An Analysis of a Governance Model in Nursing Service

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The purpose of this study was to investigate the influence of governance type on culture, nurse work satisfaction, nurse retention, and patient satisfaction with care in acute care hospitals. A theoretically derived path model was proposed to guide the study. The original intent was to analyze the path model of governance type for nursing service, however, due to high intercorrelation among the independent variables this was not possible. Therefore, in order to approximate the analysis regarding the influence of governance type on the variables, a secondary contingency analysis was used in which statistically significant differences ($p=<.05$) between the two governance types and the variables of interest were examined.

The study was conducted among 396 registered nurses working in five acute care hospitals in Southwestern Pennsylvania that had both a shared governance and a traditional governance unit within the organization. The convenience sample (n=396) of nurses meeting the inclusion criteria was surveyed, of which 59% or two hundred thirty-four registered (234) nurses responded. In addition, one hundred twenty-one (121) patients were surveyed in the same sites for their opinion of nursing care.

Results of the study suggested that governance did influence culture, work satisfaction, nurse retention, and patient satisfaction. Using the Chi-square to compare

categorical sociodemographic information, no statistically significant differences were found between the two groups of registered nurses in the two governance types.

The instruments used to measure the variables were the Organizational Culture Inventory with an average Cronbach alpha of .84, the Work Satisfaction Scale with a total scale alpha of .87, and the Patient's Opinion of Nursing Care that had a Cronbach's alpha of .88. All of the tools had established construct and content validity.

The independent two-tailed t-test was used to analyze the scores from the instruments. Statistically significant differences resulted between the scores of the nurses on the variables of nursing service and between the scores of the patients receiving care on the two governance type units. It was found that the shared governance group had a constructive culture, a higher work satisfaction and patient satisfaction than the traditional governance group that had a passive-aggressive culture type.

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CHAPTER I

INTRODUCTION

The purpose of this study was to investigate the influence of governance on organizational culture, nurse work satisfaction, nurse retention, and patient satisfaction. Prior to the passage of the Social Security Amendments of 1983 (Public Law 98-21), investigation of factors that led to patient outcomes was conducted for quality assurance concerns and not for marketing and administrative purposes (Abramowitz, Cote, & Berry, 1987). Competition for clients between hospitals did not exist. However, in 1983, the Social Security Act was amended to include a Prospective Payment System (PPS) under which hospitals were paid a predetermined rate per discharge for inpatient services furnished to medicare beneficiaries based on payment categories called Diagnostic Related Groups (DRGs). This payment could be more than hospital costs or in some cases less than the hospital costs (HCFA, 1991). B. Longest (1987) referred to the new law as "...the most significant health care legislation since medicare..."(p. 7) because it linked treatment of Medicare recipients in specific DRG categories to the amount of reimbursement received by the hospital. PL 98-21 changed the method of reimbursement from retrospective to prospective to hospitals for the delivery of health care services.

A mandate to attend to cost containment became paramount, and remains priority today, because problems such as nurse recruitment and retention were

addressed with short-term solutions, namely, sign on bonuses and new salary schemes (Porter-O'Grady, 1991a). Long term strategies to address career issues such as job satisfaction were needed (Lynaugh & Fagin, 1988). The preparation of nurses for an expanded role in decision making that would affect nursing service and influence hospital operation was not addressed (Porter-O'Grady, 1991a).

A large portion of health care costs involved nurses, who comprised the largest department of hospitals. Nurses were essential to patient care and to patient satisfaction, the latter of which was critical to hospital survival (Abramowitz, Cote, & Berry, 1987). Satisfied patients returned to a health facility for future health needs, while the attraction of new patients was influenced through positive experiences of former patients (Greeneich, 1993). In the context of the current economic and health care setting, that was an important issue to be addressed because it translated into profit or loss to the hospital. Thus, research to determine if a model of governance for nursing service would promote patient satisfaction would be critical for the financial viability of an institution.

The American Organization of Nurse Executives (AONE) identified the need to investigate nursing care delivery systems, cost, and the quality of patient care outcomes, in their top two research priorities. Nurse executives were looking at the context in which nursing took place and patient outcomes were formed, for it would be here that the nexus of cost and quality occurred.

The context in which nurses worked included the governance and the organizational culture of that workplace. If nurses were satisfied with their environment and their work, retention tended to be high, as was patient satisfaction with care (Hinshaw & Atwood, 1982; McDaniel & Patrick, 1992; Weisman &

Nathanson, 1985). Governance type was a part of the environment, and varied among units and between hospitals. Research into whether governance type influenced patient satisfaction would be salient given the current health care marketplace. To date, there was no research to support or refute the relationship between governance type and patient outcomes. Nurse executives could utilize the results of this study, whether positive or negative, to choose a context for nursing service that would facilitate satisfactory patient outcomes. It is predicted, as we approach the end of the century, that health care providers will increasingly compete on the basis of cost and quality (Feingold, Myer, & McGinnity, 1992).

The Problem

Health care administrators were expected to provide increased levels of technical care with decreased resources and still maintain high quality patient care. Outcomes of patient care measured in terms of morbidity and mortality changed since the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) recognized that quality was a process that led to a product, patient outcomes, and was not a product itself (JCAHO, 1988). Therefore, it was necessary to identify those elements affecting patient outcomes within that process.

The theoretically derived model developed for this study depicted the relationships between governance framework, culture, work satisfaction, retention, and patient satisfaction. The model identified the elements in the pathway to patient satisfaction.

(See Figure 1.)

GOVERNANCE->	CULTURE->	WORK SATISFACTION->	RETENTION->	PATIENT SATISFACTION

Figure 1. Governance as Related to Patient Outcomes.

Avedis Donabedian's Evaluation of Quality Model (1966; 1980) provided a structured approach to assessment of quality and was the theoretical basis for the proposed model. Donabedian was concerned about quality in medical care and believed that client satisfaction was an important component in the definition of quality. He concluded that practitioner satisfaction was an important factor in defining the quality of medical care (Donabedian, 1980). Although Donabedian developed his model for use in another context, it was appropriate for use in this study. Donabedian identified the evaluation of quality in terms of structure, process and outcome. In this proposed model, structure was illustrated by the governance type, process by culture, work satisfaction and nurse retention, and outcome by patient satisfaction.

This study investigated two models of governance, the bureaucratic and the shared governance model. The bureaucratic or traditional governance type was the hierarchial form in which planning, organizing, directing, and controlling was accomplished by an administrator and the decision making power resided at the pinnacle of the organization (LaMonica, 1983). The shared governance type was participatory in nature and decision making was accomplished at the unit level by groups of nurses who maintained control over practice, working conditions, and professional affairs in a systematic way (Milton, Verran, Murdaugh, & Gerber,

1992). In order to provide a framework for further discussion, the links that provided support for the proposed governance model are briefly discussed.

A profession, as described by Flexner (1915), Bixler (1959), and Blane (1975), had the following seven basic criteria:

1. a specialized body of knowledge that operated on a conceptual and intellectual level;
2. used scientific methods to improve and enlarge the body of knowledge;
3. educated practitioners in institutions of higher learning;
4. applied its knowledge and practice in areas vital to human and social welfare;
5. functioned autonomously;
6. had a culture that attracted individuals who saw the professional activity a lifetime work; and
7. had some form of social and legal sanction.

Thus, the authors (Bixler, 1959; Blane, 1975; Flexner, 1915) concluded that a profession could not flourish and fully appreciate nor utilize the human potential in a bureaucratic setting. Mauksch (1971) identified the bureaucratic framework as not being conducive to autonomous nursing practice and the achievement of excellence within that practice.

Nursing was a large department in a hospital. The magnitude of the problems that a traditional, bureaucratic governance type could create within the profession of nursing must not be underestimated. Controlling the bureaucratic system often became the major work of administration. Management was the system's custodians and the

organizational power base, who worked to keep the rules and mandates in place. This system was outside the staff nurses' domain of influence or control. Bureaucracy basically disregarded the value of the individual in the work setting (Porter-O'Grady & Finnigan, 1984). This was not congruent with the basic tenets of a profession, and logically, nurses could not practice at levels consistent with professional expectations.

The attributes of a bureaucracy which included being ordered, hierarchial, controlled, and authorative, were in direct opposition to qualities found in a professional practice such as consultative, collaborative, knowledge based, and standard centered. Bureaucracy stood in direct opposition to professional practice which embodied the attributes of shared governance. There was dissonance between the two concepts (Porter-O'Grady & Finnigan, 1984). The descriptors of professional practice conjured up thoughts and notions that were not compatible with bureaucracy.

Wake (1990) found that nursing governance tended to shift from a centralized, bureaucratic model to a decentralized model with increased committee participation and formal shared governance. This was substantiated by a survey that revealed shared governance units increased from 0.1% in 1986 to 0.2% in 1989 and were projected to increase to 5% in 1992. Chief Nurse Executives surveyed projected 49% would be formalized shared governance units in 1992 (Wake, 1990).

The Department of Health and Human Services (HHS) studied the nursing shortage of the late 1980s and early 1990s. The HHS recommended health care employers provide an environment in which nurses actively participated in the governance, administration and management of their organizations (Kusserow, 1988). Traditional bureaucratic governance with administrators at the top, and staff nurses at the bottom, did not facilitate a participatory process.

In contrast, Haddon (1989) stated that shared governance was an organizational model that offered the opportunity to create a long-term response to nursing needs. Shared governance was an organizational structure that provided a context for autonomous nursing practice (Pinkerton & Schroeder, 1988). Within this democratic framework, nurses participated in making decisions that affected their practice, work environment, professional development, and personal fulfillment. Through nursing councils, teamwork was fostered and a more active role of the nurse was encouraged in designing and implementing systems to achieve favorable patient care outcomes (Caramanica & Rosenbecker, 1991).

Although some studies about shared governance had been conducted, it was not known whether it had made a significant difference in organizational culture, nurse job satisfaction, nurse retention, and patient outcomes. These studies failed to employ rigorous methodologies, were limited by small sample sizes, or utilized different instruments to measure the factors under examination. These limitations made comparison difficult (Wakefield, Curry, Price, Mueller, & McCloskey, 1988). Examples of these were studies by Howard (1987) and by Ludemann and Brown (1989), in which new tools of unknown reliability and validity were used. These inconsistencies, therefore, affected the quality of the results, analyses, conclusions and recommendations.

Some research was conducted in small units with specific nurse populations, such as critical care units, that further limited the generalizability of the results. Thus, it has been difficult to assess the empirical value of shared governance, and the effect, if any, on culture, nurse satisfaction, retention, and the patient care outcomes.

Managerial philosophy (governance) could influence culture (Cooke, 1989). A manager who utilized a particular type of management that supported a governance type, could directly influence the culture of a work group. Culture, or the "..shared beliefs and values that led to norms and expectations for group members.." (Cooke & Lafferty, 1987), could be assessed as constructive, passive/defensive, or aggressive/defensive. Culture paralleled governance and was related to job satisfaction, motivation, productivity, and quality patient care (Cooke & Rousseau, 1987; McDaniel & Stumpf, 1993; Scott & Shortell, 1983; Shortell, Rousseau, Gillies, Devers, & Simons, 1991; Thomas, Ward, Chorba, & Kumiega, 1990). Constructive culture was positively correlated to job satisfaction, motivation, productivity and quality patient care, while the reverse was true of the other two dysfunctional culture types. Researchers demonstrated positive links between a constructive culture, employee retention, and positive patient outcomes, which were not found with passive and aggressive/defensive cultures (Cooke & Rousseau, 1988; Mitchell, Armstrong, Simpson, & Lentz, 1989; Shortell et al, 1991).

Prior research revealed a positive (constructive) cultural type, as measured by the Organizational Culture Inventory, (Cooke & Rousseau, 1988; Shortell et al, 1991), was consistently associated with positive patient outcomes. Cooke (1989) assessed twelve different cultural styles that comprised three culture composites, namely, constructive, passive/defensive, and aggressive/defensive. The constructive culture was supportive of positive interpersonal relationships, effective problem solving, and personal growth. The other two were dysfunctional and could lead to unnecessary conflict and dissatisfaction. According to Cooke (1989) the types resulted

from organizational structural variables, reward systems, managerial styles and philosophies.

Work satisfaction was correlated to nurse retention by Hinshaw & Atwood (1983). This study demonstrated that nurses experiencing a high level of work satisfaction were more likely to be retained by their institution. Further, a research study conducted by Weisman and Nathanson (1985) supported a linkage between work satisfaction and patient satisfaction [outcomes]. These findings suggested dissatisfied nurses negatively influenced patient satisfaction with care. A recent study by McDaniel and Patrick (1992) substantiated this finding by reporting a positive link between nurse retention and patient outcomes.

Lucas (1988) identified a lack of empirical data to link governance and work satisfaction. Without that tie, there was not an empirical relationship to retention and to patient outcomes as presumed by the governance model. Thus, these various theoretical links have been suggested, but research has not confirmed them.

Shortell et al (1991) found that a high nurse retention rate was associated with a positive culture, while the reverse applied to the dysfunctional cultural types. The maintainance of a stable staff of qualified professional nurses has been recognized as part of the solution to hospitals remaining financially viable. The HHS Special Commission Study reported that 60% of Chief Executive Officers and 85% of Chief Nursing Officers surveyed believed that input into decision making had a positive effect on nurse retention (Kusserow, 1988).

The negative effects of turnover (the opposite, mirror image of retention) were detrimental to a facility trying to maintain quality patient care while decreasing costs (Kramer & Schmalenberg, 1988a). Turnover influenced not only costs associated with

hiring and orientation of new staff members, but could lead to staff instability and decreased quality of patient care (Jones, 1990). It became increasingly apparent that retention of nursing staff was a key element in gaining control over unnecessary spending of health care dollars, increased quality of patient care, and therefore, increased patient satisfaction.

In summary, empirical evidence was not forth coming or conclusive about the linkages between the elements of the proposed theoretically derived model. Investigation of the governance type as a contextual framework, the culture associated with each framework, and examination of the influence of the governance type, if any, on nurse work satisfaction, retention, and patient outcomes was warranted. Therefore, this study addresses that empirical gap in the health care delivery research.

Statement of the Problem

The purpose of this study was to explore the influence of governance type on culture, work satisfaction, nurse retention, and patient care outcomes, using a shared governance model and a bureaucratic model as comparison governance types within a theoretically proposed model. In terms of the model, the effect of structure (governance type) on process (culture, work satisfaction, and nurse retention), and ultimately on outcomes (patient satisfaction) of health care would be explored.

Research Questions

1. Does governance type influence the organizational culture, the work satisfaction, and retention rate of registered nurses on a unit?

2. Does governance type influence patient satisfaction with care provided by registered nurses on a unit?

Hypotheses

1. Governance type will have a differential influence on the organizational culture, work satisfaction, and retention rate of registered nurses.
2. Governance type will have a differential influence on the level of patient satisfaction.

Limitations of the Study

There were limitations to the study. One was the use of a convenience sample of hospitals in a similar region, however, an attempt was made to recruit a variety of hospital types and sizes.

A second limitation was the degree of sophistication between the governance models in the different institutions. Likewise, the variance of organizational culture between facilities cannot be controlled in the settings, but can be controlled for in the statistical analysis.

A third limitation was the willingness, or potential unwillingness, of registered nurses to respond accurately and in a timely fashion.

Definition of Terms

1. Governance: The act, manner, function or power of government (Guralnik, 1980, p. 605), in this study of hospitals.

a. Shared governance: A type of governance used in this study, defined as a participatory nursing group practice at the unit level, that maintained control over practice, working conditions, and professional affairs in a systematic way (Milton, Verran, Murdaugh, & Gerber, 1992).

b. Traditional governance: A type of governance used in this study, defined as a hierarchial, bureaucratic form of government with a head nurse to plan, organize, direct, and control the administration of the unit and the staff (LaMonica, 1983).

2. Culture: "..a group- or organizational-level phenomenon...defined as shared beliefs and values that lead to norms and expectations from members". (Cooke, 1989, p. 7).

3. Work satisfaction: A staff member's opinion of the job in terms of pay or reward, nursing administration style, professional status accorded, and interaction with colleagues (Hinshaw, Smeltzer, & Atwood, 1987).

4. Retention rate: The percentage of registered nurses remaining in a unit employment based on the number of budgeted full-time positions during a 12 month fiscal year from July 1 thru June 30 of the year in which data were being collected. This term is an antonym to turnover, its mirror-opposite term.

5. Patient satisfaction: The patient's opinion of the care received from nursing staff (Hinshaw & Atwood, 1982)

Summary

The purpose of this study was to explore and compare the influence of governance type on culture, work satisfaction, retention of registered nurses, and patient outcomes. A theoretically derived path model was proposed to guide the study. This model illustrated Donabedian's (1966; 1969;1980; 1988) evaluation of health care quality that used the concepts of structure, process, and outcome. Since there was little empirical research that examined the relationship of governance type to patient outcomes, this study would have value in determining whether there was a context for nursing service that would be worthy of work redesign consideration.

CHAPTER II

REVIEW OF THE LITERATURE

Theoretical Framework

Two theoretical frameworks were used for this study. The first was a model of health care evaluation that framed the proposed research model and provided guidance for the sequence of the variables. In addition, a nursing theory provided structure for the nursing service application of the research.

Evaluation of Quality

The theoretical model proposed for this research was conceptualized using Donabedian's (1966) approach to the evaluation of quality that utilized measures of structure, process, and outcome. Avedis Donabedian (1966;1969;1980;1988) has provided the generally accepted classification of the techniques of quality assessment (Jonas, 1981; Kaluzny, Warner, Warren, & Zelman, 1982). Donabedian (1980, p. 83) stated that "...this three-fold approach is possible because there is a fundamental functional relationship among the three elements..", schematically shown as follows:

Structure --> Process --> Outcome.

Structural characteristics tend to influence the process of care so that its quality was diminished or enhanced, similarily, process variations produce effects on health care

(Donabedian,1980). Within the proposed research model, governance was the structure; culture, work satisfaction, and nurse retention were process; and patient satisfaction was outcome. For purposes of this initial study, the model was treated as a recursive model. See Figure 2.

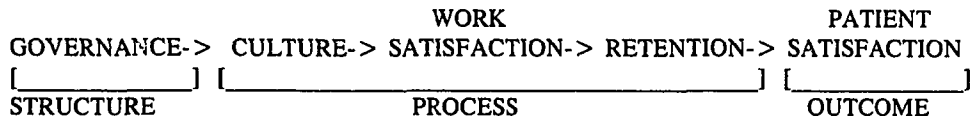


Figure 2. Proposed Recursive Model Within Evaluative Model.

Structural measures focused on the internal characteristics of the organization such as committee structure, policies, and manuals; and its personnel and specific qualifications [board-certification, licensure] (Donabedian, 1966). Structural measures examined the setting of care (Jonas, 1981). A major assumption was that better care was more likely to be provided when qualified staff and sound administrative organization were employed. Structure also included the organization of the nursing staff and influenced the kind of care provided (Donabedian, 1980). Thus, the relationship between structure and patient satisfaction had importance in the planning and implementation of care delivery (Donabedian, 1980). The application to this study model was evident because governance provided the context in which nursing took place and patient outcomes occurred.

The measurement of process activities in the management of patient care was usually determined by established criteria to measure the actual activities (Donabedian, 1966). It was also necessary to measure organizational processes to parallel assessment of clinical skills (Shortell et al, 1991). Shortell et al (1991)

identified organization culture as one of the processes most related to effective performance defined in terms of quality of patient care. Staff members worked together to provide care to the patient that would result in client satisfaction. Unit culture, composed of the norms, values, beliefs, and expectations shared by the staff members, produced staff behaviors that affected patient outcomes (Shortell et al, 1991).

Process measures of nurse work satisfaction and nurse retention were affected by the prevailing unit culture (Shortell et al, 1991). Nurse work satisfaction was an organizational activity that impacted patient outcomes (Weisman & Nathanson, 1985) as was nurse retention (McDaniel & Patrick, 1992). Thus, the elements of culture, work satisfaction and retention were the selected process measurements for this study.

Outcome measures examined the results of the encounter between the patient and the health care delivery system (Jonas, 1981). A major assumption was that health care was useful in maintaining health and that particular elements and aspects of care were known to be specifically related to successful or unsuccessful health outcomes. Donabedian (1980) argued that the patient's evaluation of care was essential because it gave information about the provider's success at meeting client values and expectations. It provided evidence of the worth of the process and structure that brought about the outcome. In this study model, patient satisfaction (outcome) was used to provide evidence of the influence of governance type (structure) and culture, work satisfaction, nurse retention (process) on the outcome. The patient's assessment of care included the elements of structure (setting, amenities of care) and process (technical management, interpersonal care, and any consequence of care). Measurement of the patient's satisfaction with these elements gave

information about the provider's success at meeting the patient's values and expectations. This information could be used to continuously monitor and guide the structure and process in which patient care occurred (Donabedian, 1980). The application for this study was to use the information to guide the development of a context in which nursing service could provide health care and satisfactorily meet the expectations and values of the patient.

Goal Attainment Theory

Individuals do not live in a vacuum, but through interrelationships are influenced by their environment and in turn, influence their environment (King, 1989). Imogene King (1981) identified three interacting systems: (1) Personal systems [individuals], (2) Interpersonal systems [groups], and (3) Social systems [society]. See Figure 3.

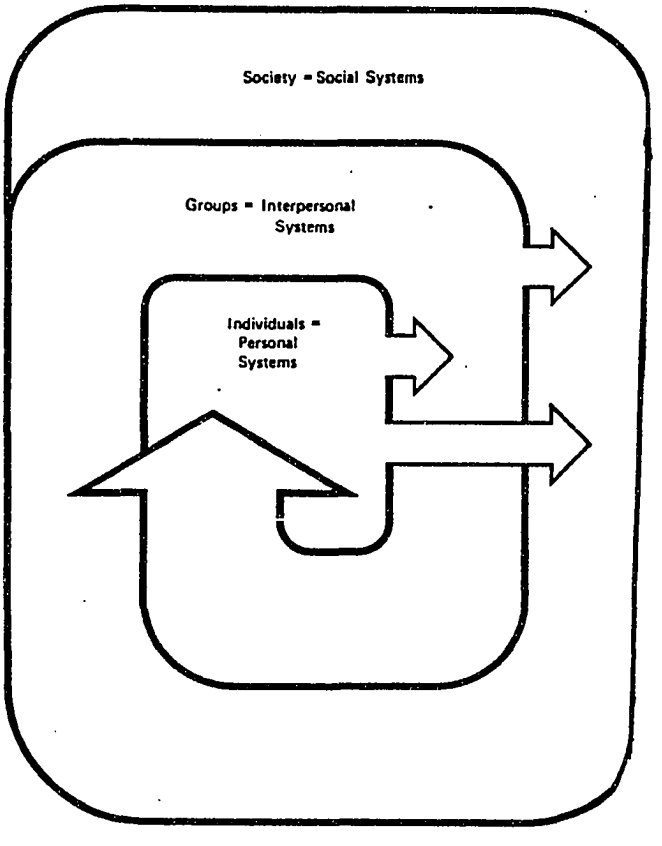


Figure 3. Dynamic Interacting Systems. Reproduced by permission.
TOWARD A THEORY FOR NURSING BY Imogene M. King
Delmar Publishers, Albany, New York, Copyright 1971

King's theory was an open system, meaning there was interaction and exchange between the systems, and between the systems and the environment. Exchange of information, e.g., communication, linked the three systems. Persons within the systems affected the behavior of each other, and were in turn, influenced by the factors within the situation. King's framework was a system of processes that included perception, communication, purposeful interactions, information, and decision-making.

Interpersonal System

The focal system in King's Theory of Goal Attainment was that of the Interpersonal System. Personal systems, the individuals, were the subsystems. Social systems, the various environments, were the suprasystems in which Interpersonal systems were experienced. Each entity was simultaneously a part and a whole that provided an emphasis on holism (Ackermann, Brink, Clanton, Jones, Moody, Perlich, Price, & Prusinski, 1989).

Primarily, the theory pertained to the Interpersonal Systems of an individual in the role of caregiver and an individual in the role of recipient of care. The goals to be attained applied to the individual who received the care. The care was provided in a health care system within society or in an individual's home (King, 1989). This framework also provided a structure to examine the relationships of nursing to health-care organizations, to clients, to health care in the community, and to society (King, 1989).

As the main focus of King's theory the Interpersonal System was concerned with individuals in dyads for example, nurse-nurse, and nurse-patient that were inherent in the health care culture. The concepts of the Interpersonal System included that of role, interaction, communication, transaction, and stress and were the foundation of Theory of Goal Attainment (King,1989).

Basic assumptions of the theory that applied to this study were: (1) individuals communicated information, mutually set goals, and took action to attain goals, (2) individuals displayed reciprocally contingent behavior whereby the behavior of one person influenced the behavior of the other, and (3) individuals had a right to participate in decisions that influenced their life, their health, and community service (King, 1981). King (1981) then derived the following propositions from the assumptions: (1) if perceptual accuracy was present in individual's interactions, transactions would occur, (2) if individuals made transactions, goals would be attained, (3) if goals were attained, satisfactions would occur, and (4) if goals were attained, effective nursing care would occur.

Integration of Theory

The level of King's theory development, as analyzed by DiNardo (1989), was primarily explanatory, and predictive of future interactions of the same phenomenon. King (1986) stated that the conceptual framework was comprehensive enough to enable theory generation. Building on that belief, the Interpersonal System of the Theory of Goal Attainment became the underpinning of this study. It was the system between the Social and the Personal Systems and could be viewed as a bridge between

the micro (Personal) and the macro (Social) system. The central emphasis was the care of the individual at the level of Personal Systems (King, 1989).

This theory provided a strong framework for unit level nursing groups, since they were composed of individuals who functioned in Personal Systems, participated in the Societial System of the organization and simultaneously functioned in a group on a unit within an Interpersonal System characterized by caring for patients. The structure accommodated the nurse-patient and nurse-nurse relationship that would be explored in this study as reflected by the variables.

The basic assumptions and propositions derived from the Theory of Goal Attainment cited successful communication as a primary step in setting goals, taking action, and having transactions occur and goals attained both for nursing service and patient care. The behavior of the individuals contributed to the culture or context in which nursing took place. Since behavior was in response to the perceived actions of others, it was critical that the perceptions be accurate to bring about transactions, goal attainment, satisfaction, and effective nursing care and positive patient outcomes. When goals were attained there was work satisfaction for the nurses as they provided nursing care that resulted in positive patient outcomes.

King's framework supported the linkages of the proposed path model from governance type to patient outcomes. The results of this study would help to determine the influence of governance type on nursing service and the goal attainment of patient outcomes.

Summary of Theory

The proposed model for this study was framed in the evaluative theory of Donabedian (1966) in which the main elements were structure, process, and outcomes. These elements corresponded respectively to governance, then to culture, work satisfaction and nurse retention, and lastly to patient outcomes. The model was evaluative of the form of governance and its influence on patient outcomes.

The Theory of Goal Attainment was characterized by a relatively high degree of generality. It was applicable to all age groups, nursing functions, practice settings, and specialty areas. The Theory of Goal Attainment had the potential for predicting the outcomes/effectiveness of the nurse-patient interactions (King, 1981) and further research would enhance its pragmatic adequacy.

The Interpersonal System was the focal system of the Theory of Goal Attainment and framed this study within the larger context of the Social System of the organization and simultaneoulsy encompassed the Personal System. The basic assumptions of this theory provided a framework in which to examine the relationships of nursing to clients, to other health care providers, to health care in the community, and to society.

Variables of the Study

Governance

Guralnik's (1980) definition of governance included the manner, or the way and method, in which government was accomplished. The governance type could range from autocratic, democratic, to laissez-faire, with many variations in between. A variety of elements could influence governance type, for example, management styles greatly affected the structure of governnce type and the degree to which it was enforced and practiced (LaMonica, 1983). This, in turn, affected the culture of the people governed (Cooke, 1987;1989) and, therefore, their productivity (Likert,1961).

Governance was the structure component in the proposed model for the study. It was hypothesized that the governance type of a nursing unit would influence the process elements of culture, work satisfaction, and nurse retention, and, therefore, the outcome of patient satisfaction. The structure provided the context in which this activity occurred, thus, the importance of governance was not to be overlooked, but explored and reviewed to further provide insight and understanding of its significance for health care outcomes.

Development of Traditional Governance

Max Weber, the "Father of Bureaucracy", laid the fundamental justification for this form of governance as the most effective for Western industrial men [sic] (Pascale & Athos, 1981). Bureaucracy had its roots in the governance forms of the

Church and the Holy Roman Empire. Later, the style changed to a military-religious authoritarian structure that has remained influential in organizations today (Porter-O'Grady & Finnigan, 1984). Bureaucracy centralized power, authority, and accountability within the control of management. Although much was done to 'flatten' the bureaucratic model, the organizational structure still reflects the bureaucratic design and has remained in place in most American organizations.

Frederick Taylor, the "Father of Scientific Management", further confirmed this as a management style through the use of "time and motion studies" (Taylor, 1911). Taylor focused on tasks done by workers and viewed people as instruments (machinery) through which the organization achieved its goals. Workers could be manipulated with a variety of incentives to be efficient and more productive (Porter-O'Grady & Finnigan, 1984).

In the traditional governance model, lines of authority and control were clearly delineated on organizational charts that emphasized reporting relationships and position placement. Policy making, direction setting, and organizational mandates were generated within a narrow hierarchic range at the top of the pyramid, while the other levels were placed to ensure that rules and regulations were followed and enforced (Porter-O'Grady & Finnigan, 1984). The design of a bureaucratic organization assigned the day-to-day activities, necessary to meet the organization's objectives, to the majority of workers in the system who had no input into the development of those objectives.

From the socio-technical literature, Triste and Bamforth (1951) described the emergence of early forms of self-managing teams in a British coal mine. Researchers in the socio-technical area were the major advocates of self-managing teams.

The group dynamics movement, led by Kurt Lewin (1947), was clearly a precursor to the emergence of self-managing teams. In his work there was a blend of theory, action research, and participation, that appeared in all the interventions of self-managing teams (Goodman, Devadas & Hughson, 1988). Other research from the group dynamics movement that influenced the development of self-managing teams included study on the antecedents and consequences of group cohesiveness (Seashore, 1970). This work demonstrated that high levels of cohesiveness characterized most self-managing teams. Research on group participation in group decision making also had a positive influence on the development of self-managing teams (Maier, 1963; Coch & French, 1968; Vroom, 1964).

The basic idea of participation represented a shift from controlling to one of sharing control and power. The underlying assumption was that it improved worker satisfaction and productivity. The movement toward greater participation clearly provided a context for the development of self-managing teams (Goodman et al, 1988).

Shared Governance

Shared governance was a management model quite opposite of the traditional hierarchial bureaucratic model that for so long had been the paradigm for nursing administration. Shared governance was also called participatory management (Porter-O'Grady, 1991), self managing work teams (Goodman, Devadas, & Hughes, 1988), and group practice model (Perry, 1990). In terms of this study, it was a systems-based model which for nursing integrated the parts of nursing practice that directly

affected the clinical delivery of care (Smith, 1990). It allowed input into decision making on the staff nurse level and provided nurses with a sense of control over their work and an interest in the success and well-being of the organization (Kusserow, 1988). A change from a hierarchial design to a systems approach ensured active nurse participation in the management process (Merker & Burkhart, 1991).

The participatory process, inherent in shared governance, could occur at any level of an institution and take the form of a wide range of organizational structures (Merker & Burkhart, 1991). The forms most often encountered are the Councilar Model, Congressional Model, and the Administrative Model. The organizational design was developed to support the principles of shared governance within an institution, a department or on a unit.

The Councilar Model, used at the departmental level, had a council for each particular aspect of institutional nursing practice such as quality assurance, education, nursing practice, and management. A staff nurse represented each unit on the council to assist with decision making for the nursing department (Merker & Burkhart, 1991). A chairperson from each council and the nurse administrator, a nonvoting facilitator and the chairperson formed the 'Coordinating Council'. The Coordinating Council supported and integrated the actions and functions of each council (Porter-O'Grady & Finnigan, 1984). See figure 4.

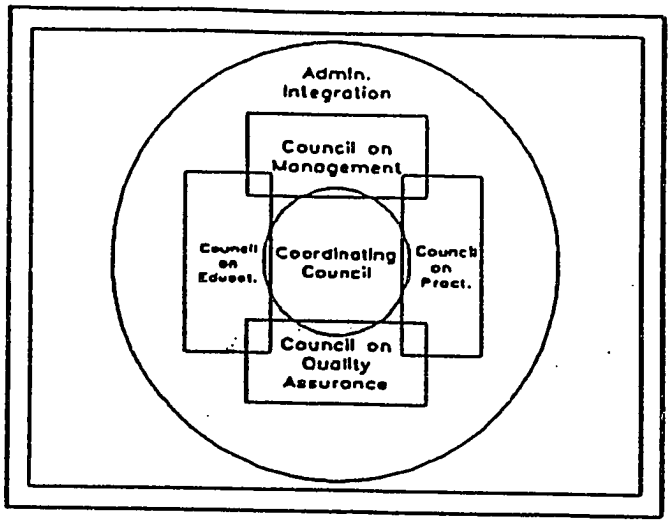


Figure 4. The Councilar Model.

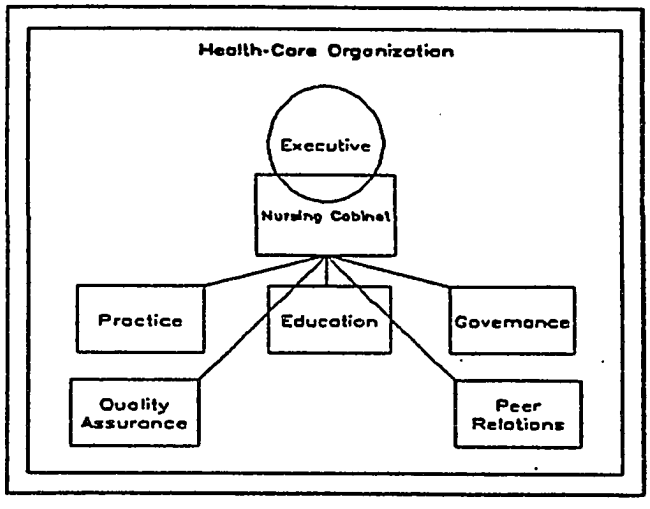


Figure 5. The Congressional Model.

The Administrative Model divided the nursing organization into two tracks, management and clinical. This model was best suited for small hospitals and was the least accountability-based or professionally structured (Wiens, 1990). The clinical and management tracks flowed directly from the executive committee with a forum group heading each track (Porter-O'Grady, 1987). See figure 6.

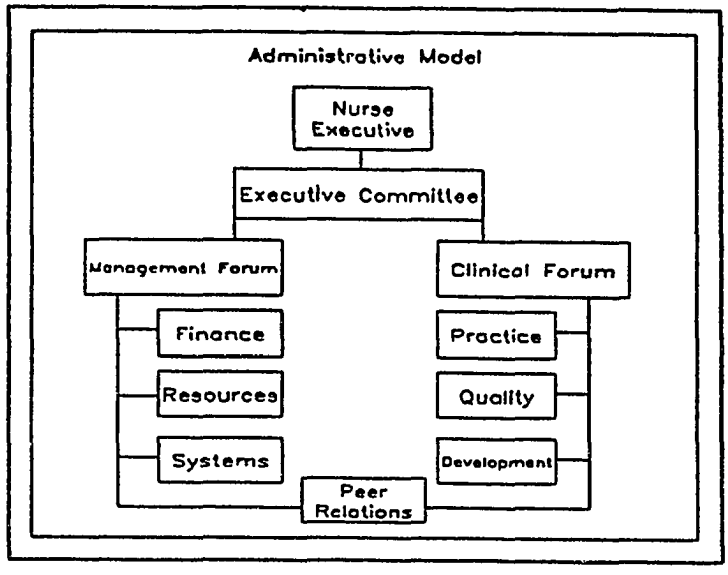


Figure 6. The Administrative Model.

In a shared governance model the role of management was not the autocratic task-master that enjoyed a master-servant relationship with the staff but, rather, a democratic leader that strived to create a work environment in which staff felt comfortable participating in work-related decisions. The role of the manager shifted from leader and decision maker to facilitator and coach (Merker & Burkhart, 1991) who 'created' by communication only the culture, environment, and context

that empowered individuals and teams to generate results (Evered & Selman, 1989). Participative managers solicited ideas from others and actually empowered people to contribute more fully and productively.

Participatory management emphasized human relations. The goal was a satisfied employee assisting with improvement of patient services, the latter the reason for which hospitals existed (Boissoneau & Schwahn, 1989). Characteristics of a participatory manager were:

. Fostered an open environment-shares information.

. Thinks 'all of us together'; evaluated people on the basis of their contributions.

. Handled people-problems directly.

. Considered personnel more important than other resources.

. Placed personal choices alongside (not above) others.

. Supported individuality.

. Favored decentralized management.

. Believed that past management failings have been mostly human.

These characteristics differed markedly from those of a traditional autocratic manager which included planning, organizing, directing, and controlling. Figure 7 concisely summarizes the dissimilarities between the attributes of bureaucracy and professional practice (Porter O'Grady & Finnigan, 1984).

BUREAUCRATIC ORGANIZATION	PROFESSIONAL PRACTICE
ordered	consultive
hierarchial	collaborative
controlled	knowledge based
vertical	lateral communication
authorative	judgment rendering
structured	developmental
administrative	standard centered
pyramidal	measurable
policy governed	interdependent

Figure 7. Dissimilarities between bureaucracy and professional practice

Research on Shared Governance

The literature indicated the first shared governance models appeared in health care in the late 1970s (Perry, 1990). There was a paucity of research about shared governance in the literature. The research to date has focused on the effect that shared governance has had on nurse work satisfaction and nurse retention.

The earliest studies, published in the late 1980's, were found in the nursing administration literature and in the critical care nursing journals. The critical care areas were interested in the definition of nursing practice, autonomy, and positive patient outcomes (Daly, Rudy, Thompson, & Happ 1991; Mitchell, Armstrong, Simpson, & Lentz, 1989;). The Mitchell et al (1989) study investigated effectiveness of a nursing care delivery system within selected management structures.

Mitchell et al (1989) characterized and quantified attributes such as collaboration, conflict resolution, and organizational climate. Organizational climate influenced organizational outcomes, such as, job performance and employee satisfaction (Duxbury, Henly, & Armstrong, 1982). The nursing unit climate was

measured by the Nurse Organizational Climate Description Questionnaire (NOCDQ). Although organizational climate and organizational culture were composed of different elements, it was important that investigation was initiated into the environment and context of health care delivery.

The Mitchell et al (1989) study was a single site study without a control unit and causal inferences regarding the relative importance of factors such as decentralized administration, participative decision making by staff, high nurse work satisfaction, and good physician-nurse collaboration could not be made, but indicated that these attributes were key variables that could be measured in multisite studies. It was found that clinical outcomes such as low mortality ratios, no new complications, and high patient satisfaction, existed in a unit characterized by a highly perceived level of nurse-physician collaboration, highly rated objective nursing performance, and significantly more positive organizational climate and indices of job satisfaction and morale than in historical comparison samples.

Two years later, a longitudinal study by Daly et al (1991) was initiated in a Special Care Unit (SCU) designed to care for chronically, critically ill patients. The SCU had a case management practice model and a shared governance management model. The purpose of that study was to compare the influence of this SCU with those of the traditional ICUs on nurse and patient outcomes. Nurse outcomes included job satisfaction, absenteeism, and retention, while patient outcomes were length of stay, complications, mortality, readmission rate, cost, and patient and family satisfaction with care. Two years later, 24 patients were entered into the study with preliminary data that evidenced an increased patient and family satisfaction in the SCU unit as measured by observed behaviors of the patient and family reported by

staff members. Although all data were not collected, the study will be followed to conclusion to determine if final results will support these early conclusions.

The Mitchell et al (1989) and Daly et al (1991) studies both investigated the context of health care delivery and examined variables including nurse work satisfaction, retention and patient satisfaction. This early research provided no conclusive links between governance type and patient satisfaction, however, investigation was initiated of the work setting.

Later in 1991 Shortell, Rousseau, Gillies, Devers, & Simons initiated research to develop measures of managerial practices and organizational processes that assessed patient outcomes and patient satisfaction. Shortell et al (1991) identified organizational culture as an important managerial practice and organizational process related to quality and efficiency of patient care. Using selected items from the Organizational Culture Inventory (OCI), Shortell et al (1991) concluded that measures of managerial practices and organizational processes could be used to explain differences in patient outcomes. In this study, a positive organizational culture as measured by the OCI resulted in a higher quality of patient care and satisfaction as measured by clinical outcomes and patient report. Shortell et al (1991) also found positive correlations between a positive culture and nurse retention. It was concluded that types of managerial practices having a team-satisfaction oriented culture, or a positive culture, consistently associated with criterion variables, including nurse retention and patient satisfaction, in the favorable direction.

Generally, the few research studies about and related to shared governance demonstrated that it facilitated autonomy and increased job satisfaction (Ludemann & Brown, 1989) and positively affected retention and professional growth for the nurse

(Goodykoontz, 1990). Daly et al (1991) identified positive nurse work satisfaction and retention, positive patient and family outcomes and a reduction in patient care costs in a special care unit.

In summary, investigation of variables related to patient outcomes in health care delivery stemmed primarily from the need to control costs. However, links were found among variables such as nurse retention, work satisfaction, organizational culture, and governance type. Patient satisfaction was also linked to all variables except governance type. A gap in the research was evident between governance type and patient satisfaction, which the purpose of this study addressed.

Research on Traditional Governance

Research conducted in the traditional governance type setting was not prevalent before 1983 when the DRGs came into being. Generally, research that was conducted studied nurses and the nursing process, and investigated burnout, rather than looking at the governance model and its effect on nursing. Results of research conducted in industry were adapted to nursing unit governance without consideration of the difference of the settings. The focus was on improving and increasing the productivity of the staff (Porter-O'Grady & Finnigan, 1984).

Culture

Historical data from industrial and organizational psychology were integrated to assist in laying a foundation for the development of shared governance. The shift from autocratic management to a more humanistic approach could be demonstrated

from the literature. It was important to understand the cultural perspective of the majority of organizations existing today because culture infiltrated the entire organization and guided the policies and practices of an institution.

Ludemann and Brown (1989) observed that the 'participatory model' could be traced to the Hawthorne studies in the 1920's (Mayo, 1963). The human relations perspective of organizations evolved as theorists like Maslow (1954; 1970), McGregor (1960), Argyris (1962), and Herzberg's (1966) work was traced through time providing a theoretical foundation upon which shared governance was built. The work of the theorists was briefly traced as the evolution of thinking and practice was chronologically followed from a traditional to a shared governance type of model.

Maslow (1954; 1970) greatly influenced management's role with the development of a hierarchial inventory of physiological, safety, social, esteem, and self-actualization needs. This produced a "ladder effect" that led to self-actualization, the top priority, but, only when all other needs are satisfied. Argyris (1962) found that the behavioral expectation for workers in the bureaucratic setting was immaturity, thus, immature behaviors were displayed in the work setting. Douglas McGregor (1960) further theorized that motivation of the worker occurred at the social- esteem and self-actualizing level of Maslow's hierarchy and saw this as a task for management, which was different from traditional management concepts.

Herzberg (1966) built on the work of Maslow, Argyris, and McGregor in his investigation of environmental factors and motivating factors such as achievement, recognition, growth, and development. Herzberg found increased responsibility and satisfaction associated with recognition for excellence had influenced workers' desire to grow and contribute more fully.

Van Maanen and Barley (1985) viewed organizational culture in terms of ecological context, differential interaction, collective understandings, and reproductive and adaptive capacity. In this structural sense, cultures only developed where people interacted with one another. The development of collective understanding was central because only when meaning was assigned to situations, through interaction, did response then result in rule, ritual, and value. The fourth factor emphasized the fact that cultures were not fixed and immutable (van Maanen & Barley, 1985).

From this brief overview, it was seen how long and difficult it was for management to realize the importance of the type of environment to provide so that the most satisfied and productive worker could evolve. Although bureaucracy was still the organizational culture in a majority of institutions, the groundwork had been laid for change to occur if the desire was there to do so.

As an organization's culture developed and matured so did the individuals that comprised the group. The culture of a group was defined as the shared beliefs and values that led to norms and expectations from members (Cooke & Lafferty, 1989). Subcultures could be formed within an organizational culture that could be different from that of the organization (van Maanen & Barclay, 1985).

Weick (1979) argued for a cognitive view of culture in which individuals developed a perception of the world by identifying patterns and constructing and attaching meaning to these patterns. The meanings attached to the patterns often focused on the behaviors that were expected and rewarded by the organization or unit. Thus, if the culture was shared by members of the same environment, then an organization could be characterized by a dominant culture, and by a subculture, that reflected distinct work and social environments within an organization. Culture could

be a group- or organizational-level phenomenon, thus, there may be many different cultures in the same organization (Cooke, 1989).

Thomas, Ward, Chorba, and Kumiega (1990) identified an 'ideal' nursing culture. This culture was constructive (emphasizing members' higher-order or "satisfaction" needs) and promoted behaviors such as achievement, and the pursuit of a standard of excellence with open enthusiasm; self-actualizing, with independent thinking and excellence in tasks performance; humanistic by taking time to mentor people; and affiliative through friendly interactions.

Traits identified within shared governance groups were: valued human relations, sensitivity greater than objectivity, cooperation rather than competition, individualistic, self-developing, and goal-oriented behaviors (Cooke & Rousseau, 1987; Management Science Associates, 1990). Groups that possessed these qualities enhanced the probability of success with a shared governance model (Shortell, Rousseau, Gillies, Devers, & Simons, 1991), thus, not all units would be a candidate for a shared governance model.

Research by Cooke and Lafferty (1989) supported the notion that the management philosophy influenced culture, which was reflected by the proposed model. The aspect of culture most immediately affected by management philosophy was what is 'valued' by the organization, and the extent to which these values were recognized and shared by group members reflected the organization's culture. Likewise, norms and expectations were shaped by the managerial philosophy, that further concurred with the research model.

Culture was the first element in the process component of Donabedian's Evaluation of Quality Model. It was theorized that culture was influenced by

governance, and then in turn, influenced work satisfaction, and nurse retention, which were the other elements of process.

Work Satisfaction

Work satisfaction was defined as the staff member's opinion about one's job in terms of pay, governance, and collegiality (Hinshaw, Smeltzer, & Atwood, 1987). Work satisfaction followed culture in the model proposed for this study and was the second variable in the process component of Donabedian's Evaluation of Quality scheme. It was theorized by Milton, Verran, Murdaugh, & Gerber (1992) that governance and culture influenced work satisfaction.

Generally, the research revealed that work satisfaction was increased in a shared governance context. Shared governance supported the profession of nursing and provided a framework that addressed four major sources of dissatisfaction among nurses, namely: (1) limited autonomy, (2) lack of communication, (3) exclusion from participation in organizational decision making, and (4) unsatisfactory compensation (Numerof & Abrams, 1984).

Dissatisfied nurses negatively influenced patient satisfaction with care (McDaniel & Patrick, 1992) and also contributed to raising the nursing turnover rate (Hinshaw, Smeltzer, & Atwood, 1983). Thus, low work satisfaction could lead to increased costs for a health care facility through high turnover rate, and decreased revenue generation from declining patient census.

Retention

In the study model, retention followed work satisfaction because it had been established that work satisfaction was related to retention (Hinshaw & Atwood, 1983; Price & Mueller, 1981,1986)). Retention was also part of Donabedian's Evaluation of Quality process component used to examine what happened between providers of care and the patient (Jonas, 1981).

It was increasingly apparent that retention of nursing staff was a key element in gaining control over unnecessary spending of health care dollars. An important resource needed by hospitals- to remain operational and financially viable- was a staff of qualified professional nurses. A challenge to operational viability that occurred in the late 1980s and into the early 1990s, was a nursing shortage (Roberts, Minnick, Ginzberg, & Curran, 1989). As a result, continual recruitment and orientation of new staff further escalated institutional costs. Health care administrators attempted a variety of nurse recruitment and retention tactics, mostly focused on short-term approachs, such as salary incentives to attract staff (Porter-O'Grady, 1991), however, the multifaceted problem had to be addressed with long-term strategies.

Turnover influenced costs associated with hiring and orientation of new staff members which led to staff instability and a decrease in the quality of patient care (Jones, 1990). The negative effects of turnover were detrimental to a facility trying to maintain quality patient care while decreasing costs (Kramer & Schmalenberg, 1988a). Although the shortage of nurses had resolved by the the early 1990's, it did not change the relationship of staff instability and decreased quality in patient care.

Patient Satisfaction

The outcome variable in Donabedian's Evaluation of Quality Model and the last variable in the proposed governance study model was patient satisfaction with nursing care, which examined the results of the encounter [process] between the patient and the health care delivery system [structure] (Donabedian, 1969). Donabedian (1980) defined patient satisfaction as an outcome or consequence of care. The patient's judgement about the "goodness" of care could relate to the environment in which care was rendered, to the technical management of care, and to the physical, psychological, or social consequences of care. Although the patient was usually limited in ability to make accurate judgments about technical components of care, the validity as a measurement of meeting expectations and valuations was not lessened. Work satisfaction and nurse retention were positively related to patient satisfaction (Hinshaw & Atwood, 1983; McDaniel & Patrick, 1992; Weisman & Nathanson, 1985), thus, patient satisfaction [outcome] was the final variable in the study model and in Donabedian's framework for evaluating quality in health care.

Summary of Variables

The proposed model, framed within Donabedian's Evaluation of Quality Model, utilized structure, process, and outcome of care. Governance type was the structure and provided the context in which nursing service was performed for patients and where nurses worked. The type of context influenced the process variables of culture, work satisfaction, and nurse retention; the three process variables

influenced patient satisfaction. However, nursing studies used selected variables suggesting linkages between them, but, there was no study examining the linkage from management to patient care outcomes. Therefore, it was not known whether governance type influenced patient satisfaction, which this study proposed to assess.

Each variable was important individually and cumulatively. The governance type was important to the nurses' work satisfaction, and could be a determinant of the retention rate of a nursing unit. Patient satisfaction, an outcome of health care, was the consumer's evaluation of health care and was used for evaluating service output and quality measures (McDaniel & Nash, 1990). Since patient satisfaction with nursing care was the strongest predictor of overall hospital satisfaction (Abramowitz, Cote, & Berry, 1987), the ramifications of patient satisfaction were far reaching into service and hospital viability, and the centrality of nurses to the development of patients' positive perceptions of their care in the hospital would increase the patient's tendency to recommend the facility (Greeneich, 1993).

As revealed in the review of the literature, the variables under study were all important factors in providing health care to patients. The variables were shown to be theoretically related. The purpose of this research was to empirically test the proposed model with its suggested relationships and help to link governance type and patient outcomes.

CHAPTER III

METHODOLOGY

Research Design

This study was an ex post facto, correlational study using survey methodology to collect data for assessment of a proposed research model of governance type. In this type of study the independent variable was not directly manipulated by the researcher (Polit & Hungler, 1978). The research was conducted after the variations in the independent variable occurred in the natural course of events.

A correlation, an index of the extent to which two variables were interrelated, did not indicate causation (Campbell & Stanley, 1963), however, the absence of correlation could rule out many simple, general, causal hypotheses as to the main effects of one independent variable. Therefore, the correlational approach could provide a preliminary survey of hypotheses.

Ex post facto correlational research played an important role in nursing, medical and social science research, because of the many problems that were not amenable to experimentation. It was also an efficient method of amassing a large amount of data in a relatively short time frame. The studies were strong in terms of their realism because they lacked the artificiality of a laboratory experiment and their results were more generalizable to other realistic settings.

Existing groups in ex post facto studies were not formed by random process but by a self-selecting process (Kerlinger, 1973). Members of the groups were there, in part, because they possessed traits or characteristics extraneous to the research problem that could possibly influence the variables of a research problem. This could be a threat to the internal validity of a study. The researcher could not assume that the groups studied were similar at the beginning of the investigation, thus, preexisting differences would be a plausible explanation for observed differences on the dependent variable (Polit & Hungler, 1978).

Site Selection

Criteria for site selection were the presence of a shared governance unit and a traditional governance unit within the organization. Therefore, nurse administrators from hospitals in Southwestern Pennsylvania were contacted to determine whether shared governance was used within the nursing department of the facility, since a comparison of shared governance and traditional governance was needed. If the institution also had both a shared governance unit and a traditionally governed unit within the same hospital the administrator was then asked to participate in this research study. Not one hospital which met the facility criteria refused to participate. The search yielded five hospitals (three metropolitan and two rural) that qualified to take part in the research, see Figure 8. The variety of hospital sites helped to address the previously identified problem of research that generalized only to a unit specific setting due to the use of specialized and selected nurses.

Two units from each hospital participated in the study. One traditionally governed unit and one shared governance as previously defined. Since the shared governance unit was used to identify qualifying facilities, the traditional unit chosen from those sites was selected to provide a match to the shared governance unit (in terms of unit size, operationalized as number of nurses employed, and care provided, operationalized as acuity and type of patients, to facilitate comparison).

HOSPITAL	# OF BEDS	LOCATION	HOSPITAL TYPE
1	416	Rural	Community
2	700	Metropolitan	Tertiary Care
3	481	Metropolitan	Tertiary Care
4	524	Metropolitan	Tertiary Care
5	488	Rural	Community

Figure 8. Summary of Research Sites.

Sample Selection

Criteria were stated for the shared governance model. The shared governance model was required to have been in place for 12 months prior to participation in this research study. The shared governance model included a "system" of registered staff nurses who actively participated in organized decision making that affected nursing practice, management activities of the unit such as time scheduling, the interview process, the budgeting process, and staff education. Likewise, criteria were met for traditionally managed units which included a head nurse that planned, organized, directed, and controlled the management activities of the nursing unit and the staff. In contrast to shared governance, the nursing staff did not participate in nurse management activities.

Subject Selection

Subject selection included staff registered nurses who were the individual unit of analysis. The inclusion criteria were all registered nurses, male and female, employed on all shifts of the selected units for a minimum of three months in a full or part time capacity. This time frame allowed a nurse to become familiar with the structure, organization and culture of a unit. All levels of nursing preparation - diploma, AD, BSN, and MSN - with varying amounts of experience participated, since all levels comprised the nursing unit staff and provided care to the patients. Those excluded from study participation were all registered nurses, male and female,

who were employed for less than three months on the selected research units, or in a management position.

Inclusion criteria for patient subject selection were the recommendation by the charge nurse of the patient to participate, agreement by the patient to participate in research, and physical and mental ability to complete a survey questionnaire. Exclusion criteria were patients who were not physically able to complete a survey questionnaire, who were disoriented or confused, or who refused to participate in research.

Instrumentation

It was critical in this study to detect differences in the subject's perception of their unit culture, therefore, the nursing unit was the referent point of measure for culture rather than the organization. If the organization was the referent, the culture of the unit in which the nurses work would not be reflected in the measurement, and the differences in the perceptions of unit cultures would go undetected. The Organizational Culture Inventory (OCI) was adaptable to the unit level of analysis. See Appendix C. It was the individual nurse's perception of the unit culture that was of interest, and the differences in perception that was analyzed in the research. Likewise, nurse work satisfaction, and nurse retention, also referenced the nursing service unit and provided parallel reference points. The nurse was the referent point for the individual patient's report of satisfaction. Thus, the instruments measured individual perceptions at the level of the nursing service unit.

Organizational Culture Inventory

The Organizational Culture Inventory (OCI) was a .."self-report tool... that measured normative beliefs and shared behavioral expectations..'(Cooke & Lafferty, 1983). 'Normative beliefs were cognitions held by individuals regarding others' expectations for his behavior as a member of a particular group..' (Fishbein & Ajzen, 1975). Shared behavioral expectations were those normative beliefs held in common by members of a group (Homans, 1950; Mills, 1967). These expectations or 'norms' prescribed ways in which members in similar positions were expected to approach work and interact with each other. This was an important component of group culture because the perscriptions were shaped by basic values and assumptions held in common by members (Homans, 1950; O'Reilly, 1989; Schein, 1985; Siehl & Martin, 1984).

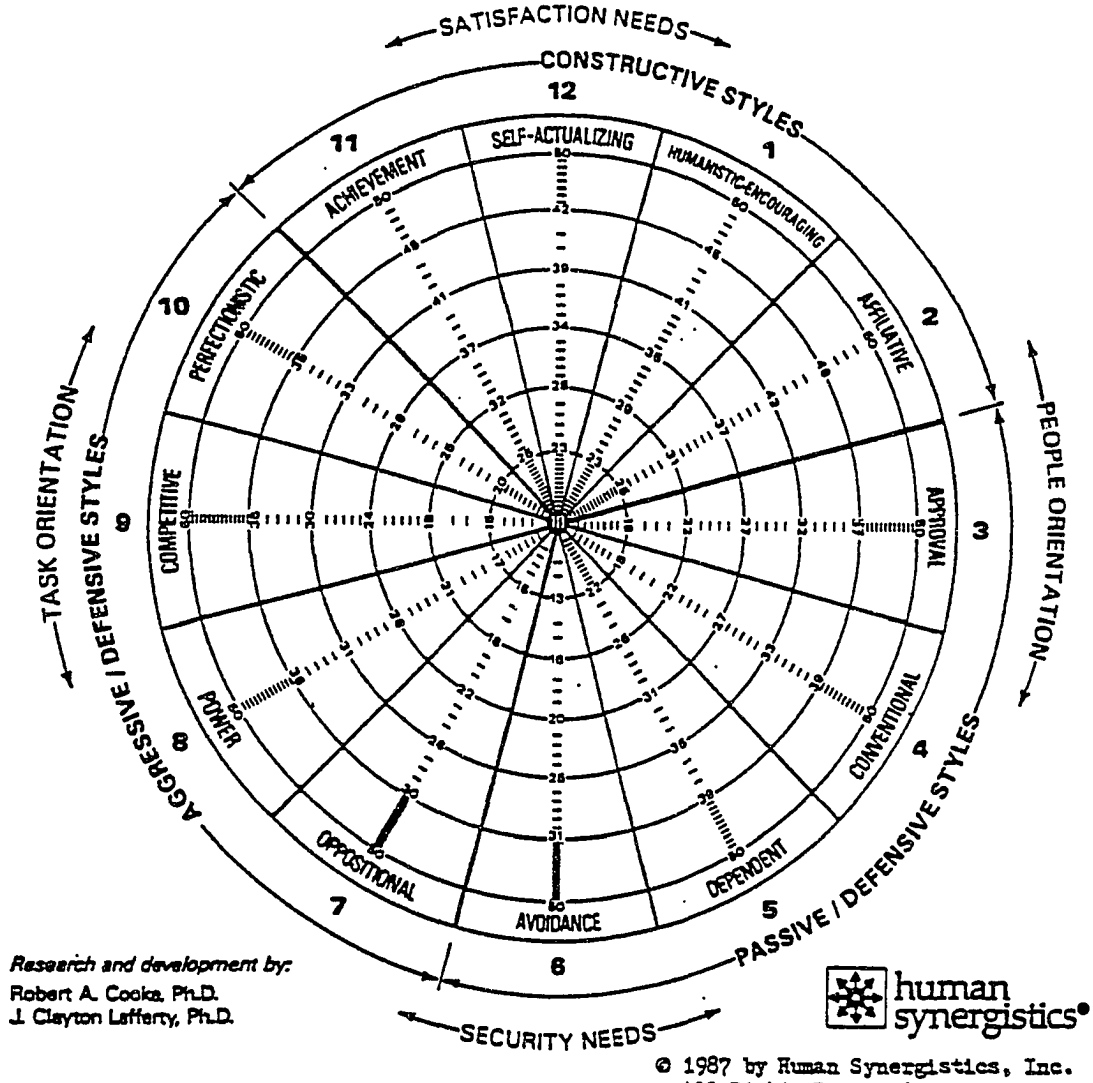
Culture was measured by 120 five-point Likert-type items that described some of the behaviors or personal styles that may be expected of members of their unit. The Likert values ranged from 1 (not at all) to 5 (to a very great extent). Ten items measured each of twelve scales that included: achievement, self-actualizing, humanistic-encouraging, affiliative, approval, conventional, dependent, avoidance, oppositional, power, competitive, and perfectionistic. The twelve scales composed the three composites: constructive, passive/defensive, and aggressive/defensive (Cooke, 1987, 1989) The constructive type included achievement, self-actualizing, humanistic-encouraging, and affiliative styles. Passive/defensive types were approval, conventional, dependent, and avoidance styles, whereas, the aggressive/defensive types were oppositional, power, competitive, and perfectionistic styles. The OCI was

the most widely tested culture inventory in terms of reliability and validity (Shortell et al, 1991), and demonstrated an average Cronbach alpha coefficient of .84, while alphas for each of the 12 scales ranged from .65 to .95 (Cooke & Szumal, 1993).

The items in this instrument measured concepts that were part of the basic assumptions of King's Goal Attainment Theory. King's framework was a system of processes that included perception, communication, purposeful interactions, information, and decision making. These concepts were in the culture characteristics listed in Figure 10 and were the basis of the items in the OCI survey. The OCI measured what people believed (perception) they were expected to think and behave in certain ways within an organization or unit.

The OCI provided process measures for Donabedian's Evaluative Model (1966) in terms of perception of expected behavior and norms of the organization (unit). This measurement focused on the manner in which the activities were conducted within the organization (unit). Cooke and Lafferty (1989) developed a circumplex that featured the twelve cultural styles, the composites they yielded, and the orientation of each group. This circumplex was also used to record the OCI test results, which will be discussed more fully in the data analysis (see Figure 9). A compilation of the twelve cultural styles in terms of the culture characteristics of the groups, expected behaviors of the group, and group norms and expectations, has been expressed in table form (see Figure 10).

The OCI contained a separate section on the back of the instrument for the collection of demographic data. This information about the nursing sample was useful in preparing descriptive statistical data about the sample.



Human Synergistics — Organizational Culture Inventory Leader's Guide

Figure 9. Circumplex to Record OCI Test Results.

FIGURE 10. Summary of Cultural Styles

CULTURAL STYLES	CULTURE CHARACTERISTICS	EXPECTED BEHAVIORS	GROUP NORM & EXPECTATIONS
1. Humanistic- Encouraging	Constructive, people-centered,participative	Supportive, constructive, open to influence with each other	Help others to grow & develop, take time with people
2. Affiliative	Constructive, interpersonal relationships	Friendly, open, sensitive to needs of others, loyal	Dealing with others in friendly way, sharing feelings & thoughts
3. Approval	Conflicts are avoided, interpersonal relationships appear pleasant	Members should agree with, gain approval of, & be liked by others	Going along with others, making sure people accept you, don't make"waves"
4. Conventional	Conservative, traditional, & bureaucratically controlled	Follow the rules, conform	Always follow policies & practices, fit into the "mold"
5. Dependent	Controlled & run from the top, non-participative	Unquestioningly do what you are told, clear all decisions with supervisor	Do what's expected, please those in authority, no individual initiative
6. Avoidance	Doesn't reward success, punishes mistakes(Negative reward system)	Shift responsibilities to others, avoid blame for mistakes	Wait for others to act first, take few chances, don't make decisions
7. Oppositional	Confrontation prevails & negativism is rewarded	Pointing out flaws, being difficult to impress	Gain status & influence by being critical, oppose ideas of others, make safe (ineffectual) decisions
8. Power	Non-participative, authority inherent on members' position	Managers take charge & control subordinates, responsive to demands of superiors	Discipline in the ranks, building up one's power base, motivate others in any way necessary
9. Competitive	Winning is valued, members are rewarded for out performing one another	Work against, not with, peers	"Win-lose" framework, job is a contest, never appear to lose
10. Perfectionistic	Values persistence, hard work, and perfectionism	Avoid all mistakes, work long hours to attain narrowly defined objectives	Do things perfectly, keep on top of everything, keep track of everything
11. Achievement	Things are done well, value members who set & accomplish their own goals	Set challenging but realistic goals & steps to achieve them	Pursue a standard of excellence, openly show enthusiasm
12. Self-Actualizing	Value creativity & quality, task accomplishment & individual growth	Gain enjoyment from work, develop self, take on new & interesting activities, be creative, seek innovative techniques	Thinking in unique & independent ways, doing even simple tasks well

Work Satisfaction Scale

The tool that measured and operationalized work satisfaction was the Work Satisfaction Scale [WSS] (Hinshaw & Atwood, 1982). It was a five-point Likert-type instrument with a scoring range from 1 (strongly disagree) to 5 (strongly agree). The tool was a 32-item scale with five subscales distributed as follows: pay or reward (7 items); professional status (7 items); interaction/cohesion (7 items); administration (6 items); and task requirements (5 items). The WSS was used to index worker satisfaction of hospital nursing staff. See Appendix D.

The WSS was revised by Hinshaw and Atwood (1982) from a work satisfaction tool created by Slavitt, Stamps, Piedmont, and Haase (1978), which was the Revised Attitude Scale to Measure Occupational Satisfaction of Hospital Nurses. The Work Satisfaction Scale was tested over a five-year span and resulted in high internal consistency and reliability. Cronbach's Alpha standardized coefficients for the subscales were .87 Pay or Reward, .69 Professional Status, .80 Interaction/Cohesion, .80 Administration, .75 Task Requirements. The total scale alpha was .87; theta was .88. Construct validity was estimated using principal components factor analysis and predictive modeling.

The subscales and the items contained within each were linked to King's Interpersonal System which was concerned with individuals in dyads, for example, nurse-nurse, and the nurse-patient. The concepts of the Interpersonal System included role, interaction, communication, transaction and stress (King, 1989). The WSS measured one of Donabedian's process components in the management of patient care and conduct of activities within an organization. Assessment of characteristics of

provider behavior and patient care management were covered by items in each of the 5 subscales. The WSS measured work satisfaction, one of the process elements in the governance model.

Patient's Opinion of Nursing Care

The instrument used to measure and operationalize patient outcomes was the Patient Opinion of Nursing Care (PONC) tool that was adapted over a period of eight years by Hinshaw and Atwood (1982), from an original instrument by Risser (1975). Alpha coefficients for the technical-professional subscale averaged .79, education coefficients averaged .78, and trust coefficients averaged .88. The instrument had a Cronbach's alpha of .88. See Appendix E.

The PONC was a Likert-type rating scale with three subscales, technical-professional care, trust, and patient education that were defined as follows:

Technical-professional factors-technical activities and the knowledge base required to competently complete the nursing care tasks.

Trusting relationship-nursing characteristics that allowed for constructive and comfortable patient-nurse interaction and communication aspects of the interaction.

Education relationship-nurses' ability to provide information for patients including answering questions, explaining care, and demonstrating techniques.

The items on this instrument directly linked with Donabedian's Evaluation Model outcome component and measured whether the services provided by the organization made a difference to their health status. The PONC did not measure

elements of structure but did include evaluation of the process component, namely, the patient's assessment of care that included elements of process (technical management, interpersonal care, and any consequence of care).

Theoretical linkage with King's Goal Attainment was apparent in the Personal Systems and the Interpersonal Systems. Information exchange and communication were measured by items in the education subscale; interactions were measured in the trust subscale; and decision making and goal setting were part of the technical-professional care subscale which required patient perceptions to complete the survey.

Data Collection

Sites that participated in the study were contacted by the Principal Investigator (PI) to obtain Internal Review Board (IRB) requirements for the conduct of research in each individual institution. The prescribed protocol was followed in each facility. Data collection required 18 months. This included the surveying of nurses and patients on 16 units in 5 facilities within an 80 mile radius of the Pittsburgh area. One facility at a time was entered into the research study to allow the PI adequate time to collect data and attend to any unique IRB requirements for a site. The PI complied with the IRB requirements for each institution, and coordinated and conducted all the research. See Appendix B.

Procedures

The registered nurse survey was conducted by the PI adhering to a predetermined schedule and the IRB requirements for that institution and the University of Pittsburgh. Contact with the Head Nurse or Unit Coordinator was initiated after the Nurse Administrator confirmed the desired units. The PI contacted the Head Nurse or Nurse Coordinator to discuss the logistics of the study and data collection.

Since all registered nurses were used, the Head Nurse or Nurse Coordinator announced the research project during a unit meeting to discuss with the staff their volunteer participation. A letter from the PI to the staff nurses of each of the selected nursing units announced the opportunity for the registered nurses to voluntarily participate in this research project. The informational letter stated the time frame for the data collection, the type of information requested, confidentiality measures, the method for dispersion of the instruments and collection when completed. The researcher personally answered questions concerning the study at any time during the data collection. The nurses were given assurance that no one would have access to the survey information they provided except the PI and her research advisor.

Packets in brown manila envelopes were prepared for the staff nurses containing the Organizational Culture Inventory (OCI), and the Work Satisfaction Scale (WSS). Responses were recorded on the instrument to decrease error in recording and transcribing from a separate answer sheet. Demographic information was collected in a section of the OCI tool. A cover letter to the nurse was included

that explained implied consent and reinforced the information originally presented during a unit meeting to nurses about the research. A certificate of research participation was also provided to the nurse. It was signed by the PI for validation and was to be used by the participant as they chose. See Appendix F.

In two of the sites the IRB required signed permission slips from the nurses before participation in the study. An IRB approved consent form was developed and included in the packet. A white envelope was provided in packet to separately contain the completed consent form. See Appendix G. The survey packets were then distributed to the participating units by the researcher in sufficient quantity to supply the number of registered nurses that met the participation criteria on the unit. The packets were coded to identify only the governance type of unit.

The patient survey was conducted by the PI adhering to a predetermined schedule and the IRB requirements for that institution and the University of Pittsburgh. Ten patients were targeted for each unit unless the census of the unit was under 10, and then the target was 5 patients. The Head Nurse or Nurse Manager reviewed the patient census with the PI and indicated those patients who were physically and/or emotionally well enough to participate in the research study.

The PI randomly chose patients and approached them according to facility IRB protocol. In two of the sites, the IRB required signed consents from the patients participating in the study. The PI explained this requirement to each patient and also assured that anonymity would be maintained. If agreeable to study participation, the patient signed the IRB approved consent slip and the PI sealed it in a separate white envelope, then placed it into a large folder in the presence of the patient. See Appendix H.

A brief explanation of the survey was given to the patient who was directed to complete the tool, however, those who required assistance were helped by the PI either by reading the items on the survey and/or assisting them to circle their chosen response. When feasible the PI would remain on the unit but outside of the room until patients were finished with the tool. However, patients were not always able to complete the survey and so it was left in their possession until the PI returned to collect it within a three day period. There were a few surveys lost when this method had to be employed, however, this small number of surveys were replaced.

The PI collected data over a three to six week time frame from a predetermined area in each facility. The PI provided boxes identified with the name of the research project and the name of the researcher. It was hoped that a consistent, convenient and neutral place for data collection, such as the nurses lounge, would enhance the response rate. A figure of a thermometer with a range from 0 to 100% was also posted on the box to show the progress of the data collection on that specific unit. During each data collection visit the PI would move the indicator higher toward 100% as the response rate increased. The PI made rounds each time data were collected to talk with the staff and answer any questions about the study. Being on site and available as often as possible served as a gentle reminder of the ongoing research and the need to complete the information in a timely fashion.

Confidentiality and Anonymity

Complete anonymity was guaranteed for the nurses and patients who participated in the research. Consent was implied for nurses and patients with the

exception of the two sites with IRBs that required written permission consent forms be collected. Anonymity was maintained by having the nurse consent signed and placed into a separate white envelope and deposited in a separate and designated box. The survey was completed and sealed in the manila envelope and placed in a different collection box. The consent and the survey envelope could not be matched at any time. The patient consent was handled in a similar manner, however, the PI collected the consents sealed in a small white envelope in a separate folder upon initial agreement to participate in the research. The patient then completed the survey and sealed it in the manila envelope and returned it to the PI during data collection rounds.

There was a concern for some of the patients that the nurses caring for them would access the survey results. They were assured, however, that there was no way to link nurses who had provided care for patients to the patient survey. The patients were guaranteed that no one but the PI would have access to the completed survey and would not be able to identify the participant after data collection.

Data Analysis

The unit of analysis was the individual nurse, thus, scores obtained from nurses' individual test results were used for analysis. The data were coded by governance type, individual registered nurse or patient, hospital site, and unit site then entered into the database. All data were double entered into PARADOX, a computer database, first by the PI and then by a data entry person. To further ensure accuracy, the second data entry had a verification mechanism whereby if a value was entered

that was different from the original entry, the screen would display the two values and the operator could verify which value was correct. A column was also created at the end of the data table that visually displayed which rows of data had been verified.

The OCI's were individually coded, scored and profiled by the PI who used SPSS to obtain values of the twelve subscales and then aggregated to provide composites reflecting the aggressive-, or passive-defensive, or constructive styles in each governance type. A comparison was then made between the culture prevailing in each governance type.

The WSS and the PONC were each coded by the PI and scored using SPSS to obtain scores used to compare the nurse and patient satisfaction in the shared governance and traditional governance units. The nurses retention rate was calculated for the individual units for comparison between the shared governance and the traditional units.

Descriptive statistics were generated to profile the study sample. Individual variables were analyzed for differences between the two governance type groups in terms of sample distribution using SPSS.

Empirical evaluation of the proposed model was not accomplished by regression analysis due to the high intercorrelation among the variables. Secondary analysis of the variables of the theoretically proposed model was completed by a two-tailed t-test on the mean total scores and the subscale mean scores of the registered nurses in the shared and traditional governance groups. Analyses were done to detect differences between the OCI and WSS scores of the registered nurses in the two governance type groups.

CHAPTER IV

RESULTS

The research questions asked if governance type influenced the organizational culture, the work satisfaction, and the retention rate of registered nurses on their respective unit; the patient satisfaction with care provided by registered nurses on these units? As originally planned, the questions were not answered due to the multicollinearity and thus the inability to statistically assess the model with the proposed path analysis. However, in order to approximate the analysis regarding the influence of governance type on the variables, a secondary contingent analysis was used, in which statistically significant differences ($p = < .05$) between the two governance types and the variables of interest were examined. These analyses were presented and discussed in this chapter.

Data were collected from five sites in three counties located in Southwestern Pennsylvania during an eighteen-month time period. The registered nurse as an individual was the unit of analysis for this study. The sample of three hundred and ninety six subjects ($N=396$) consisted of nurses who worked in hospital units that included medical-surgical, oncology, liver transplantation intensive care, ortho-neurological, maternity, cardiac intensive care, and psychiatric patients. Of the 396 surveys distributed, two hundred and thirty four ($N=234$) RNs responded for an overall response rate of 59%. The response rate by unit ranged from 45-85% with a

10% higher rate in the traditional governance type. Table 1 summarized the data collected by site and governance type. Percentage of patient responses was based on the pre-set criterion number of patients per unit.

Table 1. Data Collection by Site.

	SHARED GOVERNANCE				TRADITIONAL GOVERNANCE			
		RESPONSE				RESPONSE		
SITE	# RN STAFF	RN	%	PT	# RN STAFF	RN	%	PT
1	22	11	50	9	20	10	50	7
2	27	17	63	9	26	13	50	5
2	27	17	63	7	30	19	63	10
2	29	17	58	5	20	10	50	11
3	22	11	50	5	12	7	58	7
3	17	10	59	6	12	6	50	7
4	31	17	54	5	15	12	80	8
5	40	18	45	10	46	39	85	10
TOTAL	215	118	55	56	181	116	61	65

Descriptive Statistics

The Sample

Sociodemographic data regarding the sample included age, sex, ethnic background, education, salary level and years with the organization. Respondent nurses were 30-39 years of age (35%), female (92%), white (96%), employed

between 2-4 years with the organization (24.6%); the majority of the salaries were in the $35,001 - $45,000 range (51%). Most held an associate degree (37.5%), while 32% attained a Bachelor of Science degree.

To determine the comparability of the two nurse samples by governance type, Pearson chi-square statistics were computed to assess statistically significant differences ($p = < .05$) between the two groups on the means of the sociodemographic category and on the sub-groupings of each sociodemographic category. Since the sociodemographic data were categorical, frequencies were computed to explore distribution of the six characteristics of the sample, while the Pearson chi-square statistic was used to determine whether significant differences existed among the characteristics and between the groups.

No statistically significant differences were found between the two governance groups, confirming comparability between these two nurse samples. The one exception was in the sub-grouping of the category of years with the organization for fifteen-years and over, in which there were more nurses in the fifteen-year and over category among traditional than shared governance nurses. The traditional group had twenty-four (24) more RNs in the 15+ years group than the shared governance group. This resulted in a statistically significant difference ($p = < .05$) between them on the one sub-grouping of that category. These statistical analyses regarding the sociodemographic characteristics of the two governance-type groupings were used to confirm the similarity between these two groups of registered nurses. Based on the results of these analyses, the two groups of registered nurses were deemed similar. Table 2 contained a summary of the frequencies of the characteristics of the sample and the significance level of the Pearson chi-square for each characteristic.

Table 2. Frequencies of Sample Characteristics.

CHARACTER.	TOTAL SAMPLE		SHARED GOVERNANCE		TRADITIONAL GOVERNANCE	
	#RNs	%	#RNs	%	#RNs	%
AGE						
20-29 YRS.	63	31%	32	32.7%	31	29.8%
30-39 YRS.	71	35%	39	39.8%	32	30.8%
40-49 YRS.	45	22%	22	22.4%	23	22.1%
50-60+ YRS.	21	10%	5	5.1%	16	15.4%
NO RESPONSE	2	1%	0	0%	2	1.9%
SEX						
FEMALE	190	92%	92	92%	98	92%
MALE	16	8%	8	8%	8	8%
ETHNIC BACKGROUND						
BLACK	6	3%	3	3.1%	3	2.9%
WHITE	196	96%	94	95.9%	102	97.1%
OTHER	1	.4%	1	1.0%	0	0%
EDUCATION						
SOME COLLEGE	26	13%	11	11.5%	15	14.4%
AD/TECH DEG	75	37.5%	35	36.5%	40	38.5%
BS	64	32%	33	34.4%	31	29.8%
SOME GRAD.	14	7%	9	9.4%	5	4.8%
MS	2	1%	0	0%	2	1.9%
DIPLOMA	19	9.5%	8	8.3%	11	10.6%
SALARY						
10,000-18K	5	2.6%	1	1.1%	4	4%
18,001-25K	11	5.7%	5	5.4%	6	6%
25,001-35K	64	33.3%	33	35.9%	31	31%
35,001-45K	98	51%	43	46.7%	55	55%
45,001-60K	14	7.3%	10	10.9%	4	4%
YRS WITH ORG						
0-6MOS.	2	1%	2	2.1%	0	0%
6 MOS.-1 YR.	10	5%	6	6.3%	4	3.8%
1-2 YRS.	18	9%	10	10.5%	8	7.7%
2-4 YRS.	49	24.6%	23	24.2%	26	25%
4-6 YRS.	29	14.6%	17	17.9%	12	11.5%
6-10 YRS.	33	16.6%	21	22.1%	12	11.5%
10-15 YRS.	30	15.1%	14	14.7%	16	15.4%
*15 YRS. +	28	14.1%	2	2.1%	26	25%

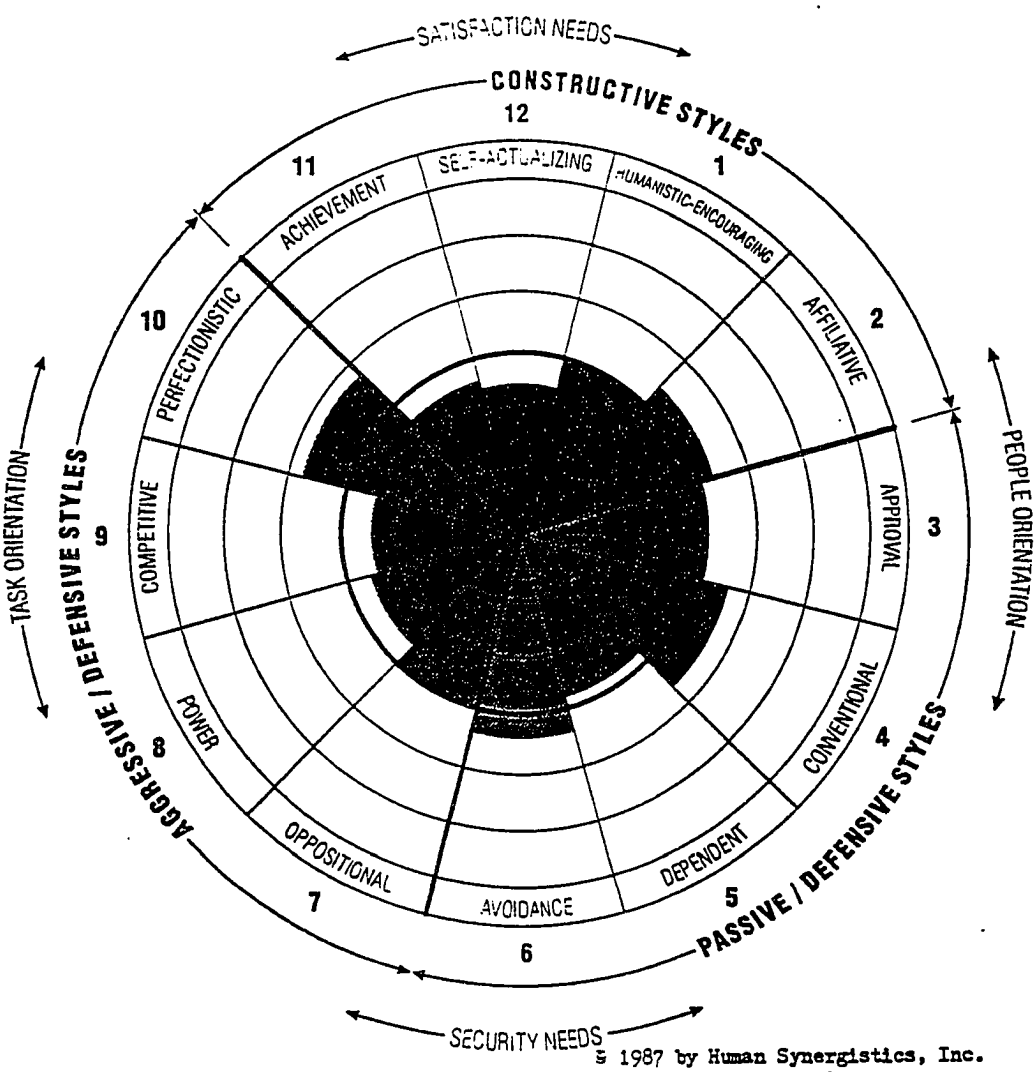
* significant $p < 0.05$.

Organizational Culture Inventory

Scoring results profiling the Organizational Culture Inventory (OCI) for the sample were presented on Table 3. For comparison purposes, the Table showed the total sample as well as the shared governance and traditional governance scores, however, discussion addressed comparisons of the two governance groups only. The scoring range for each of the twelve behavior styles was 10-50. Raw scores revealed the shared governance group scored higher on the constructive culture composite. All four behavior style mean scores of the shared governance group within the constructive culture composite ranked higher than the behavior styles of the passive-defensive and the aggressive-defensive culture types, comparing shared to traditional governance type. While profiles of both groups were in the anticipated ranges on the three culture-type composites, the shared governance group was consistently in the preferred direction compared to the profiles of nurses in the traditional governance type. Profiles of the twelve behavior styles comprising the three composites of culture-type, showing the total sample, the shared governance, and the traditional governance groups, were displayed on Circumplexes profiled by Figures 11, 12, and 13, respectively.

Organizational Culture Inventory

Total Sample



Researched and Developed by:
Robert A. Cooke, Ph.D.
J. Clayton Lafferty, Ph.D.

Figure 11. Total Sample OCI.

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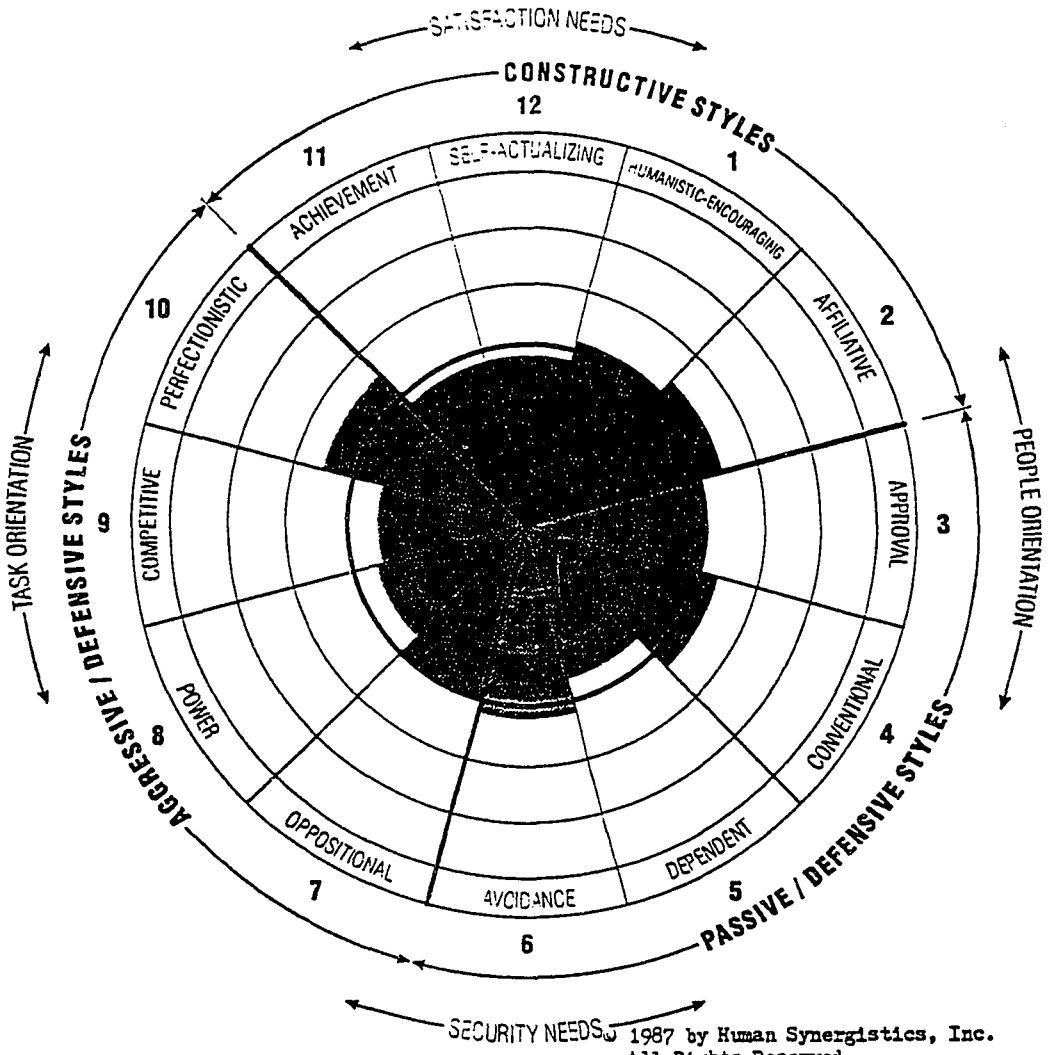
Organizational Culture Inventory

Shared Governance



Researched and Developed by:
Robert A. Cooke, Ph.D.
J. Clayton Lafferty, Ph.D.

Figure 12. Shared Governance Group ccc.

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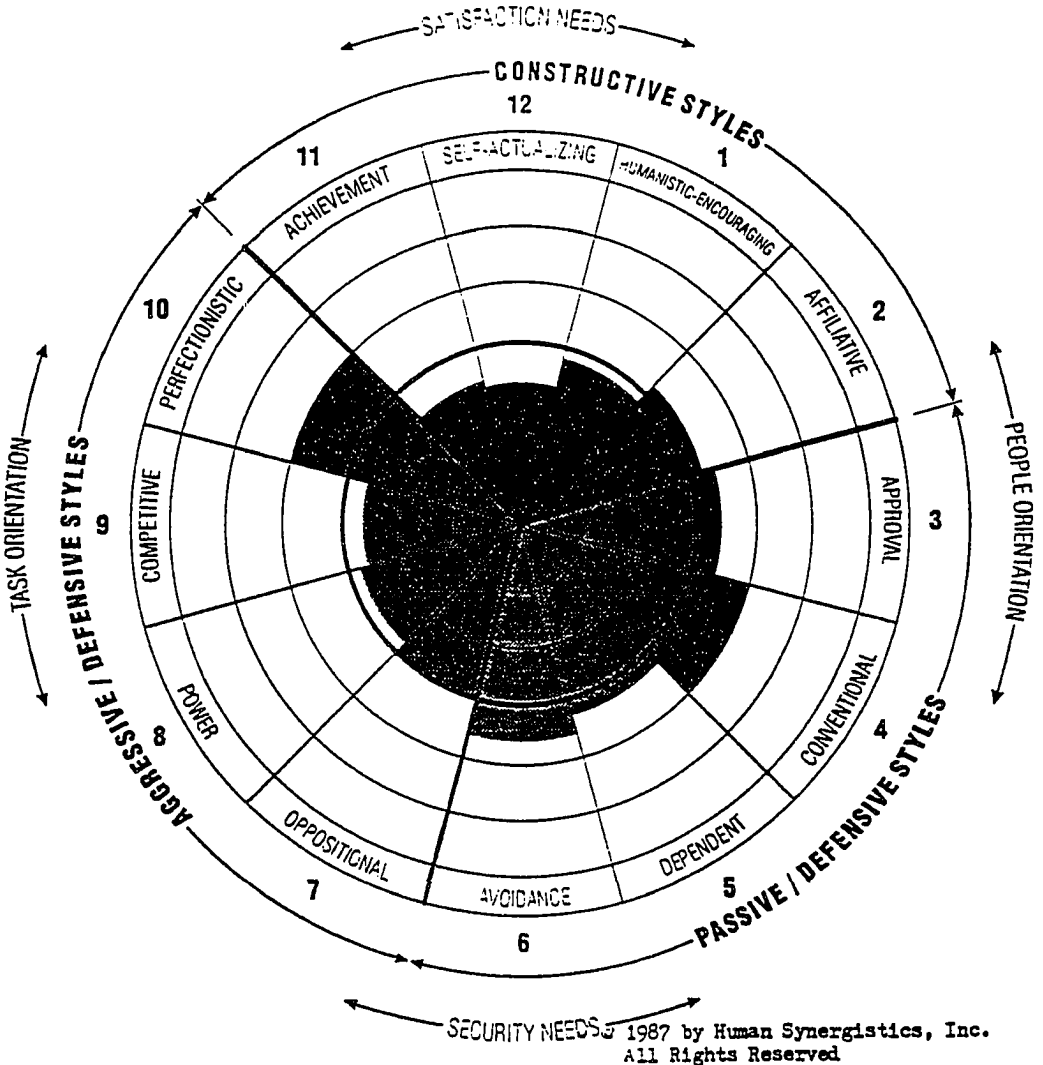
Organizational Culture Inventory

Traditional Governance



Researched and Developed by:
Robert A. Cooke, Ph.D.
J. Clayton Lafferty, Ph.D.

Figure 13. Traditional Governance Group OCI.

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To determine if there was a statistically significant difference ($p = < .05$) between the shared and traditional governance type, independent two-tailed t-tests were computed in SPSS on the composite scores for the culture types. The scoring range for each composite was 40-200. The pooled-variance t-test was computed on the mean scores of the constructive, passive-defensive, and aggressive-defensive culture types between the shared and traditional governance groups. Although the sample was a convenience sample, the large size of the respondent sample ($N=234$) assisted in approximation to normality. The assumption that samples came from populations normally distributed had to be fulfilled to use this parametric statistic. The assumption of normality was provided by the Central Limit Theorem which stated

> ".. given any parent population, not necessarily normal, having mean and standard deviation, the sampling distribution for fixed N which is generated from this population will be approximately normally distributed..." (Knapp, 1978, p.68).

As the sample size increased, the approximation to normality became closer. Results revealed a significant difference ($p = < .05$) between the two governance groups on constructive and passive-defensive, but not on the aggressive-defensive culture type.

Since the mean profiles revealed higher scores in the constructive culture composite and lower defensive cultures in shared governance group when compared to the traditional group, the statistical differences confirmed the preferred, and anticipated, direction of these culture results. The results of these comparative analyses were presented on Table 4.

Table 3. Organizational Culture Inventory Mean Scores.

CULTURE FACTORS	TOTAL SAMPLE	SHARED GOVERNANCE	TRADITIONAL GOVERNANCE
CONSTRUCTIVE:	35.13	36.22	34.11
Achievement	34.86	35.86	33.92
Self- Actualizing	31.66	33.38	30.05
Humanistic-Encouraging	35.32	36.46	34.24
Affiliative	38.69	39.19	38.22
PASSIVE-DEFENSIVE:	27.90	26.43	29.28
Approval	28.41	27.31	29.46
Conventional	30.91	28.85	32.83
Dependent	30.26	28.60	31.83
Avoidance	22.02	20.96	23.02
AGGRESSIVE-DEFENSIVE:	24.93	24.42	25.41
Oppositional	22.13	22.11	22.14
Power	24.33	23.67	24.94
Competitive	21.27	20.75	21.74
Perfectionistic	32.00	31.13	32.82

Table 4. Organizational Culture Type Mean Scores.

CULTURE TYPE	SHARED GOVERNANCE			TRADITIONAL GOVERNANCE			POOLED VARIANCE
	MEAN	SD	SE	MEAN	SD	SE	P
CONSTRUCTIVE	144.89	24	2.3	136.4	25	2.3	.012*
PASSIVE-DEFENSIVE	105.71	24	2.3	117.3	28	2.7	.002*
AGGRESSIVE-DEFENSIVE	97.61	22	2.2	101.7	24	2.2	.200

*p < .05

Work Satisfaction Scale

Results of the Work Satisfaction (WSS) scoring were reported on Table 5 showing the overall scale mean score and the five subscale scores, compared by governance type. The scoring range for the overall WSS was 32-160 while the scoring range for each of the subscales were as follows: pay/reward 7-35, professional status 7-35, interaction/cohesion 7-35, administration 6-30, and task 5-25. The variation in the latter two subscales was due to a less number of items in that subscale. Again, independent two-tailed t-tests in SPSS were used to assess the statistically significant difference ($p = < .05$) between these two groups of nurses. Registered nurses in the shared governance group had a significantly higher total mean score than the RNs of the traditional group. Among the five subscales, on three of them, professional status, interaction/cohesion and administration, the shared governance group scored

significantly higher than the traditional governance group. On the two subscales of pay and task requirements, however, there was not a statistically significant difference between the groups.

Table 5. Significance Between Groups on WSS Mean Total Scores and Sub-scales.

	SHARED GOVERNANCE			TRADITIONAL GOVERNANCE			
	MEAN	SD	SE	MEAN	SD	SE	P
WSS	96.86	14.3	1.33	91.02	13.6	1.27	.002*
SUBSCALES:							
PAY	16.44	4.8	.45	16.74	5.7	.53	.666
PROFESSIONAL STATUS	27.56	4.3	.40	26.14	3.9	.36	.010*
INTERACTION/ COHESION	25.55	4.6	.43	24.26	4.8	.44	.039*
ADMINISTRATION	13.94	4.9	.45	11.41	3.8	.35	.000*
TASK REQUIREMENTS	13.17	3.8	.36	12.56	3.9	.36	.243

*P< .05

Retention Rate

Nurse retention rate was calculated using standard procedures based on data provided by the nurse manager-facilitator of each unit. This procedure assured consistency in the data provided. Thirteen out of sixteen nurse manager-facilitators responded for an eighty one (81%) percent response rate. Table 6 summarized the nurse retention data collected from each unit. The traditional governance group had

three nurse managers who did not respond; two were from the same hospital site. Due to these non-responses, the data on Table 6 were calculated on five of the original eight clinical units. These data, however, showed the shared governance groups had a 6.2% lower retention rate than the traditional governance groups.

Table 6. Retention Rate of the Shared Governance and Traditional Governance Groups.

UNITS	SHARED GOVERNANCE	TRADITIONAL GOVERNANCE
1	80%	91%
2	90%	93%
2	93%	96%
2	80%	NO RESPONSE
3	96%	NO RESPONSE
3	75%	NO RESPONSE
4	92%	100%
5	95%	89%
RATE	87.6%	93.8%

Patient's Opinion of Nursing Care

Raw scores from the Patients' Opinion of Nursing Care (PONC) revealed that scores from the shared governance group were higher in satisfaction rating than the traditional group in the total mean scores, as well as on each individual subscales of the PONC. The results of the (PONC) survey were analyzed using two-tailed

independent t-tests in SPSS in order to detect any statistcally significant difference ($p = < .05$) between the two groups of patients cared for by RNs in the shared and traditional governance groups, respectively.

Findings, including statistical differences, were presented on Table 7, summarizing the mean total scores between the shared governance and the traditional governance groups. The total score range for the PONC was 25-175, and for each subscale range as follows: trust 11-77, education 7-49, and technical-professional care 7-49. THe difference in the scoring range of the subscales was due to the varying number of items each subscale contained. These analyses on the overall mean scores, as well as on all three sub-scales of the PONC, confirmed there was a statistically significant difference ($P < .05$) between the patient's opinion of nursing care received from RNs in the shared governance group compared to patients' care performed by the RNs in the traditional governance group. More importantly, the shared governance group of patient scores were higher.

Table 7. Significance Between PONC Mean Total Scores and Subscale Scores.

	SHARED GOVERNANCE			TRADITIONAL GOVERNANCE			P
	MEAN	SD	SE	MEAN	SD	SE	
TOTAL PONC	140.14	22.54	3.219	126.65	22.99	3.097	.003*
SUBSCALES:							
TRUST	62.18	10.17	1.439	55.95	11.05	1.38	.002*
EDUCATION	37.09	7.209	1.000	33.64	7.214	.916	.012*
TECH-PRO	39.78	6.338	.879	36.42	6.073	.778	.005*

*$p < .05$

Correlational Analysis

Correlations could not be performed between the nursing service variables and the PONC data. Due to the need to maintain anonymity, the individual nurses and the patients receiving care from these nurses were not linked together. However, a correlation could be completed between the OCI and WSS scores of the registered nurses because the nurses were assigned a number that identified them on both surveys. Table 8 summarized these results.

Table 8. Correlation Between OCI and WSS Scores by Governance Type.

	SHARED GOVERNANCE			TRADITIONAL GOVERNANCE		
WSS SUBSCALES:	CONS	PASS	AGGR	CONS	PASS	AGGR
PAY	.130	-.247*	-.286*	.049	-.244*	-.237*
PROF STATUS	.217	-.265*	-.263*	.207	-.332**	-.233*
INTER ACTION	.334**	-.235*	-.345**	.344**	-.264*	-.199
ADMINISTRATION	.297*	-.392**	-.403**	.220	-.454**	-.378**
TASKS	.128	-.154	-.202	.072	-.029	-.105

*p= .01; **p= .001.

The subscales of WSS in the shared governance group were positively correlated with the constructive culture type and negatively correlated with the passive and aggressive defensive culture types. While the traditional governance group was also positively correlated to the constructive culture type, this group was more

negatively correlated with administration, interaction/cohesion and professional status in the defensive cultures. Although these are not strong correlations they are statistically significant.

Summary of the Findings

A convenience sample of 396 registered nurses (RNs) from sixteen clinical units among five hospitals, representing shared governance settings and traditional governance units were surveyed. The sub-grouping samples reflected 118 RNs from shared and 116 RNs from traditional governance settings, respectively. Among them were seven (N=7) patient care-type units. The individual RN was surveyed to determine organizationl culture, work satisfaction, and work retention rate; the patients on their units provided an opinion of the nursing care. These elements represented those of the proposed governance model for nursing service.

In summary, analyses of the sociodemographic characteristics revealed that nurses employed among these two governance types were comparable, with no significant differences based on their mean scores. Profiles of the organizational culture revealed higher composite constructive culture, and lower defensive scores among nurses in shared governance, as preferred. There were significant differences between the two groups on constructive and passive-defensive scores, but not on aggressive-defensive scores comparing the two groups. Work satisfaction scores revealed an overall higher satisfaction scoring among nurses in the shared governance model, with statistically significant differences between the two governance group types. Lastly, patients who received care from nurses in the shared governance type,

compared to those patients' scores in traditional governance type, were significantly higher in rating as reflected in the PONC mean total scores and the subscale scores. These findings confirmed the anticipated, yet, basic elements of the proposed governance model for nursing service. Discussion and interpretation of these findings will be presented in Chapter five.

CHAPTER V

CONCLUSIONS AND DISCUSSION

Chapter five discusses the results of this study. The original intent was to analyze a theoretically derived path model of governance type for nursing service using a regression analysis to assess the influence of governance type on patient satisfaction from scores on the OCI, WSS, nurse retention and type of governance model. However, because of the high intercorrelation among the independent variables which would result in an artificially inflated R-square, it was not possible to continue with the parametric analysis needed to analyze this model. Thus, the results presented in Chapter four provided the secondary analysis, which examined the statistically significant differences between the scores of registered nurses working in the shared governance and traditional governance groups, and correlations between the WSS and OCI scores in the two governance types. This chapter will interpret those results and discuss them in light of contemporary management of nursing service units.

Conclusions

The original research question asked if governance type influenced the organizational culture, nurse work satisfaction, nurse retention rate, and patient satisfaction with care provided by registered nurses on a unit. Although it was not

possible to assess the entire proposed governance model for nursing service as initially designed, the analyses of the individual variables using the two-tailed independent t-test, were suggestive. For example, although it could not be argued based on these results that governance type directly influenced the differences in culture, work satisfaction, nurse retention, and patient satisfaction, they were suggestive. Since there were no statistically significant differences between the two groups of registered nurses employed on these clinical units, the two groups were comparable one to another. Yet, even so, there were statistically significant differences found between the two groups of registered nurses on these variables of nursing service. Since they preceived their culture and their work satisfaction differently, and, their patients perceived themselves as receiving a different level of care, one would interpret that the key difference was in the type of governance used on those respective clinical units.

Thus, without analyzing the entire theoretically proposed governance model, one suggested that since scores differed by governance group, that governance type was the determining factor. An additional and confirming piece to this argument was that the correlation between the two variables of organizational culture and work satisfaction was positive and in the anticipated direction, for both governance types. Yet to be evaluated was the entire proposed governance model. However, this study was able to assess the differences in governance type and provided further evidence that there was a difference among nursing service features based on the type of governance.

The hypotheses for this study stated governance type would have a differential influence on the organizational culture, work satisfaction, nurse retention, and patient satisfaction. Using the model interpretation as a guide, the suggested answer was affirmative.

Discussion

The preceding analyses revealed overall positive findings in the shared governance groups. The nurses had statistically significant positive culture and work satisfaction scores, as was the patients satisfaction with nursing care scores. The correlation between work satisfaction and organizational culture further modestly corroborated the statistical differences between the groups on the WSS and OCI in the preferred direction. These were, indeed, confirming and positive findings for shared governance as a model for nursing service. Since the model as a whole was not able to be assessed, each of the elements in the proposed model will be discussed separately, with final discussion focusing on their implications.

The secondary research questions asked if governance type influenced the culture, work satisfaction, and the retention rate of registered nurses working on a unit; did governance type influence the patient's satisfaction with their nursing care on the same unit? The model was originally designed to provide statistical linkages between the variables, however, this was not possible. Therefore, statistical analyses were performed to determine whether there was a relationship between governance type and each element of the model, namely, culture, work satisfaction, nurse retention, and patient satisfaction.

The Governance Model

Prior research found positive links between a constructive culture, nurse retention, work satisfaction, and positive patient outcomes (Cooke & Rousseau, 1987; McDaniel & Stumpf, 1993; Shortell et al, 1991). Other studies confirmed linkages between nurse work satisfaction, high nurse retention rate and patient satisfaction (Hinshaw & Atwood, 1982; McDaniel & Patrick, 1992; Weisman & Nathanson, 1985).

The results of this study further confirmed prior research findings (Cooke & Rousseau, 1987; McDaniel & Stumpf, 1993; Scott & Shortell, 1983; Shortell, Rousseau, Gillies, Devers, & Simon, 1991; Thomas, Ward, Chorba, & Kumiega, 1990) in which positive correlations were found between constructive culture and job satisfaction, motivation, productivity and quality patient care. The reverse was true of the other two dysfunctional culture types, passive defensive and aggressive defensive. In addition, the findings of Shortell et al (1991), that nurse work satisfaction and nurse retention were affected by prevailing unit culture, and, that nurse work satisfaction influenced patient outcomes (Weisman & Nathanson, 1985) and nurse retention (McDaniel & Patrick, 1992) was also confirmed by this study.

The converse findings of the prior research were also confirmed in this study. The traditional governance group had a passive-defensive culture, low work satisfaction and low patient satisfaction. This supported the findings of McDaniel and Patrick (1992) that dissatisfied nurses negatively influenced patient satisfaction and were also related to the nursing turnover rate (Hinshaw, Smeltzer, & Atwood, 1983). This result was important due to the implications for increased costs and declining

patient census for health care facilities. Overall, the study results obtained from the scores of the variables for the shared governance and the traditional governance groups supported prior research linking culture, work satisfaction, retention, and patient satisfaction. The link that remained unassessed was between governance type and culture.

The registered nurses in the shared and traditional governance groups had no statistically significant difference in the descriptive categories, except for the subgroup of registered nurses employed for fifteen plus years in the organization. The registered nurses within the shared and traditional governance groups were in the same hospitals to control for organizational differences, yet, nurses perceived their culture and work satisfaction differently. Nurses employed on shared governance units would have a different ambiance that nurses on traditionally governed units, therefore, result in the formation of normative beliefs regarding expectations for one's behavior as a member of that group, and shared behavioral expectations that would specify the way group members were to approach their work and interact with others (Cooke, 1989). Thus, the patient care provided by the nurses on their respective units would be reflective of these normative beliefs and expected behaviors, and one might suspect that the context in which the nurses' practiced, in turn, influenced their behavior.

As observed through the organizational culture scores of this study, there was a statistically significant difference between the groups in the resulting behavior, approach to work, and interaction with others (the process), all of which influenced patient care (the outcome). These, therefore, influenced patients' satisfaction with the nursing care provided by the registered nurses. The resulting differences were interpreted in terms of the model in the following manner:

Shared Governance->Constructive Culture-> High Work Satisfaction->Low Nurse Retention Rate-> High Patient Satisfaction.

These findings and conclusions adhere to Donabedian's (1969) Model in which the structure was related to the process which affected the outcome. Donabedian argued that the patient's evaluation of care provided evidence of the worth of process and structure which was supported in this study.

The Interpersonal System of King's Goal Attainment Theory was where the relationships of nurse to client, nurse to nurse, and nurse to unit/governance type occurred. The concepts of perception, communication, interactions, and decision making which were central to this system were measured in this study. Behaviors and beliefs of nurses were identified that seemed to affect the nurses interactions with the patients. The patient satisfaction scores demonstrated the patient's perception of the nurse-patient relationship in terms of satisfaction with care. The WSS subscale scores reflected the nurses perception of administration, their relationship with each other, and their task of caring for patients. King's theory purported that individuals through interrelations were influenced by their environment and in turn, influence that environment. This was consistent with the governance model in that the environment was the governance type and the interrelations occurred within King's Interpersonal System among the remaining variables.

Based on the two-tailed t-test results a difference was found on the measures by group. The shared governance group demonstrated a significantly higher constructive culture score both in total mean score and within each behavior style than the traditional group. The constructive culture type was comprised of achievement, self-actualizing, affiliative, and humanistic-encouraging behaviors. In contract, the

traditional governance group scored significantly higher in the passive-defensive culture type than the shared governance group. The passive-defensive culture type was dysfnctional in nature and characterized by avoidance, dependent, conventional, and need-for-approval behaviors. Prior research established links to positive patient outcomes from a constructive culture (Cooke & Rousseau, 1987; Shortell et al, 1991) and links from dysfunctional culture types to the negative patient outcomes (Thomas. Ward, Chorba,& Kumiega, 1990), which were also the findings of this study.

The two-tailed t-test was used to compare the shared and traditional governance groups' Work Satisfaction Scale (WSS) mean total scores and subscale scores. The results were significant in the positive direction of shared governance group in the mean total scores and in three of the subscales, professional status, interaction and cohesion, and administration. There was no significant difference between the groups in the subscales of pay or reward, and task requirements. Positive identification with the concepts of administration, professional status and interaction and cohesion were consistent with the literature about shared governance, thus, it was anticipated that these elements were highly regarded by the shared governance group and conversely, scored low by the traditional group who required approval, used avoidance behaviors, and were dependent in character. In two groups of similar nurses, working in a shared and traditional governance group respectively, where statistically significant different scores resulted between the groups in the measurement of culture and work satisfaction, it was suspected that governance type was the precursor to culture, since that was the differentiating variable.

Further confirmation was provided for approximating the model by the correlations between culture and work satisfaction. While the entire model was not

assessed, these separate contingency analyses approximated the assumption that governance type was an influencing feature, yet to be assessed as a whole. There was positive correlation in the shared governance group between the WSS subscale scores and the constructive culture type, in particular, a significant correlation between interaction and cohesion, and administration. A weak correlation existed in the traditional governance group between and the WSS scores and constructive culture type. However, a stronger negative relationship was demonstrated between the passive-defensive culture and the WSS subscale scores, namely, pay,professional status, interaction and cohesion, and administration.

The one finding that was not anticipated, was a statistically significant difference in the retention rate between the registered nurses employed in the two governance type groups. While the retention rate was high for both models, there was a higher rate for the traditional governance type group. The traditional governance type group had an unanticipated finding that was statistically significant in the sociodemographic category of years with the organization within the subgroup of fifteen and more years. This possible confounding result cannot be further differentiated by the data from this study, however, it is possible that these two results were interrelated. One would want to avoid the conclusion that traditional governance units had a higher nurse retention rate based solely on the results of this study. Since years with the organization could influence this result, and since other findings of this study would suggest that the shared governance unit was a more preferable employing site, one would want to assess this issue prior to drawing any firm conclusions. This difference may be further accounted for by the abundance of registered nurses in the work place, and the down-sizing and restructuring of

hospitals, with the resultant decrease in need for registered nurses. Employed nurses may be less likely to leave a secure job regardless of the context in which they work, where registered nurse and patient outcomes were not positive, as shown in this study.

Another confounding event was the nurse manager-facilitator response rate of 62%. Three of the eight nurse manager-facilitators did not respond, while 100% of the shared governance nurse manager-facilitators responded. Statistically, this could account for an inaccurate rate based on missing and/or differential response of data.

According to the Organizational culture literature, the passive-defensive culture type of nurses working in the traditional governance group, had expectations and group norms that embraced the notion of not taking few chances, "not making waves", and fitting into the "mold", while an expected behavior of the registered nurses was following rules and conforming. A culture characteristic of the passive-defensive environment was conservative, bureaucratic control run from the "top". Thus, it was suggested that the governance type framed the culture enhancing the higher nurse retention rate, albeit through dysfunctional processes.

The results revealed on the Patient's Opinion of Nursing Care (PONC) reflected a higher satisfaction score from those patients cared for by the registered nurses in the shared governance group. The total mean score, and all three subscales, revealed a statistically significant difference between the patients' satisfaction in the shared governance and traditional governance groups. There clearly was a positive affirmation of higher satisfaction in the patients receiving care from the registered nurses in the shared governance group, as opposed to the lower satisfaction reported from patients cared for by the registered nurses in the traditional governance group.

One conclusion drawn from these results was that the preceding elements of the model may have influenced the patients' responses in each group. Patients who expressed high satisfaction with care provided by the registered nurses, also had nurses with a constructive culture, working in a context of shared governance. In contrast, the patients who reported a lower satisfaction with care had nurses who had a passive-defensive culture within a context of traditional governance.

The results of this study suggested that the variables of the governance model were associated as intuitively proposed. The results also supported prior research findings, both positive and negative, about the linkages between all of the proposed variables. The use of two groups of similar registered nurse provided a comparison not available in previous research. Statistical correlation and comparision of scores obtained from nurses between the two governance groups in this study enabled a more extensive analysis to better evaluate the elements of the governance model. This study suggested a connectedness between the independent variables and patient satisfaction, which relations were made more apparent through the comparisons.

Implications

Health care administrators searched for ways to decrease cost and increase revenue. Within the boundaries of the current reimbursement/payment system, one of the options was attracting new patients, their return for further health care when necessary, and their referral of new clients. This option was linked to patient satisfaction (Greeneich, 1993). Since nursing was the key determinant of overall patient satisfaction (Abramowitz, Cote, and Berry, 1987) in prior studies,

identification and evaluation of nursing behaviors (culture) that promoted patient satisfaction (outcomes) was critical. Important also was the identification of factors, such as governance type, that influenced and promoted positive nursing behaviors which Greeneich (1993) identified as the structure supporting the nursing culture.

The results of this study provided data on which to form an opinion about a context for nursing service that facilitated positive patient outcomes. The possibility of work redesign within the context of nursing service in terms of governance type (structure) may be worthy of consideration in light of the increased competition for patients in health care and the stringent fiscal limitations imposed on health care institutions. Also, registered nurses exhibiting weak culture behaviors, such as found in the defensive behaviors within nursing service, should be identified. Development and implementation of strategies to overcome the dysfunctional behaviors of the registered nurses may prove fruitful in terms of increased patient satisfaction, an important outcome.

Administrators may want to assess nursing service to determine the strengths and weaknesses of the registered nurses on clinical units. An implication for the use of this study would be to use the proposed governance model to evaluate the nursing service units in terms of the elements of the model, and to assess the status of return patient business both for the hospital and for the individual clinical units.

Limitations

A weakness in the study was the relatively small area in which it was conducted, and a lack of a random sample. The latter was a problem presented by

employment constraints. Sites had to be selected that contained appropriate registered nurses to meet the inclusion criteria for the study. The use of a volunteer registered nurse sample may have produced different results.

Although shared governance type was positively linked to the variables in the model, a possible limitation to the utilization of the study results may be that every health care setting would not be appropriate for a shared governance type model. Assessment of the situation and setting may reveal that work redesign in terms of a shared governance model was not be feasible for staff and facility.

Recommendations

Replication of this study on a larger scale in a different region would be warranted. A study conducted statewide or on a multistate level among non-convenience samples with the same protocols and model to guide the research would be appropriate. This would be valuable to further support and validate the governance model and determine if similar results could be obtained.

Other considerations would be to adhere to a defined model of shared governance and to examine other patient outcomes such as morbidity, mortality, and length of stay on hospital units. Investigation into whether governance type may influence nursing productivity would be an additional variable of interest in terms of cost containment and managed care.

A further analysis of the proposed theoretically derived path model of governance by using other methods of mathematical computation would be of interest to determine if there was a statistical 'goodness of fit' among the variables.

APPENDICES

APPENDIX A

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March 27, 1995

Linda R. Stumpf

[redacted]

RE: **TOWARD A THEORY FOR NURSING**

By: Imogene M. King

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ACCEPTED AND AGREED:

[redacted] 3/31/95

Linda R. Stumpf Date

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April 17, 1995

Ms. Linda R. Stumpf
[redacted]

Dear Ms. Stumpf:

Pursuant to your telephone conversation with Edgar Johns, please accept this letter as permission for you to reprint our *Organizational Culture Inventory (OCI)* circumplex in your dissertation tentatively entitled *Governance Model in Nursing Service: A Path Analysis.* I ask that you include the copyright notice (© 1987 by Human Synergistics, Inc. All Rights Reserved) on the pages where the *OCI* circumplex will appear.

Enclosed are the two profiles based on the scores you provided us with for the shared and traditional governance, as well as a reprint from a study that appeared in *Psychological Reports* which should assist you with your psychometrics inquiry.

If you have any questions or if I can be of assistance, please don't hesitate to contact me.

Sincerely,

[redacted]
Kathryn D. Sockow
Copyright Administrator

/kds

Enclosures

[redacted]

March 29, 1995

Linda R. Stumpf, RN, MSN
[redacted]

Dear Linda:

Please excuse the delay in responding to your letter of March 5 and a copy of your dissertation proposal. You are conducting a study that is needed in nursing and should make a real contribution to nursing administration.

I would be delighted to receive a copy of your completed dissertation. Several doctoral students have been in touch with me the past few years who are also studying events related to nursing service administration. One is developing a theory of power for nursing administration and one is working on patient and nurse satisfaction that deals with perception. My conceptual system and theory of goal attainment are being used in practice, administration, education and research. In my retirement, I am busier that ever before and get excited when I have communication with nurses who are doing such creative work for the profession.

Thank you for sharing your work with me. I will look forward to receiving a copy of your dissertation.

Sincerely,

[redacted]

Imogene M. King, RN, EdD, FAAN

APPENDIX B

Institutional Review Board Approvals

University of Pittsburgh
SCHOOL OF NURSING

TO: Linda K. Stumpf
[redacted]
Latrobe, PA [redacted]

FROM: Janyce Dyer, DNSc, RN, CS [redacted]
Authorized Representative
Psychosocial IRB
360 Victoria Building
[redacted]

DATE: July 6, 1993

SUBJECT: **Exempt IRB Classification**
Title: Governance Model in Nursing Service: A Path Analysis
Advisor: Charlotte McDaniel, PhD, RN
File Number: 7-93-6

Your study is classified as Exempt Research under Part 45, Section 46.101(b) of the Code of Federal Regulations as follows:

> "Research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt...
> (3) Research involving a survey or interview procedures..."

The study protocol assures that data is handled in a confidential manner. No risk of criminal or civil liability is apparent nor is material of a sensitive nature to be collected.

According to IRB guidelines, this exemption is effective until July 6, 1994, and a progress report or letter of termination and final report are due to this office by that date. If any untoward reaction occurs as a result of this study, or the study is terminated for any reason, please send particulars to this office as soon as possible. If the study extends beyond one year, renewal of all protocols are mandatory and must be approved at least 30 days before the anniversary of the original approval date.

Please refer to the above IRB file number on all correspondence or telephone inquiries.

JD:vg

WESTMORELAND
REGIONAL HOSPITAL
PART OF THE WESTMORELAND HEALTH SYSTEM

Joseph J. Peluso
President & Chief Executive Officer

532 West Pittsburgh Street
Greensburg, PA 15601-2282
(412) 832-4000
FAX (412) 832-4313

September 21, 1993

Linda Stumpf, MSN, RN
[redacted]

Dear Ms. Stumpf:

Re: Governance Model in Nursing Service:
A Path Analysis

The above mentioned study was presented to the Institutional Review Board of Westmoreland Health System on July 29, 1993.

After review by the full Institutional Review Board your study was approved. You will be contacted in one year to present an annual review. If you have any questions please free to contact me.

Sincerely,

[redacted]

Georgine A. Dorundo, R.Ph.
Co-Chairman IRB

GAD:ao

Mercy Hospital

February 28, 1994

Linda R. Stumpf, RN, MSN
[redacted]

Dear Ms. Stumpf:

It is my pleasure to inform you that the Nursing Research Committee has approved your proposal "Governance Model in Nursing Service: A Path Analysis". You will need to forward your proposal and the other required documents to the Human Rights and Research Committee care of Dr. Roger Barrette.

If I can be of further assistance, please do not hesitate to call me at extension 8435. Good luck with your project.

[redacted]

Natalie Meyer RNCS, MSN, CCRN
Co-Chair, Nursing Research Committee

cc:file

The Mercy Hospital of Pittsburgh
1400 Locust Street
Pittsburgh, PA 15219-5166
(412) 232-

Mercy Hospital

March 29, 1994

Linda M. Stumpf, MSN, RN
[redacted]

RE: Protocol #410
"Governance Model in Nursing Service: A Path Analysis"

Dear Ms. Stumpf:

Thank you for submitting the above-referenced protocol to the Research and Human Rights Committee.

During discussion of the protocol at the March 28, 1994 meeting, the Committee had some recommendations as described on the attached sheet. Please submit your response at your earliest convenience to the Medical Staff Office, so that an approval letter can be sent to you.

If you have any questions, please feel free to contact me at [redacted] or Matt Tomasko, Medical Staff Office at [redacted].

Sincerely yours,

[redacted]

Roger R. Barrette, M.D., Chairman
Research and Human Rights Committee

/mdt

Attachment

cc: J. V. Narduzzi, M.D.

The Mercy Hospital of Pittsburgh
1400 Locust Street
Pittsburgh, PA 15219-5166
(412) 232-

Mercy Hospital

_____
DATE

DEAR DOCTOR_____,

MAY I HAVE PERMISSION TO ASK YOUR

PATIENT_____ TO COMPLETE A

SATISFACTION SURVEY FOR NURSING RESEARCH?

LINDA R. STUMPF MSN, RN
PRINCIPAL INVESTIGATOR

_____
DATE

TO LINDA R STUMPF:

MY PATIENT_____ MAY

BE ASKED TO COMPLETE A SATISFACTION SURVEY FOR NURSING RESEARCH.

DR._____

The Mercy Hospital of Pittsburgh
1400 Locust Street
Pittsburgh, PA 15219-5166
(412) 232-

Mercy Hospital

April 20, 1994

Linda R. Stumpf, MSN, RN
[redacted]

RE: #410
"Governance Model in Nursing Service: A Path Analysis"

Dear Ms. Stumpf:

Thank you for submitting the requested revisions to the above-referenced protocol.

This is to inform you after review of the revisions, the Research and Human Rights Committee has given the protocol approval.

As required for all approved protocols, annual reports are expected to be submitted to the Committee.

If you have any questions or comments, please feel free to call me at [redacted].

I would like to offer my personal wishes for continued success with your study.

Sincerely yours,

[redacted]
Research and Human Rights Committee

/mdt

cc: JoAnn V. Narduzzi, MD

ADMINISTRATIVE POLICY

PLEASE SEE AND CONFORM TO THE ATTACHED ADMINISTRATIVE POLICY, #136, IF APPLICABLE.

UNIVERSITY
OF PITTSBURGH
MEDICAL CENTER

Center of Excellence for Nursing Practice

NURSING RESEARCH LETTER OF ACCESS

FACILITY NAME: Montifiore University Hospital and
University of Pittsburgh Medical Center

ADDRESS: Pittsburgh, PA

DATE: April 27, 1994

NAME OF RESEARCHER: Linda R. Stumpf MSN, RN

TITLE: Doctoral Candidate

ADDRESS: Dr. Charlotte McDaniel, Advisor
414 Victoria Building
3500 Victoria Street, Pgh, PA. 15261

Dear Linda R. Stumpf:

This letter confirms my agreement to provide you with access to the departments/units at this facility, as listed below, to obtain subjects for your study titled:

Governance Model in Nursing Service: A Path Analysis

I am pleased that you will be conducting this study in our facility and I will provide you with whatever assistance you might require. I understand that you will be following the appropriate guidelines for informed consent involving human subjects, as directed by the research review process at this facility.

Access has been approved for the following areas:

9 C in UPMC Carol Elsesser, Nurse Manager

9 N and 9 S MUH Michael Barca, Nurse Manager

Sincerely,

[redacted]

Room 4221
DeSoto at O'Hara Streets
Pittsburgh, PA 15213-2582
412-647-8426
Fax 412-647-7522

The Medical Center
Beaver, Pa., Inc.

March 24, 1994

Linda R. Stumpf, MSN, RN
c/o Dr. Charlotte McDaniel
School of Nursing
Center for Nursing Research
[redacted]

Re: Governance Model in Nursing Service: A Path Analysis

Dear Ms. Stumpf:

On March 3, 1994, the Institutional Review Board of The Medical Center, Beaver, Pa., Inc., met and reviewed the above protocol, appendix and accompanying abstract.

The board recommended that signed consent forms be obtained from the patients as well as the nurses prior to their participation in the study. Prior to beginning the study, please forward copies of the consent form(s) you intend to use for the board's review.

If you have any questio[redacted]

Sincerely,

[redacted]

Cindy Gerace
Secretary, Institutional Review Board

c: M. Chapas

1000 Dutch Ridge Road
Beaver, PA 15009-9700
412-728-7000

APPROVED: April 22, 1994
Institutional Review Board
The Medical Center, Beaver

CONSENT TO ACT AS A SUBJECT IN A RESEARCH STUDY

TITLE: Governance Model in Nursing Service: A Path Analysis.

INVESTIGATORS:

Principal Investigator: Linda R. Stumpf MSN,RN
University of Pittsburgh
Pittsburgh, PA 15261
[redacted]
Office of Dr. Charlotte McDaniel, Advisor

DESCRIPTION:

I am being asked to participate in this research study because I am a patient on a unit selected for a research study about patient's satisfaction with the nursing care and if it may be influenced by the type of government used on the unit. I understand the study will also look at the nurse's satisfaction with their work, how long they have worked on the unit, and the kind of culture that exists on that unit.

The patient satisfaction will be measured by the Patient's Satisfaction with Nursing Care survey which I agree to complete. The survey consists of 25 brief statements to which the response is to agree or disagree; it will take about 15 minutes to complete. Of the five choices, I will circle only one for each statement. The results from each nursing unit will be compared to see if the type of governance that a nursing unit is managed under influences patient satisfaction with the nursing care. This will help nursing administrators decide what type of management will produce the best care and most satisfied patients.

The researcher will be available to help me while responding to the statements. There are no deceptive measures used. Only if I am well enough will I be asked to participate so that my recovery is not delayed.

RISKS AND BENEFITS:

A risk may be the concern that making critical comments about caregivers while I am under their care might result in retaliation. I have been assured that such retaliation will not be possible because the patient responses will not be made known to any caregivers. Only the Principal Investigator will have access to the responses which will not contain any identifying information. There are no direct benefits being offered to me.

COSTS AND PAYMENTS:

There will be no additional costs incurred by participation, nor will any payments be made to encourage my participation.

FREE WITHDRAWAL:

I understand that I am free to refuse to participate in this study or to withdraw at any time and that my decision will not adversely affect my care at this institution or cause a loss of benefits to which I might otherwise be entitled.

VOLUNTARY CONSENT:

I certify that I have read the preceding or it has been read to me, and I understand its contents, and that any questions I have pertaining to the research have been, or will be answered by Linda R. Stumpf MSN, RN ([redacted]5. I also understand that a satisfaction survey will be sent to me by the Beaver Medical Center. My signature below means that I have freely agreed to participate in this study.

Date _____ Signature _____

Witness _____

APPROVED: April 22, 1994
Institutional Review Board
The Medical Center, Beaver

CONSENT TO ACT AS A SUBJECT IN A RESEARCH STUDY

TITLE: Governance Model in Nursing Service: A Path Analysis.
MWH-93-097

INVESTIGATOR:

Principal Investigator: Linda R. Stumpf MSN,RN
University of Pittsburgh
Pittsburgh, PA 15261
[redacted]
Office of Dr. Charlotte McDaniel, Advisor

DESCRIPTION:

I am being asked to participate in this research study because I work on a unit selected for research that will measure the nurse's satisfaction with work, the length of time worked on the unit, and the kind of culture that exists on that unit to see if the governance type influences these variables. Patient satisfaction with nursing care will also be investigated.

Satisfaction with my job will be measured with the Work Satisfaction Scale. It consists of 32 brief statements to which the response is to agree or disagree; it will take about 15 minutes to complete. Of the five choices in the range, I will circle only one for each statement. The results from all nurses will be compared to see if the governance type of a nursing unit influences nurse's satisfaction with their job.

The culture of the unit will be assesed by the Organizational Culture Inventory that consists of 120 items. Of the five choices I will indicate only one. I will respond to demographic questions on the back of the survey. The researcher will be available to answer my questions. There are no deceptive measures used.

RISKS AND BENEFITS:

A risk may be that participation would raise concern that my responses might be used against me if strict confidentiality is not monitored. I have been assured that such confidentiality will be maintained and only the Principal Investigator will have access to the responses which will not contain any identifiers.

There are no direct benefits being offered to me, however, the results from this study will help nurse administrators assess types of governance in relation to nurse satisfaction and patient satisfaction with nursing care.

COSTS AND PAYMENTS:

There will be no additional cost incurred by participation, nor will any incentive payments made to encourage my participation.

FREE WITHDRAWAL:

I understand that I am free to refuse to participate in this study or to withdraw at any time and that my decision will not adversely affect my employment at this institution or cause a loss of benefits to which I might otherwise be entitled.

VOLUNTARY CONSENT:

I certify that I have read the preceding and understand its contents and that any questions I have pertaining to the research have been, or will be answered by Linda R. Stumpf MSN, RN [redacted] My signature below means that I have freely agreed to participate in this study.

Date _____ Signature _____

Witness _____

The Medical Center
Beaver, Pa., Inc.

May 27, 1994

Linda R. Stumpf, MSN, RN
c/o Dr. Charlotte McDaniel
School of Nursing
Center for Nursing Research
[redacted]

Re: Governance Model in Nursing Service: A Path Analysis

Dear Ms. Stumpf:

The requested informed consent forms for the above research study were reviewed and approved by the Institutional Review Board of The Medical Center, Beaver, on April 22, 1994.

I have enclosed copies for your files.

Sincerely,

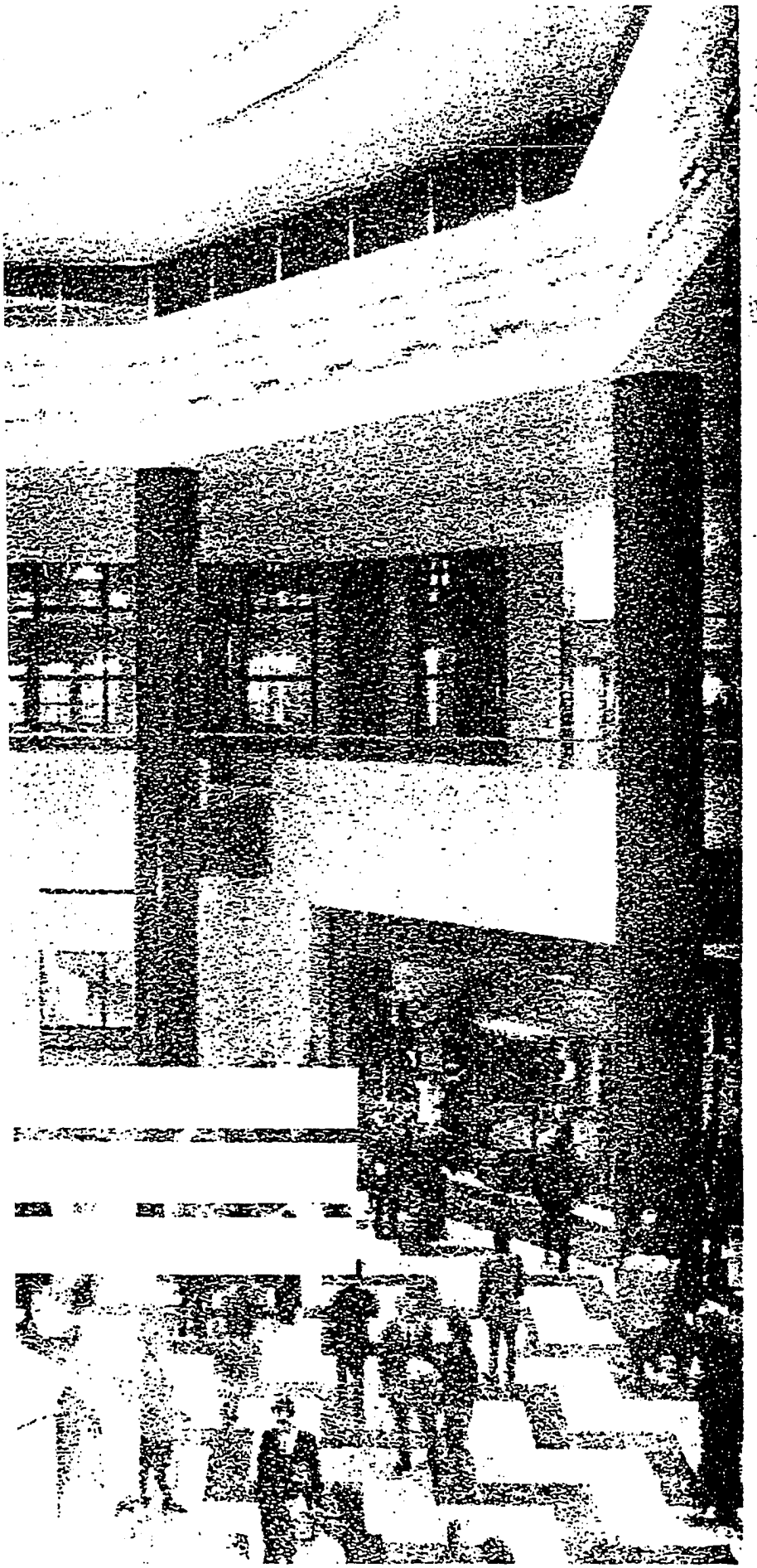
[redacted]
Cindy Gerace, Secretary
Institutional Review Board

enc.

1000 Dutch Ridge Road
Beaver, PA 15009-9700
412-728-7000

APPENDIX C

Organizational Culture Inventory



Organizational Culture Inventory

human synergistics
INTERNATIONAL

Organizational Culture Inventory: Introduction

Every organization has its own culture and set of expectations for its members. For example, some organizations are "competitive" and members feel that they must out-perform one another; other organizations are "cooperative" and members are more likely to feel they should work together as a team.

This inventory presents a list of 120 statements which describe some of the behaviors and "personal styles" that might be expected or implicitly required of members of organizations. Please read

Please think about what it takes for you and people like yourself (e.g., your co-workers, people in similar positions) to "fit in" and meet expectations in your organization.

Using the response options to the right, indicate ***the extent to which people are expected to:***

Please start here and work down the columns.
↓ (use pencil or ballpoint pen; press hard).

RESPONSE OPTIONS:

1. **Not at all**
2. **To a slight extent**
3. **To a moderate extent**
4. **To a great extent**
5. **To a very great extent**

____ point out flaws	____ stay detached and perfectly objective	____ be hard to impress	____ question decisions made by others
____ show concern for the needs of others	____ oppose new ideas	____ look for mistakes	____ remain aloof from the situation
____ involve others in decisions affecting them	____ help others to grow and develop	____ oppose things indirectly	____ refuse to accept criticism
____ resolve conflicts constructively	____ be a good listener	____ take time with people	____ play the role of the "loyal opposition"
____ be supportive of others	____ give positive rewards to others	____ encourage others	____ help others think for themselves
____ stay on people's good side	____ agree with everyone	____ back up those with the most authority	____ be liked by everyone
____ be a "nice guy"	____ stay conscious of fashion	____ switch priorities to please others	____ out-perform their peers
____ do things for the approval of others	____ make sure they are accepted by others	____ compete rather than cooperate	____ be a "winner"
____ "go along" with others	____ always try to be right	____ be the center of attention	____ maintain an image of superiority
____ win against others	____ be seen and noticed	____ never appear to lose	____ turn the job into a contest
____ work to achieve self-set goals	____ explore alternatives before acting	____ set moderately difficult goals	____ think ahead and plan
____ accept goals without questioning them	____ take on challenging tasks	____ pursue a standard of excellence	____ take moderate risks
____ be predictable	____ be a good follower	____ work for the sense of accomplishment	____ openly show enthusiasm
____ never challenge superiors	____ ask everybody what they think before acting	____ follow orders . . . even when they're wrong	____ know the business
____ do what is expected	____ please those in positions of authority	____ check decisions with superiors	____ willingly obey orders

each statement and indicate the *extent to which* the behavior described helps people to "fit in" and meet expectations in your organization.

When responding to the statements, you might find it helpful to consider the behaviors expected by and rewarded by people in higher positions. Please keep in mind that all the statements refer to the way people *within* your organization are expected to *deal with one another* rather than with people external to the organization.

After You've Completed The Inventory —

1. SEPARATE the front and back pages and total your responses on the SCORING SHEET.
2. TRANSFER your 12 totals to the Organizational Culture Profile on the other side of this page.
3. RETAIN this page and the Culture Profile.
4. Please provide the background information requested. RETURN THE SCORING SHEET so we can combine your responses with those of others.

____ cooperate with others	____ use good human relations skills	____ motivate others with friendliness	____ be tactful
____ deal with others in a friendly, pleasant way	____ treat people as more important than things	____ be open, warm	____ act forceful
____ think in terms of the group's satisfaction	____ share feelings and thoughts	____ stay on the offensive	____ play "politics" to gain influence
____ show concern for people	____ demand loyalty	____ build up their power base	____ be hard, tough
____ never relinquish control	____ use the authority of their position	____ personally run everything	____ maintain unquestioned authority
____ personally take care of every detail	____ work long, hard hours	____ set unrealistically high goals	____ do things perfectly
____ not "rock the boat"	____ never make a mistake	____ be precise . . . even when it's unnecessary	____ view work as more important than anything else
____ avoid confrontations	____ treat rules as more important than ideas	____ keep on top of everything	____ appear competent and independent
____ make a "good impression"	____ tell people different things to avoid conflict	____ always follow policies and practices	____ persist, endure
____ conform	____ accept the status quo	____ cast aside solutions that seem different or risky	____ fit into the "mold"
____ be non-committal	____ put things off	____ not get involved	____ push decisions upward
____ make "popular" rather than necessary decisions	____ "lay low" when things get tough	____ wait for others to act first	____ be open about self
____ take few chances	____ never be the one blamed for problems	____ be spontaneous	____ enjoy their work
____ shift responsibilities to others	____ be concerned about their own growth	____ do even simple tasks well	____ think in unique and independent ways
____ emphasize quality over quantity	____ resist conformity	____ communicate ideas	____ maintain their personal integrity

Organization / Department (or Code Number): _____

It would be most appreciated if you would respond to the items below. The information you provide will be used to identify trends across groups in your organization (and to support our ongoing research effort). Your responses will be treated with the strictest confidentiality.

AGE
- ☐ 1. Under 20
- ☐ 2. 20-29
- ☐ 3. 30-39
- ☐ 4. 40-49
- ☐ 5. 50-59
- ☐ 6. 60 or over
- ☐ 9. prefer not to respond

SEX
- ☐ 1. female
- ☐ 2. male
- ☐ 9. prefer not to respond

ETHNIC BACKGROUND
- ☐ 1. Asian
- ☐ 2. Black
- ☐ 3. Hispanic
- ☐ 4. White/Caucasian
- ☐ 5. Other
- ☐ 9. prefer not to respond

EDUCATION
(check highest level):
- ☐ 1. High School
- ☐ 2. Some College
- ☐ 3. Associate's/Technical Degree
- ☐ 4. Bachelor's Degree
- ☐ 5. Some Graduate Work
- ☐ 6. Master's Degree
- ☐ 7. Doctoral Degree
- ☐ 8. Other: _____
- ☐ 9. prefer not to respond

ORGANIZATIONAL LEVEL
- ☐ 1. Non-management
- ☐ 2. Line management (supervising non-management personnel)
- ☐ 3. Middle management (managing managers)
- ☐ 4. Senior management
- ☐ 5. Executive/Senior Vice President
- ☐ 6. CEO/President
- ☐ 7. Owner
- ☐ 9. prefer not to respond

SALARY (Annual)
- ☐ 1. $10,000 or less
- ☐ 2. $10,001 to $18,000
- ☐ 3. $18,001 to $25,000
- ☐ 4. $25,001 to $35,000
- ☐ 5. $35,001 to $45,000
- ☐ 6. $45,001 to $60,000
- ☐ 7. $60,001 to $75,000
- ☐ 8. $75,001 plus
- ☐ 9. prefer not to respond

YEARS WITH ORGANIZATION
- ☐ 1. Less than 6 months
- ☐ 2. 6 months to 1 year
- ☐ 3. 1 to 2 years
- ☐ 4. 2 to 4 years
- ☐ 5. 4 to 6 years
- ☐ 6. 6 to 10 years
- ☐ 7. 10 to 15 years
- ☐ 8. more than 15 years
- ☐ 9. prefer not to respond

ORGANIZATION TYPE
- ☐ 1. Accounting
- ☐ 2. Communications/Publishing
- ☐ 3. Computers
- ☐ 4. Construction
- ☐ 5. Consulting
- ☐ 6. Educational
- ☐ 7. Energy
- ☐ 8. Financial
- ☐ 9. Health Care
- ☐ 10. Hospitality
- ☐ 11. Insurance
- ☐ 12. Manufacturing
- ☐ 13. Military
- ☐ 14. Not-for-Profit
- ☐ 15. Pharmaceutical
- ☐ 16. Public Sector
- ☐ 17. Retail
- ☐ 18. Transportation/Distribution
- ☐ 19. Other: _____
- ☐ 99. prefer not to respond

PROFESSION/ OCCUPATION
- ☐ 1. accounting
- ☐ 2. advertising
- ☐ 3. administrative staff
- ☐ 4. assembly line
- ☐ 5. consulting
- ☐ 6. data processing
- ☐ 7. direct labor (not assembly line)
- ☐ 8. education
- ☐ 9. engineering
- ☐ 10. finance
- ☐ 11. law
- ☐ 12. management (genera
- ☐ 13. management informa systems
- ☐ 14. marketing
- ☐ 15. medicine
- ☐ 16. nursing
- ☐ 17. personnel/training
- ☐ 18. production
- ☐ 19. public relations
- ☐ 20. purchasing
- ☐ 21. research/developme
- ☐ 22. sales
- ☐ 23. secretarial/clerical
- ☐ 24. skilled trade
- ☐ 25. social work/psycholo
- ☐ 26. strategy/policy
- ☐ 27. student
- ☐ 28. other: _____
- ☐ 99. prefer not to respo

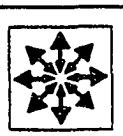
(Please circle one response for each of the items below.)

To what extent . . .	not at all	to a slight extent	to a moderate extent	to a great extent	to a very great extent
1. . . . do you *clearly know* what is expected of you as a member of this organization?	1	2	3	4	5
2. . . . do you receive *inconsistent* messages regarding what is expected?	1	2	3	4	5
3. . . . do you feel you comfortably "fit in" as a member of this organization?	1	2	3	4	5
4. . . . does your job require you to think and behave *differently* than would otherwise be the case?	1	2	3	4	5
5. . . . are you satisfied being a member of this organization?	1	2	3	4	5
6. . . . do you expect to be with this organization two years from now?	1	2	3	4	5
7. . . . would you recommend this organization to *someone like yourself* as a good place to work?	1	2	3	4	5

Research and development by:

Robert A. Cooke, Ph.D.
J. Clayton Lafferty, Ph.D.

39819 Plymouth Road • Plymouth, Michigan 48170
Telephone (313) 459-1030 • Fax (313) 459-5557



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APPENDIX D

Work Satisfaction Scale

WORK SATISFACTION SCALE-NURSE

DIRECTIONS: This is a questionnaire about nurse work satisfaction. Use an answer sheet and #2 pencil to fill in the circle that matches your response as it pertains to your current work situation. Use this key:

Key:	A	B	C	D	E
	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
	SA	A	U	D	SD

1.	When I'm at work in this hospital, the time generally goes by quickly.	SA A U D SD
2.	I am often bored because my job is routine.	SA A U D SD
3.	There is a great gap between the administration of this hospital and the daily problems of the nursing service.	SA A U D SD
4.	Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable.	SA A U D SD
5.	It makes me proud to talk to other people about what I do on my job.	SA A U D SD
6.	There is no doubt whatever in my mind that what I do on my job is really important.	SA A U D SD
7.	I have enough opportunities to make administrative decisions in planning procedures and policies for my unit.	SA A U D SD
8.	An upgrading of pay schedules for nursing personnel is needed at this hospital.	SA A U D SD
9.	New employees are not quickly made to "feel at home" on my unit.	SA A U D SD
10.	There is ample opportunity for nursing staff to participate in the administrative decision-making process.	SA A U D SD
11.	There are plenty of opportunities for advancement of nursing staff at this hospital.	SA A U D SD
12.	The present rate of increase in pay for nursing service personnel at this hospital is not satisfactory.	SA A U D SD

	Item	A B C D E
13.	I could deliver much better care if I had more time with each patient.	SA A U D SD
14.	What I do on my job doesn't add up to anything really significant.	SA A U D SD
15.	Nursing personnel at this hospital do a lot of bickering and backbiting.	SA A U D SD
16.	Considering the high cost of hospital care, every effort should be made to hold nursing personnel salaries about where they are, or at least not to increase them substantially.	SA A U D SD
17.	Excluding myself, it is my impression that a lot of nursing service personnel at this hospital are dissatisfied with their pay.	SA A U D SD
18.	I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.	SA A U D SD
19.	There is a good deal of teamwork and cooperation between the various nursing staff on my unit.	SA A U D SD
20.	There is no doubt that the hospital administrative staff cares a good deal about its employees, nursing personnel included.	SA A U D SD
21.	The nursing personnel on my service don't hesitate to pitch in and help one another out when things get in a rush.	SA A U D SD
22.	The nursing administrators generally consult with the staff on daily problems and procedures.	SA A U D SD
23.	The nursing personnel on my service don't often act like "one big happy family."	SA A U D SD
24.	There is a lot of "rank consciousness" on my unit; nursing personnel seldom mingle with others of lower ranks.	SA A U D SD
25.	The amount of time I must spend on administration ("paper") work on my service is reasonable, and I'm sure that patients don't suffer because of it.	SA A U D SD

	Items	Options	A B C D E
26.	I don't spend as much time as I'd like to taking care of patients directly.		SA A U D SD
27.	The nursing personnel on my service are not as friendly and outgoing as I would like.		SA A U D SD
28.	Even if I could make more money in another hospital nursing situation, I am more satisfied here because of the work conditions.		SA A U D SD
29.	My present salary is satisfactory.		SA A U D SD
30.	I think I could do a better job if I didn't have so much to do all the time.		SA A U D SD
31.	If I had the decision to make all over again, I would still choose my line of work.		SA A U D SD
32.	From what I hear from and about nursing service personnel at other hospitals, we at this hospital are being fairly paid.		SA A U D SD

APPENDIX E

Patient's Opinion of Nursing Care

PATIENT'S OPINION OF NURSING CARE

Please give your honest opinion for each statement on this list by circling one of the seven answers to describe the nurse(s) caring for you. Exclude others (housekeeping, doctors, dietary, x-ray, etc.) Just nurses.

1. **The nurse should be more attentive than she/he is.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

2. **Too often the nurse thinks you can't understand the medical explanation of your illness, so she/he just doesn't bother to explain.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

3. **The nurse is pleasant to be around.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

4. **A person feels free to ask the nurse questions.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

5. **The nurse should be more friendly than she/he is.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

6. **The nurse is a person who can understand how I feel.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

7. **The nurse explains things in simple language.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

8. **The nurse asks a lot of questions, but once she/he finds the answers, he/she doesn't seem to do anything.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

9. **When I need to talk to someone, I can go to the nurse with my problems.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

10. **The nurse is too busy at the desk to spend time talking with me.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

11. **I wish the nurse would tell me about the results of my test(s) more than he/she does.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

12. **The nurse makes it a point to show me how to carry out the doctor's orders.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

13. **The nurse is often too disorganized to appear calm.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

14. **The nurse is understanding in listening to a patient's problems.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

15. **The nurse gives good advice.**

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

16. The nurse really knows what he/she is talking about.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

17. It is always easy to understand what the nurse is talking about.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

18. The nurse is too slow to do things for me.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

19. The nurse is just not patient enough.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

20. The nurse is not skilled in doing his/her work.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

21. The nurse gives directions at just the right speed.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

22. I'm tired of the nurse talking down to me.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

23. Just talking to the nurse makes me feel better.

Very Strongly Agree | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Very Strongly Disagree*

24. The nurse always gives complete enough explanations of why tests are ordered.

Very Strongly Agree	*Strongly Agree*	*Agree*	*Undecided*	*Disagree*	*Strongly Disagree*	*Very Strongly Disagree*

25. The nurse is skillful in assisting the doctor with procedures.

Very Strongly Agree	*Strongly Agree*	*Agree*	*Undecided*	*Disagree*	*Strongly Disagree*	*Very Strongly Disagree*

APPENDIX F

Registered Nurse Cover Letter

Certificate of Research Participation

Approved:07/06/93
Psychosocial IRB
University of Pittsburgh

Dear Registered Nurse:

You are being asked to voluntarily participate in a multi-site study which I am conducting on Governance types. Your one-time participation consists of completing two standardized instruments requiring about 20-30 minutes. All of these data will be strictly confidential; no identifiers will be collected, and no names will be used. Data from this study will be retained in a limited access locked file in the Department of Nursing at the University of Pittsburgh for one year, and then destroyed by shredding. However, at no time will these have identifiers on them. Information from this study will be computed and analyzed in group form, will not be individually shared with anyone and would not affect your employment in any way. Any potential publication from this study would not identify you, your unit or your individual hospital. There are no known risks to participation in this study. However, the results would benefit nursing service and patient care. Thus, your participation is greatly needed.

As the Principal Investigator of this study, I can be reached through my advisor:
Dr. Charlotte McDaniel
School of Nursing, Center for Nursing Research
[redacted]

I would be pleased to answer any questions that you may have about the study or your participation in it. If at any time you wish to withdraw from this study you may do so without any adversity. However, it is important to have as many RNs respond as possible to increase the validity of the study results.

Your completion of the enclosed informed consent and surveys is greatly appreciated. For your completion of the surveys you will not be directly paid but will be given time to respond to the survey and a certificate of participation in a research study.

Thank you for your support and participation.

Most sincerely,

[redacted]

Linda R. Stumpf MSN, RN
Principal Investigator

Enc: Surveys

University of Pittsburgh
SCHOOL OF NURSING

CERTIFICATE

This certifies that _____RN,
has fully participated in the research project,
Governance Model in Nursing Service: A Path Analysis.

Your participation is greatly appreciated.

Signed,

[redacted]

Linda R. Stumpf MSN, RN
Principal Investigator

Institutional Validator

_____

Date:_____ 1993

3500 VICTORIA STREET, PITTSBURGH, PA 15261

APPENDIX G

Registered Nurse Consent Form

CONSENT TO ACT AS A SUBJECT IN A RESEARCH STUDY

TITLE: Governance Model in Nursing Service: A Path Analysis.
MWH-93-097

INVESTIGATOR:

Principal Investigator: Linda R. Stumpf MSN,RN
University of Pittsburgh
Pittsburgh, PA 15261
([redacted])
Office of Dr. Charlotte McDaniel, Advisor

DESCRIPTION:

I am being asked to participate in this research study because I work on a unit selected for research that will measure the nurse's satisfaction with work, the length of time worked on the unit, and the kind of culture that exists on that unit to see if the governance type influences these variables. Patient satisfaction with nursing care will also be investigated.

Satisfaction with my job will be measured with the Work Satisfaction Scale. It consists of 32 brief statements to which the response is to agree or disagree; it will take about 15 minutes to complete. Of the five choices in the range, I will circle only one for each statement. The results from all nurses will be compared to see if the governance type of a nursing unit influences nurse's satisfaction with their job.

The culture of the unit will be assesed by the Organizational Culture Inventory that consists of 120 items. Of the five choices I will indicate only one. I will respond to demographic questions on the back of the survey. The researcher will be available to answer my questions. There are no deceptive measures used.

RISKS AND BENEFITS:

A risk may be that participation would raise concern that my responses might be used against me if strict confidentiality is not monitored. I have been assured that such confidentiality will be maintained and only the Principal Investigator will have access to the responses which will not contain any identifiers.

There are no direct benefits being offered to me, however, the results from this study will help nurse administrators assess types of governance in relation to nurse satisfaction and patient satisfaction with nursing care.

COSTS AND PAYMENTS:

There will be no additional cost incurred by participation, nor will any incentive payments made to encourage my participation.

FREE WITHDRAWAL:

I understand that I am free to refuse to participate in this study or to withdraw at any time and that my decision will not adversely affect my employment at this institution or cause a loss of benefits to which I might otherwise be entitled.

VOLUNTARY CONSENT:

I certify that I have read the preceding and understand its contents and that any questions I have pertaining to the research have been, or will be answered by Linda R. Stumpf MSN, RN [redacted] My signature below means that I have freely agreed to participate in this study.

Date _____ Signature _____

Witness _____

APPENDIX H

Patient Cover Letter

Patient Consent Form

Approved:07/06/93
Psychosocial IRB
University of Pittsburgh

Dear Patient:

You are being asked to voluntarily participate in a multi-site study which I am conducting on Governance types. Your one-time participation consists of completing one standardized instrument requiring about 5-10 minutes. All of these data will be strictly confidential; no identifiers will be collected, and no names will be used. Data from this study will be retained in a limited access locked file in the Department of Nursing at the University of Pittsburgh for one year, and then destroyed by shredding. However, at no time will these have identifiers on them. Information from this study will be computed and analyzed in group form, will not be individually shared with anyone and would not affect patient care in any way. Any potential publication from this study would not identify you, the unit or the individual hospital. There are no known risks to participation in this study. However, the results would benefit nursing service and patient care. Thus, your participation is greatly needed.

As the Principal Investigator of this study, I can be reached through my advisor Dr. Charlotte McDaniel at the following address or telephone number:
School of Nursing, Center for Nursing Research,
[redacted]

I would be pleased to answer any questions that you may have about the study or your participation in it. If at any time you wish to withdraw from this study you may do so without any adversity. There are no known risks to participants, nor is there any payment.However, it is important to have as many patients respond as possible to increase the validity of the study results.

Your completion of the enclosed informed consent and survey is greatly appreciated.

Thank you for your support and participation.

Most sincerely,

[redacted]

Linda R. Stumpf, MSN, RN
Principal Investigator

Enc: Survey

APPROVED: April 22, 1994
Institutional Review Board
The Medical Center, Beaver

CONSENT TO ACT AS A SUBJECT IN A RESEARCH STUDY

TITLE: Governance Model in Nursing Service: A Path Analysis.

INVESTIGATORS:

Principal Investigator: Linda R. Stumpf MSN,RN
University of Pittsburgh
Pittsburgh, PA 15261
[redacted]
Office of Dr. Charlotte McDaniel, Advisor

DESCRIPTION:

I am being asked to participate in this research study because I am a patient on a unit selected for a research study about patient's satisfaction with the nursing care and if it may be influenced by the type of government used on the unit. I understand the study will also look at the nurse's satisfaction with their work, how long they have worked on the unit, and the kind of culture that exists on that unit.

The patient satisfaction will be measured by the Patient's Satisfaction with Nursing Care survey which I agree to complete. The survey consists of 25 brief statements to which the response is to agree or disagree; it will take about 15 minutes to complete. Of the five choices, I will circle only one for each statement. The results from each nursing unit will be compared to see if the type of governance that a nursing unit is managed under influences patient satisfaction with the nursing care. This will help nursing administrators decide what type of management will produce the best care and most satisfied patients.

The researcher will be available to help me while responding to the statements. There are no deceptive measures used. Only if I am well enough will I be asked to participate so that my recovery is not delayed.

RISKS AND BENEFITS:

A risk may be the concern that making critical comments about caregivers while I am under their care might result in retaliation. I have been assured that such retaliation will not be possible because the patient responses will not be made known to any caregivers. Only the Principal Investigator will have access to the responses which will not contain any identifying information. There are no direct benefits being offered to me.

COSTS AND PAYMENTS:

There will be no additional costs incurred by participation, nor will any payments be made to encourage my participation.

FREE WITHDRAWAL:

I understand that I am free to refuse to participate in this study or to withdraw at any time and that my decision will not adversely affect my care at this institution or cause a loss of benefits to which I might otherwise be entitled.

VOLUNTARY CONSENT:

I certify that I have read the preceding or it has been read to me, and I understand its contents, and that any questions I have pertaining to the research have been, or will be answered by Linda R. Stumpf MSN, RN [redacted] also understand that a satisfaction survey will be sent to me by the Beaver Medical Center. My signature below means that I have freely agreed to participate in this study.

Date _____ Signature _____

Witness _____

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