Advances in Social Sciences Research Journal – Vol.7, No.10
Publication Date: October 25, 2020
DOI:10.14738/assrj.710.9291.
Herold-Majumdar, A., Marijic, P., & Stemmer, R. (2020). Organizational Culture Empowering Nurses And Residents In Nursing Homes. *Advances in Social Sciences Research Journal, 7(10)* 590-611.

Organizational Culture Empowering Nurses And Residents In Nursing Homes

Astrid Herold-Majumdar
Munich University of Applied Sciences, Faculty of Applied Social Sciences
Am Stadtpark München, Germany

Pavo Marijic
Helmholtz Center Munich, Institute of Health Economics
Health Care Management, Germany

Renate Stemmer
Catholic University of Applied Sciences Mainz,
Faculty of Healthcare and Nursing, Saarstraße, Mainz, Germany

ABSTRACT

Purpose. If nurses should respect resident´s autonomy, nurses themselves must experience empowerment and respect for their own autonomy in the work environment. The purpose of this study is to get a deeper understanding of nurses' perception of their own empowerment in the organization's culture during an intervention program for strengthening autonomy. Design/methodology/approach. Guided semi-structured interviews and moderated group discussions were conducted before and after the intervention. A structured and evaluative content analysis of the text material were performed. Findings. In total 73 nurses and nurse aids working at frontline with the residents were voluntarily included into the study. New categories for nurses' perceived empowerment and organizational culture could be derived from the text material. Originality/value. The study's results deliver a theoretical model with a sophisticated system of categories for organizational culture as perceived by nurses that can be used for further qualitative and quantitative research and for a sustainable organization development.

Key words: organizational culture, empowerment, nurse, nursing home, autonomy

INTRODUCTION

The possibility of making choices (self-determination and decision making) and being able to implement these choices into daily (work) life practice (executional autonomy) are human rights and prerequisites for a good life (Bölenius et al., 2019; Bollig et al. 2016; Davies et al., 1997). Nurses are obligated to respect this human right and to realize it with individuals in need of nursing care unrestricted by considerations of age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status (The ICN Code of Ethics for Nurses, ICN, 2012).

Autonomy and quality of life are critical outcome factors in long-term care (Edvardsson et al. 2019; Grant, 2008; Koren, 2010; Cohen-Mansfield et al., 2000). In this context, autonomy is understood from a relational (Sherwin and Winsby, 2011) and social constructive (Moebius and Quadflieg, 2011) perspective as something that must be realized in every situation of interaction. If nurses respect patient´s autonomy, nurses themselves must experience respect for their own autonomy in the work environment. Perceived job control can make nurses feel empowered and make them less vulnerable to the adverse effects of high job demands (Kim et al. 2018; Schmidt and Diestel, 2011). Therefore, an adequate range of self-determination in the job context must be implemented into nursing care institutions.

The sustainable implementation of an empowering job environment with high degrees of job control need an organizational culture that supports members' self-determination. Less is known about how nurses' perceive organization's culture concerning their empowerment in long-term elderly care facilities. A theoretical framework with nurse-specific categories is needed to support organizational research in this specific field of work environments.

The purpose of this study was to understand what are the main categories of an organization's culture that are important for nurses to develop their autonomy in work-life. From an organizational research perspective and with an emic approach we tried to get a deeper insight into nurses' perception of the organizational culture change process during an intervention program for strengthening autonomy in the special field of elderly long-term care.

WHAT WE KNOW ABOUT NURSES' EMPOWERMENT

Staff shortage and high turnover rates are challenges for organizations in long-term care. These challenges can be handled by organizational learning and culture change processes. Bjørk and colleagues (2007) identified autonomy as a critical job satisfaction factor other than interaction followed by pay. Nurses´ perceived autonomy is a predictor of nurses´ work satisfaction, intention to leave (Nasabi and Bastani 2018; Rai, 2013; Engström et al., 2011) and quality of work life (McGillis Hall et al., 2006). If autonomy can retain nurses organizations must implement structures and cultures that increase nurses' feeling of self- determination and empowerment. Lived participation and a culture that empowers nurses can improve nurses' resilience against high job demands (Kim et al. 2018; Schmidt and Diestel, 2011).

Empowerment and high job control are strongly related to job satisfaction (Saber, 2014), organizational commitment, and turnover intentions (Lautizi et al., 2009; Wendsche et al., 2016; Zurmehly, 2008). Autonomy is furthermore a prerequisite for nurses´ self-efficacy. Without the feeling of being able to decide and to implement things at least on the operative level, nurses cannot put their own decisions or the shared-decisions with the residents into clinical practice. Decentralized decision making is necessary for a flexible reaction to a resident´s needs and wishes (Ramaswamy and Gouillart, 2010) what is vice versa the prerequisite for residents' autonomy. Furthermore, empowering frontline staff working directly with clients is correlated with effective organizational learning (Mishra and Bhaskar, 2010; Joo and Shim, 2010) and, consequently, with improved outcomes on residents' side (Barry et al., 2005). Hence, nurses´ autonomy and residents' autonomy strongly interact.

There is increasing evidence that nurses' empowerment lead to better outcomes on residents' side but less is known about how nurses perceive their empowerment in an organization's culture environment. Råholm and colleagues (2017) show in their systematic review the four main themes in qualitative research about organizational culture in nursing homes: (a) the organizational culture reflecting an inner commitment to care, (b) an organizational culture reflecting distress and insecurity, (c) the organizational culture reflecting value conflicts, and (d) the impact of organization of care and leadership on the organizational culture (Råholm et al., 2017: 87).

The focus on culture aspects that are influencing nurses' perception of their empowerment as an important prerequisite for residents' empowerment (culture change movement of the Omnibus Budget Reconciliation Act, OBRA 1987, Kelly, 1989) is missing. Balancing effective care routines within an organization that is trimmed to efficiency and core values of the nursing profession's ethics code (ICN, 2012) is a key leadership task (Råholm et al., 2017: 87). Empowering nurses and giving them a decision-making scope is playing a key role here. Hence we need a deeper understanding how nurses themselves perceive their empowerment in an organization's culture for being able to develop this culture to a more participating and strengthening culture for all members of the organization.

NURSES' PERCEPTION OF THEIR OWN EMPOWERMENT AND THE ORGANIZATIONAL CULTURE

Theoretical background and sensitive concepts

Organizational culture is understood in this context as a social control system (O'Reilly and Chatman, 1996), as a phenomenon that is socially constructed with several levels as defined by Edgar Schein (Schein and Schein 2018). Organizational culture is a stabilizing and simultaneously a dynamic construct. As a system of group-shared norms and values that are guiding attitudes and behaviors (social control system) culture can instill a sense of security and stability for the group members. Culture itself has also a dynamic aspect in the sense of learning initiated by new challenges that must be handled to survive as a group or an organization.

From this point of view organizational culture is strongly connected to organizational learning (Schein, 1993). Schein's three level model of organizational culture (Schein, 1984) try to explain the phenomenon as something that is visible and touchable (artefacts) but also intangible. The philosophical basic beliefs that are underlying the values and norms are generally not conscious. Whereas the norms and values are often explicitly stated in the mission statement of organizations. They can even appear physically in artefacts. If the appreciation of frontline worker's services is a core value of an organization the management may express this by gestures such as installing coffee machines where staff members can have coffee for free. These coffee mashines can stand for a frontline staff-oriented organization and symbolize organization's culture as an artefact. Organizational culture can empower or depersonalize its members.

Empowerment mean participating in organizational decisions to an individual and an adequate degree. Psychologically empowered nurses perceive self-efficacy. Self-efficacy means working on solutions to professional problems and experiencing that these solutions can be implemented into clinical practice and change clinical practice.

For a sustainable implementation of nurses´ autonomy and psychological empowerment an organizational learning and cultural change process must occur. The intervention program of this study was implemented to initiate such an organizational learning process. A learning organization requires a culture that enables and encourages its members to learn (Murray and Chapman, 2003: 275); in this case, this means learning how to realize autonomy in the daily life and work practice of a residential home. Organizational learning is an individual process for its members and a group process supported by organizational structures, organizational culture and by processes (Murray and Chapman, 2003). Because of the study´s intervention program, a single-loop learning (Argyris and Schön, 2018: 35) process was initiated. Organizational learning and organizational culture change processes are specific and are dependent on the organization's living world, that is to say members' perception of the organization as a living and working environment.

Nurses' living world and work environment in long-term elderly care facilities – the research field

Long-term elderly care facilities are special work environments with specific work load and challenges for frontline staff working directly with persons of advanced age and in the need of nursing care. <<The nature of long-term care>> (Kane and Kane, 1988: 133) compared to acute care settings is a longer time horizon that offers on the one hand an opportunity for quality assurance and deeper relationships between the nurse and the person in the need of nursing care. On the other hand frontline staff has a high psychological distress because they share everyday life for a whole stage in life with persons with severe physical and cognitive impairments. Nurses are often important related persons. In some cases they are the only contact partners for residents. Balancing professional distance and personal closeness is a challenge. Realizing residents' self-determination and quality of life in everyday life as important outcomes in long-term care (LCT) is a high job demand for nurses.

Nursing homes are not only places of medical treatment and professional nursing care, nursing homes are primarily places where people with long-term care need find their center of life and a place to live. Realizing privacy, one´s own life style, the feeling of being at home and of being safe are in the forehold whereas medical treatment and nursing assistance are in the background. Nursing in LTC is normally less specialized and workload is high. Sometimes there is a big range of the specification of professional tasks, from support with daily living to the management of home mechanical ventilation. In Germany the staff in nursing homes is highly skill-grade-mixed. There are geriatric nurses and general nurses with a three years course, nurse aids with a one-year course and everyday companions without any qualification in the medical field. Nurses with a Bachelor´s degree are very rare in those teams. Historically nursing care in nursing homes is regarded as less qualified than in hospitals. Relatives and family caregivers play a major role not only in the homecare setting but also in nursing homes. Family members often manage the nursing care at home over a long period before they decide to bring their dependent relative into a nursing home. The decision is often associated with feelings of guilt that can be conveyed onto the nurses. Family caregivers feel as experts for the care situation of their relative in the need of nursing care and want to give their expertise to the nurses.

Additionally there are high demands for nursing care in long-term care facilities from external quality control authorities. Home supervisory authorities, nursing care and health insurances who are paying for the services are inspecting regularly quality of nursing care in LTC facilities. External

quality control teams stay only for one or two days in the nursing home and meet residents for a few minutes to get an impression of their health status and of nursing care quality. Care arrangements and residents' nursing care need are often highly complex so it cannot be judged within a short time and on the basis of few information. Nurses feel their services frequently judged false and not valued by these authorities. These are some reasons why nurses in LTC facilities are at high risk of decreased autonomy.

For better understand how nurses themselves perceive their autonomy concerning professional decisions in their work life and how they experience organizational culture during an organizational change process with the aim to improve autonomy a qualitative research approach was chosen. The study was conducted in four nursing homes from February 2016 to February 2019 during an intervention program comprised nurses' training in autonomy and the introduction of nurses' peer group supervision (Benshoff and Paisley, 1996). In the peer-group supervision meetings nurses and nurse aides should learn about solving professional problems at the service encounter by themselves to strengthen their professional autonomy and their feeling of self-efficacy. Peer group supervision follows a systematic six-step structure and has pre-defined roles (Tietze, 2010).

The nurses should have met a minimum of once per week to discuss professional problems. The discussions were moderated, and the results were documented. Support was provided by two research associates to organize and moderate the peer group supervision meetings during the whole study period. One research associate was a male nurse specialized in elderly care and held a Master of Nursing Science. The other research associate was a male nurse for general care with a Master of Public Health. Both research associates were not staff members of the nursing homes participating in the study. On-going and ex-post evaluation was conducted during the intervention phase.

Sampling strategy

The participating long-term care facilities voluntarily applied to the study after being asked by the project leader. An ethical clearing of the study design was ex-ante given by the German Society of Nursing Science (application number16-005a). Residents were not directly affected by the study. Nurses and nurse aids were informed by written information sheets and by information events and were asked to participate in the study. They took part in the study voluntarily and could leave the study and interviewing process at any time.

Nursing homes of diverse sizes (e.g., number of beds), diverse sponsorships (two private, for-profit organizations and two not-for-profit organizations), and diverse locations (rural and urban) and of two German federal states (Bavaria, Rheinland-Pfalz) were selected for the study (heterogeneous sample). These diverse structures of the participating organizations should help to obtain deeper insight into diverse organizational cultures influenced by the environmental cultures (e.g., rural and urban environment), the size and sponsorship. Wendsche and colleagues (2016) showed that the intention to leave the job, job demands, and job control vary in for-profit and nonprofit nursing homes and home care services. Hence, the sample was built heterogeneously concerning some organizational characteristics but homogeneously concerning the setting (long-term elderly care), population (individuals with long-term care needs and of advanced age), and the participants (nurses and nurse aides). Inclusion criteria were predefined for the sampling of the participants. Nurses (general and geriatric nurses with a minimum 3-year vocational training program) and

nurse aids (with a one year training program) had to be employed in the nursing home for a minimum of half a year to have an insightful perspective of the organization's culture.

Participants from diverse units of the participating nursing homes were included in the study. The total number of n= 73 nurses and nurse aids (N_{t0}= 137 and N_{t1}= 146 nursing staff in total) participating in the study resulted from a three-step process following the hermeneutic circle: 1. information and akquision of participants who voluntarily took part in the study 2. single interviews and group discussions with the help of a theory-based, pretested guideline at t_0 3. revision of the guideline for a second round at t_1 of interviewing and group discussions on the basis of the results of the first data collection at t_0. A third round was planned but not realized because of the text material at t_1 did not show new aspects of nurses' perception of organizational culture. Data saturation could be hypothized at this stage of the study.

Methods used

Organizational change processes such as increasing nurses' work autonomy by particular interventions are long-ranging processes leading as mediators to quantitatively measurable outcomes. Sustainable organizational changing processes are accompanied by the transition of an organization´s culture and by organizational learning. We posit that an explorative and interpretative approach is appropriate to improve the understanding of how nurses experience this organizational culture change process and what the specific phenomena of organizational culture concerning nurses' self-determination in nursing homes are. The primacy of the raw data from the field in the analytical process of a qualitative approach guarantees a consequent view from an organization member´s perspective.

With this emic perspective, a deeper understanding of what organization culture means to its members´ autonomy in long-term care facilities can be gained. A phenomenological approach is required to determine the specific and phenomenological characteristics of a residential home´s culture and of nurses´ perception of their empowerment.

Guided, semi-structured interviews and moderated group discussions were conducted before (t_o) and after the intervention (t_1). The guidelines and planning of the interviews and group discussions were pre-tested. Interviews and group discussions in the main study were audiotaped, were transcribed verbatim, and a protocol was written during the group discussions. Participants´ sociodemographic data was collected after the interview and after the group discussion.

All audiotaped interviews and focus group discussions were transcribed verbatim by hand by an external typing office using VLC Media player and considering predefined transcription rules. Nurses and nurse aides with a migration background and fewer language skills in German participated in the study. Their original formulations of the answers in the interview and of the contributions to the focus group discussion were transcribed without smoothing the text. Dialect was not eliminated because the in-depth meaning of words in the original dialect cannot be substituted by standard language.

After the transcription of the audiotaped interviews, a content analysis was conducted with a deductive–inductive approach by following Mayring´s (2016) qualitative content analysis with a computer-based (MAXQDA Plus 12©, Verbi Software, 2016) structuring and evaluating (scaled

categories) approach (Kuckartz, 2014). The theory-based, sensitizing concepts were used to deductively structure the text material. Simultaneously, an open approach to work with the original text material was conducted. Subcategories were inductively gained from the text material that could not have been associated with the deductive categories. These setting-specific categories allowed a phenomenological and deepened description of nurses´ perception of organizational culture and of their own empowerment. A sophisticated category scheme with clear coding rules for each category and exemplary key quotes was developed within a multistep consensus process between three coders. The coding tree can be reproduced in the code theory models (fig. 4 and fig. 5). For the analysis of the focus group discussions, the same category system of the single interviews was used but without the evaluative categories because no group consensus about the evaluation level could be assumed.

Hermeneutic Circle

The hermeneutic circle was realized in this study by first of all structuring the interview and focus group guidelines on the basis of the underlying theory and sensitizing concepts (deductive approach) shown under chapter 3.1. The first draft of the category scheme was also built by these sensitizing concepts. With an open approach during the content analysis of the text material, more detailed subcategories were created inductively from the text material. In a second and third round of material analysis these inductive subcategories were used. The inductively built categories and their wording are very close to participants' living world and perspective as the key quotes show.
reflexivity

All coders were nurses, one coder was female, a nurse, and an undergraduate student in nursing science. The second coder was male nurse, and held a Bachelor´s in Nursing Science and a Master's degree of Public Health. Both coders had less experience in long-term elderly care. The third coder was a female nurse, a senior lecturer in nursing science and the project leader. She had more than 20 years of experience in long-term care of aged individuals in nursing homes and in-home care settings as a nurse, head nurse, an auditor, and an external consultant. The project leader did not collect data in the field but supervised the consensus conferences during the coding process. Before rating the whole text material, the inter-coder reliability was calculated and reached 93% after a multistage consensus process.

Implicit and explicit assumptions were reflected by the coder-team during the long-ranging consensus process. These reflections and memos during the coding process helped to control the transmission of the coder´s own experiences onto the text material of the field. Each coded sequence was weighted concerning the coder´s estimate regarding how strongly the text passage matched the category as it was predefined. The weights were useful for choosing adequate and convincing quotes for the explanation and validation of the categories.

DATA SET

Characteristics of the participants

Characteristics of the participants of the single interviews

At baseline (t_0), 13 individual interviews (with five nurse aides and eight nurses out of N = 62 nurses and N = 75 nurse aides) were conducted. Eighteen months after the intervention (t_1), 12 individual interviews (with five nurse aides and seven nurses out of N = 76 nurses and N = 70 nurse aides)

were carry out. The mean duration of the individual interviews was 42 minutes. Participants´ characteristics at t_0 and t_1 are shown in table 1.

Table 1: Individual interview participants´ characteristics at t_0 and t_1

	Total	**T_0**	**T_1**
Absolute number of participants	N=25	N=13	N=12
Age			
Mean (sd)	41,2 (11,5)	44,0 (12,7)	38,4 (10,1)
Median	38,5	49,0	34,5
Min - max (range)	22 - 61	22 - 61	26 - 53
Gender			
Male (%)	5 (20,0)	2 (15,4)	3 (25,0)
Female (%)	20 (80,0)	11 (84,6)	9 (75,0)
Qualification			
(geriatric or general) nurse (%)	15 (60,0)	8 (61,5)	7 (58,3)
Nurse aid (%)	10 (40,0)	5 (38,5)	5 (41,7)
Working hours			
Full-time (%)	20 (80,0)	11 (84,6)	9 (75,0)
Part-time (%)	3 (12,0)	2 (15,4)	1 (8,3)
Period of employment (in months)			
Mean (sd)	71,0 (54,2)	75,9 (56,0)	64,3 (54,1)
Median	60,0	60,0	50,5
Min - max (range)	7 - 216	14 - 216	7 - 113
Employment status			
Temporary worker (%)	0 (0,0)	0 (0,0)	0 (0,0)
Staff member (%)	25 (100,0)	13 (100,0)	12 (100,0)

Characteristics of the participants in the group discussions

In total, n = 28 nurses and nurse aides joined four group discussions at baseline (t_0). Mean number of participants in each group was 7.0. Participants´ median age was 35 years. Mean duration of the group discussion was 65 minutes. Mean period of employment was 34.3 months (approximately 3 years). Eighteen months after the intervention (t_1), n = 20 nurses and nurse aides joined the four group discussions. Mean number of participants in each group was 6.7. Participants´ median age was 42 years. Mean period of employment was 91.5 months (about 7.6 years). Concerning the median age and the mean period of employment, the sample from the focus group discussions is not comparable between t_0 and t_1. Due to fluctuation, we could not include the same individuals from the baseline sample in the study at t_1. The basic assumption of the qualitative study was that organizational learning and cultural change processes are systemic processes that can be understood as group processes independently from an individual´s perspective.

Text material and codings

The analogous English translation by the first author and not the original German text of the key quotes is cited. Insertions marked by squared brackets are made by the author. In brackets behind the quote, it is indicated if the quote is a citation from a single interview “I” or from a group

discussion "GD," and it is identified if the quote is from t_0 (baseline) or from t_1 (after the intervention) material. Due to anonymization, the abbreviations of the institutions and the codes of the participants are not shown. Results are shown from the structured content analysis and from the evaluative content analysis of the scaled categories. The absolute number of encodings is mentioned to provide an impression of how intensively topics were discussed in the interviews and group discussions.

Table 2 shows the categories inductively gained from the text material before (t_0) and after (t_1) the intervention. The categories of nurses´ perception of organizational culture show a greater variety and new aspects after the intervention (t_1).

Tab. 2 Inductively created categories of nurses´ perception of organizational culture before (t_0) and after (t_1) the intervention

Categories of organizational culture at t_0	Categories of organizational culture at t_1
no confidential handling of information in the team, speaking behind another´s back	constructive, professional and objective atmosphere
	contructive solution of conflicts by talking each other
high staff turnover and bad working atmosphere	staff´s problems and concerns are solved proactively
	flexible shift planning and scheduling
inflexible structure of the organization	no consistent handling of conflicts
bureaucratic structures	memos for the schedule without brakes
self-centredness of the wards	case discussions of new, incoming residents are important
no consistent handling of conflicts	no hierarchical differences between nurses and nurse aids
continuous coming and going of staff members and residents	solution-oriented working
	positive feedback and praise
	frontline staff participates in operative decisions but not in strategic decisions
	clearly structured daily routine
	staff is protected by the leaders for example against violent colleagues or complaining family caregivers
	gossiping
	new staff members must subordinate in the daily routine and in the hierarchy
	In the case of problems the hierarchical way is clear
	colleagues care for each other and aware of work overload
	feeling of being stucked, no change even the head nurse has no influence on changing things
	a hard core of staff members but also a high turn over
	not being resentful
	a friendly relationship among colleagues and even with superiors and clearly defined limits
	culture of handling mistakes: mistakes are discussed in the shift handover. After that everything is done.
	low willingness to help each other
	pressure to justify material consumption
	lack of adequate salary and working material – no matter where you look, everywhere shortage

Organizational learning promoting and hindering categories were gained from the text material at t_0 and t_1. Subcategories of organizational culture gained inductively from t_1 material show additionally important principles of the peer group supervision concept compared with the baseline (t_0) material. The following key concepts indicate nurses´ awareness of the principles of the peer group supervision principles: "*constructive and proactive problem solving*,"

> *"the importance of case discussions before a resident moves into the home," "no hierarchical differences between nurses and nurse aides," "solution-oriented working," and "colleagues are caring for each other and are aware of work overload."*
>
> *"Togetherness, uh, (1) that we discuss all the issues. That we, uh, enlighten the whole situation between us, that we say, for example, The resident, what are we doing there? Let's do it this way or otherwise." (I_t_1)*

Participants´ readiness to solve professional problems together with colleagues is clearly expressed in this quote. The feeling of being able to solve problems is observed in the formulation "*we clear up the whole situation between ourselves*." The intention of the study intervention programme was to strengthen the self-efficacy belief of nurses and caregivers through the self-determined solution of professional problems.

Before and after the intervention, the reduction of the material also shows categories that are not supporting a culture of nurses´ empowerment: for example, "*low willingness to help each other*" and "*feeling of being stuck, no change even the head nurse has no influence on changing things*."

> *"Or to give away your own (3) wishes, so if I say that the ward should be (2) changed or with uh (1) equipped differently, that we make changes, because I come for example not far. (1) So I've learned the geronto specialist and then (1) you learn a lot or should you implement many things, I was suggested, but then I come with a proposal, then it will be rejected. (1) And I just cannot develop that way. So I'm already working here (3), yes, roughly according to the guidelines. (1) So you cannot bring in much yourself, it's just a lot (2) rejected or there's no time for it. [to implement new things]." (I_t_0)*

In this quote the participant describes an organizational structure that does not support an organizational learning process concerning increasing autonomy. The nurse participated in a further training program for gerontological psychiatric nursing and wants to contribute new ideas and knowledge gained in this external training program into the residential home. But she/he experiences the rejection of these new ideas. The nurse does not express any feeling of self-efficacy concerning the implementation of new ideas. In this quote, a type of frustration about the refusal of suggestions for improvements is expressed.

The quote does not mention if the suggestions for improvement were refused by colleagues or by executives. An organization unable to integrate new knowledge or innovations of members who completed an individual learning process is missing opportunities to develop and to initiate an organization-wide learning process. Furthermore, the staff member who completes further training and is motivated to improve service becomes frustrated and feels they have failed. Feelings that are not supporting the perception of psychological empowerment.

Nurses´ perception of their psychological empowerment

In total n = 116 text sequences could be coded under the category "motivation and incentives" from the text material of t0 and t1. "Feeling as a team and helping each other," "getting objective and personal feedback," "having fun at work and humor," "getting opportunities for learning and maturing as qualified nurse," "being taken seriously by peers and by the head of the nursing home," "experiencing care of the superior (e.g., the head nurse) and recognizing symptoms of excessive work demand by the head," and "having career opportunities" are critical, inductive categories of motivation for the participants. "Varying work tasks" were perceived as motivating, as indicated in the following quote:

> *"Because (1) every day is different (1), for the people who are old, not every day is the same, which makes the job beautiful too, (1) because every day (2) something new occurs with the residents. And, and (2) er, therefore, that's (2) quite interesting then too." (I_t$_0$)*

The diversified tasks of a nurse in a long-term care facility seem to be an incentive for the participants. An interesting job is motivating, and in this quote, the nurse expresses a preparedness for the everyday challenges with the resident. In this sequence the nurse brings the characteristics of the job together with the motivation and with psychological empowerment (a feeling of being able to cope with the everyday challenges). Motivation is a crucial factor for nurses' perceived empowerment and for organizational learning.

The *understanding of good teamwork* is also a subcode of the category nurses´ psychological empowerment. Standing together in a skill-grade mixed team makes each team member feel empowered and able to handle professional problems and challenges. Participants´ understanding of good teamwork (n = 88 encodings in total) is characterized by the following inductive categories: "*being empathetic*" (n = 8 encodings), "*willingness of working together and helping each other*" (n = 62 encodings), "*clear organizational structure and knowing who is responsible for*" (n = 10 encodings) and "*appreciation of lower qualified colleagues*" (n = 25 encodings).

An example of the category "*willingness to work together and help each other*" contains the following quote:

> *"It´s giving and receiving. Thus, I do not only ask for something. If I see that somebody [of the team] is exhausted or is walking with a limp or whatever, I tell him: come, sit down, I am going to look after your residents [here, the residents who are in the group, the colleague is responsible for, are meant]. Well, I cannot merely take [from the team], and I must give as well. On the other hand, I cannot merely give [to the team]." (I_t$_0$)*

The "*willingness of working together and helping each other*" had n = 62 encodings the quantitatively most-often coded category in the subcategory "understanding of good teamwork." From the nurses´ perspective the high workload and the challenges when working with mostly severe physically and cognitively impaired residents can only be coped with when all colleagues work together. In this sequence the nurse expresses the need for a balance between giving and receiving by the team members.

No hierarchical differences and the "*appreciation of lower qualified colleagues*" seem to be prerequisites to function as a team as the following quote shows:

> *"The resident needs both of us. A nurse is not seen to be better than a nurse aide or a nurse aide is not seen to be better than a nurse. We all have tasks. And we have to carry out our tasks. Our goal is we want to be satisfied and their [residents´] needs are, uh…(1) what is the name? to be satisfied." (GD_t0)*

The nurse aid says in this quote that the common aim, namely, to be satisfied at work and to satisfy residents' needs, is realized in cooperative team work. To be able to achieve these aims, collegial teamwork at eye level is necessary. Working together on the same level despite diverse qualifications is another critical principle in the peer-group supervision concept of this study´s intervention program and let team members feel accepted and empowered.

To effectively implement solutions as a result of a peer-to-peer case discussion and to perceive high self-efficacy, frontline staff requires a high degree of participation in organizational decisions, especially at the operative level. If nurses experience no support in implementing solutions worked out in peer-group supervision and case discussions, they become frustrated. Self-efficacy means working on solutions to professional problems and experiencing that this solution can be implemented into clinical practice. The text material showed that if the head nurse does not support the implementation of the solutions worked out in peer group supervision, the frontline staff members lose their motivation to work on solutions for professional problems by themselves. The solution of professional problems itself is not satisfying. Frontline staff members wanted to implement these solutions in everyday worklife.

Participation in organizational decisions (n = 7 textual encodings) is a critical aspect for nurses´ empowerment. The following quote shows an example of nurses´ perception of a high degree of participation in operational decisions:

> *"When talking about software conversion or a daily routine that should be changed – we decide together. This is discussed by the whole team. For example, a physician says the resident should carry ATS [compression stockings] – that´s also a change – then, okay, we agree or we do not agree. Then, we are discussing, and we give feedback to the physician. Here, we can participate in the decision." (I_t0)*

The evaluative qualitative analysis of the data shows participants´ tendency for a higher willingness to participate in operative decisions (fig. 1) related to the direct work with residents and family members than to administrative and strategic decisions (fig.2)

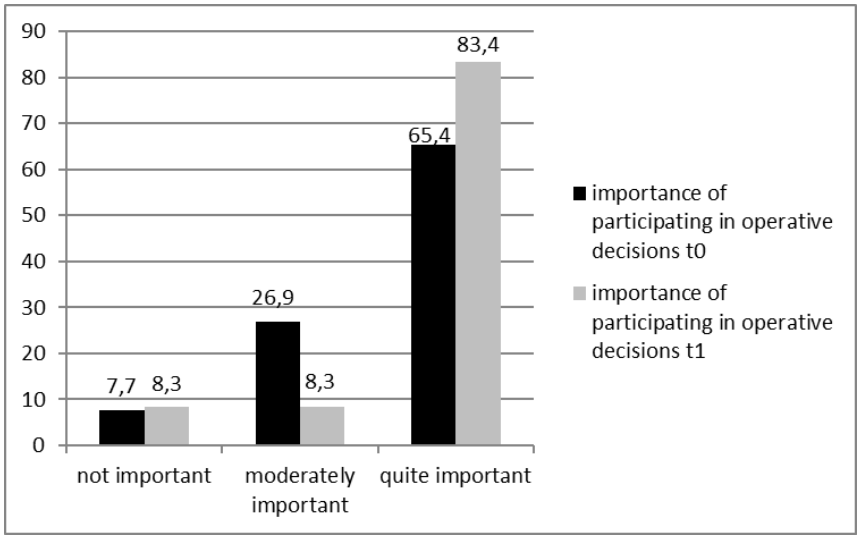

Fig. 1 Importance of participation in operative decisions from nurses´ perspective rated by the coder before (t_0) and after (t_1) the intervention, y-axis: percentage of all encodings in the category

The percentage of all encodings as a result of the scaled content analysis of the text material showed that 65.4% of all encodings in this category were scaled in the subcategory "*very important*" at t_0, whereas the percentage was 83.4% at t1 (fig. 1). During the intervention program the importance of participating in decisions directly affecting daily work with the resident seemed to increase at t_1 from the nurses´ perspective. The following quote is an example of a low degree of importance of participating in administrative and strategic decisions:

> *"And everybody knows me here. But (1) we did not have any problems here in the communication, sometimes that comes, but if you have a good er team leader, er (1) team leader, then that's all that makes it all good between us and that makes everything uh (2) neat, I have to say. I think everything works because she's [the team leader] there." (I_t_0)*

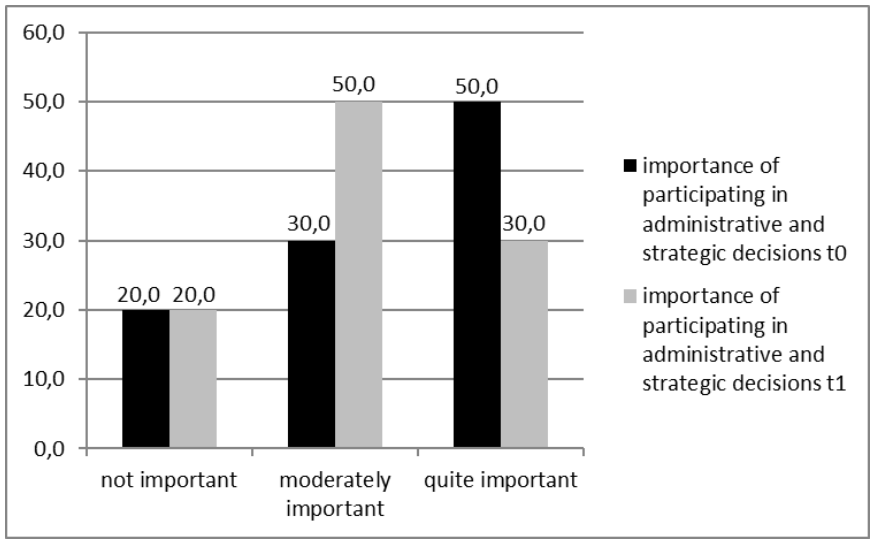

Fig. 2 importance of participating in administrative and strategic decisions from nurses´ perspective rated by the coder before (t_0) and after (t_1) the intervention, y-axis: percentage of all encodings in the category

In the following quote the nurse expresses a high degree of the importance of participating in strategic and administrative decisions, especially if the executive decides not to integrate new knowledge into the organization:

> *"I [interviewer is asking]: "Uh-huh. (2) So you would definitely (laugh) like to work more independently? B: Yes. I: Yes. B: For sure. (2) Or at least (1) that the wishes one has, um (3) are taken into account more, (1) that there are (1) conversations with the nursing home director or with the PDL [head nurse] or perhaps also with the company xy leadership, that one wants to implement that and that and if the halt says it does not work, I would like to have reasons for it. (1) Because then I would say to them, I do not know why I (1) do this training if I cannot (4) implement [new things I´ve learned in the training]. (4) Then, it's [the certificate] just a piece of paper, after all, that I have (2) in my hand (laughs)." (I_t$_0$)*

Nurses´ psychological distress

If nurses suffer from psychological distress their perceived psychological empowerment decreases. The "*feeling of not being able to master the quantity of daily work*," "*pressure from external control authorities to hold resident´s body weight*," "*feeling of not being able to fulfill resident´s demands adequately*," and "*feeling stressed when residents suffering from dementia are out of their daily rhythm and forced to stay in closed wards*" are categories of nurses´ psychological distress gained from the text material.

"B: If a colleague is taking sick leave that day we are under stress. *I [interviewer]: Mhm. B: Yes, and it is sometimes sad. Yes. Well, I have already mentioned I don´t want to become old and live in a nursing home. I: Mhm. B: Well, it is really sad. Yes. If nobody is coming [and helping you]. All alone. Yes?"* (I_t$_1$) The "*feeling of not being able to fulfill resident´s demands adequately*," especially in the case of sick leave of staff members, causes staff shortages and psychological distress. The nurse in this interview reveals her high empathy for the resident`s situation if the resident is not helped adequately. The nurse feels emotionally charged when being unable to fulfill a resident`s needs because of the lack of time.

How do nurses perceive their autonomy?

The evaluative analysis of the scaled categories shows a tendency that nurses´ perceived autonomy on the job is higher after the intervention (fig. 3).

The following quote is an example of nurses´ perceived low level of autonomy in everyday clinical practice at t$_0$:

> *"B: I am, I am very, I am very strong bound. I can (2) decide, okay, today we are five employees, we can divide who cares who, but things have to be done." (I_t$_0$)*

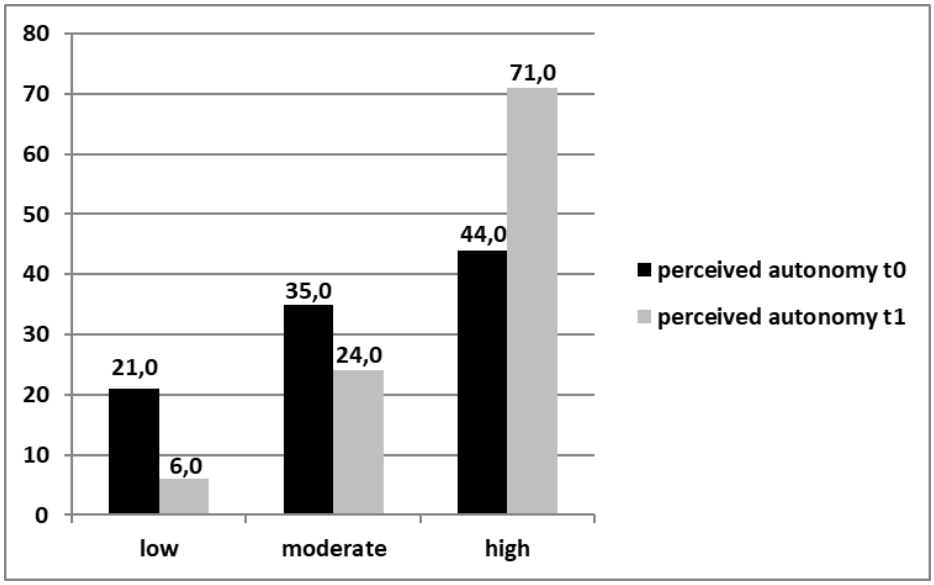

Fig. 3 nurses´ perceived autonomy: percentage of all encodings in the category "perceived autonomy" before (t_0) and after intervention (t_1)

Nurses´ perception of being bound to the nursing and medical care plan and to the planned daily routine is expressed in several sequences of the interviews and focus group discussions. Not being able to react to a resident´s daily state and a resident´s daily wishes is experienced as a restriction. If a resident refuses to perform her/his daily body hygiene or to drink the amount prescribed by the doctor, nurses have a dilemma because external quality control authorities and family members are expecting things to be executed in the manner in which they were planned and prescribed by the physician. Nurses´ understand they are advocates for the resident and must argue for a resident´s autonomous decision, especially if this decision is contrary to the nursing care plan and to a family member´s expectations concerning health care and a good quality of life.

The head nurse, as iterated by the participants, was under pressure, too. If a resident became dehydrated because he/she refused to drink, the nurses perceived themselves to be under pressure to argue regarding the quality control authorities and with family members. If the resident cannot verbally express his or her perspective, for example, due to cognitive impairment, the nurses must argue instead of the resident. The high pressure from outside can lead to the ignorance of a resident´s will:

> *"TB: Yes, all the time I have to say, "Please eat!" Because if they [the residents] lose weight, we'll get into trouble." (GD_t_0)*

The following quote is an example of nurses´ perceived high level of autonomy in everyday clinical practice:

> *"B: In principle, the daily routine [of the ward] can be influenced. There, I can decide how I plan my time, how I manage everything." (I_t_1)*

In this sequence of the interview at t_1 the nurse experienced independence in the management of the daily routine on the ward. Many other quotes showed that nurses were autonomous in decisions concerning daily routine. However, the moment this daily practice affected administrative and

strategic decisions and the moment the daily practice was contrary to the nursing care plan or to the doctor´s prescription, nurses' and even residents' autonomy seem to be clearly limited.

Code-theory models

The categories and sub-categories gained from the text material can be arranged clearly in code-theory models. Code-theory models can help to better understand complex concepts such as organizational culture. They deliver a structure for further qualitative and quantitative research. How organizational culture is perceived by their members depends on the various types of organizations in the various fields of the socio-economic system. Theories about organizational culture and how organizational culture is influencing member's empowerment and self-determination on a meta-level must be concretized for each special field and branch. While an assembly-line worker may feel empowered when processes are highly standardized nurses need spaces for decision making with the resident in daily work life practice for experiencing themselves self-determined.

Nurses´ perception of the organizational culture

Deductive and inductive categories of the structured content analysis show a complex network of nursing-home–specific characteristics of the organizational culture as perceived by the nurses (fig. 4).

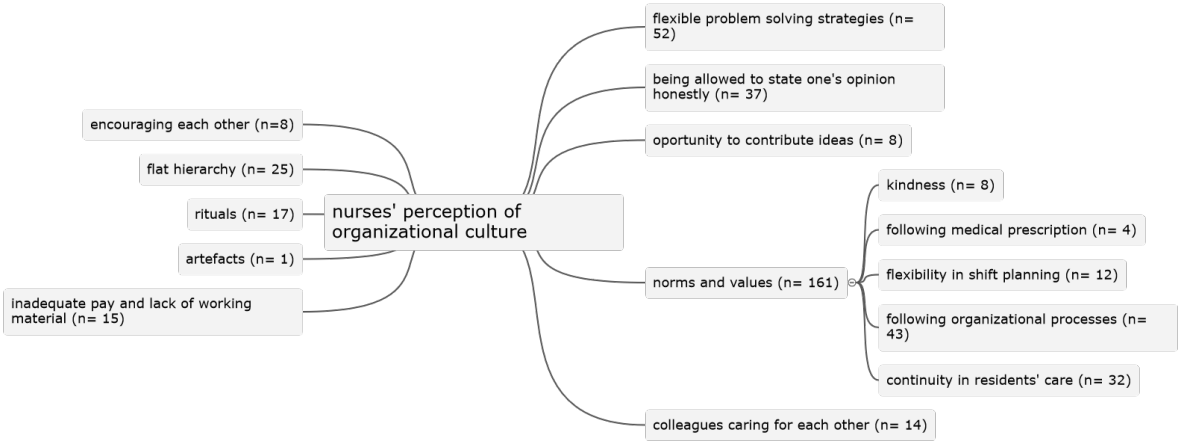

Fig. 4 Code Theory Model: organizational culture with inductive subcategories meaningful for nurses' empowerment at t_1, number of codings in brackets

Nurses' perceptions of organizational culture aspects meaningful for their empowerment are illustrated in fig. 4. Norms and values that are leading the nurses in their work environment were *kindness*, *following medical prescription*, *flexibility in shift planning*, *continuity of resident's care*, and *following organizational processes*.

In addition to autonomy and participation in operational decisions, the participants identified good teamwork as a core element of empowerment. *Colleagues are caring for each other* was a newly gained category of nurses´ perception of organizational culture after the intervention. *Caring for residents* and *caring for each other* were observed to be critical aspects of a nursing home´s culture. A *flat hierarchy and being allowed to state one's opinion honestly* are important requirements for the leadership in an empowering organization. *Flexibility in problem solving strategies* appeared as a

new category at t_1 and seem to be an effect of the peer group supervision intervention. Being *able to state one's opinion honestly* was also a new aspect at t_1 and makes the nurses feel empowered.

Inadequate pay and lack of working material was also a new category gained from the content analysis of the text material at t_1. By reading the transcripts of the interviews and group discussions, the word "*lack*" was observed in many sequences. The lexical analysis showed that the word "*staff shortage*" was used 16 times, "*lack of time*" 12 times, "*lack*" and "*lacking*" two times, and "*lack of space*" one time. "Lack" was observed to be a specific characteristic of the nursing home´s culture and contrary to nurses' desire to be paid adequately and appreciated, as important factors of perceived empowerment.

Figure 5 shows the code theory model "nurses´ perception of empowerment" with scaled and textual categories at t_1. Only if a text sequence shows concrete indications for a judgmental statement did the coder match the text passage to the appropriate scaling category. If the text sequence did not match any of the scaling categories, it was considered "not classifiable." The textual subcategories were generated inductively from the text material and showed specific, phenomenological aspects of nurses´ perception of their empowerment.

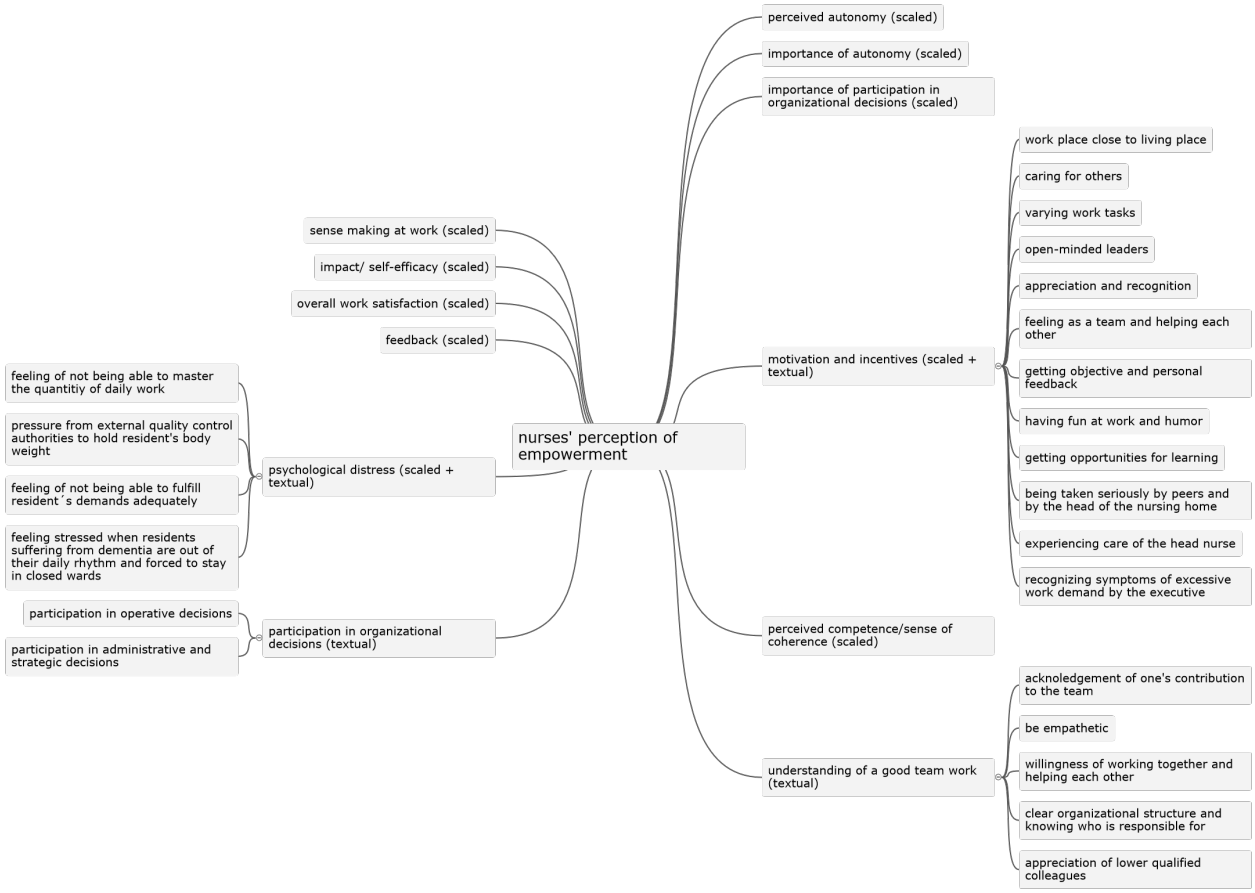

Fig. 5 Nurses´ perception of empowerment at t_1

Caring for others was coded 14 times and one of the most intensively discussed motive in the group discussions and in the individual interviews. *Work place close to living place* was a motivation to

work in the nursing home. This motive was coded 13 times. Getting *appreciation and recognition for one's work performance* was 12 times coded and also a strong incentive for the nurses. It is motivating for nurses if the *leader is open-minded* (n= 3). *Varying work tasks* (n= 1) was also discussed as an incentive for working in the nursing home. Good teamwork is empowering nurses.

Their understanding of good teamwork was analyzed by the text material. *Willingness of working together and helping each other* was coded 25 times and seem to be one of the most meaningful aspects of a good teamwork. *Clear organizational structure and knowing who is responsible for* (n= 2) seem to support a good teamwork. Nurses appreciate *colleagues' empathy* (n= 2) in the teamwork and want *to be acknowledged with their contribution to the team* (n= 1). *Participating in organizational decisions* was intensively (n= 12) discussed in the interviews and the group discussions. More often than *participating in administrative and strategic decisions* (n= 1) *participating in operative decisions* (n= 6) was an issue.

DISCUSSION

What autonomy means for nurses in long-term care facilities and how empowerment is perceived in the context of an organization´s culture by nurses was shown by our qualitative material. The inductively gained sub-categories are specific starting points for subsequent qualitative and quantitative research and for organization development.

Helping, spiritual feelings, and involvement in patient care have been reported to influence nurses' job satisfaction (Atefi et al., 2014). There is growing evidence (Wilkes et al., 2015; Crick, 2014) that *being able to help individuals* is a central motivation factor of school graduates for choosing nursing as a profession. We were surprised that spirituality was not a topic found in the interviews and group discussions of this study, whereas *helping each other* and *encouraging each other* were identified sub-categories as core values of a residential home´s culture at t_1. Helping residents and ensuring the continuity of residents' nursing care process despite staff shortages and lack of time were also observed to be core values of organizational culture from the participants´ perspective. Working conditions and organizational culture should support nurses to fulfill their wish to help each other and to help residents who are in the need of nursing care.

The evidence that organizational culture and climate is influencing nurses´ outcomes such as job satisfaction is more robust than the evidence that it influences patient outcomes (MacDavitt et al., 2007). However, good evidence is reported that nurses´ job satisfaction and nurses´ psychological distress influence patient outcomes (Aiken et al., 2013). Therefore, it is necessary to work on nurses´ job satisfaction and nurses´ empowerment to reduce psychological distress to obtain improved outcomes for residents. Self-determination in daily life practice is a core element of residential care. Realizing a resident´s autonomy requires a nursing workforce to be aware of the importance of autonomy, having an idea what autonomy means as a concept, respecting a resident´s autonomy, and being able to implement self-determined decision making in the nursing care process.

If nurses experience autonomy themselves in their work environment and in their daily work life, they can better respect and realize a resident´s autonomy. Empowering nurses means empowering residents; thus, as a first step, it is necessary to understand what empowerment means to nurses to determine starting points for their strengthening. If interventions are used, such as the peer group

supervision as in our study, risks and side effects must always be considered. The results of the analysis of the text material in the deductively applied category "importance of participating in decisions" (fig. 2 and fig. 3) showed diverse levels of importance. Empowerment can result in stress for nurses if they feel overburdened with a large margin for decision making, especially on an administrative and strategic level. Adequate and balanced participation in decision making, especially on the operational level, should be a key element in human resource management.

If the margin for decisions is too narrow, nurses feel stressed and have a dilemma when attempting to realize residents' wishes and priorities, as our text material showed. We consider it alarming that n = 70 text sequences were coded in the category "perceived psychological distress" scaled "high" at t_1 because stress is a critical predictor of decreased work satisfaction and psychological distress leads to many diseases, sick leave (Kane, 2009; Trybou et al., 2014), nurses´ early exit of the profession, and decreased patient outcomes (Aiken et al., 2013). Perceived job control can minimize these adverse effects of high job demands (Schmidt and Diestel, 2011) and sustain nurses' workforce. Therefore, a balanced strategy is required to empower nurses and provide them an adequate margin for decisions concerning everyday job practice at the frontline working with residents. Peer group supervision can be an effective human resource development instrument to empower nurses to participate in organizational decisions on an operative level.

Limitations of and reflections on the research process

Although data were collected in a heterogeneous sample, data saturation cannot ultimately be judged. The investigated theoretical concepts such as nurses´ perception of organizational culture and empowerment are highly individual and complex. There could be many more categories and subcategories that would increase the understanding of these concepts from nurses´ perspective. Intercoder reliability was 93%. Finding a consensus regarding how to understand the complex concepts used in this study and how to use the coding rules was a long-term process that included intensive discussions among the coders who had varying levels of knowledge and experience in the field. On the one hand, the process was time-consuming; on the other hand, coders´ theoretical and experience-based understandings were reflected intensively. This reflection was crucial for the coder´s ability to openly interpret participants´ perspective when examining the text material. Furthermore, the coders controlled their understandings by writing memos.

Conducting studies with a qualitative approach in the field of nursing care results in a high workload for the researcher and the participants. Staff shortages in nursing also influence quality assurance measures and the opportunity for nurses to participate actively in studies. Transcripts could not be returned to the participants because of their high workload. The identified categories could not be validated with the participants of the interviews and group discussions. Working with the text material and in-vivo codes and using, consequently, the coding rules should minimize the scope of a too-extensive interpretation of the original text material. The scientific rule-based approach can be retraced by verifying the matching of the literal quotes to the categories.

CONCLUSION

In this qualitative study many setting-specific categories that were important for nurses´ empowerment, their motivation, and their perception of a culture supporting their self-determination were observed. The identified categories of nurses´ perception of organizational culture deliver a differentiated structure for further research and for a sustainable human resource

management. To develop a culture of participation and empowerment in nursing homes, concrete starting points are required. How organization members perceive their own empowerment is critical information for personnel development. In this study, we learned that the importance of participation in organizational decisions varies by individual.

Perceived participation and an employee´s satisfaction with participation in organizational decisions depends on their expectations and individually weighted importance of participation. Organizations must find a balance between a member´s individually adequate autonomy and clearly defined structures and anticipated decisions. This balance must be adapted individually for every employee and even for every resident. Residents´ autonomy cannot be regarded without nurses´ self-determination and empowerment in the working context. Both concepts interact strongly. Interventions for strengthening nurses´ autonomy such as peer group supervision can only be fully effective if the organizational culture and organizational structures support the peer group supervision process *and* the implementation of its solutions to professional problems.

The learning process regarding how to implement and execute a resident´s individual autonomy in daily life practice in a nursing home requires empowered nurses who perceive themselves autonomy in their work environment. Peer group supervision can be an effective strategy to increase self-determination in nurses´ working context when nurses get spaces for decision making with the resident on the operative level and when nurses are supported to implement these decisions on the administrative level by the management. Theoretische Konzepte, wie die empfundene Selbstwirksamtkeit und das Empoerment, müssen für das spezifische Feld der stationären Langzeitpflege aus der Perspektive der Organisationsmitglieder konkretisiert warden, um Ansatzpunkte für die weiterführende Forschung und die Organisationsentwicklung zu finden. Die in dieser Studie identifizierten Kategorien liefern wichtige Ansatzpunkte für das Empowerment der Pflegekräfte.

References

Aiken, L.H., Sloane, D.M., Bruyneel, L., Van den Heede, K. and Sermeus, W. (2013), "Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe", International journal of nursing studies, Vol. 50, p. 143.

Argyris, C. and Schön, D.A. (2018), Die lernende Organisation: Grundlagen, Methode, Praxis, 1. Aufl., Schäffer-Poeschel Verlag, Stuttgart.

Atefi, N., Abdullah, K.L., Wong, L.P. and Mazlom, R. (2014), "Factors influencing registered nurses perception of their overall job satisfaction. A qualitative study", International nursing review, Vol. 61 No. 3, pp. 352–360.

Barry, T.T., Brannon, D. and Mor, V. (2005), "Nurse aide empowerment strategies and staff stability. Effects on nursing home resident outcomes", The Gerontologist, Vol. 45 No. 3, pp. 309–317.

Benshoff, J.M. and Paisley, P.O. (1996), "The Structured Peer Consultatioquality of lifen Model for School Counselors", Journal of Counseling & Development, Vol. 74 No. January/February, pp. 314–318.

Bjørk, I.T., Samdal, G.B., Hansen, B.S., Tørstad, S. and Hamilton, G.A. (2007), "Job satisfaction in a Norwegian population of nurses. A questionnaire survey", International journal of nursing studies, Vol. 44 No. 5, pp. 747–757.

Bölenius, K., Lämås K., Sandman P-O., Lindkvist M., Edvardsson D. (2019), "Perceptions of self-determination and

quality of life among Swedish home care recipients - a cross-sectional study" BMC Geriatrics, No. 19:142.

Bollig G., Gjengedal E., Rosland J.H. (2016), "Nothing to complain about? Residents' and relatives' views on a ''good life'' and ethical challenges in nursing homes", Nursing Ethics, Vol. 23 No. 2, pp. 142–153.

Cohen-Mansfield, J., Ejaz, F.K. and Werner, P. (Eds.) (2000), Resident satisfaction, quality of life and lived experience as domains to be assessed in long-term care, Satisfaction Surveys in long-term care, Springer Publishing Company, New York.

Crick, P. (2014), "Why do student nurses want to be nurses?", Nursing Times, Vol. 110 No. 5, pp. 12–15.

Davies, S., Laker, S. and Ellis, L. (1997), "Promoting autonomy and independence for older people within nursing practice: a literature review", Journal of advanced nursing, Vol. 26, pp. 408–417.

Edvardsson D., Corneliusson L., Boas P. V., Hanratty B., Lepore M., McGilton K.S., Schwartz L., Thompson R., Wang J. (2019), "Advancing Long-Term Care Science Through Using Common Data Elements: Candidate Measures for Care Outcomes of Personhood, Well-Being, and Quality of Life , Gerontology & Geriatric Medicine Vol. 5, pp. 1–15.

Engström, M., Skytt, B. and Nilsson, A. (2011), "Working life and stress symptoms among caregivers in elderly care with formal and no formal competence", Journal of nursing management, Vol. 19 No. 6, pp. 732–741.

Grant, L. (2008), "Culture change in a for-profit nursing home chain: An evaluation", available at: https://www.commonwealthfund.org/publications/fund-reports/2008/feb/culture-change-profit-nursing-home-chain-evaluation (accessed 2 January 2019).

International Council of Nurses (ICN) (2012), "The ICN Code of Ethics for Nurses", available at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=2ahUKEwjrtvKZkLvoAhUyxKYKHa79DrAQFjACegQICxAF&url=https%3A%2F%2Fwww.icn.ch%2Fsites%2Fdefault%2Ffiles%2Finline-files%2F2012_ICN_Codeofethicsfornurses_%2520eng.pdf&usg=AOvVaw2RqQuoAm-AGCjoDl-n_Hvn (accessed 27 March 2020).

Joo, B.-K.(B.) and Shim, J.H. (2010), "Psychological empowerment and organizational commitment: the moderating effect of organizational learning culture", Human Resource Development International, Vol. 13 No. 4, pp. 425–441.

Kane, P.P. (2009), "Stress causing psychosomatic illness among nurses", Indian J Occup Environ Med., Vol. 13 No. 1, pp. 28–32.

Kane, R.A. and Kane, R.L. (1988), "Long-term care: variations on a quality assurance theme", Inquiry, Vol. 25, pp. 132–146.

Kelly, M. (1989), "The Omnibus Budget Reconciliation Act of 1987. A policy analysis.", Nurs Clin North Am., Vol. 24 No. 3, pp. 791–794.

Kim B. J., Ishikawa H., Liu L., Ohwa M., Sawada Y., Lim H. Y., Kim H. Y., Choi Y., Cheung C. (2018), "The effects of job autonomy and job satisfaction on burnout among careworkers in long-term care settings: Policy and practice implications for Japan and South Korea", Educational Gerontology, Vol. 44 No. 5-6, pp. 289–300.

Koren, M.J. (2010), "Person-Centered Care For Nursing Home Residents: The Culture- Change Movement", Health Affairs, Vol. 29 No. 2, pp. 1–6.

Kuckartz, U. (2014), Qualitative Inhaltsanalyse: Methoden, Praxis, Computerunterstützung, 2. Auflage, Beltz Juventa, Weinheim, Basel.

Lautizi, M., Laschinger, H.K.S. and Ravazzolo, S. (2009), "Workplace empowerment, job satisfaction and job stress among Italian mental health nurses. An exploratory study", Journal of nursing management, Vol. 17 No. 4, pp. 446–452.

MacDavitt, K., Chou, S.-S. and Stone, P.W. (2007), "Organizational climate and health care outcomes", Joint Commission Journal on Quality & Patient Safety, Vol. 33 No. 11, pp. 45–56.

Mayring, P. (2016), Einführung in die qualitative Sozialforschung, 6. Auflage, Beltz, Weinheim, Basel.

McGillis Hall, L., Doran, D., O'Brien Pallas, L., Tranmer, J., Tregunno, D., Rukholm, E., Thomson, D., Pink, L., Peterson, J., Johnston, E. and Palma, A. (2006), "Quality Worklife Indicators for Nursing Practice Environments in Ontario. Determining the Feasibility of Collecting Indicator Data", available at: www.mcgillishall.com/wp-content/uploads/2010/05/QWIN_Report (accessed 27 March 2020).

Mishra, B. and Bhaskar, U.A. (2010), "Empowerment: A necessary attribute of a learning organization?", ORGANIZATIONS AND MARKETS IN EMERGING ECONOMIES, Vol. 1 No. 2, pp. 48–70.

Moebius, S. and Quadflieg, D. (Eds.) (2011), Kultur. Theorien der Gegenwart: Thomas Luckmann: Kultur zwischen Konstitution, Konstruktion und Kommunikation, 2. erw. Aufl., VS Verlag für Sozialwissenschaften, Wiesbaden.

Murray, P. and Chapman, R. (2003), "The Learning Organization. From continuous improvement to organisational learning: developmental theory", The Learning Organisation, Vol. 10 No. 5, pp. 272–282.

Nasabi N. A., Bastani P. (2018), "The effect of quality of work life and job control on organizational indifference and turnover intention of nurses: a cross-sectional questionnaire survey", Cent Eur J Nurs Midw, Vol. 9 No. 4, pp. 915–923.

O'Reilly, C. and Chatman, J.A. (1996), "Culture as social control: corporations, cults, and commitment", Research in Organizational Behavior, Vol. 18, pp. 157–200.

Råholm, M.-B. and Heggdal, H.M. (2017), "The Organizational Culture of Nursing Homes. A Systematic Review of Qualitative Studies", International Journal for Human Caring, Vol. 21 No. 2, pp. 83–90.

Rai, G.S. (2013), "Improving Quality of Working Life among Nursing Home Staff. Is it really needed?", International Journal of Caring Sciences, Vol. 6 No. 3, pp. 380–391.

Ramaswami, V. and Gouillart, F. (2010), "Building the Co-Creative Enterprise", Harvard Business Review, Oct. 2010, pp. 100–109.

Saber, D.A. (2014), "Frontline registered nurse job satisfaction and predictors over three decades. A meta-analysis from 1980 to 2009", Nursing outlook, Vol. 62 No. 6, pp. 402–414.

Schein, E.H. (1993), "On Dialogue, Culture, and Organizational Learning", REFLECTIONS, Volume 4, Number 4, Vol. 4 No. 4, pp. 27–38.

Schein, E.H. (1984), "Coming to a new a awareness of organizational culture", Sloan Management Review, Vol. 25 No. 2, pp. 3–15.

Schein, E.H. and Schein, P. (2018), Organisationskultur und Leadership, 5th ed., Verlag Franz Vahlen, München.

Schmidt, K.-H. and Diestel, S. (2011), "Differential effects of decision latitude and control on the job demands–strain relationship. A cross-sectional survey study among elderly care nursing staff", International journal of nursing studies, Vol. 48 No. 3, pp. 307–317.

Sherwin, S. and Winsby, M. (2011), "A relational perspective on autonomy for older adults residing in nursing homes", Health expectations an international journal of public participation in health care and health policy, Vol. 14 No. 2, pp. 182–190.

Tietze, K.-O. (2010), Wirkprozesse und personenbezogene Wirkungen von kollegialer Beratung: Theoretische Entwürfe und empirische Forschung, 1. Auflage, VS Verlag, Wiesbaden.

Trybou, J., Germonpre, S., Janssens, H., Casini, A., Braeckman, L., De Bacquer, D. and Clays, E. (2014), "Job-Related Stress and Sickness Absence Among Belgian Nurses: A Prospective Study", Journal of Nursing Scholarship, Vol. 46 No. 4, pp. 292–301.

Wendsche, J., Hacker, W., Wegge, J. and Rudolf, M. (2016), "High Job Demands and Low Job Control Increase Nurses' Professional Leaving Intentions. The Role of Care Setting and Profit Orientation", Research in nursing & health, Vol. 39 No. 5, pp. 353–363.

Wilkes, L., Cowin, L. and Johnson, M. (2015), "The reasons students choose to undertake anursing degree", Collegian, Vol. 22, pp. 259–265.

Zurmehly, J. (2008), "The Relationship of Educational Preparation, Autonomy, and Critical Thinking to Nursing Job Satisfaction", The Journal of Continuing Education in Nursing, Vol. 39 No. 10, pp. 453–460.