinical leadership behaviors were found to be influenced by their exposure to structurally empowering work environments, which were perceived as a result of their manager's leadership practice (Patrick et al., 2011).

### **Statement of Purpose**

The purpose of this research is to gain insight into nurses' definition of structural empowerment, their perceptions of current structures, and the type of environment oncology nurses need in order to feel empowered and have a voice in organizational and patient care decision making.

The department of nursing at this major oncology teaching hospital is currently based on a shared governance model. Direct-care nurses have an opportunity to chair and co-chair, and have membership in, committee and council structures that provide a forum to facilitate their voices on issues with regard to education, care delivery, patient safety, performance improvement, recruitment, retention and recognition of staff.

Using Kanter's 1977 theory of organizational structural empowerment as a foundation for the study, qualitative semi-structured individual interviews with oncology nurses sought to explore the experience of nurses working in a major oncology teaching

hospital. Specifically, the interviews explored nurses' perceptions of structural empowerment, their current structures of empowerment, and their perceptions on structural empowerment's ability to impact nurses' delivery of quality care. Their perceptions of having the information, resources, and opportunities for shared decision making, autonomy, and authority over their practices were also be explored.

### **Research Questions**

An assumption, based on Kanter's (1977) organizational structural empowerment theory is that this type of environment may provide nurses with the support, autonomy, authority, voice, and the resources to deliver quality, evidence-based care. Demands for restructuring health care delivery provides the opportunity for the nursing profession to change the practice of nursing and increase nurses' power bases (Blanchfield & Biordi, 1996). Peltomaa, Viinikainen, Rantanen, Sieloff, Asikainen, & Souminen (2012) posited that nurses need to increase their power base in order to optimize their contribution to safe delivery of health care.

Using Kanter's (1977) theory of organizational structural empowerment as a foundation, qualitative, semi-structured individual interviews with oncology nurses sought seek to explore the lived experience of nurses working in an oncology teaching hospital (Appendix A). The research questions for this study are:

1. What are oncology nurses' perceptions of structural empowerment?
2. How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done?

## **Potential Significance of the Study**

“In the United States, approximately 14 million people have had cancer and more than 1.6 million new cases are diagnosed each year” (IOM, 2013a, p. 1). A new call to address this system in crisis was made. The IOM, in 2012, convened a committee of cancer-care experts to assess the current quality of cancer care in the United States. They found that the quality of cancer care still requires much improvement and removal of barriers that affect health care delivery. Recommendations for improvement were made (IOM, 2013a). This study will contribute to two of the six interconnected components addressed in the IOM’s recommendations for improvement of care, which are:

1. provision of an adequately staffed, trained, and coordinated workforce, and
2. translation of evidence into clinical practice, quality measurement, and performance improvement.

Leadership characteristics and environments, which are structurally empowering, have been linked to improved staff satisfaction, engagement, and healthy work environments (Gilbert, Laschinger, & Leiter, 2010; Greco, Laschinger & Wong, 2006; Peltomaa et al., 2012). Additional knowledge gained from this study may have the potential to influence organizational structures. Clarity in what nurses deem empowering and healthy work environments may give nurse leaders the foundation and tools to implement processes to provide this environment.

As the movement to keep patients safe progresses, the inclusion of practice environment measurements in future research was recommended (Friese, 2005; Friese & Manojlovich, 2012). These include populations and samplings that would aid in detecting differences in practice environments by clinical specialty (Friese, 2005; Friese &

Manojlovich, 2012). Friese (2005) examined the practice environment and outcomes of nurses working in oncology units. He found significant differences between oncology and non-oncology nurses with regard to perceptions of the practice environment and nurse-physician collaboration. A recent systematic review has shown that most studies relating to nursing workplace empowerment and job satisfaction, have been conducted by Laschinger et al. in Ontario, Canada (Cicolini, Comparcini & Simonetti, 2013). Recommendations were made to study this topic in other countries. This results from this study will contribute to oncology-specific nursing and leadership research in the United States.

### **Definition of Terms**

*Accountability* – a practice that entails procedures and processes used by individuals and groups to justify and take responsibility for activity and actions (Larkin, Cierpial, Stack, Morrison, & Griffith, 2008).

*Authority* – legitimate power delegated to an individual (Blanchfield & Biordi, 1996).

*Autonomy* – the ability to implement power (Blanchfield & Biordi (1996). McDonald defines autonomy as “a privilege of self-governance” that allows professionals substantial control over their practice with significant room to exercise their judgement (as cited in Reid-Ponte, Creta, & Joy, 2011).

*Magnet Recognition Program®* – a program created by the ANCC that certifies health care organizations for meeting assigned levels of quality patient care, leadership, nursing excellence, and innovations in the professional nursing practice (ANCC, 2015).

*Nurse Manager* – the person with 24-hour responsibility for a unit or work group of nurses. His or her responsibilities include maintaining adequate staffing, scheduling, performing employee evaluations, and patient care standards and administrative policies (ANA, 2012). The institution for this study uses the title *Nurse Leader* in place of Nurse Manager.

*Nursing Leadership* – term used by the study institution to describe all of the nurses in leadership positions including Nurse Leaders, Directors, and Chief Nursing Officer.

*Primary Nursing* – A system for delivering nursing service that consists of four design elements: (1) allocation and acceptance of individual responsibility for decision-making to one individual; (2) assignments of daily care by case method; (3) direct person-to-person communication; and (4) one person operationally responsible for the quality of care administered to patients on a unit twenty-four hours a day, seven days a week.” (Manthey, 2002, p. 27)

*Power* – the ability to obtain for a group, subordinates, or followers, a favorable share of resources, opportunities, and rewards through an organization (Kanter, 1977).

*Relationship Based Care (RBC)* – a model of provision for what is necessary for the health, welfare, maintenance, and protection a patient that connects nurses, patients, and their loved ones. This model provides a framework that is individualized, organized, and personalized for the benefit of the patient and his or her family. It aims to effect change and transform the culture of hospitals (Koloroutis, 2004).

*Structural Empowerment* – access to the information, resources, support, and opportunity within the work setting (Kanter, 1977).

*Structural Empowerment (Magnet Definition)* – the ways in which the workplace environment supports professional engagement, commitment to professional development, teaching and role development, commitment to community, and recognition of nurses (Kercher & Harris, 2011).

*Structure of Information* – having the data, technical knowledge, and expertise needed to deliver efficient care to get a job done (Laschinger & Havens, 1996).

*Structures of Resources* –having the materials, personnel, funding, and time to get a job completed (Kanter, 1977).

*Structures of Support* – receiving feedback, leadership, and guidance from superiors and colleagues (Kanter, 1977).

*Structures of Opportunity* – a set of circumstances that provide growth, challenge, and advancement (Kanter, 1977).

*Shared Governance* – unit-based and/or hospital-wide council structures to ensure that staff nurses can control their practice and are accountable for quality patient outcomes. “Effective councils accomplish organizational goals through the active participation of staff in decision making activities” (Brody, Barnes, Ruble, & Sakowski, 2012, p. 28).

## **Chapter Summary**

This chapter presented the foundation of research that has shown that an empowering workplace environment impacts staff satisfaction, engagement, nurse and physician collaboration, and patient and organizational outcomes (Cummings et al., 2009; Manjolovich, 2007). According to Kanter’s (1993) theory of organizational structural empowerment, structurally empowering environments provide the support, information,

and resources that are needed to get accomplish goals. Through the lens of oncology nurses in a major oncology teaching hospital, this study sought to explore oncology nurses' overall perceptions of structural empowerment, the existence of empowering structures and nurses' perceptions of how current existing structures facilitate the delivery of safe, quality care.

Kanter's (1993) theory of organizational structural empowerment sets the foundation for this study and its research questions. This study, through a qualitative descriptive design using interview techniques, will explore nurses' perceptions of structural empowerment. The research questions addressed are:

1. What are oncology nurses' perceptions of structural empowerment?
2. How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done?

The study will be significant and contributory to health care administrators and policy while they plan the redesign of existing health care systems. Oncology nurse perceptions of what structurally empowering environments should look like may differ from those of nurse leaders. The study will also be significant in its contribution to oncology nursing literature.

A topical review of the literature, as it pertains to nurse power, structural empowerment, and leadership characteristics, will be presented in Chapter 2. In addition, the topical review of the literature will be related to the research problem, theoretical rationale, and research questions.

Chapter 3 details the interview design methodologies, research context, participants, data collection, and data analysis for the study. Chapter 4 presents the results

of the study, and Chapter 5 discusses the interpretation of the results presented in Chapter 4.

## **Chapter 2: Review of the Literature**

### **Introduction and Purpose**

The health care system has begun a decade of transitions that, for the nursing profession, promises to change the practice of nurses, expand current nursing roles and create new ones, and provide many opportunities for nurses to participate in shaping the future delivery system. With the passage of the Affordable Care Act (ACA) in 2010, care delivery and financing systems are undergoing significant transformations that will accelerate in 2014, when major provisions of the legislation are implemented (Buerhaus et al., 2012, p. 318).

Changes in the U.S. health care system also reflect increases in patient acuity and complexity of care delivery. There is an exponential recommendation for nurses to be recognized for their skill base, need for autonomy in patient care, and empowerment in participatory decision making (Blanchfield & Biordi, 1996; Kuokkanen, Leino-Kilpi, & Katajisto, 2003; MacPhee et al., 2011).

Blanchfield and Biordi (1996), basing their research on the theory of power, sought to measure the perception of staff nurse authority and autonomy through the lens of the nurse and the nurse leader. Their goal was to look for similarities or differences between these views. Authority was defined as legitimate power delegated to an individual, and autonomy was defined as the ability to implement that power.

Significant differences were found between nurses' and nurse leaders' perceptions of authority and autonomy and their importance. Nurses saw themselves as having

greater autonomy than was perceived by nurse leaders. The nurses' autonomy is thus lacking in what Blanchfield and Biordi (1996) deemed as "sanctioned power." This discrepancy in views, rooted in nurse leaders' lack of awareness of their staff members' autonomous acts, may lead to lack of leadership support.

Kuokkanen et al. (2003) studied nurses' self-perceptions of empowered characteristics and nurses' perspectives of what factors promote nurse empowerment. Their findings showed that job satisfaction, commitment to the job, and participation in professional activities strongly correlated with feeling empowered. The need for nurses to have real influence and decision-making power over issues concerning their work was emphasized. Recommendations were made for a "best practice" environment that promotes a less hierarchical structure, team work, and a transformational leader, which then provides the means and resources necessary for nurse empowerment (Kuokkanen et al., 2003).

MacPhee et al. (2011) evaluated a leadership program that aimed at developing leadership skills using the theory of empowerment as a framework for program development. They believed that if nurse leaders learned to use structural and psychologically empowering strategies, it would result in safer work environments and better nursing outcomes. The nurse leaders' application of learned strategies, which included implementing information sharing and participatory decision making, made it possible to empower nurses (MacPhee et al., 2011).

Organizational structures and nursing leadership that foster nursing practice and are professional and autonomous have been shown to increase nurse empowerment.

Empowerment, as an intervention, has been shown to increase the satisfaction of frontline employees (Larkin et al., 2008; Upenieks, 2003).

Larkin et al. (2008) presented the use of shared governance models and collaborative governance structures in hospitals. These models and structures were designed to optimize nurses' control over their own practice. The researchers emphasized participation and communication within and across disciplines. Larkin et al. presented four guiding concepts that support a collaborative (shared) governing structure. These concepts include equity, ownership, partnership, and accountability. Equity symbolizes a mutual respect for an individual's participation toward a common goal. Ownership describes the recognition by an individual employee of the impact he or she has on the success of the organization. Partnership relationships influence the achievement of organizational goals, and accountability is assumed for individual and collective decisions and performance (Larkin et al., 2008).

Collaborative (shared) governance is designed so that it includes structures that promote a shared vision, participatory decision making, and common goals. It leads to a workforce that is committed, productive, and empowered. Nurses use this structure to make choices and decisions as long as they have the information and knowledge to do so (Erickson, Hamilton, Jones, & Ditomassi, 2003). The practicing clinician, in this type of environment, is given the authority, responsibility, and accountability for the care of patients in an environment that is collaborative and respectful of the contributions of its team members (Erickson, Jones, & Ditomassi, 2012).

A supportive leadership environment, which allows nurses to speak up when patient safety may be a concern, increases nurses' perceptions of a collaborative

environment (Sayre, McNeeses-Smith, Phillips, & Leach, 2012). “Speaking up is defined as using one’s voice to make known to someone, with positional power or authority to take action” (Sayre et al, 2012, p. 458).

Sayre et al. (2012) implemented and evaluated a program that taught nurses how to speak up and advocate for patient safety. The program provided nurses with real-life patient scenarios. Built into these scenarios were opportunities for nurses to speak up to enhance safety. The program also provided a commitment by the chief nursing officer and the medical staff leadership to support the nurses for speaking up. Nurses, upon completing the program, felt more empowered to raise their concerns relating to patient safety. A supportive leadership can provide this transformative environment for nurses that would encourage them to speak up, in order to achieve the highest level of patient safety (Sayre et al., 2012).

There is a need for increased efforts by nurse leaders to provide nurses with consistent structurally empowering environments that promote a culture of safety (ANCC, 2015; Armstrong & Laschinger, 2006; Kanter, 1993; Kramer et al., 2010; Manojlovich, 2007). This type of organizational structure does not just happen, it must be supported by nurse leaders who are strong, who value nursing excellence, and who have the power to influence change (ANCC, 2015; Upenieks, 2003). A healthy and empowering work environment has been shown to require strong nursing leadership at all levels within an organization, in particular at the point-of-care or unit level, where patient care is delivered (Sherman & Pross, 2010).

Transformational and authentic leadership styles and characteristics are identified in the nursing literature as potentially influencing positive effects on nurse empowerment

and nursing and organizational outcomes (Laschinger & Smith 2013). The nurse-leader role is essential in promoting a professional practice environment that empowers nurses to participate in patient care decisions (Armstrong & Laschinger, 2006; Dechairo-Marino, Jordan-Marsh, Traiger, & Saulo, 2001; Laschinger & Smith, 2013; Manojlovich, 2005). Managers, however, are confused about the true meaning of empowerment and how to empower their subordinates (Fock, Hui, Au, & Bond, 2012).

In nursing, empowering and transformational leadership behaviors have been identified as optimally contributing to nurse satisfaction and feelings of empowerment (Kramer et al., 2004; Kramer & Schmalenberg, 2004). Nurses report characteristics of effective nurse leaders as those who provide the resources necessary to allow them to deliver effective quality care and to function autonomously, who provide opportunities for life-long learning, and who empower their staff to form collegial nurse and physician relationships (Kramer et al., 2004).

This literature review addresses the need for nurses to have an environment that provides opportunities for advancement, voice, and power in their role as a member of the health care delivery team. The concept of structural empowerment, its origins within sociology, and the feminist movement and its influence on the evolution of the work and image of nursing, will be discussed. The literature review addresses Kanter's (1977) theory of organizational structural empowerment, its connection to the role of the transformational leader in the promotion of a structurally empowering environment, and the influence that they both have on health care and the profession of nursing.

The theory of transformational leadership is analyzed from the viewpoints of Burns (1978), Bass (1999), Avolio (2011) and their colleagues and critics. The literature

review highlights how a transformational leader can impact organizational structures and functions to provide nurses with a structurally empowering environment.

The purpose of this research is to gain insight into nurses' definition of structural empowerment, their perceptions of current structures, and the type of environment oncology nurses need in order to feel empowered and have a voice in organizational and patient care decision making. It explores what nurses perceive as an effective, structurally empowering environment, which facilitates, for them, the delivery of safe and efficient care. Findings from this study may offer administrators with valuable insight into how to improve work environments in order to maximize nursing and patient outcomes.

## **Review of the Literature**

**Kanter's theory of organizational structural empowerment.** Kanter (1993) defined power as "the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet"( p. 215). Access to empowerment structures is associated with the degree of formal and informal power an individual has in the organization. Formal power is found in environments that promote flexibility, visibility, and creativity. Formal power is achieved through having a job that is recognized as valuable and indispensable. Informal power is developed from intercollaborative relationships with peers, followers, and superiors within and outside of an organization (Kanter, 1993).

Kanter's (1993) theory speaks not only to the empowerment of the follower but also to the empowerment of the leader, as the person who would bring resources to a subordinate, through their relationship with the organization. Good leaders were defined as those who could command more of the organizational resources, and who had access

to the “inner circle” of people possessing decision making capabilities. Effective managers, were described as having “people sensitivity” and “credibility.” Credibility, being of the utmost value, was defined as having competence plus power. These leaders were seen as people who would get to places and get things done. Sensitivity gets a person to be liked, but credibility shows followers that a leader can produce (Kanter, 1993).

Brown & Kanter (1982) suggested that managers need to: (a) take control of their power within the organization, (b) recognize and use the power they have (more than they think), (c) unlock channels of communication, (d), obtain greater control over their job, (e) create visibility for self and function, and (f) build relationships with professional colleagues and the “powerful.”

Kanter’s 1993 theory of organizational structural empowerment originated within the corporate world. It speaks to power as being developing because of access to an organizational structure of power. Kanter distinguished power from “hierarchal domination,” and considered power to be more the ability to get things done, to mobilize resources, and to provide whatever it is that someone needs to accomplish the task at hand. Few have this capability; therefore, it keeps others from accomplishing what needs to be done. Kanter saw the meaning of power “being closer to ‘mastery’ or ‘autonomy,’ than to domination or control over others” (Kanter, 1993, p. 215). Having a monopoly on power renders others powerless. Kanter believed that good human relations without power could result in low morale. A leader who possesses power is a leader who has the resources, information, and support to accomplish the work and who provides similar opportunities to his or her subordinates (Kanter, 1993).

***Kanter, sociology, and feminism.*** Rosabeth Moss Kanter is a Harvard School of Business professor. The origin of Kanter's influence on nursing can be traced to Kanter's past history in the field of sociology and work within the feminist movement (Kanter, 1993). Kanter coined the word "tokenism" to describe a person, or token, who is a member of a skewed minority group within an organization. The ease of excluding these token individuals from organizational endeavors can be derived from racial or gender lines. The rise of women into the world of organizational structures was seen as a struggle equivalent to the women's movement (Kanter, 1993). Wuest (1994), a nurse theorist, described nursing struggles as similar to tokenism, whereby nurses have had difficulty as being seen as a true professional with knowledge to share. Nurses' skills have been viewed as nurturing versus scientifically based. Nursing, historically a women's occupation, has been surrounded by issues of liberation and oppression. "The three positions of maintaining the status quo, seeking equality, and seeking to change the social order can be seen in nursing's development" (Wuest, 1994, p.358).

***Testing Kanter's theory: nurse power.*** Manojlovich (2007) performed a systematic review of nurse power. The review looked at the history of nurses' power over nursing practice, the kinds of power over nursing care needed for nurses to make their optimum contribution with control over the context of nursing practice, control over competence, and the current state of nurse empowerment. Kanter's theory of structural empowerment and structural empowerment and works by Laschinger and colleagues were examined. Manojlovich also looked at the theories of psychological and relational empowerment. The review found that empowerment for nurses consisted of three components: a workplace structure that promotes empowerment, a psychological belief

that one has the ability to be empowered, and the knowledge that there is power in the relationships and caring that is provided by nurses (Manojlovich, 2007).

Manojlovich (2005), in a previous study, used Kanter's theory of structural empowerment and the social cognitive theory to understand the effect of unit-level nursing leadership on the relationship of structural empowerment and nurses' self-efficacy to professional nursing practice behaviors. A non-experimental, comparative design was used. Four instruments were used to collect data from 251 Michigan nurses: (a) Conditions for Work Effectiveness-II (CWEQ-II), (b) the Caring Efficacy Scale, (c) the Manager's Activity Scale, and (d) the Nurse Activity Scale. Controlling for educational level and years of work experience, findings showed that there was no direct relationship between nursing leadership and professional practice behaviors. The relationship between structural empowerment and professional practice behaviors was stronger in the presence of nursing leadership, but it did not depend on the level of nursing leadership. An indirect effect of nursing leadership was noted.

*Testing Kanter's theory: structural empowerment.* Heather K. Spence Laschinger partnered with her colleagues to expand on Kanter's structural empowerment theory and applied it to the profession of nursing and health care. These studies explored a range of topics which included: (a) the impact of empowering work environments on patient outcomes and safety (Armstrong & Laschinger, 2006; Lashinger et al., 2010; Purdy et al., 2010), (b) nurses' perceptions of the impact of empowerment on job satisfaction and engagement (Gilbert et al., 2010; Greco et al., 2006; Laschinger, Finegan, & Wilk, 2009; Laschinger, Finegan, Shamian, & Wilk, 2001, 2004; Matthews, Laschinger, & Johnstone, 2006), (c) the comparison of structural empowerment and

Magnet hospital characteristics (Armstrong & Laschinger, 2006; Laschinger et al., 2003), and (d) the effects of structural empowerment and leadership on collaborative practice and shared decision making (Laschinger & Smith, 2013; Laschinger, Sabiston, & Kutzscher, 1997).

Armstrong and Laschinger (2006) sought to understand how organizational structures interact to create a culture of safety where high quality care was feasible. A predictive non-experimental design was used as part of a qualitative study to test Kanter's theory. The study was conducted in a small community hospital in Canada. Forty nurses were surveyed (51% response rate). The study compared: (a) nurses' workplace empowerment and its effects on the ratings of Magnet hospital characteristics in their work settings, (b) workplace empowerment and its effect on the ratings of a patient-safety culture, and (c) the combination of workplace empowerment and Magnet hospital characteristics on the ratings of a patient-safety culture. The instruments used to collect the data were: CWEQ- II, Lake's Practice Environment Scale of the Nursing Work Index, and the Safety Climate Survey.

Testing showed that structural empowerment had a significant positive relationship to Magnet characteristics and a patient-safety culture. The combination of structural empowerment and Magnet hospital characteristics was a significant predictor of staff nurses' perceptions of a patient-safety culture. "The results of this exploratory study provide evidence to suggest that nurse leaders have the ability to improve the level of patient safety in their organization by creating an empowering professional practice environment" (Armstrong & Laschinger, 2006, p. 131).

Laschinger et al. (2010) proposed a model of nurse/patient empowerment. Using Kanter's theory as a foundation, they saw an empowering environment as influencing nurses' empowering behaviors. Nurses who were empowered had a tendency to empower their patients. Kanter's concept of empowerment can be compared to nurses' therapeutic relationships with their patients and nursing care outcomes. Laschinger et al. concluded that "nurses work with patients/clients to ensure that they have the necessary information, support, and resources to promote optimum health and well-being" (p. 7).

***Testing Kanter's theory: psychological empowerment.*** Laschinger et al (2010) looked to broaden Kanter's structural empowerment model. Using Kanter as an initial reference, they sought to explore the concept of psychological empowerment as a result of structural empowerment, with the proposal that the presence of both would impact job strain and work satisfaction. Psychological empowerment, which stems from the work of Spreitzer (1995), is defined by Laschinger et al. (2001) as the psychological state that employees must experience in order for empowerment interventions to be successful. Four components of psychological empowerment were listed: meaning, competence, self-determination, and impact. Nurses need their belief systems and values to match organizational job requirements, they need to have confidence in their ability to deliver quality care, feel in control of their work, and to feel that they can influence outcomes within their institution. The study sample consisted of 300 male and 300 female nurses from all areas of Ontario, Canada. Three items were selected for measurement from a series of scales, which reflected Kanter's theory: formal power, informal power, and perceived access to work empowerment structures of opportunity, information, support, and resources.

Spreitzer's (1995) 12-item psychological empowerment scale was used to measure the concepts of meaning, competence, self-determination, and impact. A modified version of the Job Content Questionnaire was also used. This scale consisted of five items measuring psychological demands and six measuring authority over decision making. Results are supportive of structural empowerment resulting in psychological empowerment, thus, positively impacting job satisfaction and engagement, which was in contrast to Kanter's belief that regardless of personality, all people should benefit from empowerment. Spreitzer speculated that, perhaps, only people with a high need for achievement may be impacted and those not motivated, might not be influenced by this empowering environment (Laschinger et al, 2001, 2004).

***Testing Kanter's theory: nursing leadership.*** Kanter's (1977 or 1993) model has been tested to explore power of nursing leadership. A descriptive, non-experimental design linked chief nurse executive (CNE) organizational structures to staff nurse perceptions of workplace empowerment in two Canadian hospitals. Two self-reported instruments were used, the CWEQ-II and the Global Empowerment Scale. The hypothesis proposed that staff nurses who work in hospitals with a CNE-in-line authority structure would have higher levels of empowerment than those who worked in hospitals with a CNE in a staff authority structure (Matthews et al., 2006).

The in-line CNE had larger control of the budget, higher numbers of subordinates, and a larger span of control within the health care organization. They found that the CNEs who had in-line positions versus staff positions had more access to formal power. Empowerment was seen as power through association (Matthews et al., 2006). There was

a significant difference that supported the hypothesis of staff nurses' perceptions of access to an empowering structure in the presence of an in-line CNE structure.

The role of the CNE was found to be responsible for promoting an empowering culture. The CNE must ensure that nurse managers are empowered within the organization with access to the resources necessary to achieve organizational goals. Advancement within the organization should be based on accomplishments and not hierarchy. Systems and structures for empowerment should be built that promote shared governance and shared decision making (Matthews et al., 2006).

Laschinger et al., (2003) tested Kanter's theory linking nurses' perception of workplace empowerment, Magnet hospital characteristics, and job satisfaction in three independent studies of nurses in different work settings. All three studies were predictive and non-experimental in design. Two studies sampled staff nurses, one in an urban tertiary care hospital, and the other in a network of eight rural community hospitals. The third study sampled acute care nurse practitioners in urban tertiary care hospitals. Two hypothesis were tested: (a) higher levels of workplace empowerment are positively related to perceptions of autonomy, control over practice environment, and collaboration with physicians within the work setting Magnet hospital characteristic), and, (b) higher levels of empowerment and Magnet hospital characteristics in nursing work settings are positively related to nurses' job satisfaction. They sought to explore if strategies proposed in Kanter's structural empowerment theory (access to support, information, resources, and power) had the potential to result in work environments that could be described in terms of Magnet hospital characteristics. They proposed that when nurses perceive their

work environment as empowering, they feel more supported to practice professionally, and describe their environment in Magnet-like terms.

Nurses' perceptions of structural empowerment were found to be empirically related to workplace characteristics that define Magnet hospital settings. Access to resources and support had a great impact on the control over their practices and autonomy, and informal power had a strong impact on nurse-physician relationships (Laschinger et al., 2003). These work environments promoted work settings that supported professional practice. Nurses who perceived managers to be collaborative and supportive were more likely to stay within an organization (Armstrong & Lashinger, 2006; Laschinger et al., 2003).

***Kanter and transformational leadership in nursing.*** James MacGregor Burns (1978) was the first to introduce the concept of “transforming” leadership. He described how power is used, the purpose behind the use of power, and the relationship between the leader and the follower. He saw power as an aspect of leadership and all leaders as power holders. However, he did not see all power holders as leaders. The difference between leaders and power holders was that leaders take followers' goals, motives, feelings, and needs into consideration (Burns, 1978). Leaders do this by engaging and getting to know their followers. Positive leadership is demonstrated when the leader engages followers to do things that are beneficial to both the leader and the follower. If form of leadership benefits only the leader who possesses the power, then it is an ineffective use of leadership. The relationship between the leader and the followers can either be transforming or transactional in nature. In transforming leadership relationships, the power bases do not outweigh each other, but instead, they are mutually supportive for a

common purpose (Burns, 1978). In contrast, transactional leadership involves making contact with others for the purpose of exchanging something of value. Transactional leadership is an exchange of one thing for another without further expectations from either party. There is no expectation of elevating each other to a higher purpose (Burns, 1978). The theory of transforming leadership has influenced many works on leadership and leadership development (Avolio, 2011; Bass, 1999; Kouzes & Posner, 2007; Northouse, 2013; Sosik & Cameron, 2010).

Bernard Bass expanding on Burns' 1978 work, emphasized the leader's influence on followers by introducing the concept of transformational leadership in place of Burns' "transforming leadership." Transformational leadership is realized through empowering or moving the follower through the implementation of idealized influence (charisma), inspiration, intellectual stimulation, or individualized consideration (Bass, 1999). Idealized influence is exhibited by transformational leaders by exhibiting high moral and ethical standards. These standards are emulated by their followers. These are leaders who provide followers with a sense of mission and vision. These leaders inspirationally motivate and prompt followers to do more by encouraging commitment to the shared vision of the organization. They intellectually stimulate the followers by facilitating creativity and innovation. They promote followers to challenge the status quo, even if it is in contradiction to other leaders' or organizations' beliefs and values. Transformational leaders give individual consideration to their followers. They act as coaches and mentors while considering their individual needs (Bass, 1999; Northouse, 2013).

Bernard Bass (1999) spoke to the history of social and organizational conformity. He explained that as human beings, we have evolved from the 1950s era of not

questioning the church, government, or the organizational leader to the 1990s where skepticism and cynicism replaced the norms of an unquestioning society. Changes in society were calling for a more transformational style of leadership, which fosters autonomy and the questioning of authority (Bass, 1999). Through follower development, transformational leadership is described as promoting maturity, a quest for achievement, self-actualization, and the concern for the well-being of others (Bass, 1999).

The full-range leadership model depicts leadership as a range of leadership characteristics from laissez-faire to transactional to transformational (Avolio, 2011). Avolio spoke to this model within the organizational setting. The full-range leadership model presents transformational leadership as the ultimate form of leadership to be achieved and developed. Transformational leadership concentrates on improving the performance of followers and developing the follower to his or her fullest potential (Avolio, 2011). He stated that transformational leadership, alone, may not suffice, but in the presence of the higher forms of transactional characteristics, it has been very successful (Avolio, 2011). Fully transactional leaders will achieve results and high performance, but they do it without motivating, developing, or challenging followers as would the transformational leader (Avolio, 2011). A transformational leader's role is to promote staff empowerment and actualization through role-modeling behaviors, promoting a sense of individual power, and representing the needs of the follower or of the mission within the organization (Avolio, 2011; Bass, 1990).

Northouse (2013) presented the strengths and weaknesses of the transformational leadership theory. The strengths included: a multi-perspective history of research; an intuitive appeal, because the leadership characteristics "made sense"; a promotion of the

importance of the follower in the leadership process; and the enhancement of other leadership models. The weaknesses identified included: lack of full validity testing; portrayal of transformational leadership as a personality trait, rather than learned behavior; and lack of causality between transformational leaders and changes in followers or organizations (Northouse, 2013).

Sosik and Cameron (2010) expanded on the concept of transformational leadership; their aim was to present a “prescriptive content model describing what happens to trigger authentic transformational leadership behavior” (p. 251). They looked at character and role it played in determining who was able to display outstanding leadership (Sosik & Cameron, 2010). Their model presented the possibility of a wide range of character strengths influencing authentic transformational leadership behaviors, which brings out the best in self and others.

Transformational leadership has served as a foundation for nursing research. Magnet research studies have deemed transformational leadership and transformational characteristics as the preferred type of leadership (Upenieks, 2003; Laschinger & Smith, 2013). The Magnet principles promote the need for the existence of institutions that are led by transformational leaders (ANCC, 2015).

A progressive nurse leader is able to transform a nursing practice into one that promotes nurse autonomy, voice, and shared decision making. They can create an atmosphere that supports infrastructures, promote trust, accountability, and open communication (Upenieks, 2002). In order to promote empowerment, nurse leaders need to be less of an authoritarian, and more of a facilitator (Upenieks, 2002). This was tested through a qualitative, descriptive design. Upenieks’ study sought to explore: (a) What

type of leadership traits are effective in an acute care environment? (b) Does power and gender interface with leadership effectiveness? and (c) What are the predominant components of a successful organization that supports the role of nurse leader?

Interviews were conducted with a convenience sample population consisting of 16 nurse leaders from four acute care hospitals in two geographical locations (academic center and a community hospital). Kanter's theoretical structure, (formal/informal power, opportunity, resources, and information) was validated by 83% of the nurse leaders interviewed (Upenieks, 2002).

The leadership-culture phenomenon, according to Casida, Crane, Walker, & Wargo et al. (2012), is still understudied in nursing. Using data from a previous dissertation, Casida et al. sought to further elaborate the phenomenon of the relationship between leadership, culture, and performance on a patient care/nursing unit of a health care organization. They used the frameworks of full-range leadership theory and the Denison organizational culture model (DOCM) to inform their study. The DOCM is based on the premise that the culture of the organization has a strong influence on its performance (Denison & Mishra, 1995, as cited in Casida et al, 2012). The model presents that the effectiveness of high-performing organizations is characterized by four culture traits that are nurtured by the leadership. These traits include adaptability, mission, involvement, and consistency. Adaptability refers to an organization's ability to translate the demands of the business environment into action, and employees sense an environment that creates change, is customer focused, and promotes organizational learning. "Mission refers to the organization providing employees with a sense of focus, strategic intent, goals, objectives, and an organizational vision. Involvement refers to a

culture that provides a sense of empowerment, team orientation, and skill development. Consistency refers to having a sense of a collaborative, coordinated culture of support that promotes shared governance systems. Employees with shared core values demonstrate agreement and coordination.

Casida et al. (2012) employed a descriptive research design using data provided by 278 staff nurses. Staff nurses (SNs) were recruited from high-performing critical-care and non-critical-care areas representing four hospitals in the northeast region of the United States. Other criteria included working on a day shift, having been employed for greater than six months and reporting to the same nurse manager during that time.

The Multifactor Leadership Questionnaire (MLQ) short form was used to measure nurses' perceptions of leadership behaviors, and the Denison Organizational Culture Survey (DOCS) was used to measure nurses' perceptions of the nursing unit culture. Most study participants were female (91%), and 64% were educated at the baccalaureate level (Casida et al, 2012).

Findings showed that the type of unit and Magnet designation influenced leadership behaviors as perceived by the SNs. Critical care areas found their leaders less transformational than their non-critical care counterparts, and Magnet hospital nurses found their leaders more transformational and slightly more transactional than the non-Magnet groups. In regard to nursing unit culture, there were no significant differences in the SNs' perceived culture with respect to gender, race, certification, and years of professional practice or tenure. However, significant differences were noted based on education level, type of unit, and Magnet designation. Baccalaureate-prepared nurses were more likely to report higher levels of the mission culture trait than those with

diploma or associate degrees. Non-critical care SNs reported higher ratings in all four culture dimensions than the critical care SNs. SNs in non-Magnet hospitals rated their consistency culture trait higher than their non-Magnet counterparts (Casida et al., 2012). Results of their multi-regressional analyses showed that more than 24% of the effects on the nursing unit culture can be explained by the transformational and transactional behaviors displayed by the nurse managers (Casida et al., 2012).

### **Summary**

This qualitative, descriptive study is looking to contribute answers to the question of what types of environment are nurses seeking in order to be able to deliver quality, safe, patient care. Increased complexities of health care call for an empowered nursing workforce. The literature reveals that nurses, who are autonomous, have control over the content and context of their own practice, and nurses who are empowered to speak up and advocate for safe patient care and outcomes are essential. In order for nurses to feel that they have empowered, an environment that fosters such empowerment must be put in place (Kuokkanen et al., 2003; Peltomaa et al., 2012; Sayre et al., 2012).

Kanter's 1993 theory of organizational structural empowerment will serve as a foundation for looking at the characteristics of the health care environment of oncology nurses at an urban teaching hospital. Kanter viewed the possession of power as having the ability to use or mobilize the information, resources, and support needed to accomplish goals. The level of power (formal or informal) that an individual has influences their ability to achieve these outcomes (Kanter, 1993).

The topical and theoretical literature reviews in this chapter have helped to identify the problem and have informed the development of the research questions and

design choice. This study, through a qualitative, advocacy/participatory worldview, using a descriptive approach through interviews, reveals oncology nurses' perceptions of structural empowerment. Chapter 3 details the interview design methodologies, research context, participants, data collection, and data analysis for the study.

## **Chapter 3: Research Design Methodology**

### **Introduction**

Using Kanter's (1977 or 1993) theory of organizational structural empowerment as a foundation, interviews with oncology nurses sought to describe nurses' perception of structural empowerment. In addition, the interviews sought to discover how the oncology nurses' organizational structures provided the opportunities, resources, information, and support to influence their ability to work in a supportive, empowered, and collaborative environment where they felt they had a voice in organizational and patient-care decision making.

The study findings have the potential to influence improvements in organizational structures within health care facilities. These structural changes may improve the quality of the nursing care environment and practice. The findings may also contribute to oncology-related research literature in the United States.

A qualitative, advocacy/participatory worldview was the foundation for this research. Creswell (2009) stated that, "advocacy research provides a voice for participants, raising their consciousness or advancing an agenda for change to improve their lives" (p. 9). A descriptive qualitative approach was used to study oncology nurses' perceptions of the types of environment they need in order to get meet all of the requirements of their jobs and partner with physicians and other members of the health care team to deliver safe, efficient patient care.

Polit and Beck (2010) explained that a qualitative, advocacy/participatory worldview design reflects the researcher's desire to understand the realities and viewpoints of the study participants—realities and viewpoints that were unknown or understood at the beginning of the research. Qualitative inquiry is a means of exploring and understanding an individual's or group's views on a topic (Creswell, 2009). This approach uncovers qualitative versus quantitative data about the participants' experiences, engages the participants, and facilitate the participants' descriptions of the experience rather than report data or measurements (Moustakas, 1994).

Research questions for this study were designed using the foundation of Kanter's (1977 or 1993) theory of structural empowerment and the description of how this type of environment provides the information, support, resources, and opportunities to achieve professional and organizational goals. The essential research questions that guided this study include:

1. What are oncology nurses' perceptions of structural empowerment?
2. How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done?

**Positionality.** In descriptive research, a researcher sets aside any prior thought, conception, or judgment he or she may have regarding the topic (Sadala & Adorno, 2002; Reiners, 2012). Creswell (2013) presented this concept as "bracketing." Moustakas (1994) described the concept of "epoch," similarly, as requiring a new way of looking at things. Here the researcher "focuses on a specific topic freshly and naively, constructs a question or problem to guide the study, and derives findings that will provide the basis for further research and reflection" (Moustakas, 1994, p. 47). Researchers are advised, in

some forms of research, to decenter themselves and come to “unknow,” the subject matter. This is another way of saying that researchers must clear their vision and thinking of their assumptions, prior knowledge, and belief systems (Munhall, 2012).

One of the goals of this study was to describe the participants’ perceptions and lived experience, without allowing the researcher’s preconceived thoughts or judgments to influence the data collection or data analysis processes. As a nurse for 17 years, it was easy for the researcher to identify with the challenges that nurses face in attempting to maintain control over the content and context of their practice. This researcher, on occasion, experienced barriers to the delivery of quality care due to influences of professional, relational, and organizational structures; therefore, this researcher needed to “bracket” perceptions of what an empowered work environment should look like.

The face-to-face qualitative inquiry might have seemed more intrusive than a completely anonymous quantitative survey, but with the researcher being an insider to the world of nursing, these experiences gave the researcher credibility with research participants. The experience did require establishing a relationship of trust, sensitivity, and effective communication skills.

### **Research Context**

The setting is a major oncology teaching hospital, with greater than a 450-bed capacity. It is nationally ranked among 144 other hospitals in its provision of quality cancer care. The organization is composed of adult and pediatric care delivery sites including general and critical inpatient acute care, outpatient care, and perioperative care. Over 2,000 registered nurses practice in all of these areas.

The care delivery model is primary nursing. The nurse who is primarily responsible for the coordination of care delivery for the case load of oncology patients generally has a bachelor's degree or higher education. The professional registered nurse works within an interdisciplinary team of support staff, physicians, physician assistants, nurse practitioners, and other consultant services personnel, such as social workers, case management workers, integrative medicine personnel, and cardiology employees. Clinical Nurses are led by a designated nurse leader for the specific unit or service. The nurse leader reports to a divisional director of practice. The divisional directors report to the chief nurse executive for nursing who, in turn, reports to the hospital administration.

Some of the resources available to nurses are the newest technologies, promotional opportunities, tuition assistance for education, shared governance structures, opportunities for self-scheduling (within the confines of patient care needs), structures for monitoring quality of care data, and opportunities for performance improvement activities.

### **Research Participants**

Qualitative inquiry requires getting rich data, which can come from a just few people. Qualitative researchers recommend one to 10 study participants, even though much larger numbers have been used (Creswell, 2013). Data saturation and representativeness of results may also determine the final number (Englander, 2012). In qualitative research, the intent is not to generalize the information in the same sense that positivist research does, but to gain in-depth knowledge and information regarding individual perceptions (Creswell, 2013; Sadala & Adorno, 2002). Englander emphasized

that the goal is understanding the issue, not measuring it. This can be accomplished through small sample sizes (Englander, 2012).

A purposeful, criteria-based sampling approach was used in choosing participants for the interviews. The criteria for participant eligibility entailed working as a registered nurse in this particular setting under the supervision of a nurse leader for greater than 18 months, 50% participation in direct-patient care delivery, and having a clinical ladder promotional ranking of Clinical Nurse (CN) II-IV. Criteria based on race, age, or gender identity was not collected.

A request for participants went out to all clinical nurses, levels II-IV, within the institution, via their institutional email addresses, delineating the purpose of the study, and a link was included to an electronic survey to elicit the criteria for potential participant eligibility (Appendix B). Of the respondents eligible for the study, the first seven for each category of Clinical Nurse II, III, and IV were chosen, for a total of 21 nurses, who were invited to participate. The letter of invitation defined the details of the study's aim, time commitment, assurance of confidentiality, and security and disposition of the data. Of the 21 nurses invited to participate, seven accepted the invitation and agreed to complete the interview (Appendix C). After setting mutually agreed-upon times and on-site locations, face-to-face interviews were conducted.

### **Instruments Used in Data Collection**

According to Creswell (2009), qualitative researchers are, themselves, the key instrument for gathering information when using interviews or focus groups for data collection. There is usually no relying on instruments developed by others. For this study,

the instruments used for data collection were semi-structured, in-depth interviews, which were audio recorded, and field notes.

**Validity.** “Validity has been associated with psychometrics and has often served as an argument for disqualification of qualitative research, claiming that qualitative research is not scientific, since it does not meet required objective qualitative criteria” (Kusmanic, 2009, p. 40). This positivist view of research is in stark contrast to qualitative approaches where the researcher is the main instrument of analysis. Instead of concepts, such as reliability and validity, the qualitative researcher focuses on “believability.” Believability involves providing the reader with enough details, descriptions of procedures, and quotes from the interviews to allow the reader to make his or her own decision about believability (Willis, Jost, & Nilakanta, 2007). The believability approach was used in this study.

In order to increase believability, the interview questions were reviewed by the nursing research committee at the study institution. This is a committee of nurse researchers who serve as mentors and facilitators for those conducting nursing research. They are the first step toward Institutional Review Board (IRB) approval. The interview questions were revised as recommended.

**In-depth interviews.** According to Kvale and Brinckmann (2009), the purpose of qualitative interviews is to elicit the subjects’ own perspectives and to develop themes as well as the relationships between themes. They allow the subjects to disclose the meanings behind their experiences. In a semi-structured setting, “the interview is usually transcribed, and the written text and sound recording, together, constitute the material for the subsequent analysis of meaning” (Kvale & Brinckmann, 2009, p. 27). For the purpose

of this study, the interview questions (interview protocol) served as the “instrument” for data collection for the interview methodology.

A list of in-depth interview questions served as the instrument for data collection for the interview methodology. It was informed by Kanter’s (1993) theory of organizational structural empowerment. Kanter described an empowered work environment as one having access to information, support, resources, and opportunities. Opportunity refers to the ability for growth and movement within an organization, as well as opportunities for employees to further their education. Power stems from having the information or being “in the know” regarding organizational decisions or policies, the resources to obtain the needed materials, the access to personnel or to funding to get the work accomplished, and having the support from superiors for risk-taking behaviors and critical decision making (Kanter, 1993).

**Field notes.** Field notes were taken and referred to during data collection and analysis. These were used to document the researcher’s personal thoughts, impressions, and prejudices and the participants’ non-verbal behaviors. Note taking before, during, or after the data-collection process added substance to the exploration of what was transcribed. Note taking can also facilitate researchers through the bracketing process and can be used to reflect on personal values, role conflicts, potential lack of neutrality, or to describe new and surprising findings (Polit & Beck, 2012). These notes can be reflective of participant observations, researcher responses, and ideas relating to coding or analysis of the data, which is a practice supported by qualitative researchers (Creswell, 2009; Saldana, 2013).

In order to ensure the utmost protection of the participants' identities, the researcher was the only person to have access to the recordings and transcripts. Therefore, the reliability of the transcriptions was tested by the researcher personally transcribing the audio tapes, verbatim, and reviewing the audiotapes on three or more occasions, while comparing results. The transcripts included notes indicating hesitancy when answering questions, laughter, or sighs. The notes reflected participants' non-verbal reactions, such as smiles, tears, or lack of eye contact.

All participants' names, recordings, and notes were treated as confidential, and all participants were assigned numeric pseudonyms. The audiotapes were deleted upon completion of the study. Quotations from the interviews, which contained information that would make it possible to identify the person interviewed, other colleagues, or the institution, were deleted. Data from interviews, and transcripts, were stored on a password-secured network drive, or locked in a secured place accessible only to the researcher. At the conclusion of the study, all research-related materials and data will be stored for three years and will then be disposed of according to Saint John Fisher College's IRB requirements. All of this information was communicated with research participants.

To further ensure confidentiality and not disclose participant identity, the participants were not required to sign a written consent (Appendix D). "A signed informed consent form, links the interviewee to the research, which may prevent people from participating" (Rubin & Rubin, 2012, p. 91). Consent was waived by both the Saint John Fisher College and the research organization's IRBs. Verbal agreement to voluntarily participate in the study was obtained, and consent was implied when the

participants chose to be interviewed. The participants were made aware that participation was voluntary and that they could withdraw or stop the taping at any time.

### **Procedure for Data Collection and Analysis**

The interviewer met in person with the participants for one-on-one interviews. Interviews commenced on a rolling basis as soon as the participants were identified and scheduled. The sessions were audiotaped, and reflective notes were taken as appropriate. The interviews were conducted, on average, for approximately one hour. The interview protocol was followed, which included an introductory question that elicited general content relating to the participants' chosen career, which was then followed by the major research questions and probing questions. Follow-up, semi-structured questions were asked based on participants' responses. Throughout the interview, the researcher clarified with participants the perceptions of what was said to ensure accurate analysis. These questions elicited exploratory-descriptive data from the participants regarding the definition and perceptions of structural empowerment and the availability of support, information, and resources that impacted their work life (Appendix A).

In qualitative research, data analysis involves organizing the data, carefully reading through the content several times (immersing one's self in the details), coding and organizing themes, representing the data in tables, graphs, or narratives, and then forming an interpretation (Creswell, 2013). Coding and retrieving involves creating words or short phrases (codes) that summarize or give essence to the data and then looking for patterns or clusters of meaning in those codes (Creswell, 2009; Saldana, 2013). This method generally produces themes that consist of related codes that have similar meaning.

For the purpose of this research and utilizing the expertise provided by the works of Creswell (2009, 2013) and Saldana (2013) the data was collected and then analyzed through the use of coding methodology. Codes are words or short phrases that summarize or give essence to a portion of verbal or written data. Coding can start by using concepts and themes, which are asked about during the interview or concepts and themes that may be found in the research literature (Rubin & Rubin, 2012). Using “pre-figured” codes or categories (often from a theoretical model or the literature) is popular in the health sciences (Rubin & Rubin, 2013).

For the purpose of this study, pre-figured codes based on Kanter’s theory of structural empowerment were used. However, sometimes as new themes emerge, they may prompt the researcher to add, eliminate, or modify other themes or concepts (Rubin & Rubin, 2013).

During the first cycle of coding, all transcripts from the in-depth interviews were read multiple times, so that the researcher immersed self into the data. The first cycle consisted of coding the data based on preconfigured codes using concepts from Kanter’s theory of organizational structural empowerment and the research questions. The codes used in this cycle were information, support, resources, and opportunities. In the second cycle of coding, the words or statements were then categorized into themes and sub-themes.

In reviewing the second cycle of codes the theme of “structures of power” (“shared governance”) emerged which directly fit into Kanter’s theory. The themes and sub-themes were descriptive of the participants’ experience with the concept of structural empowerment in their current work-life. The analysis of this qualitative descriptive study

followed the following schematic: (a) data was first organized by giving each transcript a numeric pseudonym, (b) the researcher then read and re-read through each transcript, immersing self in the data, making notes and extracting themes verbatim from the transcripts, (c) the researcher then “bracketed” own personal experiences with the concept. This assisted the researcher to set aside own experiences and focus on the participants’, (d) the researcher then extracted these large pieces of data and grouped them by selected themes and frequency of themes, (e) the themes were then used to describe the participants views and perceptions of work structures, and (f) these results were then reported using figures, table or discussion.

### **Summary**

This chapter outlined the interview methodology used in a descriptive, qualitative study conducted at a large oncology teaching hospital when exploring oncology nurses’ perceptions of structural empowerment and its impact on their work life and on the delivery of safe and efficient quality care. The foundation of this study was based on theoretical lens of Kanter’s organizational structural empowerment theory. Kanter’s theory proposes that power comes from having structures of power, and that this structure promotes an effective work environment where support, resources, information, and opportunities are available to get the job the done. At the helm of this environment is a transformational leader (Kanter, 1993).

A descriptive, qualitative study, using interview methodology, was used to explore oncology nurses’ perceptions of structural empowerment. The research participants consisted of seven oncology nurses. The participant selection was targeted at nurses ranging in ranking of CNII-IV, with greater than 18 months’ experience, and

participating in greater than 50% of direct patient care. Participant eligibility was determined based on the nurses' responses to the purposeful sampling criteria, through electronic survey technology. The first 21 initial demographic survey respondents, to evenly represent all levels from CNII-CNIV, were followed up with an invitation letter to participate. The invitation letter was an opportunity to provide more information and detail on the objectives, timeline of the study, the participant's role in the study, risks, and information relating to areas of confidentiality and to ensure an understanding that they had the freedom to decline participation at any point in the interview with no repercussions. Of the 21 initial respondents, seven agreed to being interviewed.

The semi-structured interview questions were based on the theoretical lens of Kanter's (1993) organizational structural empowerment theory as discussed in Chapters 1 and 2. The goals were to gain clarity into the nurses' perceptions of structural empowerment, their perceptions of their current environment, and their current environment's role in providing them with the information, opportunity, support, and resources needed to provide collaborative, safe, and efficient patient care. Data collection and analysis of the data consisted of coding the data, identifying themes, categorizing the themes, and reporting the descriptive findings via tables and excerpts from the interviews. Chapter 4 presents these results, and Chapter 5 presents the discussion of the findings.

## Chapter 4

### Research Questions

This chapter outlines the findings of a descriptive, qualitative study conducted at a major oncology teaching hospital. Through the utilization of semi-structured one-on-one interviews with seven oncology nurses, this study sought to describe the nurses' perceptions of organizational structural empowerment, its impact on their work-life, and its ability to provide for nurses that which is needed to care for their patients. This study was inspired by the Institute of Medicine's call for the facilitation of the delivery of quality care by providing nurses with an environment that provides the education, leadership skills, and opportunities for shared decision making and collaboration as partners within the health care team (IOM, 2011).

The foundation for this study and the research questions were based on the theoretical lens of Kanter's organizational structural empowerment theory. Kanter's theory proposes that effectiveness on the job is contingent upon the structural aspects of having the information, support, resources, and opportunities needed to get the job done. This environment is provided by a leadership that is transformative, has power, is supportive of employee needs, and provides the structures that promote empowerment (Kanter, 1993).

**What are oncology nurses' perceptions of structural empowerment?** The participants defined structural empowerment as being founded in having the intrinsic clinical competence, knowledge, tools, and support from colleagues, and other

departments, in order to get the work done. Structural empowerment was seen as having a forum of shared governance that is inclusive and consistent and where nurses are involved in practice and organizational changes and committed to the organizational goals. A shared governance structure was described as where all levels of nursing have input into the rules and policies that govern the unit or organization. Shared governance is being able to voice your opinion, and be able to have someone, or someplace, to take those opinions to, and having connections to the right people.

The majority of the participants defined structural empowerment as an environment that allows nurses to practice within their professional parameters. It is an environment that promotes autonomy and collaborative partnerships that are founded on others trusting in their clinical expertise and leadership capabilities. Structural empowerment allows nurses to bring their own culture and individuality to the practice without fear of restrictions. This includes an environment that empowers and allows for the individual to participate in professional and personal decision making and an environment that allows for individualized career and advancement choices.

**How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done?**

The participants expressed that patients have an expectation that their caregivers will work together to get them the care they need, and provide it in an environment where they feel “humanized” and supported. The participants were empathetic to the experiences of their patients and families. Generally, they perceived themselves as having strong relationships with their nurse colleagues, physicians, and the multidisciplinary team (social worker, case managers, dieticians).

Most participants believed that they had the opportunity to have ownership for their practices and access to a forum for sharing ideas and addressing issues. While the participants also felt there was opportunity for career advancement, they discussed challenges that, at times, made advancement challenging.

The majority of the participants indicated that autonomy, accountability, and all aspects of professionalism have a higher impact on their work environment. Partnerships with physicians, nurse colleagues, and the multidisciplinary team were also key. Having the right resources was important, but all of the above-mentioned aspects of their working environment are integral to their ability to perform their job functions.

### **Data Analysis and Findings**

Transcripts of the interviews were coded using pre-configured or a priori coding based on Kanter's theory of organizational structural empowerment. During the first cycle of coding, all transcripts from the in-depth interviews were read and re-read, so that the researcher immersed self in the data. The codes used in this cycle were based on Kanter's theory, which are information, support, resources, and opportunities. Statements or words that fit into these codes were then categorized into themes and sub-themes. While reviewing the second cycle of codes, it is important to note that the theme of "shared governance" emerged, which directly fit into Kanter's theory and the use of the concept of "structures of power." These codes were cross analyzed and categorized into themes and sub-themes. There were five major themes and 16 sub-themes. Table 4.1 demonstrates a summary of the results, data analysis, and findings.

Table 4.1

*Themes and Sub-Themes Relating to Structural Empowerment*

Numbers of Themes	Themes	Sub-Themes
1	Opportunities	Educational opportunities Clinical experience
2	Resources	Time as a resource Educational materials Colleagues as resources Intrinsic resource to set boundaries and build resiliency
3	Information	Challenges with Technology Council as source of information Leader as source of information
4	Support	Relationships with colleagues Relationships with patients Trust Empathy Lack of communication
5	Structures of power	Shared Governance Autonomy & Accountability

In order to understand the participants' perspective while working within their current environments, it was important to elicit from them how long they had been working in oncology, their level of participation in direct patient care, and where they were within the clinical ladder promotional structure. It was also important to ask them what motivates them to have chosen this career and specialty. Knowing these motivating factors adds to the description of the participant population. Asking this question, particularly, even though it did not directly relate to the research questions, also served as

an “ice breaker” in the hope to build a conversational partnership. The term conversational partnership, conveys respect for the interviewee, and it reinforces that the interviewee is an individual with distinct experience, knowledge, and perspectives that are unlike anyone else’s (Rubin & Rubin, 2012).

Table 4.2

*Description of Individual Interview Participants*

Participant	Years in Current Area of Practice	Clinical Ladder Ranking	% of Patient Care	Motivation to Practice
1	>6 years	CNIV	>50%	Interest in human systems Higher calling
2	3-6 years	CNIV	>50%	Friend suggested it Interest in Medical field
3	18 month to 3 years	CNII	>50%	Externship experience Family referral
4	3-6 years	CNII	>50%	Family with cancer Interest in medicine Externship experience
5	>6 years	CNII	>50%	Previous employment Drive for oncology
6	>6 years	CNIV	>50%	Liked routine Family with cancer
7	>6 years	CNIII	>50%	Mother was a nurse Original dream

*Note:* CN = Clinical Nurse

**Descriptive analysis and demographic information of interview participants.**

Clinical Nurse (CN) is the title given to nurses within this organization. They are ranked

by levels of clinical and leadership expertise. The CNI is an advanced beginner with less than 18 years' experience. The CNII level is considered competent, CNIII is proficient, and the CNIV is considered to be at an expert level. They may have rankings of II-IV, regardless of years of service, because those rankings are assigned by meeting certain criteria that measure clinical and leadership expertise (Table 4.2).

The participants in this study held clinical rankings of Clinical Nurse II to Clinical Nurse IV. They ranged in years of experience from 18 months to greater than six years. All participated in direct patient care greater than 50% of the time. Two of them reported selecting nursing and oncology as a career because they experienced family members with a diagnosis of cancer. These nurses were similar in that they both had previous experience with the institution either through previous positions or externships, which was the motivating factor for securing a position within the organization. One participant had never really given oncology much thought but sought a job at the organization through the recommendation of a family member. Three participants expressed choosing nursing and oncology because of a passion for nursing or a higher calling. One participant did not mention what the motivation was for choosing nursing but did mention liking the current environment's routine

**Participant # 1** is a Clinical Nurse IV and has been working in the oncology area for over six years. A CNIV is recognized as the expert nurse and leader at the point of care (bedside). Participant #1 started with a career in the business sector before moving to nursing.

Nursing is a second career for me. . . . I knew I wanted to go back to school, I wanted to see what the next big thing was . . . not nursing, it seemed a bit

daunting, I don't know why . . . then when I was at work, I was working on a project, I was working on it for a few months—and it was not going anywhere. . . . I wanted to figure out what to do with my life . . . so I decided to take on nursing . . . coming to oncology . . . . It was part of seeing it as a higher calling . . . a higher path . . . . Something that would have more meaning to me in my life.

**Participant # 2** is a Clinical Nurse IV and has been working in the practice area for three to six years. Participant #2 was influenced by a peer's recommendation to seek work in an oncology setting.

I have always wanted to work in the medical field . . . started with an interest in . . . but then went into nursing. I knew very little about this institution. . . . I had no real course work (pause) a friend of mine recommended this institution because they took good care of her father . . . so I took the job...I am surprised that I liked it so much.

**Participant # 3** is a Clinical Nurse II. This level is considered the clinical competent level of nursing at point of care. Participant #3 experienced the effects of a nursing shortage and hiring freeze, and found it difficult to get a job. On the recommendation of a family member, Participant #3 applied for a job within the organization and was hired.

Well . . . I graduated in \_\_\_\_with my Bachelor's in Nursing. . . . I never thought I would end up here . . . was not sure if oncology was for me . . . I found out through a family member that worked here that they were short [staffed] . . . . I was offered the job, so I decided to give it a try, and I have been here ever since. . . . This is such a special patient population. I am happy I began here.

**Participant # 4** is a Clinical Nurse II and has been working in the study environment for three to six years. This participant has a personal experience with cancer. Participant #4 had also participated in an externship at the study institution.

So I was drawn to nursing. My cousin was sick with breast cancer when I was growing up. . . . I was always interested in the medical field, I did an externship here . . . enjoyed the teamwork, and then decided to come back.

**Participant # 5** is a Clinical Nurse II and has been working in the study environment for over six years.

I knew I wanted to go into nursing school. My mom had cancer and survived it. . . . I went into nursing because I worked here . . . I always had a drive for oncology.

**Participant #6** is a Clinical Nurse IV and has been working in the study environment for more than six years. Participant #6 is currently enrolled in a Master's of Nursing program. "sort of transitioned into this whole . . . arena. . . . I just like the whole . . . routine."

**Participant #7** is a Clinical Nurse III. This ranking represents the proficient level of expertise within nursing. Participant #7 has more than six years working in the study environment.

From childhood, I wanted to be a nurse . . . my mother was a nurse. . . . I got side tracked a bit . . . but then went back to my original dream. . . . I took the job, and the rest is history. . . . I think I was looking for something that mattered . . . where I would learn something with a lot of patient contact and teaching.

**Cross analysis of individual interviews.** Upon completion of the interviews, during first cycle of coding, participant statements were extracted from the transcripts

and categorized into five major themes related to the a priori coding used, which was based on Kanter’s theory of organizational structural empowerment. These were (a), opportunity, (b) resources, (c) information, and (d) support. Upon a second cycle review, a fifth theme emerged from participant statements, and that was structures of power (Table 4.3).

Table 4.3

*Frequency of Themes Relating to Structural Empowerment*

Number of Themes	Themes/Sub-Themes	N-7	Frequency of Theme
1	Opportunities		
	Presence	7/7	25
	Lack of	4/7	9
2	Resources		
	Presence	7/7	26
	Lack of	6/7	9
3	Information		
	Presence	7/7	30
	Lack of	3/7	12
4	Support		
	Presence	7/7	34
	Lack of	5/7	16
5	Structures of Power		
	Presence	7/7	11
	Lack of	0/7	0

**Theme 1: opportunity.** All participants reflected on the opportunities offered by the institution that help build and recognize their knowledge and skills; these opportunities included resources for education, recognition of clinical expertise, and the clinical ladder promotion program.

*Sub-theme: educational opportunities.* The participants reported that opportunities for ongoing professional development is encouraged and structures are in place which facilitate this through career counseling, flexible scheduling, tuition reimbursement, and funding for continuing education courses. They expressed that taking advantages of these opportunities is dependent upon self-motivation and initiative. Five of the seven participants are currently enrolled in a master's program and receiving tuition assistance. One participant mentioned receiving funding and the opportunity to attend and present at a professional conference.

“It has been wonderful how the institution has supported my education, initially through tuition reimbursement, but also how my charge nurse and nurse leader have helped with my schedule . . . so I get the time in to attend school.”

*Sub-theme: clinical expertise.* The concept and expectation of clinical expertise was discussed by the participants in relation to the physicians recognizing and trusting the expertise of the nurse. The participants found that recognition of their expertise in the management of the patient's care depends on the physician's comfort level with the nurses input. There are physicians who respond quickly when the nurse asks for their input in caring for patients.

I guess it depends on what you are asking for or what information you are bringing to the table . . . if I tell them (doctor) there is something happening with . . . patient . . . and I feel they need to see the patient. The positive response is that . . . they will get up from their chair and go with me to see the patient . . . and address it . . . we can collaborate on what needs to be done . . . and they will write the orders needed.

At times, however, the participants perceive a lack of responsiveness from novice physicians. The nurses, when meeting with resistance, are comfortable escalating the issue to other members of the team.

Sometimes not such a positive response . . . sometimes new residents are unsure, and uncertain of what they need to do. There is a delay in the positive response. Maybe they are not confident in making that decision . . . new intern . . . so they have to seek more support to gain confidence . . . before making that decision. I would probably talk to their fellow on the team. Just to say . . . “I am asking this person for this, but I am not getting the answers. They are not making the decision. . . . Can you please make the decision or talk to them about it so I know what to do?”

The participants reported that clinical expertise is also recognized by the institution through their clinical ladder promotion opportunities for nurses. These opportunities offer nurses the capability to move toward positions that recognize their clinical and leadership capabilities

I am going for my CNIII . . . you can make of this job, what you want, it depends what you want to do with it, and then you make the effort . . . you can make your own path . . . this hospital lets you do that. Most nurses I know that are CNIV can choose to stay where they are . . . you really can make it your own.”

Two participants expressed that they find the clinical ladder beneficial and motivating. The participants, through a recommendation and application process, must meet certain criteria depending on the clinical level they are seeking.

If you are hired, just like me as a CNI, you become a CNII after one year of experience. Then, as a CNIII, you have to have a certain level of experience . . . you need to do presentations, serve on a committee, you have to be seen as a leader within the unit . . . and a few other requirements—I think it’s an appropriate process . . . it helps the unit have nurses progressing and striving.

One participant felt that, based on observation, some nurses tended to get promoted and then no longer participate in the expected leadership activities of the unit.

I do think the new changes are beneficial . . . I did see a lot of new nurses become CNIIIs [and] CNIVs over the years and never really do anything extra on the unit . . . ok . . . and once they were [a] CNIV, they stayed there for their careers—never had to precept or be in charge. They just stayed CNIVs. I think the new process shows peoples’ commitment, effort, and their work as well.

There were some challenges expressed by the participants around opportunities for sustaining rankings within the clinical ladder process. The participants recognized the need for professional growth and organizational citizenship, but felt that there was a lack of recognition for the clinical expertise and mentoring that happens at the unit level or point of care.

You know . . . in terms of the clinical ladder, I do not think enough is emphasized on clinical skills . . . so you can become a CNIV, a top-level nurse, but not based on clinical skills. . . . It’s all based on your exemplar and evidence-based project.

Three participants expressed their concerns with nurses being potentially “demoted” if they do not maintain their clinical ladder maintenance criteria. According to

participants, these demotions may result from nurses not meeting new standards and requirements.

Some of the best nurses I know are not given the credit [they deserve], because they are not involved. They are not here to do councils, their primary focus is patient care. They do not care [to be involved in] informatics or QA (quality assurance) . . . they can get penalized for it; they can get demoted because they do not meet the new criteria... I guess yeah . . . they [the nurse] did not have enough—did not do enough . . . ok . . . but what about what they do every day . . . to hear the nurse on the phone . . . and watch the nurse in clinic. I do not think that is fair . . . that made me almost not want to climb the ladder . . . be a little rebellious (pause) what does that prove, it doesn't prove anything . . . so there is strength in the clinical piece that I do not think is focused on. I personally, I get the need for education and the evidence-based practice . . . I understand it and can see both sides of the coin (pause) but not all people do.

Even though they are aware there is a forum for voicing these concerns, such as in town hall meetings, some participants felt a hesitancy in voicing any opinions they may have about the current maintenance criteria.

“You” want people to be more professionally developed . . . but a presentation is not a motivator . . . does not make you a better nurse . . . there is a value to clinical expertise. I know they have town hall meetings . . . but, I would not tell the CNO those things. Besides, a part of me, I understand where they are going. . .

.I know that is what they are considering an expert, if you do all those things. . . .  
but I guess I have always been more on the clinical side of nursing. I think there is  
value to . . . I think there is value to school, NPs and stuff, but there is value to  
clinical nursing, and I feel that sometimes that gets overlooked, but these are the  
people who are the mentors to those who are going to school as far as clinical  
care. . . . I think there is an imbalance, but if you look at it . . . I guess everyone  
has the opportunity to go to school.

***Theme 2: resources.*** Resources refers to having access to the internal and  
external materials and structures needed to accomplish goals. This was the third-most  
mentioned theme in the transcripts. Examples expressed by the nurses included having  
the educational teaching materials, time, and access to their interdisciplinary team in  
order to deliver quality care. They also spoke about the individual skills, capabilities, and  
human resources available to manage the stressors of the work. There was little mention  
of lack of resources (the theme was mentioned only nine times in the transcripts). Lack of  
resources was not necessarily an issue for nurses except, perhaps, on the off hours or  
weekends.

I come in with baseline knowledge and experience, but I also need the tools to  
accomplish that in the room or on the phone, such as the handouts, and the time to  
get it all done. So I guess I need the time, tools, knowledge, and experience . . .  
and the support that comes [from others] with making all of this happen.

***Sub-theme: educational materials.*** The participants reported that online practice  
resources and guidelines help promote and support independent and collaborative  
decision making. The participant's perceptions of having the tools needed for patient

teaching sessions were mixed. One participant liked the new technology and ease of being able to incorporate it into the patient teaching sessions, “Online education materials are great. When I started it was all in booklets . . . did not have them all the time . . . and it’s great, patients have access to them too, and we can email them.”

Another has the opposite view and prefers the resources they were accustomed to:

We used to have our own routine, our own forms, and the education sheets that this organization’s nurses put together; and now we went to the electronic version. . . . I am not crazy about those new electronic forms.

*Sub-theme: time as a resource.* The participants reflected on time as an important resource. Time seems to be an ongoing issue. They feel that having enough time to spend with their patients and the patients’ families is important. Time to get all the tasks done that need to get done is important. There are situations where the participants feel they are given the time and that quality, not the quantity, of the work is emphasized as the priority.

Time management is very individualized to the patient . . . patient teaching . . . end-of-life talks . . . it’s hard to balance. If you have a newly diagnosed patient, scared out of their minds, you need to give them the time that they deserve . . . it impacts wait times . . . impacts all, but it is what it is. It is important that we put the time in.

There are also other situations where they just have to take the time, even if it may impact workflows. They can take the time, but according to a participant, “something else, then, needs to give.” When asked to clarify, the participant said, “You

pay for it with long days, clinic hours, or patient wait times.” One participant, in particular, said he/she felt empowered by the ability to utilize the time needed.

As nurses, you are taught you are empowered to do things, but you go to some institutions . . . but then “wow” that is not really the case. But at this institution, I definitely feel I have that . . . for example . . . Surgical case times are very important, but if I feel I have a patient that needs another hour of care at the end of the procedure, I do not feel that there will be repercussions to me. Even though they stress . . . we want everyone [the surgeon, the nurse] to be on time, these surgeries are expensive . . . But if I feel I need to take better care of this patient at the end of the procedure, and that they need something else from me . . . I am not concerned or afraid that I will be reprimanded by a superior because the patient always comes first . . . I am allowed to practice that here, I am allowed to do that here . . . it’s throughout . . .

*Sub-theme: colleagues as resources.* The participants’ responses indicated that their interdisciplinary teams are also a resource that can be utilized in the delivery of care. They feel that it takes a collaborative and willing interdisciplinary team to provide the individual “special level of care” the patient needs. Physician and Nurse Practitioner colleagues are also great resources for information and guidance in the care of these patients.

But what I noticed about here . . . because it’s what we do all day, we are good at it. Here they [the patients] need so many different areas of care, it’s so collaborative.

When asked what the participant meant by a different level of collaborative care delivery, in response to this question, the participant created a scenario as if he/she was talking to a patient. In the make-believe interchange about the services available to the patient, the participant illustrated the interdisciplinary nature of the organization. The strong teamwork among specialists was evident. Here he/she tells the patient:

It's not just the surgeon taking care of you, it's not just the nurse. If I see that you need help and that you are going to go home and you live in a three story house . . . . It's not just the nurses' problem to call the social worker . . . I noticed . . . the surgeon wants to follow up, the case manager wants to follow up . . . everyone is aware [of what] you need . . . they know it takes all the different disciplines to come together, all disciplines are involved.

According to the participants, colleagues may also serve as resources for knowledge. The direct-care colleagues assist with the internal day-to-day management of the patient care. Nurse Leaders (NLs) serve in a more global capacity.

As a nurse, if you do not have the answer, you know where to get the answer . . . on the local level, if its side-effect management. . . . I go to the doctor . . . and the NP are fantastic resources. If it's an ethical or behavioral issue, I could go to my nurse leader . . . in truth, we do not have that . . . . I do not go to my nurse leader with local level issues, and I do not think the NL expects that.

*Sub-theme: setting boundaries and building resiliency.* The participants implied that managing the emotional aspects of the work requires resources too. One participant spoke about needing internal resources in order to set up defenses against the impact of the work.

No one tells you how to build a wall. You just build a wall . . . if you don't, you would be a basket case. Somehow you can build these walls . . . and when you do break down . . . there is a resiliency . . . you just get up and go back to it.

Another participant defined the work as emotional and spoke to the challenges of caring for a patient with cancer, the long-term relationships, and the strong bonds that are built between the nurse and the patient throughout the cancer journey. Assistance with coping strategies are the social work resources that are available to unit nurses.

I think it supports it . . . the social worker will have a session in our conference room and talk about how we are feeling . . . how the work is impacting the nurse and our work. I think that is one way it's supported . . . to talk about things as a unit . . . boosts morale; you are together in this . . . you are not going through it alone. Colleagues are going through similar emotions. Time to deal . . . having good friends and family to hear how your work is going.

***Theme 3: information.*** This theme was the second-most mentioned of all the themes, right after the theme “support.” The participants expressed that information comes from multiple sources, which include structures of information technology, council structures, and nurse leaders.

*Sub-theme: challenges with technology.* Receipt of information may be impacted by occasional lack of access to electronic information between departments with regard to patient concerns and flow through the continuum of care. Despite these challenges, participants report that this environment through involvement in council structure promotes a collegiality among its team members, to attempt to fix these issues and

provide safe quality care delivery. Progress on plan to resolve these issues however, may not be communicated back to the individual employees.

I think there is a lack of information. I think our department is so focused on our own issues . . . I see that things happen in outpatient, and it's not communicated to peri-anesthesia, who doesn't communicate with inpatient. There are issues of patients not being electronically transferred to our areas, and if we needed stat labs . . . . I don't know, even an X-ray, they would be looking for patients upstairs not knowing they were in our area . . . it's still not resolved. . . . I do not know what is happening with it. . . . I do not know if it's a priority, but it's a priority to me . . . and it affects my workflow....

*Sub-theme: council as a source of information.* The participants reflected that the council structure is a good forum for information sharing and the learning of new practices, policy changes, and quality measures. However, how well this flows is dependent upon the maturity and functionality of the council. "You get up-to-date information on clinical documentation changes, practice changes; it's important knowing the practice expectations." Some express that through their unit-based councils, they have created a nice core of people to freely ask information from all the time. They believe it has a tremendous effect on patient outcomes, job performance, and stress levels.

*Sub-theme: leader as a source of information.* The Nurse Leader keeps staff informed through staff meetings and the facilitation of in-services.

A lot of times nurses go to conferences . . . and that information is brought back and shared at staff meetings . . . new products come in and we have trials, its

discussed, and in our in-services, we get trial updates, so they just don't disappear; they let us know if it worked or didn't work . . . we look out for that.

The participants stated that some Nurse Leaders also participate in the council structure. If staff are unable to attend the council meeting, the Nurse Leader will fill them in on what was discussed and if there are any changes in practice. The participants stated that sharing information through the council structures, staff meetings, and attending conferences offers them the opportunity to keep up to date with new policies, standards of practice, and organizational changes.

***Theme 4: support.*** Support was the most frequently mentioned theme within the transcripts. Support refers to the feedback, mentorship, and encouragement received from supervisors, colleagues, patients, and families. It also can refer to support for taking risks. The participants perceived themselves as having an environment of mutual support from colleagues in order to cope with the intensity of the work. These relationships, they feel, are built on recognition, respect, appreciation, and trust in each other's clinical expertise. Support also comes from patients' recognition and gratitude of having received quality care.

*Sub-theme: relationships with colleagues.* Relationships with colleagues are founded in all members of the team recognizing that the patient and family are the center of the focus. Regardless of patient acuity and inter-personal conflicts among the teams at times, the nurses are still able to deliver care safely and effectively. The participants felt that they had the resources of a multidisciplinary team in order to get patients' needs met.

I think because we work with such heavy issues with cancer and [in] a heavy environment . . . and because I work with such amazing people, we all kind of get

it done . . . it's such a community here. . . . Nurses [are] held in high regard [along] with MDs . . . it's a team environment . . . people ask, how do you do it? I say it's the people I work with.

These relationships are perceived as generally cohesive, but challenged at times when the teams are working under stressful conditions, are short staffed, and/or are "super busy." The patient population is perceived as impacting these relationships. Sharing a common goal of caring for the cancer patient bonds them and builds a sense of family or community.

I think those relationships with [the] physician[s] has a big impact on the work, when you are able to approach someone and get information easily and there are no tensions involved, you are more efficient, your clinic moves faster, your patients get help quicker, and I think you have less stress throughout the day . . . when you are working with someone who is not available, either physically not available or you can't reach [them], or [who] does not want to be bothered, it creates stress, and it impacts your ability to care for your patient. It's the triple effect . . . it's the same whether it's through the physicians or through nursing.

When reflecting on leadership support, some participants described it as motivating people and recognizing their hard work. They believe it's about visibility, showing support, and showing yourself.

The NL is in a tough position. I know my NL is very supportive . . . NL asks if I need time to accomplish things . . . and NL is available . . . anytime I ask to see the NL, NL says yes, cuts out time for me; if not that day, during the week . . . NL signed off on all my classes . . . gives me time, asks if I need time . . . but they are

in a tough position. Sometimes the nurse leader does not get involved in day-to-day stuff.

The participants found that there is visibility from the nursing leadership, but not micromanaging. They perceive that leaders need to take care of the “bigger picture” things versus unit-level issues. Unit-based issues are handled by the senior nursing staff. One participant, however, mentioned that he/she felt the lack of leadership supervision on the night shift.

I was on night shift for a year and a half, and now I am on days . . . I think leadership is more present on days. That is good, not so much on the night shift . . . could be a little better with that . . . but I know that is hard. With the schedules and stuff . . . but just having a presence . . . asking how is your day going . . . that’s enough . . . that makes you feel better.

*Sub-theme: relationship with patients/families.* The participants reflected on their relationships with patients. The majority agreed that the diagnosis of cancer, itself, makes for a different type of relationship. Patients and families are cared for over many years, and strong bonds are formed. According to some participants, that is why primary care works. The organizations use of the primary nursing role is good for the patient. It provides consistency and quality care. These types of relationships influence the participants’ collaborative commitment to the delivery of quality care. Patients have total confidence and trust. One participant speaks to liking the positive feedback from patients and families.

I like the positive feedback . . . . It means that I feel good about what I do . . . all the time and effort I put into it pays off. It's a sense of accomplishment that I am good at doing this.

Another participant speaks to how the oncology population is a special type of patient population that has unique needs.

Unlike an accident victim, this is a patient who maybe felt something, went to routine screening or was diagnosed with cancer, here, or in another institution . . . and they start to go on this journey . . . I feel . . . they are afraid; there is a lot of fearfulness and a lot of unknowns with oncology. . . . I think it takes a special touch from the nurses, physicians, radiologists . . . all people they come in contact with need a special level of care. . . . I think that is what I mean by special population; so much is affected . . . their health is affected, and their job is affected, their family life, their role in society is affected; it touches every aspect of their life . . . (thoughtful pause) . . . I think, as a health care provider, you need to know how to address it at different levels.

*Sub-theme: empathy.* The participants expressed that an immersion into the world of oncology, either professionally or personally, has impacted their level of empathy for their patients. It has raised an appreciation for the journey that these patients are on and the impact it has on all aspects of their lives. One participant spoke about how experiencing the death of two close family members recently to cancer has given the participant a different perspective on the work.

or when you hear those words, "There is nothing more we can do." . . . I think it has made me a better nurse, here, being on the other side of it . . . or even when

people are upset or stressed out. I can see the other side . . . I think those experiences in my own personal life have made me a better nurse here.

According to one participant, working in oncology can be life affirming and can give one a different appreciation for life.

I never liked oncology, but it has given me . . . an appreciation of what the patients, young and old, are facing with their mortality . . . until you work in oncology, you never know what these people are living through . . . the courage, the hope they inspire [in] us [is] more than we inspire [in] them.

*Sub-theme: trust.* The importance of trust was seen across almost half of the participant responses to the interview questions. Trust seemed to be the foundation underlying all of their relationships. The participants expressed the importance of trusting and feeling trusted by patients/families, physician colleagues, nurse leaders, and nurse colleagues. The participants believed that the NL and the physician trust their clinical judgements. They feel partnered with their physicians.

The beauty is , I can say to my doctor [collaborating doctor], the patient needs this or that and there is total support and total respect for my nursing judgement, that I can make many decisions on my own...I know I am appreciated and respected for my years in nursing and my judgement.

One participant shared how watching a patient transformed from a very anxious, fearful, and uninformed patient to a reassured, less tense trusting individual was very rewarding.

I find it very rewarding in so many ways. I get . . . could say I get a rush . . . I get a lot of satisfaction when I get that family, first time into clinic

that's a wreck . . . I am doing all the teaching . . . the mood gets lighter . . . they feel satisfied, no, not satisfied, reassured. They say, "I feel so much better" . . . tension is gone. They trust you. You built that rapport with them.

Another participant attributes improved patient relations to the primary care model.

Yes, total confidence and trust. That is why primary care works. They see us all the time . . . [the] same nurse . . . I would see them in [the] clinic, and they would say, "How was your vacation? We missed you." They know when you are not there so . . . I think this organization's use of [the] primary nursing role is good for the patient.

***Theme 5: structures of power.*** The concepts of shared governance, autonomy, and accountability were explored.

*Sub-theme: shared governance.* The presence of a shared governance structure was perceived by the participants as a forum for "being at the table."

Shared governance refers to the formal systems that are in place within the organization that promotes flexibility, creativity, and participation in decision making. These include councils or shared governance structures. The study institution's shared governance structures consists of unit, divisional , and departmental based council structures which have particular deliverables and which bring information to and receive information from each other and to the leadership.

The participants felt that a shared governance structure, not only allows them the opportunity to practice within the paradigm of their roles, it partners with them in

developing institutional goals. Shared governance, according to the participants, also promotes evidence-based practice.

With shared governance . . . you don't hear we are doing this "because it's how we have always done it" . . . when we make changes . . . it has been thought out. Many people have had input in[to] the changes. Not one person is making the decision; there is a comfort level in that.

According to the participants, these shared governance structures convey to them where they stand in relation to patient care by giving them the resources that allow for autonomy.

I think the committee work is getting stronger as we go on . . . we even had growing pains . . . not knowing which direction to go in with the committee work. But, I think it's positive, because when nurses are involved in change, then it's more effectively implemented, and the staff are more satisfied...and patient care improves. I do think it's a positive thing.

At times, the participants felt that some agendas were still very top-down, especially at the unit based council level. The next participant was talking to, and comparing, the departmental and divisional councils with the unit-based councils. To paraphrase;

If a decision is made at the unit based council (UBC) level, I would then ask how does that go up? . . . where does that go up? . . . I think the UBC just has a place on our unit . . . it's a good place to decide to do things this way or that . . . filter things through our nurse leader . . . I feel like the older structures of the coordinating councils . . . and the departmental councils are still the best venue

[for communicating information in both directions] . . . where I feel that unit based councils deal with directives that are more top down-, and then we have to make the decisions based on those directives on how we divvy up or do the work . . . I don't think they figured out how to make both fit . . . they are trying to fit in these two different structures [new council structure with the old council structure], but I do not see it happening, or if it is it is very slow.

Slow progress toward change is voiced as due to certain structural barriers, lack of commitment, and lack of communication. Another participant spoke to the difficulty of trying to make change happen at times through the councils:

I find it hard to make changes. I think the process is really slow, and it's hard to get the right people in room together . . . the true stakeholders . . . even if they have an interest . . . it's hard to get the people together. . . . I think it's the commitment from [the] people, for instance—we have different nurse leaders—different departments, but we work directly with each other . . . everyone has different styles and different priorities.

*Sub-theme: autonomy and accountability.* The participants believed that autonomy is encouraged and accountability to leadership, peers, and patient and family is expected. The participants felt that they have an ownership of their practice and an accountability to provide trusting, safe quality care to their patients and their families. They have autonomy and accountability when it comes to their work and as a member of the health care team.

We are their other hand [physicians] . . . doctors from other areas are surprised at how autonomous we are here . . . . I come out of the room with my assessment

and Dr. \_\_\_ trusts me, takes it at face value . . . and it's the partnership too, some people just click.

According to the participants, having autonomy means that the institution provides an environment that allows nurses to feel that they can practice within their professional capacity. It allows nurses to bring their "own culture and individuality" to the practice without fear that this is not what the institution wants them to do. Participants speak to this culture of nursing by reflecting:

I feel like here . . . we share a lot of the responsibilities to keep the unit running. . . . We have a good working relationship with the NL . . . and the NL trusts us to take on these roles. . . . I feel that we have a lot . . . we are empowered . . . to make decisions and do things that affect our unit . . . since the [NL/Clinical nurse specialist] are not really working side by side and day by day in everyday decision making. . . . We have a unit-based council, which has a chair and co-chair . . . where we meet once a month to discuss issues and, troubleshoot if there are problems on unit.

The participants spoke about not only having the autonomy to do their work, but also about taking accountability for the results or quality of the care delivered. One participant defined having autonomy as a privilege that one can only keep if he or she is accountable for the outcome.

I hold myself accountable for everything that goes on from the time I step onto the unit . . . until I leave. I am the nurse taking care of that patient, I assumed that role, I know I have to take care of that patient . . . and that things go right for that patient . . . no matter who I have to call or what

conversations I have to have . . . for me, I have that autonomy . . . but having autonomy is a privilege. If you are not accountable for your own actions, try to blame others, then I think you lose the right to have that autonomy.

### **Summary of Results**

The two research questions that guided this study were:

- What are oncology nurses' perceptions of structural empowerment?
- How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done?

The study concluded with the identification of findings that gave insight into the nurses' perception of structural empowerment, and the findings presented a snapshot of organizational views with regard to access to opportunities, resources, information, support, and formal structures of power.

**The study participants highlighted shared governance structures as an important empowering structure and shared opinions on the organizations practice of shared governance.** The participants found the current structures of shared governance within the study institution were an effective method of “being at the table” during time of decision making when it is relevant to their practice. They also indicated that shared governance is a forum for information gathering and sharing. They noted that some agendas can be “top down”. They would like to see a more interconnectedness between the unit-based councils and the departmental councils; they express that communication between councils and functionality of the councils is dependent upon the maturity of the existing structure.

**Interview participants also recognized the need for promotion of continued professional development and growth, but there are processes that make this difficult at times.** The participants report that there exists within the institution ample opportunity for professional growth through educational and professional opportunities as well as through organizational citizenship activities such as participation in councils and taskforce groups. The clinical ladder structures allow for promotional opportunities as long as certain criteria are met and maintained. Some participants were seeking increased recognition of the nurse at the point of care, who they perceived as having clinical expertise, leadership, and mentoring capabilities. They perceived that the new promotional criteria, which are based on participation in council structures, professional conference presentations, or publications, may exclude the clinical expert at the point of care, who is interested in giving his/her best to the patients, families, and colleagues at the point of care.

**While the majority of participants perceived the nurse leader as in charge of bigger institutional issues, there was concern expressed for novice nurses needing closer supervision.** The majority of the nurses reported having a sense of autonomy when it came to addressing unit-based issues, they had self-scheduling, and if there were conflicts or practice issues, they were handled by the senior staff. Nurse Leaders would check in but not necessarily get involved at that level. One participant mentioned that leadership visibility is needed on the night shift where more novice staff are found and where there is less supervision and human resources.

**Inconsistency with adequate communications were reported.** Positive lines of communication scored high on the data analysis, and it appeared to be related to positive

relationships and the presence of council structures. However, there were 14 occasions where lack of information was coded in the transcripts. Data analysis showed that a breakdown in communication can be related to practice changes, organizational updates, or colleague-to-colleague communication breakdowns. One participant mentioned that the electronic patient flow programs were not updated as they should be and patient location was difficult to establish online. On these occasions, the participants reported a perceived lack of access to information.

The participants in the study reflected on many recent changes that have come about because of new endeavors undertaken at the study institution. These changes include new technologies, and promotional process workflows and structures. Some changes were perceived as having come too quickly and some too slowly. The study participants did not necessarily object to the changes, but their issues involved the perception that the changes came without much information, notice, or input from the staff.

**The study participants reported that caring for the oncology population can be very rewarding but also very demanding and emotionally challenging.** Empathy, setting emotional boundaries, and building resiliency emerged as part of the theme of support. Remarkably themes relating to emotional well-being surfaced 50 times and ranked the highest of all the themes. Participants reported that their main line of supportive resources are their colleagues, who some consider their “second family.” Social work staff are also available for counseling and self-care sessions.

## **Chapter 5: Discussion**

### **Introduction**

Through the lens of oncology nurses in a major oncology teaching hospital, this study sought to explore nurses' overall perceptions of structural empowerment and their perceptions of how current existing structures provide the support, opportunities, information, and resources needed to get their work done and impact the delivery of safe, quality care. The findings were based on data gathered from in-depth interviews with seven oncology nurses who worked within their current clinical area for more than 18 months, had a ranking of CNII-IV, and spent more than 50% of their time in direct patient care. The findings from this study were also consistent with published authorities outlined under the literature review. This chapter presents details on the implication of the findings, limitations of the study, and recommendations for improving organizational structures

### **Implication of the Findings**

**Implication 1: Shared governance structures may need to be reexamined to ensure standardization across the organization.**

The profession of nursing has been perceived by society as a trustworthy one. There is no written contract or retainer that is negotiated between a patient and a nurse. The patient trusts that the nurse has the knowledge, skills, and attitude to keep him or her safe. The nurse trusts that the educational foundation that he or she has received will enable safe care for the patient. The nurse has also learned to trust his or her intuition—

that gut feeling that there is a subtle change in the patient's presentation. The nurse must trust the other members of the health care team. The nurse understands that the care of the patient takes a team approach, and each member caring for the patient has a unique and important contribution. The notion of team work is founded in trust and is essential to positively impacting patient outcomes. The nurse must also trust that the institution will provide the necessary resources to keep the patient and staff safe. A shared governance structure, where information on practice changes, practice needs, and evaluation of practice happens, led by the nurse at point of care, is where these resources can be found.

**Implication 2: Nursing staffs' perceptions of the promotional maintenance standard criteria may actually impede staffs' motivation to advance within the organization or to maintain current status.** The participants see the clinical ladder initiative as an excellent venue for the continued professional development and promotion of nursing staff. They believed that it is an environment that allows for individualized career and advancement choices.

However, participant responses indicate that there is opportunity to review the promotional process to ensure that it is meeting its objectives and that staff have a clear understanding of the expectations. Nurses need motivation to pursue a career path, but perceived impassable processes make it difficult. Leadership is advised to explore staff perceptions that the practices meant to promote professional engagement may actually be an impediment.

**Implication 3: Situational leadership models may assist nurse leaders in better selecting the appropriate supervisory style needed by nurses at various levels of professional development.** The transformational leader is at the helm of a structurally

empowering environment. Providing a relationship-based care approach to management for the staff is key. More information is needed to evaluate the need for more supervisors or senior staff on the night shift. The leadership may find themselves leading different groups of peoples. Perhaps a more situational leadership style is needed in this setting. The night-shift leader may need to be flexible with leadership styles in order to fit the individual employee.

**Implication 4. There is a need to evaluate current structures of communicating information.** The participants found that a lack of communication impacts workflow, patient care delivery, and safety. In health care, information must be reliable and up to date. Within the health care industry, there are many rapid changes that impact technology, treatment approaches, and diagnostic capabilities. In the field of cancer care, it is imperative that nurses understand new concepts and how to translate new information into patient care and education. Accessibility of this information is key. The ability to implement change is important, and adaptation to change can be smoother if it is accomplished using good communication skills or techniques.

**Implication 5: Providing the right type and quantity of support nurses need may assist in maximizing nurses' ability to care for their oncology patients.** Oncology care is physically and emotionally charged; preventive coping skills are needed by the staff who care for this patient population. The themes of empathy, emotional boundaries, and resiliency did not come up in the general structural empowerment literature, as these are not intuitively empowering concepts. This leads the researcher to deduce that these are concepts that may be unique to a study on structural empowerment and oncology nurses.

## **Limitations**

While the researcher adhered to traditional qualitative methods to perform this research, the limitations in this study include (a) the inability for generalizability, (b) the inability to test for trustworthiness, (c) the inability for an in-depth exploration of the concepts of transformational leadership, and (d) the possibility of bias. A more detailed explanation of the study limitations follows, along with the processes that were put into place to minimize such limitations.

Generalizability is the degree to which research methods justify the inference that the findings are true for a broader group than just the study participants; usually the inference is that the findings can be generalized from the sample population (Polit & Beck, 2012). The goal of this study was to provide contextual understanding of the experiences of seven oncology nurses. Its intent is not to generalize to the larger population. Its intent is only to describe their views and their experience with current work-life structures of empowerment within the study institution.

The findings for this study could not be validated for trustworthiness because triangulation could not be achieved. Triangulation requires utilizing multiple sources and methods for collecting data to increase the believability of the findings (Creswell, 2013). While the initial design of this study was to conduct triangulation using archival data, this was not achieved. The use of archival data from a previously administered quantitative study and a focus group was not approved by study institution. In order to build trustworthiness, the researcher referred to field notes to support the verbal responses from participants. The findings were explicitly reported, and prefigured codes were utilized

based on Kanter's theory and Kanter's definition of these concepts by the selection of themes in an effort to avoid biased interpretations from the researcher.

Another limitation to the study was the inability to fully and directly explore Kanter's (1993) concepts of transformational leadership and its role in the provision of a structurally empowering environment. Understanding the role that the nurse leader plays in the establishment of structures of empowerment is a major concept that needed to further exploration. At the core of Kanter's empowerment structure is transformational leadership and the role the nurse leader plays in creating structures of empowerment in the workplace. A similar study on leadership using focus groups was already done at study institution. Therefore, the scope of study was limited to in-depth interviews. The research council, CNO and the researcher agreed that, a broader focus on structural empowerment made sense. In spite of these limitations, and based on the participants' expressed observations, there was enough evidence to suggest that nurses felt transformational leadership was present in their workplace.

Third, there was the presence of potential bias. As a nurse researching nurses, there was a comfort level when entering the participants' world. The researcher's background in nursing, oncology, and nursing education made it easy to build a conversational partnership with the participants. The researcher had access to participants who were willing to share authentic perceptions of the lived experiences of their professional practice. However, there was always the potential for biases and untruthful data, whether it manifested itself in the form of the researcher hearing and making a judgment about the data, based on her own lived experiences, or the potential of the participants providing data that they believed the researcher desired to hear.

To eliminate or reduce the possibility of biases, bracketing was key in minimizing bias. The researcher sought to maximize the validity of the research by utilizing bracketing during the literature review, data collection, and analysis. Bracketing was utilized throughout the data collection by the reflection of the researcher's own values, interests, and emotional reactions to the participants' responses to the interview questions. In order to enhance the trustworthiness of the data analysis, the researcher continuously clarified the responses with the participant and verified verbal and nonverbal cues. Other attempts to minimize bias included the researcher presenting participant responses verbatim to reinforce the interpretation of the findings. Differing viewpoints were also reported, as warranted, to minimize a one-sided interpretation or reporting of the results.

### **Recommendations**

**Recommendation #1: Shared governance structures may need to be reexamined to ensure standardization across the organization** and to ensure that it is consistently led by and provides a voice for direct-care nurses. A more standardized, less subjective approach to council leadership selection may facilitate this goal. A more consistent and deliberate approach to engagement of direct care staff is needed. An opportunity exists to assess these structures to determine if they are still meeting the intended goal. Their interconnectedness and information-sharing processes need to be reviewed to ensure that staff who did not attend informational meeting are made aware of the information shared at these forums.

**Recommendation #2: Interview participants recognized the need for promotion of continued professional development and growth.** Some participants

perceived the clinical ladder criteria as difficult to maintain, in the midst of nurses wanting or needing to spend more time in the clinical area or not having the “protected” time to participate in other activities. This has implications for staff wanting to seek learning, leadership, and promotional opportunities. Nursing Leadership is encouraged to evaluate current processes for feasibility to maintain these standards. Are the appropriate resources to facilitate this process in place, supported or accessible? Are the objectives of the program being met? Are mutual goals being fulfilled? How is this affecting staff satisfaction and morale? How can staff be motivated or facilitated to maintain the expected criteria? Is there a need for staff and perhaps, nurse leaders to better understand this process? Leadership is advised to gather data to get more clarity on how this current structure is working and if it is achieving intended goal.

**Recommendation #3: There is a need to evaluate current structures of communicating information.** A gap analysis is needed to investigate weak areas of communication—whether they are electronic or verbal. The leadership is encouraged to assess the current status of the electronic and technological equipment that might assist the staff with the communication processes that are lacking. Maintaining open lines of communication between departments is crucial to safe patient care delivery. Investigating better ways to manage and inform staff of change is recommended. Educating staff on how to access some of this information may also be needed.

**Recommendation #4: Regular assessments should be performed of the psychosocial and support needs of the interdisciplinary team.** A healthy workforce promotes healthy outcomes for patients and the organization. The study institution’s model for practice is based on the concept of relationship-based care (RBC). The three

relationships include care of patient/family, care of colleagues, and care of self. This model provides a framework for organizing care, effecting change, and transforming the cultures of health care institutions. Within a caring, healing environment, RBC individualizes and personalizes the delivery of care (Koloroutis, 2004). Ongoing assessments of how the model is realized within the institution would assist leaders in designing structures to support it.

**Recommendation #5: Conduct more research relating to structural empowerment and oncology** Future research could build upon this study. More research is recommended in the following areas:

- Research with qualitative and quantitative methods to further explore new findings relating to nurses' need for psychological and emotional support as another line of "power" as it relates to Kanter's (1993) theory of structural empowerment.
- Look at the situational leadership models and their influence on structurally empowered work environments for nursing.
- Use quantitative research to examine the correlation between years of experience and clinical ranking and the satisfaction of oncology nurses with their current environment.

## **Conclusion**

The delivery of safe and efficient patient care has been entrusted into the hands of the nurse as the primary coordinator of that care. The delivery of patient care and its influence on patient care outcomes has been discussed previously in this study's literature section. The role and scope of the practice of oncology nurses has continuously been

evolving into one that requires a highly skilled, educated, autonomous, accountable, and empowered workforce. This study sought to explore nurses' work structures to identify if those work structures met the needs of the oncology nurses of today.

This descriptive qualitative study posed two research questions:

1. What are oncology nurses perceptions of structural empowerment?
2. How do oncology nurses perceive themselves as having the information, support, opportunities and resources needed to get their job done?

Kanter's (1993) theory proposed that organizations, led by a transformational leader who can access Kanter's four main lines of power and bring these to their employee, is providing a structurally empowering environment. These lines or structures of power include (a) opportunities for continued skill acquisition and professional advancement; (b) support in the form of feedback, allowing risk-taking and trusting; (c) resources that may be human or material; and (4) information needed about the work or the organizational structures and processes in order to participate in decision making.

This descriptive qualitative study used in-depth interviews to explore seven oncology nurses' perceptions of structural empowerment at a major oncology teaching hospital. Interviews were audiotaped and transcribed, and the data was organized by the use of a priori coding based on Kanter's (1993) structures of power. Data was then categorized into themes and sub-themes. The themes included opportunities, resources, information, support, and structures of power. The sub-themes included educational opportunities, clinical expertise, time as a resource, educational materials, colleagues as resources, intrinsic resource to set boundaries and build resiliency, challenges with technology, council as source of information, leader as the source of information

relationships with colleagues, relationships with patients, trust, empathy, lack of commitment, shared governance, autonomy, and accountability. The literature review discussed in Chapter 2 supported all but three sub-themes, and these were setting emotional boundaries, resiliency, and empathy.

Empathy, setting emotional boundaries and resiliency are themes which need further exploration when looking at supportive structures of empowerment. Kanter's (1993) theory speaks to support in regard to giving feedback, allowing others to take risks, and being visible, but not much is mentioned in Kanter's work about the transformational leader offering or providing the "emotional" support needed to complete one's assigned job responsibilities. This finding opens up opportunities for research in oncology as it relates to empowering nurses through the provision of emotional, and perhaps spiritual support in order for them to continue to give of themselves to their patients and colleagues, and continue the delivery of quality care.

There were five major findings and recommendations identified from the participants' data:

1. Shared governance structures are a great forum for being at "the table" and being heard; however, an evaluation of these structures are recommended to ensure that the objectives of shared governance are truly being met, and that structures are standardized throughout the organization. The findings showing shared governance are highly valued by nurses as a forum for collaborative decision making and as a venue for input into the content and context of their practice are congruent with the literature discussed in Chapter 2 (Barden et al. 2011, Houston et al, 2012).

2. The participants reported that even though structures of promotional opportunities exist, the process needs to be reviewed in order to address potential impediments to promotion.
3. The participants reported that the nurse leader's role is found to be more globally focused than unit based. The unit senior staff have been given, or felt they have been given, the autonomy and accountability to manage unit-based concerns. One participant mentioned that more supervision is needed on the night shift where more novice staff can be found working. This leads to the recommendation that a more situational leadership style needs to be investigated or promoted.
4. The participants reported inconsistencies in lines of communications due to inadequate use of technology, lack of communication across disciplines and departments, and lack of communication across council structures. Nurses are generally included in the change process, but this is still seen as inconsistent in some areas and on occasions. Issues relating to not being fully informed or part of the change process surfaced. Recommendations were made for leadership to investigate this further and to search newer technologies that may facilitate improvements in this area.
5. The study participants reported that caring for the oncology population can be very rewarding but also very demanding and emotionally challenging. Recommendations were made for an assessment of the current resources available to staff for emotional and spiritual support. Promotion of structures supportive of Relationship Based Care was also recommended.

The findings from this research hope to generate further discussions/research regarding oncology nurses' perceptions of structural empowerment. They may also provide nursing leadership with a starting point that may be useful in evaluating current structures of empowerment for oncology nurses. The findings will also support the need for further research into the psychosocial needs of the oncology nurse, which may impact care delivery.

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## Appendix A

### Interview Protocol

**Additional Demographics-Ice Breaker:** Please share with me your professional journey and what has brought you to nursing as a profession and to oncology in particular?

**Research Question #1.** What are oncology nurses' perceptions of structural empowerment?

- How would you define Structural Empowerment?

**Research Question #2.** How do oncology nurses perceive themselves as having the information, support, opportunities, and resources needed to get their job done?

- Can you share with me your perspective of working in this current environment?
- How do you envision this type of structure facilitating your work-life?

## Appendix B

### Part #1

#### Introduction Letter to Potential Participants

Dear Nurse Colleague,

My name is Altagracia (Grace) Mota; I am a candidate for a doctoral degree in the St. John Fisher College (SJFC) Ed.D. Program in Executive Leadership. I am working under the direction of my dissertation chair, Dr. Claudia L. Edwards.

I am conducting a study as part of my degree requirements and I would like to 4your potential participation. My dissertation research explores perceptions of oncology nurses in the workplace.

Being an oncology nurse, your input is highly valued and needed, and I very much appreciate your potential participation. Your participation in the study will consist of a one to one interview with me. It will be scheduled at a mutually agreed upon date, time and location on site. It will require approximately one and a half hours of your time.

Your participation and the information you share with me will be treated with the utmost confidentiality, and your name will never be associated with the information we discuss.

If you are interested in participating, *below is a link to a survey (which will take less than 3 minutes to complete)*, that will ask you a few questions which will guide me ( the researcher) in assessing if you match the criteria for participation in this study.

If interested, *please submit survey by* \_\_\_\_\_

**(LINK HERE)**

*If you are selected to participate*, you will be contacted to discuss the research in more detail.

Thank you for your interest in participating in this study. I look forward to hearing from you soon.

Sincerely

Altagracia (Grace) Mota

Student @ Saint John Fisher College, Ed.D. Program in Executive Leadership

## Part #2

### Sample Electronic Survey Questionnaire

\*Link will take participants *to an electronic survey questionnaire* which will elicit from them responses relating to demographics and criteria for participant selection.

Thank you for considering participating in my research study. Below you will find a few questions I would like for you to answer. It should take five minutes of your time. It will help us to know more about you and assist in selecting the number of people needed for this study.

Once you complete this form I will review and get back to you within one week. Please know that you are not obliged to participate, you can change your mind if you decided to withdraw and everything you say from this point on is confidential.

**Name:** \_\_\_\_\_ **Preferred Contact Information**\_\_\_\_\_

#### **Time Working as a Nurse in Current Area:**

- Less than 18 months
- 18 Months to Three years
- Three Years to Six Years
- Greater than six years

#### **Time Spent Participating in Direct Patient Care**

- Less than 50%
- Greater than 50%

#### **Title:** (Choose one)

- Clinical Nurse II
- Clinical Nurse III
- Clinical Nurse IV
- If you did not choose one of the above, please indicate  
Other \_\_\_\_\_

## Appendix C

### Letter of Participation



Ed.D. Program in Executive Leadership

3690 East Avenue  
Rochester, NY 14618  
585-899-3852  
<http://soe.sjfc.edu>

[February 5, 2015]

Dear Nurse Colleague:

Thank you for expressing an interest in participating in my research study. ***You have been selected to participate.***

As previously mentioned in my introductory letter, my dissertation research explores perceptions of oncology nurses in the workplace.

Being an oncology nurse, your input is highly valued and needed, and I very much appreciate your participation. Your participation in the study will consist of a one to one interview. It will be scheduled at a mutually agreed upon date, time, and location on site. Interviews will take place **February 16<sup>th</sup> through March 27<sup>th</sup>**. There is flexibility for evenings/weekends too. It will require approximately one and a half hours of your time.

**Please contact me via Telephone or E-mail to discuss/schedule your time, by February 13<sup>th</sup>, 2015**

The interview will be audiotaped and some hand written notes will also be taken. Your participation and the information you share with me will be treated with the utmost confidentiality, and your name will never be associated with the information we discuss.

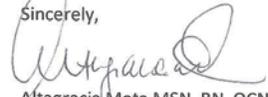
Data from interviews and transcripts will be stored in a password secured network drive, accessible only to me. To ensure utmost confidentiality, transcription of the interviews will be done by me. Any direct quotes presented in analysis will be noted by the gender neutral term of "nurse" .

At the conclusion of the study only deidentified data will be shared with and submitted to Saint John Fisher College and Faculty. The final report based only on aggregate data will be used to report findings. These findings may be used to inform action plans to improve nurse work-life and satisfaction.

Your voluntary agreement to participate in the study will be confirmed at the beginning of the interview. Once the interview begins, please know that you may withdraw at anytime.

Thank you for your interest in participating in this study. I look forward to seeing you soon.

Sincerely,



Atagracia Mota MSN, RN, OCN

Cell Phone # 914-473-7194

Student @ Saint John Fisher College, Ed.D Program in Executive Leadership



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## Appendix D

### Informed Consent

**Title of study:** Structural Empowerment: A Qualitative Inquiry into the Work Life of the Oncology Nurse

**Name(s) of researcher(s):** Altagracia Mota (Student, Saint John Fisher College Ed.D. Program in Executive Leadership), *email:* [REDACTED]

**Faculty Supervisor:** Dr. Claudia L. Edwards Ph.D. (Dissertation Chair), [REDACTED]  
[REDACTED]

Due to the minimal risk of this study, a waiver of informed consent was approved by SJFC and Organizational IRB. Agreement to being interviewed will imply consent. The interview procedure and plan for protecting participant identity was reviewed at the beginning of the session and participant confirmed verbal agreement with their voluntary willingness to participate and provide their views on the study topic.