# THE RELATIONSHIP BETWEEN NURSES' WORK ENVIRONMENT AND QUALITY OF CARE

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**ABSTRACT**

Nurses' practice environments have changed dramatically in the last decade and as a result nurses are experiencing increased work pressure and stress in their professional practice. This descriptive study explored the relationship between nurses' professional practice environment and family's perception of quality care. Professional nurses working on two units (A & B) were surveyed using: A Work Environment Scale (WES, Moos, 1987) and Index of Work Satisfaction (IWS, Stamps & Piedmont, 1986). Families who received care on these two units also completed two adapted questionnaires: Nurse-Patient Interaction Scale (Krouse, Krouse & Roberts, 1988) and Patient Satisfaction Survey (Mergivern, 1986). Nurses practicing on Unit B reported higher levels of satisfaction with their work than nurses on Unit A. Significant differences were found between the two groups regarding nurses' satisfaction with supervisor support ($t$=-2.73, $p$=.009), work pressure ($t$=3.10, $p$=.004) and physical comfort ($t$=-3.14, $p$=.003). Nurses' perception of supportive management was positively related to their role clarity ($r$=.57, $p$=.000), job commitment ($r$=.50, $p$=.001) and inversely related to work pressure ($r$=.-51, $p$=001). Parents from Unit B reported significantly higher levels of satisfaction with nursing care ($t$=-3.16, $p$=.003) and nurse-parent interactions ($t$=-1.58, $p$=.06). Based on the key results of this study initiatives are being established in both care areas to support nursing practice which will enable nurses to provide quality nursing care.

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# Chapter 1

## Introduction

### Background to the Problem

Nurses' work environments have become more challenging due to increased nursing care demands in combination with organizational restructuring. The implementation of professional practice models, the re-engineering of organizational structures, and the physical restructuring of the work environment requires that nurses revise the way they practice. The objectives of such strategies are often intended to empower nurses in their nursing practice. Nurses are challenged to meet the needs of the families for whom they care while sustaining their own professional work satisfaction.

Unfortunately, the restructuring of work environments can have a detrimental effect on nurses professional practice, as well as the quality of patient care. Luther (1996) studied nurses before and after hospital restructuring and found that downsizing and work redesign left nurses feeling isolated, powerless, and demoralized. Patients indicated on patient satisfaction surveys that they could identify a change in the nurses. After the restructuring, patients rated their care as fair to poor and indicated that their needs were not met while in hospital.

There is limited research that has demonstrated the relationship between the care patients receive and the level of satisfaction of the nurses.

Kanter (1979) proposed that the organizational aspects of the work environment have a significant impact on employee effectiveness. Organizational aspects of nurses' work environment have been the focus of research by Laschinger and her colleagues. Wilson and Laschinger (1994) examined the relationship between nurses' work environment and their investment in the organization. They found strong correlations between nurses' perception of power and opportunity, and commitment to the organization. In one study to examine such relationships Havens and Laschinger (1995) found that staff nurses' perceptions of work empowerment were significantly related to perceived control over nursing practice, involvement in organizational governance, self-perceived work effectiveness and work satisfaction.

Researchers have shown that nurses who are more satisfied with their work environment also perceive that they have enhanced job effectiveness. Can a relationship be established between job satisfaction and the quality of care that patients receive and that nurses perceive they are providing? Nathanson and Weisman (1985) measured the job satisfaction of 344 registered nurses and found that job satisfaction predicted patient satisfaction which in turn

predicted adherence to treatment regimes. If adherence to treatment regimens was considered a measure of quality of care by these researchers then it would also demonstrate a link between nurses' job satisfaction and quality of care.

Caution is needed in discussions of quality of care and job effectiveness. The concept of quality care has not been mutually defined by the nurse and the patient. Laschinger (1996) based on the results of her research, concludes that nurses who view their work environment as empowering are more likely to provide high quality care using more effective work practices.

This study examined the relationship between nurses satisfaction with their work environment and parent satisfaction with the quality of care. It was anticipated that parents whose children were cared for by nurses who were satisfied with their work environment would experience positive nurse-parent interactions and enhanced quality of care. There is limited evidence to support this theory. Therefore, in an ever changing health care system, further exploration of such issues as the work environment, nurses' sense of autonomy, job satisfaction and the impact this has on nurse-parent relationships is required.

## Purpose of the Study

The purpose of this study was to examine whether the time since the unit had been restructured affected nurses' perceptions of their work environment and how these

perceptions were related to the care provided to children and their families. Nurses who experienced significant restructuring including the merging of philosophical and physical environments of care, and nurses who experienced such restructuring 18 months ago were asked to participate in the study.

## Conceptual Framework

This study was developed within Kanter's (1979) structural theory of organizational behavior. This framework has been used to examine factors in nursing work environments that influence the way nurses respond to work experiences. Kanter's (1977) organizational behavior theory suggests that opportunity and power within organizations determine work attitudes and behaviors. According to Kanter, when workers have access to opportunity that allows for professional growth they display a positive set of attitudes such as higher motivation and commitment, and experience more work satisfaction. For nurses, these attitudes would be reflected in a more self-confident and innovative approach to nursing practice. However, it is not clear how this impacts on nurse-patient relationships and quality of care.

Rosabeth Kanter's (1977) theoretical model is based on a study of work environment in a large American industrial corporation. The central concept of her theory is that an individual's effectiveness on the job is largely shaped by

the structural aspects of the job. She holds that work attitudes and behaviors are developed in response to problems and situations experienced within the work environment, not personal attributes. Kanter (1977) identifies three areas that determine job performance, attitudes and behaviors:

1. The structure of the power which includes lines of information, lines of support, and lines of supply.
2. The structure of opportunity which encompasses conditions that facilitate individuals' chances to advance within the organization and develop their knowledge and skills. According to Kanter, when individuals do not have access to resources, support, information, opportunity, they experience powerlessness. They are accountable without power, creating feelings of frustration and failure.
3. The composition of peer clusters which entails the social composition of people in approximately the same situation (i.e. gender, age).

She maintains that these three factors have the potential for explaining the differences in individual responses to situations in the work environment. This study examined the structure of power as it relates to the nurses' work environment and quality of care provided. Consistent with Kanter's theory, the extent of control nurses' believe they have over the conditions of their work environment was expected to be an important factor influencing work

effectiveness with patient care. Power is considered a positive concept in terms of mastery or autonomy in the work environment, as opposed to domination or control. According to Kanter (1977) power is most effective when it is shared, thereby empowering others. Empowerment generates autonomy by increasing the decision making participation of individuals which results in more effective actions by individuals and groups.

***Power***

Kanter (1979) defines power as the ability to get things done by mobilizing resources, human and material. Power is found in both the formal and informal organization. Formal power pertains to authority of one's position. Kanter (1979) claims that power does not necessarily come with an authority position. It is often accumulated through informal processes of the work structure. Informal organizational structure is made up of alliances with peers and supervisors. Those who have both informal (influence) and formal (authority) power have the ability to get things done in the organization. Those with access to power and opportunity structures are highly motivated and are able to motivate and empower others.

Kanter (1979) supports the notion that, for job activities to be empowering, they must be extraordinary, visible and relevant to the organization's functioning. People or organizations do not get credit for doing what is

expected or ordinary. Routinization of tasks reduces opportunities to be creative. Therefore, roles that allow flexibility, creativity, and innovation may accumulate power more readily than routine roles.

Kanter (1979) maintains that the strength of the relationship between work effectiveness and power is dependent upon: access to support, information and resources necessary for task achievement, and the ability to elicit cooperation from colleagues required to perform work. Support is necessary and is defined as the feedback and guidance received from peers and supervisors.

Kanter(1979) maintains that those who perceive themselves as having power will foster a higher group morale and cooperation among their colleagues. Jobs are evaluated in terms of advancement potential and opportunities for personal growth. Opportunities include autonomy, growth, sense of challenge and the chance to learn (Kanter, 1979). The theory would suggest that nurses who perceive themselves as having opportunities would invest themselves in their work and seek ways to learn thereby contributing to personal growth and development. It was anticipated that nurses practicing in these work environments would experience positive nurse-parent interactions that would not be realized by those nurses in low opportunity positions. It is reasonable to conclude that nurse-parent interactions, as

a measure of quality of care, would be impacted by the work environments where nurses practice.

### *Quality of Care*

Research regarding the concept of quality of care indicates there are many varied meanings for health care professionals and patients. The literature is primarily from the health care professionals' perspective based on audits and quality assurance tools. Due to heightened patient awareness, and the American influence of the 'consumer' driven health care environments, there are two unfolding perspectives regarding quality of patient care. The two perspectives have been created by the health care professionals providing the care and the patients receiving the care.

Joiner (1996) maintained that caregivers can no longer define quality by their standards alone. She found, in an analysis of patient satisfaction surveys, that nursing service is the most influential factor in the overall rating of the hospital. She documented that the areas of nursing service which were found to exceed the patient's and family's expectations beyond routine hospital care were in the areas of empathy and caring. The ordinary or routine care is expected, but, the extraordinary, and going beyond the expectations of the patients is not. When nurses go beyond the ordinary, they are perceived as being empathetic

and caring. This is consistent with Kanter's (1979) theory of an effective worker in that workers are not recognized except for the extraordinary characteristics they employ in their work practices. According to Joiner (1996), patients and families expect nurses to be competent and organized, but, they see caring as something different, something special.

The concept of quality of nursing care requires in-depth exploration which was not within the scope of this study. For the purposes of this study, nurse-parent interactions were assessed and evidence of positive interactions resulting in parent satisfaction are considered an indicator of quality of care.

## Literature Review

The literature that related most specifically to this study included nurses work environment, restructuring, empowerment, job satisfaction, job stress, and the issues of quality of care from both the nurses' and parents' perspective.

Other factors that influenced nurses' work environment, such as the relationship between nurse managers and empowered staff, were not examined in this study.

### *Work Environment*

As nurses' work environments have changed, the literature has become more detailed regarding what satisfies

nurses' in their jobs. Three studies were used to outline information regarding work climate, and staff nurse involvement in organizational decision-making.

The term "organizational climate" refers to measurable properties of the work environment, perceived directly or indirectly by the people who live or work in that area and assumed to influence their motivation and behavior. The organizational climate has been described as the psychological atmosphere of the workplace (Gillies, Franklin & Child, 1990). Nurses described their organizational climate as high in responsibility, warmth, support and identity. These terms appear simple, but, in actuality highlight the findings throughout the job satisfaction literature. A second study reported findings of nurses' work climate which are related to nurses' job satisfaction. Chandler (1986) was the first nurse researcher to test Kanter's theory in nurses' work environments. Using the Conditions of Work Effectiveness Questionnaire(CWEQ), 246 nurses rated their perceptions of how much they experienced working conditions of support, information, resources, power and opportunity. Staff nurses identified support, opportunity, and information as important factors determining work effectiveness. Scores were low to moderate in all areas and suggest that nurses were not highly empowered in their work. The sharing of information and interdepartmental relationships (formal and informal) were

important work factors; this was an indication of the value of communication and comradery among nurses.

The importance of work environment was described in the landmark magnet hospital study (McLure, Poulin, Sovie, & Wandelt,1983). The key factor in the nurses' satisfaction was the recognition of the significance of staff nurse involvement in decision-making. Havens and Mills (1992) found that staff nurse involvement was moderate with regard to activities that may position them to influence their practice. For example, in 1990, staff nurse involvement to influence practice was at the midscale level, on average 5 of 11 items were implemented by more than 50% of the respondents. The areas of interest ranged from nurse-physician collaboration to monitoring budget expenses of the unit. These researchers made prospective predictions based on their findings and proposed that staff nurse involvement would increase in subsequent years for decisions that affect nursing care, working conditions and the work environment. They predicted that rapid change would produce highly educated and expert health care workers who play essential roles in the management of their work.

Nurses want work environments which provide them with organizational support, autonomy within their practice, and shared communication and decision-making regarding issues affecting patient care. This is consistent with Kanter's (1979) notion of an effective work environment. The

research indicates, that as nurses' work environments rapidly change so will nurses' expectations of how they practice within those environments.

***Restructuring***

Mergers and restructuring have been common occurrences in the business world and are becoming the trend in healthcare. Nornhold (1994) reports that, during the 1980's and early 1990's, nurses saw great gains in salaries and increased numbers and influence, but now nurses are faced with hospital closures, salary and position cuts due to budget cutbacks, and fewer nurses are being asked to do more. She termed this period the 'hyperchange' in the hospital environment and claims that it has a profound impact on nurses who are experiencing downsizing, decentralizing, role shifting and work redesign. Laschinger (1996) believes this creates a sense of disempowerment for nurses working within the system because the control of the environment is being taken away from those people who actually perform the work. Worthington (1996) describes restructuring as a time of great stress and anxiety for employees. In her opinion, all members of the staff will experience disorganization, confusion and chaos during the crisis period of reorganization.

Nurses who have experienced restructuring in their work environment describe feeling unimportant (Suderman, 1996;

Godfrey, 1996; Poole, Stevenson & George, 1995) and relate their experience to a significant loss (Suderman, 1996; Godfrey, 1996). Suderman (1996) acknowledges that restructuring does not necessarily result in unemployment for nurses, but, they experience significant changes in their workplace which threatens their well-being. Suderman used a qualitative in-depth interview approach with 10 nurses who had experienced significant redesign efforts in their hospital. Most of the nurses described experiencing grief and loss. Nurses described feeling devalued and unimportant. Suderman does note that the nurses acknowledged that growth and learning did occur as result of redesign. The time frame after restructuring occurred when they acknowledged this was not provided.

To provide a more intimate picture of how nurses responded to restructuring, two researchers included nurses' verbal descriptions of how the redesign made them feel emotionally. Godfrey (1996) includes a description of one nurses' assessment of other nurses' responses to the closure of their inpatient unit. She felt that the nurses moved through the stages of shock, denial, anger, then acceptance. Nurses' comments regarding their personal feelings about the process included "slap in the face", "stab in the back", "no consideration for all our hard work and loyalty" (Godfrey, 1994,p.91). She reported that the staff spent weeks struggling to imagine the reality of the closure.

Poole, et al. (1995) recounted the comments of an experienced nurse regarding the merger of an obstetric unit with a newborn nursery. "The obstetrics staff will be cross trained to take care of both mothers and infants. Many are pessimistic that the change won't work, they don't feel valued and fear working in the other unit" (Poole, Stevenson & George, 1996, p.40 ). These comments reflect the nurses' anxiety about the process and impact of the redesign.

If nurses are reporting such adverse reactions to the restructuring process why has restructuring continued to occur? Smeltzer and Formella state that the consideration of cost and quality of health care are the main reasons for restructuring the work that is done in hospitals. Institutions are redesigning work environments to reverse the trends of declining patient and staff satisfaction. Smeltzer and Formella (1996) were interested in how nurses spent their time and how their work could be restructured to spend more time on direct patient care activities. Staff nurses were surveyed at baseline, post implementation of restructured work, and one year later. Work redesign was the delegation of non-nursing activities that would allow the nurse more time for patient care. Smeltzer and Formella report that the most important values for nurses in their study in order of importance were: the provision of quality patient care, care planning/ teaching/discharge, individual care/professionalism, compassion and comfort. In regards to

nurses' issues, the four most important values reported were: team spirit, communication between nurse and physicians, competent staff, and reduced paperwork. Pre-implementation, nurses spent 54% of their time in direct patient care, one year later they reported spending 68% of their time for patient assessment, treatment, medication administration and care planning. Clinical quality indicators such as medication errors and patient falls were reduced post implementation and one year later. Nurses reported being more satisfied one year later with patient care time distribution. Overall patient satisfaction had improved from pre-implementation to the one year follow-up survey.

In contrast, Campbell (1987) found that nurses altered their practice due to fiscally motivated restructuring and that this negatively impacted on patient satisfaction. Dissatisfied nurses and patients have been the catalyst for the research in this area. Poole, Stevenson and George (1995) contend that hospital redesign is leaving bewildered, disenchanted front-line care providers behind. They believe for redesign efforts to succeed, administrators need to take a more humanistic approach to achieve a successful culture change which will create a positive working environment. They have maintained that highly involved, well informed staff are essential to the success of work environment redesign.

There is little consistency in the research regarding satisfaction with restructured work environments. One factor that several researchers omit from their descriptions of the studies is the time frame after restructuring when the evaluations were completed. A study by Kovner, Hendrickson, Knickman and Finkler (1994) examined care delivery models and nurse satisfaction at baseline and one year later. Interventions such as nursing practice models (case management, shared governance) and reorganizations of delivery of care were implemented at different times throughout the year. The authors did not disclose the time frames at which an intervention took place and time span until the nurses were comfortable with their environment. Kovner et al. (1994) report that even among nurses who eventually liked their work environment there was an initial period of dissatisfaction.

The literature suggests that it is the process or the anticipated process of the restructuring that causes nurses to be dissatisfied. The nurses feedback in terms of the length of time after restructuring has occured might affect nursing satisfaction with their work environment.

The literature provided recommendations for nurses experiencing restructuring. Singleton and Nail-Hall (1995) suggested that the following strategies are required to achieve a successful merger: look at committee structures, select appropriate people to be involved, conduct social

events, keep everyone informed, acknowledge the complexity of the process and that there will be a lack of information, review accomplishments, and pay attention to scheduling, and the adherence to nursing care standards. Appenzeller (1993) describes the merging of two hospitals in a large U.S. city. She stated that clarifying and developing nursing roles and relationships, fostering team building, negotiating and resolving differences, and planning for the future were essential in their merger process.

***Autonomy/Empowerment***

There are many definitions in the organization literature of empowerment and autonomy, each encompassing similar elements of the concept. These concepts are not identical in meaning, but are closely related in practice. One essential element in the empowerment process involves creating work environments that provide nurses with opportunities to influence their practice. Havens and Mills (1992) state "empowerment connotes the legitimization of staff to use their knowledge and talents meaningfully to impact their practice environment" (p.62). They believe that nursing staff shortages, reduced budgets, and heightened awareness of patient outcomes have stimulated the development of new organizational structures. Thus, these new structures are supporting nurses to exercise their desire to be involved in the decision-making process.

Research indicates staff nurse perceptions of job related empowerment is significantly related to organizational commitment (Acorn, Ratner & Crawford, 1997; McDermott, Laschinger & Shamian, 1994), burnout, job autonomy, and participation in organizational decision making (Bruce, Gurnham & Christie, 1995; Wilson & Laschinger, 1994; Hatcher & Laschinger, 1995; Radice, 1994; Sabiston & Laschinger, 1995) and job satisfaction (Dwyer, Schwartz & Fox, 1992; McCloskey, 1990; Roedel & Nystrom, 1988). Radice (1994) examined the relationship between empowerment of nurses ($n$=20) in a New York teaching hospital and their job satisfaction. The results indicate a strong positive relationship ($r$ =.63, $p$=.003) between empowerment and job satisfaction. As nurses perceived the level of constraint was reduced, their job satisfaction was increased.

Restructured health care environments have resulted in decentralization of power and decision making. Acorn, Ratner and Crawford (1997) report that nurses who work in very decentralized or extremely decentralized hospitals score higher in autonomy, satisfaction and organizational commitment than nurses who work in somewhat decentralized hospitals. Therefore, nurses who have decision-making power within their professional practice are more satisfied than those who do not.

The creation of empowered work environments for nurses is a developing trend in nursing settings. Nurses value empowerment when it enables them to better care for their patients and achieve their health care goals (Perley & Raab, 1994). Sabiston and Laschinger (1995) conclude that nurses who perceive themselves as being empowered are more likely to enhance patient care through more effective work practices, however, they did not have any measure of effective work practices.

Wilson and Laschinger (1994) surveyed 161 hospital nurses who reported their work environment to have moderately empowering characteristics ($\underline{m}$=2.77/5). These researchers offer two explanations for this that are based on their review of the literature for nurses' powerlessness in the hospital setting. First, they note that powerless behaviors have been related to a nurse's personality. Second, any interventions employed to empower nurses have been directed towards nurses' behavior. This is contrary to Kanter's (1979) perspective which maintains that it is the work environment that results from the organizational structure that shapes the employees' behaviors and attitudes, thereby, empowering those who participate in meaningful decision making ultimately enhancing job satisfaction.

Muldary (1983) proposed that a lack of autonomy and power engenders feelings of frustration, victimization and

helplessness. She believed that, in relation to other health professionals, "nurses are the most frequent sufferers of this experience because they are charged with tremendous responsibilities but are given no real power of authority" (Muldary, 1983, p.90). This is evident in Attridge's (1996) qualitative study where themes of powerlessness were demonstrated in nurses' descriptions of various work situations. All situations involved basic fundamental human issues and were characterized as 'unsafe' and/or 'out of control' by the nurses. Nurses described feeling alone and abandoned. The patients' perspective was not obtained in this study. Strategies for changing the power structure included: respecting and valuing nurses, offering collegial support, and facilitating nurses' autonomy.

Autonomy and empowerment have been significantly related to nurses' satisfaction with their jobs and work environment. It is well documented that powerless nurses are not satisfied. Nurses are striving to create strategies through nursing care delivery models and organizational restructuring to empower themselves to practice professionally and provide quality patient care.

### *Job Satisfaction*

Nurses' satisfaction with their jobs has been a significant factor to consider as it can impact job

performance and patient outcomes (Kovner, Hendrickson, Knickman, Finkler, 1994). Job satisfaction is defined by Price and Meuller (1986) as the degree of positive affective orientation toward employment. It is one of the most frequently mentioned concepts in the literature describing nurses' burnout, commitment and turnover (Meuller & McCloskey, 1990). Also, Blegen's (1993) meta-analysis of nurses' job satisfaction identifies stress and organizational commitment as strongly related to satisfaction.

Kanter (1979) maintained it is the organizational structure that impacts on the individuals' job satisfaction, not personal characteristics. One study investigated both organizational factors as well as individual characteristics such as nurses' educational preparation. A study by Hinshaw, Smeltzer, and Atwood (1987) had a total population of 1597 nursing staff with 62% of the sample being registered nurses. The organizational factors included group cohesion and control over practice and autonomy. Group cohesiveness was defined as how integrated a nurse felt as part of the organization and colleague environment. The findings indicated that group cohesion is more important to job satisfaction of baccalaureate prepared nurses' than to those nurses who have diplomas. These researchers reported that important satisfiers for nurses were professional status and general enjoyment in their position.

Professional status and enjoyment correlated significantly with the ability to provide quality nursing care. This study established important links between nurses' job satisfaction and nurses' work environments. It provided a baseline from which to compare other studies which may have only examined one aspect of the nurses' work environment.

The relationship between nurses' job satisfaction and maintaining satisfactory relationships among nursing staff had been acknowledged as early as 1940 by Nahm. Blegen (1993) also identified elements involved in interpersonal relationships that have been consistent predictors of nurses' job satisfaction. These elements include work group cohesion, communication, and social integration.

This link between job satisfaction and the importance of work group relationships was further explored by two additional research studies. These studies were also interested in the impact of redesigned work environments on nurses' job satisfaction. Leppa (1996) and Tumulty, Jernigan and Kohut (1994) have investigated restructured work environments, work group reorganization and this impact on nurses' job satisfaction. Specifically, Leppa (1996) was interested in the relationships between work group disruption (absenteeism), nurse satisfaction with interpersonal relationships, and nurse perception of patient safety and quality of care. The nurses in four hospitals were studied (N=908), one suburban middle class, two inner-

city, and one inner-city middle class. Satisfaction with interpersonal relationships was considered an indicator of work group cohesion in this study as measured by Stamps and Piedmont's Index of Work Satisfaction scale. Nurse to nurse interaction had the highest satisfaction rating across all hospitals (range: 5.1-5.4/7). This underscored the importance of nurse interactions and group cohesion to job satisfaction. Lower satisfaction was reported by units with higher absenteeism and agency use. Nurse to nurse interaction was positively correlated with nurses' perceptions of patient safety ($r$=.30) and quality of care ($r$=.37).

Tumulty, Jernigan and Kohut (1994) acknowledged that the restructuring of health care delivery systems is creating dramatic changes in nurses' work environments. Their study explored the relationship between nurses' work environments and their job satisfaction and found, in general, that perceptions of nurses' work satisfaction was low (2.1-5.3/7, $M$= 3.84, $n$=159). Those nurses who reported being highly satisfied were also significantly more positive in their perceptions of the overall work environment ($F$ = 26.954, $p$ <.01). These researchers found that support and cohesion varied significantly by unit and that the nurses on units with stronger peer support were more satisfied. In addition, nurses who worked as maternal/child care providers were significantly more

satisfied and perceived a more positive environment on the relationship dimension. The authors attempted to explain this as a result of the primary model of nursing care that was practiced.

Another group of researchers investigated the relationship between nursing care delivery models and nurse satisfaction. Kovner, et al.(1994) studied the impact of management interventions and various nursing care delivery models on nurse satisfaction. Changing the work environment in an attempt to provide an atmosphere that would lead to increased satisfaction was the main objective. Kovner et al. (1994) noted that most of the innovations increased the autonomy and decision making power of the professional nurses. Nurse satisfaction was measured using the Index of Work Satisfaction (Stamps & Piedmont, 1986) at baseline and one year later in both groups. They found that nurses ranked pay as most important to their job satisfaction, followed by autonomy and professional status.

Organizational restructuring, work environment, nursing care delivery models, pay, autonomy, and, most commonly, work group relationships have been identified as factors which affect job satisfaction. The strong links found between work group relationships and cohesion and job satisfaction present an important message for hospital administrators and managers who want to support their staff in satisfactory work environments.

***Nurses' Job Stress***

There is evidence in the literature that has suggested a linkage between the amount of stress nurses perceive they are experiencing and the quality of care patients receive. Various studies have also reported that the climate of the unit or the care which is typically provided (intensive, chronic, acute) on that particular unit to be a predictor of nurses' job stress. Kanter (1977) would support this notion as it would be the organizational structure of the unit that dictates the care provided.

The first study explored job stress that nurses' experience and the impact on patient outcomes. Dugan, Lauer, Bouquot, Dutro, Smith, and Widmeyer (1996) completed a study using surveys that involved the self-reported stress of nurses caring for patients who incurred falls, medication errors and various patient incidents. Over a three month period there were staffing problems, including high levels of turnover, absenteeism, back injuries and needle sticks. The results indicated a significant relationship between nurses' stress and the occurrence of patient incidents ($R^2$ =.19, $p$=.05, $n$=48). Other explanations for these incidents were not discussed. This study provided evidence that when nurses' experience stressful working conditions, the quality of their patient care is compromised.

There is some evidence that the unit climate affects the stress experienced by nursing staff. A common belief in

the nursing profession is that intensive care nurses experience more stress than other hospital nurses. Dewe (1988) found that intensive care nurses experience more difficulty in nursing critically ill patients but the nurses on medical, continuing care, and orthopaedic units experience stressors more frequently. In addition, Gowell and Boverie (1992) found that nurses on a medical/oncology unit reported higher stress than nurses on any of the other seven acute care units in the study. This study reported that stress was the most strongly related factor to job satisfaction. Moore, Kuhrik, Kuhrik, and Katz (1996) surveyed acute care surgical nurses to determine their perceptions of work related stress. Workload, changing assignments, and lack of resources were responsible for 32% of the perceived stress for this sample of nurses. Other stressors reported were delegation of responsibilities, under-staffing, decreased patient contact, less control over work events, and job unpredictability.

Hinshaw, Smeltzer and Atwood (1987) reported a major finding from their study with 1597 nurses was that job satisfaction buffered job stress. The more satisfied nurses were with their jobs, the less stress they experienced. Professional job satisfaction was strongly predicted ($R^2$=.49, $N$=1597) by job stress ($B$=-.47). Job stresses included all the decisions that accompany patient care, multi-disciplinary collaboration and conflicting values, and

juggling multiple care expectations of all professionals as well as patients.

Dugan et al. (1996) suggest that workplace stress is becoming an epidemic in nursing for various reasons. They advise management to support nurses in strategies to increase their self-esteem and enhance their empowerment, in order to gain control over as many aspects of their work environment as possible. They contend that such steps, empowerment and sense of control are helpful in reducing stress.

### *Quality of Care*

The common theme that resurfaced in the literature is concern about the environment in which health care professionals practice and the impact this has on the provision of care. This concern is consistent with Kanter's (1979) theory that work environment is responsible for the job effectiveness of the employees.

Kanter's (1979) theory is supported by Kramer (1974) who postulated that a nurse's care-giving is less effective when the environment and organizational climate surrounding the patient is not healthy. Nurses who are not happy or are unable to practice in their work environment may experience some difficulty in creating a positive patient environment which promotes well-being.

The organizational structure continues to play an

integral role in the provision of quality care as illustrated by the following study. Aiken, Smith and Lake (1994) report that the same factors that led hospitals to be identified as effective organizations for nursing care are also associated with lower mortality rates among Medicare patients. They concluded that nursing care was of higher quality in satisfying work environments and had an important impact on lower mortality rates among hospitals.

Another study examined more specifically a redesigned work environment and quality of care. Silberzweig and Gigure (1996) reported the results of a study in a hospital that experienced redesign of their patient care delivery system. The study was initiated because they anticipated the quality of patient care might be compromised in the redesign effort. Quality of care was defined in this study in terms of Florence Nightingales' notion that a healthy environment supports healthy patients. Nightingale believed that it is the nurse's responsibility to provide an environment that maximized the healing process by reducing environmental stressors (Nightingale, 1989).

Silberzweig and Gigure (1996) proposed that nurses can create this environment by being there to listen, comfort and teach. These researchers made the assumption that most patients expect good medical care but it was their experience of 'illness' care or nursing care that determined their satisfaction with the quality of care in the hospital.

Thus, if patients recover in a healthy environment created by the nursing staff, then based on Kanter's (1979) theory the nursing staff should be satisfied and supported by the organizational structure in their work. The satisfaction with their jobs and the work environment will impact on the quality of the environment that nurses are able to provide for their patients.

Within nurses' work environment are many relationships that nurses develop which can be important to patient care. Work group relationships, in addition to influencing nurses job satisfaction, have been identified as important factors to consider in the provision of quality care. Hoffman and Martin (1994) believe that the nurses' perception of their work environment and the collaboration between health care professionals affect the delivery of quality patient care. They reported on a study that was performed in a children's hospital examining nurses perceptions of their work environment using the Work Environment Scale (Moos, 1986). They concluded that high quality team performance contributed to the two nursing goals of positive patient outcomes and enhanced staff satisfaction. Knaus, Draper, Wagner and Zimmerman (1986) carried out a study of 5030 patients in critical care areas and found that the involvement and interaction of critical care personnel, namely doctors and nurses, can directly influence patient outcomes in intensive care units. They reported the best

outcomes in terms of lower predicted mortality occurred in units with the most effective nurse-physician communication. That is, the highest quality of care appeared to require a high degree of involvement and communication by both doctors and nurses. Thus, work group relationships continue to be main contributors to nurse and patient satisfaction with quality of care.

In terms of direct patient care, some research has been completed to examine specifically what quality care means to both nurses and patients. Strasen (1988) notes that patients evaluate quality care based on the attention nurses give to their needs: answering call lights promptly, providing physical contact, maintaining a clean environment and providing food and choices. Greeneich (1992) identified three areas that are important in patient satisfaction with quality of nursing care: nurse personality characteristics (sensitivity, friendliness, kindness, helpfulness), nurse caring behaviors (empathy, compassion, communication and comfort measures) and nursing expertise (knowledge, technical skill, and organizational skills). They note that one unsatisfying experience can make the whole episode dissatisfying. This is an important point to consider when exploring patient satisfaction with nursing care and reporting results.

The acknowledgement of the importance of patient satisfaction to providing cost effective quality based care

has created new areas of research. Joiner (1996) recounted the process of one hospital's experience with improving patient satisfaction and how they measured quality of care. An in-depth analysis of patient satisfaction surveys, nursing research studies and her own beliefs about nursing practice led Joiner (1996) to describe four concepts that represented empathy. She used empathy as a proxy measure for quality of care. The four concepts were caring, respect, encouragement, and 'going the extra mile'.

Nurses from various committees in Joiner's study participated in the development of standards of practice related to caring as well as behavioral criteria. Four Standards of Caring were established and included: effective nursing staff communication with families and other disciplines; nurses demonstrating courteous consideration and respect; nurses promoting a sense of rest to patients/families; and the community of caring extending beyond the patient and family to their nursing colleagues. These standards were implemented through education sessions, and monthly follow-up, and evaluating the use of an observational data collection tool (for example, patients were called by their first names only with permission, noise levels were kept to a minimum).

It was found that the criteria were met 94% of the time. A positive effect of the caring standards on the patient satisfaction surveys was found and all questions

regarding nursing service had increased over time. Nurses reported that an increased perception of support from the organization increased their empathetic responses to the patients. This further illustrates Kanter's (1979) notion that organizational structures' supporting workers can enhance job effectiveness.

Luther (1996) examined quality of care from both the nurse and patient perspective. She considered patient satisfaction an indication of the quality of care provided by an organization. It was found that patients and nurses defined quality of care differently. Nurses spoke of quality of care in clinical terms including the adherence to treatment regimen, appropriate administration of medications, charting, and documentation. In contrast, patients used terms like communication, listening, responsiveness, availability to answer questions, and attention to individual needs and kindness. Luther's results regarding nurses' perceptions of quality of care underscore the reality of the gap between nurses' and patients' perceptions of quality of care.

The work by Brown and Ritchie (1989) provided further evidence of this gap between what nurses believe they are accomplishing and what they really are practicing. In their study of 25 pediatric nurses, all of the nurses indicated they were adequately prepared to care for parents of hospitalized children. However, their descriptions of

relationships with parents indicated otherwise. Their study was conducted in a pediatric setting where parents were included in the 'patient' definition. Brown and Ritchie (1989) found that nurses set limitations on parental involvement in care and they explained their findings in terms of three inter-related factors. First, nurses were unaware of the impact their behavior had on the relationships with parents and the care they provided for them. The second factor involved the lack of opportunity for nurses to develop their communication skills with families. Third, the power structure of the hospital influenced the behaviour of nurses towards parents regarding nursing care and relationships. They noted that the nurses seemed unaware of how the hospital environment influenced them and their professional behaviour. Themes of Kanter's (1979) theory are illustrated through-out the research studies discussed, highlighting the importance of the organizational structure to nurses' work environment and ultimately the provision of quality care.

Joiner's (1996) findings were interesting to compare with Brown and Ritchie (1989) and Luther's work, as communication was noted as an important component of quality care by all three. Brown and Ritchie (1989) found that nurses did not have the opportunities to develop their communication skills, while the other two studies indicated this was important to patients as part of quality care. The

research revealed a gap between what patients believe they need and evidence indicating they are receiving it. The challenge is to unite the nurses' and patients' philosophies of quality nursing care and determine the commonalities of these perspectives.

## Summary

Limited research has been completed with respect to the impact of the redesigned nurses' work environment and the affect this has on the quality of care that is provided to patients. Most of the literature about mergers of hospitals was anecdotal, offering suggestions on how to implement a successful merger, whether it is whole hospital or unit based. The literature completed is descriptive and provided some groundwork for future research.

The research on nurses' satisfaction with their jobs and work environment is more developed, providing convincing evidence that key areas of nurses' practice affect their job satisfaction and work environment satisfaction. Researchers have found significant relationships between work environment and job satisfaction (Bruce et al. 1995; Tumulty & Kohut, 1994), and nurses' perceptions of empowerment and organizational commitment, autonomy, burnout, and participation in organizational decision-making (Bruce et al. 1995; Hatcher & Laschinger, 1996; Sabiston & Laschinger, 1995; Wilson & Laschinger, 1994). Work environment factors related to job satisfaction include control over nursing

practice (Laschinger & Havens-Sullivan, 1996; Hinshaw, Smeltzer & Atwood, 1987; McCloskey & McCain, 1987), group cohesion (Leppa, 1996; Hinshaw, Smeltzer & Atwood, 1987), autonomy (Acorn, Ratner & Crawford, 1997; Sabiston & Laschinger, 1995; Hinshaw, Smeltzer & Atwood, 1990; McCloskey & McCain, 1987), job stress (Moore et al. 1996; Gowell & Boverie, 1992; Hinshaw, Smeltzer & Atwood, 1987), and quality of work relationships (Tumulty, Jernigan & Kohut, 1994, Knaus, Draper, Wagner,& Zimmerman, 1986; Dugan et al. 1996). Work environments characterized by autonomy, control over practice, and positive group cohesion are often associated with higher levels of job satisfaction.

Quality of care has been examined from the health care professional perspective but new research is asking patients their perceptions of quality care. These results have been reported but there is little evidence that they have been used in changing nursing practice. One of the challenges is for health care professionals and patients to mutually define quality of care. Health care professionals and patients have varied expectations of what quality of care means (Joiner, 1996; Greeneich, 1992; Brown & Ritchie, 1989; Luther, 1996, Strasen, 1988).

The relationships between nurses' satisfaction with their work environment and jobs and the impact this has on the provision of quality of care based on the nurses' and patients' perspectives have yet to be clearly established.

The evidence in the research discussed using Kanter's (1979) framework suggests there is a relationship between these factors, however, the linkages have not been made. This study examined these relationships in the interest of establishing these linkages. The following were the proposed hypotheses and questions of this research study:

**Hypotheses and Questions**

The hypotheses for the study were:

Hypothesis 1 a): The nurses on the unit that was restructured 18 months ago will be more satisfied with their work environment and jobs than the nurses on the unit which experienced restructuring 6 months ago.

Hypothesis 1 b): The parents on the unit that was restructured 18 months ago will be more satisfied with the quality of care than the parents on the unit that was restructured 6 months ago.

Hypothesis 2: There is a positive relationship between nurses' satisfaction with their work environment and their job satisfaction.

Hypothesis 3: If the nurses' working on one unit are more satisfied with their jobs and work environment than those on the second unit, then, the families receiving care on the first unit will be more satisfied with their child's nursing care.

Hypothesis 4: The higher reported parent satisfaction scores the higher the scores for nurse-parent interactions.

Question 1) What is the influence of length of stay, child's age, parent's age, time parent spent visiting in hospital, number of previous admissions on parent's satisfaction with nursing care?

## Chapter 2

## Methodology

This descriptive, correlational study explored the relationship between nurses' professional work environments and families' perceptions of quality patient care. Professional nurses working on two units that had physically merged their nursing care environments were asked to complete questionnaire packets. Families who received care on these two units were also asked to complete a questionnaire packet.

### Setting

The IWK Grace Health Centre has a shared governance model in the nursing organizational structure. Nurses from all positions within the Health Centre represent their colleagues as council representatives discussing nursing administrative and practice issues. Staff nurses, managers and administrators have created this organizational structure to ensure nursing practice decisions within the Health Centre are made by the nurses who are affected by those decisions. The Health Centre's management team recognize that nurses' work environment is an important component in nurses' job satisfaction and believe that it impacts the provision of quality of care to patients and families.

The IWK Grace Health Centre support the philosophy of family centred care as proposed by the Association for th e Care of Children's Health (ACCH). This philosophy acknowledges the integral role of the family in the planning and provision of care.

Along with other health care institutions, the IWK Grace Health Centre has examined restructuring and redesign of nurses' work environments. The nurses working in these two units had experienced a great number of changes in 18 months prior to the study. The nurses on both units had issues related to job stress, nurse and patient satisfaction, unit redesign, and concern regarding quality of their care.

Unit A experienced the merger process in April 1996. This 25 bed inpatient unit with an average census of 13, an average number of monthly admissions of 100, had an average length of stay between 48 and 72 hours. This unit was the result of the blending of nurses from two units, one which provided care to infant surgical and cardiovascular patients, and the other provided care to children having general or specialty surgical procedures, gynecology and plastic surgery patients. Both units practiced total patient care prior to merging. Physical restructuring was not required for this merger to occur but nurses from one of the units had to leave their physical work environment to care for their patient population on the other unit. Nurses

blended their nursing expertise to care for all children and families on the new unit. This created some anxiety for the nurses as some had to work in a new environment, providing care to families with an unfamiliar diagnosis, and develop new work relationships with other health care professionals.

Unit B was a newly merged nursing unit in the IWK Grace Health Centre. The nurses on this unit primarily provided care for nephrology and oncology patients and families. This was an 18 bed inpatient unit with an average census of 13, average monthly admission rate of 30 families and an average length of stay of 13 days. Previously, the oncology and nephrology units were geographically separated and the professional care models were different for each unit. One unit stated that they practiced primary nursing while the other stated they practiced total patient care. The nurses were challenged to blend the two cultures and professional care models to meet the needs of the patients and families and sustain the quality of care to which the families were accustomed. Six months prior to the study, the geographical space in which care was provided to these two patient populations was altered to make one nursing unit. Nurses continued to care primarily for the patient population of their original nursing unit but, on occasion, cared for children requiring nursing expertise in an area where their practice has not been concentrated. This caused some

anxiety on the part of the nursing staff regarding quality of care that they provided to children and families.

## Sample

The population of interest was all professional nurses providing care to inpatient families on the two restructured nursing units of 6 North and 5 South at the IWK-Grace Health Centre. The total population of 69 nurses working full-time and part-time were surveyed.

Exclusion criteria:

1. nurse who was on a leave of absence for any reason.
2. casual nurse who had worked less than .4 of a full-time equivalent on the units for 6 months preceding the study.

The family sample included the parents of 48 children who received inpatient care on 6 North and 5 South. The family participant was randomly chosen on a daily basis. Mothers, fathers, and legal guardians were invited to participate but the preference was that the participant be the parent who had the most contact with the nursing staff during the hospitalization.

The exclusion criteria were:

1. The family was experiencing major crisis, for example, child's medical status was unstable, or the unit charge nurse believed that participating would add considerable strain to the social situation.
2. The child had been an inpatient for longer than 3 months.

## Data Collection

The data was collected using surveys of nurses and parents with established questionnaires. The professional nurse completed the Work Environment Scale (WES, Moos, 1987, Appendix A) and the Index of Work Satisfaction (IWS, Stamps & Piedmont, 1986, Appendix B). The parent completed The Nurse-Patient Interaction Scale (Krouse, Krouse, Roberts, 1988, Appendix C) and the Patient Satisfaction Survey adapted for parents (Mergivern, 1986, Appendix D).

The study was introduced at a staff meeting of the 6 North and 5 South nursing units. For the nursing staff, the questionnaire packets were distributed, individually addressed, to each nurse on the unit. Each packet included a covering letter (Appendix E), the questionnaires, and a return envelope. The covering letter described the study, the time frame, and method for returning the completed questionnaires.

Nurses were asked to identify whether or not each item on the WES was present in their workplace, and their level of agreement with each statement in the Work Satisfaction Scale (IWS). After a 14 day period, a letter (Appendix F) was sent to each nurse on the unit thanking those who have already returned their completed questionnaire and encouraging the non-respondents to answer promptly.

Parents whose children received care on Unit A or B inpatient nursing units were invited to participate in the

study. Parents were approached on an individual basis. A letter (Appendix G) describing the study, the time frame and the method of returning the questionnaire was given to the parents at this time. Study participants were asked to complete the questionnaires based on their current hospital experience. The families were asked to complete surveys within 24 to 72 hours after being enrolled in the study, while they remained as inpatients. The parent surveys were returned to the Nursing Research Department in a sealed envelope. Parents were given the option of giving the questionnaire directly to the investigator the day following enrollment instead of sending it in inter-hospital mail.

## Instruments

The Work Environment Scale (WES) consisted of 3 dimensions measured by 90 items representing 10 subscales. Participants were asked to indicate which statements are true of their work environment and which are not. The first dimension, relationships, included subscale measures of involvement, peer cohesion, and supervisory support. The second dimension of personal growth measured autonomy, task orientation, and work pressure. The system maintenance and system change dimension consisted of scales measuring clarity, control, innovation and physical comfort. Each response that indicates a positive work environment was assigned a value of 1, thereby permitting the calculation of a total and subscale scores. The instrument has been tested

extensively with many groups, including nurses and health care workers. Adequate reliability and validity have been reported. The Form R subscale internal consistencies ranged from .66 to .84 in a sample of nurses (Constable, 1984). Test-retest reliabilities varied from .69 for clarity to .83 for involvement (Moos, 1994).

The Index of Work Satisfaction (IWS) involved two sections. The first section measured the relative importance of various aspects of job satisfaction. The second section measured the respondent's level of satisfaction with these components using a Likert type scale. The 60 item scale indexed satisfaction with autonomy, interaction, professional status, organizational policy, administration and task requirements. Each component produced a separate score which, when added together with other components, provided a total score. Adequate reliability and validity have been reported. A factor analysis was utilized to assess validity and produced seven factors accounting for 59% of the variance among the items. Internal reliability, determined by the use of Cronbach alpha coefficient was reported as .912 (Stamps & Piedmont, Slavitt & Hasse, 1978).

The Nurse-Patient Interaction Tool (N-PIT) was a 44-item Likert type developed by Krouse, Krouse and Roberts (1988). It was developed to assess patients' perceptions of nurse-patient interactions. It was adapted for use with

permission from the authors. Wording of questions was changed to be appropriate for parent respondents. The internal consistency of the overall scale was .76( Krouse & Roberts, 1989).

The Patient Satisfaction Survey (Megivern, 1986) was a 37 item survey assessing satisfaction with nursing care. It was developed for use by patients or family members of patients in critical areas and was adapted for use, with permission, in a previous study by Ritchie, Bruce, Knox, Belliveau, English and Turner (1994) at the IWK Grace Health Centre for completion by parents. Ritchie et al. (1994) excluded 5 items from the scale such as flexibility of visiting hours and waiting room facilities and also reworded survey questions to be appropriate for parent respondents. Megivern, Halm and Jones (1992) reported that content analysis was used to determine reliability. Interrater reliability was established for this analysis with a 90% agreement rate.

## Data Analysis

The findings were analyzed using descriptive and inferential statistics. Total and subscale scores were calculated where appropriate. Descriptive statistics were used to provide a summary of the demographic profile and the mean scale scores for both the parents' and nurses' questionnaires.

T-tests were used to examine between unit differences on nurses' Work Environment Satisfaction subscale scores (WES), nurses' job satisfaction (IWS), and the parent satisfaction scores (PSS). The means on the WES and the IWS were compared between the two nurses' groups. T tests were used to determine differences between: nurses' satisfaction with their work environment (WES) and parent satisfaction with the quality of nursing care (PSS), nurses' job satisfaction (IWS) and parent satisfaction with the quality of nursing care, parent satisfaction with the quality of nursing care(PSS) and nurse-parent interactions (N-PIT). Pearson $r$ correlations were used to determine a relationship between nurses' satisfaction with their work environment (WES) and nurses' job satisfaction (IWS). Regression analysis was used to analyze the influence of demographic factors, for example, age of child, if parent rooming in or not, length of stay, age of parent, and number of previous admissions on parent satisfaction.

Focus groups were used to share the results with the nursing staff of each unit. Nurses comments during these sessions provided further support for the findings and aided in explaining some of the unit differences.

**Limitations**

The units were not completely homogeneous other than they both had been restructured, and care for inpatient pediatric children and families. There were extraneous

variables which cannot be controlled for on each of the units, such as length of stay, diagnosis, and nursing care delivery model. There was no baseline, pre-restructuring data available to determine the similarity between units prior to any merger.

## Ethical Considerations

Participation in this study was voluntary. Nurses and parents received a covering letter inviting their participation and explaining that participation would not affect the nurses' employment or the care received by the family. There was no anticipated risk to any participant. Only grouped data is presented protecting the anonymity of the participants. All responses are confidential. Return of completed questionnaires served as consent to participate in the study.

Letters (Appendix H) were sent to all physicians who provided care to inpatients on these two units informing them about the study.

# Chapter 3

## Findings

This chapter includes the results of the statistical analysis as outlined in the methodology. An overview of the nurse and parent questionnaire results are provided in response to the posed hypotheses. Quantitative findings for both parents and nurses are presented in table format and qualitative feedback from parents regarding their perceptions of the quality of nursing care is noted.

Sixty-nine surveys were distributed to the nursing staff of two in-patient units: 41 surveys were returned for an overall response rate of 59%. Sixteen nurses from Unit A responded (69%), while twenty-five were returned from Unit B (54%). Both inpatient areas were very busy during the time the nurses and families were surveyed. Nurses commented that there could have been a better response rate if they had not been so busy. Demographic data collected from the nurses showed that nurses working on Unit B were younger and more of them were baccalaureate prepared, as compared to the nurses practicing on Unit A, who were mostly diploma prepared. The hours of employment were very similar for both groups. There were no casual nurse respondents from Unit A (Nurse Demographic Data, Table 1).

**Table 1**
**Nurse Demographics (N=41)***

| Variable | Unit A (16) | % | Unit B (25) | % |
|---|---|---|---|---|
| AGE | | | | |
| 20-30 yrs | 3 | 18 | 7 | 28 |
| 31-40 yrs | 4 | 25 | 13 | 52 |
| 41-50 yrs | 6 | 38 | 2 | 1 |
| >50 yrs | 1 | 1 | 0 | |
| EDUCATION | | | | |
| Diploma | 12 | 75 | 8 | 32 |
| Baccalaureate | 2 | 13 | 13 | 52 |
| EMPLOYMENT | | | | |
| Full-time | 8 | 50 | 10 | 40 |
| Part-time | 7 | 44 | 9 | 36 |
| Casual | 0 | 0 | 4 | 16 |

*Not all respondents provided all demographic information

In the following section, each hypothesis will be presented and discussed briefly. Both parts of the first hypotheses regarding time since restructuring occurred and satisfaction with work environment for nurses and quality care for families were not supported by this sample of nurses and families.

**Hypothesis 1a:** The nurses on the unit that was restructured 18 months ago will be more satisfied with their work environment and jobs than the nurses on the unit which experienced restructuring 6 months ago. The nurses on unit A ($M$=45.2, $SD$=7.20) were less satisfied with their practice environment (WES) that was restructured 18 months before the study, as compared with unit B ($M$=49.1, $SD$=7.09) that was restructured 6 months prior to the study. This was

consistent with the nurses' responses on the job satisfaction survey (IWS), Unit A scored lower (M=163.8, SD=22.7) than Unit B (M=171.4, SD=28.4).

**Hypothesis 1b**: The parents on the unit that was restructured 18 months ago will be more satisfied with the quality of care than the parents on the unit that was restructured 6 months ago. The parents on Unit A, which had been restructured before Unit B, were less satisfied than those parents whose children who had received care on Unit B. The scores for Unit A were lower on both instruments, N-PIT (M= 125, SD=14) and PSS (M=120.9, SD=14.73) as compared to Unit B, N-PIT( M=131, SD=13.4) and PSS ( M=131, SD=12).

**Hypothesis 2:** There is a positive relationship between nurses' satisfaction with their work environment and their job satisfaction(r=.28, P=.03,1 tailed significance). The data analysis did support this relationship between nurses' satisfaction with their practice environment and nurses' satisfaction with their jobs. The nurses on Unit B were more satisfied with their work environment and their jobs as compared to Unit A. For these two groups of nurses, the mean scores for both the WES and IWS were higher for Unit B (WES, M=49.1, IWS M=171.4) as compared to Unit A (WES M=45.2, IWS, M=163.8).

**Hypothesis 3:** The higher the reported nurses' job

satisfaction and nurses' work environment satisfaction, the more satisfied the parents will be with nursing care. The two groups of nurses' job satisfaction scores (IWS) were compared. On Unit A the IWS score was (*M*= 163.8, *SD*=22.7) while on Unit B the IWS score was (*M*=171.4, *SD*=28.4). The WES scores for both areas had the same trend, Unit A scores were lower, (*M*=45.2, *SD*=7.20) than Unit B (*M*= 49.1, *SD*=7.09). Differences were found using a two sample *t*-test between the nurses from the two units surveyed in this study on satisfaction with their jobs (IWS) ($t_{39}$= -.90, *p*=.37) and Work Environment Scale (WES) ($t_{39}$=-1.69, *p*=.09). Some individual subscales for each survey had statistically significant differences (Tables 4 & 5). The nurses who practiced on Unit B were generally more satisfied with their practice environment and jobs than the nurses on Unit A. The parents on Unit B were more satisfied with the quality of care provided by the nursing staff than the parents on Unit A. The means for the N-PIT for Unit A were (*M*=125, *SD*=14) and Unit B (*M*= 131, *SD*=13.4). A two sample *t*-test was also used to compare the two groups of parent scores on the N-PIT ($t_{46}$=-1.58, *p*=.06) and on the PSS ($t_{41}$=-2.40, *p*=.01) (N-PIT and PSS graphs, fig.3). Therefore, this hypothesis was supported by the data analysis.

**Hypothesis 4:** There was a positive relationship between parent satisfaction scores and nurse-parent interactions

($r$=.65, $P$=.000, 1 tailed significance). The families from Unit B scored higher on both the Nurse-Patient Interaction Tool ($M$ =131, $SD$=13.4) and the Parent Satisfaction tool ($M$ =131., $SD$=12). The NPIT scores for the families Unit A were (M=125, $SD$=14) and Parent Satisfaction Questionnaire were (M=120.9, $SD$=14.7).

Additional questions were explored using Spearman's rho correlation regarding the magnitude of possible relationships between nurse's demographic data such as age and education and satisfaction with jobs and work environment. The nurses perceptions of work practice satisfaction varied with age, and educational preparation for nursing practice. Spearman's rho was also used to determine strength of relationships between parents' satisfaction with nursing care and reported family demographics such as child's age, parent age and length of stay. Unit specific parent satisfaction with nursing care was not explained in any way by predisposing factors such as age of parent, whether the parent roomed in the hospital with their child, or child's length of stay. Although it is of note that the children admitted to Unit A were younger than those admitted to Unit B.

## Relationship, Personal Growth, System Maintenance and Change Dimensions

The ten subscales in the Work Environment Scale assess three underlying sets of dimensions. The Relationship dimension is made up of the involvement, coworker cohesion and supervisor support subscale. Nurses' identification of personal growth dimensions in their work environment is measured by compiling the results from the autonomy, task orientation and work pressure scale. The work pressure scale scores were reversed. System maintenance and change dimensions were measured by combining the clarity, managerial control (reversed scores), innovation and physical comfort scales. Significant differences were found between the two units on the system maintenance and growth dimension scales(Table 2). Bruce et al. (1995) gathered the same information from nurses in the IWK site of the Health Centre. These results are compared on the Work Environment Scale and the Index of Work Satisfaction.

**Table 2**

**Relationship, Growth and System Maintenance Dimension**

| | N | Mean | SD | t | P | M✚ | SD✚ |
|---|---|---|---|---|---|---|---|
| Relationship | 16(A) | 12.00 | 2.68 | -2.23 | .03* | 17.88 | 4.14 |
| | 25(B) | 14.24 | 3.38 | | | | |
| Growth | 16(A) | 12.12 | 2.84 | -1.12 | .27 | 19.55 | 3.27 |
| | 25(B) | 13.10 | 2.90 | | | | |
| System | 16(A) | 12.12 | 2.84 | -3.13 | .002** | 15.33 | 3.81 |
| | 25(B) | 16.20 | 3.75 | | | | |

✚ Bruce et al.(1995) n = 180

## Nurses' Perceptions of Support from their Practice Environment

The nurses from both areas had similar responses regarding their perceptions of support from their management structure although Unit B perceived their environment to be significantly more supportive than Unit A (WES, Table 3). There were trends found in the supervisor support and role clarity scales with both units being quite dissatisfied but Unit A was significantly more dissatisfied than Unit B. The nurses on Unit A and B responded quite differently in terms of what they perceive to be present in their work environments as compared to the sample of nurses who responded in 1995 (Bruce et al.).

**Table 3**

***Work Environment Scale***

| Subscales | Unit A n = 16 | | Unit B n = 25 | | | | | |
|---|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | t | p | M✚ | SD✚ |
| Involvement | 4.43 | 1.45 | 5.36 | 1.91 | -1.64 | .10 | 7.01 | 1.90 |
| Peer Cohesion | 5.00 | 1.46 | 4.96 | 1.69 | .08 | .93 | 5.69 | 1.59 |
| Supervisory Support | 2.56 | 1.59 | 3.92 | 1.52 | -2.73 | .009* | 5.14 | 1.72 |
| Autonomy | 5.31 | 1.53 | 5.08 | 1.75 | .43 | .667 | 6.26 | 1.79 |
| Task Orientation | 6.25 | 1.80 | 5.88 | 1.09 | .82 | .418 | 7.13 | 1.67 |
| Work Pressure | 8.43 | 1.31 | 6.80 | 1.82 | 3.10 | .004* | 6.10 | 2.31 |
| Role Clarity | 2.75 | 1.57 | 3.64 | 1.41 | -1.89 | .06 | 4.87 | 1.91 |
| Managerial Control | 5.06 | 1.84 | 4.96 | 1.39 | .20 | .84 | 5.14 | 1.90 |
| Innovation | 3.50 | 1.46 | 4.56 | 1.71 | -2.05 | .04* | 5.34 | 2.35 |
| Physical Comfort | 1.93 | 1.91 | 3.96 | 2.07 | -3.14 | .003* | 4.52 | 2.40 |

✚ **Bruce et al. (1995) n = 180**

The nurses from both units reported being similarly satisfied with their peer support at work, and their satisfaction with managerial control. There were slight differences between the nurse's responses regarding involvement and the support provided to make their own decisions (autonomy) as well as with task orientation. This scale captured how satisfied nurses were regarding their expectations of their daily routine and how well rules and policies were communicated. Unit B nurses reported being more concerned about and committed to their jobs than the nurses on Unit A.

Significant differences were reported between units on four of the 10 subscales, physical comfort, innovation, work pressure and supervisor support. Of the two nursing care areas, Unit B had recent physical environment renovations with which the nurses reported being satisfied, as compared to the nurses on Unit A which had not had any updating of their physical practice area. The nurses from Unit A scored very low on this satisfaction scale. On the innovation subscale, Unit B nurses indicated that they were more accepting of change and new approaches in their practice environment, scoring above Unit A. Work pressure, or the degree to which work demands and time pressure dominate the work environment, was reported as being very high on both units, but the nurses on Unit A were significantly more dissatisfied than the nurses on Unit B. Nurses from both

units indicated their dissatisfaction with the extent to which management is supportive of nurses and encourages them to be supportive of each other. Unit A nurses perceived less management support than the nursing staff working on Unit B. The support subscale was quite different from the results reported by Bruce et al. (1995). Other specific areas which indicate a decline in satisfaction with work environment are involvement, role clarity, innovation, and physical comfort. Overall, there were strong relationships between supervisor support and involvement ($r$=.50, $p$=.001), support and work pressure ($r$ =.-51, $p$=.001), support and role clarity ($r$=.57, $p$=000), and a moderate positive relationship between support and coworker cohesion($r$=.36, $p$=.02). Essentially, the more supported nurses perceived management to be of their nursing practice, the more nurses were concerned and committed to their jobs and the less work pressure they experienced. The more management support nurses perceived having, the more friendly and supportive staff perceived each other to be and the clearer nurses were about what was expected of them on a daily basis. Role clarity was also positively related with involvement ($r$=.43, $p$=.007) and negatively with work pressure ($r$=.-59, $p$=.000). Thus, the clearer nurses were about their role, the more involved they were in their professional practice and the less work pressure they perceived.

Managerial control was found to be positively related to task orientation ($r$=.42, $p$=.01) and work pressure ($r$=.35, $p$=.03) while it was negatively related to management support ($r$=-30, $p$=.05). Thus, the more control nurses perceived management to have, the more tasks nurses reported having to do in their practice, the more work pressure they experienced and the less supportive they believed management to be of their nursing practice.

Strong positive correlations were found between innovation and involvement ($r$=.63, $p$=.000), and innovation and supervisor support ($r$=.41, $p$=.01). Nurses who reported being more satisfied with the variety, changes and new approaches (innovation subscale) in their practice area also experienced less work pressure ( $r$=-.46, $p$=.004). Nurses who indicated that they were more satisfied with their physical surroundings also reported being more involved ($r$=.40, $p$=.01). All subscale relationships make sense in terms of the direction and strength.

The coefficient alphas' for the subscales for the WES for this population of nurses were as follows: involvement (.69), coworker cohesion (.43), supervisor support (.47),autonomy (.40), task orientation (.31), work pressure (.64), clarity (.29), managerial control (.45), innovation (.60), physical comfort (.67). Overall, these alphas were lower than those reported by the authors of the scale (Moos, 1987).

The second questionnaire, the Index of Work Satisfaction (Stamps & Piedmont, see Table 4), illustrated a similar trend between Unit A and Unit B, regarding nurses satisfaction. Consistent with the results from Bruce et al.'s, all scales were scored lower by the nurses on both Unit A and B. Significant differences were found between Unit A and B regarding job satisfaction in areas such as professional status, or the overall importance felt about the job at the personal level and to the organization. Consistent with the findings from the Work Environment Scale, the nurses from Unit B were more satisfied with their jobs than the nurses from Unit A. There were also differences found between the units with respect to constraints or limitations perceived to be imposed upon job activities by the administrative organization.

**Table 4**

**INDEX OF WORK SATISFACTION**

| | Unit A n=16 | | Unit B n=25 | | | | | |
|---|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | t | p | M✚ | SD✚ |
| Professional Status | 4.99 | .694 | 5.54 | .658 | -2.56 | .01* | 5.53 | .72 |
| Interaction | 4.93 | .958 | 4.34 | 1.07 | 1.78 | .08 | 5.21 | .80 |
| Autonomy | 4.24 | .893 | 4.59 | .942 | -1.19 | .24 | 5.14 | 1.01 |
| Task Orientation | 2.82 | 1.00 | 3.07 | .981 | - .79 | .43 | 3.69 | .94 |
| Organizational Policy | 2.69 | 1.00 | 3.36 | .958 | -2.14 | .03* | 3.44 | 1.04 |
| Pay | 1.64 | .71 | 1.73 | .82 | - .39 | .69 | 2.57 | 1.11 |

**✚ Bruce et al. (1995) N = 180**

Relationships were found between professional status and pay ($r$=.29, $p$=.04), pay and organizational policies ($r$=.43, $p$=.002), organizational policies and professional status ($r$=.28, $p$=.05) and organizational policies and task requirements($r$=.63, $p$=.000). Satisfaction with organizational policies was also highly correlated with autonomy ($r$=.53, $p$=.000). The more satisfied nurses were with the tasks of their job, the more autonomous they perceived themselves to be in their work practice. The internal consistency of the IWS was measured using Cronbach's alpha with an overall coefficient alpha of .72. The coefficient alpha for the individual subscales are as follows: professional status (.35), interaction (.83), autonomy (.79), task (.77), organizational policies (.77), and pay (.79). These alphas, with the exception of professional status, were in the expected range.

The results of the data analysis using the demographic variables support a significant inverse relationship between nurses' age and the perception of supervisor support ($r$= -.37, $p$=.01), age and role clarity ($r$=-.33, $p$=.03) and age and autonomy ($r$=-.36, $p$=.03). Therefore, younger nurses perceived more supervisor support, reported themselves to be more autonomous and were clearer about what the expectations of their professional roles were on a daily basis. Relationships were also found between nurses who had baccalaureate education as compared to diploma prepared

nurses (Table 5).

Nurses who had more nursing education perceived having more professional status and less work pressure, identified more tasks in their jobs and were clearer about their roles at work.

**Table 5**

***Nurses' Education Comparison by Subscale***

| IWS | Diploma (n=20) | | Baccalaureate (n=15) | |
|---|---|---|---|---|
| | M | SD | M | SD |
| Pay | 1.59 | .52 | 2.05 | 1.25 |
| Prof Status | 5.23 | .76 | 5.74 | .45 |
| Interaction | 4.55 | 1.02 | 4.87 | 1.01 |
| Task Req'mt | 3.02 | 1.12 | 3.26 | 1.10 |
| Org'n Policy | 3.25 | 1.11 | 3.44 | 1.12 |
| Autonomy (7 pt scale) | 4.48 | .95 | 4.82 | .95 |

| WES | Diploma (n=20) | | Baccalaureate (n=15) | |
|---|---|---|---|---|
| | M | SD | M | SD |
| Physical | 2.75 | 1.96 | 4.33 | 2.20 |
| Role Clarity | 2.92 | 1.64 | 4.06 | 1.35 |
| Super Support | 3.42 | 1.79 | 4.17 | 1.95 |
| Innovation | 4.33 | 1.79 | 5.06 | 2.15 |
| Peer Cohesion | 4.63 | 1.66 | 5.72 | 1.56 |
| Mgmt Control | 4.71 | 1.90 | 5.00 | 1.61 |
| Involvement | 4.96 | 1.85 | 6.17 | 1.86 |
| Task | 5.67 | 1.43 | 6.61 | .98 |
| Autonomy | 5.75 | 1.57 | 5.22 | 1.83 |
| Wk Pressure (10 pt scale) | 7.67 | 1.97 | 6.89 | 1.45 |

## Parent Perceptions of Nursing Care

A total of 48 families participated in the study, 25 from Unit A and 23 from Unit B (Family demographic data Table 6). Some parents chose not to complete all of the demographic data, and two parents completed only one of the two surveys. Parents of children who had been in hospital for more than 24 hours and less than 3 months were invited to participate. For those parents who were interested in participating, the parent who had experienced the most contact with the nursing staff were encouraged to complete the questionnaire.

This study proposed that the higher the parent satisfaction scores, the more satisfied parents would be with nurse-patient interactions. The two questionnaires completed by the parents were considered the measures of quality nursing care for this study. Families admitted to Unit A had a shorter length of stay, thus a higher turnover and more readily available for sample consideration. The families admitted to Unit B had longer lengths of stay, therefore there were fewer families to be randomly selected for the study.

**Table 6**

**Family Demographics (N=48)**

| | Unit A (25) | Unit B (23) |
|---|---|---|
| **Parent Age** | | |
| 21-30 yrs | 9 | 4 |
| 31-40 | 12 | 10 |
| 41-50 | 3 | 3 |
| >50 | 0 | 1 |
| **Child Age** | | |
| 0-12 month | 8 | 1 |
| 1-3 years | 6 | 0 |
| 4-6 years | 1 | 8 |
| 7-10 years | 3 | 7 |
| >10 years | 3 | 2 |
| **Marital Status** | | |
| Married/partner | 21 | 15 |
| Not Married | 4 | 6 |
| **Parent Roomed In** | | |
| Yes | 17 | 17 |
| No | 6 | 2 |
| Some Nights | 2 | 2 |
| **Previous Adms** | | |
| **1-2** | 8 | 4 |
| 3-4 | 1 | 0 |
| 5 or more | 7 | 5 |
| None | 9 | 12 |
| **Length of Stay** | | |
| 24-48 hrs | 2 | 2 |
| 48- 1 week | 18 | 12 |
| 1-2 weeks | 4 | 1 |
| >2 weeks | 0 | 6 |

The Patient Satisfaction Survey (PSS, Mergivern, 1986, adapted for parents) assessed parent's satisfaction with nursing care. The Cronbach alpha for the PSS was .84.

***Sample Questions PSS***

1. The way the nurses listened to me was_____.
. The way the nurses involved the family in making decisions was_____.
3. The way the nurses on all shifts worked together on my care was_____.

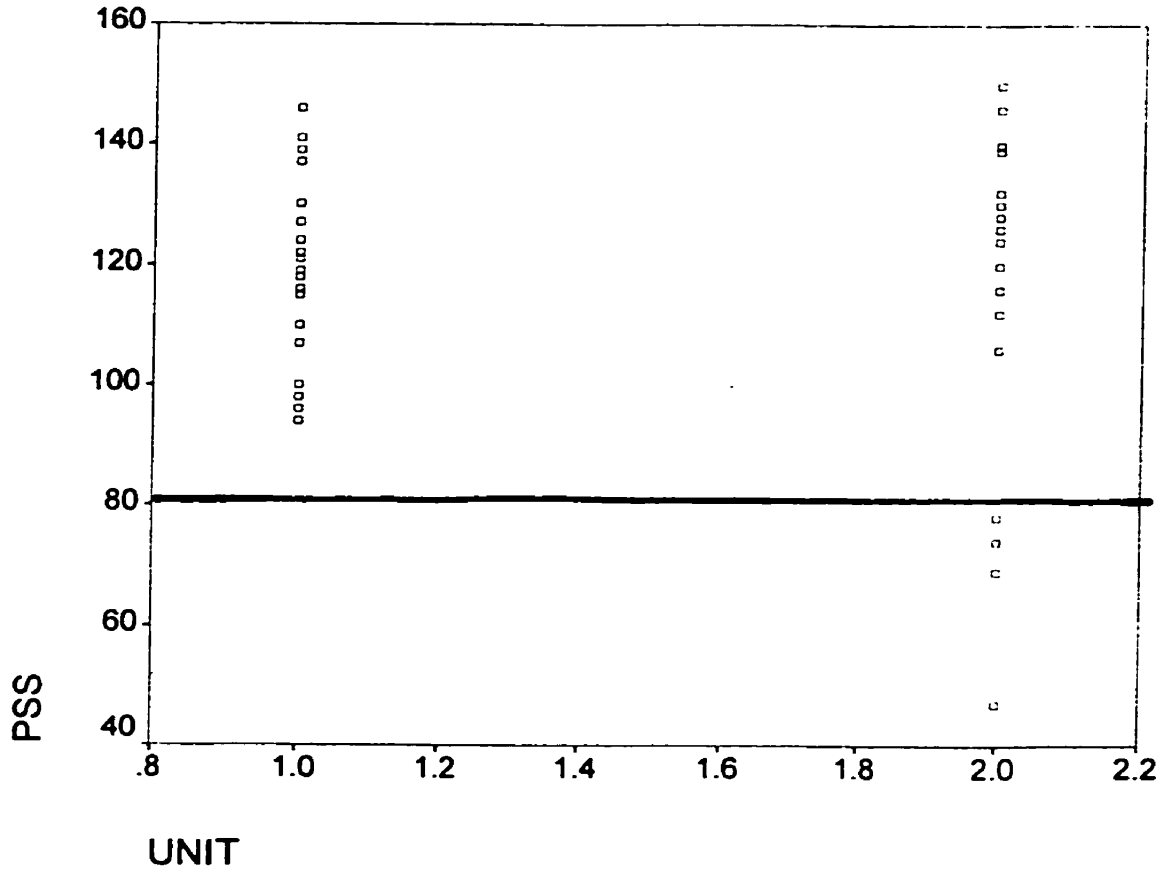
(Possible responses: Excellent, Good, Satisfactory, Fair, Poor)

A total score was taken from the 30 scale items for a total possible score of 150. There were significant differences found between the two nursing units regarding parent satisfaction with nursing care as indicated in the hypothesis section. As noted, four families were removed as they plotted very differently from the majority of the families from Unit B.

The scores for those families that were removed were 45, 69, 74 and 79 (Fig.1 PSS Scatterplot).

Figure 1 PSS Scatterplot






Of the four families that were removed from the analysis, demographic data from two of the families were provided. Of these, both had partners or were married, roomed in with their child, had 1-2 previous admissions, and average length of stays of 2-3 days. The parents were in the 31-40 age range and their child was between 4 and 6 years old. The demographic information does not provide enough information to explain why these families may have been so dissatisfied with the nursing care. Possible explanations for their marked dissatisfaction with care could have been related to the fact that two of the four had received specialized

diagnosis specific care on one of the units prior to merger. This supports the notion that their expectations for care may be different from what was previously provided. The third parent survey that was excluded had comments written by the parent regarding the shortage of nursing staff to care for this parent's child, they felt their child had been "neglected". The fourth survey that was excluded did not have any written comments and the parent did not return the demographic sheet.

Parent Satisfaction Survey results including these four families' scores in the analysis yields the following when a two sample t-test is performed Unit A ($M$=120.9, $SD$=14.73) and Unit B ($M$=119.3, $SD$=28.1). These mean scores are very similar indicating no differences between the units with all families included in the analysis. Closer examination of the large standard deviation for Unit B illustrates the fact that their are some outlying responses that do not represent the majority of the families from this unit. When these families are not included in the analysis, the standard deviations are very similar, Unit A ($M$=120.9,$SD$=14.73) and Unit B ($M$=131, $SD$=12).

The second survey, Nurse-Patient Interaction Survey (Krouse et al, 1988, adapted for parents) assessed parents' overall satisfaction with their interactions with the nursing staff of the unit to which they were admitted at the time of the survey. This scale consisted of 44 items about

nurse-parent interactions asking the parent to respond on a 1 to 4 point scale regarding how often the interaction occurred while in hospital. The coefficient alpha for this parent population was .97.

***NPIT Sample Questions***

1. Do you feel your concerns were included in the decisions?
2. Did the negotiated plan agree with what you thought the plan should be?
3. Do you feel your child received good care?

(Possible responses: Not at all, very little, a fair amount, a great deal.)

A total possible score for this scale was 176. Parents responded consistently with the nursing care satisfaction survey, that they were significantly more satisfied with the interactions they had with the nursing staff on Unit B ($M$=131, $SD$=13.4) than Unit A ($M$=125,$SD$=14), $t$=-1.58, $p$=.06.

The parents from Unit B provided more written feedback than those parent respondents from Unit A. There were fifteen parents from Unit B who supplemented their surveys with written comments. Of these, four had negative comments. In comparison, seven of the parents from Unit A gave feedback regarding quality of nursing care, with two commenting on areas of dissatisfaction.

Overall, there were more positive comments from Unit B in comparison to Unit A. The parents on Unit B described nurses who were "exceptional", "caring and compassionate"

and "went out of their way to do everything and more" for the children. Also, these parents commented on how the nurses explained things to both the parents and the children, and how important this was to family members. Parents from Unit A also noted that nurses were "excellent" "caring" and "outgoing", but there were fewer of these comments. The negative feedback ranged from concerns around timeliness of pain medication administration to nurses who appeared to not be interested in caring. Parents from both units mentioned how busy the nurses were and identified some of the challenges they perceived the nurses had experienced.

**Summary**

All the hypotheses were accepted except for the first regarding nurses' satisfaction with their practice environment and time since unit experienced any restructuring. There was no relationship established between more satisfied nurses and longer time since restructuring occurred in their work area.

This study does support the notion that the more nurses perceive to be supported by their work environment, the more innovative and involved they are. Also those nurses who reported feeling more supported by the management structure perceived experiencing less work pressure. Overall, a more supportive practice environment with less managerial control meant more satisfied nurses. Baccalaureate prepared nurses perceived their work environment to be a more satisfying

place to practice than those nurses who graduated from diploma schools. There were more baccalaureate prepared nurses on Unit B than on Unit A. Nurses with more professional education perceived themselves to be practicing in a more supportive environment, experienced more professional status, and were clearer about their roles. These nurses reported being more involved and working in more innovative areas. The families who received care from these nurses reported being more satisfied with the quality of nursing care. The demographic information from the families did not explain why the families on Unit B were more satisfied than the families on Unit A. The qualitative results added credibility to the quantitative findings from the parent surveys.

Chapter 4

## Discussion

The underlying assumption of this study is based on the notion that nurses who are professionally contented by their practice environment provide care that is more satisfying to children and families. Kanter's theoretical framework (1977) proposed that when workers had access to opportunity that supported professional growth, they develop positive attitudes about their professional practices such as higher motivation and commitment. As a result, employees experience more satisfaction in their work environment.

The findings of this study provide further evidence to support the primary notion in Kanter's organizational theory. Nurses who report themselves to be more supported or empowered are more involved and believed their work environment supported more innovative practice. The group of nurses that were more satisfied did not emerge as more autonomous than the less satisfied group, but there were issues surrounding these nurses' interactions with other health care professionals that may have obstructed this outcome. The results of this study suggest that nurses who report themselves to be more satisfied in their practice environment provide care to families that is more satisfying as reported by the parents in this study. When exploring the relationship between nurses' practice environment and the provision of quality care, it is important to

acknowledge particular factors that might support this link. Based on these results, there are certain factors in nurses' practice environment consistent with Kanter's theory that appear to be more important to nurses' work satisfaction than others. The concepts examined in this study provided some insight into those areas that nurses are most concerned about in their practice.

The surveys given to parents for feedback were not as well developed as those for the nurses. These surveys were adapted for parents as there is little available to evaluate parent satisfaction. As a result, parents volunteered more written feedback, detailing what they liked or did not like about the nursing care.

The method of collecting the data from both parents and nurses was moderately effective. The parents were instructed to complete the surveys and to place them in the inter-hospital mail or were asked to give them to the unit receptionist for placement in the hospital mail baskets. Of those surveys provided, approximately 85% were returned.

Surveys were distributed to the nurses of both units in their personal unit specific mail slot. The mail slots for each unit were in geographically different areas which may account for the variation in response rate between units. The nurses on Unit A had a mail file present on the unit where they spent the majority of their working day. While the nurses from Unit B had their mail delivered to a mail

file in the nurses' professional lounge area. The nurses from Unit A did not have a professional lounge area.

The response rate was higher from the nurses on Unit A (69%) than Unit B (54%) possibly due to the fact that the surveys were so accessible in their work area. In addition to the accessibility issue, the nurses practicing on Unit A were distinctly more dissatisfied with their jobs and practice area as indicated by the survey results.

It was an atypical period in the Health Centre during data collection. Two weeks after data collection began, the nurse manager from Unit B resigned from her position in the Health Centre for unknown reasons. The manager had been on a leave for the past 5 months. By their own description, the nurses said they were shocked by this resignation. There was an acting manager during this person's leave. In addition, there was the threat of a nursing strike which seemed imminent in the Health Centre due to a breakdown in contract negotiations. Nurses from both areas were equally concerned about the strike which was eventually averted.

Randomization of parents into the study occurred as expected, but there were fewer families admitted to Unit B. Therefore, the sample size was lower and the length of time to collect data was extended beyond the original expected time period of 6-8 weeks to 10-12 weeks. Only one family declined participation in the study as they felt they did not have enough interaction with nurses to evaluate their

care. While in hospital, this particular family had a mental health worker who provided care on a one to one basis to their child in addition to the nursing staff.

There were approximately eight families from both areas that were randomized into the study, but, were not invited to participate due to the fact that completing the questionnaires may contribute additional emotional discomfort to an already stressful situation. This was one of the limitations as one of the sources for consultation on this issue was the nurse caring for the individual family, in addition to the charge nurse. There was the potential that the nurse may have felt that it was her individual care that was being evaluated and did not want a particular parent to have an opportunity to provide feedback. The nurses acknowledged being very busy and felt they were not providing very good care and feared personal reprisals via the parents in their evaluations. When possible, the charge nurse provided feedback for those families randomized into the study. Reasons for excluding the eight families ranged from new diagnosis of health condition, to parental stress during the hospitalization. There were no differences between the units regarding these numbers. There were differences as indicated by the nursing workload measurement system that the nurses on Unit A (107%) were working at a higher utilization rate than the nurses on Unit B (90%).

The sample of nurses that did respond from each area

had some distinctive characteristics that may explain in part why one area was more satisfied than the other. The nurses from Unit A were older and did not have as much professional education as the nurses on Unit B. Sixty-three percent of the nurses from Unit A were 30-50 years of age, as compared to Unit B where 80% were in the 20-40 age bracket. Seventy-five percent of the nurses from Unit A were diploma prepared with only 13% having their nursing degrees, while 52% from Unit B were baccalaureate prepared and 32% with diplomas in nursing. The findings of Hinshaw et al. (1987) indicated that group cohesiveness or peer cohesion as was examined in this study, was more important to job satisfaction in baccalaureate prepared nurses than those nurses who graduated from diploma schools. In another study completed at the same Health Centre, younger nurses having more professional education, and those nurses who were baccalaureate prepared perceived having more supervisor support (Bruce, Gurnham & Christie, 1995). Bruce et al. found that nurses who were more supported by their management structure also experienced more peer cohesion.

The nurses from Unit B were baccalaureate prepared but scored lower on the satisfaction with their peer cohesion scale. This could be explained two ways: one, that peer cohesion was more important to degree prepared nurses and their expectations were higher and not met, therefore, they were more dissatisfied with these relationships; or two, it

was a result of the challenging situation with the other discipline that the nurses on Unit B were experiencing. It is interesting that the nurses from Unit A were so dissatisfied with the supervisor support (M=2.56/10) they received but were moderately satisfied with their peer cohesion relationships (5/10). Hinshaw et al.(1987) also reported that one important satisfier for nurses was their professional status; this was consistent with this sample of nurses. The nurses' hours of employment between the units were unremarkable except there were no casual staff respondents from Unit A and 16% from Unit B. Not all nurses provided all demographic information.

Tumulty, Jernigan and Kohut (1994) examined nurses' job satisfaction using the IWS (Stamps et al. 1978) and found that perceptions of nurses' work satisfaction was low (2.1-5.3/7, M=3.84, (N=159). The scores of nurses from Unit A ranged from 1.64-4.99/7, with an overall M=3.5(n=16). These were lower than Tumulty et al's group, while Unit B scored from 1.73-5.54/7, M=3.7, (n=25). These findings support other research that has shown that nurses who were more satisfied with their jobs were significantly more satisfied with their work environment (Bruce et al. 1995; Tumulty et al. 1994). Tumulty et al.(1994) found that nurses' perceptions of supervisor support also varied significantly by unit.

Kovner et al.(1994) explored nurses job satisfaction

using the Index of Work Satisfaction Scale and found that nurses ranked pay as most important followed by autonomy and professional status. In this study, both groups of nurses ranked pay as most important, followed by autonomy for Unit A and interaction was second for Unit B. This is an interesting finding given that the nurses from Unit A clearly felt unsupported by their work environment and valued being autonomous, something they did not perceive was available to them. In examining the nurses from Unit B's issues, they have had significant difficulties with interactions with other health care professionals on their unit and the importance of healthy interactions may have surfaced in this subscale.

Despite the sample size being much smaller than the other studies examining these same concepts, the findings are very similar, with the same trends with regards to what satisfies nurses and what supports them in their job and practice environment.

**Nurses' Satisfaction with Practice Environment**

The Work Environment Scale (WES) (Moos, 1987) has been a well used tool to evaluate health care providers satisfaction with their work environment. As professional practice areas become more complex and demanding, health care professionals are seeking uncomplicated ways to express their satisfaction with their work areas. The WES provided the nurses in this study with the opportunity to give

feedback on many dimensions in their practice area. One area that emerged as interrelated with the others was that of supervisor support. Supervisor support is defined as the extent to which management is supportive of employees and encourages employees to support one another. Kanter (1977) would consider supervisor support as an essential structure of power.

Nurses in U.S. 'magnet' hospitals cited supervisor personnel who support nurses' decision making responsibilities as one area that is important to nurses' work satisfaction (Aiken, Smith & Lake, 1994). The structure of power was an essential area which Kanter (1977) identified that determined job performance, attitudes and behaviors.

Nurses from both areas were dissatisfied with their supervisor support, but Unit A was more dissatisfied than Unit B. There was a significant difference between nurses' satisfaction with supervisor support between the units. Nurses from Unit A articulated in the focus group sessions why they did not believe they were supported by their management structure. They believed that if they were truly supported they would not be expected to work in a physical area that was not conducive to caring for others when they did not feel cared for themselves. An effective supportive physical environment would be deemed as one of Kanter's (1977) essential components in the structure of power.

Kanter's proposed that support is necessary, defining it as the feedback and guidance received from peers and supervisors.

In Joiner's (1996) study, nurses reported that an increased perception of support from the organization increased their empathetic response to the patients. Empathy was considered to be one of the nurse attributes identified by patients that was an indication of quality of care (Joiner, 1996).

The nurses from Unit A reported experiencing significantly higher work pressures as compared to Unit B, although both units reported scores above the norm according to Moos(1987). Nurses from Unit A commented that if more nursing staff were provided to care for the families then they would feel less work pressure and more supported by nursing management. The nurses from Unit B accounted for this increase in work pressure by commenting on the lack of cross training for new care requirements for the families of the other merged unit and the lack of nursing staff to care for the families added to this pressure. There is evidence that indicates that nurses who experience stressful working conditions compromise the quality of their patient care (Dugan et al. 1996). This may explain the relationship between the nurses' work pressure and parents' satisfaction with the quality of nursing care.

Of interest, work pressure is not significantly higher

for the nurses on Unit B as compared with the 1995 scores, but other subscales show remarkable differences. It is important to note that the nurses who responded from Units A and B are only a subset of those who responded in 1995. Many changes have occurred in the Health Centre since 1995 including unit mergers, hospital mergers, and implementation of Program Management.

The nurses from Unit A experienced more work pressure and more work stress (Work Stress Index, WES, 1987) and the parents were not as satisfied with the care the nurses provided to their children in comparison to the nurses and parents on Unit B. These findings support the notion that job satisfaction buffers job stress (Hinshaw et al. 1987). The more satisfied nurses were with their jobs, the less stress they experienced. One environmental issue that was of great concern to the nurses on Unit A, as noted, was their satisfaction with their physical work area. This unit had not experienced any recent renovations or upgrades to enhance the physical comfort of the nurses work space. The nurses practicing on Unit B were significantly more satisfied with their physical work area as indicated by their scores and their feedback in the focus group sessions. They had a large nursing station for charting and for informal interactions with other health care professionals. Unit B also was equipped with a larger medication preparation area (approximately 6' x 10') while Unit A's

medi-prep area about 3' x 5' in size. The nurses on Unit B had a choice of rooms for assignment preparation and professional development as well as space for personal time such as breaks, meals and a place to put personal belongings. The nurses on Unit A had a small cupboard in their medi-prep area that was shared amongst the nursing staff for purses and any other personal items. In one of the several focus group sessions disseminating the results of the study, one of the nurses from Unit A commented that she guessed they should be happy, "at least they had their own bathroom". Nurses from Unit A also commented that the lack of physical comfort was an example of why they were dissatisfied with the support received from the management structure.

Power is defined as the ability to get things done by mobilizing resources, human and material (Kanter, 1979). According to Kanter (1977), when individuals do not have access to resources, information and opportunity, they experience powerlessness and become very dissatisfied with their work environment. Kanter proposed that these employees are accountable without power, creating feelings of frustration.

This would describe some of the feelings of the nurses who attended the focus group sessions from Unit A. For this study, these three concepts, supervisor support, physical comfort and work pressure appear to be important factors in

the professional practice satisfaction of the nurses on Unit A. Supervisor support emerged as a important area to place efforts with the goal to improve nurses' practice environments for both groups of nurses.

Support was positively related with involvement, which was the extent to which employees are concerned about and committed to their jobs. The nurses on Unit B scored higher on the involvement subscale than nurses on Unit A. The difference was clinically significant and approached statistical significance. According to Kanter (1977), employees who have opportunities to develop a positive set of attitudes such as higher motivation and commitment experience more work satisfaction. This was evident from the responses from the nurses who practiced on Unit B. Support was positively correlated with role clarity. The nurses on Unit A were significantly more dissatisfied than Unit B. Nurses from both areas scored unexpectedly low on the role clarity subscale. It was anticipated that these scores would be low considering the expansion of nurses roles, but it was surprising how dissatisfied the nurses were with this aspect of their practice.

It is presumed that Kanter (1977) would be concerned about the lack of role clarity that both of these groups of nurses report. If nurses were unclear about their roles Kanter would say that these nurses did not have access to the necessary information and resources, and the ability to

elicit cooperation from colleagues required to perform their work. The nurses from both units remarked on their impression of their new roles in the focus group sessions. Both areas have experienced changes in the diagnosis specific care as their population of families has expanded. The nurses from both units have had to learn how to care for other health conditions and family needs while work with the other units healthcare providers. These issues alone were challenging for the nursing staff.

The nurses repeatedly commented in the focus groups on how difficult it was to care for the new health conditions and perceived it to be more stressful due to a lack of cross training.

The nurses on Unit A who were older and had practiced longer noted in the group sessions that their roles had changed the most. The younger nurses commented there had not been a great deal of variation since they began practicing, their roles had already been significantly expanded, and they had learned to practice in the expanded role.

Expanded roles were defined by nurse participants as: more autonomous nursing practice, less support for decision making, less accessible nursing support for decisions, learning to collaborate with colleagues, and taking on other health care provider roles when they were absent (i.e. physiotherapy, nutritionist and social work).

Both groups of nurses remarked that there was a great deal of uncertainty in their roles since they merged with the other area and had to care for new health conditions. This caused anxiety and stress as they felt they were not competent or did not have control over their practice. Leveck and Jones (1996) reported that the great diversity of patient diagnoses and acuity level, lack of recognition and respect, lack of control in the work environment, lower staffing levels per patient and larger diverse physical environments may contribute to nurses' perceptions of higher stress levels and professional dissatisfaction.

The American Journal of Nursing surveyed 7560 nurses who reported that they were taking care of more patients, have been cross trained to take on more nursing responsibilities, and have substantially less time to provide nursing care (Rothschild, Berry & Middleton, 1996). Nurses who practice in 'magnet' hospitals cited one of the important organizational attributes of their workplace is control over the practice environment, including decentralized decision making including matters such as adequate staffing and the facilitation of communication between nurses and physicians (Aiken et al. 1994). Nurses in Chandler's (1986) study identified support, opportunity and information as important factors determining work effectivenes as well as the sharing of information and interdepartmental relationships.

Based on the results of their study, Havens and Mills (1992) predicted that rapid change in health care would produce highly educated and expert health care workers who play essential roles in the management of their work. It is worth noting that these results imply that younger nurses with baccalaureate degrees were more professionally prepared for their nursing practice. Nurses who were degree prepared perceived experiencing less work pressure, felt more supported by management and were clearer about their roles.

Baccalaureate prepared nurses also reported being more involved in their professional practice environment although the scores did not reflect a more autonomous group. In fact, the two groups of nurses scored only moderately on the scales indicating their perception of autonomy in their practice. This may explain why significant differences were not found on the growth dimension which includes autonomy. The inter-disciplinary difficulty may have had an impact on this finding.

Research has demonstrated that staff nurse perceptions of job related empowerment is significantly related to organizational commitment (Acorn, Ratner,& Crawford, 1997; McDermott, Laschinger & Shamian, 1994) and participation on organizational decision making (Bruce, Gurnham, Christie, 1995; Wilson & Laschinger, 1994, Hatcher & Laschinger, 1995; Radice, 1994, Sabiston & Laschinger, 1995).

These results indicate that nurses from both areas

experienced moderate managerial control and low supervisor support, although one area was significantly lower than the other, resulting in moderate perceptions of autonomy in their practice. The nurses from both areas did not perceive themselves to be supported by their organizational policies in their practice. These results would not be surprising to Kanter due to the proposed relationship between power and autonomy and satisfaction with work environment. The nurses from Unit B were more involved and perceived their environment to support more innovative practice with less managerial control. Both groups of nurses were moderately contented with their peer relationships and this was echoed in the focus group sessions.

**Nurses' Job Satisfaction**

Issues related to nurses' satisfaction with their jobs are very closely linked to their work environment satisfaction. Similar concepts were examined with the comparable results. Nurses' perception of autonomy (IWS, 1986) in their practice was virtually the same as the WES (1987). There were no differences between the two groups. Examining the scores for autonomy, both groups of nurses reported moderately empowering characteristics (Unit A $\underline{M}$=4.24/7 and Unit B $\underline{M}$= 4.57/7) in their work setting, even though Unit B was more prominent compared to Unit A.

Research indicates that nurses perceptions of autonomy are significantly related to job satisfaction (Dwyer,

Schwartz & Fox, 1992; McCloskey, 1990; Roedel & Nystrom, 1988). Radice (1994) found that as nurses perceived the level of constraint was reduced, their job satisfaction was increased. Differences in their job satisfaction emerged in the area of professional status. The nurses on Unit B perceived having more status as compared to nurses on Unit A. Professional status and Kanter's use of the term of power would be comparable concepts. Professional status was general feeling toward the profession, usefulness and status of the job. Kanter (1979) supported the idea that for job activities to be empowering, they must be extraordinary, visible and relevant to the organizations functioning. Thus, nurses who perceive their status to be higher, and significantly higher in this case, would be more empowered and more satisfied in their practice environment.

In addition, baccalaureate prepared nurses from both areas had higher scores on this scale as compared to nurses prepared in diploma schools. A baccalaureate degree has been viewed as a status symbol for nurses in the profession and is now the expected for entry to practice, therefore it is not surprising that nurses who hold degrees perceive having more professional status than nurses who are diploma prepared.

In this study, nurses from Unit B were less satisfied with their interactions with other health care professionals. This was perceived to be related to a

challenging interdisciplinary relationship that nurses from Unit B were experiencing with other health care providers on their unit. The nurses from Unit B were not surprised by this result as they commented in the focus group that their interactions with some of the members from another discipline with whom they worked closely has been strained at times and they have sought ways to ameliorate the situation.

Research has shown that nurses perceptions of their interactions with other health care providers have an impact on their ability to provide quality care as a result of their work satisfaction (Hoffman & Martin, 1994; Knaus et al, 1986). Nurses from both Unit A and Unit B were equally satisfied with peer relationships, but, as stated, there were some issues on Unit B as far as satisfaction with other health care professional interactions. This finding did not seem to affect the satisfaction with nursing care of the parents in this study as was the case with patients in the studies previously noted.

Although the nurses in this study were only low to moderately satisfied with their peer relationships, it did not seem to affect the parent satisfaction with care. It is not known if the families from Unit B that were excluded due to their outlying scores were cared for by those nurses who were experiencing the difficult relationship with the other health care professionals on the unit. If so, this could

have explained some of the families evaluation of care.

Both groups of nurses were equally dissatisfied with their pay rates but this questionnaire was completed prior to a new pay agreement by the union which provided the nurses with an increase in salary. Nurses reported being low to moderately satisfied on both instruments regarding task orientation. Nurses who practiced on Unit B identified more tasks as did those who held degrees in nursing, which for the most part were the same group.

The nurses on Unit B were significantly more satisfied with the organizational policies supporting their nursing practice but both groups reported low satisfaction in this area. In this situation, the nurses who perceived being supported by these policies were also more satisfied with their practice environment consistent with Kanter's theory.

The impact of restructuring on both units was considered, and specifically, time since the units had become merged. It was proposed that the nurses practicing on the unit that had been merged the longest would be more satisfied with their work environment as compared to the nurses who had only experienced the merger 6 months earlier. This was not the situation. Nurses from both areas described similar responses to the merger process and outcomes. The unit that had been more recently merged conveyed more immediate issues regarding cross-training and were more dissatisfied with this matter. Nurses described

their dissatisfaction with this issue in terms of lack of support from management, and lack of information to safely provide care to their patients.

Nurses from Unit A (merged longer) described an overall sense of dissatisfaction with their management structure and cross-training was only one issue that was noted. The nurses from Unit A recalled being more concerned about this matter immediately following the merger of the two units and experienced increased stress due to believing themselves to be unprepared to care adequately for their patients and families.

Kovner et al. (1994) reported that for nurses who eventually liked their restructured environment, there was an initial period of dissatisfaction. It appears that the nurses from Unit A have moved beyond that initial period of dissatisfaction. This is another limitation of the study, in that there is no baseline data from specific units in this health care facility prior to the unit restructuring; Bruce et al. (1995) indicated that the nurses were more satisfied with their jobs and scored higher on their work satisfaction when compared to the current results. Aiken et al. (1994) concluded that nursing care was of a higher quality in satisfying work environments.

Overall, the nurses from Unit B reported being more contented with practice environment in terms of Kanter's (1977) formal and informal power structures and the support

they perceived from the management structure. Nurses from both areas were only moderately satisfied with their jobs and practice environments.

**Parent Satisfaction with Nursing Care**

Two instruments were used to elicit feedback from parents regarding their satisfaction with nursing care. Some parents believed that it was a way of checking up on the nurses and expressed their dissatisfaction with this method of evaluation, whereas other parents responded very positively, taking the opportunity to praise the nursing staff for the quality of care they provided.

Quality care has been defined by patients as maintaining clean environment, answering call bells promptly, providing physical contact, (Strasen, 1988) and nurses' caring attributes such as sensitivity and the nurses' skill and knowledge (Greeneich, 1992). Other descriptions of quality of care include terms such as respect, encouragement and `going the extra mile' (Joiner, 1996) as well as communication, listening, responsiveness, and attention to individual needs (Luther, 1996).

The two groups of families in this study were not homogenous in terms of their health needs requiring hospitalization. Unit A was primarily a surgical care area and Unit B was a medical area. This limitation is twofold, first, because the groups were assumed to be so dissimilar due to being admitted to different units for different

reasons and secondly, as this information was not collected on each family in the demographic section. Therefore, I am unable to comment on diagnosis related or perceived severity of illness or surgery and whether this has an impact on satisfaction with care.

Demographic information collected did suggest that parents of younger children (0-3 yrs) were less satisfied with the nursing care than the parents of children aged 4 years and up. In another study completed at the same health centre (Chisholm, 1997), parents of infant and toddler-aged children experienced more anxiety about hospitalization before, during, and after the event as compared to parents of older children admitted for similar reasons. It is not believed that the age of the child was the sole reason for their dissatisfaction, but it may have contributed to the parents expectations or concerns during hospitalization for Unit A families. In addition, the families from Unit A had experienced more hospitalizations than Unit B. Thirty-two percent of the families from Unit A had at least 1-2 previous admissions, as compared to only 17% from Unit B. The families from Unit A had a higher percentage of 2-day to one week admissions (72%), whereas the majority of admissions on Unit B (52%) had been in hospital approximately 24-48 hr prior to the survey. Other than these differences, the characteristics for the families were quite comparable. As noted, one drawback is not having the

diagnosis related information, i.e. surgical, oncological, nephrology, and medical reason for admission. This information would have contributed another level of information which could helped in explaining the differences between the units.

Parents who may or may not have had the support of a partner/spouse did not respond any differently in terms if their satisfaction with nursing care in this sample. Although it is of note that all families did not complete all demographic data, possibly for fear of recognition despite guarantees of confidentiality and anonymity.

The instruments that were used, the PSS (Mergivern, 1986) and the N-PIT (Krouse et al. 1987) were both adapted for parent respondents. Some of the questions were not completely pertinent but, were included to maintain the completeness of the questionnaire. The mean scores on the N-PIT ranged from 1.33-3.84 for Unit A and 1.39-3.83 for Unit B. For the PSS, the mean scores ranged from 3.36-4.48 for Unit A and 3.39-4.78 for Unit B. Questions regarding areas that have been proven to be important indicators for quality of care were scored differently and amongst the highest means for both areas, with Unit B means being consistently higher. For example, the way parents scored nurses' listening skills for Unit A the $\underline{M}$=4.28, while Unit B the mean was 4.56. Similar trends were found with parents perceptions of the nurses ability to teach, Unit A = 4.32,

Unit B= 4.61, and Comfort Unit A, M=4.40. Unit B M=4.61. These findings were also consistent regarding parents perceptions of the time nurses spent with the family, Unit A (M=4.16) Unit B (M=4.67). It is difficult to draw overall conclusions based on individual questions, it is important to note that these particular areas which have been found to be determinants of quality care were important to both groups of parents, but scored higher by the parents on Unit B.

Overall, the parents from both areas seemed to be generally satisfied, but between the written feedback and the mean scores from both surveys the parents from Unit B were more satisfied. Parents from Unit B voluntarily described nurses who provided comfort and appropriate teaching. Silberzweig and Gigure (1996) proposed that nurses create a healthy healing environment by listening, comforting and teaching. These researchers made the assumption that good medical care was expected, but it was patients experience of 'illness' care or nursing care that determined their satisfaction with the quality care in the hospital. This was supported by Kanter's (1979) notion that providing an organizational environment advocating for employees to carry their roles effectively. Leveck and Jones (1996) reported that quality of care was explained by two variables: medical surgical units were less likely to deliver high quality care as compared to other specialty

areas, and nurses who experienced lower levels of job stress demonstrated higher levels of quality of care. These two findings are supported by this sample of nurses. It is difficult to make generalizations, but the evidence of this small study adds further support to the relationship between these concepts.

Limitations of this study include small sample sizes for both nurses and families. A larger sample would have added more credibility to the findings and would have either contributed to the groups of dissatisfied or satisfied families. Also, demographic data should have included information on diagnosis for admission for families and length of time each nurse had been practicing as a professional nurse.

**Implications for Research and Practice**

Future studies should continue in the same vein, examining nurses and families perceptions of quality care and bringing together these views to create one expectation of quality interactive care. It is important to involve parents and families in questionnaire development to accurately evaluate what families perceive as quality of nursing care.

There is some indication that parents of younger children may have different expectations of quality nursing care, but this notion would need to be explored further. Diagnosis or reason for admission potentially could play a

role in how satisfied parents are with the care. These surveys were not completed at the end of hospitalization, but, at different points of their stay. Therefore, attitudes may change over time depending on total time spent in hospital. It is essential to invite family participation to evaluate the changes we have experienced in our nursing practice environment at different points in the hospitalization.

The data collected from the nurses provided more specific future directions in terms of research. Necessary areas for future research include exploring nurses perceptions of supervisor support, especially during the hyper-change in our health care environments. It would be advantageous to know what nurses perceive as supportive to their practice and how this could be provided considering current limited budgets.

Support seems to be one of the critical links to nurses perceptions of work pressures and clarity of their professional roles. Role clarity is another large issue with changing role expectations and restructuring. This carries a large responsibility with regard to current and future practice issues. How are nurses roles being defined? Are nurses being involved in the planning? Why are baccalaureate prepared nurses more satisfied and apparently more adaptable to these fluctuating work environments? Nurses who are more supported are clearer about their roles.

Nurses who are more supported and clearer about their roles are more involved.

In this study, the nurses who perceived themselves to be more supported were more involved and the families were more satisfied with the care they provided. These relationships are assumed, but more research is required to examine the intricacies of these concepts. Nurses' perceptions of the quality of care they are providing would be an important parallel to evaluating parents perception of care.

Appendix A

# WORK ENVIRONMENT SCALE

## FORM R

PAUL M. INSEL & RUDOLF H. MOOS

1. The work is really challenging.
2. People go out of their way to help a new employee feel comfortable.
3. Supervisors tend to talk down to employees.
4. Few employees have any important responsibilities.
5. People pay a lot of attention to getting work done.
6. There is constant pressure to keep working.
7. Things are sometimes pretty disorganized.
8. There's a strict emphasis on following policies and regulations.
9. Doing things in a different way is valued.
10. It sometimes gets too hot.
11. There's not much group spirit.
12. The atmosphere is somewhat impersonal.
13. Supervisors usually compliment an employee who does something well.
14. Employees have a great deal of freedom to do as they like.
15. There's a lot of time wasted because of inefficiencies.
16. There always seems to be an urgency about everything.
17. Activities are well-planned.
18. People can wear wild looking clothing while on the job if they want.
19. New and different ideas are always being tried out.
20. The lighting is extremely good.
21. A lot of people seem to be just putting in time.
22. People take a personal interest in each other.
23. Supervisors tend to discourage criticisms from employees.
24. Employees are encouraged to make their own decisions.
25. Things rarely get "put off till tomorrow."
26. People cannot afford to relax.
27. Rules and regulations are somewhat vague and ambiguous.
28. People are expected to follow set rules in doing their work.
29. This place would be one of the first to try out a new idea.
30. Work space is awfully crowded.
31. People seem to take pride in the organization.
32. Employees rarely do things together after work.
33. Supervisors usually give full credit to ideas contributed by employees.
34. People can use their own initiative to do things.
35. This is a highly efficient, work-oriented place.
36. Nobody works too hard.
37. The responsibilities of supervisors are clearly defined.
38. Supervisors keep a rather close watch on employees.
39. Variety and change are not particularly important.

40. This place has a stylish and modern appearance.
41. People put quite a lot of effort into what they do.
42. People are generally frank about how they feel.
43. Supervisors often criticize employees over minor things.
44. Supervisors encourage employees to rely on themselves when a problem arises.
45. Getting a lot of work done is important to people.
46. There is no time pressure.
47. The details of assigned jobs are generally explained to employees.
48. Rules and regulations are pretty well enforced.
49. The same methods have been used for quite a long time.
50. The place could stand some new interior decorations.
51. Few people ever volunteer.
52. Employees often eat lunch together.
53. Employees generally feel free to ask for a raise.
54. Employees generally do not try to be unique and different.
55. There's an emphasis on "work before play."
56. It is very hard to keep up with your work load.
57. Employees are often confused about exactly what they are supposed to do.
58. Supervisors are always checking on employees and supervise them very closely.
59. New approaches to things are rarely tried.
60. The colors and decorations make the place warm and cheerful to work in.
61. It is quite a lively place.
62. Employees who differ greatly from the others in the organization don't get on well.
63. Supervisors expect far too much from employees.
64. Employees are encouraged to learn things even if they are not directly related to the job.
65. Employees work very hard.
66. You can take it easy and still get your work done.
67. Fringe benefits are fully explained to employees.
68. Supervisors do not often give in to employee pressure.
69. Things tend to stay just about the same.
70. It is rather drafty at times.
71. It's hard to get people to do any extra work.
72. Employees often talk to each other about their personal problems.
73. Employees discuss their personal problems with supervisors.

74. Employees function fairly independently of supervisors.
75. People seem to be quite inefficient.
76. There are always deadlines to be met.
77. Rules and policies are constantly changing.
78. Employees are expected to conform rather strictly to the rules and customs.
79. There is a fresh, novel atmosphere about the place.
80. The furniture is usually well-arranged
81. The work is usually very interesting.
82. Often people make trouble by talking behind others' backs.
83. Supervisors really stand up for their people.
84. Supervisors meet with employees regularly to discuss their future work goals.
85. There's a tendency for people to come to work late.
86. People often have to work overtime to get their work done.
87. Supervisors encourage employees to be neat and orderly.
88. If an employee comes in late, he can make it up by staying late.
89. Things always seem to be changing.
90. The rooms are well ventilated.

*Nurses and Work Satisfaction*

***Part A (Paired Comparisons)***

Listed and briefly defined on this sheet of paper are six terms or factors that are involved in how people feel about their work situation. Each factor has something to do with "work satisfaction." We are interested in determining which of these is most important to you in relation to the others.

Please carefully read the definitions for each factor as given below:

1. **Pay—dollar remuneration and fringe benefits received for work done**
2. **Autonomy—amount of job-related independence, initiative, and freedom, either permitted or required in daily work activities**
3. **Task Requirements—tasks or activities that must be done as a regular part of the job**
4. **Organizational Policies—management policies and procedures put forward by the hospital and nursing administration of this hospital**
5. **Interaction—opportunities presented for both formal and informal social and professional contact during working hours**
6. **Professional Status—overall importance or significance felt about your job, both in your view and in the view of others**

***Scoring.*** These factors are presented in pairs on the questionnaire that you have been given. Only 15 pairs are presented: this is every set of combinations. No pair is repeated or reversed.

For each pair of terms, decide which one is *more important* for your job satisfaction or morale. Please indicate your choice by a check on the line in front of it. For example: If you felt that Pay (as defined above) is more important than Autonomy (as defined above), check the line before Pay.

___ Pay or ___ Autonomy

We realize it will be difficult to make choices in some cases. However, please do try to select the factor which is more important to you. Please make an effort to answer every item; do not change any of your answers.

| | | |
|---|---|---|
| 1. ___ Professional Status | or | ___ Organizational Policies |
| 2. ___ Pay | or | ___ Task Requirements |
| 3. ___ Organizational Policies | or | ___ Interaction |
| 4. ___ Task Requirements | or | ___ Organizational Policies |
| 5. ___ Professional Status | or | ___ Task Requirements |
| 6. ___ Pay | or | ___ Autonomy |
| 7. ___ Professional Status | or | ___ Interaction |
| 8. ___ Professional Status | or | ___ Autonomy |
| 9. ___ Interaction | or | ___ Task Requirements |
| 10. ___ Interaction | or | ___ Pay |
| 11. ___ Autonomy | or | ___ Task Requirements |
| 12. ___ Organizational Policies | or | ___ Autonomy |
| 13. ___ Pay | or | ___ Professional Status |
| 14. ___ Interaction | or | ___ Autonomy |
| 15. ___ Organizational Policies | or | ___ Pay |

*Part B (Attitude Questionnaire)*

The following items represent statements about satisfaction with your occupation. Please respond to each item. It may be very difficult to fit your responses into the seven categories; in that case, select the category that *comes closest* to your response to the statement. It is very important that you give your *honest* opinion. Please do not go back and change any of your answers.

***Instructions for Scoring*** Please circle the number that most closely indicates how you feel about each statement. The *left* set of numbers indicates degrees of *disagreement*. The *right* set of numbers indicates degrees of *agreement*. The *center* number means "undecided." Please use it as little as possible. For example, if you *strongly disagree* with the first item, circle 1; if you *moderately agree* with the first statement, you would circle 6.

***Remember:*** The more strongly you feel about the statement, the further from the center you should circle, with disagreement to the left and agreement to the right.

| | Disagree | | | | | | Agree |
|---|---|---|---|---|---|---|---|
| 1. My present salary is satisfactory. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Most people do not sufficiently appreciate the importance of nursing care to hospital patients. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. The nursing personnel on my service do not hesitate to pitch in and help one another out when things get in a rush. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. There is too much clerical and "paperwork" required of nursing personnel in this hospital. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. The nursing staff has sufficient control over scheduling their own work shifts in my hospital. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. Physicians in general cooperate with nursing staff on my unit. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. I feel that I am supervised more closely than is necessary. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Excluding myself, it is my impression that a lot of nursing personnel at this hospital are dissatisfied with their pay. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Nursing is a long way from being recognized as a profession. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. New employees are not quickly made to "feel at home" on my unit. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. I think I could do a better job if I did not have so much to do all the time. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. There is a great gap between the administration of this hospital and the daily problems of the nursing service. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. I feel I have sufficient input into the program of care for each of my patients. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. There is no doubt whatever in my mind that what I do on my job is really important. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. There is a good deal of teamwork and cooperation between various levels of nursing personnel on my service. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | Disagree | | | | | | Agree |
|---|---|---|---|---|---|---|---|
| 17. I have too much responsibility and not enough authority. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. There are not enough opportunities for advancement of nursing personnel at this hospital. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. There is a lot of teamwork between nurses and doctors on my own unit. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. On my service, my supervisors make all the decisions. I have little direct control over my own work. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. The present rate of increase in pay for nursing service personnel at this hospital is not satisfactory. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. I am satisfied with the types of activities that I do on my job. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23. The nursing personnel on my service are not as friendly and outgoing as I would like. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24. I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25. There is ample opportunity for nursing staff to participate in the administrative decision-making process. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26. A great deal of independence is permitted, if not required, of me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27. What I do on my job does not add up to anything really significant. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28. There is a lot of "rank consciousness" on my unit. Nursing personnel seldom mingle with others of lower ranks. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29. I have sufficient time for direct patient care. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30. I am sometimes frustrated because all of my activities seem programmed for me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31. I am sometimes required to do things on my job that are against my better professional nursing judgment. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32. From what I hear from and about nursing service personnel at other hospitals, we at this hospital are being fairly paid. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 33. Administrative decisions at this hospital interfere too much with patient care. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34. It makes me proud to talk to other people about what I do on my job. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 35. I wish the physicians here would show more respect for the skill and knowledge of the nursing staff. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36. I could deliver much better care if I had more time with each patient. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 37. Physicians at this hospital generally understand and appreciate what the nursing staff does. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 38. If I had the decision to make all over again, I would still go into nursing. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 39. The physicians at this hospital look down too much on the nursing staff. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 40. I have all the voice in planning policies and procedures for this hospital and my unit that I want. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 41. My particular job really doesn't require much skill or "know-how." | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 42. The nursing administrators generally consult with the staff on daily problems and procedures. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | Disagree | | | | | | Agree |
|---|---|---|---|---|---|---|---|
| 43. I have the freedom in my work to make important decisions as I see fit, and can count on my supervisors to back me up. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 44. An upgrading of pay schedules for nursing personnel is needed at this hospital. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

## Notes

[1]Stamps, P.L., et al. "Measurement of Work Satisfaction Among Health Professionals." *Medical Care* 16: 337-52, April 1978.
[2]Slavitt, D.B., et al. "Nurses' Satisfaction with Their Work Situation." *Nursing Research* 22:114-20, March/April 1978.
[3]———. "Measuring the Levels of Satisfaction of Hospital Nurses." *Hospital and Health Services Administration* 24:62-77, Summer 1979.

Appendix C

**Nurse-Patient Interaction - Parent Version**

**Please answer the following questions about the visits which you had with the nurse. Circle the appropriate number for each question. (1= not at all, 2= very little, 3=a fair amount, 4= a great deal)**

**Sample Question:**

| | | | | |
|---|---|---|---|---|
| **Do you enjoy eating ice cream?** | **1** | **2** | **3** | **4** |

| | | | | | |
|---|---|---|---|---|---|
| 1. | **How much input did you feel that you had into the decisions about the child's plan of care?** | 1 | 2 | 3 | 4 |
| 2. | **Do you feel you had control over the plan that was decided on?** | 1 | 2 | 3 | 4 |
| 3. | **Do you agree with the suggested plan of care?** | 1 | 2 | 3 | 4 |
| 4. | **Are you likely to follow the plan?** | 1 | 2 | 3 | 4 |
| 5. | **Do you feel you were involved in the decisions made during visits?** | 1 | 2 | 3 | 4 |
| 6. | Do you feel you understood what the nurse was saying? | 1 | 2 | 3 | 4 |
| 7. | Do you feel that your concerns were included in the decisions? | 1 | 2 | 3 | 4 |
| 8. | How much were you influenced by the suggestions nurse? | 1 | 2 | 3 | 4 |
| 9. | Do you feel you will be able to follow the suggested plan? | 1 | 2 | 3 | 4 |
| 10. | How satisfied were you with the visit with the nurse? | 1 | 2 | 3 | 4 |
| 11. | Did the negotiated plan agree with what you thought the plan should be? | 1 | 2 | 3 | 4 |
| 12. | Are you likely to seek another discussion with nurses or anyone else about your involvement? | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| 13. | Do you feel the nurse understood your problem(s)? | 1 | 2 | 3 | 4 |
| 14. | Did you feel you were in control of the encounter? | 1 | 2 | 3 | 4 |
| 15. | How much did you feel frustrated by the visit? | 1 | 2 | 3 | 4 |
| 16. | Did you disagree with the suggested plan? | 1 | 2 | 3 | 4 |
| 17. | Were you frustrated with the visit? | 1 | 2 | 3 | 4 |
| 18. | Do you feel the nurse knew what you were thinking about your problem(s)? | 1 | 2 | 3 | 4 |
| 19. | Do you feel your child received good care? | 1 | 2 | 3 | 4 |
| 20. | Do you feel the nurse did not tell you all she knew about your child's condition? | 1 | 2 | 3 | 4 |
| 21. | Do you feel the nurse was interested in having you involved in the decisions? | 1 | 2 | 3 | 4 |
| 22. | Did you feel confused about your problems? | 1 | 2 | 3 | 4 |
| 23. | How much time did the nurse spend talking to you? | 1 | 2 | 3 | 4 |
| 24. | How much did you contribute to the final decision about the child's care? | 1 | 2 | 3 | 4 |
| 25. | Did the nurse allow you to speak up? | 1 | 2 | 3 | 4 |
| 26. | Did the plan decided upon agree with your thoughts about care prior to the visits? | 1 | 2 | 3 | 4 |
| 27. | Do you feel the nurse paid attention to what you were saying? | 1 | 2 | 3 | 4 |
| 28. | How often do you feel the nurse asked for your opinions? | 1 | 2 | 3 | 4 |
| 29. | How much time did you spend presenting your feelings about the plan to the nurse ? | 1 | 2 | 3 | 4 |
| 30 | How often did the nurse use words that you did not understand? | 1 | 2 | 3 | 4 |
| 31. | Did the nurse explain medical/nursing words to the you? | 1 | 2 | 3 | 4 |
| 32. | Do you feel you'll be able to complete the plan? | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| 33. | Are you confident about the plan selected? | 1 | 2 | 3 | 4 |
| 34. | Are you comfortable with the nurse's judgement? | 1 | 2 | 3 | 4 |
| 35. | Do you feel the nurse suggested appropriate treatment or levels of involvement in care? | 1 | 2 | 3 | 4 |
| 36. | Do you feel the nurse was forcing his or her opinion on you? | 1 | 2 | 3 | 4 |
| 37. | Do you feel the nurse understood the child's illness and concerns and your concerns? | 1 | 2 | 3 | 4 |
| 38. | Did the nurse allow you enough time to explain your problem(s)? | 1 | 2 | 3 | 4 |
| 39. | How quiet were you during the visit with the nurse? | 1 | 2 | 3 | 4 |
| 40. | How comfortable were you with the diagnosis made? | 1 | 2 | 3 | 4 |
| 41. | Were your ideas included in the treatment decisions? | 1 | 2 | 3 | 4 |
| 42. | Did you feel you had to agree with the nurse during visits? | 1 | 2 | 3 | 4 |
| 43. | Do you feel you were able to get your point across? | 1 | 2 | 3 | 4 |
| 44. | At the end of visit(s), did you and the nurse agree about the treatment or plan? | 1 | 2 | 3 | 4 |

**PARENT'S SATISFACTION WITH NURSING CARE**

**(Modification to be made for child respondents in brackets)**

**For the following questions, please mark the appropriate space which best describes your experience while your child has been on this unit. Please skip any item that does not apply to you.**

**(Note each item provides a response set of Excellent, Good, Satisfactory, Fair, Poor)**

1. **The way the nurses SHOWED CONCERN and COMPASSION was**
2. **The way the nurses TOOK TIME to explain things to me was**
3. **The way the nurses LISTENED TO ME was**
4. **The PRACTICE of the nurses who cared for my child (Me) was**
5. **The CARING ATTITUDE of the nurses was**
6. **The way the nurses were THERE FOR ME WHEN I NEEDED was**
7. **The way the nurses PERSONALIZED my care to meet MY NEEDS was**
8. **The way the nurses PERSONALIZED my care to meet MY CHILD's (my parents) NEEDS was**
9. **The way the nurses WATCHED OVER MY CHILD (ME) was**
10. **The information from the nurses about what I (my parents) could do TO HELP MY CHILD (ME) while in the hospital was**
11. **The suggestions from the nurses on the ALTERNATIVES or OPTIONS for my child's (my) care was**
12. **The suggestions from the nurses on how to DEAL WITH MY STRESS was**
13. **The explanations/teaching the nurses provided on my child's (my) condition, tests, procedures, and treatments was at a LEVEL I COULD UNDERSTAND**
14. **The suggestions from the nurses about OTHER HOSPITAL PERSONNEL who could help me with SPECIAL PROBLEMS were**
15. **The way the nurses on all the shifts WORKED TOGETHER ON MY CARE was**

16. The information SHARED WITH MY FAMILY by the nursing staff was

17. The way the nurses attempted to UNDERSTAND my SITUATION was

18. The AVAILABILITY of nurses to meet family needs during and between visits was

19. The PRIVATE TIME the nurses gave us during visits was

20. The encouragement of nurses about how the family could HELP THE CHILD (ME) (feeding, bathing, emotional support) was

23 The AMOUNT OF TIME the nurses spent with me was

24. The way the nurses were COMFORTABLE in answering my questions was

25. The way the nurses INVOLVED the family in MAKING DECISIONS about my child's care was (not included for children)

26. The way the nurses REPEATED INFORMATION in DIFFERENT FORMS (conversation, booklets) was

27. The TIMELINESS OF INFORMATION provided by the nurses about my child's (my) condition and treatment was

28. The way the HEALTH CARE TEAM COMMUNICATED with me was

29. The way the nursing staff controlled UNNECESSARY NOISE was

30. The way the nurses responded to my child's (my) needs for PAIN MANAGEMENT

31. The PROFICIENCY of the nurses on the TECHNICAL ASPECTS of my child's (my) care was

32. Overall, HOW SATISFIED were you with the care you received on this unit?

Additional Comments:

## Appendix E

The Relationship Between Nurses' Work Environment and the Quality of care

Dear Colleague

As part of my studies at Dalhousie University I am interested in doing a study about your work. The purpose of the study is to examine the relationship between nurses' satisfaction with their work environment and families perceptions about quality care. Your unit is the result of two units blended together and I am interested in the environment as a result of this merger. I am working under the supervision of Dr.Judith Ritchie, Director of Nursing Research, who is my thesis advisor.

Your participation in this study is essential in the process of understanding nurses' work environment and how it affects the care we provide to families. To allow for the possibility of future surveys to monitor change over time, each questionnaire packet will have a code number. The surveys will be numbered by the secretary in the Nursing Research Department, only she will have access to the corresponding names and numbers. She will not reveal the code list to any other person, including me, and the secretary will not have access to the returned questionnaires. Your responses will be confidential. Only grouped data will be reported.

The nurses and parents on two units will be completing the surveys and the results will be compared between the units. Parents will be asked to complete surveys about their perception of the quality of care. Whether you choose to participate or not will not affect your employment status. Your participation will include completing the two questionnaires enclosed which should take approximately 20 minutes. **Please return your completed questionnaires in the supplied envelope to the Nursing Research Department,** via the interdepartmental mail, by **_date.**

The results of this study will be presented on your unit and will be submitted for publication. If you have any questions please contact me at 832-0205,or Dr.Ritchie 494-2611

Thank you for your time and interest in this study. Your contribution to this important issue regarding nurses' work and patient care is invaluable.

Sincerely,

Margot Latimer
Principal Investigator

## Appendix F

### The Relationship Between Nurses' Work Environment and the of Quality of Care

Hello Nursing Colleague

Thank you for supporting this study looking at your work environment and how this may affect the care you provide to families. I really appreciate the time you have taken to complete the questionnaires and return it to me. If you have not yet filled this out, and have a few moments in the next few days to do so, I am still accepting surveys.

Remember, your participation is voluntary and your answers are anonymous and confidential. The surveys can still be returned to the Nursing Research Department through the interdepartmental mail.

Thank you again for your support.

If you have any questions, please contact me.

Sincerely,

Margot Latimer
Prinicipal Investigator
832-0205

Appendix G

Study Information

Dear Parent

I am a nurse at the IWK-Grace who is completing a masters degree in nursing at Dalhousie University. I am working under the supervision of Dr. J. Ritchie, a professor at Dalhousie University and Director of Nursing Research at the IWK-Grace Health Centre. I am doing a study on the unit where your child is receiving nursing and medical care. The purpose of this study is to examine nurses' perceptions of their work environment and how it relates to the care they provide. I am interested in your ideas about the nursing care that has been provided to you and your child during this hospital stay.

Your part in is to complete two surveys - this should take about 15 minutes. Please think about this hospitalization experience when you are answering the questions. Your responses will be confidential, only I will have access to your answers. The results will be reported as a group not by individual parents' responses.

Whether you choose to take part or not will not affect the care your child receives in hospital. Taking part is voluntary. You may withdraw from the study at any time.

Please place the completed surveys in the provided envelope and return to the Nursing Research Department by the following date _____ .

If you have any questions, please do not hesitate to call me at 832-0205.
Dr Ritchie can be reached at 494-2611.

Thank You

Margot Latimer

Appendix H

Dear Doctor _____

My name is Margot Latimer. I am an IWK-Grace nurse who is a graduate student in the Master of Nursing program at Dalhousie University. For my thesis work I will be conducting a study on the units of 5 South and 6 North with parents and nurses.

As you are aware, these two units have undergone some mergers in the last 18 months. There is evidence in the literature regarding the impact of nurses'restructured work environments on their job satisfaction. There is little research examining the area of nurses' satisfaction and patient's satisfaction with the quality of care provided by the nursing staff. The purpose of this study is to examine the relationship between these two areas.

The study will consist of two questionnaires for the nurses to complete regarding satisfaction with work environment and two questionnnaires for parents to complete regarding their satisfaction with nurse-parent interactions. The proposed start date of the study will be late November 1997.

If you have any questions regarding the study please do not hesitate to contact me.

Thank You

Margot Latimer
832-0205

# PARENT INFORMATION SHEET

Age <20 yrs ____ 21-30___ 31-40___ 41-50___ >50____

Child's Age_____

Marital Status

Married/Partner _____ Not Married _____

Roomed In While Child in Hospital

Yes _____ Some nights _____

No _____

If no, about how many hours daily have you been able to visit in the past week (or since admission if less than a week)?____

How long has your child been in hospital this admission?_____

Previous Admissions

1-2 _____ None _____

3-4 _____

5 or > _____

# NURSES' DEMOGRAPHIC PROFILE

Age group 20-30__ 31-40__ 41-50__ >50__

Highest Level of Education in nursing (Please indicate if you are currently in a program)

Diploma _____

Baccalaureate _____

Masters _____

Primary practice area at time of survey

Nephrology _____

Oncology _____

Surgery _____

Employment Status

Full time _____

Part time _____

Casual _____

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