

**A QUALITATIVE STUDY: COMMUNITY NURSES' EXPERIENCE OF
ORGANIZATIONAL TRUST**

by

Leanne Calvin

BSN, The University College of the Cariboo, 2002

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF**

MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

December 2013

© Leanne Calvin, 2013

ABSTRACT

This master's thesis project stems from awareness of the impact of restructuring and standardization in the health organization, and introducing changes that impact community nurses' practices and policies. Previous studies on nurses' organizational trust have utilized a quantitative design and have focused on nurses working in the acute care sector. This qualitative inquiry explored nurses' experience of organizational trust and factors that influence it within a community health context. The study aims were to provide awareness to health organizations as to how they may avoid negative impacts of decreased trust of community nurses' and increase the likelihood of positive acceptance of changing health services and a restructured organization.

The British Columbia healthcare system is becoming more reliant on the community nursing sector to address increasing demands in healthcare due to several factors such as an aging population, rise in chronic diseases, and limited financial and human resources. If community nurses do not have trust in the health organization, there may be resistance to changes that have been designed to improve health services. This may result in poorer health outcomes for the population and increased burden on the acute care system. Health organizations that are not aware of factors that may influence community nurses' organizational trust may encounter higher rates of job turnover, decreased productivity and challenges in maintaining a viable healthcare system.

A qualitative design with an interpretative description approach was used along with theoretical concepts pertaining to organizational trust. Community nurses within the interior region of British Columbia, Canada received invitations to participate via email. Data collection involved semi-structured interviews with 10 participants which were digitally recorded and transcribed professionally. The analysis of the data utilized techniques employed in

interpretative description. Interpretative description techniques involve the identification of emerging patterns and themes within participants' experiences and relationships within between these patterns to develop a richer understanding of the phenomenon.

Three main themes identified were 1) leadership support 2) organizational restructure 3) evolving health services and practices. These three main themes yielded the following conclusions: that nurses' perception of leadership support, particularly nurse-leader relationships can significantly influence their trust in the health organization; and that nurses' lack of participation in decision-making during change can negatively impact their trust in the health organization. The major implications that arose from this study include: 1) implications for leadership to implement strategies to improve interpersonal relationships with nurses, collaborative change processes and a shared vision, and develop opportunities for them to engage with organizational structures; 2) implications for practice to include nurses in decision-making and utilize change models; 3) implications for policy to have a nurse representative at the senior level of leadership.

PREFACE

This thesis is an original intellectual product of the author, L. Calvin. The fieldwork reported in Chapters 2-4 was covered by UBC Ethics Certificate number H12-01927 and Interior Health Review Ethics Board Certificate number 2012-13-038E.

TABLE OF CONTENTS

ABSTRACT.....	ii
PREFACE.....	iv
TABLE OF CONTENTS.....	v
ACKNOWLEDGEMENTS.....	viii
CHAPTER 1: PRESENTING THE ISSUE.....	1
Problem Statement	4
Purpose.....	4
Research Questions	5
Situating Myself in the Work.....	5
Definition of Terms.....	5
Summary	6
CHAPTER 2: LITERATURE REVIEW	8
Search Strategy.....	8
Factors that Influence Organizational Trust.....	9
Organizational Trust, Change, Job Satisfaction, and Retention.....	9
Organizational Trust, Nurse-leader Interactions, and Relationships.....	12
Organizational Trust, Leadership Style, and Job Satisfaction.....	15
Summary	17
CHAPTER 3: RESEARCH METHODS	20
Methodology	20
Sampling Plan	21
Recruitment Strategies	22
Data Collection Procedures.....	23
Data Analysis	23
Ethical Considerations.....	25
Ensuring Scientific Quality.....	26
CHAPTER 4: FINDINGS	29
Introduction.....	29
Situating the Participants.....	29

Findings.....	30
Leadership Support	30
Clinical Practice Support and Nurse-leader Relationships.....	31
Communication.	34
Autonomy in Practice.	37
Organizational Restructure.....	38
Knowledge of the Organization’s Changes.	39
Change Communications and Rationale.....	41
Work Space.....	42
Evolving Health Services and Practices.....	43
Nurse Participation in Decision-Making.	43
Vision Transparency.....	45
Summary of Key Findings	46
CHAPTER 5: DISCUSSION AND RECOMMENDATIONS	48
Introduction	48
Discussion	49
Nurse-leader Relationships.....	49
Nurse Participation in Decision-Making.	51
Communication of Organizational Change.	52
Implications for leadership, Practice, and Policy.....	54
Implications for Leadership.....	54
Practice Implications.	55
Policy Implications.....	56
Limitations	57
Recommendations for Leadership of the Organization.....	57
Recommendations for Future Research	58
Summary of Discussion and Recommendations.....	59
REFERENCES	61
APPENDIX A: LETTER TO COMMUNITY MANAGERS	69
APPENDIX B: EMAIL SCRIPT FOR MANAGERS.....	71
APPENDIX C: INVITATION TO PARTICIPATE.....	72

APPENDIX D: RESEARCH PROMOTION POSTER	74
APPENDIX E: PARTICIPANT CONSENT FORM	75
APPENDIX F: PARTICIPANT DEMOGRAPHIC FORM.....	78
APPENDIX G: INTERVIEW GUIDE	79

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude for the participants who participated in this study. Your thoughtfulness and consideration in sharing your experiences openly and honestly provided me with an opportunity to grow and develop as a professional and as a human being. I appreciate that recounting your experiences was at times difficult to express and perhaps presented a degree of awkwardness due to the context of the inquiry. I am thankful for the learning that you have afforded me and hope that your contributions will provide insightful information for other researchers and health care leaders to further develop upon.

I am very thankful for all the support that Sue Parker provided in doing all the transcription of the data and a big thank you to Anita Minh for helping me with the formatting of the thesis. I sincerely appreciate the research grant from the Lyle Creelman Endowment Fund for Public Health Research that was awarded by the UBC Nursing Research Grants Office.

I am extremely fortunate to have been supported by the Interior Health leadership team in allowing me time in their busy schedules to promote this research endeavour. You have been a consistent support not only during this phase of my academic development but also during my early years as a novice nurse. I want to extend many thanks for your continued support and encouragement. To Cathy Thibault, Kris Weatherman, Rae Sampson, Mary-Anne Waters, Francesca Brar, Philip Snyman, Maureen Mackinlay and Sandy Da Silva you are my good fortune and I couldn't have done it without you.

My committee members Judy Lynam and Cheryl Zawaduk have extended themselves to me during my long journey. I have appreciated their optimism, flexibility and availability to provide thorough and thoughtful feedback that was intellectually nurturing. You provided ongoing encouragement and facilitated my learning in a comfortable and caring way. I cannot

thank you enough for believing in me and my success in this program, despite our inability to meet face-to-face during this study your presence was always near and I thank you.

Vicky Bungay, my supervisor has supported me to the extent that I remain at a loss for words. Vicky has stretched my ability in academic thinking and writing, which has developed my professional capacity and personhood. She has been extremely patient, understanding, thoughtful, and fun and has accommodated my many trials during this significant time in my life. I will not forget how you took me to a place that I once dismissed, dared to dream, and now live in. You will always be an instrumental thought in my perception of who I have become and where else I could go. I am honored to be one of your many students who are lucky to cross paths with you. I cannot thank you enough.

My husband Gary and two sons Kirk and Justin, you are my reason for drive, perseverance, and achievement. I would not have had this venture without your presence, patience, and support. I am so proud of your ability to adapt, overcome and thrive. We have done this together and now we have crossed the finish line.

CHAPTER 1: PRESENTING THE ISSUE

The health care system was and continues to undergo change and restructuring in response to such factors as human resource shortages, increasing prevalence of chronic diseases, advances in technology, and limited financial resources (B.C. Ministry of Health Service Plan, 2010). The continuous restructuring and change are often problematic for nurses as they may contribute to fluctuating nursing roles and practices, potential loss of employment, and the destabilization of regular work. Furthermore, a lack of communication between organizational leaders and nurses further exacerbates nurses' experiences of distress during change (Gregory, Way, LeFort, Barrett & Parfrey, 2007 & MacPhee, 2007). Ultimately, organizational changes and the related uncertainty and disruption in nursing practice may result in increased job dissatisfaction, reduced job performance, and less commitment among nurses to their employing organizations' goals and ideals; all factors that have been shown to reduce the effectiveness of organizational change and restructuring as well as the quality of patient care provided by the health care system (Reineck, 2007; Gregory et al. 2007; Williams, 2005).

Researchers (e.g., Gregory et al., 2007; MacPhee, 2007) concerned with the increasing distress among nurses and resultant barriers to effective change have contributed to a growing body of literature that seeks to examine nurses' experiences of change, particularly within the context of their faith and confidence in the intentions and actions of the administrative leaders within their healthcare agency. More specifically, researchers have begun to examine nurses' perceptions and experiences of organizational trust. Organizational trust, defined as "the extent to which one is willing to ascribe good intentions to and have confidence in the words and actions of other people" (Cook & Wall, 1980, p. 39) has been identified as a key aspect of effective health care restructuring. High levels of trust among employees result in increased

willingness to work in uncertain conditions, stronger commitment to change, and greater abilities to adapt more readily to change (Williams, 2005). By contrast, a loss of organizational trust is experienced as a loss of faith and confidence for those in positions of formal leadership (Reineck; Gregory et al.; & MacPhee, 2007) and research has showed that low levels of nurses' organizational trust may have contributed to more difficult change processes, reduced job performance, decreased job satisfaction and retention, greater cost expenditures, and compromised quality of patient care (Reineck; Gregory et al.; Williams). Insights gleaned from the literature explained how health organizations could maintain, build, or regain nurses' trust. Studies indicated that organizational trust could be promoted by having open dialogue, transparent agendas, incorporation of employee feedback and participation, and supportive leadership behaviours (Dirks & Ferrin, 2002; Chen, Wang, Chang, & Hu, 2008; Williams, 2005; Gregory et al., 2010; Spence Laschinger, Finegan, & Shamian, 2001).

The community health care setting is an area that continues to undergo extensive organizational change. The Interior Health Authority in British Columbia (BC) is in the process of restructuring community health services. Health services including community nursing, public health, Aboriginal health, and community mental health have been brought together under one administrative portfolio as Community Integrated Health Services (CIHS). Under the CIHS portfolio community services are encouraged to work together and integrate their services rather than work independently. For example, standardized policies and procedures are currently being developed to guide practice across these sectors. Nurses in these sectors are in the process of adopting new clinical practices such as: management of anaphylaxis in adults, working alone safety, and end of life care. Along with clinical practice changes, nursing roles, responsibilities, and titles have been reshaped. Nurse clinical practice educators (CPE's) who provided clinical

education and practice support to front-line community nurses have been displaced and have had to reapply for positions titled as knowledge coordinators, where they may have to work in a different area (e.g. childhood immunization programs versus planned maternity discharge and breastfeeding clinics). Organizational reporting structures have also changed and many front-line nurses in these settings have new managers some of whom are not nurses. In light of the evidence regarding change, it is possible that nurses' trust in their organization may have been negatively impacted (Spence Laschinger et al., 2001); which raised my curiosity about the impact of change on community nurses' trust within Interior Health.

To date, research in the area of organizational trust and nursing has emphasized the acute care setting. In my review of the literature regarding organizational trust and nursing none of the studies looked at the community nursing sector, rather all studies involved nurses who worked in acute care hospitals. Nurses practicing in the community environment however, may undergo different experiences in comparison to nurses practicing in the acute care environment. The community setting differs from the acute setting in that nurses do not have face-to-face support from peers and supervisors when providing care to clients (Underwood et al. 2009). Community nurses may also encounter greater autonomy than in some acute care settings and may only interact with their team prior to seeing clients or during staff meetings (Underwood et al.). The opportunity for clarification and support on new procedures, guidelines, and policies whether they are clinical or administrative is often limited to beginning and end of shift, rather than having the availability of other nurses' support throughout their shift (Underwood et al.). Communication between nurses and their leaders often occurs via email or over the telephone rather than in person (Underwood et al.). Working in the community involves a fluctuating environment for nursing care such as, a client's home or various community clinics or schools

(Underwood et al.). Community nurses are isolated from their peers, supervisors, and managers to a greater extent than acute care nurses working in facilities (Underwood et al.). In addition, there may be fewer opportunities for team building, and increasing morale due the nature of independent nursing practice and the vast community environments.

It is prudent for health organizations to have an understanding of how community nurses' trust may be impacted by change. As the changing healthcare environment includes a shift towards increased community nursing care provision (CNA, 2006); it is beneficial for health organizations to have insight into community nurses' experience, perceptions, and factors that impact their organizational trust to avoid negative potential consequences as indicated below.

Problem Statement

The British Columbia healthcare system is becoming more reliant on the community nursing sector to address increasing demands in healthcare due to several factors such as an aging population, rise in chronic diseases, and limited financial and human resources (B.C. Ministry of Health Service Plan, 2010). If community nurses do not have trust in the health organization, there may be resistance to changes that have been designed to improve health services. This may result in poorer health outcomes for the population and increased burden on the acute care system. Health organizations that are not aware of factors that may influence community nurses' organizational trust may overlook effective strategies that could help avoid higher rates of job turnover, decreased productivity and challenges in maintaining a viable healthcare system.

Purpose

The purpose of this study was to explore nurses' experience of organizational trust and factors that influence it within a community health context.

Research Questions

This study explored the following two questions:

1. What are the experiences of nurses' organizational trust in the community health context?
2. What are the factors that influence community nurses' organizational trust?

Situating Myself in the Work

In 2002, I obtained my Bachelor of Science in Nursing degree at the University College of the Cariboo which is located in the Thompson, Cariboo, Shuswap region of British Columbia Canada. I have been employed with Interior Health since the beginning of my career and have enjoyed working in diverse practice settings including: mental health, public health, community nursing and acute care. I have experienced the organization as a positive workplace environment where employees are supported in their professional development and evidence-informed practices. I believe Interior Health's values of quality, integrity, respect, and trust are central to fostering employee engagement and quality improvement initiatives in health service delivery which span across the continuum of care. In the journey of pursuing my Master of Science in Nursing degree I developed personal awareness of organizational change and its impacts during the Interior Health restructure. I was intrigued to learn more about organizational change which propelled my curiosity of organizational trust and related factors of leadership, job retention and satisfaction, and change. My aim is to provide salient information for all formal and informal leaders within a health organization by highlighting the complexities of organizational trust.

Definition of Terms

For the purposes of this study a community nurse was one who practiced in the publically funded healthcare system, and was registered by the College of Registered Nurses of British Columbia (CRNBC). Community nurses worked in a variety of practice settings exclusively in

either: public health which includes health promotion and prevention services; community nursing which includes home health services, ambulatory clinics, long-term care case management; primary care clinics; and community mental health services including case management and geriatric outreach services (Underwood et al., 2009).

Organizational change for the purpose of the study meant change that was implemented in order to reflect new leadership directives that affected practice, policy, and reporting structures (Vlasses & Smeltzer, 2007; Morjikian, Kimball & Joynt, 2007; Cutcliffe & Bassett, 1997).

Summary

As the healthcare system strives to cope with existing pressures by changing the way it delivers service, health organizations should be prudent in ensuring community nurses' organizational trust. Furthermore, inquiry of the experiences, perceptions and factors that impact community nurses' trust may extend the organization's capacity to maintain or rebuild their trust, as it is relatively unexplored. This study will add to the current literature that relates to nurses' organizational trust. An overview of the following thesis chapters is provided below.

This thesis consists of five chapters. In chapter 1 the issue is situated, and is followed by a problem statement, purpose of the study, research questions, situating myself in the work, and definition of terms. Chapter 2 includes a review of the literature in regard how organizational trust is associated with change, job satisfaction and retention, nurse-leader interactions and relationships, and leadership style. In chapter 3 a description of the research methodology is provided, along with the sampling plan, recruitment strategies, data collection procedures, data analysis, ethical considerations, and ensuring scientific quality. The participants are situated and the findings of this study are included in chapter 4. Finally, chapter 5 entails a discussion of the

research findings in regard to nurse-leader relationships, nurse participation in decision-making, and communication of organizational change. Implications for leadership, practice and policy are included along with limitations, and recommendations for leadership and future research.

CHAPTER 2: LITERATURE REVIEW

In the initial stages of determining my study focus I explored a diversity of literature with regard to organizational change and leadership styles in the context of health and nursing. I elected to focus on these topics and gained a thorough understanding during my graduate course work. Upon the review of this literature I came across the concept of organizational trust which was intertwined in organizational change theory and leadership theory. The following section provides an account of literature searches in health related data bases that provided me with a foundation of knowledge in organizational trust and inspired me to pursue further inquiry of this topic.

Search Strategy

Several online searches were performed using terms relating to nursing and organizational trust and organizational change for the time period of 2000-2011. Data bases searched included PubMed, CINAHL, and EBSCO. This yielded seven relevant searches that were manageable for review, which are noted as follows: organizational trust and successful change produced 41 results; organizational trust and nurses leadership produced 108 results; nurse middle manager and change produced 27 results; nurses' organizational trust produced 97 results; community care nurses' organizational trust produced 14 results; community care nurses trust of managers produced 23 results; nurse trust of supervisors produced 20 results. After review of the above-mentioned search results, eight journal articles were found that addressed nurses' organizational trust as a primary focus. The eight articles included studies that used quantitative or a mixed methods research approach; and involved front-line nurses and nurse leaders who worked in acute care environments. I could locate no published study that examined any aspect of organizational trust in a community setting. Factors affecting nurses'

organizational trust according to the literature entail not only, organizational change processes, but also organizational citizenship behaviours (OCB's), and supportive leadership styles. The following sections will describe findings from the literature that reflect how these factors may impact nurses' organizational trust.

Factors that Influence Organizational Trust

Organizational trust has been associated with many factors that may influence nurses' experiences of organizational trust. Several studies have reflected that elements such as: change; job satisfaction and retention; nurse-leader interactions and relationships; and leadership style have an effect on nurses' organizational trust. Data collected for these studies were obtained from surveys completed by nurses working in the acute care setting. The tools employed in the surveys typically used rating scales. None of the studies examined the issue of organizational trust in a community health context using a qualitative design. Descriptions of these studies are provided below.

Organizational Trust, Change, Job Satisfaction, and Retention.

The Gregory and colleagues (2007) Canadian study surveyed 343 registered nurses (RN's) practicing in acute care settings. The investigators were interested in knowing how point of care RN's working in acute care rate organizational culture, work-related attitudes, and likelihood of retention after health system reform (Gregory et al.). Another study purpose was to test a model which linked: a) emotional climate, practice issues, and collaborative relations with trust in the employer; b) job satisfaction with organizational commitment and intent to stay (Gregory et. al.). Data collection focused in the following areas: 1) trust in employer 2) job satisfaction 3) organizational commitment and 4) intent to stay. In the analysis, internal consistency and inter-correlations were based on Cronback's α and bivariate correlations,

respectively (Gregory et al.). The study found that while registered nurses (RN's) were satisfied with their jobs, the majority of "RN's believed that restructuring had negative repercussions for organizational culture, were distrustful of employers' ... had low levels of commitment to their organizations, and were unsure about staying with current employers" (Gregory et al., p. 123). As well, they demonstrated that trust and job satisfaction were significant direct predictors of commitment (Gregory et al.). The researchers indicated that interventions targeting organizational culture may result in greater levels of trust, satisfaction and commitment (Gregory et al.). In addition, the researchers concluded that health managers must work with employees to develop strategies to improve organizational culture and trust; in a system which is continuously changing (Gregory et al).

Williams (2005) used a case study approach to examine components of nurse's job satisfaction such as communication with supervisors, job recognition, and fairness, with organizational trust. The study was conducted in a 302 bed acute care hospital where 472 surveys were included in the final analysis. The Index Work Satisfaction Tool (IWS) was used to measure nurse satisfaction. Organizational trust was assessed using the Organizational Trust Index (OTI). A correlation matrix was used to examine the relationship between organizational trust and nurse satisfaction. Organizational trust was significantly and positively correlated with nurse satisfaction. Williams stated that "rampant organizational change has reportedly left nurses feeling betrayed, stressed and vulnerable" (p. 203). Williams further indicated that employees who have trust in their organization were more willing to work in uncertain conditions, had a strong commitment, and adapted more readily to change. It is practical to explore levels of trust amongst nurses prior to the implementation of change, as they make up a

large portion of a health organization's employees; and having nurses' trust may facilitate an easier transition of change.

Spence Laschinger, Finegan, and Shamian (2001) conducted a survey that yielded 412 usable questionnaires. These investigators' interest was in examining a model linking front-line nurses' empowerment, organizational trust, job satisfaction, and organizational commitment (Spence Laschinger et al.). The majority of nurses who participated in the study worked in Ontario medical-surgical, and critical care areas (70% combined), with fewer nurses working in maternal child and psychiatry (30% combined). Five and seven point Likert scales were used and structural equation modeling (SEM) techniques were employed. Results of this study supported that staff nurse empowerment impacted their trust in management which ultimately impacted job satisfaction and commitment. The researchers explained that access to support and trust in management were strongly related, which suggested that when nurses were provided with feedback and guidance from managers and were given the flexibility to use their judgement and make decisions, their trust in management increased. In presenting their findings Spence Laschinger and colleagues (2001) state, "[a]s current organizations restructure and reengineer in the name of efficiency and effectiveness, trust in management has become an increasingly important element in determining organizational climate, employee performance, and commitment to the organization" (p. 7). Furthermore, Spence Laschinger and colleagues stated, "[n]urses, the largest group of health-care providers in hospitals, have been particularly hard hit by recent downsizing. It is quite possible that their mistrust of the system could potentially threaten the quality of patient care" (p. 7). This study showed that nurses who were afforded effective leadership support and opportunity to have input into decision-making had increased trust in the organization. In the midst of organizational change which aims to improve

effectiveness in health service delivery and client health outcomes, trust of nurses may be a significant predictor of successful change; hence exploration of nurses' trust in the community setting can provide valuable insights to organizations.

This literature provided me with the insight that I needed to look at how change, job satisfaction and retention may influence community nurses' trust in the organization. These previous studies helped me to realize that in exploring nurses' trust nurses needed to have the opportunity to share their experiences about changes in their organization and how that impacted their sense of trust, job satisfaction and motivation to stay in their present position. This literature was used to frame my research questions and the interview guide questions in order to further explore nurses' experiences of organizational trust and factors that influence it. The interview guide questions that were informed by the literature provided an opportunity for nurses to describe their experiences for example, how their leaders supported them, the types of interactions they had with leaders, what they found most helpful, what attributed to their sense of job satisfaction, what motivated them to stay in their jobs, and how they were impacted by change. In addition to the evidence presented by these quantitative studies, I aimed to generate new knowledge through exploration of community nurses' subjective accounts to allow for other realities which may be different to what is already known about nurses' organizational trust. This may help to reshape how health organizations address community nurses' organizational trust.

Organizational Trust, Nurse-leader Interactions, and Relationships.

Chen and colleagues (2008) conducted a study which involved 200 nurse supervisor-nurse dyads from three medical centres and three regional hospitals. It is unclear which country the data came from, however; data were obtained through 400 questionnaires. The investigators

hypothesized that leader-member exchange (LMX) quality would have a positive effect on the level of subordinate: trust in their supervisors; perceived supervisor support; and organizational citizenship behaviours. Other hypotheses included: subordinate trust in their supervisor would have a positive effect on their organizational citizenship behaviours (OCB); trust will mediate the relationship between LMX and subordinate OCB; and perceived support from supervisors will mediate the relationship between LMX and OCB (Chen, Wang, Chang, Hu, 2008). The questionnaire was comprised of four parts: 1) demographics 2) leader-member exchange 3) level of trust in supervisor 4) perceived supervisor support. A five-point rating scale was used for each section (Chen et al.). Data reliability was assessed using Cronbach's α value for variables, which ranged from 0.84-0.91 indicating high reliability (Chen et al.). Pearson's product moment correlation was utilized to evaluate correlations between variables and LISREL 8.0 path analysis was used to verify the study hypotheses (Chen et al.). The researchers reported that the quality of exchange between nurses and their supervisors impacted the level of trust the nurse had in the supervisor (Chen et al.). High quality relationships were reported to be formed between nurses and their supervisors by sharing emotions, loyalty and contributions which will increase trust and perceived supervisory support (Chen et al.). The researchers recommended that supervisors must strive to cultivate organizational trust and a supportive climate that will promote nurses to take on extra-role responsibilities (Chen et al.). In addition, the researchers concluded that when nurses and nurse supervisors have good interactions, commitment to the organization is enhanced, job turnover is reduced, and collective effectiveness is improved (Chen et al.).

Altuntas and Baykal (2010) conducted a study that looked at levels of nurses' organizational trust and organizational citizenship behaviours (OCB's) and investigated

relationships between the levels of organizational trust and OCB's. Two questionnaires 1) Organizational Trust Inventory and 2) Organizational Citizenship Level Scale, were used in the data collection which was obtained from 482 nurses working in hospitals located in the European district of Istanbul. Number and percentage calculations and Pearson's correlation were used to analyse the data. The study revealed that nurses had higher levels of trust in their managers and coworkers than in the organization. In addition, the researchers found that nurses who trusted their managers, coworkers, and institutions also demonstrated organizational citizenship behaviours such as "conscientiousness, civic virtue, courtesy and altruism" (p. 186). Trust is thought to be critical in all relationships formed within the organization, especially between nurses and their managers (Altuntas & Baykal). If trust can be established and maintained it is beneficial to staff and the organization as they can more readily move towards a common goal and collaborate toward the pursuit of the goal (Altuntas & Baykal). This point aligns with observations of researchers such as Lapierre and Hackett (2007) who expressed that staff who exhibit OCB improves the quality of the relationship with their supervisor and consequently this can lead to greater job satisfaction. Increased job satisfaction has been related to increased trust in the organization.

A greater understanding of factors that influence organizational trust such as nurse-leader quality relationships can have a positive impact on job satisfaction and retention. This in-turn can enable organizations to minimize expenditures involved with job-turnover and allocate resources to education and training that promotes quality relationships which has a cyclical positive effect on trust and ultimately can position the organization to have nurses as allies in health service reform.

This literature informed my study as I have used concepts of organizational trust theory such as: nurse-leader interactions and relationships to guide my inquiry. By using these concepts of organizational trust theory I explored nurses' experiences of their interactions with leaders, how they perceived leader support and how this influenced their sense of trust in the organization. By utilizing a qualitative design I hoped to contribute to the existing literature by providing a deeper meaning of how the concepts of organizational trust pertain to community nurses' experiences. As I looked at nurses' experiences I identified patterns of nurse-leader interactions and relationships. I was able to link how leaders' behaviours and actions could foster effective nurse-leader relationships and what nurses' considered to as crucial in the relationship.

Organizational Trust, Leadership Style, and Job Satisfaction.

Several studies have indicated that increased job satisfaction is associated with higher levels of organizational trust (Williams, 2005; Spence Laschinger et al., 2001; Dirks & Ferrin, 2001). These authors in addition to Failla and Stichler (2008); Chen, Wang, Chang, and Hu (2008); and Raup (2008) have also explained that a nurse manager's supportive leadership style was positively related to the job satisfaction of nurses.

Failla and Stichler (2008) conducted a study on nurse manager and staff perceptions of the manager's leadership style. A cross-sectional, descriptive correlational and comparative design was used with 92 questionnaires of which 14 were completed by nurse managers (Failla & Stichler). The Bass and Avolio's Multifactor Leadership Questionnaire (MLQ) which uses a Likert-like rating scale to measure the leadership characteristics of nurse managers; in addition the Gordon Personal Profile and the Thinking Scale of the Myers-Briggs Type Indicator were

used (Failla & Stichler). Job satisfaction was measured by the Stamps Index of Work Satisfaction Questionnaire Part B (IWS-B) (Failla & Stichler).

The researchers' findings pertaining to leadership style and job satisfaction indicated that transformational and transactional leadership styles were correlated with job satisfaction, however, their analysis also emphasized that transactional leadership style was critical to empower nurses and ensure a professional practice environment (Failla & Stichler). These authors (Failla and Stichler) definition of transformational leadership is informed by the work of a number of other scholars including Bass (1999); Spinelli (2006); McGuire and Kennerly (2006). Their conceptualization of it was described as leaders' behaviors that elevate followers to higher levels of achievement through inspirational motivation, intellectual stimulation, and individual consideration. Transactional leadership was described as leaders who sets goals, gives directions and uses rewards to reinforce employee behaviors (Spinelli; McGuire & Kennerly). They (McGuire and Kennerly; Kramer and colleagues, 2008; Spinelli; Failla and Stichler) proposed that if nurse managers promote nursing autonomy, and empowerment which were considered to be characteristics of transformational leadership, and elicited behaviours such as providing clear expectations and facilitating teamwork, which may be categorized as transactional leadership; they were considered as being highly supportive to their nurse subordinates. Hence Kramer and colleagues and Failla and Stichler found that supportive leadership styles may indirectly improve nurses' level of organizational trust.

The research clearly indicated that a blend of these two leadership styles increase nurses' perception of having supportive leadership. By examining community nurses' experience of organizational trust and factors that influence it, organizations may be able to ascertain if leaders

are exhibiting characteristics of transformational and transactional leadership styles and act accordingly in supporting their leaders in order to promote increased job satisfaction.

This literature has informed my study in that I have the awareness that a blending of transformational and transactional leadership styles can positively impact job satisfaction and trust. These previous studies have provided a foundation for me to use open-ended questions to explore nurses' subjective accounts of how their leaders encouraged, empowered, and directed nurses and how that has impacted their sense of job satisfaction and trust in the organization. Understanding through a different angle of vision (Thorne, 2008) which interpretative description techniques employ; I aimed to further the knowledge of how leaders exhibit these leadership traits in a community health context through meaning-making of patterns and themes collated from nurses experiences.

Summary

Research on nurses working in a variety of acute care settings suggests that organizational trust is associated with increased team work, reciprocated respectful and courteous behaviours, commitment to stay, job satisfaction, organizational effectiveness, and acceptance of change (Spence Laschinger et al., 2001 ; Gregory et al., 2007; Chen et al., 2008; Williams, 2005; and Altuntas & Baykal, 2010). Moreover, scholars propose that nurses' trust of the organization is enhanced when nurse leaders supported nurses by encouraging their autonomy, engage them in collaborative problem solving and strategizing, and provide direct and clear communication (Chen et al.; Raup, 2008; Spence Laschinger et al.).

Organizational trust was also positively related to employee performance, and decreased absenteeism (Demircan & Ceylan 2003; Chen, Hui, & Seago, 1998; Yahyagil & Deniz 2004; Altuntas & Baykal, 2010). Positive work environments were key to attracting and retaining

nursing staff. Therefore, organizations that endeavour to be aware of trust levels and build organizational trust amongst nurses, may receive cost-benefits associated with decreased staff turnover (Walters, 2005; McGuire & Kennerly, 2006).

The literature reviewed provided evidence that nurses' organizational trust in the acute care setting was related to factors of: change; job satisfaction and retention; nurse-leader interactions and relationships; and leadership styles. In addition, nurses' performance and attendance in the acute care setting improved when they were able to trust the organization; this may also lead to improved care and better health outcomes for consumers of health care services. "Despite the focus on trust as essential to organizational success, there has been little systematic study of trust in healthcare and no studies that examine the influence of nursing leadership practices on nurses' trust and work outcomes" (Wong & Cummings, 2009 p. 531). There is a gap in the literature with respect to studies that explore nurses' organizational trust in a community health context. Nurses who work in the community may not interface with their leaders in the same way as acute nurses due to varied work environments and independent practice in the community; as opposed to nurses who provide care in an acute hospital with colleagues and leaders in the same setting. It is sensible for health organizations to have applicable evidence that guides their perspectives and actions to increase the likelihood of suitable strategy and success in establishing and maintaining community nurses' trust. The alternative for health organizations is to rely on research that is solely based on studies of acute nurses' trust which may not be practical or appropriate.

My study aimed to fill our gap in knowledge related to organizational trust and factors that influence it such as: leadership interactions and relationships; change; job satisfaction and retention; and leadership style. Current studies that have applied a quantitative study design

have presented valuable knowledge in regard to concepts of organizational trust theory. These contributions have provided a useful platform for further study. However, human beings and their contexts, interactions, and experiences are complex and multi-faceted. Therefore, I added to our existing knowledge base through the exploration and analysis of subjective data to highlight and value multiple realities and truths. I have used a qualitative approach so that knowledge could be developed through a different reference point of gathering subjective evidence to analyze identified patterns and themes and relationships between these patterns to gain a deeper understanding of nurses' experiences. As I have provided rich description about how community nurses have experienced organizational trust and related factors I hoped to add to what is already known about organizational trust theory. Through this endeavour health organizations may have further understanding of how to rebuild and maintain nurses' organizational trust in order to carry out effective change processes and improved health service delivery.

CHAPTER 3: RESEARCH METHODS

I employed a qualitative design with an interpretative description approach. Thorne (2008) explains that often it is rare that nothing will be known about a subject; however, a credible argument to engage in a qualitative study is when the study asks the next logical question that develops disciplinary knowledge based on themes and patterns of subjective and experiential elements of the subject; or when the links between elements and the larger experiential context have not yet been made. As my review of the literature yielded only quantitative studies involving nurses who worked in the acute care sector, I was compelled to look at the patterns and themes of community nurses' experiences of trust in the organization and through an interpretative description approach provide greater insights of this topic. Theoretical concepts pertaining to organizational trust also informed the research approach. Application and description of this methodology is presented initially in this chapter. The following sections will provide an account of research method components such as: methodology; sampling plan; recruitment strategies; data collection procedures; data analysis; ethical considerations; and ensuring scientific quality.

Methodology

Interpretive description allows for the scientific discovery of knowledge that is derived from the subjective, tacit, and patterned experiences of individuals within a healthcare setting (Thorne, 2008). This methodological approach was favourable as a qualitative study strives to gain insights through apparent themes that are constructed by subjective evidence (Thorne, 2008). This research approach allowed inquiry of a particular issue within an applied context of health care. Key elements of interpretative description include: valuing the subjective and experiential knowledge as a primary source of clinical insight; utilizing human commonalities as

well as individual expressions of difference; acknowledging a socially constructed component to human experience which cannot be separated; recognizing that the reality of human experience involves multiple realities which may be contradictory to each other; understanding that the inquirer and the object of inquiry interact and influence one another (Thorne). Interpretative description seeks to explore features or elements of a common issue, but will look to come to an understanding of them that respects their natural complexity (Thorne). This methodology enabled me to develop a richer understanding of an applied context so that it is useful knowledge for clinical practice and policy development.

With the use of interpretative description the phenomena of organizational trust was explored and provided further knowledge as study participants articulated their experience. In addition, by applying this methodology, I identified patterns within the data and relationships between these patterns. As the intent of this study was to obtain an understanding of nurses' experience of organizational trust in a community health context; through the use of dialogue in semi-structured interviews; the qualities of interpretative description provided a suitable means to achieve this endeavour.

Sampling Plan

The sampling plan included a small sample of participants who met specific inclusion criteria and were able to provide an account of their experience of organizational trust. This may be referred to as a purposeful sampling method. This sampling involves specific settings in which individuals are recruited who have experience in the phenomenon that is being explored (Thorne, 2008). Purposeful sampling intends to seek participants that will have a willingness to engage with the researcher to share their observations and thinking about their experience rather than just simply living in their experience (Thorne).

Community nursing sites within the Interior Health Authority were selected to recruit participants. The aim was to recruit ten participants, amongst the community nursing sites. Two inclusion criteria were exercised for participant selection. First, each participant required a minimum of two years experience as a community nurse with the Interior Health Authority, in order to allow for an established practice experience and familiarity with organizational processes, functions, and leadership. Second, only participants who had regular employment such as, permanent full-time or permanent part-time positions with the health authority were selected for the study; in order to seek out those participants who were more frequently engaged with the organization.

Recruitment Strategies

I provided a letter to each site manager outlining the study purpose, participant criteria and time commitment (see appendix A). I obtained permission to engage nursing staff into the study from each site manager and requested that they forward an email script (see appendix B) to permanent nursing staff. The email script included: an invitation to participate letter and a poster attachment (see appendix C & D) with a brief introduction of the research topic, participant inclusion criterion, time commitment, and consent and demographic forms. The Principal Investigator (PI) and Co-Investigator contact information was included in the invitation so that participants could contact the PI or Co-Investigator directly. Consent (see appendix E) and Demographic (see appendix F) forms were included in the invitation. Once these forms were completed they were collected by the Co-Investigator via email prior to the interview. A copy of the signed consent was provided to the participants. Interviews were scheduled for 60 minutes. The interview process was guided by a series of topics and questions as detailed in my interview guide (see appendix G).

Data Collection Procedures

The following data collection methods as indicated by Polit and Beck (2008) were utilized. A cross-sectional method was applied such that data was collected at one point in time. I did 60 minute semi-structured interviews with 10 participants. During the interview process I referred to an interview guide as noted above in appendix G.

I limited myself to facilitating no more than two interviews per day in order to maintain a manageable workload. Interviews were conducted in-person. I took notes during the interviews that I reflected on in a reflexive journal. I noted participant responses that spoke directly to the questions and also responses that conjured up my feelings, so that I could attend to potential biases during analysis. The interviews were recorded by a hired transcriptionist who transcribed the recorded data into an electronic copy for analysis. I checked all transcribed data for accuracy.

Data Analysis

The interpretive description research approach supported me to develop understanding and meaning of the experiences and perceptions of nurses' organizational trust through the identification of essential themes that were apparent in the data (Thorne, 2008; Polit & Beck, 2008). Exploring the experiences of community nurses' organizational trust and factors that influence it through careful and rigorous description; provided me the opportunity to expand upon what is already known and contribute further understanding about this particular phenomenon (Thorne). Polit and Beck also provide knowledge of using a qualitative approach in that it is constructionist which involves putting segments of data together into meaningful conceptual patterns. These scholars (Polit and Beck) explain that qualitative analysis is an inductive process that involves revealing the pervasiveness of main ideas. In this section I

provide an account of how I employed the following data analysis techniques sections of which have been adapted from Thorne and Polit and Beck.

A committee of UBC faculty assisted me throughout the data analysis process to enhance the rigor of the study and offered guidance and support as I am a novice researcher. The analysis involved reading the entire set of transcripts several times to obtain an overall view of the data rather than relying on my immediate impressions (Thorne, 2008). I also listened to the recordings in order to get a sense of the words, pauses, and expressions to gain a deeper understanding of the experiences (Thorne, 2008). A selective approach (Thorne) was used in that, “statements or phrases that seem essential to the experience” (Polit & Beck, 2008, p. 521) of nurses’ organizational trust were extracted. These statements and phrases were initially identified for consideration of broad categories rather than specific categories so as not to jeopardize the opportunity to elaborate on the meaning (Thorne). The statements or phrases were analysed for their meaning and different ideas of the meaning were put forth (Thorne) with the support of my thesis supervisor. I gave attention to words, statements, and ideas that spoke to organizational trust theory for instance, “she’s very centred in the nurses’ well-being” in order to guide and inform the analysis (Thorne, Polit & Beck). It was necessary to revisit the transcripts multiple times after themes had been identified in order to ensure that the data fitted the themes. Themes needed to be refined during this process. The themes were transformed into either a specific or general statement (s), which provided structure of the participant’s experience of organizational trust. I was attentive to the attributes of organizational trust theory as I applied the concepts of supportive leadership, job satisfaction and retention, leadership style, and organizational change while I coded the data.

I was open to divergent patterns or themes that arose from the data, to explore alternative explanations (Thorne, 2008). Thick and vivid descriptions of the participants, their context, and experiences are provided (Thorne, Polit & Beck, 2008). In addition, I considered the “interconnectedness” between this study and literature on this topic to search for congruence (Polit & Beck) which also ties back to Thorne’s interpretative frame.

Further to these analysis processes I demonstrated sensitivity by respecting the participants and being compassionate to their experiences (Polit & Beck, 2008). I displayed respect by ensuring confidentiality of the participants which is described below in ethical considerations.

Ethical Considerations

Ethical approval for the research inquiry was sought from The University of British Columbia Behavioral Research Ethics Board and the Interior Health Research Ethics Board, prior to engaging with the participants. Informed written consent was obtained from the participants before any data collection methods were carried out. I reviewed with each participant the purpose of the study, their roles and rights as a participant, and provided a copy of the consent for their information. All participants were informed that they had the right to refuse to answer any questions during the interview and had the right to withdraw from the study during any phase of the research process without affecting their employment. I provided all participants with the contact information of my thesis supervisor, Dr. Victoria Bungay. I informed all participants that their identity and workplace would be kept confidential with the use of participant coding with a unique identifier, no identifying qualifiers were associated to a participant (Polit & Beck, 2008). Data was handled in a secure manner, by using electronic passwords for computer files and locked boxes for hard copy material (Polit & Beck). I was

sensitive and respectful of participant experiences as I did not cast judgement and allowed them to respond without being interrupted or pressured to move on. I also accommodated interview times that were conducive to their schedules. Upon completion of the study each participant received a brief report of the study to inform them of the research findings and to demonstrate transparency of how the data was incorporated (Polit & Beck). In addition, a ten dollar coffee card was provided to each participant in appreciation of their time and contribution.

Ensuring Scientific Quality

To ensure the scientific quality of the study I attended to four techniques that were applicable to qualitative research appraisal as indicated by Litva and Jacoby (2007) and Polit and Beck (2008). The four techniques include: credibility, transferability, confirmability, and authenticity. Within these four techniques I have also infused Thorne's (2008) objective quality considerations within interpretative description.

The first technique is demonstrating that the work is credible which involves establishing confidence in the accuracy of the data and the related interpretations (Polit & Beck, 2008). I exercised credibility through: reviewing the entire data set multiple times looking for similarities; member checking by confirming interpretations of data with my supervisor; triangulation by using quotes from different participants to illustrate findings and by using more than one point of view in developing coding structure and final accounts (Litva & Jacoby, 2007). Similarly, Thorne (2008) explains that representative credibility in the form of triangulation of data sources is needed and that different angles of vision in analyzing the data are expected. I exercised representative credibility by identifying themes in broad categories and scrutinizing the data themes over time and considered alternative meanings to ensure appropriate categorization.

The second technique of ensuring scientific quality is transferability. This refers to the extent that the findings are relevant to other groups or settings (Polit & Beck, 2008). Although I am unable to fully assess the transferability of my findings to other settings, my detailed and rich account of the nurses' experiences once published, will assist readers to determine the applicability to other contexts (Polit & Beck, 2008). Thorne (2008) notes that analytic logic can be achieved by providing thick description that is presented with participant quotes to openly display the congruence of the researcher's interpretation. I have provided several examples of participant quotes in order to be transparent about the interpretation and meaning of the data that was presented.

A fourth technique used to attain scientific quality is confirmability. This refers to the neutrality of how the data was handled (Polit & Beck, 2008). Confirmability can be exercised between two or more people involved in the research who compare data accuracy, meaning and relevance (Polit & Beck). The data was scrutinized with my supervisor and re-coding was undertaken to improve accuracy to allow appropriate meaning and relevance to be recognized and established. Thorne (2008) expressed that a system to check our interpretations with research participants is another measure of quality consideration referred to as interpretative authority. I did not confirm the interpretation of the data with the participants during the analysis phase; however, I did paraphrase their statements during the interview to ensure coherence and at times requested that they provide further explanation so that I could extrapolate a deeper accurate meaning and discuss it with my supervisor.

Authenticity is the final technique that I employed in striving to demonstrate scientific quality. Authenticity refers to the researcher's effort in being fair and faithful in showing different realities (Polit & Beck, 2008). Authenticity is demonstrated when the readers can feel

the tone of the participants' experiences and develop sensitivity to the issues being portrayed (Polit & Beck). Authenticity and analytic logic (Thorne, 2008) as described above can be displayed through thick description. To demonstrate authenticity and analytic logic I included participant quotes in the findings to portray the reality of their experience and to provide a contextual basis for my descriptions and to show congruence between the data and its interpretation.

In this chapter, I have described the methodology of a qualitative design with an interpretative description approach that was used for this study. I have also explained details of the sampling plan; recruitment strategies; data collection procedures; data analysis; ethical considerations; and how I ensured scientific quality.

CHAPTER 4: FINDINGS

Introduction

In this chapter I provide an account of the study findings regarding nurses' experience of organizational trust and factors that influenced it within a community health context. I begin with a description of the participants. Next, I discuss the participants' experiences in three overlapping categories (a) leadership support, (b) organizational restructure, and c) evolving health services and practice. In each category I capture the factors that influenced the participants' organizational trust. A summary of key findings concludes this chapter.

Situating the Participants

I conducted face-to-face interviews with 10 nurse participants. The participants ranged in age between 30-60 years. Two participants worked in part-time positions and 8 participants worked in full-time community nursing positions; with a range of community nursing experience of 5-30 years. The participants' education level ranged from diploma to Master's degree. The participants worked in front-line positions with adult, youth and child populations and often engaged with clients who had co-morbidities, and limited resources in the context of social determinants of health (e.g. education, housing, finance, and social support). Their work involved promotion and prevention services, home health services, mental health services, long term care case management, and chronic disease management.

The participants were asked to describe what it was like to work in their practice setting and most of them described their work environments as fun, and enjoyable, which was due to the support and camaraderie of colleagues. Participants also described their practice as challenging; however, supporting clients' health needs in the community setting was personally and professionally satisfying. All participants expressed that they experienced enjoyment in their

interactions with either their colleagues, clients or both. The participant quote below resonates how most participants described their experience of working in their practice area.

P67: The thing I like the best is the contact you have either with clients or other colleagues like you do really have, can have some meaningful contact with both groups.

Findings

My analysis of nurses' experiences of organizational trust illustrated that the nurses were engaged with a diverse array of people and organizational processes including: interactions with managers and team leaders; changing organizational structures; and evolving health services and practices; which were evidenced by standardized nursing processes, redefined roles and responsibilities, and changes to service delivery. I identified three overarching and interrelated themes (a) leadership support, (b) organizational restructure, and c) evolving health services and practice that best illustrated how the nurse participants talked about their experiences of organizational trust and related influential factors. In the following pages, I present each of these analytic categories in detail and include a brief overview of the definition I applied to the category as well as detailed discussion of the relevant sub-categories that emerged within my analysis. The paramount fundamental learning that the findings exemplified were 1) that nurses' perception of leadership support can significantly influence their trust in the health organization and 2) that nurses' lack of participation in decision-making of change can negatively impact their trust in the health organization.

Leadership Support

The nurse participants discussed two main nursing leaders in relation to their practice; team leaders and program managers. All of the nurses had program managers that they ultimately reported to. Some nurses also had a team leader. Team leaders were described as primary people responsible for nursing supervision and support. For those who had only a

manager, they relied on the manager for these functions. For the purposes of presenting the findings, I refer to managers and team leaders as leaders as there were no notable differences in relation to how the nursing described these individuals and roles in relation to leadership support.

Drawing from the analysis, I defined leadership support as nurses' perceptions of characteristics and actions of leaders which pertained to: clinical practices; engagement in personal connections or nurse-leader relationships; communication; and autonomy in practice. The participants described how their leaders supported their clinical practice and also spoke about their relationship with their leader and valued this relationship as an integral component of support. Another factor of support included participants' communication with their leaders. Effective communication processes were considered to be an extension of good leadership support by participants. When participants' attained personal satisfaction which was attributed to their sense of autonomy in practice; this also transcended to feeling supported. Leadership support in the domains of clinical practice, nurse-leader relationships, effective communication, and reward and recognition was a central aspect that influenced participants' experiences of organizational trust.

Clinical Practice Support and Nurse-leader Relationships.

The participants reported that a leader who had front-line experience in the community setting was an important feature in being able to provide relevant clinical support. Participants conveyed that leaders who had front line experience could better understand the nurses' context of practice and had a better understanding of practice issues and asked questions that were relevant to their practice.

P54: Well for me the new manager that we have has only been there a couple of months but she has a really strong background in the area that I work. So personally she's excellent so I can say something to her and she knows what I'm talking about. I can ask her questions, I can run things past her and she knows what I'm talking about.

Conversely, participants reported that leaders who did not have front-line experience in community nursing were less able to understand practice concerns such as: workload, client complexities, and job stress.

P71: The last two we've had managers that aren't nurses and so they can't always relate to the issues [such as dealing with clients' concerns or family dynamics, or job stress related to workload] that we deal with.

Participants also reported a belief that leaders who were from a discipline other than nursing or appeared disinterested in the community health care setting were less able to provide clinical support.

Clinical practice support was also described in relation to supporting the participants' health. Supportive leaders were those who enabled the nurses to take time off or to revise their job duties when they had substantial health challenges, some of which were life-threatening. Participants with supportive leaders reported that they did not feel pressured to return to work or resume regular duties during their illness and expressed that leaders were empathetic and acknowledged that time was needed to recover.

P25: They've been very good with me...and they've been very accommodating so that I am able to function relatively normally in my system, they've been great about that sort of thing.

Those participants who had experienced personal health challenges indicated that their leader was concerned with their personal well-being and that it this was integral to how a leader provided support. Participants conveyed that leaders who supported their clinical practice during times of health and illness enhanced their feeling of trust in their leaders who represented the organization.

Some participants conveyed a belief that nurse-leader relationships were just as important as nurse-client relationships. Participants expressed gratitude when nurse-leader relationships

were fostered on a daily basis for example some leaders asked how nurses were doing on a personal level and demonstrated a caring relationship.

P38: [The leader] usually walks through the office and does a good morning, how are we doing today that sort of thing... [The leader is] very centered in the nurses well-being and I think that can get forgotten when you're trying to do the best things for patients. And I think she tries to consider both and that comes across when you talk to her.

Having the opportunity to vent frustrations to leaders was appreciated by participants.

They acknowledged that when their frustration concerned something that could not be changed for example, a change in service delivery, participants explained that their thoughts and feelings were heard. Participants acknowledged that leaders were often tasked with competing job demands that involved organizing staff resources and other administrative type duties, which limited their ability to spend more time with them.

Celebrations of seasonal events such as birthdays and Christmas gift exchanges as well as coffee break conversations enhanced the relationships between nurses and leaders, according to participants. The nurse-leader relationship was held in high regard in that despite having adequate clinical support, some participants did not feel wholly supported in their job without having a good relationship with their leader.

P42: Yeah so more just like clinical support and kind of the facts and that's where the support is, I don't feel it any other way.

P55: We have minimal interaction with [the leader]... very minimal...[the leader] knows we're just operating but we don't have the support from, yeah, the support is not there.

Participants described that absence of a nurse-leader relationship based on personal connection left a void. Participants who experienced this void sensed that they were not valued or cared about as a person. This oversight in feeling cared about as a person had a negative impact on participants overall job satisfaction. Nurses who expressed that they had a good

nurse-leadership relationship contributed to their perception of having effective leadership support and this increased their sense of job satisfaction.

Connected nurse-leader relationships fostered good communications and for some participants the connectedness enhanced clinical practice.

P42: Well I mean the positive are the ones where I have a better relationship, it's people who listen to you, reflect what they hear from you, you know, support you in your decisions or, you know, I don't know give you the time to listen and guide you but in a positive way.

P89: [The leader is] very understanding... recognizes the stress that we work under... [the leader] really supports us and goes over the details. And [the leader] goes by what I'm saying...totally trusts me so that's a big one.

Participants appreciated interacting with leaders who took the time to attend to their personal lives for example, asking about family prior to engaging in clinical discussion. Participants expressed that personal connection was the cornerstone for effective communication in practice. Nurse-leader relationships that demonstrated a caring attitude from leaders was interpreted as support and participants were more inclined to reciprocate these behaviours and have confidence in the organization. Leaders who exhibited positive nurse-leader relationships may have been supported through the organization's leadership program which foster's self-awareness, interpersonal relationships, staff empowerment, conflict resolution and a host of other leadership courses that are currently available. The leaders' personality traits may have also complemented their skills and training in developing effective nurse-leader relationships.

Communication.

Communication that pertained to their work and organizational change was also described as an essential aspect of leadership support. Some participants expressed that informal communication was favoured over formal communication. Participants considered informal communication to include day-to-day discussions which could be initiated with their leader

without a scheduled meeting; and that informal communication elicited opportunity to engage with their leaders without feeling inferior. Formal communications were considered by participants to be transpired in written communications and scheduled face-to-face meetings which some participants perceived as precipitating a power imbalance.

P38: I think informal is easiest, I think because people feel free to speak freely in informal interactions. Whereas it's almost like that principal's office when things are more formal sometimes.

Participants also recognized that there were times that formal communications were necessary. In these situations however, they preferred face-to-face communications as opposed to email correspondence especially when the communication was about changes to service delivery.

Some participants explained that abundant email communications to a broad group of nurses could easily be misinterpreted or missed all together.

P25: And [emails] get missed and hopefully somebody who picks it up and brings it to a meeting and says is this what it actually is? You know because they'll put a pile of information into something and it gets sent out and then it's like oh, this is going to impact what we're doing this year.... But if I have an issue with my [leader] or I need something I walk down the hall.

Having the opportunity to communicate in-person allowed a two-way process whereby clarification, reaction, questioning, and resolution were more easily established according to participants. However, if there was a good nurse-leader relationship communication via phone and email was considered to be effective even though it was not always immediate.

P42: I feel more supported and easy to talk to my distant supervisor who I rarely see but I feel like I have more of a bond with them.

Participants described that support was evident in varying degrees and leaders who scheduled regular meetings to discuss practice concerns in a collaborative manner were favoured. Regular engagement with participants provided an experience of feeling heard, valued and understood. When participants had the opportunity to be involved in discussions relating to

practice issues such as implementing a new nursing procedure they explained that the communication was productive and worthwhile when their input was utilized. In some instances, participants were able to self-identify learning needs and be included in the problem-solving process.

P96: Here's something I'm really struggling with and we just have a conversation about it and it's really about us bouncing ideas off each other and [the leader] saying well, why don't you try this? Or [the leader will] say gee that is a dilemma, what are some of the things you think you could do?

P67: I would say that's how [the leader] supports me that I have a chance to talk through [the] issues this is my, my most immediate [leader] and that, that we work to try and, you know, to work through any issues that's how [the leader] supports me, yeah. And really has a sense of trust in what I am saying.

Regular meetings were considered to foster critical thinking, and reflection on practice with a non-judgemental, non-punitive approach.

Communication and leadership support were also described in relation to a leader's availability. Leaders who welcomed nurses to connect with them "at any time" were viewed by participants as being supportive. Participants expressed appreciation for being able to access their leader by going to their office, calling them on the phone, or emailing them and getting a quick response whenever the need arose. Participants identified that while it was preferred to have their leader located in the same site as it was convenient in having access to support, it was recognized that support could also be facilitated remotely via phone and email if the leader was available.

P89: The manager, she's supportive, she's really supportive I don't see her on an everyday basis but she's very approachable like email or telephone call.

P71: The last two [leaders] [had] a lot more . . . open door policy which I think is hugely valuable. Then you know you're valued so I've really appreciated the last while with the managers.

Effective communication was enhanced when participants perceived that their leader was supportive and made an effort to have a personal connection and this fostered their trust. Participants' who viewed leaders as being unsupportive by not engaging them in regular collaborative communication expressed that it was difficult to trust the organization.

Communication regarding recognition and reward of excellence in practice was another factor of leadership support which positively influenced participants' organizational trust. Participants expressed feeling greater support when recognition and or reward were attributed to their practice by the leader. Individual acknowledgement or recognition via informal communication about demonstrated excellence in practice was considered to be more meaningful than acknowledging a large group of nurses at one time. At the time of the study, the organization had specific strategies to support formal and informal individual staff and group recognition. Recognition was promoted by senior leadership across the organization in that all employees were encouraged to acknowledge each others' excellence in practice in daily interactions through informal communications with one another or by submitting a written acknowledgement to the newsletter; however participants did not refer to either of these forms of recognition.

Autonomy in Practice.

Participants expressed that having autonomy in practice was highly related to job satisfaction. Participants also indicated that having autonomy in their day-to-day activities was congruent to the nature of the work.

P89: So I have a lot of autonomy I make my own day, I make my own schedule, I make my own appointments I can cancel them or do whatever and they completely trust us in whatever we do.

Participants who expressed having autonomy explained that they were trusted by their leaders, and this feeling of being trusted evoked a reciprocal feeling that they could trust their leaders. While having autonomy was a construct of the community position, participants expressed that they felt trusted to manage their day, in that the leader was not checking-up on them, requesting to see their schedule of appointments, or micro-managing their daily routines. During the organizational restructure some participants expressed that having a lack of decision-making ability in changes to practice curtailed their feeling of autonomy which had a negative impact on their feeling valued and subsequently reduced their sense of job satisfaction.

Organizational Restructure

At the time of this study, the participants' health organization was going through several changes simultaneously including changes within its leadership structure and changes to health service delivery programming including community nursing. These broad and significant changes were referred to as an organizational restructure for the purpose of the study's findings. This organizational restructure began in 2010 and has continued to evolve to the present day. The restructure of the organization assigned individuals into different leadership positions with different titles from the previous structure. This contributed to community nurses being grouped into one large Community Integrated Health Services (CIHS) administrative portfolio within the organization. Participants' experiences of the restructure negatively influenced their trust in the organization; a fact that was influenced by several interrelated factors including: their understanding of the change process, the communications they received about the changes, and the overall effect of these changes for their work settings and space allocation.

Knowledge of the Organization's Changes.

Having awareness of information about the organizational changes was a substantial factor influencing participants' sense of organizational trust. Participants indicated that they had limited knowledge of who the current senior leaders were and how these leaders were arranged or ranked in the organization. Participants were aware of who their direct leader was but expressed difficulty in understanding how the new structure was designed and who the senior leaders were within the CIHS administrative portfolio and how this portfolio interfaced with the rest of the organization. The participants' direct leader was an important intermediary between them and senior leadership; however, limited knowledge overall reporting structure left them feeling uncertain and confused.

P38: Sometimes I wish [the health organization] wasn't such a big corporation I think like I know who my direct manager is but I don't really understand the structure above me.

One participant expressed that it was helpful when a senior leader had regular visits at the site in that the participant knew the senior leader's name and understood that it was her leader's superior.

Some participants explained that the new structure provisioned a new communication process whereby nurses could not directly contact the leader who had responsibility in the domain of their query; rather participants had to direct their queries to their immediate leader who would then correspond with another leader. This new structure often precipitated delayed responses to participants' questions about practice issues and new directions for programs which ultimately affected their ability to do their work. This is described in the participant quote below.

P25: Our go to person [our leader who we have to address all questions to] and that's for everything in the system you don't just phone somebody or email another level up you're supposed to go through your [leader] so that slows things down..

Participants also described that there were too many leaders in the organization; and some participants perceived that there was no voice for community nursing at the senior leadership level. The participants acknowledged that there was a Chief Nursing Officer (CNO) in their health organization. However, unlike the previous structure there was no policy in place to support the CNO to have formal ability to make decisions with the Senior Executive Team (SET); and participants described this as a disadvantage for community nursing. Participants expressed that while senior nurse leaders were positioned in SET they represented the acute care sector and did not voice concerns for community nursing.

P55: Like [the former CNO] was knocked down [the former CNO] used to be in this SET committee, dropped down so nursing didn't have a voice anymore....Nursing didn't have a voice and that was a big impact...That is the big impact over all and nursing still doesn't have a voice... Even though they say that nurses are up there they're not representing nursing [the new CNO] doesn't have a seat at that table yet there's nurses there but they're for acute care or they're for it's not, they're not there for nursing.

In some instances, the restructure resulted in new job descriptions for point of care nurses and nurse educators. Many community nurses were displaced and had to reapply for positions as a result of these restructuring process. The process for acquiring new positions was done in accordance to the Nurses Provincial Collective Agreement (2012) which meant that seniority was a significant factor in the hiring process and nurses with less seniority were displaced from their previous position and had to take on a new position. Some of the participants indicated that they preferred their previous nursing position and that changing positions was stressful and overwhelming.

P38: I was bumped a year and a half ago and completely changed positions and then we had the contract change with the thirty-seven and a half hour work week and we had community did a job description change at the same time. So we had a big shuffle of

positions and job descriptions.....then with the shuffle I'm now into [program] nursing ...and it's not my favorite.

P71: Being bumped, displaced. I have been bumped and I know this, I don't know if it happens more than the hospital but just because I work with a lot of senior nurses and they've, [been] talking about at least two other times before me of rotation changes and restructuring. And so that, there's a shift of like positions and so people get displaced.

Experienced nurses were less inclined to change positions and expressed that the displacements, changes to job descriptions, and having to reapply for positions was frustrating and for some it was a motivator to retire and avoid the stress and frustration that accompanied the change.

Participants explained that having limited knowledge of the organizational restructure and the inability to seek out leaders at different levels was not sensible. Participants perceived that the restructure created an absent nursing voice for community nurses and that changing job positions created a sense of uncertainty which was stressful and ultimately compromised their trust in the organization.

Change Communications and Rationale.

One of the challenges that the participants reported was that they were not provided timely communication and rationale for many of the changes that were implemented during the restructure. Participants explained that they would have preferred communications related to changes in service delivery and programs prior to the implementation of change. Some participants expressed that communications regarding change were withheld until just before the change was to take place and this created frustration and feelings of being undervalued in that they did not have an opportunity to provide input into the change.

P71: I've had three managers currently and there is a manager that even though you went to meetings in my head I felt like there was more going on that they weren't telling you. And then all of a sudden at the last minute they'd tell you; and I felt that was frustrating.

In addition, participants explained that change sometimes occurred without any communications about the rationale for the change. They also expressed that without clear communications about the change rationale, understanding and acceptance of the change was undermined. The lack of communication compounded their stress and left them feeling disrespected.

P25: I know they like to say we're, we're here for the long term...but really it's not and I don't feel that they are it's just the flavor of the month sometimes. You get told to do something, why are we doing this, you know, certain things I think we're just doing for statistics.

Participants conveyed that they did not have timely communications and rationale for change, and this made it challenging to have faith in the organization's intent and made them sceptical of the organization's restructuring.

Work Space.

Many of the participants explained that changes during the restructure had negative impacts on their work environment or physical work space which negatively impacted client care. During the restructure some community nurses' caseloads changed along with the location of their work stations and computers and phone lines were not set up. Participants explained that clients' continuity of care was disrupted for example, home visits were missed and clients could not readily contact their nurse when needed.

P71: Every nurse had a different area of town now and so every client has a different nurse which is hard for clients. Anyway so it's just a whole restructuring, whole new boundaries of the city, everyone has different caseloads....So we, we need to figure out how to even it out...and so how do you begin [to deal with] all the issues that happened I don't know it's a lot. The phones aren't connecting, you know, the client can't get a hold of their nurse because it's they don't know what number to [call].

Participants indicated that the accommodation of work space was not sufficient. For example, the clinic room could not support the changes in practice that had recently occurred;

providing clinic services such as wound care and intravenous (IV) therapy for an increased number of clients in small quarters was challenging at best.

Participants also reported challenges with orientating new staff for instance, there were not enough computers available to for new staff to complete their electronic charting;

P38: ...including equipment when we're doing orientation with new staff members they don't really have anywhere to sit or computer to use or those sorts of things. So you almost have to wait until the nurses are gone for the day and use one of the work stations that is assigned to someone else.

P38: Our space is very chaotic, we have a very small space, we have expanded in staffing levels but our space has not gotten bigger.

The participants reported that the work space was a basic necessity to provide care and mentorship. Not having enough work space precipitated feelings of frustration and being disregarded. This related to their sense of worthiness in the organization and further influenced their thoughts of not being able to trust the organization.

Evolving Health Services and Practices

As the restructure in the organization unfolded there were changes in health service delivery and nursing practices (e.g., increased client health assessments during clinic visits). Participants reported that there was a lack of nursing participation in decision-making about changes, a lack of logistical planning to support transitions, and a lack of vision transparency or clarity of organizational goals. Each of these factors, as illustrated below, negatively impacted nurses' trust in the organization.

Nurse Participation in Decision-Making.

Participants indicated that changes to practice and programs had minimal input from nurses who did the work and were affected by the changes. The participants expressed that nurses' were left out of the decision-making process, which minimized their expertise and left

them feeling undervalued and powerless; all of which negatively impacted their willingness to trust the organization's initiatives.

P55: Okay so how do we trust? We don't know what's going on, we're seeing too much go down how do we trust what's supposed to be happening when we're not involved in the discussion and when it totally involves us and how is somebody outside of where we work making decisions and not talking to us as care providers and that's us as a group.

During change implementation some participants reported that they felt that the change was thrust upon them without logistical planning or thought as to how the changes could be smoothly facilitated. The nurses noted that they found themselves struggling to carry out changes that were not conducive to their daily program schedules; as no forethought was given to how they would realistically provide increased services.

P73: But like some other stuff, you know, here's what the plan is get input don't just launch it and then tear it apart later because it didn't work and start all over, it's just constant changes.

Participants explained that their input should have been sought prior to change implementation; their insights would have attended to the logistics and whether the change was viable. The lack of logistical planning created more changes and reconfiguring in some cases as reported by the participants.

P71: And I think it's just a natural process of change like if, if things are changing there needs to be a period of transition so I'd say before that because it was normal to us how the structure of the office worked and how it flowed. So right now it's a bit more, we call it chaos it's been for a while actually because it's just crazy, yeah.

Participants indicated that if nurses were involved and had input in decision-making processes and changes that it would demonstrate that they were valued and appreciated, and that the change process could have been more successful.

Vision Transparency.

Participants reported that they were unaware of the broad vision for changes to health service delivery and nursing practice. They indicated that while the changes were happening, the vision of where the organization was going was unclear. Their role in community was changing without a clear understanding of organizational direction and this lack of vision transparency led to frustration and feelings of being disrespected.

P25: I feel they just pulled that structure off, broke it into pieces, threw it in the air and it just settled wherever it was amongst the other portfolios of all the restructuring. There's a little bit of [program] here, there's a little bit there, a little bit there . . .

Participants conveyed that changes did not always align with their personal philosophies of healthcare service. Nurses had been working in programs which were now reduced or eliminated and had no new point of reference to work from. Some participants expressed that they believed that "change was happening for the sake of change", and not with the aim to improve service or practice.

Participants did not know why the changes were occurring and felt that they were powerless to do anything about the changes. They acknowledged that their direct leaders had little control about the changes moving forward and tried to facilitate the rollouts without increased resources and had limited flexibility in how health service and practice changes could be operationally executed.

P73: Maybe I don't know though how much power [the leader] has anyway so it may be back to the top down thing maybe it's not realistic to expect [the leader] because those on top still are like...

P67: Things come down we're very top heavy organization and you get, things will come down where your [leader], your [leader's leader] had no control over what was coming, it was, you were just told this is what's going to happen frequently with no increase in staffing and it's all very frustrating for everybody.

The participants' experiences and perceptions of a lack of vision transparency in the midst of the organizational restructure that was without provision of rationale for changes compromised the trust that nurses' had in the organization.

Summary of Key Findings

Participants' experiences of organizational trust and factors that influence it within the community health context revealed that they generally enjoyed their workplace due in part to leadership support, client interactions and collegial harmony. Leadership support was appreciated when there was an interface of clinical and personal support. Having connected relationships with leaders contributed to supportive clinical practice and promoted effective communication. Communication was most effective when regular meetings occurred in a context of respectful, collaborative, face-to-face dialogue. When participants perceived good leadership support it positively influenced their trust in the organization. However, it was clear that not all participants had the same experiences. Some participants did not feel well supported due to a lack of having a personal connection with their leader and regardless of the clinical support provided by the leader participants did not perceive being wholly supported when the nurse-leader relationship was absent. As well, some the participants expressed that communications were not provided in a timely manner in regard to change and that rationale was not provided for the changes taking place. These alternate experiences negatively impacted participants' trust in the organization.

The experiences of the organizational restructure were a source of frustration for participants. There was a lack of understanding around how the structure was set up and rationale for changes to services and practices were not clearly articulated by leadership. The restructure had also involved job displacements and revised job descriptions; this created

shuffling of positions which was stressful; and left some nurses in positions that were not as well-liked as their previous positions. Participants indicated that with changes to programs and practice, the current workspace was no longer adequate and that cramped working conditions had a negative impact on providing client care and orientating new staff. Participants' experiences of the organizational restructure had a negative impact on their trust of the organization.

Finally, evolving health services and practices had limited input from community nurses. Participants explained that nurses did not have the opportunity to be involved in decisions that directly related to their practice and that their knowledge and expertise was not utilized. As changes were made to services and practices, logistical planning was not at the forefront, this negatively impacted nurses' ability to do their day-to-day work. Along with logistical planning for changes, the broad vision for these changes was not apparent. Participants indicated that they were unsure of where the organization was headed due to a lack of vision transparency with respect to the organization's future goals and initiatives. The lack of nurses' participation in decision-making, absence of logistical planning for changes to services and practices, and shortfall in having a transparent vision in the organization negatively influenced participants' willingness to have trust in the organization.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

Introduction

In this chapter I discuss the contributions of this study in the area of community health nursing practice and organizational trust. Nurses' experiences conveyed how leadership support, organizational restructure and evolving health services and practices constituted influential factors that impacted their trust in the organization. Knowledge gained from community nurses' experiences is important for health organizations to consider as the emphasis of health services are shifting from acute hospital facilities to the community setting (Canadian Nurses Association, 2006). Nurses are the primary healthcare professionals in the community setting; and acquiring, maintaining and rebuilding their trust can be foundational to job satisfaction, retention, acceptance of change, and improvements in client care (Williams, 2005). The paramount fundamental learning that the findings exemplified were 1) that nurses' perception of leadership support can significantly influence their trust in the health organization and 2) that nurses' lack of participation in decision-making of change can negatively impact their trust in the health organization.

This final chapter focuses on discussion of: nurse-leader relationships; nurse participation in decision-making; and communication of organizational changes. Recommendations of this study propose that health organizations demonstrate commitment to: foster meaningful nurse-leader relationships, value nursing expertise and participation in decision-making and support nurses to understand rationale of change and organizational vision through transparency and open communication.

Discussion

Nurse-leader Relationships.

Through this exploration of nurses' experiences of organizational trust and factors that influenced it in a community health context, it was evident that the nurse-leader relationship was paramount to the nurses' perception of feeling supported. Participants described how they felt supported by their leaders in a clinical context in and also in a relationship context. However, the personal connection between the nurse and leader were the key to nurses' feeling supported. Participants conveyed that being acknowledged as a human being who was recognized beyond their professional domain with different dimensions including family, personal life celebrations, challenges, and milestones actualized being wholly supported. When leaders took the time and effort to connect about personal matters, it demonstrated a sense of caring and authenticity that essentially validated the support from their leader. Other researchers have reported similar findings and described this type of leadership as authentic. Authentic leadership has been reported to promote trust, healthy work environments (Shirey, 2006), and aid in retention and recruitment (Avolio & Gardner, 2005; Kerfoot, 2006). While participants in my study appreciated support with clinical practice it did not reach the depth of support of what they attributed support should be.

Young-Ritchie, Spence Laschinger and Wong (2009) indicated that when leaders make it a priority to invest time and energy in developing relationships with staff, they are more likely to have better teamwork and collaboration. These findings were reiterated in my research. The existence of a personal relationship between a nurse and leader was the apex of support, according to the participants; without relationship connection clinical support as a standalone component of support did not meet participant expectations of nurse-leader support.

McCloughen, O'Brien and Jackson, (2009) studied mentoring relationships for nurse leadership and found that these relationships were created from a special human connection; a distinctive coming-together which provided the foundation for the mentoring relationship. These authors also indicated that the impetus for mentoring relationships was embedded in informal personal connections where two people saw the meaning and value in each other; the importance of genuine caring, friendliness, mutual respect, and belief in each other's integrity were personal attributes that generated a sense of connection and compatibility. In this context friendliness was distinct from friendship and respectful professional boundaries could still be achieved (McCloughen, O'Brien & Jackson). The feature of personal connection in mentoring relationships resonates with what participants desired in their interactions with their leaders. Hurley and Linsley (2007) report that adopting humanistic principles is an effective approach to increase trust amongst staff and provides support to those struggling to cope with change.

Transformational leadership characteristics such as fostering a sense of empowerment, autonomy, and inspiration have also been demonstrated to be supportive leadership qualities (Failla & Stichler, 2008). Some participants described their leaders to be open and collaborative and they fostered critical thinking and self-reflection. Participants expressed feeling empowered and had sense of autonomy when they engaged with leaders who exhibited these behaviours which were representative of a transformational leadership style as indicated by other nurse researchers (McGuire & Kennerly 2006; Failla & Stichler 2008; Meredith, Cohen, & Raia 2010; Gurka, 1995; Ward 2002) and this created a sense of job satisfaction for participants which is related to organizational trust (Dirks & Ferrin, 2002). Hurley and Linsley (2007) explained that by embracing transformational leadership nurses were supported to use their voice in the development of services and had a sense of ownership and influence.

Nurse Participation in Decision-Making.

In this study, collaboration was a critical aspect of leadership support and organizational trust. Engaging in a collaborative process whereby the leader did not tell participants what to do, but rather facilitated a discussion to identify potential solutions displayed recognition and value to their expertise. Aiken et al. 2001 suggested that leaders must ensure that nurses are supported to make practice decisions based on their expertise and knowledge and have control over their practice environments in order to avoid job dissatisfaction. The leaders that were described in my study as those who did not engage participants in decision-making processes fostered a feeling of disrespect and disempowerment which propagated a negative outlook on the organization. When nurses did not have the ability to contribute to decision-making their sense of having autonomy and control over practice was absent. Similar findings in another study by Kramer and Schmalenberg (2003) showed that nurses who had a lack of involvement in practice related decisions were likely to experience job dissatisfaction which negatively influenced organizational trust.

The effects for trust in leadership were astounding. Similar to findings from other researchers (e.g. Dirks & Ferrin, 2001; Gillispe & Mann, 2004) there were several factors that influenced nurses' trust of their leaders a) common values b) sharing a vision c) consulting with team members when making decisions. And as it has been noted elsewhere, if these three variables are not congruent or present between nurses and leaders nurses' trust in the organization is compromised. Participants explained that nurses had no input into logistical planning which contributed to the downfall of some program and practice changes that took place, and participants became frustrated when unsuccessful change resulted in further changes to revamp programs and practices. These experiences demonstrated a lack of having common

values, shared vision, and consultative decision-making. Gillespie and Mann (2004) who reported that when people have an opportunity to dialogue and share in decision-making they are more comfortable with change. Participants indicated that there was resistance and resentment in regard to changes in programs and practices when nursing input was not utilized in decision-making; all negative reactions that have been reported elsewhere (e.g., Murphy, 2006; Penna et al. 2009; MacPhee, Wardrop, & Campbell, 2010) when non-collaborative processes occur during change. As nurses did not have input into decision-making of practice and program changes, this significantly diminished their sense of organizational trust.

Communication of Organizational Change.

Studies which focused on organizational change indicated that communication was critical to successful implementation of change (Cutcliffe & Bassett, 1997; Morjikian, Kimball, and Joynt, 2007; & MacPhee 2007). While some participants in my study explained that having open informal communication was valued, they also expressed that the lack of timely communication in regard to organizational changes created uncertainty, stress, resistance to change, and mistrust in the organization. These consequences of poor communication during times of change have been well substantiated in the literature (Shanley, 2007; Morjikian, Kimball, & Joynt; Spence Laschinger, Finegan, & Shamian, 2001). Conversely, other studies have reported transparent sharing of information enhances followers' trust in leaders (Norman, 2006; Wong & Cummings, 2009).

In this study community nurses expressed an interest in knowing how their organization was structured. A lack of understanding of the structure created a feeling of disconnect with higher levels of leadership for participants. As there was an absence of nurse-leader connectedness for some participants it fueled their perception that their opinions did not matter.

Shobbrock and Fenton (2002) explained that effective leaders counteract barriers to change such as apathy and low morale by being visible and being positive. Participants expressed that disregarding nurses' contributions and necessity of their understanding of the organizational structure jeopardized their investment and trust in the organization.

Rationale for change was not provided in a timely manner; in some cases it was not provided at all and nurses were frustrated with this lack of information. Nurses were sceptical of the organization's intent and resistive to change when rationale for change was not communicated. Nurses did not understand the reasons for change and believed that change was happening for the sake of change without a justified purpose. Nurses also attended meetings and sensed that leaders were withholding information about the change which created a feeling of suspicion towards the organization and lack of trustworthiness. Previous studies have shown that mistrust occurred when information was withheld, resources were deficient and when employees were not supported by their leaders (Spence Lashinger, Finegan, & Shamian, 2001).

Changes to health service delivery did not accompany the organization's vision of goals or direction. Nurses had difficulty understanding the organization's perspective of what they were striving to achieve. A clear vision and mission can unify nurses' values in the organization which can be used as a vehicle to strategically plan change by articulating where the organization has been, where it is now and where it wants to go (MacPhee, 2007). Participants perceived that they were powerless to do anything about the changes that were happening and the lack of vision transparency increased their level of uncertainty of why changes were taking place which was worrisome and stressful. The organization's vision can be a conduit for nurses to develop their own department philosophies and to relate it to their local work environment to more readily embrace change (Roussel & Swansburg, 2006). Likewise participants in this study expressed

that information was not forthcoming about change, nursing resources were limited and they were burdened with increased duties, and in some case there was a lack of support by their leaders. Organizations may help leaders to guide nurses through informal positive relationships to provide support, information and resources needed to function successfully (Kanter, 1997).

Implications for leadership, Practice, and Policy

Thus far, I have discussed the study findings in the context of the current knowledge regarding nursing leadership, practice, and organizational trust. In the next section I draw upon this discussion to identify the study implications for leadership, practice, and policy within a community health nursing context.

Implications for Leadership.

Health care leaders may find ways to develop partnerships with front-line community nurses to identify and implement strategies to improve interpersonal relationships with nurses, collaborative change processes and a shared vision in order to sustain and establish trust in the organization (Altuntas & Baykal, 2010). As the nurse-leader relationship was identified as a necessary component of leadership support, leaders can engage in Interpersonal Mastery which is based on the notion that greater self-awareness can result in improved interactions with others (Koeble, Bird, & Bonney, 2008). Leaders can endeavour on Interpersonal Mastery which focuses on communication skills and the use of models to portray leadership strategies to empower front-line staff, mid-level and senior level leaders in the organization (Koeble, Bird, & Bonney). Leaders who empower nurses to achieve higher goals supports autonomy and personal growth which is indicative to transformational leadership and job satisfaction which can then lead to increased trust in the organization (Failla & Stichler, 2008; Gregory et al., 2007). Leaders may strive to adopt a transformational leadership style which places emphasis on

interpersonal relationships by exhibiting; authenticity, which helps foster trusting relationships (Astin & Astin, 2000; Swanson, 2000); expertise, in intellectually stimulating others' creativity, new ideas and personal growth; vision, to motivate others' to achieve desired goals (Trofino, 2000; Perra, 2000); flexibility, to assist others' to thrive in a changing environment (Ward, 2002); shared leadership, to equalize power amongst others' and support professional development (Kitson, 2001; Drucker 1999); and charisma, to instill others' confidence with enthusiasm (Dunham-Taylor, 2000; Blase, 1999; Swanson 2000, Trofino, 2000). Leaders may be cognizant of demonstrating trusting behaviors that entail 1) integrity including, reliability and fairness 2) benevolence including, kindness and compassion 3) ability including, skill and aptitude and 4) predictability including, stability and dependability, as these attributes are likely to be reciprocated by their staff (Tseng, Chen, & Chen, 2005). When leaders are deemed trustworthy nurses are likely to engage in teamwork and sharing and develop an emotional attachment and trust in the organization (Tseng, Chen, & Chen).

Leaders can support nurses to understand and analyze the organizations in which they are working and develop opportunities for them to engage with organizational structures. These initiatives are proactive in creating a shared responsibility of nurses to be accountable and responsible for their awareness and participation in becoming adept in administrative contexts of the organization.

Practice Implications.

Nurses need to be included in decision-making and be a part of the change process in order to facilitate smooth transition of practice changes, nurses are involved with the care and are able to provide valuable input to have successful outcomes (Reineck, 2007). Change models in practice can help to promote collaboration and simplify complex situations and provide a

common understanding and focus for leaders and front-line nurses (Wolf & Greenhouse, 2007). A change model can also support nursing innovation and generate new ideas and approaches to practice and community health programs (Wolf & Greenhouse). Collaborative decision-making can prevent potential negative impacts to changing practice (Olade, 2004) for example, nurses' perspectives can address practices that are not logistically manageable and avoid reconfiguration of practice which uses up time, monetary resources, and contributes to change fatigue frustration for nurses (Reineck, 2007). Organizations can be cognizant of the number of new practices being rolled-out in a given time period, as too many changes in a short period of time can be overwhelming for nurses and contribute to resistance of change, burnout and low morale in the workplace as was evidenced in the study findings. Hence, involving nurses in the practice change process can promote successful outcomes for the organizational and client health outcomes. Vlasses and Smeltzer (2007) express that successful change requires nurses to be positioned at the forefront of change and aligned with design teams and innovators.

Policy Implications.

Organizations may want to consider having a nurse representative at the senior level of leadership who can provide a voice for front-line nurses and contribute to policy making; this can help to create a sense of comfort and ease for nurses who may be critical of policy that does not reflect a nursing perspective (Underwood et al., 2009). Nurses are the largest group of healthcare professionals in the health organization (Laschinger, Finegan, & Shaimian 2001) therefore; it is prudent to enable their decision-making power and expertise at a policy level; to promote acceptance and adherence of policies and to infuse a nursing perspective and knowledge that attends to client care practices. Policies may be constructed to ensure that nursing representation and input is sought and utilized in practice and programs for client care; this may

be facilitated by a nurse executive. Previous studies suggest that leaders and policy makers develop and implement supportive and nurturing strategies that will enhance the organizational culture (Gregory, Way, Barrett, & Parfrey, 2010). Organizational culture includes aspects of emotional climate, practice-related issues, and collaborative relations and all were positively associated with trust in the employer (Gregory et al.).

Limitations

Limitations of this study can be attributed to the small sample of participants who participated within one region of the health organization. As the study was conducted during a time of organizational restructure, participants' experiences may have reflected early reactions, thoughts and perceptions of the changing environment. Timing of the study may not have allowed participants to reflect long-term on their experiences; hence their experiences related to organizational trust may be perceived differently in a few years or during a time when change is not as substantial.

I would like to acknowledge that I had a degree of closeness to the study issue as I am an employee of Interior Health and I was present during the organizational restructure. This has given me a greater contextual understanding of the data and may have influenced the analysis in how I derived meaning from the patterns and themes.

Recommendations for Leadership of the Organization

Senior leaders of the organization should promote a relational approach to supporting nurses that involves easy access to leaders who provide regular clinical guidance with a collaborative approach. Leaders can be provided with training in interpersonal relationships and managerial skills such as Personal Mastery (Koeble, Bird, & Bonney, 2008); which emphasizes the importance of connecting on a personal level and attending to communication and

collaboration. In addition, attention to front-line nurses' recognition and reward for example, personal acknowledgement of good work done, and flexible hours of work that are conducive to family and work life balance.

It is recommended that change implementation be clearly communicated and include the rationale and long-term goals and direction that the organization is striving towards. Leadership can promote understanding of the organizational structure by meeting face-to-face with nurses to explain their role and level of support to their practice area. Leaders may demonstrate that nursing expertise is valued by including them in decision-making processes for practice change and policy development. Prior to change implementation dedication to logistical planning can be exercised as well as consideration to work space accommodation.

Leadership can recognize that nurses are interested in the organizational vision and exercise vision transparency. The data gathered in this study suggests greater transparency of goals, direction and vision can foster improved understanding and acceptance of change and enhance organizational trust amongst nurses.

Recommendations for Future Research

Recommendations to consider for future research include: using larger sample sizes of community nurses to explore how their trust is fostered and sustained; recruiting nurse participants across a greater demographic area and across health organizations to promote breadth and sharing of ideas in regard to community nurses' organizational trust; including managers and senior leaders in the exploration of nurses' organizational trust to provide insight of leaders' challenges and perspectives on promoting organizational trust to create a rounded inquiry of both groups. Further research into organizational culture and trust may provide greater understanding of factors that influence trust (Gregory et al., 2010). Stakeholders such as

front-line nurses, mid-level and senior level leaders, and government policy-makers may want to invest resources to support ongoing research that captivates employee engagement, shared leadership, and transparency in health service restructuring that will address future challenges in adequate care delivery. It is evident from this study that the exploration of community nurses' experience of organizational trust that factors of having 1) good nurse-leader relationships such that nurses perceive a sense of connectedness with their leaders and 2) nurses afforded the opportunity to be involved in decision-making changes; that it would be prudent to explore further how these dimensions could be actualized. Finally, as there is limited research in organizational trust further exploration in this area as it relates to inter-professional leaders of community based teams, may provide greater insights of how health organizations can facilitate stronger collaborative networks consisting of formal and informal leaders in the pursuit of improved service delivery and client health outcomes.

Summary of Discussion and Recommendations

In this chapter I have described pertinent discovery of nurses' experience of organizational trust in a community health context; explained implications for nursing leadership, practice and policy, and attended to recommendations for leadership and future research. First, leadership support that provides clinical guidance in a collaborative manner, with the intention to foster personal connections is appreciated and valued by nurses. Second, involving nurses in practice change and decision-making can demonstrate value of nursing expertise and be empowering to nurses. Third, clear communication that cultivates understanding of organizational structure and rationale for change is important in motivating nurses to be on-board with the change. Recommendations for organizational leadership are to ensure clear communication that conveys transparent organizational vision. These

recommendations have addressed factors that are related to leadership style, job satisfaction, and organizational change; which can positively influence nurses' trust of the organization.

REFERENCES

- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H., . . . Shamian, J. (2001). Nurses' reports on hospital care in five countries. *Health Affairs (Project Hope)*, 20(3), 43-53.
- Altuntas, S., & Baykal, U. (2010). Relationship between nurses' organizational trust levels and their organizational citizenship behaviors. *Journal of Nursing Scholarship : An Official Publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau*, 42(2), 186-194. doi:10.1111/j.1547-5069.2010.01347.x
- Astin, A.W., & Astin, H. S. (2000). Leadership reconsidered: engaging higher education in social change. Battle Creek (MI): WK Kellogg Foundation.
- Avolio, B.J. and Gardner, W.L. (2005). Authentic leadership development: getting to the root of positive forms of leadership. *The Leadership Quarterly*, 16(3), 315-38.
- Bass, B. M. (1999). Current developments in transformational leadership: Research and applications. *The Psychologist-Manager Journal*, 3(1), 5-21. doi:10.1037/h0095852
- Blase', J., & Blase', J. (1999). Principals' instructional leadership and teacher development: teachers' perspectives. *Education Admin Q*, 35, 349-378.
- British Columbia Ministry of Health Services (2010). 2010/11-2012/13 Service Plan. Retrieved October, 1, 2010 from <http://www.bcbudget.gov.bc.ca/2010/sp/pdf/ministry/hserv.pdf>
- British Columbia Nurses Union (2012). *Nurses Provincial Agreement*. Retrieved from https://www.bcnu.org/ContractAdministration/Provincial_Collective_Agreement.pdf
- Canadian Nurses Association (2006). *Toward 2020 Visions for nursing*. Ottawa: Canadian Nurses Association.

- Chen, C. H., Wang, S. J., Chang, W. C., & Hu, C. S. (2008). The effect of leader-member exchange, trust, supervisor support on organizational citizenship behavior in nurses. *The Journal of Nursing Research : JNR*, 16(4), 321-328.
- Chen, X. P., Hui, C., & Segó, D. J. (1998). The role of organizational citizenship behavior in turnover: Conceptualization and preliminary test of key hypotheses. *Journal of Applied Psychology*, 83(6), 922–931.
- Cook, J., & Wall, T. (1980). "New work attitude measures of trust, organizational commitment, and personal need fulfilment. *Journal of Occupational Psychology*, 53, 39-52.
- Cutcliffe, J. R., & Bassett, C. (1997). Introducing change in nursing: The case of research. *Journal of Nursing Management*, 5(4), 241-247.
- Demircan, N., & Ceylan, A. (2003). [The concept of organizational trust: Reasons and results.] *Journal of Management and Economy*, 10(2), 139–150.
- Dirks, K. T., & Ferrin, D. L. (2001). The role of trust in organizational settings. *Organization Science*, 12(4), 450-467.
- Dirks, K. T., & Ferrin, D. L. (2002). Trust in leadership: Meta-analytic findings and implications for research and practice. *Journal of Applied Psychology*, 87(4), 611-628.
doi:10.1037/0021-9010.87.4.611
- Drucker, P. (1999). *Management challenges for the 21st century*. New York: Harper Business.
- Dunham-Taylor, J. (2000). Nurse executive transformational leadership found in participative organizations. *The Journal of Nursing Administration*, 30(5), 241-250.
- Failla, K. R., & Stichler, J. F. (2008). Manager and staff perceptions of the manager's leadership style. *The Journal of Nursing Administration*, 38(11), 480-487.
doi:10.1097/01.NNA.0000339472.19725.31

- Gillespie N. & Mann L. (2004) Transformational leadership and shared values: the building blocks of trust. *Journal of Managerial Psychology*, 19(6), 588–607.
- Gregory, D. M., Way, C. Y., LeFort, S., Barrett, B. J., & Parfrey, P. S. (2007). Predictors of registered nurses' organizational commitment and intent to stay. *Health Care Management Review*, 32(2), 119-127. doi:10.1097/01.HMR.0000267788.79190.f4
- Gregory, D. M., Way, C. Y., Barrett, B.J., & Parfrey, P. S., (2010). Predictors of perceived health care quality for registered nurses during and after health care reform. *Health Care Management Review*, 35(4), 301-311.
- Gurka, A. M. (1995). Transformational leadership: Qualities and strategies for the CNS. *Clinical Nurse Specialist CNS*, 9(3), 169-174.
- Hurley, J., & Linsley, P. (2007). Leadership challenges to move nurses toward collaborative individualism within a neo-corporate bureaucratic environment. *Journal of Nursing Management*, 15(7), 749-755. doi:10.1111/j.1365-2934.2006.00747.x
- Kanter, R. M. (1997). *On the Frontiers of Management*. Cambridge, MA: Harvard Business Press.
- Kerfoot, K. (2006). Authentic leadership. *Nursing Economic\$,* 24(2), 116-117.
- Kitson, A. (2001). Lost in familiar places ... again (on the nature of nursing leadership). *Applied Nursing Research*, 14(2), 113-116.
doi:<http://dx.doi.org.ezproxy.library.ubc.ca/10.1053/apnr.2001.22380>
- Koebler, M., Bird, D., & Bonney, C. (2008). The role of personal mastery in clinical practice: How personal leadership can transform the workplace. *Journal of Perianesthesia Nursing : Official Journal of the American Society of PeriAnesthesia Nurses / American Society of PeriAnesthesia Nurses*, 23(3), 172-182. doi:10.1016/j.jopan.2008.03.006

- Kramer, M., Maguire, P., Schmalenberg, C., Brewer, B., Burke, R., Chmielewski, L., . . . Waldo, M. (2007). Nurse manager support: What is it? structures and practices that promote it. *Nursing Administration Quarterly*, 31(4), 325-340.
doi:10.1097/01.NAQ.0000290430.34066.43
- Kramer M, Schmalenberg CE. (2003) Magnet hospital nurses describe control over nursing practice. *Western Journal of Nursing Research* 25, 434-452.
- Lapierre, L. M., & Hackett, R. D. (2007). Trait conscientiousness, leader-member exchange, job satisfaction and organizational citizenship behaviour: A test of an integrative model. *Journal of Occupational & Organizational Psychology*, 80(3), 539-554.
- Litva, A. & Jacoby, A. (2007). Qualitative research: critical appraisal. In J. Craig, R. Smyth (Eds.), *The evidence-based practice manual for nurses* (pp. 153-183). Toronto: Churchill Livingstone Elsevier
- MacPhee, M. (2007). Strategies and tools for managing change. *The Journal of Nursing Administration*, 37(9), 405-413.
- MacPhee, M., Wardrop, A., & Campbell, C. (2010). Transforming work place relationships through shared decision making. *Journal of Nursing Management*, 18(8), 1016-1026.
doi:10.1111/j.1365-2834.2010.01122.x
- McCloughen, A., O'Brien, L., & Jackson, D. (2009). Esteemed connection: Creating a mentoring relationship for nurse leadership. *Nursing Inquiry*, 16(4), 326-336. doi:10.1111/j.1440-1800.2009.00451.x
- McGuire, E, & Kennerly, S. (2006). Nurse managers as transformational and transactional leaders. *Nursing Economics*, 24(4), 179-185.

- Meredith, E. K., Cohen, E., & Raia, L. V. (2010). Transformational leadership: Application of magnet's new empiric outcomes. *Nursing Clinics of North America*, 45(1), 49-64.
doi:<http://dx.doi.org.ezproxy.library.ubc.ca/10.1016/j.cnur.2009.10.007>
- Murphy, F. (2006). Using change in nursing practice: A case study approach. *Nursing Management (Harrow, London, England : 1994)*, 13(2), 22-25.
- Morjikian, R., Kimball, B., Joynt, J. (2007). Leading change the nurse executive's role in implementing new care delivery models. *The Journal of Nursing Administration*, 37(9), 399-404.
- Norman, S. M. (2006). The role of trust: implications for psychological capital and authentic leadership, unpublished doctoral dissertation, *University of Nebraska*, Lincoln, NE.
- Olade, R. (2004). Strategic collaborative model for evidence-based nursing practice. *Worldviews on Evidence-Based Nursing*, 60-68.
- Penna, D., Martel, H., Neuwirth, E. B., Rice, J., Filipski, M. I., Green, J., & Bellows, J. (2009). Rapid spread of complex change: A case study in inpatient palliative care. *BMC Health Services Research*, 9, 245. doi:10.1186/1472-6963-9-245
- Perra, B. M. (2000). Leadership: The key to quality outcomes. *Nursing Administration Quarterly*, 24(2), 56-61.
- Polit, D. F., & Beck, C. T. (2008). Analyzing qualitative data. In H, Kogut, E. Harris (Eds.), *Nursing research generating and assessing evidence for nursing practice eighth edition* (pp. 219-247). Philadelphia: Wolters Kluwer Lippincott Williams & Wilkins.
- Polit, D. F., & Beck, C. T. (2008). Developing an approach for a qualitative study. In H, Kogut, E. Harris (Eds.), *Nursing research generating and assessing evidence for nursing practice eighth edition* (pp. 219-247). Philadelphia: Wolters Kluwer Lippincott Williams & Wilkins.

- Raup, G. H. (2008). The impact of ED nurse manager leadership style on staff nurse turnover and patient satisfaction in academic health center hospitals. *Journal of Emergency Nursing: JEN : Official Publication of the Emergency Department Nurses Association*, 34(5), 403-409. doi:10.1016/j.jen.2007.08.020
- Reineck, C. (2007). Models of change. *The Journal of Nursing Administration*, 37(9), 388-391. doi:10.1097/01.NNA.0000285137.26624.f9
- Roussel L., & Swansburg R. (2006). *Management and Leadership for Nurse Administrators 4th Ed.* Sudbury, MA: Jones and Bartlett Publishers.
- Shanley, C. (2007). Management of change for nurses: Lessons from the discipline of organizational studies. *Journal of Nursing Management*, 15(5), 538-546. doi:10.1111/j.1365-2834.2007.00722.x
- Shirey, M. R. (2006). Authentic leaders creating healthy work environments for nursing practice. *American Journal of Critical Care*, 15(3), 256-268.
- Shobbrook, P., & Fenton, K. (2002). A strategy for improving nurse retention and recruitment levels. *Professional Nurse*, 17(9), 534-536. PubMed PMID: 12025015.
- Spence Laschinger, H. K., Finegan, J., & Shamian, J. (2001). The impact of workplace empowerment, organizational trust on staff nurses' work satisfaction and organizational commitment. *Health Care Management Review*, 26(3), 7-23.
- Spence Laschinger, H. K. (2004). Hospital nurses' perceptions of respect and organizational justice. *The Journal of Nursing Administration*, 34(7-8), 354-364.
- Spinelli, R. J. (2006). The applicability of bass's model of transformational, transactional, and laissez-faire leadership in the hospital administrative environment. *Hospital Topics*, 84(2), 11-18.

- Swanson, J. W. (2000). Zen leadership: Balancing energy for mind, body, and spirit harmony. *Nursing Administration Quarterly*, 24(2), 29-33.
- Thorne, S. (2008). *Interpretive Description*. California: Left Coast Press Inc.
- Trofino, A. J. (2000). Transformational leadership: Moving total quality management to world-class organizations. *International Nursing Review*, 47(4), 232-242.
- Tseng, H., Chen, T., & Chen, F. (2005). Constructing and testing a model of trustworthiness, trust behavior and organizational identification. *Journal of Nursing Research*, 13(4), 293-303.
- Underwood, J. M., Mowat, D. L., Meagher-Stewart, D., Deber, R. B., Baumann, A. O., MacDonald, M. B., . . . Munroe, V. J. (2009). Building community and public health nursing capacity: A synthesis report of the national community health nursing study. *Canadian Journal of Public Health = Revue Canadienne De Santé Publique*, 100(5), 11-111.
- Vlasses, F., & Smeltzer, C. (2007). Toward a new future for healthcare and nursing practice. *The Journal of Nursing Administration*, 37(9), 375-380.
- Ward, K. (2002). A vision for tomorrow: Transformational nursing leaders. *Nursing Outlook*, 50(3), 121-126.
- Williams, L. L. (2005). Impact of nurses' job satisfaction on organizational trust. *Health Care Management Review*, 30(3), 203-211.
- Wolf, G., & Greenhouse, P. (2007). Blueprint for design creating models that direct change. *The Journal of Nursing Administration*, 37(9), 381-387.

Wong, C., & Cummings, G. (2009). Authentic leadership: A new theory for nursing or back to basics? *Journal of Health Organization and Management*, 23(5), 522-38.

doi:<http://dx.doi.org.ezproxy.library.ubc.ca/10.1108/14777260910984014>

Young-Ritchie, C., Laschinger, H., & Wong, C. (2009). The effects of emotionally intelligent leadership behaviour on emergency staff nurses' workplace empowerment and organizational commitment. *Canadian Journal of Nursing Leadership*, 22(1), 70-85.

Yahyagil, M. Y., & Deniz, Y. (2004). [*Perceptions of employees working in a healthcare institution of organization climate and stress factors, and their intentions to quit jobs.*] A. Kose & O. Yazar (Eds.), *11nd National Health Institutes Management Conference book* (pp. 58–73), Istanbul University, Turkey.

APPENDIX A: LETTER TO COMMUNITY MANAGERS



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

The University of British Columbia
School of Nursing
Vancouver Campus
T201-2211 Wesbrook Mall
Vancouver, BC Canada V6T 2B5

Phone 604 822 7417
Fax 604 822 7466
www.nursing.ubc.ca

Date: Month/Day/Year

To: Community Manager (personalize)

Re: Permission Request to Recruit Research Participants

As a graduate nursing student at the University of British Columbia I am seeking permission to engage front-line community nurses in a research study that will contribute to my thesis work in the Master's of Science in Nursing program.

The purpose of the study is to explore nurses' experience of organizational trust and factors that influence it in the context of community health. The study aims to provide useful information to health organizations such as Interior Health, which may promote smooth transitioning during times of change, uphold organizational efficiency and productivity, and maintain quality client care.

I have obtained approval from the Interior Health Research Ethics Board as well as The University of British Columbia Research Board to conduct this study.

I am striving to recruit 12 community nurse participants who currently hold permanent full-time or part-time positions. Nurse participants will be engaged in a 60 minute interview which can be facilitated in-person or via teleconference, at a location of their choice at the convenience of the participant. The interviews will be conducted on nurses' own time, outside of work time.

I am hopeful that you will support this study by forwarding the enclosed 'invitation to participate' letter, consent, and demographic forms to your community nurses. A script email has been provided along with the 'invitation to participate' for your convenience.

If you have any questions or concerns please do not hesitate to contact me at XXX.

Your support is greatly appreciated!

BACKGROUND

The health care system is undergoing continuous change and restructuring in response to such factors as human resource shortages, increasing prevalence of chronic diseases, advances in technology, and limited financial resources (B.C. Ministry of Health Service Plan, 2010).

The literature indicates that organizational changes and the related uncertainty and disruption in nursing practice may result in increased job dissatisfaction, reduced job performance, and less commitment among nurses to their employing organizations' goals and ideals; all factors that have been shown to reduce the effectiveness of organizational change and restructuring as well as the quality of patient care provided by the health care system (Reineck, 2007; Gregory, Way, LeFort, Barrett & Parfrey, 2007; Williams, 2005).

More specifically, researchers have begun to examine acute care nurses' perceptions and experiences of organizational trust. Organizational trust has been identified as a key aspect of effective health care restructuring as high levels of trust among employees result in increased willingness to work in uncertain conditions, stronger commitment to change, and greater abilities to adapt more readily to change (Williams, 2005).

As the changing healthcare environment includes a shift towards increased community nursing care provision (CNA, 2006); it is beneficial for health organizations to have insight into community nurses' experience, perceptions, and factors that impact their organizational trust.

Sincerely,

(Co-investigator's Name)

APPENDIX B: EMAIL SCRIPT FOR MANAGERS



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

The University of British Columbia
School of Nursing
Vancouver Campus
T201-2211 Wesbrook Mall
Vancouver, BC Canada V6T 2B5

Phone 604 822 7417
Fax 604 822 7466
www.nursing.ubc.ca

Email Script for Managers

Managers may copy the script below to send in the email to staff. Documents to be attached to the email include: a) invitation to participate letter b) poster c) consent form d) demographic form.

Script:

Please see attached information regarding a UBC Nursing Graduate Student request for research participants. If you are interested in participating in this study outside of working hours, please contact the co-investigator directly. Co-investigator contact information is provided in the 'invitation to participate'. Other documents attached relate to this study and include: a poster, consent form, and demographic form.

APPENDIX C: INVITATION TO PARTICIPATE



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

The University of British Columbia
School of Nursing
Vancouver Campus
T201-2211 Wesbrook Mall
Vancouver, BC Canada V6T 2B5

Phone 604 822 7417
Fax 604 822 7466
www.nursing.ubc.ca

Invitation to Participate

[Date]

To: Community Nurses

Re: Invitation to Participate in Research Study

As a graduate nursing student at the University of British Columbia I am seeking to participants to engage in a research study that will contribute to my thesis work in the Master's of Science in Nursing program.

The purpose of the study is to explore nurses' experience of organizational trust and factors that influence it in the context of community health. The study aims to provide useful information to health organizations such as Interior Health, which may promote smooth transitioning during times of change, uphold organizational efficiency and productivity, and maintain quality client care.

I have obtained approval from the Interior Health Research Ethics Board as well as The University of British Columbia Research Board to conduct this study.

I am striving to recruit 12 community nurse participants who currently hold permanent full-time or part-time positions and have a minimum of two years experience. Nurse participants will be engaged in a 60 minute interview which can be facilitated in-person or via teleconference at a time and place which is convenient to the participant. The interview will be conducted outside of working hours.

This opportunity allows community nurses to share their experiences of working in the organization. Every effort will be taken to protect the identity of participants.

If you are interested in participating in this study, please contact me at XXX by [date two weeks from the letter]. The enclosed consent and demographic forms are requested to be completed prior to the interview date and forwarded to the email address above.

Your support is greatly appreciated!

BACKGROUND

The health care system is undergoing continuous change and restructuring in response to such factors as human resource shortages, increasing prevalence of chronic diseases, advances in technology, and limited financial resources (B.C. Ministry of Health Service Plan, 2010).

The literature indicates that organizational changes and the related uncertainty and disruption in nursing practice may result in increased job dissatisfaction, reduced job performance, and less commitment among nurses to their employing organizations' goals and ideals; all factors that have been shown to reduce the effectiveness of organizational change and restructuring as well as the quality of patient care provided by the health care system (Reineck, 2007; Gregory, Way, LeFort, Barrett & Parfrey, 2007; Williams, 2005).

More specifically, researchers have begun to examine acute care nurses' perceptions and experiences of organizational trust. Organizational trust has been identified as a key aspect of effective health care restructuring as high levels of trust among employees result in increased willingness to work in uncertain conditions, stronger commitment to change, and greater abilities to adapt more readily to change (Williams, 2005).

As the changing healthcare environment includes a shift towards increased community nursing care provision (CNA, 2006); it is beneficial for health organizations to have insight into community nurses' experience, perceptions, and factors that impact their organizational trust.

Sincerely,

(Co-Investigator Name)

APPENDIX D: RESEARCH PROMOTION POSTER



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

A Research Inquiry with Community Health Nurses



Are you a Community Nurse interested in participating in a nursing research study?

We are interested in exploring Community Health Nurses' perspectives about their trust in health care organizations.

If you would like more information about this study or would like to participate contact:

Co-investigator: XXX

Principal Investigator: XXX

Organizational trust matters

APPENDIX E: PARTICIPANT CONSENT FORM



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

The University of British Columbia
School of Nursing
Vancouver Campus
T201-2211 Wesbrook Mall
Vancouver, BC Canada V6T 2B5

Phone 604 822 7417
Fax 604 822 7466
www.nursing.ubc.ca

Participant Consent Form

Organizational Trust in Community Nursing

This document is to obtain written informed-consent of the participant to participate in the research study as noted below:

To explore the experience of nurses' organizational trust in the community health context.

The researchers involved in this study include:

Principal Investor:

Co-Investigator:

Co-Investigator:

Co-Investigator:

Purpose:

The purpose of this study is to explore nurses' experience of organizational trust and factors that influence it within a community health context. You are being invited to participate in this study because you have 1) a minimum of two years experience as a community nurse with the Interior Health Authority and 2) regular employment with the Interior Health Authority such as, permanent full-time or permanent part-time position. This study will contribute to graduate thesis work in the Master's of Science in Nursing Program at the University of British Columbia.

Study Procedure:

Twelve participants will be asked to share their experience of organizational trust in the community health context during a 60 minute interview which will be facilitated by the co-investigator. Separate interviews will be conducted with each participant face-to-face or via telephone and will be scheduled according to the participant's preference. The co-investigator will use an interview guide and may take written notes during and after the interview. The interview will be digitally recorded and transcribed by a hired transcriptionist who will sign a confidentiality statement.

All data collected in this study will be stored in a locked file cabinet or in computer files that will be password protected.

Participants will also be asked to complete a brief demographic form that includes, age range, gender, years of practice as a community nurse, position title, whether you hold a full-time or part-time regular position at Interior Health, and education level. Demographic information will not be included as part of the data analysis or in the finalized thesis report.

Potential Risks:

There are no anticipated risks to participating in this study.

Potential Benefits:

There are no direct benefits. However, the findings of this study may help to promote organizational awareness and understanding of nurses' experience of organizational trust and factors that influence it.

Upon completion of the study each participant will receive a brief report of the study's research findings via email.

Confidentiality:

Participant names and other identifying information will be kept strictly confidential. Participant names will be replaced with numerical codes, no identifying qualifiers will be associated to any participant. The results of this study will be communicated in written papers or oral presentations with all personal identifiers removed.

The use of participant quotes may be used in the final report; no identifying qualifiers will be used.

Individual information collected during the interview will not be shared with the employer. Participation will in no way affect employment.

Remuneration/Compensation:

Participants of this study will receive a \$10 coffee card in appreciation of their time and contribution.

Contact for information about the study:

If you have any concerns/questions or if you would like further information about the study, you may contact Principal Investigator or Co-Investigator at XXX.

Contact for concerns about the rights of research participants:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at XXX or if long distance e-mail to XXX. For any ethical concerns you may also contact the Chair of the IH Research Ethics Board at XXX.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Please forward the signed consent form to [student email] prior to your interview date.

Participant Signature

Date

Printed Name of the Participant

If you ***do not*** want a brief report of the study and findings please tick the following:

– I do not want a brief report of the study and findings.

APPENDIX F: PARTICIPANT DEMOGRAPHIC FORM



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

The University of British Columbia
School of Nursing
Vancouver Campus
T201-2211 Wesbrook Mall
Vancouver, BC Canada V6T 2B5

Phone 604 822 7417
Fax 604 822 7466
www.nursing.ubc.ca

Participant Demographic Form **Study no. _____**

1. How long have you worked as a community nurse for Interior Health?

2. Is your position regular full-time or part-time?

3. What is your position title?

4. What is your age range?

- 20-24 yrs
- 25-29 yrs
- 30-34 yrs
- 35-39 yrs
- 40-44 yrs
- 45-49 yrs
- 50-54 yrs
- over 55 yrs

5. What is your highest level of education in nursing?

6. What is your gender?

- male
- female

APPENDIX G: INTERVIEW GUIDE

Introduction:

1. Acknowledge receipt of signed consent form and demographic form; confirm understanding study topic, procedure/interview process, use of data, measures to ensure confidentiality.
2. Request that participant not use any names during interview process.
3. Inquire if participant has any questions/concerns prior to commencing the interview.

Research Question:

What is the experience of nurses' organizational trust in the community health context and what are the factors that influence nurses' organizational trust?

Guiding Questions:

1. What is it like to work here?
 - Do you have fun at work?
 - Has it always been like this?
 - What do you like best about it?
2. How do you work with supervisors and managers?
 - How does your supervisor support you?
 - How do you communicate with your manager?
 - What is most helpful in your interactions with your supervisor/manager?
3. Tell me what makes you stay in your present position?
4. What would make you leave your present employment (other than personal reasons)?
5. Talk about a time when you felt very supported by current supervisor/manager in community nursing?
6. Is there an example of when you didn't feel supported?
7. If you had 3 wishes to improve your work environment what would they be?
 - What would be of most benefit to you?
 - What would most benefit your clients?
 - How is your feedback/input used in the workplace?