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NURSES' TRUST IN MANAGERS: THE ROLE OF AUTHENTIC LEADERSHIP AND WORKPLACE EMPOWERMENT

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NURSES' TRUST IN MANAGERS: THE ROLE OF AUTHENTIC LEADERSHIP AND WORKPLACE EMPOWERMENT

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Abstract

Nurses' trust in their manager and structural empowerment are key elements of healthy nurse work environments that can influence important work outcomes such as nurse turnover. The purpose of this secondary analysis was to examine the relationship among authentic leadership, structural empowerment, and nurses' trust in their manager in a sample of Ontario acute care nurses, and determine if structural empowerment mediates the relationship between authentic leadership and trust. Authentic leadership and structural empowerment each had individual direct positive effects on nurses' trust in their manager, but structural empowerment was not found to mediate the relationship between authentic leadership and nurses' trust. Authentic leadership accounted for 48% of the variance in nurses' trust in their manager. Results indicate the importance of nurse managers' authentic leadership and structural empowerment as a way to increase nurses' trust in their manager and contribute to a healthy work environment.

Keywords: authentic leadership, structural empowerment, trust, mediation, nursing management, healthy work environments

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Chapter One

Introduction

Recently, high rates of absenteeism and nationwide nursing shortages have drawn attention to nurses' work environments (Schalk, Bijl, Hollands, & Cummings, 2010) and heightened awareness about possible links between the quality of the work environment and high levels of nurse turnover and poor quality care outcomes (Heath, Johanson, & Blake, 2004; Laschinger & Finegan, 2005). Ongoing nursing shortages and rising costs have prompted many healthcare organizations to acknowledge the benefits of healthy nurse work environments and association with healthier staff and patients (Tomey, 2009). In particular, strong nursing leadership that promotes nurse empowerment, including access to adequate resources and support, and nurses' trust in their manager are essential characteristics of healthy workplaces that organizations must improve upon to ensure positive outcomes such as nurse retention (Anthony et al., 2005; Shirey, 2006). In general, nurse turnover has negative consequences for patients, nurses, and organizations. Although nurse turnover is inevitable to some degree in healthcare, the problems associated with turnover are intensified when poor work conditions and unhealthy workplaces are the reason nurses leave an organization.

Effective leadership and management, empowerment, and trust are aspects of a healthy work environment that significantly influence nurses' sense of wellbeing and can impact important healthcare outcomes (Kramer, Schmalenberg, & Maguire, 2010; Laschinger & Finegan, 2005). For instance, according to reports in the literature, healthy work environments are linked to improved patient care and are associated with higher

organizational commitment, overall increased efficiency, higher staff morale, increased job satisfaction, employee engagement, reduced personnel problems, reduced absenteeism, and successful recruitment and retention efforts (Cornett & O'Rourke, 2009; Sherman, Edwards, Giovengo, & Hilton, 2009; Whitehead, 2006). For this reason, the creation of healthier work environments is assumed to be a reasonable way to improve nurse, patient, and organizational outcomes, and a strategy to both recruit and retain nurses. Certainly this objective is worth pursuing given that Canada is in the midst of a global nursing shortage that is projected to worsen, and is reported to contribute to problems with nurse retention (McGillis Hall et al., 2009). According to the Canadian Nurses Association (CNA) (2009), Canada alone will be short 60,000 full-time equivalent registered nurses by the year 2022. This highlights the urgency of creating healthy work environments with favourable work conditions that appeal to practicing nurses, and perhaps even attract new nurses to a particular organization, or better yet, the nursing profession.

Nursing leaders, including nurse managers and administrators, are fundamental to nurse retention, and on account of their leadership role, have an inherent duty to ensure a healthy workplace for employees and patients alike (Anthony et al., 2005; Shirey, 2006). Specifically, nurse managers are central to the development of cultures built on trust where staff can feel comfortable, satisfied, and safe in providing quality care to patients in the healthcare setting (Rogers, 2005). Targeted efforts by nurse managers to address the problem of nurse turnover, such as creating healthy work environments that empower, satisfy, attract and retain registered nurses now and in the future, are not only imperative, but within the scope of the nurse manager role.

Research has shown that leadership style can have a negative or positive effect on nurses' work environments (Malloy & Penprase, 2010; Murphy, 2005), and suggests that the quality of leader-follower relationships is predictive of significant individual, group, and organizational outcomes such as nurses' overall satisfaction, organizational commitment, and turnover (Cummings et al., 2010; Gerstner & Day, 1997; Tomey, 2009). Kane-Urrabazo (2006) suggested that in order for nurse managers to develop a healthy culture and work environment, they must exemplify trustworthiness, facilitate trust, empowerment, and mentoring as well as demonstrate consistency between words and actions in their leadership. This implies that managers must demonstrate specific behaviours or leadership qualities in order to be effective in the creation of a healthy workplace, and be cognizant of their personal leadership style and subsequent influence of their actions and behaviour on healthcare outcomes.

The Registered Nurses Association of Ontario (RNAO) (2010) emphasizes the significant role of nurse leaders in the creation of healthy work environments and specifically advocates for transformational leadership practices. They suggest that nurse managers can create and sustain healthy workplaces for nurses through building relationships and trust, promoting an empowering work environment that supports knowledge and integration, and by balancing competing values and priorities (RNAO, 2010). Despite the general popularity of transformational leadership, the concept of authentic leadership, considered the root of positive leadership styles such as transformational, ethical, and servant leadership (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Avolio & Gardner, 2005), is emerging as the proposed style of leadership needed to build healthy work environments and promote trust in the healthcare setting

(AACN, 2005; Wong & Cummings, 2009a). Authentic leadership is closely related to transformational leadership, however, there is only a partial theoretical overlap; authentic leaders' strong sense of self and transparent interactions with others is believed to be the key difference between the two leadership styles (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008).

The distinct underlying components of authentic leadership include: *self-awareness, balanced information processing, internalized moral perspective,* and *relational transparency* (Gardner, Avolio, Luthans, May & Walumbwa, 2005; Walumbwa et al., 2008). These features of authentic leadership have positive implications for the development of nurses' trust. In their theory of authentic leadership, Avolio et al. (2004) describe authentic leaders as persons who are genuine and true to themselves, value open communication, and set high moral standards based on honesty and integrity. Authentic leaders are aware that their role carries a responsibility to act in the best interests of others, and realize that their ethical behaviour sends a strong message to others in terms of how they decide to think, and most importantly, behave (Avolio et al., 2004). A key trait of authentic leaders is their tendency to lead by example, inspiring others to likewise achieve authenticity in their behavior (Gardner et al., 2005). In the simplest terms, authentic leaders are positive role models for others. They are considered trustworthy and honest, and ultimately generate an atmosphere of trust and respect in the workplace through their leadership role (Avolio et al., 2004). These are crucial qualities for healthy work environments, especially those that thrive on teamwork and collaboration, such as in healthcare.

Healthy work environments are consistently described as environments where staff nurses are supported by their manager and colleagues, effective communication and team collaboration are encouraged, supportive and caring interpersonal relationships and organizational culture are priorities, and access to training, education and support for nurses' role is provided (AACN, 2005; Cornett & O'Rourke, 2009; Lavoie-Tremblay, 2004; MacDermid et al., 2008; Parsons & Newcomb, 2007; Rathert & Fleming, 2008; Schmalenberg & Kramer, 2007; Spector, Coulter, Stockwell, & Matz, 2007; Stichler, 2009; Tallman, 2007; Tomey, 2009; Whitehead, 2006). Structural empowerment in particular is an important characteristic of a healthy workplace (Laschinger & Finegan, 2005; Laschinger, Finegan, & Wilk, 2009; Laschinger & Sabiston, 2000; Shirey, 2009), and in healthcare organizations, nurse managers have been declared largely responsible for creating healthy, empowering workplaces for nurses (Cornett & O'Rourke, 2009; Shirey, 2009; Tallman, 2007). Generally referred to as structural empowerment, empowering conditions in the workplace include full access to information, resources, support, and opportunities to learn and grow (Gardner et al., 2005; Laschinger, Finegan, & Shamian, 2001). Nurses tend to feel empowered when managers openly share information, provide ongoing support and appropriate resources, including adequate time and staff, and when they encourage and create opportunities for nurses' education and professional growth.

Based on their position in the organization and proximity to nurses, nurse managers are best suited to provide the conditions of structural empowerment that contribute to a healthy workplace. Although nurse managers hold a great degree of power when it comes to facilitating structural empowerment, budgetary challenges

require them to shape nurses' work environments in healthcare systems that value cost reduction and overall efficiency along with quality care. With an increased focus on efficiency, nurses are faced with limited resources and "struggle to influence administrators to create and sustain the systems they feel are necessary to support their work" (Rogers, 2005, p.421). Restructuring of healthcare organizations in the late 1990's left nurses disempowered, and ultimately resulted in damaged trust between nurses and management (Laschinger & Finegan, 2005; Rogers, 2005; Vestal, 2003), which has been linked to job satisfaction, organizational commitment, and turnover intentions (Dirks & Ferrin, 2002). Under these circumstances, it is expected that nurse managers who demonstrate authentic leadership may be more successful in fostering nurses' trust and supporting nurses' needs in the workplace than managers who do not consider building supportive relationships with followers a high priority.

A strong focus on effective nursing leadership is crucial to improving relational aspects of nurses' work environments, empowering nurses, regaining nurses' trust, and addressing urgent issues such as nurse retention and turnover. Research has shown that poor quality relationships in the workplace can have both physical and psychological health effects (Carlson & Warne, 2007) and contribute to negative working conditions, which is a major reason for nurse turnover (Laschinger et al., 2009). Healthcare organizations rely on nurses to provide excellent patient care. Nurses, in turn, rely on their managers to be supportive and provide the conditions necessary for them to safely fulfil their role as patient care providers in the organization. If nurses continue to have poor working relationships, distrust their managers, lack access to adequate resources and support, do not feel empowered, and are dissatisfied with their jobs, then turnover rates

are likely to increase and the quality of patient care will be further compromised (Laschinger et al., 2009; O'Brien-Pallas et al., 2010; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010). Organizations may also suffer substantial financial consequences of unhealthy work environments that perpetuate negative outcomes such as nurse turnover; costs related mostly to recruitment, orientation and training, and lost productivity (Jones, 2005; Jones, 2008; O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). Nurses may leave their workplace for any number of reasons, but no organization can afford to lose valuable nurses, and subsequently compromise quality patient care, because of work environments characterized by low levels of empowerment and trust, increased stress, and dysfunctional relationships with colleagues and managers. The implication is clear that healthcare organizations must actively address factors related to nurse turnover, such as low levels of empowerment and trust, known to contribute to unhealthy work environments.

As previously stated, authentic leadership is the proposed style needed for nurse managers to effectively create and sustain healthy work environments characterized by high levels of empowerment and trust. However, there is a significant gap in the nursing literature that describes the mechanisms by which leaders influence nurses' attitudes, behaviours and other outcomes. For this reason, Avolio et al.'s (2004) theory of authentic leadership was chosen as the theoretical framework for this study. Currently, no studies examine the relationship between authentic leadership and empowerment, or authentic leadership in combination with structural empowerment and trust. Thus, the purpose of this study was to test Avolio et al.'s (2004) theory of authentic leadership in a sample of Ontario nurses in an effort to better understand the relationship between

authentic leadership, structural empowerment, and trust, and to determine if structural empowerment mediates the relationship between authentic leadership and nurses' trust in their manager.

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Chapter Two

Manuscript

Nurse managers are an integral part of nurses' work environments. Specifically, their management role affords them a great degree of power to create the conditions for nurses' work, generally referred to as structural empowerment, and enables them to shape cultures built on trust where staff can confidently provide quality care to patients (Rogers, 2005). In short, nurses' empowerment and trust in their leaders are essential characteristics of healthy work environments that nurse managers are capable of influencing through their behaviour and actions.

Empowerment is based on trust and respect, and is established when there is a focus on shared values and effective communication among all employees in a supportive work environment (Smith, 2008). According to Kanter, structurally empowering work conditions include access to information, resources, support, and opportunities to learn and grow; thus, it is believed that nurse managers empower their staff when they openly share information, provide support and resources, and create opportunities for education and professional growth (Laschinger, 1996). Structural empowerment enables nurses to work to the best of their ability to create positive nurse, patient, and organizational outcomes, and is central to a healthy work environment (Laschinger, Finegan, & Wilk, 2009).

Trust in leadership is also foundational to healthy workplaces (Wong & Cummings, 2009a), and is associated with positive organizational outcomes such as organizational commitment, organizational citizenship behaviour, satisfaction with

leaders, and intention to stay (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Rogers, 2005; Williams, 2005). Healthcare restructuring in the 1990's damaged trust between nurses and nurse managers and as a consequence, negatively impacted relationships (Lucas, Laschinger, & Wong, 2008; Young-Ritchie, Laschinger, & Wong, 2009). Therefore, regaining nurses' lost trust is essential given that lack of trust and poor relationships between nurses and their managers contribute to unhealthy work environments.

Dissatisfaction with the nursing work environment, including lack of empowerment and low levels of trust, is related to increased stress and nurse burnout, and is a major cause of nurse turnover. Turnover is believed to contribute to the current shortage of nurses, and itself may be a symptom of an unhealthy nurse work environment (Faulkner & Laschinger, 2008; Laschinger, Finegan, & Wilk, 2009; Kane-Urrabazo, 2006; Wong & Cummings, 2009a, 2009b). Nurse turnover and retention is an urgent problem in Canada that is further magnified by the worldwide nursing shortage (McGillis Hall et al., 2009; O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). Nurses' increased workload, inadequate resources, lack of support from managers, and low levels of both empowerment and trust are characteristics of unhealthy work environments that contribute to high levels of nurse turnover (Cornett & O'Rourke, 2009; O'Brien-Pallas et al., 2010).

Positive leadership styles such as transformational and authentic leadership are associated with healthy work environments (Cummings et al., 2010; Shirey, 2009; Tomey, 2009). In the healthcare setting, the concept of authentic leadership is emerging as the proposed style of leadership needed to build trust, and for nurse managers to create

and sustain healthy work environments that are associated with the promotion of patient safety, excellent patient care, and recruitment and retention of nurses (AACN, 2005; Wong & Cummings, 2009a, 2009b). Authentic leaders are described as persons who are honest, and have high levels of integrity and a strong sense of morality (Avolio et al., 2004). These leaders are acutely aware that their behaviour and actions send a powerful message to others, and strive to act as role models who lead by example to facilitate a positive atmosphere in the workplace built on trust and respect (Avolio et al., 2004; Gardner, Avolio, Luthans, May, & Walumbwa, 2005).

To summarize, nurse empowerment, trust, and authentic leadership behaviour are indicative of healthy nurse work environments (Kane-Urrabazo, 2006; Shirey, 2006; Shirey, 2009). However, it is unclear how authentic leadership style specifically influences nurses' trust in their manager or if structural empowerment has a mediating effect on the relationship between authentic leadership and nurses' perceptions of trust. Currently, there are no studies that examine the relationship between authentic leadership style and empowerment, or the effect of both authentic leadership and empowerment on trust in the manager. Therefore the purpose of this study is to examine the relationships among authentic leadership, structural empowerment, and nurses' trust in their manager.

Theoretical Framework

The authentic leadership model, described by Avolio et al. (2004), outlines a process linking authentic leadership to followers' attitudes and behaviors. Authentic leadership is described as "a pattern of behaviour that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-

awareness, an internalized moral perspective, balanced processing of information, and relational transparency on the part of leaders working with followers, fostering positive self-development" (Walumbwa, Avolio, Gardner, Wernsing & Peterson, 2008, p.94; Walumbwa, Luthans, Avey, & Oke, 2011). Authentic leaders know who they are, what they believe and value, and they act upon those values and beliefs while being transparent in their interactions with others; they are perceived by others as being aware of their own and others' values, knowledge, and strengths; aware of the context in which they operate; and who are confident, hopeful, optimistic, resilient, and high on moral character (Avolio et al., 2004). Authentic leaders are genuine in their relationships with others and demonstrate relational transparency through openness and appropriate self-disclosure, which is thought to build trust in followers (Wong & Cummings, 2009a), and strengthen interpersonal relationships.

The underlying components of authentic leadership development include: *self-awareness, balanced information processing, internalized moral perspective,* and *relational transparency* (Gardner et al., 2005; Walumbwa et al., 2008*). Self-awareness* is analogous to personal insight and is linked to self-reflection, a process by which leaders continuously reflect on aspects of themselves, their values, emotions, motives, and goals in order to make meaning of the world around them. An important point about self-awareness is the focus on emotions. Authentic leaders are in touch with their emotions and the effects of emotions on others (Gardner et al., 2005). *Balanced processing* refers to the ability of leaders to objectively assess, process, and evaluate positive and negative self-esteem related information, which enables them to respond to situations in a mature fashion rather than using ego-defense mechanisms because of unresolved negative

emotions (Gardner et al., 2005). *Internalized moral perspective*, which is central to a leader's ability to influence the behaviour of others, is described as "acting in accord with one's values, preferences, and needs as opposed to acting merely to please others or to attain rewards or avoid punishments" (Gardner et al., 2005, p. 356). Follower trust is based on the actions of leaders, so in order to convince others of a leader's integrity, a leader's actions must be aligned with his/her values; leaders must do what they say they will do and also believe in what they are doing in order to be trusted. *Relational transparency* is central to authentic leadership (Shirey, 2006), and involves presenting one's genuine self to others through selective self-disclosure in order to create bonds with others based on trust, while encouraging them to do the same (Gardner et al., 2005). Authentic leaders are believed to influence the development of followers by acting as a good example and modeling positive values, psychological states, and behaviours; it is believed that modeling desired behaviour and setting high moral standards will 'cascade' across various levels of the organization and influence the behaviour and actions of others to emulate those of the leader (Gardner et al., 2005). Leaders who model authentic leadership behaviours set the tone for an organization's culture and the standards for others to follow (Shirey, 2009).

Related Research

Authentic Leadership

In a non-nursing population, Walumbwa et al. (2008) developed and tested a theory-based measure of authentic leadership using five separate samples obtained from China, Kenya, and the United States. Authentic leadership had positive relationships

with supervisor-rated performance as well as job satisfaction, organizational commitment, and satisfaction with the supervisor. Specifically, results of the study revealed that authentic leadership predicted organizational citizenship behaviour (OCB) ($\beta = .30, p < .01$), organizational commitment ($\beta = .28, p < .01$), and follower satisfaction with supervisor ($\beta = .26, p < .01$). In another study of 387 Chinese telecom employees from two separate firms, Walumbwa, Wang, Wang, Schaubroeck, and Avolio (2010) showed that the relationship between authentic leadership and organizational citizenship behaviour (OCB) was fully mediated by identification with the supervisor and empowerment. Empowerment was conceptualized as psychological empowerment rather than structural empowerment, and measured using a 12-item scale developed by Spreitzer (1995) that includes four dimensions of empowerment: competence, impact, meaningfulness, and self-determination. The authors found that authentic leadership significantly predicted OCB ($\beta = 0.20, p < 0.01$), followers' work engagement ($\beta = 0.26, p < 0.01$), level of identification with the supervisor ($\beta = 0.40, p < 0.01$), and empowerment ($\beta = 0.25, p < 0.01$) (Walumbwa et al., 2010).

In the context of retail, Clapp-Smith, Vogelgesang & Avey (2009) conducted a study at the group level of analysis to investigate the relationship between authentic leadership, trust, positive psychological capital (PsyCap), and performance in a sample of 89 employees from a small chain of 26 Mid-western clothing stores. PsyCap was defined as a positive state of development characterized by self-efficacy, hope, resiliency, and optimism. Trust in management mediated the relationship between PsyCap and performance and partially mediated the relationship between authentic leadership and performance (Clapp-Smith et al., 2009). Although perceptions of authentic leadership

and trust were measured at the group-level, results demonstrated that authentic leadership had significant positive relationships with trust in management and performance. Similarly, Walumbwa et al. (2011) found that both group-level psychological capital and trust mediated the relationship between authentic leadership and the outcomes of citizenship behaviour and performance in a sample of 146 work groups of bank employees in the United States. Study findings suggested that authentic leadership had a significant positive relationship with collective psychological capital ($ß = 0.37, p < 0.01$) and group trust ($ß = 0.27, p < 0.01$). Results of these studies show that authentic leadership is related to perceptions and behaviours at both the individual and group level, indicating that authentic leaders may be successful in developing trusting relationships not only with individual nurses but with a group of nursing staff at the unit level.

Few empirical studies have tested authentic leadership in a nursing population but two studies have been reported. Wong, Laschinger, and Cummings (2010) found that authentic leadership positively influenced staff nurses' trust in their manager ($ß = 0.43, p < 0.001$) and had an indirect effect on work engagement ($ß = 0.22, p < 0.001$), which in turn predicted voice behavior ($ß = 0.22, p < 0.001$) and perceived unit care quality ($ß = 0.23, p < 0.001$) in a sample of Ontario acute care nurses. The authors also found that personal identification mediated the relationship between authentic leadership and trust. These findings indicated that by demonstrating authentic leadership behaviours and facilitating genuine interactions with others, nurse managers can improve workplace conditions in the healthcare setting and develop trusting relationships with followers (Wong et al., 2010). Additionally, Giallonardo, Wong, and Iwasiw (2010) conducted a study that integrated Avolio et al.'s (2004) model of authentic leadership with Schaufeli

and Baker's (2004) concept of work engagement to examine new graduate nurses' perceptions of preceptor authentic leadership, work engagement, and job satisfaction. Results suggested that when preceptors demonstrate authentic leader behavior, new graduate nurses feel more engaged and are more satisfied with their work (Giallonardo et al., 2010). It is believed that nurse managers' demonstration of authentic leadership behaviour may have a similar effect on nurses' perceptions of empowerment in the workplace and trust in their manager.

Empowerment

Laschinger and colleagues have explored the concept of empowerment in the nursing profession in a number of studies designed to test Rosabeth Moss Kanter's *Structural Theory of Organizational Behavior* (Laschinger, 1996). The premise behind Kanter's theory in the context of nursing is that when nurses lack appropriate structural conditions to accomplish their work, and specifically do not have access to resources, information, support, and opportunity, they lack power (Kanter, 1993; Laschinger, 1996; Laschinger & Havens, 1996), which subsequently contributes to an unhealthy work environment for nurses. Structural empowerment is a term used to describe conditions that enable optimal role performance, and is considered to be present in work environments where employees have open access to information about their work and the organization, are provided with necessary and adequate resources to do their job such as time and equipment, are fully supported by their manager, and are provided with professional and education opportunities to learn and grow (Laschinger, Finegan, & Wilk, 2009).

Nurses gain power through the ability to access these empowerment structures in their workplaces (Laschinger & Havens, 1996). Power is the central feature of Kanter's theory, and is explained as the ability to get things done through mobilization of resources (Laschinger, 1996). Formal power refers to the actual authority to get things done and jobs that are visible, have discretion, offer recognition, and contribute to organizational goals, whereas informal power pertains to relationships that are developed either within or outside the organization, and includes connections with peers and subordinates (Greco, Laschinger, & Wong, 2006; Laschinger & Sabiston, 2000). Several studies have connected empowerment to organizational commitment, and research has shown that structural empowerment is also related to nurse job satisfaction, autonomy, control over nursing practice, self-efficacy, productivity, trust, respect, and burnout (Faulkner & Laschinger, 2008; Laschinger et al., 2009; Laschinger & Sabiston, 2000). Research has shown that empowered nurses are more likely to feel a sense of control over their work, have high self-esteem, are more satisfied with their job, and engage in productive and efficient work behaviours (Laschinger & Sabiston, 2000).

In a study of Canadian nurses, leader-empowering behaviours were found to influence nurses' perceptions of formal and informal power, as well as access to information, support, resources, and opportunity (Laschinger, Wong, McMahon, & Kaufmann,1999). Providing nurses with purpose and meaning in their work, including them in decision-making, enhancing their skills and facilitating goal accomplishment, having confidence in their abilities, and encouraging autonomous practice in a supportive environment are leader behaviours associated with nurse empowerment (Laschinger et al., 1999). Using Kanter's theory of structural empowerment, Greco et al. (2006)

examined the relationships among leader empowering behaviours, perceptions of staff empowerment, areas of work life, and work engagement. Leader empowering behaviours included providing autonomy as well as purpose and meaning to employees' work in an effort to increase employees' sense of worth, seeking input from employees and encouraging participation in workplace decisions, and facilitating accomplishment of employees' professional goals. The sample included 322 Ontario registered nurses and results showed that structural empowerment fully mediated the relationship between leaders' empowering behaviour and burnout/engagement (Greco et al., 2006). Moreover, findings indicated that leadership behaviour affected nurses' engagement/burnout through its effect on empowerment (Greco et al., 2006). These findings suggest that high quality relationships between nurse leaders and their followers will have a similar positive effect on nurses' perceptions of structural empowerment in the workplace.

Trust

Trust is defined as "the willingness to be vulnerable to another party when that party cannot be controlled or monitored" (Mayer & Gavin, 2005, p.874), and is described as "a generalized behavioral intention to take risk, whereas its outcome is actually *taking* risk" (p.874). Increased trust is expected to lead the trustor to engage in more risk-taking behaviours in the relationship with the trustee (Mayer & Gavin, 2005). Trust has been damaged between nurses and management, largely due to organizational changes and the focus on increasing efficiency in the healthcare environment (Laschinger & Finegan, 2005; Rogers, 2005; Vestal, 2003). Nurses are frustrated by increased job demands and the expectation to provide quality patient care using fewer human, material, and financial

resources, and by the reduced visibility and general lack of availability and support of nurse managers (Laschinger, Purdy, & Almost, 2007).

Trust has been associated with important organizational outcomes such as risk taking, cooperative behaviours, increased creativity and critical thinking, team effectiveness, satisfaction with the workplace, and organizational commitment (Rogers, 2005). Nurse empowerment, autonomy, job satisfaction, and affective commitment have also been empirically linked to trust (Finegan & Laschinger, 2001; Laschinger, Finegan, Shamian, & Casier, 2000; Williams, 2005; Williams, 2006). Prior nursing research indicates that trust is developed through empowerment; it has been found that structurally empowering work conditions are associated with increased trust in management, and managers who empower their staff are more likely to be seen as trustworthy (Laschinger et al., 2000; Laschinger & Finegan, 2005).

Employee trust in their manager is a key element of a healthy work environment, and is positively linked to a variety of outcomes in healthcare organizations, and for nurses in particular (Lowe, 2005; Shirey, 2006). However, few studies were found in the healthcare literature examining the impact of leadership style on followers' trust in management (Wong & Cummings, 2009a). In a meta-analysis of research findings on trust in leadership, Dirks and Ferrin (2002) found significant relationships among trust and attitudinal outcomes such as belief in information, job satisfaction, organizational commitment, and intention to quit, and other outcomes including job performance and organizational citizenship behaviour. Trust in leadership was found to have the strongest relationships with job satisfaction (r = .51) and organizational commitment (r = .49), and also had significant relationships to turnover intentions (r = -.40). In particular,

transformational leadership has been significantly associated with trust in leaders. Transformational leaders are known to show concern and respect for followers and place emphasis on relationships (Dirks & Ferrin, 2002), thus it is anticipated that authentic leadership will also be positively related to trust.

Highly transparent leaders are believed to instill greater levels of trust in their followers (Walumbwa et al., 2008). Transparency is present when leaders communicate openly with others, share personal information regarding thoughts and values, are open to giving and receiving feedback, consistently provide reasons and rationale for workplace decisions, and show congruency between words and actions (Avolio & Gardner, 2005; Norman, Avolio, & Luthans, 2010). Recently, Norman et al. (2010) provided empirical support for the positive relationship between leaders' level of transparency and follower trust in their field experiment using a sample of 304 participants from the information technology (IT) field. Transparency was strongly related to follower trust in the leader, and the authors determined that individuals trust leaders who are more transparent and open about their decision-making process, especially during the downsizing process (Norman et al., 2010).

Authentic Leadership, Empowerment and Trust

Research has shown that authentic leadership is positively correlated to trust in the leader (Carsten et al., 2008; Clapp-Smith et al., 2009; Norman et al., 2010; Walumbwa et al., 2011; Wong et al., 2010), and structural empowerment is related to nurses' increased perceptions of respect and trust in management (Laschinger & Finegan, 2005). However, no studies examining the link between authentic leadership and

structural empowerment or the mediating effect of structural empowerment on the relationship between authentic leadership and nurses' trust in their manager were found in the literature.

Structural empowerment and transparency in decision-making processes are believed to increase nurses' sense of autonomy and control over their environment, and increase perceptions of trust (Williams, 2006). However, the role of structural empowerment remains unclear in authentic leaders' development of follower trust. Avolio et al.'s (2004) authentic leadership theory links authentic leadership to followers' attitudes and behaviours, including commitment, job satisfaction, task engagement, and psychological empowerment. While structural empowerment involves positive conditions for work, psychological empowerment is a psychological mindset that employees must experience in order for empowerment interventions to be successful (Spreitzer, 1995), and is considered a consequence of structural empowerment (Laschinger, Finegan, Shamian, & Wilk, 2001b). Several studies have linked structural empowerment to psychological empowerment (Laschinger, Finegan, Shamian, & Wilk, 2001b, 2004; Laschinger et al., 2009; Manojlovich & Laschinger, 2002). In addition, mediation effects of psychological empowerment have been shown, indicating that structural empowerment may also function as a mediating variable. For instance, Knol and Van Linge (2009) found that psychological empowerment functioned as a partial mediator between structural empowerment and innovative behaviour in their study using a sample of 519 registered nurses from the Netherlands.

Summary of Literature

Research has shown that leadership style influences nurses' empowerment and trust in their manager, and positive leader behaviour is associated with higher perceptions of both empowerment and trust. Employees with supportive managers that communicate openly and honestly with staff are more likely to feel empowered and trust their leader than employees with leaders who do not show concern for followers and are not transparent in their interactions. Although no studies link authentic leadership and structural empowerment, research has shown that leader empowering behaviour was positively associated with structural empowerment. The implication is that authentic leadership will have a similar positive association with nurses' perceptions of structural empowerment. No studies currently examine the relationship between authentic leadership, structural empowerment, and nurses' trust in their manager. Findings from this study may provide nurse managers with a better understanding of how their leadership influences empowerment and trust and motivate them to facilitate work conditions conducive to healthy work environments.

Hypothesis and Rationale

The following hypothesis was tested in this study:

Nurses' structural empowerment partially mediates the relationship between managers' authentic leadership and nurses' trust in their manager.

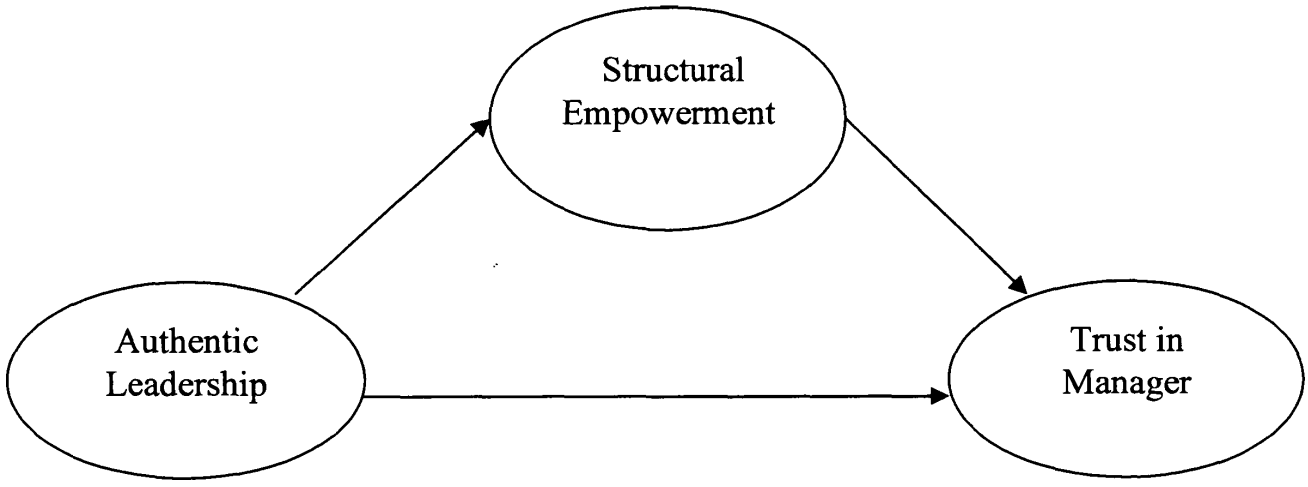


Figure 1. *Hypothesized Model*

Previous studies have reported authentic leadership to have a direct effect on trust (Clapp-Smith, 2009; Norman et al., 2010; Wong & Cummings, 2009a; Wong et al., 2010), and it is anticipated that results of this study will be comparable. Authentic leadership is also expected to have a positive relationship to empowerment. Authentic leadership characteristics, including the emphasis on relational transparency, honesty, and open communication may play a significant role in promoting nurses' trust in their manager, and may also increase nurses' perceptions of structural empowerment particularly relating to the information and support components of structural empowerment. Authentic leaders behave in an ethical manner, openly share information with others, make the development of others a priority, and are supportive of others' ideas, concerns, and needs (Avolio et al., 2004). This behaviour may be demonstrated through open communication, providing opportunities for nurses to learn and grow, and ensuring adequate resources in the workplace. Furthermore, authentic leaders focus on developing relationships with others, which is believed to have a positive influence on nurses' perceptions of informal power given that informal power is thought to develop

from close relationships with peers, managers, and subordinates (Gilbert, Laschinger, & Leiter, 2010).

Based on findings in the literature, it is hypothesized that authentic leadership will have a significant positive relationship with trust, especially if authentic leadership is found to positively affect nurses' perceptions of structural empowerment. If nurses have a positive relationship with their manager based on respect and open communication, and feel supported and empowered in the workplace as a result of meaningful interventions by their manager, then they are more likely to feel their needs are being met, and thus more apt to trust their manager.

Methods

Design and Sample

A secondary analysis of data from the study entitled *The Influence of Authentic Leadership on Trust and Work Outcomes of Registered Nurses* (Wong, Laschinger, & Cummings, 2008), which utilized a non-experimental, cross-sectional, predictive survey design, was conducted to test the hypothesis for this study. Ethical approval was received from the University of Western Ontario Ethics Review Board for Health Sciences Research in July 2008 (see Appendix D). A random sample of 600 registered nurses who were working in acute care teaching and community hospitals in Ontario at the time, were selected from the College of Nurses registry list and asked to participate in the original study (Wong et al., 2008). Inclusion criteria indicated that subjects must be registered nurses working full-time and part-time in direct care positions in acute care

community and teaching hospitals in Ontario. A final sample of 280 useable surveys was obtained for a 48% response rate.

In order to determine the appropriate sample size for this secondary analysis, a power analysis was conducted. Based on an alpha of 0.05, two predictors, and a power level of 0.80 (Faul, Erdfelder, Lang, & Buchner, 2007), the calculation revealed that 68 participants were required to detect a medium effect size (0.15). Therefore, the sample size of 280 participants was sufficient for the present study.

Instruments

Internal consistency reliabilities (Cronbach's alpha coefficients), response ranges, anchors and number of items for all scales used in the study are reported in Appendix B.

Authentic leadership. Authentic leadership was measured using the recently validated *Authentic Leadership Questionnaire* (ALQ) (Avolio, Gardner, & Walumbwa, 2007; Walumbwa et al., 2008). This is a 16-item Likert scale that measures the degree of leader authenticity. The ALQ is divided into four subscales: relational transparency (5 items), internalized moral perspective (4 items), balanced processing (3 items), and self-awareness (4 items). All of the scale items are rated on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*frequently, if not always*). Each subscale is averaged to produce a total scale score between 0 and 4 with higher scores representative of higher levels of authenticity. Confirmatory factor analysis has supported the construct validity of each of the four components of authentic leadership, and acceptable internal consistency has also been consistently reported; Cronbach's alphas range from 0.70 to 0.90 (Walumbwa et al., 2008). Walumbwa et al. (2011) conducted a confirmatory factor analysis and found that authentic leadership was distinct from transformational leadership and reported an alpha

coefficient of 0.83 for overall scale reliability. In this study, Cronbach's reliability coefficient for the ALQ was 0.97 with subscales ranging from 0.86 to 0.93.

Structural empowerment. Structural empowerment was measured using *The Conditions of Work Effectiveness Questionnaire II* (CWEQ-II) (Laschinger, Finegan, Shamian, & Wilk, 2001a). This scale consists of 19 items that measure 6 components of structural empowerment: access to opportunity, information, support, resources, formal power and informal power, and a 2 item global empowerment scale, used for construct validation purposes. All items are measured on a 5-point Likert scale ranging from 1 (*none*) to 5 (*a lot*). According to Laschinger et al. (2001a), items on each of the six subscales are averaged to provide a score for each subscale ranging from 1 to 5. The scores of the 6 subscales are then summed to create the total empowerment score, a range from 6 to 30. Higher scores represent higher perceptions of empowerment. Scores ranging from 6 to 13 are described as low levels of empowerment, 14 to 22 as moderate, and 23 to 30 as high. The 2 item global empowerment items are averaged to create a score ranging from 1 to 5, however this score is not included in the total structural empowerment score. A high positive correlation between this score and the total structural empowerment score provides evidence of construct validity for the structural empowerment measure. A confirmatory factor analysis also revealed that the CWEQ-II scale has evidence of construct validity (Laschinger et al., 2001a). Cronbach's alpha reliabilities in previous studies have ranged from 0.79 to 0.82 (Laschinger & Finegan, 2005). In this study, Cronbach's reliability coefficient for the CWEQ-II was 0.97 with subscales ranging from 0.66 to 0.85; the global empowerment scale was found to have a Cronbach's reliability coefficient of 0.90.

Trust in manager. The variable of trust was measured using Mayer and Gavin's (2005) *Trust in Manager Scale*, a 10-item scale that measures an individual's willingness to be vulnerable to their immediate manager or supervisor. All trust items are rated on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Five of the items reflect general willingness to be vulnerable to others, while the remaining 5 items measure a willingness to engage in more specific risk-taking behaviors (e.g., "I would tell my manager about mistakes I've made on the job, even if they could damage my reputation") (Mayer & Gavin, 2005, p.879). Factor analysis supported the overall scale, and Cronbach's alpha has been reported as 0.76 to 0.82 (Mayer & Gavin, 2005). For this study, the Cronbach's reliability coefficient of the *Trust in Manager Scale* was 0.83.

Data Collection

Data for the original study was collected using a mailed survey. A modified Dillman approach (2007) was used to increase response rates. The idea behind Dillman's method is for researchers to increase the rewards and decrease the perceived costs for participants included in a study (Records & Rice, 2006). When the method is followed entirely, average response rates are 34% to 50% for the first mailing, 60% for the second mailing, and 72.4% for the third mailing (Records & Rice, 2006). Three mailings were used to collect data for this study. Nurses received a survey that included a letter of information about the study, a questionnaire and a researcher-addressed, stamped envelope in which to return the completed questionnaire. A $2.00 coffee voucher was included with each survey as a token of appreciation for participation. Two weeks after the first mailing, a follow-up thank you and reminder letter was sent to all participants.

Three weeks after the reminder letters were sent, a follow-up letter and replacement questionnaire including a return envelope were sent to all non-respondents.

Data Analysis

Statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) version 18.0 for Macintosh (SPSS Inc., 2010). Descriptive statistics and reliability estimates were generated for all of the study variables, and were used to summarize and describe data. Cronbach's alpha reliability estimates were calculated for each instrument and subscales (Polit & Beck, 2008). Pearson correlations, hierarchical multiple linear regression, and mediation regression analysis (Baron & Kenny, 1986) were used to test the study hypothesis. Finally, the level of significance (alpha level) was set at 0.05 in order to control for the risk of making a type I error when testing the hypothesis (LoBiondo-Wood & Haber, 2005).

Results

Descriptive Results

Demographic data were collected and presented in Tables 1 and 2. The majority of registered nurse respondents were female (93.5%) with a mean age of 43.4 years. Most nurses held college diplomas (69.5%) and worked full-time (65.6%) in teaching hospitals (54%). The CNO (2010) demographic characteristics of nurses in Ontario are similar to those of the study participants. For example, statistics show that the majority of nurses in Ontario are female (95%), average 46.5 years of age, and are employed full-time (65.5%) in a hospital setting (64.9%) (CNO, 2010).

The mean and standard deviation of each study variable are presented in Table 4 along with reliability analysis of the scales and subscales of study measures (LoBiondo-Wood & Haber, 2005; Polit & Beck, 2008). Data were assessed for skewness and kurtosis values for each variable; all variables were found to have values between + 1 and – 1 for both skewness and kurtosis indicating normal distribution of data (Munro, 2005). Further, a linear relationship was found to exist between the independent variable (authentic leadership) and dependent variables (structural empowerment and trust), thus meeting a key assumption for multiple regression (Polit & Beck, 2008).

Table 1. *Means and standard deviations for nurses' demographic characteristics*

Demographic characteristics	*n*	*M*	*SD*
Age	268	43.41	9.72
Years experience in nursing	275	18.85	10.96
Years employment at current organization	258	13.42	9.82
Years employment on current unit	257	8.60	7.43

(n = 280)

Table 2. *Frequencies for nurses' demographic characteristics* (n = 280)

Demographic characteristics	(n)	%
Gender		
Female	261	93.5
Male	18	6.5
Employment status		
Full-time	183	65.6
Part-time	85	30.5
Casual	11	3.9
Type of hospital		
Teaching (academic)	149	54.0
Community	127	46.0
Education		
College diploma	194	69.5
Baccalaureate degree	80	28.7
Masters degree	5	1.8
Specialty area		
Medical-surgical	99	35.8
Critical care	40	14.5
Ambulatory care	41	14.9
Maternal-child	36	13.1
Emergency	30	10.7
OR/PACU	24	8.7
Psychiatry	6	2.2

Nurses perceived their managers to have a moderate level of authentic leadership ($M = 2.35$, $SD = 0.99$) with most subscales averaging below 2.50 on the four-point scale. Managers were rated highest on internalized moral perspective ($M = 2.52$, $SD = 1.02$) and lowest on self-awareness ($M = 2.06$, $SD = 1.17$). Few studies have used the ALQ in nursing samples making it difficult to compare results, however, higher ALQ means have been reported in a study of nurse preceptors and studies with non-nursing samples. For example, Giallonardo et al. (2010) found that new graduate nurses perceived their preceptors to have a moderate level of authentic leadership ($M = 3.05$, $SD = 0.62$), and authentic leadership scores in studies of American corrections personnel and telecom employees in China ranged from 2.84 to 3.38 respectively (Carsten et al., 2008; Walumbwa, et al., 2010). In a sample of intact work groups from a large U.S. bank at the group level of analysis, Walumbwa et al. (2011) obtained a higher ALQ mean ($M = 3.01$, $SD = 0.73$) than was reported by nurses in this study.

Overall, staff nurses felt moderately empowered ($M = 18.88$, $SD = 3.37$). Nurses perceived themselves to have the most access to opportunity ($M = 3.99$, $SD = 0.78$), but felt they had a relatively low level of formal power ($M = 2.52$, $SD = 0.85$). These findings are similar to those reported by Lucas et al. (2008) in their study of 150 acute care nurses who perceived their work environment to be moderately empowering ($M = 18.24$, $SD = 3.18$), and also rated access to opportunity the highest ($M = 4.05$, $SD = 0.73$) and formal power lowest ($M = 2.63$, $SD = 0.83$). Faulkner and Laschinger (2008) reported similar results in their study of acute care nurses. Nurses reported moderate levels of structural empowerment ($M = 17.8$, $SD = 3.3$), rated opportunity highest ($M =$

4.0, $SD = 0.79$), and felt they had the least access to formal power ($M = 2.4$, $SD = 0.86$) (Faulkner & Laschinger, 2008).

Nurses reported only moderate levels of trust in their manager ($M = 3.26$, $SD = 0.64$). Few studies with nursing samples could be found that used the same trust in manager measurement scale as the one in this study, thus comparisons are difficult to make. However, in a sample of Midwestern United States manufacturing plant employees, Mayer and Gavin (2005) reported that employees had slightly lower level of trust in their plant managers ($M = 3.21$, $SD = 0.77$) than nurses in this study.

Test of the Hypothesized Model

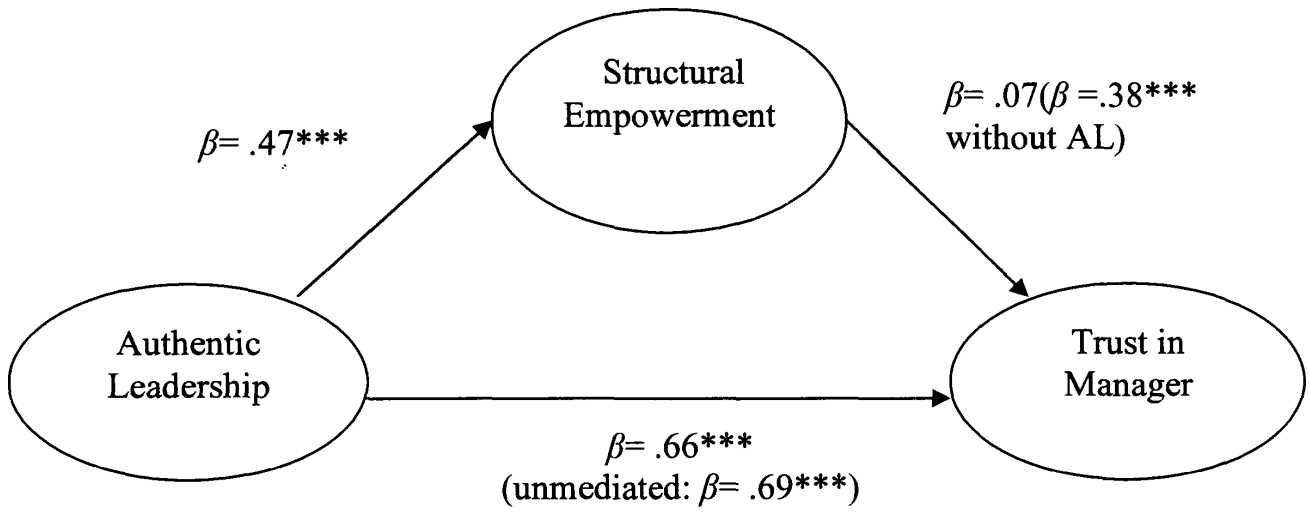
Mediation analysis was used to test the study hypothesis. According to Baron and Kenny (1986), four conditions must be met in order to establish mediation: (1) the independent and dependent variables must be significantly related; (2) the independent and mediator variables must be significantly related; (3) the mediator and dependent variables must be significantly related and; (4) the relationship between the independent and dependent variables must be reduced (partial mediation) or removed and becomes non-significant when the mediator is added (full mediation). Using multiple linear regression, the first step showed a significant relationship between authentic leadership and trust in manager ($\beta = 0.69$, $t = 15.83$, $p < 0.001$), so the first condition was met. The second requirement for mediation was met because authentic leadership was found to have a positive relationship to the hypothesized mediator, structural empowerment, ($\beta = 0.47$, $t = 8.68$, $p < 0.001$). Step three found a significant relationship between structural empowerment and trust ($\beta = 0.38$, $t = 6.77$, $p < 0.001$), therefore the third condition was

also met. In the final step authentic leadership followed by structural empowerment were entered in separate blocks with trust as the dependent variable. Authentic leadership accounted for 48% of the variance in trust ($F_{(1, 271)} = 247.46, p < .001, R^2 = .48$) and was a significant predictor of trust ($\beta = .66, t = 13.35, p <= .001$), although the beta dropped slightly in size. The addition of structural empowerment accounted for only an additional 1% of the variance in trust ($R^2 = .49$) and became insignificant ($\beta = .07, t = 1.49, p = .14$) when added to the equation in step four (Table 3). This result does not meet Baron and Kenny's (1986) fourth condition for mediation, and therefore suggests that structural empowerment does not have a mediating effect on the relationship between authentic leadership and nurses' trust in their manager. Thus, the hypothesis was not supported. Results of the final hypothesized model are depicted in figure 2.

Table 3. *Coefficients of Final Model for Study Hypothesis*

Model	**Variables**	**R^2**	**Adjusted R^2**	***β***	***t***	***Sig.***
Model 1	Authentic Leadership	.48	.48	.69	15.83	<.001
Model 2	Authentic Leadership	.48	.48	.66	13.35	<.001
	Structural Empowerment	.49	.48	.07	1.49	.137

Dependent Variable: Trust in Manager



Note. $p<.001$***

Figure. 2. *Final Model*

Relationship of Demographic Variables to Major Study Variables

No significant differences were found between the major study variables and the demographic variables gender, level of education, type of unit, and type of hospital. However, analysis of variance revealed some statistically significant differences between two of the study variables (authentic leadership and empowerment) and employment status. Full-time and part-time nurses differed in their reports of managers' authentic leadership ($F_{(2, 272)} = 3.56, p = 0.03$). Full-time nurses perceived their managers to have lower levels of authentic leadership ($M = 2.24$ $SD = 1.00$) than part-time nurses ($M = 2.59$, $SD = 0.91$).

Additional Analysis

In this study, authentic leadership was highly correlated with both trust in the manager ($r = .69, p < 0.01$) and total empowerment ($r = .47, p < 0.01$). Trust in the

manager was correlated with each authentic leadership subscale. However, the strongest relationships were with self-awareness ($r = .67, p < 0.01$) and balanced processing ($r = .64, p < 0.01$). Of the subscales, trust in manager had the lowest correlation with relational transparency ($r = .60, p < 0.01$). Similarly, total empowerment had strong correlations with each of the authentic leadership scales, though self-awareness ($r = .45, p < 0.01$) and balanced processing ($r = .45, p < 0.01$) were again found to have the strongest relationships with total empowerment. Total empowerment was also significantly correlated with trust in the manager ($r = .38, p < 0.01$), and had the strongest relationships with formal power ($r = .33, p < 0.01$), informal power ($r = .34, p < 0.01$), and global empowerment ($r = .34, p < 0.01$). Finally, of the empowerment subscales, support ($r = .44, p < 0.01$) and formal power ($r = .43, p < 0.01$) had the strongest correlation to authentic leadership. Table 4 outlines correlations among study variables.

Table 4. *Means, Standard Deviations (SD), Reliability Analysis and Correlation Matrix*

Variable	*M*	*SD*	α	1	2	3	4	5	6	7	8	9	10	11	12
1. Authentic Leadership	2.35	0.99	.97												
2. Relational Transparency	2.49	1.00	.88	.92**											
3. Balanced Processing	2.31	1.11	.86	.92**	.78**										
4. Internalized Moral Perspective	2.52	1.02	.89	.91**	.78**	.79**									
5. Self-Awareness	2.06	1.17	.93	.93**	.78**	.86**	.79**								
6. Trust in Manager	3.26	0.64	.83	.69**	.60**	.64**	.63**	.67**							
7. Total Empowerment	18.88	3.37	.88	.47**	.41**	.45**	.41**	.45**	.38**						
8. Opportunity	3.99	0.77	.85	.12*	.13*	.10	.11	.11	.20**	.51**					
9. Information	3.04	0.86	.84	.26**	.22**	.22**	.28**	.26**	.20**	.69**	.33**				
10. Support	2.93	0.90	.83	.44**	.38**	.45**	.41**	.42**	.29**	.75**	.23**	.45**			
11. Resources	2.89	0.86	.81	.31**	.27**	.31**	.26**	.29**	.22**	.65**	.12	.27**	.43**		
12. Formal Power	2.52	0.85	.76	.43**	.36**	.42**	.37**	.46**	.33**	.78**	.19**	.47**	.51**	.50**	
13. Informal Power	3.55	.67	.66	.31**	.28**	.29**	.28**	.30**	.34**	.67**	.33**	.33**	.38**	.30**	.52**
14. Global Empowerment	3.29	0.99	.90	.36**	.31**	.34**	.34**	.35**	.34**	.62**	.16**	.33**	.42**	.60**	.53**

*$p < 0.05$, two-tailed ** $p < 0.01$, two-tailed

Discussion

Avolio et al. (2004) developed their theory to guide future research about the mechanisms through which authentic leaders influence followers' attitudes, behaviours, and performance. In this study, it was hypothesized that structural empowerment partially mediates the relationship between authentic leadership and nurses' trust in their manager. However, the hypothesis was not supported. Notwithstanding, positive relationships between each of the study variables were confirmed. Both authentic leadership and structural empowerment had significant individual positive direct effects on nurses' trust in their manager highlighting the importance of leader behaviour and the presence of empowering working conditions for fostering trusting relationships. Authentic leadership was found to be a strong predictor of empowerment, suggesting that authentic leaders provide the necessary conditions for nurse empowerment, perhaps through their unique understanding of nurses' needs in the workplace and their ability to create empowering conditions.

Findings from the current study illustrate the significance of authentic leadership in the healthcare work environment. As expected, managers' authentic leadership behaviour was shown to have a positive relationship with nurses' perceptions of structural empowerment, and higher levels of trust in their manager. Nurses in this study reported their managers to have only a moderate level of authentic leadership and felt only moderately empowered. Similar findings for nurses' perceptions of both authentic leadership and empowerment have been reported. For example, Wong et al. (2010) reported that Ontario staff nurses perceived their managers to be moderately authentic, and Giallonardo et al. (2010) also reported a moderate level of authentic leadership in a

study of Ontario new graduate nurses and their preceptors. Further, Lucas et al. (2008) found that staff nurses from two community hospitals in Ontario perceived their work environment to be moderately empowering, and in another study of Canadian hospital staff nurses, Faulkner and Laschinger (2008) reported that nurses were only moderately structurally empowered. Finally, in a study that included nurses, allied healthcare professionals and management from 41 units in hospitals in Ontario and Nova Scotia, Gilbert, Laschinger, and Leiter (2010) found that these professionals rated their workplaces as moderately empowering. Equally important, nurses reported moderate levels of trust in their manager. No direct comparisons could be made with other studies using a sample of registered nurses due to researchers' use of different measures of trust, however, this does not preclude comparisons as measures used in other studies may be highly correlated with Mayer and Gavin's (2005) trust measure.

Of the authentic leadership components, nurses rated managers' level of self-awareness lowest in this study. These findings correspond to other studies of authentic leadership that used a nursing sample (Giallonardo et al., 2010; Wong et al., 2010). Avolio et al. (2004) described self-awareness as an ongoing process in which leaders are aware of and understand their own talents, strengths, values, and purpose that results mainly from positive social exchanges between leaders and followers (Avolio & Gardner, 2005). It is possible that low levels of managers' self-awareness may indicate a lack of open communication between nurses and their managers in the workplace, and negatively impact nurses' level of trust. However, in this study the authentic leadership component of self-awareness was significantly and highly correlated with nurses' trust in their manager ($r = .67, p < .01$). Empowerment also had the strongest relationship to

managers' level of self-awareness ($r = .45, p < 0.01$) compared to the other components. Gardner et al. (2005) described self-awareness as personal insight of the leader, and as a process of self-reflection whereby leaders gain clarity about who they are and what they value to build a strong sense of self that forms a basis for their decisions and actions. Perhaps managers with high levels of self-awareness demonstrate greater consistency among their values, words and actions, thereby positively influencing followers' perceptions of trust and empowerment.

Of the ALQ subscales, relational transparency had the second highest mean ($M = 2.49$, $SD = 1.00$), yet lowest correlation with trust in manager ($r = .60, p < 0.01$) despite being a distinguishing feature of authentic leadership and the component most believed to build trust in followers (Shirey, 2006; Wong & Cummings, 2009a). Conversely, self-awareness had the lowest mean ($M = 2.06$, $SD = 1.17$), but had the highest correlation with nurses' trust in their manager ($r = .67, p < 0.01$). Internalized moral perspective had the highest mean ($M = 2.52$, $SD = 1.02$) and also had a higher correlation with trust ($r = .63, p < 0.01$) in the manager than relational transparency. In general, higher levels of leader transparency are expected to increase follower trust (Walumbwa et al., 2008). Norman et al. (2010) provided strong support for the positive link between transparent leader behaviour, such as openness in sharing information (also an element of structural empowerment), and follower trust, though their results showed leader transparency induced higher levels of affective trust ($F = 17.33$) compared to cognitive trust ($F = 12.39$). The authors suggest that causal mechanisms influencing each form of trust may differ and that affective trust may be more influenced by one's emotions (Norman et al., 2010). Self-awareness is linked closely to emotions, and authentic leaders' high levels of

self-awareness indicates that they are in touch with their own and others' emotions, and the effects of emotions on others (Gardner et al., 2005). Perhaps the emotional connection nurses experience as a result of interactions with their leader may have a greater impact on nurses' perceptions of trust in their manager than managers' level of transparency or willingness to disclose information. Internalized moral perspective refers to managers' ability to make decisions guided by personal values and beliefs, and internal moral standards opposed to pressure from external forces such as the organization or society (Walumbwa et al., 2010). It is possible that mangers may instill greater levels of trust in nurses if it is clear that managers' decisions are the result of their careful and thoughtful consideration of factors rather than organizational influence or persuasion.

Study results showed that authentic leadership was correlated highest with the support subscale of structural empowerment ($r = .442, p < 0.01$). Authentic leaders care about the feelings, emotions and needs of employees and thus are apt to be a great source of support in the workplace, not to mention attentive to providing necessary resources for nurses to do their job effectively. Furthermore, authentic leaders' emphasis on open communication and transparency means that authentic leaders are likely to share important information freely with employees, which may also be considered supportive behaviour in the healthcare setting.

Empirical research has confirmed that certain variables mediate the relationship between authentic leadership and follower outcomes, attitudes, and behaviours. For example, followers' identification with their leader and feelings of psychological empowerment are variables that have been shown to mediate the relationship between authentic leadership, and both OCB and work engagement (Walumbwa et al., 2010).

Personal identification is described as a process in which one's belief about a person becomes self-defining (Avolio & Gardner, 2005). Authentic leaders are thought to identify with their followers through open communication, by emphasizing the growth of followers and through leading by example; these leaders facilitate personal identification by connecting with the self-concept of followers (Avolio et al., 2004). Wong et al (2010) reported that nurses' personal identification with the leader was found to mediate the relationship between authentic leadership and trust in their manager.

The present study focused on structural empowerment rather than psychological empowerment, which may be considered more closely related to variables that imply social connections such as trust in management. It is possible that results may have differed had psychological empowerment been a part of this study. To illustrate, structural empowerment refers to the conditions for work, whereas psychological empowerment is one's psychological response to those conditions. Psychological empowerment is comprised of meaning, competence, self-determination, and impact (Spreitzer, 1995). Meaning refers to congruency between one's beliefs, values, behaviours, and job requirements; competence refers to employees' confidence in their work performance abilities; self-determination relates to feelings of control over one's work; and impact entails being able to influence organizational outcomes (Laschinger et al., 2001b). Perhaps employees' level of psychological empowerment is a mediator of authentic leadership and trust considering that trust in one's manager is more of an attitude, behaviour or feeling influenced by actions and behaviours of the manager as opposed to a tangible condition that is either present or not present in the work environment. Although provision of structural empowerment may be a natural outcome

of authentic leadership through managers' supportive, caring, honest and transparent behaviour, as suggested by the direct effects on trust, and their tendency to encourage and promote the talents and strengths of followers, the psychological response to those behaviours may have more significance in explaining how authentic leaders develop follower trust than the actual presence of those conditions.

Furthermore, structural empowerment has been shown to lead to psychological empowerment, which in turn leads to positive outcomes (Laschinger et al., 2001a, 2001b; Wagner et al., 2010). It is possible that both facets of empowerment may in fact be necessary for empowerment to have a mediating effect on the relationship between authentic leadership and nurses' trust in their manager. Laschinger et al. (2001b) demonstrated the combined effect of structural and psychological empowerment in predicting job satisfaction, and it would be interesting to see if the combination of structural and psychological empowerment together would show mediation in additional studies of authentic leadership and the development of follower trust. Nevertheless, it is possible that because authentic leadership and trust are so highly correlated, intervening variables, such as structural empowerment, have little chance of providing further explained variance. This study suggests that authentic leadership behaviour may be all that is needed to increase nurses' trust in their manager. Structural empowerment is also a way to increase nurses' trust in this instance, however, not as a mediator.

Limitations

A potential limitation of this study may be collection of baseline data by use of a cross-sectional design, and self-report measures in the form of mailed surveys. Cross-

sectional designs are useful for describing the status of phenomena at a fixed point in time, but are not well suited to inferring causality or changes over time (Polit & Beck, 2008). Longitudinal studies have an advantage over cross-sectional designs in that data can be collected from the same group at different points in time and explore differences and relationships; cross-sectional studies reduce the researcher's ability to establish definitive causal relationships among variables (Lo-Biondo Wood & Haber, 2005). Another limitation is the potential for response bias with the use of self-report questionnaires; response bias occurs when "people respond to questions in characteristic ways, independently of content" (Polit & Beck, 2008, p.446). Finally, results are only generalizeable to Ontario registered nurses working in acute care community and teaching hospitals.

Conclusion

Results of this study provide support for authentic leader behaviour in healthcare by showing that managers' authentic leadership leads to nurses' increased perceptions of structural empowerment and trust in their manager, key components of a healthy workplace. Findings also indicate that authentic leadership and structural empowerment each build nurses' trust. However, despite having a positive relationship with both authentic leadership and trust, structural empowerment does not mediate the relationship between them. Prior research has shown the importance of positive interpersonal relationships when it comes to ensuring nurse and patient wellbeing in healthcare. Authentic leaders develop and nurture relationships with employees through honest, respectful, and transparent communication, and strive to act in the best interest of themselves, employees, and the organization. Authentic nurse managers role model

desired behaviours, and act to define the conditions and structures within nurses' work environments that contribute to empowerment and foster nurses' trust. Therefore, demonstration of authentic leadership behaviour is a significant way for nurse managers to contribute to positive healthcare outcomes.

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Chapter Three

Discussion

For the purpose of this study, Avolio, Gardner, Walumbwa, Luthans, and May's (2004) theory of authentic leadership was used to investigate relationships among authentic leadership, structural empowerment, and trust, and determine if structural empowerment mediated the relationship between authentic leadership and nurses' trust in their manager. As expected, authentic leadership and structural empowerment were each found to have a strong direct effect on nurses' trust in their manager. However, results showed that structural empowerment did not mediate the relationship between authentic leadership and nurses' trust in their manager. Nonetheless, findings suggest that promotion of authentic leadership behaviour and workplace empowerment is worthwhile, especially in healthcare. Avolio et al.'s (2004) authentic leadership theory may be a useful guide for the development of authentic leadership behaviour in nurse managers, and provides rationale for the importance of adopting this leadership style in healthcare settings. Results of this study also highlight the need for further authentic leadership research in the context of nursing.

Implications for Theory

This secondary analysis is the first study linking authentic leadership and structural empowerment. Previous studies have shown positive associations between leader-empowering behaviours and structural empowerment. Results of this study provide further support for the connection between positive leadership styles and increased structural empowerment. Furthermore, findings from this study support other

studies linking structural empowerment and trust. As well, it is perhaps the first study to specifically use Mayer and Gavin's (2005) trust measure to assess nurses' level of trust in their manager. Finally, this study contributes to authentic leadership research in the context of nursing and healthcare, and further adds to our knowledge of the nomological network for authentic leadership.

Implications for Hospital Administrators

Unhealthy work environments have detrimental effects on nurses, patients, and organizations and generally contribute to negative outcomes such as nurse turnover. Hospital administrators may help combat this problem by encouraging authentic leadership behaviour of nurse managers and implementing programs designed to foster authentic leadership development. Nurse managers' authentic leadership behaviour is a promising way to strengthen interpersonal relationships, increase nurses' perceptions of structural empowerment and trust, and contribute to an overall sense of wellbeing in the workplace. Demonstration of authentic leadership behaviour in nurse managers may significantly improve relational aspects of the healthcare work environment, and is a cost effective way for healthcare organizations to invest in their most precious resource, nurses, and subsequently improve patient care. Cultivating consistent authentic leadership behaviour of nurse managers may help administrators facilitate the creation of healthy work environments for nurses that promote retention and lessen nurse turnover, and possibly mitigate other negative healthcare outcomes.

Results of this study show that authentic leadership is significantly correlated to nurses' structural empowerment and trust in their manager, and prior research has

confirmed that both factors are important in creating and sustaining healthy work environments. For this reason, focused efforts to educate managers about the effects of leadership behaviour on various healthcare outcomes should be made, and programs that support nurse managers' learning and development of their personal authentic leadership style should be implemented and continuously monitored to determine effectiveness.

A focus on efficiency and cost reduction in healthcare has resulted in substantial cuts to management positions as a cost saving measure (Rogers, 2005). Although hospitals may experience short-term savings by reducing the number of nurse manager positions, they run the risk of facing higher costs in the long-run as a result of removing a much needed support system for nurses and further contributing to unhealthy work conditions that lead to nurse turnover (Duffield, Roche, Blay, & Stasa, 2010). Effective and visible nursing leadership has been linked to positive healthcare outcomes (Malloy & Penprase, 2010; Murphy, 2005; Rogers, 2005) and is a key component of a healthy work environment for nurses, and therefore patients. Fewer nurse managers in the organization results in broader spans of control for managers who remain, requiring them to juggle multiple demands (Anthony et al., 2005; Lucas, Laschinger, & Wong, 2008). Consequently, nurse managers have little time to adequately meet the ongoing and ever changing needs of staff, or develop meaningful relationships and foster trust with nurses. Thus, it is imperative that hospital administrators acknowledge the crucial role of nurse managers and their unique position in the healthcare workplace and consider ways to replenish these assets to the organization.

Another important implication of this study may be the recognition that administrators must also demonstrate authentic leadership behaviour if they desire similar

behaviour of nurse managers at the unit level. Authentic leaders are positive role models known to behave ethically and with integrity, and communicate openly and honestly with others to create a sense of trust and respect in the workplace (Avolio et al., 2004; Gardner, Avolio, Luthans, May, & Walumbwa, 2005). Hence, nurse managers are unlikely to adopt or sustain authentic leadership behaviour if administrators at every level of the organization do not value or emulate this leadership style as well. Furthermore, research has shown that structural empowerment is essential to a healthy workplace for nurses, and it follows that managers would also benefit from conditions of structural empowerment such as full access to information, resources, and support from administration, and opportunities to learn and grow in their management role. Ultimately, administrators must be committed to embracing authentic leadership behaviour and providing nurse managers with ongoing support in their attempt to support staff at the unit level and create a healthy work environment.

Implications for Nurse Managers

Studies indicate that employees with managers that demonstrate authentic leadership qualities tend to be more satisfied with both their leader and job, and show higher levels of empowerment and organizational commitment (Greco, Laschinger, & Wong, 2006; Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008), which is quite relevant given the issue of nurse retention and turnover. Yet, research also indicates that negative aspects of nurses' work environments including ineffective nursing leadership, feelings of disempowerment, and low levels of trust currently contribute to nurse turnover (Shirey, 2006; Tomey, 2009).

Results of this study suggest that authentic leadership positively affects structural empowerment and nurses' trust in their manager, so nurse managers should feel confident that adopting authentic leadership behaviour is likely to result in positive nurse outcomes such as nurses' increased perceptions of empowerment and trust. Through their supportive behaviour and attention to the needs and emotions of others, authentic leaders may help to foster nurses' sense of empowerment. Through their authentic leadership, nurse managers can facilitate empowerment by communicating openly and providing nurses with relevant information about the workplace, supporting nurses by listening to and understanding their concerns and ensuring adequate resources are in place to meet their needs, and also encouraging and facilitating nurses' personal and professional development. Authentic leadership behaviour is thought to improve relationships among managers and nurses through respectful, open and honest communication, which is desirable in healthcare. For example, research has shown that respectful interprofessional collaboration and effective team communication positively affect nurse and patient outcomes (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005). It is believed that authentic leaders' relational transparency, consistency between their values, words, and actions, and general respect and regard for the development of employees lends to their ability to facilitate and promote conditions of structural empowerment and to foster trust among employees.

Relational transparency is a distinguishing feature of authentic leadership that is present when leaders openly and honestly share information with others, value giving and receiving feedback, and provide clear rationale and explanations for decisions and actions (Avolio & Gardner, 2005; Norman, Avolio, & Luthans, 2010). Nurse managers need to

recognize that nurses are impacted by organizational decisions, and should keep nurses informed and seek their input as required regarding issues related to the healthcare workplace.

Internalized moral perspective also plays a role in the ability of nurse managers to lead authentically. Nurses in this study rated their managers highest on internalized moral perspective compared to other components of authentic leadership. Managers must avoid making decisions based on external pressure caused by groups or organizational ideals, but rather based on internal moral standards and personal values; demonstration of consistency between values and actions is likely to enhance nurses' perceptions of trust in their manager (Walumbwa et al., 2008). For example, as nurses, nurse managers recognize that nurses need sufficient time and resources to properly and safely care for patients. Managers should make every effort to ensure appropriate resources and supports are in place for nurses to carry out their work, and are not distracted with non-nursing tasks or overwhelmed with additional responsibilities as a result of organizational pressures to reduce costs. Nurses may place higher levels of trust in their manager if they believe that decisions are indeed made by the manager after thoughtful consideration of nurses' and workplace needs, rather than blindly executed based on organizational mandate.

In order to lead effectively, nurse managers should continuously reflect on how their behaviour and actions influence others and consciously create a supportive atmosphere in the workplace built on respect and trust. In particular, nurse managers may find Avolio et al.'s (2004) authentic leadership theory useful in furthering their understanding about the importance of self-reflection and self-awareness in the leadership

process. Authentic leaders demonstrate self-awareness by understanding one's strengths and weaknesses, and the process of how one makes meaning of the world, and also by being alert to their impact on others (Walumbwa et al., 2008). Authentic leaders' acknowledgement of their own strengths and weaknesses may lead to more open and trusting relationships between leaders and their followers. For instance, managers that are comfortable admitting their weaknesses and discussing their personal beliefs and values, may show an element of vulnerability and subsequently facilitate trust in others by appealing to followers' own willingness to be vulnerable to the manager. Employees lack trust when they are unwilling to be vulnerable, and this is thought to take away from their ability to contribute to the organization in a productive way; time and energy is devoted to self-protection and defensive behaviours rather than to effective work behaviours (Mayer & Gavin, 2005). When employees feel safe to share personal concerns about their work in conversations with their manager, then the manager has an opportunity to give constructive feedback, offer assistance, or even correct deficiencies in the system that employees have identified (Mayer & Gavin, 2005). However, if nurses are unwilling to share important information with the manager due to poor interpersonal relationships and fear of a negative interaction, then the health of the work environment is jeopardized and patient care may suffer as a result.

Balanced processing is demonstrated through leaders' objective analysis of all sources of relevant data before making decisions as well as seeking views from others that may challenge their values or deeply held beliefs (Walumbwa et al., 2008). Through their use of balanced processing, authentic leaders engage their followers, solicit followers' ideas, and include them in decision-making processes, which is important for

fostering relationships and increasing nurses' sense of empowerment and feelings of autonomy and job satisfaction (Lucas et al., 2008). In healthcare settings, nurse managers are in the best position to build and nurture positive relationships with nurses and influence nurses' perceptions of the overall work environment. So, in addition to including nurses in decision-making, nurse managers must actively demonstrate that they value, respect and appreciate nurses' professional knowledge. Nurses that feel valued, respected, and appreciated by their managers are more likely to feel empowered and satisfied with their job, and remain with the organization (Laschinger & Finegan, 2005).

Implications for Nursing Research

Authentic leadership is a promising way to improve aspects of the work environment known to contribute to negative working conditions, and has been deemed an important way for nurse managers to create and sustain healthy work environments (AACN, 2005; Shirey, 2006). However, a limited number of studies have been conducted using Avolio et al's (2004) theory of authentic leadership in nursing and healthcare. In particular, few studies have examined the mechanisms through which authentic leadership influences nurses' specific attitudes and behaviours. Results of this study showed that structural empowerment does not mediate the relationship between authentic leadership and nurses' trust in their manager, however, it is possible that the addition of psychological empowerment may provide greater understanding of the relationship between authentic leadership, empowerment, and nurses' attitudes such as trust in their manager. Further studies should be conducted that test both structural and psychological empowerment as mediating variables. In addition, studies that test the relationship between authentic leadership of nurse managers and variables such as

nurses' organizational commitment or intentions to stay would be useful to determine implications of authentic leader behaviour on nurse turnover.

Conclusion

In summary, results of this study demonstrate the importance of authentic leadership in the healthcare setting, especially with regard to nurse managers' ability to improve the work environment and increase nurses' perceptions of empowerment and trust through authentic leader behaviour. Essentially, authentic nurse managers create empowering conditions in the workplace and increase nurses' sense of trust in their manager. As shown, encouragement of nurse managers' authentic leadership should be made a priority in organizational wide efforts to decrease factors related to unhealthy nurse work environments and those known to result in compromised quality patient care, such as nurse turnover. Authentic leaders are visible, supportive, and share information openly with staff, are sensitive to their own and others' emotions, and emphasize building quality relationships with employees. Nurse managers that demonstrate this behaviour are crucial to creating and sustaining healthy work environments for nurses. Relational aspects of the work environment contribute extensively to the overall perception of a healthy workplace and impact important healthcare outcomes. In times of economic constraint, developing authentic leadership of nurse managers is a cost-effective, wise, and critical investment that organizations must make to support nurses in their workplace, facilitate quality patient care, and discourage nurses from leaving the organization or the profession altogether.

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APPENDIX A

Study Instruments

Authentic Leadership Questionnaire Sample Items

(Avolio, Gardner, & Walumbwa, 2007)

The following survey items refer to your immediate manager's leadership style, as you perceive it. Think about your experiences with this individual over the previous 12 months. *Judge how frequently each statement fits his or her leadership style*:

My manager:	**Not at all**	**Once in a while**	**Sometimes**	**Fairly often**	**Frequently, if not always**
1. Says exactly what she or he means	0	1	2	3	4
2. Demonstrates beliefs that are consistent with actions	0	1	2	3	4
3. Solicits views that challenge her or his deeply held beliefs	0	1	2	3	4
4. Seeks feedback to improve interactions with others	0	1	2	3	4
5. Tells you the hard truth.	0	1	2	3	4

Due to copyright restrictions only five items of the Authentic Leadership Questionnaire can be published in this thesis.

Legend

Self-awareness: 4
Balanced Processing: 3
Relational Transparency: 1, 5
Internalized Moral Perspective: 2

Conditions of Work Effectiveness Questionnaire-II (CWEQ-II) User Guide

The CWEQ-II (Laschinger, Finegan, Shamian, & Wilk, 2001), a modification of the original CWEQ, consists of 19 items that measure the 6 components of structural empowerment described by Kanter (opportunity, information, support, resources, formal power, and informal power), and a 2-item global empowerment scale which is used for construct validation purposes. Items on each of the six subscales are summed and averaged to provide a score for each subscale ranging from 1-5. These scores of the 6 subscales are then summed to create the total empowerment score (score range: 6-30). Higher scores represent higher perceptions of empowerment. The construct validity of the CWEQ-II was substantiated in a confirmatory factor analysis that revealed a good fit of the hypothesized factor structure ($\chi^2 = 279$, df = 129, CFI = .992, IFI = .992, RMSEA = .054). The CWEQ-II also correlated highly with the global measure of empowerment (r = 0.56), providing additional evidence of construct validity. Details of this analysis can be found in Laschinger, Finegan, Shamian and Wilk (2001).

The 2 global empowerment items are summed and averaged to create a score ranging from 1-5. This score is not included in the structural empowerment score. The correlation between this score and the total structural empowerment score provides evidence of construct validity for the structural empowerment measure.

CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE - II
(User Guide)

The following 4 scales refer to Kanter's 4 empowerment structures: access to opportunity, information, support and resources.

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

	None		Some		A Lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge.	1	2	3	4	5

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

	No Knowledge		Some Knowledge		Know A Lot
1. The current state of the hospital.	1	2	3	4	5
2. The values of top management.	1	2	3	4	5
3. The goals of top management.	1	2	3	4	5

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

	None		Some		A Lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific comments about things you could improve.	1	2	3	4	5
3. Helpful hints or problem solving advice.	1	2	3	4	5

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

	None		Some		A Lot
1. Time available to do necessary paperwork.	1	2	3	4	5
2. Time available to accomplish job requirements.	1	2	3	4	5
3. Acquiring temporary help when needed.	1	2	3	4	5

The following 2 subscales are measures of Kanter's formal (Job Activities Scale or JAS) and informal power (Organizational Relationships Scale or ORS).

JAS

IN MY WORK SETTING/JOB:	None				A Lot
1. The rewards for innovation on the job are	1	2	3	4	5
2. The amount of flexibility in my job is	1	2	3	4	5
3. The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

ORS

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

	None				A Lot
1. Collaborating on patient care with physicians.	1	2	3	4	5
2. Being sought out by peers for help with problems	1	2	3	4	5
3. Being sought out by managers for help with problems	1	2	3	4	5
4. Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.	1	2	3	4	5

The 2-item global empowerment subscale listed below is used only for construct validation and is not included in the total empowerment score.

	Strongly Disagree				Strongly Agree
1. Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2. Overall, I consider my workplace to be an empowering environment.	1	2	3	4	5

Trust in Manager (Mayer & Gavin, 2005)

Instructions: Think about your immediate manager. For each statement circle the number that best describes how much you agree or disagree with ach statement.	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
1. If I had my way, I wouldn't let my manager have any influence over issues that are important to me. (R)	1	2	3	4	5
2. I would be willing to let my manager have complete control over my future in this organization.	1	2	3	4	5
3. I really wish I had a good way to keep an eye on my manager. (R)	1	2	3	4	5
4. I would be comfortable giving my manager a task or problem which was critical to me, even if I could not monitor her/his actions.	1	2	3	4	5
5. I would tell my manager about mistakes I've made on the job, even if she/he could damage my reputation.	1	2	3	4	5
6. I would share my opinion about sensitive issues with my manager even if my opinion were unpopular.	1	2	3	4	5
7. I am afraid of what my manager might do to me at work. (R)	1	2	3	4	5
8. If my manager asked why a problem happened, I would speak freely even if I were partly to blame.	1	2	3	4	5
9. If someone questioned my manager's motives, I would give her/him the benefit of the doubt.	1	2	3	4	5
10. If my manager asked me for something, I respond without thinking about whether it might be held against me.	1	2	3	4	5

Items # 1, 3 & 7 are reverse scored

Trust is defined as "the willingness to be vulnerable to another party when that party cannot be controlled or monitored" (Mayer & Gavin, 2005, p. 874).
Nurses' perceptions of the degree to which they feel trust in their immediate manager.

Trust in Management Scale (Mayer & Gavin, 2005) - 10-item scale that query an individual's willingness to be vulnerable to their immediate manager or supervisor. Five of the items reflect general willingness to be vulnerable to others while the remaining 5 items measure a willingness to engage in more specific risk-taking behaviours (e.g., "I would tell my manager about mistakes I've made on the job, even if they could damage my reputation") (Mayer & Gavin, 2005, p. 879). All trust items are rated on a 5-point Likert scale ranging from 1= "strongly disagree" to 5= "strongly agree".
Cronbach's alpha for the 10-item scale has been reported as 0.82 and .81 and .75 for the generic and specific subscales respectively (Mayer & Gavin, 2005).
Factor analysis for the overall scale has been conducted.

Mayer, R.C., Davis, J.H., & Schoorman, F.D. (1995). An integrative model of organizational trust. *Academy of Management Review, 20*(3), 709-734.
Mayer, R.C., & Gavin, M.B.(2005). Trust in management and performance: Who minds the shop while the employees watch the boss? *Academy of Management Journal, 48*(5), 874-888.

Demographic Questionnaire

1. Gender:
   - ❑ Female
   - ❑ Male

2. Age: _____ years

3. Highest Level of Education:
   - ❑ High School
   - ❑ College Diploma
   - ❑ Bachelor's Degree
   - ❑ Master's Degree
   - ❑ Doctorate

4. Are you currently enrolled in an educational program?
Yes ___ No ___ Program name _____

5. Type of hospital where you are employed:
   - ❑ Teaching (Academic)
   - ❑ Community

6. What is your current employment status at this hospital?
   - ❑ Full time
   - ❑ Part time
   - ❑ Casual

7. Is your employment:
   - ❑ Permanent
   - ❑ Temporary

8. My **preferred** employment status is:
   - ❑ Full time
   - ❑ Part time
   - ❑ Casual

9. How many years have you worked:

a) in your profession? ____ years _____months

b) in your present facility? ____ years _____months

c) on your current unit? ____ years _____months

10. What type of unit do you work on? **Select the ONE unit where you work the MOST hours**
    - ❑ Medical
    - ❑ Surgical
    - ❑ Intensive Care
    - ❑ Obstetrics
    - ❑ Pediatrics
    - ❑ Operating Room
    - ❑ Post-anesthetic Care
    - ❑ Psychiatry

- ❑ Emergency
- ❑ Ambulatory Care
- ❑ Other – Specify: _____

11. What is the position title of the person to whom you report?
_____(e.g., manager, coordinator, etc.)

12. How long have you reported to this person? _____ years ____months

13. How frequently do you see/meet with your manager on average?
- ❑ every day
- ❑ once or twice a week
- ❑ once or twice a month
- ❑ once or twice in 6 months
- ❑ once or twice a year
- ❑ other – please specify:_____

14. What was the last shift you worked?
- ❑ Days
- ❑ Evenings
- ❑ Nights

15. How many hours do you work... (not including overtime)
a. In a normal work week: _____ hours
b. In the past week: _____ hours

16. How many patients were on your unit during the last shift? ___ # of patients

17. How many of these patients were assigned to you? ___ # of patients

18. How many overtime hours did you work in your last work week?
_____ hours

19. In the **past year**, has the amount of overtime required of you
- ❑ Increased
- ❑ Remained the same
- ❑ Decreased
- ❑ Not applicable

20. In the **past year,** on how many occasions have you missed work due to illness/disability?
_____ #occasions

21. In the **past year**, what is the <u>most common</u> reason you missed work? (Choose one only)
- ❑ Physical illness
- ❑ Injury (work related)
- ❑ Family situation
- ❑ Mental health day
- ❑ Other: _____

Please share any other thoughts about your work setting you feel we should know about:
comments

APPENDIX B

B. 01 Reliability Analysis, Means and Standard Deviations for Scales and Subscales

Reliability analysis, means and standard deviations for scales and subscales

Instrument	Response range/anchors	No. Items	Alpha	Mean	*SD*
Authentic leadership	0 – 4	16	0.97	2.35	0.99
	Not at all to frequently,				
	if not always				
Relational transparency	0 – 4	5	0.88	2.49	1.01
Balanced processing	0 – 4	3	0.86	2.31	1.11
Self-awareness	0 – 4	4	0.93	2.06	1.17
Internalized moral perspective	0 – 4	4	0.89	2.52	1.02
Trust in manager	1 – 5	10	0.83	3.26	0.64
	Strongly disagree				
	to strongly agree				
Structural empowerment					
CWEQ – II	1 – 5	19	0.88	18.88	3.37
	None to a lot				
Opportunity	1 – 5	3	0.85	3.99	0.77
Information	1 – 5	3	0.84	3.04	0.86
Support	1 – 5	3	0.83	2.93	0.90
Resources	1 – 5	3	0.81	2.89	0.86
Formal power	1 – 5	3	0.76	2.52	0.85
Informal power	1 – 5	4	0.66	3.55	0.67
Global empowerment	1 – 5	2	0.90	3.29	0.99
	Strongly disagree				
	to strongly agree				

APPENDIX C

Letters of Information

C. 01 Letter of Information

C. 02 Follow-up Letter of Information

Information and Consent Form for Survey

Study Title: The Influence of Authentic Leadership on Trust and Work Outcomes of Registered Nurses

September, 2008

Dear Nursing Colleague,

We would like to invite you to participate in a research project we are conducting. The purpose of this study is to examine the influence of the leadership practices of first line patient care managers on nurses' trust in leadership and some important work outcomes of registered nurses in teaching and community hospitals. Your participation in this study will be vital in allowing us to analyze how the nature and work of front-line patient care leaders can help or hinder nurses' practice and outcomes for patients.

In order to examine this topic, we have developed a questionnaire that asks for your assessment of your manager's leadership practices, your working conditions, structures that support your work, and the outcomes of your work in terms of involvement in work, performance, job satisfaction, and perceptions of the quality of care in your organization and also some general questions about yourself. Your name was randomly selected from a registry list of the College of Nurses of Ontario. Your participation in this research is entirely voluntary. You may refuse to participate, refuse to answer any of the questions, or withdraw from the study at any time without penalty. The enclosed questionnaire should take about 30 minutes to complete. Completion and return of the questionnaire indicates your consent to participate in the study. While we would like you to answer all the questions, if you do not wish to answer a particular question, please feel free to leave it blank.

Your responses will be kept strictly confidential and locked in a filing cabinet in Dr. Wong's office until the data have been analyzed. Individual responses will only be seen by a research assistant who will enter them into a computer file. Each questionnaire is identified by a code number to enable us to send out a reminder letter to individuals who have not responded. Your name will never be attached to your questionnaire and once the study is completed, the questionnaires will be destroyed.

As a small token of our appreciation for your contribution to the study, we have included a coupon redeemable at Tim Horton's. When the research project is complete, we would be happy to send you a copy of the results. If you are interested in receiving the results, please write your name and address on the enclosed small **blue** form and return it with your completed questionnaire. To ensure that your responses remain anonymous, this form will be separated from the rest of your questionnaire when it arrives back in Dr. Wong's office. This identification will also be destroyed after the summary of the results is mailed to you. While the results of this study may be published, they will only be presented as group data, ensuring that identification of individual responses will be impossible.

While there are no known risks to this study, your participation will give you the opportunity to provide information useful for leadership practices that are most helpful in promoting trust and positive working conditions for nurses. Should you have any questions about the conduct of this study or your rights as a research subject, you may contact the Director, Office of Research Ethics, The University of Western Ontario, or email at:

We would very much appreciate your participation in this research project. If you choose to participate, please use the pre-addressed, stamped envelope enclosed to return the questionnaire to Dr. Wong's office. If you do not wish to participate, please return the blank questionnaire, after which we will <u>not</u> contact you again. If at

any time you would like to withdraw from the study, please contact the Principal Investigator and your data will be removed from our files. This letter and the Tim Horton's coupon are for you to keep, regardless of whether or not you decide to participate. If you have any questions, please feel free to contact Dr. Wong at the phone number or e-mail address listed below. Thank you very much for considering this request.

Sincerely,

Carol Wong, RN, PhD
Principal Investigator
Assistant Professor,
Arthur Labatt Family School of Nursing
The University of Western Ontario

and

Dr. Heather Laschinger, RN, PhD
Co-investigator
Professor
Arthur Labatt Family School of Nursing
The University of Western Ontario

Follow-up
Information and Consent Form for Survey

Study Title: The Influence of Authentic Leadership on Trust and Work Outcomes of Registered Nurses

October 2008

Dear Nursing Colleague,

A few weeks ago, we sent you a letter inviting you to participate in our study of nursing leadership, trust and work outcomes of registered nurses. So far, we have not heard from you and are writing to nurses who have not returned the questionnaire to ask you one more time if you would consider helping us with this study by completing the questionnaire. We realize that nurses have busy lives and therefore, time is precious. However, if you could find some time to complete the questionnaire, we would sincerely appreciate your help.

While participation is strictly voluntary, we understand that you may have chosen not to take part. If you have misplaced the first questionnaire package, we have enclosed another one with the hope that you will share your thoughts by completing the questionnaire. We have also enclosed another Tim Horton's coupon as a small token of our appreciation for your contribution to this study. The coupon is for you to keep regardless of whether or not you decide to participate.

Our questionnaire asks for your assessment of your manager's leadership practices, your working conditions, structures that support your work, and the outcomes of your work in terms of involvement in work, performance, job satisfaction, and perceptions of the quality of care in your organization and also some general questions about yourself. Your name was randomly

selected from a registry list of the College of Nurses of Ontario. Your participation in this research is entirely voluntary. You may refuse to participate, refuse to answer any of the questions, or withdraw from the study at any time without penalty. The enclosed questionnaire should take about 30 minutes to complete. Completion and return of the questionnaire indicates your consent to participate in the study. While we would like you to answer all the questions, if you do not wish to answer a particular question, please feel free to leave it blank.

We want to assure you that your responses are completely confidential and that no individual responses will ever be identified in sharing the results. We also would be very pleased to send you a copy of the final report if you wish to have one. If you are interested in receiving the results, please write your name and address on the enclosed small **blue** form and return it with your completed questionnaire. To ensure that your responses remain anonymous, this form will be separated from the rest of your questionnaire when it arrives back in Dr. Wong's office. This identification will also be destroyed after the summary of the results is mailed to you. While the results of this study may be published, they will only be presented as group data, ensuring that identification of individual responses will be impossible. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

If you have already responded, we would like to thank you for your time and support. If you do not wish to participate, please return the blank questionnaire in the pre-addressed, stamped envelope and you will not be contacted further. If you have any questions regarding this study, please do not hesitate to contact Dr. Wong by e-mail or by phone at

Sincerely,

Carol Wong, RN, PhD
Principal Investigator
Assistant Professor,
Arthur Labatt Family School of Nursing
The University of Western Ontario

and

Dr. Heather Laschinger, RN, PhD
Co-investigator
Professor
Arthur Labatt Family School of Nursing
The University of Western Ontario

APPENDIX D

Letter of Approval

D. 01 The University of Western Ontario Review Board of Health Sciences Research Involving Human Subjects Certificate of Approval

D. 02 Permission for use of the Authentic Leadership Questionnaire

Western

Office of Research Ethics

The University of Western Ontario
Room 00045 Dental Sciences Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. C.A. Wong
Review Number: 15292E **Review Level:** Expedited
Review Date: July 17, 2008
Protocol Title: The Influence of Authentic Leadership on Trust and Work Outcomes of Registered Nurses
Department and Institution: Nursing, University of Western Ontario
Sponsor:
Ethics Approval Date: July 18, 2008 **Expiry Date:** October 31, 2009
Documents Reviewed and Approved: UWO Protocol, Letter of Information, Reminder Letter, Follow-up Letter
Documents Received for Information:

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

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

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

Investigators must promptly also report to the HSREB:

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

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

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

Chair of HSREB: Dr. Paul G. Harding

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland	☐ Elizabeth Wambolt	☐ Grace Kelly	☑ Denise Grafton

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cc: ORE File

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Instrument: Authentic Leadership Questionnaire (ALQ)

Authors: Bruce J. Avolio, William L. Gardner, and Fred O. Walumbwa

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Sincerely,

Vicki Jaimez
Mind Garden, Inc.