STAFF NURSES' PERCEPTIONS OF THEIR
POWER BASES IN A
NURSING CARE SETTING

by

KAREN ELIZABETH WATSON
B.Sc.N., The University of Toronto, 1983

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES
School of Nursing

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
April 1990
© Karen Elizabeth Watson, 1990
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of NURSING

The University of British Columbia
Vancouver, Canada

Date APRIL 24, 1990
Abstract

The purpose of this study was to describe staff nurses' perceptions of their power bases in their work environment. Power, the capacity to set conditions, make decisions and take action that influences others, is an increasingly important issue within the nursing profession. In the nursing literature, nurses have been encouraged to consider the power to influence nursing care as an attainable goal and a necessary element in the change process. Empowering staff nurses may become a strategy for coping with the nursing manpower shortage. However, research about nursing power has focused on the nurse manager and little is written about staff nurses' perception of their power.

A grounded theory research design was used to collect and analyze data. Data were collected through interviews of nine staff nurses in a 369 bed British Columbia community hospital. A comparative content analysis was used to analyze the data.

The findings showed that the staff nurse participants were able to recognize certain factors in their work environment that impacted on their sense of power. The nature of nurses' work and the communication of information were found to be the most significant factors. The communication of information was perceived to positively influence nurses' sense of power, while the nature of
nurses' work was found to limit nurses' sense of power. Nurses' lack of control over client care was found to contribute to a sense of powerlessness and was linked to units using team nursing.

The eight power bases outlined in Randolph's framework, were useful as a basis for describing the staff nurses' perceptions of their organizational power bases. The staff nurses studied were found to have the most affinity for referent, expert, information, and connection power bases. These nurses were found to have the least affinity for reward, coercion, legitimate, and resource power bases. Primary nursing was found to enhance legitimate power while team nursing was found to enhance connection power. The source of power most frequently mentioned by the nurse participants was personal power in relation to oneself. This did not fit into Randolph's framework and was not well defined. This has implications for nursing since support for the professional nature of nurses' work was found to strengthen nurses' sense of personal power.

Knowledge about the perceptions described by the subjects in this investigation provides information to assist nurses' to identify power bases that they may not recognize. As well, increased understanding about staff nurses' perceptions of power should enable nursing administration to identify strategies for retaining nurses and enhancing client care.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>iv</td>
</tr>
<tr>
<td>List of Tables</td>
<td>viii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>ix</td>
</tr>
<tr>
<td><strong>Chapter I - Introduction</strong></td>
<td></td>
</tr>
<tr>
<td>Background to the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Theoretical Perspective of the Investigation</td>
<td>3</td>
</tr>
<tr>
<td>Research Question</td>
<td>4</td>
</tr>
<tr>
<td>Purpose</td>
<td>4</td>
</tr>
<tr>
<td>Assumptions</td>
<td>5</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>5</td>
</tr>
<tr>
<td>Limitations</td>
<td>6</td>
</tr>
<tr>
<td><strong>Chapter II - Review of Literature Related to the Problem</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>8</td>
</tr>
<tr>
<td>Models of Power</td>
<td>9</td>
</tr>
<tr>
<td>French and Raven</td>
<td>9</td>
</tr>
<tr>
<td>Etzioni</td>
<td>11</td>
</tr>
<tr>
<td>Ferguson</td>
<td>12</td>
</tr>
<tr>
<td>Hagberg</td>
<td>13</td>
</tr>
<tr>
<td>Organizational Power Research</td>
<td>15</td>
</tr>
</tbody>
</table>
Chapter III - Methodology

Introduction..................................................30
The Research Setting........................................30

Selection of Participants
Criteria for Selection........................................31
Selection Procedure..........................................31
Demographic Information of Participants..............32

Data Collection
Ethical Considerations......................................33
Procedure for Data Collection..............................34

Data Analysis
Data Coding..................................................35
Procedure for Comparative Analysis....................36
Chapter IV - Presentation and Discussion of Findings

Introduction .................................................. 38
Themes ......................................................... 38
  Nature of Nurses' Work .................................. 39
  Non-Client Focused Tasks ............................... 44
Communication .............................................. 47
Recognition .................................................. 52
Satisfaction .................................................. 55
Control ....................................................... 58
Resources ..................................................... 62
Discussion of Power Bases ............................... 63
  Personal Referent ....................................... 64
  Personal Expert ......................................... 66
  Positional Reward ...................................... 69
  Positional Coercive ................................... 70
  Positional Legitimate .................................. 71
Organizational Information ............................. 73
Organizational Connection .............................. 75
Organizational Resources ............................... 76
Personal Sense of Self .................................... 77
Summary ...................................................... 79

Chapter V - Conclusions and Implications

Introduction .................................................. 82
Major Conclusions .......................................... 82
Implications for Nursing .................................. 84
Control ......................................................... 84
Personal Power ............................................ 86
Information Processing ................................. 87
Connection Power ........................................ 88
Nursing Research ......................................... 89
Summary ........................................................ 90
References ...................................................... 92

Appendices:

Appendix A - Information Letter ....................... 96
Appendix B - Interview Guide One ..................... 97
Appendix C - Interview Guide Two ..................... 99
Appendix D - Interview Guide Three .................. 101
Appendix E - Consent Form ............................. 102
List of Tables

Table | Page
--- | ---
1. Sources of Power Bases | 26
Acknowledgements

I would like to thank the staff nurses who shared with me their personal perceptions of their work environment. I owe Elaine Baxter, Director of Nursing at Surrey Memorial Hospital, my sincere gratitude for her ongoing professional support. I would like to express appreciation to the members of my thesis committee, Janet Cormick and Carol Jillings, for challenging me and for their contribution to this investigation. Finally, I wish to thank Kevin and Chase for their diversion tactics that provided 'comic relief' during the work of this investigation.
Chapter I
Introduction

Background to the Problem

Registered nurses comprise the largest professional group in health care agencies. When nursing positions are vacant, client care is directly affected through the closing of beds or the delay of various services. Client care is indirectly affected when nurses take on extra work to cover for the vacancies, leaving less time to spend attending to individual client needs. According to 1988 membership data in the province of British Columbia, only 84% of registered nurses are practicing nurses ("RNABC Membership", 1989). Many agencies have vacant nursing positions in various departments. Trends in health care indicate there will continue to be a high turnover rate in nursing positions, with agencies experiencing up to 38% vacant positions ("Battling the nursing shortage", 1988). Filling vacant positions and retaining nurses has become a priority for nursing administration. "Improved working conditions are essential to promote career longevity, job stability and decreased turnover" ("RNABC Position Statement", 1989).

Nurses give many reasons why they leave the practice of nursing. Lack of job satisfaction is one of the overriding factors identified in work retention studies (Butler & Parsons, 1989). Job dissatisfaction is often the result of many forces within the environment. These forces may
include monetary compensation, administrative support, scheduling, recognition, autonomy, power and relationships with other disciplines. For staff nurses, job satisfaction has been linked to a sense of control over the management of client care ("Autonomy Key", 1988). In a study conducted by Bush (1988), both locus of control and powerlessness were found to impact on nurses' job satisfaction. Of the two, powerlessness was most significantly related to job satisfaction (Bush, 1988). Nurses are dissatisfied with their work when they lack the power to meet client needs. Nurses are demonstrating their frustrations with their status in the work setting by leaving the work force.

As a clinician, this investigator has encountered many nurses who complain they cannot tolerate the politics of a particular employing agency. This is sometimes given as a reason for leaving an employer. They imply through the use of the term "politics", that covert behaviour is influencing decisions. Nurses complain about their lack of opportunity to use decision making skills, control resources, and exercise professional autonomy. It may be that this is the nurses' way of describing their sense of powerlessness (Maraldo, 1985). Hagberg (1984), a management consultant, describes powerlessness as feeling constantly manipulated by others and thus dependent on others. This is not viewed by Hagberg as an end stage but rather as a beginning stage towards recognizing one's own power bases. Powerlessness
has also been described as "the extent to which nurses believe they are not permitted job-related independence and the freedom they perceive they need in order to exercise judgement in their professional practice" (Bush, 1988, p.718). Nurses are concerned about policy decisions affecting nursing practice and the quality of care provided to the consumer; but they often feel powerless to change these policies (Campbell, 1984). Moving from a sense of powerlessness to a sense of power is one way of addressing these concerns. Nurses' perceptions of their work environment may impact on their sense of power.

Theoretical Perspective of the Investigation

Power to many people is seen as a desirable but unattainable goal. It is desired because people with power are perceived to be in control of themselves and others. This is equated with the ability to make changes or maintain the status quo, depending on the values and beliefs of the power holder. Power is perceived to be unattainable when people do not understand the variety of sources of power or when they have been conditioned not to desire power.

Literature suggests that women have been socialized not to desire personal power (Grissum, 1976). Since the majority of nurses in Canada are female, nurses have been influenced by this conditioning. For some nurses the concept of power evokes negative feelings, but nurses must understand power and use it to achieve organizational goals (Gorman & Clark,
Power is an increasingly important issue within the nursing profession, as it has been for many years with women in general (Ferguson, 1985; Maas, 1988). Nurses are encouraged to consider power to influence the nursing care provided as an attainable goal and a necessary element in the change process (Smith, 1985; Lerner, 1985). However, much of the literature focuses on nurse managers and little is written about staff nurses' perception of their power.

**Research Question**

The research question for this research investigation was:

"How do staff nurses perceive their power bases within their work environment"?

**Purpose**

Nurses' use of power has been researched but mainly in the context of the managers in the nursing department, i.e. the head nurse, supervisor and nursing executive (Del Bueno, 1986; Johnson et al, 1988). However, it is the staff nurses providing direct client care who are in a position to either perceive the need for new policies, or who are asked to implement the established policies. Staff nurses have a unique contribution to make to the decision making process on their unit, so it is important to understand what they perceive to be factors impacting on their involvement. If nurses think of themselves as powerless, their ability to
recognize strategies for change is limited. This investigation addressed the problem of staff nurses' perceptions of their sources of power bases within the context of their work environment. The intent was to analyze the nurses' responses and to identify phenomena contributing to nurses' sense of power.

The concept of power is abstract and difficult to observe. This investigation focuses on the recognition of power bases in relation to the provision of professional nursing care.

Assumptions

It was assumed that staff nurses have sources of power in their work environment. It was assumed that staff nurses may have difficulty identifying their power bases and how to utilize them. It was also assumed that increasing staff nurses' ability to use their power was a desirable goal. This investigator made these assumptions based on the content of relevant nursing literature (Farley, 1987; Maas, 1988; "Nurse power", 1984; Kidder & Gruending, 1989; Trofino, 1989; Schattschneider, 1988).

Definition of Terms

The following are operational definitions of the terms used in this investigation.

Power: the capacity to set conditions, make decisions and take action which influences others.
Nurses' power: the ability to control decisions affecting direct client care; the staff nurses' perception of their actual or potential ability and willingness to influence the behaviour of others to achieve nursing objectives.

Power bases: the eight sources of power outlined in the conceptual framework that represent relationships between the staff nurse and the environment.

Change: the process of actualizing an alteration in the status quo.

Work environment: the physical, psychological, social and emotional forces existing in the nurses' place of employment; this includes the immediate unit and the organizational structure supporting it.

Limitations

This investigation did not measure the strength or amount of power available or utilized by staff nurses. The investigation aimed to discover and describe the sources of power that existed in the form of power bases. In the process of analyzing this data, inferences were made about the effectiveness of nurses' power and these will be discussed in relation to the conclusions.

The sample of staff nurses was limited to the medical-surgical nursing field of one agency; therefore the investigation has limited generalization to all fields of
nursing. The investigation did not attempt to compare staff nurses to nursing managers, nor did it compare staff nurses from different agencies. Also, variables such as education, years in nursing, sex, and marital status were not a focus of this investigation.
Chapter II

Review of Literature

Related to the Problem

The concept of power is defined and operationalized in many different ways depending on the field of study. It is a term appearing in almost all fields of academic study from the humanities to the sciences. Most notably there is an abundance of literature in political science and sociology addressing the relevance of power relationships. The power inherent in hierarchical organizational structures has been delineated from various perspectives. In the past ten years nursing literature has begun to explore the importance of power to nursing. However, a review of the nursing research of power phenomena indicates that empirical evidence has not been sought (Beck, 1982). Relatively little is known about staff nurses' view of the concept of power or about staff nurses' use of power to make changes in client care.

This chapter reviews theoretical, research and opinion literature. Models of power drawn from a variety of social sciences are described and themes identified. Research studies in organizational power, and specifically health care, are examined in relation to nursing. The nursing literature is reviewed to summarize current trends in thinking about power and the staff nurse. Finally, a
conceptual framework is presented for consideration during analysis of data.

Models of Power

Power is conceptualized in various ways in political science and sociology. Four models of power will be reviewed in order to examine their contribution to the discussion of nurses' power.

French and Raven

French and Raven (1959) were pioneers in the study of social power. Their work was novel for their time since they did not assume power was analogous with domination. Since the publication of their work in 1959, the model of power described by French and Raven has been analyzed and utilized as a basis for study in power literature. Four premises introduced by French and Raven have become standard assumptions in most power literature. Power is the outcome of a relationship between two agents rather than being merely an attribute. The purpose of this relationship is for one agent to influence the action of the other agent, but not necessarily dominate. In order for power to function, the agents must perceive that it is possible to exert influence. Finally, power is not a constant. An agent can be powerful in one setting or situation but not necessarily in every one.
French and Raven (1959) viewed power as the potential influence between a person and the social agent acting to exert a positive force on the person. The strength of this influence is based on the relationship between the social agent and the person. They described five bases of power as: (a) reward power, based on the person's perception that the social agent can reward him; (b) coercive power, based on the person's perception that the social agent can punish him; (c) legitimate power, based on the person's perception that the social agent has a right to influence him; (d) referent power, based on the person's relationship with the social agent; and (e) expert power, based on the perception that the social agent has expertise in the area to be influenced (French & Raven, 1959, p.156).

French and Raven (1959) used their distinction of five bases of power to compare the changes resulting when each was operationalized. In this way they were able to describe the phenomena of social influence and thus social power. Influence was found to be the relationship between two subsystems and power was the maximum possible influence (French & Raven, 1959, p.152). The five bases of power they outlined represent different variables characterizing the relations between two agents. Power is not usually derived from just one of these sources so various combinations are possible.
French and Raven did not specify organizations in their model, however social relationships do exist in formal organizations. The bases of power depicted can be applied to many levels of personnel within an organization.

Etzioni

Etzioni (1961), a political scientist, examined power in relation to organizations and government bureaucracy. Etzioni's view of power also depicted a relationship in which one agent is perceived to have influence. He viewed power as "an actor's ability to induce or influence another actor to carry out his directives or any other norms he supports" (p. 4). Thus, compliance is an element between those with power and those over whom they exercise it.

Those who have access to a means of power are said to be in 'power positions'. The purpose of their power is to actualize organizational goals. To do this, people in power positions must have a positive orientation to organizational power. Etzioni implied that positions of authority are legitimate positions of power. Thus the types of power he depicted are linked to actions of management. This is not consistent with French and Raven (1959) who implied any position has potential for power.

Etzioni described three types of power. Coercive power involves a threat of sanctions. The actor in the power position is perceived to have the ability to discipline or
remove something of value to another actor. This is similar to French and Raven's concept of coercive power. Remunerative power requires control over material resources such as salaries and benefits. This is typically associated with management positions. Normative power involves manipulation of symbolic rewards. Remunerative and normative power, when combined are similar to French and Raven's concept of reward power. Etzioni did not address the attributes or expertise of the power holder. Complex organizations such as hospitals use all three types of power but usually rely more on one type (Etzioni, 1961).

Ferguson

Ferguson (1985), a nurse educator, described a power model within organizations. Complex organizations such as hospitals are where most nurses work, thus this environment affects nurses' use of power (Ferguson, 1985). Ferguson's model of power consists of governance, management and the performance of program activities. The relationship between the three components enables institutions to achieve results leading to set goals (Ferguson, 1985, p.10).

This model, more than the two previous models, depicts a hierarchical relationship. Power is gained through knowledge that is perceived to confer authority. Ferguson (1985) promoted the concept of nurses acquiring substantive knowledge of power, politics and policy in order to move
into these power roles. Governance was viewed as the "power-head" that initiates policy making. Few women or nurses are currently involved at this level. This level of power has the greatest influence on decisions in the organization. Management involves the interpretation of policy and implementation of program activities. Ferguson noted that more women and nurses are operating at this level, but are limited in their effectiveness by their lack of input into policy making. Performance of program activities is the final category of power and this is the level where most nurses work. Staff nurses in this hierarchical power model are considered to have very few sources of power since they are not included in policy or unit decision making.

Hagberg

Hagberg (1984) depicted a model of power emphasizing the stages of personal power in organizations. This model is quite different from the previous models since relationships between agents is not the focus. Hagberg defined personal power as "the extent to which one is able to link the outer capacity for action (external power) with the inner capacity for reflection (internal power)" (Hagberg, 1984, p.xvii). Power is perceived to be partly a result of personal skill and attitudes. Hagberg's power model has six stages with needs identified at each stage.
These needs must be met before a person moves to the next stage. It is a linear model; that is, one moves through the stages sequentially. However, it is possible, and likely, that people go back to earlier stages and begin again when life circumstances change dramatically. Since personal power rather than organizational power is the focus, a person can progress through the six stages regardless of their current position in the organization. The goal is to gain power through self actualization, then be able to utilize this power in a variety of situations.

Stage one is termed powerlessness. The person feels trapped or manipulated by others and needs self esteem and skill development to progress. Stage two, power by association, occurs when a person identifies with a role model and requires self confidence to move on. Stage three, power by symbols, involves visible marks of control over others. This includes titles or status and the need is for integrity. Stage four, power by reflection, is less visible and is characterized by mentoring others seeking power. The need is to be less egotistical. Stage five, power by purpose, refers to those considered to have 'vision' and who have gained a reputation for their acquired expertise. Stage six, power by gestalt, is the most abstract description of power. Those who have achieved stage six are said to have wisdom and an understanding of the world.
Hagberg's model is useful when analyzing individuals within an organization and their sense of self-fulfillment. Self-actualization is seen as a powerful means of influencing others.

Organizational Power Research

Organizations are described and examined at length in the literature. As resources become more finite and pressure groups increase, organizations are experiencing greater conflict (Perrow, 1979). Power is often viewed as the means by which conflicts are resolved through the decision making process in an organization (Morgan, 1986, p.158). Conflict resolution is not considered to be a negative process. Conflict resolution can be a creative force enabling the organization to redefine itself in a changing environment and it legitimizes the need for power at all levels. Power through human relations is increasingly a focus of organizational theorists (Gibson et al, 1985; Randolph, 1985; Mintzberg, 1983). Organizational power impacts on goal achievement, resource utilization and interpersonal relations. For the purposes of this investigation three research studies relating to health care organizations will be discussed.

Women in Organizations

Chernesky and Tirrito (1987) did not actually complete a research study themselves but they synthesized the data
obtained from other research related to women in health care. In their report they focused on the various sources of organizational power available to women, no matter what position they held in the organization. As social workers, their analysis was directed towards the role of the female social worker, however, they explained that the principles were the same for any discipline. Four structural sources of organizational power were identified as "network centrality, organizational criticality, access to resources, and control of uncertainty" (Chernesky & Tirrito, 1987, p.95). Any position within the health care agency addressing the problems and needs of the organization was viewed as potentially powerful. The concept that various individuals in an organization have potential power was also reported by Vakil (1983).

The impetus for the report by Chernesky and Tirrito was the relatively low number of women holding positions of high status and authority given the preponderance of women in the health care system. This is often found in nursing where nurses constitute the largest percentage of the staff in most agencies but have little control over decision making (Garant, 1981, p.189). Chernesky and Tirrito (1987) reported "women are more likely to advance into top-level positions if they acquire mentors, participate in support networks, use informational systems, make themselves visible, and fit into the organizational culture" (p.94).
Four structural sources of organizational power were found to aid in the advancement to positions of authority. Network centrality refers to the number of persons and departments that must interact with the position in order for their work to be accomplished. This can be linked to the degree of involvement in conflict resolution. Organizational criticality represents positions essential to the achievement of the organization's mission. Access to resources both human and material is an increasingly important source of power. Control of uncertainty refers to the ability to assist the organization to deal with changes.

The research study undertaken by Del Bueno (1986) reported similar findings to Chernesky and Tirrito. Individuals were perceived as powerful when they use political "savvy", have a power base from which to network, and have a share of scarce resources (p.125). Del Bueno went on to report that power bases are rarely given to an individual or group, hence power must be 'grasped' by nurses. According to Del Bueno, women and nurses must recognize where power is available in the organization and work towards gaining access to or enhancing power.

Organizational Power and Nursing

Maas (1988) perceived nursing to be in a position to exert power through the collective use of organizational relations. Research of non-nursing organizations resulted
in a causal model of the process of interorganizational power. This model was defined as the basis of power, the exercise of power, and the manifestations of power (Maas, 1988, p. 153). Maas speculated that similar characteristics exist in nursing organizations.

The basis of power refers to the amount and type of resources possessed to which others want access. The type and availability of resources vary depending on the organization in question. In hospitals, nursing personnel are an essential and valuable resource (Grissum, 1976). Maas suggested that to capitalize on the current nursing shortage, "nursing should seize this opportunity by attempting to control the numbers of nurses with specific qualifications who enter practice, so that the perceived value of nurses will increase" (1988, p. 155).

The exercise of power is the ability to coordinate and use resources. Once the resources are identified, whoever can control and manipulate them to meet the needs of the organization has power (Maas, 1988). The structure of the organization influences the type of control available to nursing. By gaining control of the utilization and costing of nursing services, nursing can acquire the power to meet the goals of client care. The manifestations of power are the outcomes of the basis of power and the exercise of power. This relates to the specific strategies used in goal directed interactions.
In the discussion of the results of the study, Maas stated nursing organizations function similarly to any organization. Nursing has a need to gain power in order to influence and participate in policy decisions (Maas, 1988, p.161). "The model can be used to identify aspects of the basis and exercise of power that nursing currently has, and to consider specific strategies of interactions" (Maas, 1988, p. 163).

Managers and Nonmanagers

Farley (1987) investigated the nurse's individual orientation to power rather than the collective use of power. Farley's study compared nurse managers to nonmanagers in their orientations to power and in their communication styles. With the use of the "Power Orientation Scale", six power orientations were outlined. The scale examined how power was valued and perceived. The results from the scale were matched with the respondents results on the "Social Style Profile". The profile defined a person's style in terms of assertiveness and responsiveness.

The analysis of the data showed there was a significant difference between the power orientations of nurse managers and nonmanagers in four of the six areas studied. Nurse managers perceived power more positively than staff nurses. The managers also rated higher in their orientation to power.
as political and inherent to autonomy. There was not a significant correlation between these differences and differences in the social styles of those studied. Farley concluded "nurses need to become more comfortable with the concept of power and how it may be gained and maintained in organizations" (Farley, 1987).

**Power and the Staff Nurse**

In nursing literature in the last five years, there has been an increasing interest in the concept of nursing power; however, few research investigations of this concept can be found. Much of the literature focuses on the need to recognize the value of increasing nursing power. Power is linked to professionalism, change, and leadership. Strategies for empowering and assisting nurses to achieve their professional potential are suggested.

**Perceptions of Power**

Staff nurses confront and deal with situations involving power every day whether at work or in their personal lives (McClure, 1985). In order to see these situations as opportunities to use power, the literature suggests the nurse must be able to recognize and understand the nature of power (Grissum, 1976; Maraldo, 1985). Secondly, nurses must have the will to use the power they have (Courtemanche, 1986, p. 40). Nurses are encouraged to recognize power as a positive force. There is power in
caring that enables nurses to empower their clients (Benner, 1984, p. 208). Gorman and Clark's (1986) study of nurses' perceptions of power, found nurses have the knowledge and skill to make decisions but have difficulty resolving practice problems due to a lack of power. Power was found to evoke negative feelings in nurses. Nurses did not understand power or how to use it. Nurses were filled with the perception of powerlessness because someone else made decisions in areas in which nurses should play a part.

In Gorman and Clark's study, four strategies were tested to empower nurses: (a) apply the nursing process to organizational problems; (b) engage nurses in change activities; (c) strengthen collegiality; (d) support by nursing administration (Gorman & Clark, 1986, p. 130). Following the implementation of these four strategies staff nurses reported a greater sense of control over their practice. The results of the study suggest making decisions and taking action that achieves nursing objectives is how nurses can use power.

Professionalism

Gorman and Clark (1986) linked empowerment to professionalism. "Professional (nurses) can be prepared to function more effectively in organizations and organizations can be designed to promote better use of professional skills" (Gorman & Clark, 1986, p.134). Trofino (1989)
linked the power of the staff nurse to a professional work environment. Trofino stated that empowering nurses is a function of the nursing and hospital administration's commitment to delegating responsibility and authority to the staff nurse. Staff satisfaction and retention are enhanced when the agency's philosophy and structure foster a professional environment.

Nursing authors promote the need for nursing professionals to utilize power and for nurses to be educated to recognize their power bases (Stevens, 1983; Maraldo, 1985; Beck, 1982). The first step suggested by these authors is to recognize power and its availability. Referent and expert power bases are considered to be readily available at the staff nurse level (Estabrook, 1986, p. 61). "Nurses must identify and develop the many personal and professional power bases available to them in order to be able to make a difference in health care as well as to survive as a profession" (Stevens, 1983, p. 3). Making a difference in health care means influencing change.

**Change**

The literature indicates power is central to making change. "Power is an inevitable part of all forms of human interaction, and those persons, including nurses, who deny this fact will only find themselves at a serious disadvantage in making change" (Kalisch & Kalisch, 1982, p.
3). Power is not an end in itself but rather a means to improving client care. "We (nurses) have a reason for wanting power - to allow us to do those things we know best how to do, and receive the credit we deserve" (Diers, 1978, p. 54).

As members of the health care team nurses are involved in many relationships. "Nurses need to use power strategies to assert their control over nursing practice and to plan for changes in nursing that are compatible with the present and future needs of their clients" (Kidder & Gruending, 1989, p.10). How nurses perceive themselves and their sources of power influences how others perceive nurses and how much autonomy nursing is granted. "By using strategies designed to implement changes, nursing will be a more nearly autonomous profession with more open power to help patients through our ability to get decisions and plans implemented" (Grissum, 1976, p. 238).

Leadership

All nurses, whatever their formal role, lead and manage others to some extent (Kron & Gray, 1987, Ch. 16). The nursing process involves decision making, goal setting and planning; to do these things nurses must be leaders and managers. Effective leadership involves the "exercise of power and influence through interpersonal interaction processes" (Sullivan & Decker, 1985, p. 131). The
perception of power is inherent in the leadership process. The ability to influence others, including patients, comes from one's power bases (Douglass, 1984). Nurses at all levels within the organization have potential power. Diagnosing problems and defining nursing actions for clients are examples of how nurses use their personal power. This is defined as the "power of caring" (Schattschneider, 1988).

Schattschneider (1988), a nurse, described a study of the power in physician-nurse-patient relationships. The findings indicated nurses did not recognize or promote their power at lower levels in the organizational structure. Staff nurses did not recognize that power is inherent in cognitive processes such as applying nursing theory and nursing diagnoses. Schattschneider (1988) stated nurses need to "recognize and affirm power which is an inner strength rather than an outside force - power which is an expression of who (nurses) are rather than what (nurses) do" (p.13). The staff nurse has the power to identify client care issues, interpret these to management, and have input into decisions affecting client care (Estabrook, 1986).

**Conceptual Framework**

A conceptual framework is a means of analyzing the power bases of staff nurses. In order to analyze organizational behaviour in general, Randolph (1985) developed a conceptual framework of power. Randolph (1985)
linked the model of power described by French and Raven with an analysis of organizational behaviour (p. 298). The framework groups sources of power into three categories: personal, positional, and organizational. Each category represents two or three specific sources of power: personal referent and expert; positional reward, coercive and legitimate; organizational information, connection and resource. These sources of power are considered to be potential power bases that can be translated into action through political behaviours (Randolph, 1985, p.314). Political behaviours involve the use of power but these cannot be undertaken without first recognizing and knowing how to use sources of power (Randolph, 1985, p. 308).

The framework outlined by Randolph (1985) to describe sources of power bases can be used to study any personnel level within the organization. This is appropriate as a basis to study the staff nurse position. The conceptual framework is summarized in Table 1.

Personal sources of power, referent and expert, were considered by Randolph to be the two most common sources. These two power bases were not linked to any particular management or professional task so are applicable to any personnel in an organization. Randolph emphasized the importance of subordinates and peers perceiving referent and expert power. An individual must develop a reputation over time for this source of power to be accessed. At the staff
Table 1

Sources of Power Bases

<table>
<thead>
<tr>
<th>Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>referent</strong> - the person has characteristics such as charisma, reputation or style that draws admiration, respect and identification from peers.</td>
</tr>
<tr>
<td><strong>expert</strong> - the person exhibits competence in performing certain aspects of the job.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>reward</strong> - the person exerts control over something valued by others such that the person is able to reward other people for desired behaviour.</td>
</tr>
<tr>
<td><strong>coercive</strong> - the person has the ability or influence with the person who has ability to punish people for not doing what the person wants.</td>
</tr>
<tr>
<td><strong>legitimate</strong> - the person is perceived to have the right to influence others based on the position held on the unit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organizational</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>information</strong> - the person has access to information or knowledge that is of value to others.</td>
</tr>
<tr>
<td><strong>connection</strong> - the person links with other people in the organization.</td>
</tr>
<tr>
<td><strong>resource</strong> - the person controls the supplies, equipment, budget of the unit.</td>
</tr>
</tbody>
</table>

nurse level, colleagues and clients provide the source of power.

Positional sources of power are reward, coercive, and legitimate. These are titled positional because the attributes and relationships involved are usually based on the individual's management position in the organization. The staff nurse does not have traditional management functions but the nurse does manage client care. Positional sources of power are also evident in peer and collegial interactions.

Organizational sources of power refer to access to information, connections and resources. The structure of the organization determines who has formal access to these power bases and how these are valued. It is possible to access these sources of power through informal means.

Randolph's framework does not imply every person in the organization has equal amounts or use of the sources of power. To effectively use power the individual should have as many sources of power as possible and know in which situations to use them (Randolph, 1985, p. 310). Utilizing power bases leads to the development of other power bases. This framework provides a structure for examining staff nurses' perceptions of their power bases.
Summary

Power has been described from various perspectives. Four models of power have been developed in the social sciences including those of French and Raven (1959), Etzioni (1961), Ferguson (1985), and Hagberg (1984). Each author focused on a different aspect of power and used different terminology to depict the process of power. They were similar in that power was viewed as positive and attainable but they differed in how this was accomplished. Four themes appeared in the four models of power. Power was a result of the perceptions of the power holder and the persons influenced. Power was the result of a relationship or interaction between two elements. Power holders exerted an influence over those with less power. Power differed in its availability and utilization depending on the situation.

Any one of the four models of power presented in this investigation could be used to analyze nurses' power. For the purposes of this investigation the conceptual framework designed by Randolph (1985), based on the work of French and Raven, is outlined for application to the analysis of nurses' perceptions of power.

The literature presented on organizational power emphasized that power is not limited to authority figures in an organization. Each study focused on a different opportunity for using power. A review of the literature
suggested that available power is underutilized especially by women and nurses in health care organizations.

Research studies on staff nurses' power are limited. The opinion of many authors is that discrepancies exist between the potential power available to nurses and their actual identification and use of this power (McClure, 1985; Maraldo, 1985; Farley, 1987; Maas, 1988; Gorman & Clark, 1986; Schattschneider, 1988). While nursing literature has focused on the value of power for nursing, few are written from the perspective of the staff nurse. Further research is indicated to identify staff nurses' perception of their power and how their work environment is involved in this perception.
Chapter III
Methodology

Introduction

This investigation followed a qualitative methodological approach as outlined by Glaser and Strauss (1967) and Munhall and Oiler (1986). The grounded theory research design allowed for the exploration of a range of staff nurses' perceptions. The lack of empirical evidence about factors related to the power of the staff nurse prompted the use of this methodology to describe the phenomenon. This investigation took place between September and December 1989.

This chapter describes the methodological approach used by this investigator. It outlines the research setting, selection of participants, demographic information of participants, data collection, data coding and data analysis.

The Research Setting

Four medical-surgical units of a 369 bed community hospital located in the lower mainland of British Columbia served as the setting for this investigation. The patient acuity ranged from long term preplacement to short term treatment, with the average length of stay 13 days. The average patient population for each unit was 40. The hospital employs 450 registered nurses full time or part
time and 230 casual staff nurses. No data were available on the educational preparation of the staff nurses.

Selection of Participants

Criteria for Selection

The criteria for sample selection were: (a) full time staff nurse with RN status; (b) employed at the hospital for at least two years; (c) worked on the current unit at least one year; (d) consent to participate; and (e) able to communicate in English. This investigator did not intentionally limit the sample to females, however only females volunteered and females made up 90-95% of the nursing staff on the units. Two years in the hospital and one year on the unit were chosen as criteria to ensure that participants had experience with their working environment.

Selection Procedure

The method of selection of participants was non-random convenience sampling. This investigator selected participants from four units within the hospital. Initially the head nurses of three units were approached and asked to identify three potential volunteers from their unit. Head nurses were asked to give information letters about the investigation to their registered nursing staff. Nurses were encouraged in the letter to contact this investigator if interested in participating.
Within four weeks, one head nurse had indicated she would not be able to identify three participants. The director of nursing asked a fourth unit to solicit participants. A total of six registered nurses agreed to be interviewed through this process, three people short of the goal set by this investigator. To identify three more participants, this investigator telephoned head nurses from three more units. A total of nine participants volunteered for the investigation, representing four units within the agency.

Two of the participants had recently become assistant head nurses on their units. This investigator asked them to respond from a staff nurse perspective since they had more experience with this role. Of the remaining seven participants, one had only worked on the unit for six weeks. This participant was included in the investigation because she had nine years experience in the agency and her previous unit was one of the four involved in the investigation.

Demographic Information of Participants

A total of nine female registered nurses participated in the investigation. Six participants graduated from hospital diploma programs and two graduated from foreign college programs. One participant graduated from university with a B.S.N. Their years of nursing experience ranged from 2 to 33, with an average of 19 years in nursing. Experience
on their current unit ranged from 6 weeks to 9 years, with an average of 3.5 years.

Data Collection

Ethical Considerations

Prior to initiating this investigation, this investigator obtained approval from the University of British Columbia's Screening Committee for Research Involving Human Subjects. The Nursing Research and Education Committee of the hospital then reviewed the proposal for the investigation. Upon approval from the hospital, this investigator met with the Nursing Department involved to explain the purpose of the investigation.

The nursing administrator gave each participant a written explanation of the investigation prior to contact with this investigator. Written consents (Appendix E) from participants were obtained at the beginning of the first interviews. The written consent stated the participant would not be identified in any way and withdrawal from the investigation could occur at any time. No participants chose to withdraw from the investigation. Confidentiality was maintained by coding the participants' names on the transcripts and erasing the tapes at the completion of the investigation. Access to the data was limited to this investigator and the advisory committee. The consent form informed participants they could refuse to answer any
question. The written consent included a statement that the participant's employer would not be made aware of an individual's comments. This investigator conducted interviews in a private room in the agency to facilitate confidentiality.

Procedure for Data Collection

The purpose of this investigation was to describe phenomena from the perspective of the staff nurse. To accomplish this goal this investigator utilized the inductive approach of the "grounded theory" method (Glaser and Strauss, 1967). The description of grounded theory methodology outlined by Munhall and Oiler (1986) guided this investigator during the data collection, coding and analysis phases of the investigation.

The author, as principal investigator, collected, transcribed and analyzed the data. Two taped interviews with each participant occurred during her working hours. Each participant was asked questions from an interview guide ensuring the consistent collection of a broad scope of data. However, as topics considered to be relevant to the purpose of the interview arose, participants were encouraged to expand on their response to a particular question. Taping the interviews allowed coding of observations about the participants' comfort with the questions. After the first three initial interviews, the interview guide (Appendix B)
was altered to clarify questions, so the data collected were most relevant to the topic under investigation. A second interview guide was developed (Appendix C). Prior to the second round of interviews, the data were coded and the existence of trends established. The second interviews gave the participants an opportunity to expand on the content of their first interview and to address the trends identified (Appendix D).

**Data Analysis**

**Data Coding**

Following each interview, this investigator coded the raw data using the level one coding described by Munhall and Oiler (1986). At this point, no effort was made to standardize the codes used so a variety of theoretical perspectives could be identified. The code names related directly to the content of the data and frequently were the exact words used by the participant. Coding incorporated verbal and non-verbal communication. This investigator coded in the margin of the data sheets so participants' remarks could be linked to codes at a later stage. An analysis of the initial level one coding in consultation with the thesis committee members, directed this investigator to adjust the interview guide to obtain more relevant data (Appendix C).
Once the initial interviews and level one coding were completed, level two coding was undertaken. Six categories were established incorporating the codes identified: (a) recognition, (b) communication, (c) workload, (d) non client focused tasks, (e) satisfaction, (f) control, (g) resources. The category names reflected a trend or theme identified by this investigator after grouping the codes. Level one codes represented the components or properties of the themes. Coding and analysis occurred simultaneously as memos regarding significant findings and components of categories were recorded. A comparative analysis was made between the codes within the level two categories and the conceptual framework. Identified trends and gaps in the data base became the basis for the second interview guide.

Following the second interviews, data were coded and categorized under the same six themes in order to clarify and validate the analysis. Level one codes were then analyzed within the context of the conceptual framework. The product of coding was a grid spreadsheet on which codes within themes were grouped in relation to corresponding power bases.

Procedure for Comparative Analysis

This investigator utilized the constant comparative method to analyze the data. Trends and patterns in the coding, categorizing and identification of theoretical
constructs were noted. Properties of themes were defined by using the coded components of categories. The themes were then compared to the eight sources of power bases outlined in the conceptual framework. This process related the understanding obtained from the data to the theoretical construct. The conceptual framework provided a means to relate the data to academic knowledge and specifically the concept of power.

Data coded and organized under themes but not linked with the conceptual framework were analyzed separately. The findings of the analysis will be reported in chapter four.
Chapter IV

Presentation and Discussion of Findings

Analysis of the data collected by this investigator found that the nine staff nurses recognized certain sources of power. This chapter presents a discussion of the findings based on the themes identified and the framework set out by Randolph. The analysis is divided into three main segments. The first segment outlines the nine staff nurses' responses and categorizes them under six themes. The degree to which these themes relate to power bases will be discussed. The second segment cross references the responses under the themes with the power framework used by Randolph and highlights data not categorized by theme. The third segment presents a ninth source of power, not part of Randolph's framework, but identified during analysis of data. This source of power will be referred to as personal sense of self.

Themes

After coding the data, this investigator identified six themes: nature of work, communication, recognition, satisfaction, resources and control. These themes represented a grouping of codes with similar properties. The codes reflected the nine participants' perceptions of the factors in their work environment that impacted on their sense of power. In general, their comments indicated that
even if they did not associate their perceptions with sources of power, they were able to recognize issues and circumstances significant to them. The nature of their work and communication patterns within the agency were most frequently identified as relevant issues. The concept of control was the most difficult issue for the participants to understand and all participants required clarification and prompting before answering questions related to this.

Nature of Nurses' Work

Statements made by the participants relating to the type of work undertaken for client care and the amount of work involved were most frequently presented as issues. A significant number of comments were made regarding non-client focused tasks.

All nine participants indicated that the amount of trust and respect given nurses influenced the type of nursing care provided. When clients trusted the nurse participants, the clients appeared more cooperative, perceived their care more positively, and had a greater understanding of their care. The trust and respect of the head nurse and co-workers contributed to more autonomous practice.

It allows you to use your own judgement in making decisions. I think if you didn't have the trust of the head nurse you would probably question a lot of your own decisions and double check them with people more often.
Having the trust and respect of clients and nurses did not reduce the amount of workload but participants reported it made the work more productive and gratifying. This was important on units where the amount of time spent with clients had decreased; thus the nurses studied felt the quality of time had to compensate for this. The participants perceived the trust and respect of clients, peers, and supervisors gave them referent power to make their work more effective. These staff nurses felt empowered to meet client needs.

Wanting to strengthen nursing's focus on client needs was a consistent theme throughout the interviews. When asked what one thing they would change on their unit, participants expressed a desire to have more time with the patients when they could listen to concerns or do patient teaching. These statements reflect the feelings of the majority of the nine participants.

I wish I had more time with the patients. I think basically I really like bedside nursing. When it comes around to the teaching part you don't have much time to teach because you're so busy.

The time that we do have we're doing chores. We could perhaps spend the time with the patient. We've lost that, some how we've lost this time with the patients. And yet there are more and more of us. And we're doing more and more. We're busy. But we seem to have lost quality time with patients.

The types of client focused activities that several of the participants valued were assessments, priorizing client
problems, client teaching, holistic care, interaction with family and promoting client independence. Activities seen to facilitate these were doing a nursing care plan, restructuring the unit so it had a specific client focus, nurses helping each other and consistent client assignment. The participating nurses implied that these activities gave them opportunities to use their nursing knowledge. The nature of nurses' work was considered by all of the participants to contribute to their expert power base; when they were able to practice professionally. However, several participants thought their expertise was not valued by others. One participant recognized the need to assert her nursing knowledge to have a greater impact on physicians' decisions.

We pussyfoot around saying well do you think this and do you think that. I think it would be nice to say things with a lot more authority. Like not, 'do you think?': I think this.

Knowing how and when to communicate nursing knowledge was perceived by this participant to increase her potential expert power. Other participants indicated that nursing knowledge and practice influenced the kind of information nurses' share. Nursing histories and ongoing assessments were the primary information base sought by other disciplines. Nursing interventions were reportedly sought by other nurses. All participants expressed the belief that the nature of their work gave them information power.
Providing twenty-four hour direct care to clients was considered to give nurses information no other discipline had.

Participants' descriptions of their work days were similar for those working in primary and team nursing systems. Their outline of their work was task oriented. Feeding patients, giving medications, calling doctors, and documenting care were the tasks most frequently described. Nurses participating in the investigation felt there were more 'ought to be dones' than when they first entered nursing. Combined with the increasing pressure of time constraints and trying to meet someone else's deadline, tasks not related to client care were perceived as inhibiting factors.

I think that's the trouble, you know you have this many things you really think ought to be done, you get this many done, then run out of time. That is what's so frustrating, you have more and more things that ought to be done, have to be done.

We're doing more and more, we're busy. But we seem to have lost quality time with patients.

This may explain why it was difficult to solicit participants for the investigation. Participation in research was not mentioned as an accepted function of nursing work. This investigator observed that participants considered the interviews to be an added task and time constraint.
Upon analysis of the data, this investigator found that participants did not recognize their responsibility to provide individual client care as a potential source of legitimate power. The one participant who worked on a unit using a primary nursing model felt she had legitimate power to influence client care. She perceived a responsibility for individual client care and control of that care. The rest of the participants worked on team or modified team nursing units. It was not clear whether it was a result of team problem solving or combined responsibility for the care of clients, but these participants did not recognize their legitimate power to control their work. Following the nursing process and documenting care were not recognized as ways that nurses could influence other nurses. Participants varied in their opinion of how valuable the nursing care plan was in conveying information.

I'd say, (the nursing care plan) would be a problem that is specific to the patient with a plan, goals and nursing's specific activities. It would communicate to everybody what you're trying to accomplish and how to go about it.

Keeping care plans updated with relevant information was viewed by most as an arduous task. Verbal information sharing was preferred by many participants but they admitted this was not helpful on units with many casual staff who did not know the clients. This response reflected the common view that nursing care plans were a luxury to be indulged when time was available.
Really when you see how little they get used by nurses you really wonder whether kardexes are all they're cracked up to be. It's a great idea in theory. You sit down and write the nursing care plan on this patient, you change it and keep it up to date and so on. But you never see nurses look at them.

Preoccupation with tasks and inadequate use of the nursing process were found to be negative factors; limiting the potential expert, information and legitimate power bases of those studied. Participants did not recognize that nursing care plans could promote expert, legitimate and information power bases when they were used to assist nurses to meet client needs. Participants were not able to recognize this as a source of power partly because their descriptions indicated that planning and communicating nursing care were inconsistently done. This sample of nurses reported a lack of continuity and lack of specificity of client assignments on most units. Since most participants did not have a specific client assignment, assessments and planning occurred during team planning. Sometimes the night staff wrote and updated care plans for all the clients. These factors served to limit the individual power bases of the nurses studied.

*non-client Focused Tasks*

Related to the nature of nursing work issues was the concept of non-client focused tasks. Traditionally the term non-nursing tasks is used but analysis of the data showed
that these participants were more frustrated by non-client focused tasks. Participants considered some of nurses' work non-nursing tasks if someone else was equally able to do them, but participants did not object to doing these tasks if they were client focused. Frustration was expressed about doing non-nursing tasks that were also non-client focused. Cleaning refrigerators and cupboards, checking medication administration records, transferring patients and doing "office work" were a few of those mentioned. Terms used to summarize these tasks were "clerical tasks" and "mechanical work". Many participants suggested some type of worker be hired in the hospital to attend to these tasks.

I would put on unit aides to do the errands and to do the cleaning the medicine cupboards, the refrigerators once per week, run patients to activities and order supplies.

Factors considered to detract from focusing on client care were considered to limit legitimate power. Being short staffed, not having adequate supplies, doing non-nursing tasks and doing paperwork were mentioned as issues by all participants. Three participants raised the issue of having to do work they thought the physicians should be doing themselves. Phoning physicians with patient assessments because the physician had not attended the patient or leaving reminder notes on the kardex for them were viewed as negative factors.
They leave everything to us. We're baby-sitting them. If anything needs to be reordered we're phoning them, they're not checking on the profile.

The participants did not recognize the physician's dependence on them for information as a potential power source. Although one participant identified documentation as a source of power, the others indicated that legally they recognized the necessity for documentation but they did not view this as part of their nursing role. It was considered a non-client focused task. Even though participants were observed to be comfortable with discussing the topic of information sharing as part of their work, their perception of this as a source of power was limited.

The nine participants expressed concern about the loss of client contact when non-client focused tasks were undertaken. When asked how they would address these factors most participants commented that they felt powerless to change them since the issue was out of their control. Some blamed the agency's budget, others blamed nursing's lack of power in general. Their responses indicated a lack of perceived legitimate power to influence the nature of their work. Heavy workloads combined with the perception of being kept busy doing non-client focused tasks contributed to a few of the participating nurses' sense of dissatisfaction with nursing.

In summary, while the nature of nurses' work was perceived by the participants to be potentially powerful,
negative factors limited the extent to which expert, legitimate and information power bases were recognized. The nature of nurses' work was viewed as a positive factor in terms of referent power. This power base was perceived to have more influence over clients and peers than any other discipline.

Communication

Various types of communication with numerous people were mentioned by the staff nurse sample. This was discussed in an impersonal fashion even though each participant was asked to describe who she communicated with. Communication was described between staff nurses, patients, nursing administration, medicine and all support disciplines in the hospital. Although participants were not asked to state names, they did not refer to the people in the positions. Instead they referred to the positions themselves. Dietary, pharmacy, occupational therapy, physiotherapy and social services were the terminology used by most. This implied that the connection with the people in the positions was a weak one and not a one-to-one relationship. This contributed to a limited perception of connection as a power base. Communicating between nurses to plan care and communicating with physicians to give information were the two most frequently described phenomena.
Communication between nurses was seen as a necessity for providing client care. Participants felt a strong sense of connection with nurses on their team. Conferring with a partner to provide care and planning care at team meetings were the norms. Team nursing contributed positively to nurses' perceptions of connection as a source of power. One participant, in response to the question on her sources of power, responded that unity on the unit contributed to a sense of power. The prevailing view was that through working and problem solving together, power to provide quality care was enhanced. This also represented a source of support and resulted in increased morale.

Verbal communication between nurses was reported to happen through face to face contact and through taped report. Written notes in the communication book or kardex were the second most frequent methods of communication. Charting was not described as a common means of communication between nurses. The nursing care plan was mentioned as a means of communication and this was considered to be synonymous with the kardex. Comments about the nursing care plan reflected a differing extent to which care plans were used on the units.

A lot of times I think they're there just because we have to put something. I think most people glance at the problem, and then sort of form their own plan in their head. Unless it's a major problem or dressing or something that really deserves a very specific plan to follow. Then they'll look at the plan.
We use it a lot because especially with a lot of casuals that we have, there is a basis of information and referrals and stuff.

During the initial interviews, when participants were asked how they related with other disciplines, they stated they had good working relationships of a collegial nature. Many implied they had not considered this before and had difficulty describing their relationship. Initially trust and respect were not mentioned. During the second interviews each participant was asked to identify who trusted and respected them. Clients, peers, administration, families and colleagues were mentioned in that order of frequency. To a certain extent, communication was perceived as open and based on a trusting relationship. Communication patterns in the agency were considered to promote referent power. However, participants expressed reluctance about having to communicate with physicians as often as they did.

I don't like calling a doctor to remind him that a patient needs a laxative order or something like that. I still like calling the doctor only if I have to.

Similar to the factor of time constraints related to the nature of nurses’ work, time consuming communication was viewed as a negative factor in the work environment. These staff nurses felt that most of their contact was unnecessary so felt that communication interfered with patient care.

These feelings reflected many issues. Some nurse participants were uncomfortable with their changing role and
with the expectations set for them. Two participants mentioned that they preferred the system where the head nurse called the physician.

There's a lot of phoning doctors. I've been away from day shift for a long time and at one time the head nurse was there and they looked after phoning doctors. Now we have to do the phoning.

These staff nurses perceived that when the head nurse or team leader phoned it saved time and eliminated repeat phone calls by various nurses to one physician. These contacts were considered unnecessary if they were directed at checking up on the physician to make sure orders had been written or if the physician was asking the nurse to do his work. One participant in particular felt strongly that communication with physicians was meeting the physician's needs and not the client's needs.

Some (physicians) over-trust us. They leave everything up to us. And we're baby-sitting them. If anything needs to be reordered we're phoning them, they're not checking on the profile. Their patient's conditions, they won't come they'll phone and see how they are...So they leave too much up to our discretion which I don't know if that's trust or what it is.

Another reason for phoning the doctor that evoked negative feelings about the need for time consuming communication was to query something the nurse felt capable of dealing with herself. One participant summed this up by saying:

I think a lot of the decisions we are capable of making, but we have to phone the doctor. An increase in diet, really stupid things, bowel regime, things that are really silly. Nursing should have the power to determine those things.
Participants expressed mixed feelings about communicating with physicians. Certain participants stated that even though others depended on them to communicate client information, they did not feel this necessarily meant they had information power. This type of comment reflected the emotions expressed by several participants.

It's frustrating when you feel you have no power. When you know based on your assessment that something should be changed, and you bring it up to the doctor and the doctor hums and hohs and forgets about it.

Often nurse participants felt they provided information and it was not acted on or the information was used without recognition given to the nurse as the source. This contributed to a sense of dissatisfaction with nursing.

Team and multidisciplinary meetings were considered the most helpful forum for interdisciplinary communication and planning of care. At these meetings nursing had direct input and a collegial relationship existed. The staff nurses studied felt their contribution was valued by all disciplines and they were consulted for their assessment of patients. Involving more people in the planning of care was seen as a way to improve quality of client care.

In summary, communication was generally perceived as a positive factor in the nursing care setting, except when the information communicated was not acted upon. Next to the nature of nurses' work, communication was perceived to be an important factor in relation to the sources of power.
available to the nine participants. Where the nature of nurses' work was perceived to have potential for power that was not realized, participants perceived communication to promote referent, information and connection power bases. The nine participants indicated that the significance of these power bases increased if the content of their communication was well received.

**Recognition**

Recognition and the desire for feedback were consistently referred to as visible, tangible elements in participants' work environment. The degree of importance given to recognition as a source of power varied but the process for giving recognition was easily identified by participants. Evaluations done by the head nurse were seen as most reliable in terms of feedback. It also was considered the most desirable positive feedback to gain. The staff nurses studied felt that recognition from their head nurse meant more than peer or hospital recognition of excellent nurses. The following response was typical of participants' views of feedback.

I think it would really help boost morale if we did get more positive feedback from the head nurse. From someone that is in a charge role rather than from your fellow staff members. It means a lot more to get it from your head nurse.

This recognition came through formal evaluations or informal transfer of functions. The most frequent type of
recognition mentioned by the staff nurse in the sample was being assigned extra responsibilities. The head nurse was perceived to have reward power based on her position as administrator. Being given extra responsibilities such as charge nurse or committee member was portrayed as a desirable and empowering action. One participant described this as "indirect feedback". This indicated the head nurse's trust and respect for the individual and served to increase staff confidence and self esteem. It was perceived to empower nurses to gain referent and expert power bases. Since the informal or indirect feedback was more visible to peers and colleagues, it was considered to contribute more to expert and referent power than formal evaluations.

The types of nurse characteristics participants considered worthy of recognition included: experienced, knowledgeable, skillful, competent, efficient, caring, conscientious and able to relate to patients. Each participant identified different criteria for determining an excellent nurse. Only one participant clearly stated that she perceived peer recognition to be valued.

"I think that we are quite supportive of one another and we often try to say that you did a really good job or that you did that well. That's really about the best kind of recognition."

Some participants acknowledged the benefit of peer support but admitted this rarely was actualized through recognition.
I think we are aware of who (excellent nurses) are but it's just that they're not given recognition. In our hearts we know that they deserve it.

With no consistent notion of excellence it was found to be difficult to know when and how to give feedback. Participants perceived nurses to have very limited reward power. As a result they did not recognize their ability to empower peers. The concept of recognizing strengths of peers was referred to in terms of enhancing personal morale but not in terms of enhancing referent and expert power. Participants felt nursing expertise was acknowledged through awards given yearly by the hospital. However, they felt this did not affect them personally since only a few people received an award. It was not considered a source of power for individual staff nurses.

When asked to describe an excellent nurse two participants made demeaning comments about themselves, implying they did not recognize their own expertise. One staff nurse in the sample stated:

I got an excellent evaluation but that's not the way I feel about myself.

Participants were quick to identify personal limitations such as limited educational preparation but slow to recognize personal strengths. It seemed easier to talk of nurses as a group. The nursing group was referred to as 'we', 'they', or more often 'the nurses'. This trend was contradicted when participants were directly questioned
about their sources of power. At least four of the nine staff nurses sampled listed personal sense of self esteem as a source of power. Attributes such as kindness, caring and conscientious were perceived as empowering nurses to care for their clients needs. One participant's response encapsulated the views of many.

(Power) has to come from yourself. I don't know where we get it from but it just comes....Your confidence that you're able to do your job.

As one participants stated, having a "love of life" or a personal sense of well-being was perceived to give nurses the power and motivation to achieve nursing goals.

In summary, the theme of recognition was not perceived to be a strong external source of power but was considered to be a strong internal source of power for nurses. Those same participants who stated their source of power was a personal sense of self esteem were also the nurses who stated they felt satisfied with nursing.

Satisfaction

Participants' satisfaction with the profession of nursing varied widely. One participant expressed contentment with her nursing role and function. One was getting ready to leave the profession by taking courses toward a new career. The remainder of the participants expressed emotions somewhere between these two extremes. Some desired more complexity and challenge in the nursing
role; some desired less. Nursing was described both as stimulating and as depressing.

The factors identified as contributing to satisfaction with nursing were: (a) functioning as a patient advocate, (b) gaining positive feedback, (c) feeling like nurses make a difference in the health of the patient, and (d) having good relationships with colleagues and peers. All participants expressed satisfaction in receiving positive feedback from clients.

I really enjoy working with patients and I think the greatest satisfaction is when a patient says thank you for the care that they've gotten. That's really rewarding.

Those participants who expressed satisfaction with the profession of nursing felt they had personal power to cope with the challenges of nursing.

Factors contributing to dissatisfaction with nursing were summarized through coding as an inability for the value given nursing to keep up with the changes in nursing. Feeling ignored when decisions were being made, lack of contact with individual clients and lack of change in nursing image were cited as examples. This participant's comments reflected the emotions expressed by the nine participants.

There's a lot more expectations of us too. We're expected to have a lot more skills, keep them up and yet have less time to use them. I think that's becoming very frustrating.
Even though all participating nurses expressed frustration with the increasing expectations, only those who felt powerless to influence these issues also expressed dissatisfaction with nursing. For these participants, the personal power gained through self esteem was not sufficient to overcome the lack of other power bases. Two participants in particular were able to recognize potential power bases for nurses but felt these were not actualized and therefore they felt powerless.

Then you feel really powerless. They're not taking your assessment into consideration.... that's when you feel not very good about nursing and not very good about the relationship you have with the doctor.

In terms of Hagberg's model of power, these two nurses were at stage one: powerlessness.

Some common factors that the literature suggested contributed to nursing satisfaction were not mentioned by the participants. Money, scheduling and control were not identified as major issues. Perhaps since the investigation was conducted two months after a new contract was negotiated the nurses felt the issue of money had been dealt with for awhile. Some participants expressed satisfaction with only working night or evening shifts. Whether working twelve or eight hour shifts the nurses did not want to change their scheduling. The concept of increasing nurses' control over decisions affecting patient care was never raised by the participants.
In summary, satisfaction with nursing was perceived more as an outcome of power rather than a factor contributing to power. While a personal sense of self esteem was perceived to contribute strongly to satisfaction, by some it was not perceived as the most important source of power.

Control

When asked to describe the ways they had control over the care they provided, all nine participants hesitated. Many asked that the concept be clarified before responding and their responses demonstrated a varied understanding of the concept. This investigator clarified the concept of control by saying "What about having input into decisions that are being made about patient care?" For some the concept of control was concrete. Time management and self organization were referred to as controlling mechanisms. This was tied into prioritizing patient needs and deciding what could afford to be left undone.

I organize my own work. We have to assess our priorities, sometimes you have no choice – you have to look after what has to be done.

Responsibility was a word used to describe various components of nursing. Having input into decisions affecting patient care was also mentioned. These issues were also mentioned when outlining the amount of control...
utilized. One participant who worked on unit using primary nursing stated:

As staff nurse you have full control over the care. Because you do everything and the responsibility is all with the primary nurse. You plan your day as you think is best for the patient and carry on as you can. I think the control is right with you....I think the staff nurse is in full control of the situation.

This participant indicated she had more autonomy to plan care and increased responsibility for individual clients than was indicated by the other eight staff nurses. The participant functioning as a primary nurse implied that primary nursing strengthened her source of legitimate power. She perceived that as a function of her position as primary care giver, she had legitimate control over her clients’ care.

There was evidence that control could be directly or indirectly applied. Manipulating physicians to make certain patient care decisions was seen as a valid but not as a rewarding use of control.

You sort of have to use a bit of manipulation actually. That is something you learn in nursing is how to get the doctors to take care of their patients in what you think is the best way. You might know better since you are there.

The ways in which you control it; by making suggestions at meetings. You can suggest things to the head nurse.

This type of contribution to patient care decisions was termed by one participant as "using the back door to change".
The fact that nursing has contact with the patients twenty-four hours per day and thereby has information unavailable to others, was considered a means of control. Participants reported that physicians sought them out to gain information about their patients. One participant indicated this was a source of information power.

You see the patient more than he does, he just comes in and out so he doesn’t see it on an overall basis. And a lot of them really rely on you knowledge of what’s happening with the patient and how the changes have been happening. They will change the therapy or the treatment according to what you say and that is a source of power.

However, many felt that once information was attained, the physician did not further consult the nurse to discuss patient care. One participant felt this decreased her legitimate power.

You feel that this patient needs this and you feel it’s important and it’s not getting done. And you feel really frustrated once you bring it up to the doctor and the doctor doesn’t agree with you or just doesn’t think it’s important and leaves it....If you really think it’s something important you have to keep following it up. That is a feeling of powerlessness that you can’t do anything.

It was difficult to determine how the nine staff nurses studied controlled their work. Through their lack of understanding of the concept, the participants indicated they were limited in their ability to control their own practice let alone influence others. Participants thought their legitimate power was undermined by physicians giving orders and directing patient care. Many times participants
mentioned having to check with the head nurse before taking action. In effect much of the control described by participants rested in group problem solving. Nursing care plans were discussed in team meetings. Decisions affecting nursing care were debated in multidisciplinary meetings. Rather than influencing others based on the fact that the nurse was responsible for client care, a few participants felt they had to manipulate others covertly in order to accomplish nursing goals.

Involvement of this staff nurse sample in groups such as hospital and nursing department committees was limited. One participant was involved in a committee to examine the retention of nurses. Whether other hospital committees have staff nurse members is unknown, since the participants were not able to identify committees where staff nurses were involved. This was typical of the responses to the question "what hospital committees are nurses on?"

I'm not too familiar with all the different committees that are going at the moment.

Committees serving local interests at the unit level were more readily identified but the scope of the committees was limited. These committees did not have input regarding patient care but rather dealt with staff issues such as education or social events. The degree to which participants perceived the power of connection to impact on
the provision of client care was limited by their lack of involvement in committees.

In summary, the issue of control was significant more in the lack of data obtained than in the frequency with which control was mentioned. Participants working with team nursing perceived less individual control and less legitimate power. While the issue of control over the decisions affecting client care was not as frequently expressed as the nature of nurses’ work, it was found to be a significant factor influencing participants’ perceptions of power. Lack of control contributed to a sense of general powerlessness.

Resources

One area over which all nine participants felt they had no control was resources. Budget cuts and government funding were blamed for lack of necessary equipment and supplies. Hospital finances were viewed as government controlled and therefore untouchable. Participants complained that with beds full, staffing shortages and difficulty obtaining equipment and supplies, quality of patient care was suffering.

One example of successful lobbying to influence allocation of resources was given. When the nurses on one unit were informed that their unit would be re-designated a discharge planning unit, they strategized to have input into
the final decision. The nurses met outside the hospital to list the reasons why their unit was not a good physical or human resource for a discharge planning unit. A petition was circulated and signed by nurses and physicians. A presentation was made to the nursing administration. The result was a decision to leave the designation a medical unit. When asked what sources of power assisted their efforts, one participant responded that unity and documentation were the two main factors. Even after successful lobbying these participants did not feel they had any significant resource power.

In summary, on an issue specific basis, participants expressed that a certain amount of power was achieved. However, this perception was not linked to power over resources but rather referent and connection power. Generally participants felt that in terms of power this was a strong negative factor in their environment.

Discussion of Power Bases

The framework documented in the literature by Randolph (1985) was used by this investigator to design the interview guidelines and to cross reference the data categorized under themes. While analyzing the data, the conceptual framework was referenced to clarify this investigator's understanding of participants' perceptions of power bases. Power bases examined were: personal referent and expert; positional.
reward, coercion, and legitimate; organizational information, connection and resources. Environmental factors influencing participating nurses' perceptions of potential sources of power have been discussed in relation to the themes. This segment of the chapter explores data that this investigator found related specifically to the power bases and was not consistent with any one theme. The variety of themes contributing to sources of power bases will also be discussed.

Personal Referent

Personal referent power is present when the nurse has characteristics such as charisma, reputation or style that draws admiration, respect and identification from peers (Randolph, 1985). This investigator was interested in what individuals or groups of people trusted and respected the nurses studied. Also examined was to what extent these nurses tried to gain the trust and respect of people.

Since participants did not volunteer information about referent power during initial interviews, during the second interview each participant was asked to identify whether anyone trusted and respected her. In response to this direct question participants were able to identify peers, clients, families, administration and other disciplines.

I guess co-workers (trust and respect me). Patients because they trust themselves to us for their care. I think also family.
The effect this trust and respect had on the staff nurses studied was to improve the quality of care they were able to provide. Clients were described as more receptive to nursing actions, administration gave participants freedom to practice more autonomously and other disciplines collaborated to meet client needs.

I think it makes it easier for me. (Clients) are more cooperative and they seem to like my guidance and direction. I find I can do more with them that way.

The themes found to be related to personal referent power were the nature of nurses' work, communication, and satisfaction. Effectiveness of nurses' work and degree of satisfaction with nursing were seen as outcomes of referent power while communication was perceived to impact on referent power. The nature of nurses' work and satisfaction were perceived as being influenced by referent power because the advantages of being trusted and respected were actualized. Participants expressed the belief that being trusted and respected gave them power to make their work more effective. Trust and respect contributed to the level of confidence and degree of pride in their work.

Communication was perceived more as an influencing factor on the degree of referent power. Communication patterns in the agency were considered to promote this source of power. Participants expressed support for the communication systems in place.
When participants were asked to identify their sources of power, referent power, or being trusted and respected by others was not mentioned. The descriptions of their work environment indicated they did recognize the value of referent power but this was not considered a significant source.

**Personal Expert**

When the nurse exhibits competence in performing certain aspects of the job then personal expert power is available (Randolph, 1985). This investigator was looking for ways the nurses in the sample considered themselves experts and to what extent they felt they had knowledge that was important to others in performing their jobs. Themes found to be related to personal expert power were recognition, nature of nurses' work, and control.

Recognition of expertise and the nature of nurses' work were found to be factors contributing to participants' perceptions of their expert power. Recognition of others' expertise was relatively easy for participating staff nurses, but what was more difficult for them was to determine how, for individuals, this translated into organizational power. The nature of nurses' work was perceived by most of the nine studied to give nurses a chance to use their personal expert power. Participants recognized nursing knowledge went into drafting care plans.
and expertise was valued when providing client care. The fact that nurses had knowledge of interventions to achieve optimal client health was recognized by some as powerful in its importance to ancillary disciplines. Even though nurses have always had this potential power one participant felt that only recently were nurses able to use it.

I think nursing is better. We can participate more. Have more to say....As nurses we tended just to sit back and let the others run the show.

Nursing knowledge of the total person on a twenty-four hour basis was recognized by some participants as a potentially powerful factor. However, all nine participants expressed the belief that too much time was spent doing non-client focused tasks. Time spent away from direct client care was perceived to diminish nurses' expert and legitimate power. With the perception of a diminished expert and legitimate power base, nursing satisfaction was decreased.

In response to the question of how much control nurses have in their work, personal expert power was not mentioned. Making suggestions based on nursing knowledge to physicians or at team meetings was not always perceived as giving nurses the power to have input into decision making. Hence, while the nurses studied did recognize the power of expertise they had difficulty identifying ways this impacted on the client care they provided.
Many participants perceived others to have more expert power than themselves and were more comfortable recognizing expert power of others, like the nurse clinicians. Nurse clinicians were considered by the staff nurses to be specialists in their area of practice. During this investigation the employment status of the nurse clinicians changed to part time positions and participants began to verbalize the power inherent in that role. While the nurse clinicians were working full time participants did not perceive the power that the clinicians' expertise warranted. These nurses had become conditioned to gaining input from the clinicians without considering how the role of the clinician impacted on the unit. Once the clinicians were reduced to part time and the participants lost that resource, the sudden diminishing of power caught their attention. One participant stated:

I'm certainly not pleased with them cutting out the senior resource nurses, the instructors that we have, because they are such a great resource for this hospital.

Their value to the staff nurses appeared to increase as nurses recognized the power of their expertise.

In response to the question about their sources of power, one participant did respond that nursing knowledge was a source of power. This participant thought nursing experience was recognized by physicians and others, and that this influenced the degree of input nurses had. Other
participants recognized the value of nursing expertise as a source of power but they had difficulty expressing how this impacted on client care.

**Positional Reward**

The potential for reward power exists when the nurse exerts control over something valued by others such that the nurse is able to reward other people for desired behaviour (Randolph, 1985). This investigator examined how the nurse would be able to reward someone the nurse thought had done a good job. The extent to which participants recognized this source of power was limited. The theme of recognition was found to be related to this source of power but not in an empowering way.

Typically the nine nurses perceived reward power to be an authority position based source of power. Head nurses and directors of nursing were perceived to have positional reward power. Participants expressed more desire to be rewarded by superiors than to be rewarded by peers or to give reward. One participant referred to positional reward power when describing the control available to the charge nurse to delegate responsibilities. Hospital based awards or prizes did not contribute to the participants' sense of power since only a few nurses had received awards; the participants did not feel this process influenced them personally.
Giving peers positive feedback through verbal praise was the most common way participants perceived nurses give recognition. Creating a supportive team environment was another method of recognition mentioned. However, participants did not perceive this to be a factor impacting on their power. No participants mentioned the power inherent in rewarding clients by recognizing their accomplishments. Giving recognition to other disciplines and to head nurses was also not addressed.

**Positional Coercive**

This investigator found that coercive power was also presumed to be a source of power only for those in positions of authority. Coercive power exists when the nurse has the ability or influence with the person who has the ability to punish people for not doing what the nurse wants (Randolph, 1985); thus it was important to look for the extent to which participants took action if someone made an error or broke a rule.

In response to the question "What would you do if you discovered a nurse had made an error?", participants replied that they would speak to the nurse and then fill out an incident report form. No ability to reprimand the other nurse existed except by giving negative feedback. No participants mentioned the possibility of giving each other constructive feedback. Many participants implied that they
were uncomfortable with this source of power and rarely used it unless something severe occurred. The head nurse was perceived to have this source of power.

Position Legitimate

Legitimate power exists when the nurse is perceived to have the right to influence others based on the staff position she holds on the unit (Randolph, 1985). This investigator analyzed in what circumstances those nurses in the sample used their position to get someone to do some tasks and to what extent others had a duty to follow the nurses' requests. Participants indicated this was a source of power that they did not often consider and that they were uncomfortable discussing. Upon analysis, the related themes were found to be communication, the nature of nurses' work and control.

Most of the nurses studied did recognize the potential power in collegial relationships as they influenced team decision making. However, participants felt blocked in their ability to use legitimate power when communication and decision making were taken over by others. Participants stated that head nurses chaired many of the meetings and liaised with others. The participant who worked on a unit using primary nursing indicated she had autonomy to plan care and responsibility for individual clients. Primary nursing was perceived by this participant to strengthen
legitimate sources of power for nurses. However, for most of the participants, being responsible for clients and the task of writing nursing care plans were not perceived as sources of legitimate power. Care plans were viewed as tasks, not as a process of controlling care.

As discussed under the theme of control, participants had difficulty recognizing their ability to control their own practice or to influence others. Also, legitimate power in relation to clients was never mentioned by participants. The nurse-client relationship was described as one in which nurses influenced clients to do something to improve their health. Teaching clients about their treatments and about their general health were given as two examples of this. Most participants recognized that nurses influence decisions clients make about lifestyle changes. However, looking to clients as a source of power was not considered by the participants.

When asked to list their sources of power, the level or responsibility and accountability as staff nurses was not mentioned. The data indicated that participants' perceptions of the nature of nurses' work, especially in relation to non-client focused tasks, negatively impacted on their sense of legitimate power.
Organizational Information

For organizational power based on information the nurse has access to information or knowledge that is of value to others (Randolph, 1985). This investigator examined what kind of information these nine nurses had access to, and whether that information was needed by someone else. This investigator was seeking what ways others depended on the participant for information. This investigator observed that the concept of information was one the participants felt comfortable discussing. They did not request that the questions about information be clarified and they exhibited a sense of pride in relating their interactions. When asked during the second interviews what their sources of power were, several participants stated information and documentation.

The themes communication, the nature of nurses' work, satisfaction and control were found to relate to this source of power. Communicating information was the main reason given for interdisciplinary and peer interactions. Charting, meetings, phone calls, audio-taped report and the kardex were the media participants reported were used to transmit information. Participants recognized that information was sought by physicians and other disciplines to provide background for treatment plans. This sample of nine staff nurses also thought information was sought between nurses to provide continuity of care between shifts.
and to supplement nurses' knowledge of particular clients. Communication and the nature of nurses' work were found to be strong contributing factors for the information power of the nurses in the sample.

Priorizing information was given by only one participant as a way nurses gain control of their care. The manner in which information was presented to others was not mentioned as a control mechanism for nurses. When asked to identify ways they controlled their work, information processing was not mentioned by participants. Two participants felt that when information was presented it was not always received the way they expected. Their descriptions implied they were presenting information that had not been processed. The process of interpreting information using nursing judgement and then transmitting information based on this nursing judgement was not mentioned in connection with control of client care.

Even though the potential for using information power to control client care was not recognized, participants still felt information power was important to them. The factors of communication and nature of their work were perceived as important influences on information power. Next to personal power, information power was most frequently mentioned.
Organizational Connection

Organizational connection is a source of power when the nurse links with other people in the organization (Randolph, 1985). This investigator explored who the participants had contact with in the agency and to what extent they were involved in hospital committees. Committee participation was chosen by this investigator as an indicator of the nurses' broader connection within the hospital. The themes communication, nature of work, satisfaction and control were found to be related to this power source.

Nurses were reported to connect with people with whom they needed to communicate information about client care. Participants listed nurses, physicians, administrators, dieticians, pharmacists, occupational therapists, physiotherapists and social workers. Frequently these professionals were described in an impersonal fashion indicating the participant did not have a personal relationship with the individual. Participants did not recognize the value in connecting with people for purposes broader than direct client care. Influencing policies within the agency was not mentioned as an outcome of connection power.

Participants' involvement on nursing and hospital committees was limited. One individual in the study was a member of the nursing retention committee and the other nurses were aware of this committee and its goals. When
asked to name a committee they would like to be involved in, most participants could not give an answer. Some stated they did not know what committees were available. Others stated this was not something that interested them. Knowledge of the committee system and visibility of staff nurses on these committees were not recognized as a potential source of organizational connection.

When questioned about their sources of power, one participant mentioned that a sense of unity amongst nurses on the unit was significant. Those participants working within team nursing systems did perceive that the support gained through this connection was a source of power. At the unit level, participants recognized the power of connection even though they did not perceive this in a broader perspective.

Organizational Resource

The power source of organizational resource refers to when the nurse controls the supplies, equipment, and budget of the unit (Randolph, 1985). This investigator analyzed the input the nurses studied had into the availability of supplies, equipment and staff. Recognizing that resources are often management controlled, this investigator also examined how participants influenced the person who had control of the supplies, equipment and staffing. This related to the theme of resources.
Generally participants stated they had no control over unit resources nor over the person who does control resources. Head nurses were not perceived by participants to have control, hence influencing them was not perceived to affect resources. The hospital budget and government funding were considered to have control of resources. Influencing these factors was perceived as beyond the scope of power of the staff nurse.

Not only was organizational resource not perceived as a source of power by these nurses but it was seen as a source of powerlessness. Without adequate supplies, equipment and staffing participants felt quality of care was jeopardized and their ability to control their work limited. In describing their work day, participants indicated they were so busy that they did not have the time or energy to plan care.

**Personal Sense of Self**

Upon analysis of the data, this investigator discovered that participants perceived a source of power that did not fit Randolph's (1985) framework. This was confirmed when during the second set of interviews several nurses responded to the question on sources of power by stating power comes from the person himself. The implication was made that personal attributes were powerful regardless of the individual's relationship with others. The themes most
strongly linked to personal sense of self were recognition, nature of nurses' work, satisfaction and control.

The nurses in the sample indicated they valued personal attributes that contribute to nursing expertise. Kindness, caring, patience, conscientiousness and ability to relate to clients were personal attributes mentioned. Some participants admitted they felt proud and confident about their work. They perceived their power existed in relation to the strength of their character. Hagberg (1984) described this as self-actualization. Nurses in the study had strong beliefs about what it meant to be a nurse and what was nursing practice. For many this was interpreted as valuing "bedside nursing". Personal sense of self was considered a factor in relation to nurses' power to deal with work issues. While most participants thought personal power was a significant source of power, other participants who felt they had not been able to practice nursing in a professional manner, felt this was not a strong source of power.

Participants who did not feel personal power was available, described physical and psychological pressures that they perceived prevented nurses from meeting client needs. Nursing was perceived as a physically demanding profession: complicated by the preponderance of shift work. Deadlines, increasing client acuity and being short staffed had caused changes in the sense of self-actualization for most nurses in the sample. Participants described
experiencing a personal sense of failure if they were too busy to do all the "ought to be dones" and hence could not meet client needs.

As discussed under the theme satisfaction, the degree of personal satisfaction with the profession varied. Views of the profession as a whole impacted on personal sense of power. One participant who had decided to leave nursing did so because she no longer had a sense of her identity as a nurse. Lack of satisfaction with nursing as a profession decreased her sense of personal power. She felt personally powerless to help clients.

A positive personal sense of self was perceived by most of the participants to empower them to control their work by enabling them to utilize other sources of power. Having a personal power base was perceived as enhancing referent, expert and legitimate power bases. Whether it was through meeting clients' needs or organizing themselves, these participants felt capable of tackling change.

Summary

The perception of the suitability and accessibility of the sources of power bases for nurses has been examined using a grounded theory research design. From the collection of statements made by nine staff nurses, six themes were identified. The themes nature of nurses' work, communication, recognition, satisfaction, control and
resources were found throughout the data. When comparatively analyzed with the conceptual framework, these themes became factors in participants' perceptions of their power bases. The nature of nurses' work was found to be the environmental factor most frequently associated with power. It was perceived to positively influence referent, expert and informational power. As well, for some participants the nature of nurses' work positively influenced a sense of personal power. The nature of nurses' work was perceived to be a negative factor when non-client focused tasks and lack of individual responsibility inhibited legitimate power.

Communication was also found to be frequently linked with participants' perceptions of their power bases. Communication was perceived to have the potential to positively influence information and connection power. The degree to which participants felt communication was effective, varied. Recognition and satisfaction were not found to be perceived as significant factors influencing power. Participants related expert and reward power more to recognition of others than of themselves. Satisfaction with nursing as a profession was described by participants as more of an outcome of power rather than a contributing factor.

The theme of control was not perceived as a strong determinant of power bases. Participants appeared uncomfortable with discussing this concept and lacked
understanding of its implications. The connection between lack of control and the nature of work issues was not made by participants. Lack of control was found to negatively influence legitimate power. One area participants all indicated they felt no sense of power was in relation to their lack of control over resources. These two themes were perceived to contribute to a sense of powerlessness.

The findings of this investigation indicated that this sample of staff nurses did not recognize all the sources of power available to them. Of the eight power bases outlined in the conceptual framework, participants recognized factors in their environment influencing four potential sources: personal referent, personal expert, organizational information, and organizational connection. Positional reward, coercive and legitimate, along with organizational resource, were not perceived to be sources of power for nurses.

Data within themes that did not relate directly to the eight power bases were examined as a group and were found to reflect another source of power. This power base has been entitled personal sense of self. Personal power was most frequently mentioned by the participants as a source of power for nurses. A strong sense of personal power was perceived to positively influence several other power bases. These findings and the implications arising from them will be discussed in chapter five.
Chapter V

Conclusions and Implications

The question addressed in this investigation was how staff nurses perceived their power bases within their work environment. The findings of this investigation indicated that the nurses investigated were able to perceive certain sources of power while other sources were not apparent to them. This chapter presents the major conclusions of this investigation and identifies implications for nursing.

Major Conclusions

Power is important to nurses working in complex organizations because it influences the delivery of client care and the degree of job satisfaction. However, little is known about staff nurses' perceptions of their power. This investigation examined the perceptions of nine staff nurses about their power bases. Conclusions drawn from the analysis of data included the following:

1. The nine staff nurses were cognizant of factors in their work environment that impacted positively on their sense of power. These nurses were also aware of factors contributing to a sense of powerlessness.

2. The nature of nurses' work and communication were two significant environmental factors impacting on these nurses' perceptions of their power bases.
3. The concept of control over decisions affecting client care was not well understood by the nurses. The degree of control nurses had over client care was not recognized as a source of power.

4. Randolph's framework was one way of understanding the power bases available to nurses. Of the models of power described in the literature review, this conceptual framework provided the broadest organizational perspective of power.

5. The eight power bases in the conceptual framework were not equally important or available to staff nurse participants.

6. The nurses investigated recognized and felt the most affinity for four of the eight power bases outlined in the conceptual framework: personal referent, personal expert, organizational information, and organizational connection.

7. Personal sense of self was itself considered to be a source of power.

8. The degree of personal power felt by the nurses studied influenced their satisfaction with nursing.

9. Other sources of power existed for these nurses as evidenced by the themes described in the nursing care settings studied.
10. Nurses did not recognize certain power bases available to them: positional reward, positional coercive, positional legitimate, and organizational resources.

**Implications for Nursing**

Although the data analyzed cannot be generalized past the nine staff nurses studied, the findings of this investigation suggest implications for nursing. The four main implications drawn from this investigation are related to the theme of control, the power of personal sense of self, the processing of information and the need for connections. The findings also have implications for the need for further nursing research.

**Control**

The findings of this investigation indicate that factors in the nursing practice setting affect staff nurses' perceptions of their power to influence client care. According to the findings of this investigation, certain factors within the nurses' work environment limit nurses' perceptions of their power bases. Positional legitimate power is not perceived as a source of power when nurses work in a team nursing system or when they delegate responsibility for client care to their head nurse. Primary nurses perceive this as a source of power because they have the responsibility to control the care for assigned clients. Primary nurses perceive they have the power to influence
decisions affecting the care of their clients as a function of their legitimate position as staff nurse. A modified team approach was reported by participants to promote legitimate power to some extent. Nurses responsible for the coordination of care for assigned clients may find it easier to accomplish their workload on a daily basis when they function under a team approach. In modified team nursing, nurses don't give up legitimate power because they are responsible for particular clients. What they gain is the support of the nursing team to accomplish the physical demands of the job. This connection with the nursing team reinforces the power of connection but weakens the sense of legitimate power.

The legitimate power base could be a strong source of power for staff nurses if nurses could recognize the potential control they have over their nursing practice. Nurses have potential legitimate power over decisions affecting client care based on their responsibility to provide care. Applying nursing theory and developing nursing diagnoses are potentially powerful actions. The concept of primary nursing is based on a positional legitimate power base. Even in team nursing, nurses are assigned to monitor and plan care for clients on a daily basis. Staff nurses are able to describe their responsibilities and opportunities for input into decision making but do not feel these give them control. Factors in
the environment such as lack of consistent application of the nursing process and lack of recognition of the legitimacy of nurses' responsibilities weakens this power base. Nurses are unable to recognize how to strengthen their control over client care.

**Personal Power**

Staff nurses identify power, not only in their relationships with others, but also in relation to themselves. Personal sense of self is a source of power when the nurse has attributes that characterize a professional nurse. Kindness, caring and conscientiousness are valued as powerful attributes. Although these attributes influence how nurses relate to others, staff nurses recognize them in their own right. Personal sense of self is perceived as a powerful end in itself rather than just a means to an end, i.e. relating to others. The power of self is weakened when nurses feel dissatisfied with the profession and when negative factors such as low staffing levels and high time pressures limit self-fulfillment. The findings of this investigation indicate personal power is an untapped source of power for nurses.

Even though by definition personal sense of self is a source of power that is internally generated, it can be fostered. Nurses who feel they have power because of their personal attributes are generally more satisfied with
nursing. Personal power contributes to a sense of pride about nursing and about work. Nurses feel more in control of themselves so are better prepared to take control of others. Personal power can be fostered through self improvement opportunities, peer recognition and client feedback. Nurses indicate they feel personally powerful when they are allowed to function as professionals doing what they like best: bedside nursing.

**Information Processing**

This investigation's findings showed that communication between nurses, and between nursing and other disciplines, positively influences information and connection power bases. The type of information nurses have access to is valued by others because of nursing's knowledge base and continuity of care. Although nurses are able to perceive the value of information as power, there is a need for nurses to examine how this information is formulated and disseminated. Since nurses recognize information as a source of power, nurses can capitalize on this by improving their effectiveness through the development of consistent information systems. It is possible for nurses to unknowingly give up some of their information power base by giving unprocessed information. There is value in the nursing care plan in delineating the nursing process and thereby documenting and processing nursing information.
Staff nurses perceive organizational information power to be their strongest source of power. The advantages and necessity for communicating information about the client is well known. As resource persons for others, nurses use this source of power to influence changes in client care. Staff nurses feel comfortable with this type of power, possibly because they use it every day. Documenting care both planned and provided is a tangible way that the power of information is actualized. The strength of this power base is weakened when information sharing is done informally or not kept up to date. Nurses perceive paperwork to be a negative factor in their environment when it becomes time consuming or interferes with the provision of client care. Nurses have difficulty recognizing how manipulation of information is a control mechanism.

Connection Power

Opportunities for nurses to connect with other disciplines have been developed. Multidisciplinary meetings and telephone contacts occur regularly. Nurses give up some of this power when they allow others, such as the head nurse or assistant head nurse to connect for them. The full potential of the connection power base is not recognized by nurses. Connecting with other people, even if it is a necessity, is resented if it means taking time away from direct client care. This sense of infringement on their
time makes it difficult for nurses to recognize the value in connecting for reasons other than direct client care. Increasing nurses' visibility and contribution to agency committees would serve to strengthen the power of connection. However, nurses will not feel comfortable with this unless quality client care is assured in their absence.

**Nursing Research**

This investigation used a small sample of staff nurses from a medium sized community hospital in the British Columbia lower mainland. This limits the generalizability of the findings. It would be useful to replicate this investigation in other agencies and with a larger sample of participants to determine if differences in agencies impact on how staff nurses perceive their power bases.

This investigation did not focus on the issue of how staff nurses use their power or to what extent they are able to use their power. Behaviours of staff nurses were not examined. Further research is indicated to describe staff nurses' use of power.

It would be useful to explore each of the power bases individually. The properties of the power bases may not be limited to the themes identified in this investigation. This would lead to further understanding of the factors impacting on staff nurses' sense of power. The power of personal sense of self and the concept of powerlessness have
not been well defined. The data analyzed in this investigation did not go into depth about the personal stages of power identified by Hagberg.

Finally, further research is indicated to determine if efforts on behalf of the nursing profession or the agency to increase nurses' perceptions of their power bases, would influence nurses' satisfaction and retention.

Summary

The findings of this investigation into staff nurses' perceptions of their power bases indicated that the nine staff nurses studied perceived that certain sources of power were available to them based on their personal sense of self and the communication of client information. However, certain sources of power were not recognized by participants, particularly in regards to the nature of nurses' work and nurses' lack of control over client care. These were found to be limiting factors for legitimate power. This has implications for nursing since primary nursing was found to enhance legitimate power and team nursing was found to limit legitimate power.

The conceptual framework was found to be a useful tool for describing nurses' power relationships in an organizational setting. However, the conceptual framework did not adequately describe personal power based on power in relation to oneself. Capitalizing on nurses' sense of
personal power may have implications for nursing satisfaction and retention efforts.

Further research is indicated to broaden the scope of these findings and to describe nurses' use of their power bases.
References


Appendix B
Interview Guide One

You have received an information letter from me. I would like to explore with you your perceptions of your work situation.

General

1. How long have you been a nurse?

2. What type of basic nursing education did you complete? Have you taken any courses since your graduation?
   If yes, explain how this has affected your nursing care.
   If no, what types of courses would you like to take if you had the chance?
   Why would these be helpful?

3. How long have you worked on this unit? What other types of nursing units have you worked on?
   Describe how this unit differs from other units you have worked on.

4. Describe for me a typical day shift for you on the unit.

5. In what ways does your role change on other shifts?

Specific

6. Describe the groups of people within the hospital that you interact with on a regular basis.
   How do you feel when you interact with these people?

7. Describe the ways in which you have control over the care you provide.

8. How would you describe an excellent nurse?
   How are excellent nurses given recognition?

9. What would you do if you discovered that another person had made an error?

10. Are you on any hospital committees?
If yes, what is the purpose of the committees and what is your role?

If no, are there any committees you would like to be a part of and why?

11. If you could change one thing at work what would that be? Why?

Explain how you would go about making that change?

12. Now that you have been in nursing ___ years, what are your thoughts about nursing?
Appendix C

Interview Guide Two

You have received an information letter from me. I would like to explore with you your perceptions of your work situation.

General

1. How long have you been a nurse?

2. What type of basic nursing education did you complete? Have you taken any courses since your graduation?
   - If yes, explain how this has affected your nursing care.
   - If no, what types of courses would you like to take if you had the chance?

   Why would these be helpful?

3. How long have you worked on this unit? What other types of nursing units have you worked on?

   Describe how this unit differs from other units you have worked on.

4. Describe for me a typical day shift for you on the unit.

5. In what ways does your role change on other shifts?

Specific

6. Describe the groups of people within the hospital that you interact with on a regular basis.

   How do you feel when you interact with these people?

7. Describe the ways in which you have control over the care you provide.

8. How would you describe an excellent nurse?

   How are excellent nurses given recognition?

9. What would you do if you discovered that another person had made an error?
10. Are you on any hospital committees?

   If yes, what is the purpose of the committees and what is your role?

   If no, are there any committees you would like to be a part of and why?

11. If you could change one thing at work what would that be? Why?

   Explain how you would go about making that change?

12. Now that you have been in nursing ___ years, what are your thoughts about nursing?
Appendix D

Interview Guide Three

1. Since our last interview, do you have any thoughts or comments that you would like to add to what you said?

2. Who trusts and respects you as a nurse?

3. How does this respect influence your practice?

4. Define nursing care plans.

5. How are nursing care plans implemented?

6. Describe your sources of power at work.