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The impact of employing a clinical nurse educator on a nursing uni
THE IMPACT OF EMPLOYING A CLINICAL NURSE EDUCATOR ON A NURSING UNIT

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MASTER OF EDUCATION

LETHBRIDGE, ALBERTA
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To Mom and Dad,
who are always there and encouraged me to go out
and learn about the world.

To the Nursing profession I love
and the patients who make my work so enjoyable.
The issues of job satisfaction for nurses and nurses' continuing clinical competence have become major concerns for the nursing profession as evidenced by a growing volume of research into these areas. Both job satisfaction and clinical competence of nurses can affect quality of care (of which patient satisfaction is one facet).

This study focussed on the concepts of job satisfaction and clinical competence of nurses, and patient satisfaction—their interrelationships, and how they were affected by the implementation of a Staff Development Nurse on one nursing unit in an active treatment hospital. A hospital-based Job Enhancement Project provided a unique opportunity to combine a dynamic real-life situation with an additional case study approach to examining the issues though interviews and documentation of the relationships among the nursing unit staff over an 18-month period of time.

Both quantitative and qualitative methods were used to gather pertinent information in addressing the research questions. Focus unit nursing staff questionnaires returned initially (13 of 27) and at the one-year mark (six of 27) of the Project, and interviews with six key participant nursing staff were used to survey nurses' perceptions of their own job satisfaction and clinical competence as well as their perceptions of their peers' job satisfaction and clinical competence. The patients admitted to the focus unit during the Project time frame were also invited to complete patient satisfaction surveys. The Staff Development Nurse and the Nursing Unit Manager were interviewed to give their perspectives. The Staff Development Nurse kept a journal of her work for the 18 month period, and so did the researcher. Frequencies, percentages, and content analysis of qualitative data provided the statistical and descriptive information for interpretation.

One finding in this study was that the Staff Development Nurse did have a positive influence on the clinical competence of some of the nursing staff on the focus unit, which
may have in turn had a positive influence on nurses' perceptions of job satisfaction. The Staff Development Nurse was an immense support for the Nursing Unit Manager. However, the major finding in this study was that there were many other factors which influenced nurses' perceptions of job satisfaction, many of them which were beyond the control of the SDN. The SDN actually became a mitigating factor or a buffering agent in helping the nursing staff cope with these other factors.

This study contributes to the growing body of research on nurses' quality of working life and some of the influencing factors. It may also provide insights into the relationships between nurses and patients, and the role definition of a nurse educator on one nursing unit.
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Over the three year period and 2100 hours of this research, I have been involved with many people. I extend my thanks to the Nursing Department at Lethbridge Regional Hospital for giving me the opportunity to do the research. Thanks must also be extended to the members of my thesis committee: David Smith, for reminding me about what is important in the world; Craig Loewen, for living part of his life parallel to mine and reminding me of the details, and Peggy-Anne Field for being a kindred spirit. No words can explain the kind of appreciation and respect I hold for my advisor—Myrna Greene. She is tactful, professional, an excellent role model, patient, and positive. She was there for me through it all, and I thank her. I cannot forget the others who helped me with the logistics: Jay DeMars and her excellent word processing, Bob Boudreau for saving my “bacon” with SPSS, and Marlene Menard and her quantitative analysis support. To my friends and family who have accepted many rainchecks from me throughout the days of my Master’s Degree—I will “have a life again”. Last, but most importantly, to the nursing participants in the study, a heartfelt thank you, for trusting me and for sharing your perspectives. You do make a difference.
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CHAPTER ONE
THE PROBLEM

Introduction

The issues of job satisfaction for nurses and nurses' continuing clinical competence have become major concerns for the nursing profession, as evidenced by a growing volume of research into these areas. There is also a small amount of research to suggest that nurses' perceptions of their own and their peers' clinical competence can affect perceptions of job satisfaction (Kramer, 1990). According to Ritchie (1988), both job satisfaction and clinical competence affect quality of care (of which patient satisfaction is one facet).

The focus of this study was how perceptions of job satisfaction were interrelated with perceptions of clinical competence and patient satisfaction. Another focus was to assess how the issues of job satisfaction, clinical competence, and patient satisfaction were affected by the implementation of a nurse educator.

Background to the Problem

The concept of job satisfaction, simply defined as the way one feels about one's job, has generated substantial interest in the general and nursing literature. Locke's work in 1968 with the interactionist model and definition of work satisfaction caught the attention of many writers and researchers. Since then, others have examined this issue from different points of view, finding links between job satisfaction and rewards and values (del Bueno, 1982; Katzell & Yankelovich, 1975; Vroom, 1964), turnover (Larsen, Lee, Brown, & Shorr, 1984; McCloskey, 1974), quality of supervision and the need for nursing autonomy (Mottaz, 1988), achievement and recognition (Cronin-Stubbs, 1977), and group cohesion (Hinshaw, Smeltzer, & Atwood, 1987).
More recently, issues of nurses' own well-being and quality of working life have surfaced as issues related to job satisfaction. Nursing is no longer considered the ideal occupation for women. In 1986 Working Women Magazine named nursing as one of the 10 "dead-end" occupations (Wilson, 1987). Throughout the past decade, nurses in Alberta have repeatedly expressed concerns about their quality of working life. At least 15 studies and reports regarding nursing work life issues in Alberta have been produced since 1977. Nurses held three legal strikes in 1977, 1980, and 1982, and one illegal strike in 1988. Improvements in wages and benefits were the result of the efforts of organized labour representing nurses, but in spite of improvements in wages and benefits, nurses in Alberta were not satisfied with their role (Premier's Commission, 1988).

The strike in 1988 was prolonged, bitter, and divisive. Nurses called for long-lasting solutions to the quality of their work life. Following the strike in 1988, the Premier of Alberta called together a commission to look yet again at the issues of job satisfaction for nurses in Alberta. As a result, the Premier's Commission for Future Health Care for Albertans released an interim report on the "Concerns of Nurses in the Hospital and Nursing Home System." The report outlined the specific concerns of nursing personnel in the province regarding their low morale and high levels of job dissatisfaction, concerns that were no different from concerns identified by nurses in other provinces, the United States, and the United Kingdom (Premier's Commission, 1988).

The words on the last pages of the Interim Report for the Premier's Commission on Future Health Care for Albertans seem to capture the reality for nurses in Alberta:

Many nurses believe that they are not properly recognized by society at large, by others in the health care system, and even by others in their own profession as to their future roles, worth, and importance. Many nurses are frustrated with the status quo and worry that their work commands no respect; they feel
nursing is not appreciated as a needed, worthy, and complex area of endeavor. A sense of powerlessness pervades the nursing profession. Clearly the lack of action on repeated recommendations in many previous reports has raised the frustration level among members of the nursing profession. This frustration will continue if matters remain unresolved, if questions remain unanswered, if concerns are not addressed, and if recommendations are lost in bureaucracies of governments, institutions, and associations (1988, pp. 22-23).

Since 1988, the Government of Alberta, the Alberta Hospital Association (AHA), the Canadian Nurses Association (CNA), Canadian Hospital Association (CHA), and the Alberta Association of Registered Nurses (AARN) have all dedicated resources to examine job enhancement and satisfaction issues, and strategies for nurses.

Clinical competence (defined by Benner, 1982) is a feeling of mastery and an ability to cope with and manage the many contingencies of nursing work. Clinical competence is often thought of as a goal to achieve. For nurses to become "clinically competent" means to have achieved mastery of these nursing tasks and possess an ability to cope with any situation. Benner (1982) has pointed out that in addition to basic and ongoing educational preparation, competence, as an achievable goal, grows out of working experience—not the mere passage of time and longevity—but a refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory.

Clinical competence can also be viewed as a process, especially when considering the educational preparation, ongoing education, and the patient care experiences nurses have throughout their careers (Benner, 1982). From the process point of view, nursing competence embodies knowledge, skills, and attitudes that are constantly being modified by developments in the sciences, humanities, and by changes in society itself (AARN, 1985). The complexity and responsibility of nursing practice today requires long-term and ongoing career development. Nurses who work in the health care system must keep current, be accountable, and be clinically competent at all times.
Quality of care, as defined by the extent to which care is judged to be effective, is the ultimate objective of the nursing profession (AARN, 1986). Along with overall quality of care, patient satisfaction (or how patients judge the kind of care they are receiving) is extremely important to professional organizations and accrediting bodies (AARN, 1986). Patient satisfaction is used here to judge (from the patient perspective) whether quality of care is effective. Patient satisfaction and quality of care are influenced by many factors, including nurses' job satisfaction and clinical competence of nurses.

This study focused on these three concepts—job satisfaction, clinical competence of nurses, and patient satisfaction—their interrelationships, and how they were affected by the implementation of a Staff Development Nurse in an active treatment hospital.

Lethbridge Regional Hospital Job Enhancement Project

The relationships among job satisfaction for nurses, their perceived levels of clinical competence, patient satisfaction with nursing care, and the influence of an education nurse have been examined in the context of a job enhancement project on one nursing unit at the Lethbridge Regional Hospital, a 264 bed active treatment facility in the southern Alberta city of Lethbridge. The population of the city itself is about 63,000 people. (For a detailed description of the facility, the mission and role statement, types of clinical services and programs, and current and projected activity levels, please see Appendix A, the first and second page of the Application For Support Under The Job Enhancement Fund For Nursing Initiatives).

Background to the Project

The nursing department at the Lethbridge Regional Hospital had recently undergone a major organizational change to a more decentralized structure. In addition to the organizational changes, the nursing department wanted to determine what clinical staff education and development strategies were best suited to the department, nurses' job satisfaction, and the satisfaction of patients.
A major nursing recruitment and retention report completed by Fleming (1989) for the Lethbridge Regional Hospital recommended that ongoing education and staff development for nurses be addressed. Based on these recommendations and the opportunity to access funding, a job enhancement committee was formed at the Lethbridge Regional Hospital. The committee produced the proposal contained in Appendix A, which was accepted by the hospital's Board of Directors. It was submitted to the Provincial Job Enhancement Fund in January, 1990. The proposal was approved and funded jointly in January 1991, by the Job Enhancement Fund and the Lethbridge Regional Hospital.

Intent of the Lethbridge Regional Hospital Project

The Lethbridge Regional Hospital (LRH) Project focused on the institution of a full-time unit-based Staff Development Nurse to coordinate and provide clinical development through a variety of strategies for the nursing staff on a pre-selected focus unit. The role of the Staff Development Nurse (SDN) was to assess, plan, implement, and evaluate those clinical development strategies on both an individual and group basis, that would assist nurses in attaining enhanced levels of clinical competence and job satisfaction.

The idea for this Project came from the fact that the availability of competent nurses was and still is crucial to the success of all patient care programs run in the hospital. In addition, a noteworthy finding in a study conducted on nurse staffing patterns (Kramer, 1990) concluded that nurses' perceptions of adequate staffing may be unrelated to actual numbers of staff, but significantly related to the nurses' perceptions of the clinical competence of their nursing unit peers.

The question the LRH Project wanted to address was to determine how significantly perceptions of the clinical competence of a nurses' peers impacted on his/her own feelings of job satisfaction. Based on the literature review conducted, the relationship between job satisfaction and the clinical competence had not been explored to any great
extent. It was anticipated through the LRH Project, by monitoring nurses' perceptions of their job satisfaction and clinical competence over time, that beneficial differences could be found among the nurses with an on-unit SDN.

Patients were also requested to determine their levels of satisfaction with the nursing care they received on a particular nursing unit. These measures were obtained in a general fashion prior to the SDN's arrival to the focus unit, and daily throughout the entire time the SDN worked in the unit. The original proposal submitted to the Premier's Initiatives also included a control unit, selected on the basis of comparison scores on job satisfaction and clinical competence (See Appendix A, page 5). This idea was abandoned before the Project started, because job satisfaction scores of the four possible units were not close at all.

The goal of the LRH Project was to examine the relationships among job satisfaction, clinical competence, and patient satisfaction. The LRH proposal stated that the results of the project would be specifically analyzed to determine:

a) how successful the institution of an on-unit, full-time SDN was in enhancing individual and group levels of clinical competence,
b) the correlation of nurses' perceptions of the clinical competence of nursing peers to job satisfaction, and,
c) if the institution of the SDN positively impacted job satisfaction and was a proven job enhancer for staff nurses.

The intent of the LRH Project was that recommendations be made regarding this form of nursing staff development: the benefits and implications of the role itself, scope of responsibilities, and position within the organization. This was to provide useful feedback to the hospital's nursing department to make appropriate organizational decisions about clinical competence and if the institution of a SDN positively impacted job satisfaction for the nursing staff. Recommendations regarding the number and placement of SDNs would then be made.
The Thesis Study

The Lethbridge Regional Hospital Job Enhancement Project provided a unique opportunity to combine the dynamic real-life situation of the Project with an examination of the relationships among the larger issues of job satisfaction, clinical competence, and patient satisfaction with nursing care in a slightly different manner. In addition to the LRH Project, this study took a case study approach to examining the issues of job satisfaction, clinical competence, and patient satisfaction through interviews and documentation of the relationships among the nursing unit staff over a period of time.

The writer was hired to conduct the research for the Job Enhancement Project and also used this opportunity to complete a thesis. Two committees existed to guide the entire Project: a job enhancement advisory committee for the hospital Project, and a thesis committee for the thesis requirements. The research questions evolved as a result of a thorough literature review and in consultation with both committees.

Statement of Purpose

The purpose of this research was to examine the relationships among job satisfaction for nurses, their perceived levels of clinical competence, and patient satisfaction with nursing care, through the assessment of a job enhancement project at the Lethbridge Regional Hospital.

Research Questions

The research questions were based on the original Lethbridge Regional Hospital proposal (pp. 5-8) and expanded through the literature review and in consultation with both advisory and thesis committees. The following questions were formulated to guide the study:

1. What is the impact of implementing a full-time, unit-based Staff Development Nurse position on:
a) nurses' perceptions of their own job satisfaction?

b) nurses' perceptions of their peers' job satisfaction?

c) nurses' perceptions of their own clinical competence?

d) nurses' perceptions of their peers' clinical competence?

e) patients' levels of satisfaction with their nursing care?

2. What are nurses' perceptions of other factors affecting their job satisfaction, for example: the support or resistance from other staff, the Nursing Unit Manager (NUM), and/or the organization; changing workloads; changes to nursing care delivery systems; patient perceptions of nurses meeting their needs; and changes in patients' services?

Related Terminology

The definitions listed here were operationalized to match the goals of the study and the manner in which they were intended to be used.

1. Nursing Staff. The following individuals were considered to be nursing staff for the purposes of this project: all full-time and part-time registered nurses (RNs) with or without a degree and licensed practical nurses (LPNs) and graduate nurses (those who graduated from a recognized school of nursing, but had not yet received full registration with the AARN).

This definition encompassed any of the above accepted people who were working on the focus unit at the beginning of the Project and any staff members fitting the criteria who were hired to the focus unit any time during the length of the Project. This Project included any staff member who covered a maternity leave or absence position for any regular staff member of the focus unit during the Project time frame.

2. Nursing Administration. The Director of Surgical Nursing Services, the Senior Nursing Director and the Vice-President-Patient Care Services were referred to in this study as part of nursing administration. The Director of Surgical Nursing Services
coordinated the management of number of nursing units. The Senior Nursing Director coordinated the management of all the hospital nursing areas, and the Vice-President-Patient Care Services handled both nursing and support services in the hospital. Collectively, these three persons and the other Directors of Nursing at LRH, and the secretaries are known as the "Nursing Department".

3. Nursing Unit Manager (NUM). The Nursing Unit Manager was considered the manager of the unit, responsible for the daily functioning on one nursing unit.

4. Focus Nursing Unit. This term referred to the nursing work area under the direct supervision of a particular nursing unit manager. The focus nursing unit chosen for this study was unit 4C—a general surgical 32-bed unit at the LRH. The NUM was in charge of this unit and the regular nursing staff were assigned to work on this unit.

5. Patients. Patients refers to those people who were admitted to the focus unit and who were being cared for directly by the nursing staff on the focus unit. Patients who consented were asked about their satisfaction with the nursing care they received during their stay on the focus unit, just prior to being discharged.

6. Significant Others. This term applied to any person, family member or friend who was involved with the patient in their care during their hospital stay and/or during the discharge phase of their care. Significant other did not refer to nursing staff working with the patient in a nursing capacity. Significant others were requested, if they were available, to comment on their perceptions regarding the nursing care patients received on the focus nursing unit and their satisfaction with that care, and may have helped their loved ones either complete the Patient Satisfaction Survey or filled it out themselves for the patient.

7. Peers or Co-Workers. These two terms referred to the nursing staff on the nursing unit, the people with whom any given nurse on the focus unit worked. As part of the nursing staff, these individuals were asked to give their perceptions and opinions of
their own and others' job satisfaction, and levels of clinical competence (own and others').

8. Perception. For the purposes of this study, perception referred to the ability to mentally grasp, find meaning, and interpret qualities through the senses; our understanding of or beliefs about something (Guralnik, 1980). Interpretation is also influenced by the inner psychological field of the person, an individual's personal character, motivation and cognitive structure (Lewin, 1951, p. 7). Specifically related to job satisfaction and clinical competence, Chaska's (1978) definition fits nicely: "a view of performance of self and others, past or present, relative to an idealized norm" (p. 357). Perceptions of the nursing staff on the focus unit were requested regarding job satisfaction, clinical competence and patient satisfaction with nursing care.

9. Staff Development Nurse (SDN). This term referred to a nurse with appropriate education and experience who was hired to provide assessment, planning, implementation, and evaluation of those educational strategies that, on both an individual and group basis, would assist nurses in attaining higher levels of clinical competence. This nurse was responsible for a broad professional/educational mandate, and for the purposes of this research, responsible to the nursing staff on the focus nursing unit only; all reference points for the SDN were based from the specific nursing unit chosen. A job description and job summary are contained in Appendix B.

10. Job Satisfaction. Job satisfaction is the fluctuating attitudinal state of an individual derived from perceptions that situational job factors important to the individual are present in the job (Kramer & Hafner, 1989). On the focus unit, nursing staff were asked for their opinions and perceptions of their own job satisfaction and the perceived job satisfaction of their peers.

11. Clinical Competence. Benner (1982) defines and uses the term clinical competence as a feeling of mastery and an ability to cope with and manage the many
contingencies of clinical nursing. For this particular study, clinical competence was not referred to as a proven capacity to perform specific functions based on predetermined standards, but rather as perceptions of that performance. Nursing staff on the focus unit were asked for their opinions and perceptions regarding their own levels of clinical competence and perceived levels of clinical competence in their peers.

12. Patient Satisfaction. Patient satisfaction encompasses the perceptions that patients obtain appropriate nursing care to meet their needs (Ferguson & Ferguson, 1983). Patients who consented were asked prior to discharge to offer their opinions and perceptions about the nursing care they received in general, while on the focus unit, and nursing care regarding specific situations related to their care, based on the recognized rights of patients.

13. Quality of Care. This term is defined as a combination of the patient's perception of the beneficial results of care and the extent to which the care is judged effective according to an established set of indices or standards (Bliersbach, cited in Calder, 1991). Hearne (cited in Calder, 1991) takes the definition one step further, and states that quality entails continuous improvement and striving for excellence. Patient satisfaction is also an important indicator of judgement of quality of care. For this research, patient satisfaction served as a surrogate for quality of care.

14. Nursing Practice. Nursing practice for this study was defined as a direct service, goal directed, and adaptable to the needs of the individual, family, and community during health and illness (AARN, 1980). Professional practitioners of nursing bear primary responsibility and accountability for the nursing care clients receive (AARN, 1980).

15. Administration. This term refers to the senior management personnel including the Vice-President-Patient Care Services and all of the other Vice-Presidents at LRH, the hospital President and the hospital Board of Directors.
Limitations of the Study and Mitigating Variables

Perhaps the major limitation of this study was that it examined only perceptions of clinical competence, rather than actual clinical competence. Nevertheless, people generally act on the basis of their perceptions of others, and it is these perceptions of competence that are presumed to have some relationship to job satisfaction (Kramer, 1990). Patient satisfaction with nursing care is only one facet of quality of care, but serves as a surrogate measure in that it is an important aspect of care and the information is more readily available.

The results of the study were also limited by a number of other factors. The participants for this project were restricted to people listed in the terminology section (mainly nursing staff). Information was not intentionally gathered from, but at times was forthcoming: physicians, housekeeping staff, nursing students, dietary staff, other staff considered support staff to the nursing unit, or any nursing staff member who worked relief on the focus unit in addition to other nursing units at the Lethbridge Regional Hospital or elsewhere.

Results of this study were also limited by the restrictions associated with interviews and questionnaires. The Hawthorne Effect is another influencing variable; the staff on the focus unit and other randomly selected nurses were asked to complete job satisfaction/clinical competence surveys on a regular basis, which have focused their attention on the issues being addressed.

The concept of time is also a very important consideration. This project involved a major innovation; measurable changes in attitudes and behaviours usually take much longer than the 18-month time frame of this project.

One major influencing factor was the slightly different philosophies between the LRH Project and the research study. An SDN was hired for the focus unit. The LRH Project was partially designed on this pivotal position. An assumption was made that by
the SDN fulfilling her job description, perceived clinical competence of the nursing staff was affected, as was their perceived levels of job satisfaction. Essentially the SDN position has been evaluated in one sense, on how well job satisfaction, clinical competence, and patient satisfaction were enhanced.

At the same time that the SDN position was assumed to be a pivotal part of the research design, it is also likely that other factors influenced perceived levels of job satisfaction and clinical competence. For example, organizational changes, nursing department changes, and staff changes affected both perceived job satisfaction and clinical competence, as well as the impact of the SDN position. In addition, there may have been personal as well as professional factors affecting some of the nursing staff that may be the largest responsible factors. Similarly nursing turnover, perceptions of autonomy, and the image nurses hold of themselves may have all affected their perceptions of job satisfaction and clinical competence.

Finally, the involvement of the researcher has had an effect on the process and outcome of the study. This factor is explored more fully in Chapter Three.

Significance of the Study

The goal of any nursing research is to contribute, influence, and enhance nursing practice that is essential for the nursing profession (Brink & Wood, 1988). Pringle (1989) states that we need to increase our research activity on the work life of nurses, considering nurses' critical impact on the health care system, and the serious consequences job satisfaction may have for both the organization and the individual. From a quality of work life perspective, research is needed to supply information to those responsible for providing the right combination of rewards and recognition to increase the satisfaction of the clinical nurse. This particular research will hopefully also provide a database and profile of nurses at the Lethbridge Regional Hospital to be used for a number of quality of work life issues.
Job satisfaction is now valued as a desirable organizational and humanistic outcome rather than merely as a determinant of organizational effectiveness (Fraser, 1984; Larson et al., 1984; Marquis, 1988; Smith, Kendall, & Hulin, 1969). Explanations for the cause of job dissatisfaction and methods of improving the job itself must be investigated. Pursuit of theoretical understanding of job satisfaction assumes importance when it is considered in the wider contexts of modern work realities (Smith et al., 1969).

Research is also needed to build on existing models of clinical competence such as Benner’s (1982) model. The literature tells us that quality of work life and job satisfaction are intensely affected by the level of competence nurses have (CNA/CHA, 1990; Kramer & Hafner, 1989; Stamps & Piedmonte, 1986). Other factors may have more or less influence, but ongoing education to increase clinical competence is a significant factor; one that would have severe health care repercussions if it were not considered.

In nursing practice, quality of care is a priority. This research presented an opportunity to add information about the beneficial and sustaining factors involved in the intimate relationship between the nurse and the patient, whether it be strengths in communication, expertise in performing nursing tasks, or in the concept of care. The relationship between the nurse and the patient ultimately affects the quality of work life for nurses.

Nursing manifests many of the characteristics Roberts (1986) describes when examining oppressed groups: a lack of self-esteem, a divisiveness (or lack of cohesion), a devotion to routine, and a retreating from initiative. De Bella, Leoni de and Siddal (1986) characterize some people in nursing as being afraid of success and also as having passive-aggressive behaviour. Nursing is categorized as a female-dominated profession, but Stamps and Piedmonte (1986) caution that this only means that women hold the highest number of positions. The relationship of the predominately female profession to
perceived job satisfaction and clinical competence is even more important within hospital nursing where females are largely subservient to the male-dominated medical profession (Stamps & Piedmonte, 1986).

Friere (1984) is quite adamant that freedom is not granted to an oppressed group by the dominant or oppressing group; freedom is won through one's own efforts in self-liberating education. Based on this notion, one could speculate that nursing is undergoing a transition in moving from a long history of dependence toward the relatively new stage of self-determination and control. The freedom to develop nursing as a profession can only come from nursing itself; it will not be bestowed upon nursing by anyone else. Nursing research like this particular study of job satisfaction may help in that development.

An investigation of this nature should be of use to those individuals charged with the responsibility for developing and implementing a program for enhancement of clinical competence in a hospital setting. As outlined previously, hospitals have a variety of educational positions and structures designed to enhance nurses' ongoing education. Few of the positions or educational structures have been investigated or evaluated for their overall effectiveness. Therefore, this research is timely and appropriate. By completing research of this type, the gap between theory and practice may also be narrowed.
CHAPTER TWO
LITERATURE REVIEW

Introduction

The purpose of this chapter is to identify and summarize relevant literature about the separate concepts of job satisfaction, clinical competence, and patient satisfaction. Relationships among the three concepts is examined, gaps in the literature and the related research are identified and finally the literature review is related back to the Project for the Lethbridge Regional Hospital.

Job Satisfaction

Few other topics in the working world have generated as much controversy as has the question of the nature of job satisfaction. Job satisfaction issues, much like nurses' work life issues, have become very complex.

Kramer and Hafner (1989) define job satisfaction as a fluctuating attitudinal state of an individual, derived from perceptions that situational job factors important to the individual are present in the job. Satisfaction occurs when an individual's needs and job characteristics are compatible and discrepancy between expectations and reality is minimized (Larson et al., 1984). These modern definitions are products of literally hundreds of theories and pieces of research about job satisfaction from Elton Mayo's time in the 1930s until present day.

Theoretical Context of Job Satisfaction

Much of the research outlined here has assumed a specific theory or parts of theories on job satisfaction. These theories have created a perplexing multitude of perspectives with which to compare and evaluate the results. An overview of pertinent theories is offered here to help clarify the research presented.
Early investigations in job satisfaction focused on examining the effects of equipment design and physical working conditions on worker productivity, based on the assumption that the work role was a continuum along which the worker shifted in response to intrinsic and extrinsic changes. Theorists hypothesized that if the presence of a variable in a work situation such as increase in salary led to satisfaction, then if the variable was removed, the worker would be dissatisfied (Carroll, 1969). This idea gave way to examination of broader social effects on job satisfaction and productivity.

Despite a vast number of studies numbering in the ten-thousands, on the nature and causes of job satisfaction, there has been little progress made in understanding job satisfaction. McCallum and Wright in 1979 remarked that the research into job satisfaction had shown a general lack of cohesiveness, a profusion of different definitions, lack of definition of various terms, and a definite lack of continuity. In many respects, that situation holds true today.

The concept of job satisfaction is frequently linked to the concept of motivation through the early psychological movement. The principle that individuals are motivated by their personal needs and their personal self-interest underlies almost every management and economic theory, and is contained explicitly or implicitly in all theories of motivation (Robbins, 1979). This principle is often referred to as “Individual Need Theory” or “Need Fulfillment Theory.” Robbins says that motivation is the willingness to do something and is conditioned by this action’s ability to satisfy some need for the individual. People who are motivated appear to exert a greater effort to perform, driven by the desire to achieve some goal they perceive as having value to them (Robbins, 1979). Work satisfaction from this perspective, is positively related to the degree to which personal needs are met in the work situation. Two of these theorists include Maslow (1943) and his Need Hierarchy theory, which some say has become the most significant theory in job satisfaction, and Alderfer’s (1966) Existence, Relatedness and Growth (ERG) theory.
Maslow's (1943) theory was based on the notion that a person's needs develop in a sequence from the lower to higher order needs. The five need categories were: (a) physiological needs of breathing, eating, obtaining shelter; (b) safety needs of protection, security, structure, order, law; (c) soci-affection needs of belonging, acceptance, friendship, love; (d) esteem needs of self-confidence, independence, achievement, competence, knowledge; and (e) self-actualization needs of self-fulfillment, self-development and realizing one's own potential. Maslow suggested that if the lower order needs were not satisfied, the higher order needs would be less likely to motivate behaviour. He felt that most normal individuals are both partially satisfied and dissatisfied in all of these needs at the same time. It is largely Maslow's work that has amplified the conflict between work as a means of production and work as a means of self-actualization (Stamps & Piedmonte, 1986).

Alderfer (1966) and others have examined Maslow's theory and despite serious testing, could not support the way in which Maslow set it up. Alderfer then designed an alternative—his ERG theory. This theory assumes that people have three major core needs which they strive to meet: a) existence needs such as food, pay, fringe benefits, and good working conditions; b) relatedness needs such as significant others, sharing of thoughts and feelings with family, friends, co-workers, superiors; c) growth needs such as making positive differences personally and environmentally, utilizing capacities to the fullest, and finding opportunities for self-actualization. The progression through the core areas was largely sequential, and Alderfer assumed that when the growth needs were satisfied, efforts would be targeted toward another area.

Many researchers and "interactionist" theorists refer to personal motivators affecting job satisfaction as being either "intrinsic" and extrinsic." Intrinsic motivators are those that increase feelings of personal worth of an employee and include competence, achievement, and self-actualization (Robbins, 1979). Extrinsic motivators
are those external factors that have a concrete reality for a person: food, shelter, and money (Robbins, 1979).

From an organizational point of view, an incentive may be described as a "pre-effort" stimulator by which employees may be motivated, and find more personal worth in their work; making their work more satisfying (Fleming, 1989). Intrinsic incentives might include: free tuition for university course work, educational offerings on the job site, positions on committees, and rotating charge responsibilities. Higher pay for charge duties and self-scheduling options may be considered extrinsic incentives.

Expectancy theory, an offshoot of the Need Fulfillment theory, states that behaviour is determined by a person's belief about the likelihood of behaviour leading to various desirable or undesirable consequences. Victor Vroom's Expectancy Theory (cited in Robbins, 1979) states that individual motivation will be significantly determined by the values an employee attaches to the process of the efforts that lead to good performance, what good performance means in terms of rewards, and how those rewards fit with personal goals (Robbins, 1979). The degree to which a current job fills the individual's personal work-related needs is a measurement of job satisfaction (Stamps & Piedmonte, 1986).

Maslow's (1943) work formed the basis for the development of ideas about job enrichment by Herzberg and others. Herzberg, Mausner, and Snyderman (1959) were the first group to really concentrate on specific motivators in their Two Factor theory: the intrinsic factors that seemed associated with job satisfaction (achievement, growth recognition, the work itself, responsibility and advancement) and a separate set of extrinsic "hygiene" factors related to job dissatisfaction (company policy and administration, status, supervision, job security, salary, interpersonal relationships, and working conditions). Herzberg et al. suggested that positive extrinsic factors were seen as able to prevent job dissatisfaction, but not able to create job satisfaction, that
satisfaction and dissatisfaction are not polar opposites, but separate and sometimes unrelated phenomena. Only when the actual tasks of a job were stimulating to the worker would positive satisfaction arise.

This theory, according to Stamps and Piedmonte (1986), is the most controversial. They state that criticism of the Two Factor theory centres around two arguments. The first is that the theory was developed using only one type of employee. The second argument is far more compelling in that others have found the relationships among motivational and hygiene factors and work satisfaction to be neither consistent nor always in a predictive direction. This theory is still widely disputed.

Stamps and Piedmonte (1986) note that all of these theories contain a specific ideology—that of reinforcing the organization’s goals and workers’ failure to adjust to the system. An understanding of organizational factors that influence work satisfaction are not always recognized in any of these theories.

The Facet-Satisfaction theory examines environmental determinants of job-related satisfaction. Environmental factors include: supervision, pay, promotion, co-workers, and the job itself. According to McCallum and Wright (1979), the Job Descriptive Index, by Smith et al. (1979) was devised to measure job satisfaction according to the presence or absence of these factors and was, up to 1979, the most widely used measurement tool of job-related satisfaction.

Another theory that has surfaced is based on Festinger’s (Wernimont, 1966) theory of cognitive dissonance, where job satisfaction is referred to as a dynamic process of balancing one factor against another, rather than a static process of having a particular level of all-over satisfaction. Wernimont (1966) has proposed an open system of job satisfaction which contains the variables of intrinsic and extrinsic factors. He states that for his model it does not seem meaningful or useful to try to relate a theoretical collective term such as "overall job satisfaction" to output variables. He views job satisfaction as
more suitable for a logical and semantic analysis than to an empirical or research resolution. He states that the relationship between job satisfaction variables and other important aspects of the business environment can be more effectively studied and modified when the entire system can be viewed in its proper perspective.

Definitive theories of work satisfaction have been elusive because of the complexity of determining what makes workers happy or unhappy. Stamps and Piedmonte (1986) observe that the theoretical framework most used in nursing research on job satisfaction is Herzberg's (1976) Two Factor theory—the most controversial.

Factors Influencing Job Satisfaction

Nurses have been called the connective tissue of a hospital (Berland, 1990) and they continue to be essential in coordinating care around the clock and throughout the year (Berland). Providing patient care has become a sophisticated multilevel process. Relationships with physicians, patients, families, and other health care providers have become much more complicated and stressful with emerging ethical, economic, and technological innovations. For nursing, job satisfaction has become one of the most pressing issues of our time.

Although the nursing profession has been active in Canada for many decades, research on nursing and job satisfaction of nurses from a Canadian perspective is glaringly absent or sparse at best in the literature. It is often difficult to relate studies done in the United States with the current situation in Canada because of the number of private hospitals and the lack of organized nursing unions in the United States. Hospitals in the United States may institute innovative means for attracting and keeping staff which cannot be duplicated in Canadian hospitals because of the existence of union-negotiated contracts. The benefit for nurses on the Canadian side is that the nursing unions in Canada have helped a workforce that was essentially female to gain better
financial remuneration with wage differentials for hours of work, shortened work weeks, enhanced benefits, longer maternity leaves, and a voice for patient care concerns through collective agreements known as "professional responsibility." Pertinent United States studies will be examined here as well as available Canadian studies and will address the complexities of job satisfaction for nurses.

Job satisfaction appears to multifactoral, not a single barometer that goes up or down but rather an interplay of balancing and buffering effects of personal motivators, incentives, and rewards. What one employee views as a highly desirable incentive or reward, another employee may not. As a further complexity, any one factor has varying effects on employee satisfaction, the effects depending upon the employee's expectations and the importance he or she places on that factor (Larson et al., 1984).

Turnover. Turnover generally refers to situations in which nurses leave their present positions. A number of aspects related to turnover will be examined here. From a research point of view information about job satisfaction is embedded in the research on nursing turnover, because turnover has been such a critical problem for nursing agencies in the past. Both absenteeism and turnover rates reduce organizational effectiveness, and although both are related to satisfaction, the direction and nature of their relationship is not always clear (Stamps & Piedmonte, 1986).

Mottaz (1988) tells us that research on work organizations in general and the health care field strongly suggests that turnover is an outcome of work dissatisfaction. Several studies suggest that employee turnover among nurses has been a very serious problem in the United States, approaching epidemic proportions (Brief, 1976; McCloskey, 1974; Munro, 1983; Wandelt, Pearce, & Widowson, 1981; Wolf, 1981), although for the last two to three years it has not been as great a problem (Hinshaw, Smeltzer, & Atwood, 1987). Price and Mueller (cited in Mottaz, 1988) report that nurses have overall more than three times the turnover rate of teachers and one and one-half the rate of social
workers; only police officers, factory supervisors, and factory workers report lower levels of satisfaction.

High turnover rates in nursing have some serious consequences. High turnover may have a demoralizing effect, resulting in both lower levels of productivity and to less group cohesion (Mottaz, 1988).

The concept of incentives and rewards is illustrated in a study of nurse turnover which McCloskey (1974) conducted. McCloskey studied the question of job satisfaction and turnover from the Expectancy Theory (1964) and Maslow's (1943) Need Fulfillment Theory point of view. Up to this point in the literature the question of what motivates a nurse to stay on the job had rarely been asked. McCloskey found that nurses rated intrinsic rewards higher than extrinsic rewards when they gave reasons for staying on the job. When nurses left their jobs (not counting transfer of spouse, health, and pregnancy), the lack of intrinsic rewards was cited as the major reason. Most nurses wanted opportunity to attend educational programs and to have flexible schedules to continue course work for credit. Career advancement within nursing, not necessarily in administration was desired, as was recognition for good work from peers and supervisors. McCloskey also found that higher pay did not necessarily keep a nurse on the job, that it was the intrinsic rewards that did. However, when nurses considered starting new jobs, the most important attractions were extrinsic incentives (salary, hours of work, schedules, and benefits). This move to consider turnover as an organizational problem rather than one of the nurses' personality characteristics was positive and enabled work dissatisfaction to be addressed from a different angle.

Other studies have found similar results. Gellerman (1970) was one of the first to propose that it is the extrinsic incentives that draw a person to a job but it is the intrinsic rewards that keep a person on the job and stimulate him/her to do good work. In addition to what Gellerman (1970) and McCloskey (1974) uncovered, Larson et al. (1984) added
professional incentives such as: opportunities for growth, teaching, the work environment, relationships among health professionals, and primary care nursing. Barhyte (1987) conducted a study on retention of nurses compared to their level of practice. Although she did not reference a particular theory, Barhyte was mainly interested in the environmental aspects (or Facet-Satisfaction) of the job. She found that retention increased when career advancement through clinical laddering was available to staff nurses.

Redfern (1978) disagrees with McCloskey (1974) and others (Alexander, Weisman, & Chase, 1982; Powills, 1988) in relation to the intrinsic rewards; she found that nurses who stayed in their jobs were more satisfied with extrinsic satisfiers like hospital policies, working conditions, pay, and advanced opportunities than were their counterparts who left. She found no differences in certain intrinsic factors such as autonomy, security, use of ability, achievement, and responsibility. One of the reasons Larson et al. (1984) have given for the conflict is that McCloskey (1974) and others did not consider the possible discrepancy between the expectations of these nurses and what they actually encountered in their jobs.

In an attempt to evaluate the complex nature of job satisfaction for nurses and actually try to predict nurse turnover, Hinshaw et al. (1987) set up and tested an elaborate five-stage sequential model, using material from Vroom's (1966) Expectancy Theory. Their goal was to explore the relationship between the organizational and individual factors predicted to influence job satisfaction and anticipated actual turnover of staff. Individual factors included: age, education, kinship responsibilities, experience in nursing, tenure in the agency, and initial expected tenure. Organizational factors were: group cohesion, control over practice, autonomy, and job stress (defined as numerous decisions inherent in patient care, continual resolution of conflicting values between professional and bureaucratic demands, and juggling multiple care expectations of
various health professionals and clients). Hinshaw et al. (1987) divided job satisfaction into two parts, organizational satisfaction and professional/occupational satisfaction. Organizational satisfaction factors included: positive or negative opinions of pay, reward, nursing administration management style, staff nurses' professional status accorded, and interaction with colleagues. Professional/occupational satisfaction factors were: opinions of quality of care, time allowed to conduct nursing duties, and general enjoyment of nursing positions (see Figure 1).

In the Hinshaw et al. (1987) study data were obtained from 1597 nursing staff members (RNs-62 percent, LPNs-19 percent, Nursing attendants-19 percent), working three or more shifts per week in seven urban and eight rural hospitals in the southwestern United States. The nursing staff were from a variety of clinical areas and educational backgrounds. All of the nursing staff were given previously tested self-reporting questionnaires initially and then were followed for one year to see who would leave the organization and for what reason(s).

The results of this study were very interesting. In the total sample of nursing staff, 72.61 percent of the "stayers" in 15 hospitals could be predicted by their self-reported anticipated turnover scores, educational level, and clinical service. Individuals with a degree could be expected to leave due to their higher mobility unless certain retention strategies were used (higher group cohesion, team respect, greater professional recognition especially in the delivery of quality patient care, and increased feelings of competence) which led to general enjoyment of one's position. Individuals who were functioning in the specialty areas were less apt to terminate voluntarily.

While the research findings supported the use of satisfiers to retain nursing staff, it was clear to Hinshaw et al. (1987) that these satisfiers had to be tailor-made according to certain nursing staff mobility and control conditions such as educational preparation, clinical service, and urban/rural location.
Figure 1: Theoretical model: anticipated turnover among nursing staff. (Key: + = relationship predicted to be positive; i.e., the factors vary together either up or down. - = relationship predicted to be negative; i.e., the factors vary inversely (e.g., as one increases, the other decreases).

Results of a turnover study done by Prescott and Bowen (1987) concur with Hinshaw et al. (1987) and Larson et al. (1984) that nurses stay as well as leave for a number of reasons. In a descriptive study of 1044 staff nurses who “stayed” and 111 nurses who “left,” Prescott and Bowen determined profiles of the two groups. The leavers were given a pre-selected list of job factors and asked why they left. Their responses divided into two categories: factors within a hospital's ability to change (salary and benefits, working conditions, and nursing practice) and non-work-related reasons (pregnancy and relocation). The stayers were given the same preselected list of job factors, but they were asked to list inadequate factors in their current positions. The pattern between the two groups was the same, in that the following factors appeared in the top seven on both lists: workload, staffing, time with patients, flexible scheduling, respect from nursing administration, promotion opportunities, and salary.

Three items the leavers had on their list but the stayers did not have were: opportunities to expand nursing knowledge, the intellectual stimulation of work, and responsibility of staff nurses to make decisions about patient care. The stayers also had three inadequate factors listed that did not seem as important to the leavers: fringe benefits, respect by physicians, and hospital provided child care. In later interviews with leavers, Prescott and Bowen (1987) reported that some nurses identified benefits and relationships with physicians as important to their decision to leave. These findings are consistent with the literature (Barhyte, 1987; del Bueno, 1982) and the same as those of McCloskey (1974), although the terms intrinsic and extrinsic incentives and rewards are not used by Prescott and Bowen. The important concept these two studies have highlighted is that a significant portion of turnover is controllable by the organization.

From a different point of view, Kramer (1982) conducted a study of factors in the work situation that caused dissatisfaction. She noted that half of the degree nurses left hospital nursing and one-third left the profession because of dissatisfaction. The
explanation was reality shock, the conflict between the socialization process in school and the reality of working in bureaucracies.

Larson et al. (1984) cite other researchers (Araujo, 1980; Mottaz, 1988; Seebolt, Pavett, & Walker, 1978) who substantiate the belief that job satisfaction and employment longevity are correlated, although they are quick to conclude that job satisfaction is only one of several factors that contribute to turnover and absenteeism and that the degree and direction of change in job satisfaction are heavily influenced by the nurses' expectation as well as the value they attach to particular factors.

Larson et al. (1984) have examined the complexities associated with measuring job satisfaction outside of turnover. They support Vroom's Expectancy theory mainly, and Herzberg's Two Factor theory to a degree, and caution that when the innumerable factors that could possibly affect job satisfaction are multiplied by the individual employee's expectations and the value placed on each factor, it is easy to see that a single one dimensional measure of job satisfaction is at best superficial, and at worst, meaningless and misleading.

Larson et al. (1984) believe that satisfaction of employees cannot be obtained with a "shopping list" of job factors that can be maximized. They cite Herzberg, Mausner, and Snyderman (1959) who state that satisfaction occurs when an individual's needs and job characteristics are compatible and discrepancy between expectations and reality is minimized. Larson et al. have found that if a clear understanding of the functions and tasks of a job are given, and that when the expectations of the job are modified to reflect the realities of the organization, job longevity and job satisfaction are significantly increased.

Using this model of relationships between job satisfaction and work performance, Larson et al. (1984) conducted a study to test their theory that: a) the expectations one brings into a job, and b) the subjective evaluation of how well those expectations are met, strongly influence that individual's satisfaction, regardless of the realities (see Figure 2).
Figure 2: Relationships between job satisfaction and performance.

Source: Larson, Lee, Brown, & Shorr, 1984, p. 34.
Larson et al. (1974) developed a New Employee Assessment tool to measure 35 quality of work life factors. Eighty-seven questionnaires were mailed out to new nursing employees at the end of their six-month probationary period at a 336-bed, acute care, university-affiliated hospital in the United States. A return rate of 69 percent was achieved. In this study, high levels of job satisfaction were related to professional issues such as learning, whereas factors with which employees were least satisfied were related to employment issues such as salary and staffing. The most striking result reported was that all 35 satisfaction variables were significantly predicted by respondents’ job expectations and the importance they placed on working conditions. Mean satisfaction scores were not significantly different according to educational preparation, shifts worked, and entry level into the job, probably due to the homogeneity of the group. The Larson group concluded that effective assessment and intervention strategies must be considered in light of the personal expectations of the job and the importance those values hold for the nurses. One of the most important issues Larson et al. raised is the fact that measuring job satisfaction is difficult and that we all need to reexamine our assumptions about why, what and how we accurately measure job satisfaction.

The Magnet Hospital Example. It makes good sense to look at the literature describing hospitals which have been successful in attracting and retaining satisfied staff.

In an attempt to address the nursing shortage, in 1982, the American Nurses’ Association sponsored the original magnet hospital study (McClure, Poulin, Sovie, & Wandelt, 1983) that resulted in the “magnet hospital” designation of a national sample of 41 hospitals across the United States. The purpose of the study was to identify the factors associated with the success of the magnet hospitals and to share the findings with other hospitals.

A “culture of excellence” was found (McClure et al., 1983). The more significant characteristics of such a culture are listed below:
(a) management style: The visible head nurse, supervisor, and clinical specialists are identified as key supports and resource persons. The environment encourages and values nurse-to-nurse consultation. Nurses are included in decision-making at the unit, department, and administration levels. Efforts are directed at making work life easier for the nurses, with satellite pharmacies and educational and wellness programs, to name a few.

(b) organization of patient care: The system of patient care is decentralized to patient care units. Staffing is done based on adequacy, quality, and patient need. There is a low nurse-to-patient ratio; nurses do not feel overworked or overwhelmed and have the opportunity to care for all of the patient needs.

(c) personnel policies: There are flexible work schedules to accommodate nurses, incentives such as scholarships, interest free loans to students, social, and recognition programs with wide visibility.

Aside from the wealth of descriptive data found, the process for selection of these magnet hospital was interesting. From a recruitment and retention point of view, not even the task force realized what a powerful impact the designation of being made a "magnet hospital" would eventually carry on the ability of those hospitals to recruit and hire qualified nursing staff. The special designation and the subsequent magnet hospital studies have created an enhanced status and aura for these hospitals that other undesignated institutions have not received. Many of the magnet hospitals still enjoy a full complement of staff and have never had a problem choosing qualified nurses from those who apply (Kramer, 1990; Kramer & Schmalenberg, 1988a; 1988b).

Kramer and Schmalenberg (1988a; 1988b) have since carried on the magnet hospital study. An on-site follow-up study was performed on a one-third sample of the 41 original magnet hospitals drawn proportionately by region of the country, and on a random sample of 1634 staff nurses working these hospitals. In the follow-up study, it
was found that not only did a culture of excellence still exist in these hospitals, but also in general they were not encountering either an internal or external shortage despite the prevalence of one of the most severe nursing shortages in the history of American nursing. Five out of 15 hospitals had an all-RN staff, the median percent of budgeted RN positions filled was 96 percent, the ratio of RNs to occupied beds was 1.4 to 1, nurses had an average of eight years at their present place of employment, and turnover rates were very low with virtually all head nurses indicating that they could still pick and choose nurses who applied for jobs.

This one-third sample was again contacted in late 1989 for follow-up (Kramer, 1990), collecting data from telephone interviews with 14 of the 16 Chief Nursing Executives. These hospitals were still among the leaders; nursing administration and staff had successfully designed new and better methods of care.

The question that begs an answer is: "Why has turnover been such a serious problem?" Many possible reasons have been suggested, and some researchers conclude, according to Stamps and Piedmonte (1986), that absenteeism and turnover are both viewed as by-products of organizational problems. Many researchers believe further that autonomy for nurses is one of the most important organizational and professional issues (Cuddy, 1990; Harrison, 1987; Kramer, 1990; Larson et al., 1984; McClure et al., 1983; Mottaz, 1988; Stamps & Piedmonte, 1986).

Autonomy. Allen, Calkin, and Peterson (1988, p. 40) define autonomy as a measure of freedom an employee has to define his or her own tasks or projects, the methods or procedures used to accomplish those tasks, how problems or exceptions will be handled, and what criteria will be used to evaluate performance.

The Mottaz (1988) research is included here to highlight the autonomy issues. Mottaz studied job satisfaction and autonomy using the interactionist's model of job satisfaction to investigate the sources of work satisfaction for nurses and to determine the
way work rewards and values combine to influence work satisfaction. The model states that the greater the perceived congruence between work values and rewards, the greater the satisfaction.

The registered nurse sample for this study consisted of 312 full-time and part-time staff nurses from diverse clinical backgrounds in four hospitals. The nursing group was part of a larger study with seven other occupations. The participants were given a questionnaire consisting of work rewards and values identified from the literature: task autonomy (degree of self-directedness in task performance), task significance (degree to which the task is considered interesting and rewarding), supervisory assistance (degree to which supervisors are perceived as supportive and helpful in job matters), co-worker assistance, working conditions, salary, promotional opportunities, and fringe benefits.

Mottaz (1988) found that nurses placed great value on task autonomy, supervisory assistance, salary, and task significance, but stated that their jobs provided low levels of these items. They reported acceptable levels of task involvement, but only because task involvement is inherent in the tasks nurses do. Mottaz found that autonomous, meaningful, and interesting tasks appeared to have a strong and positive effect on work satisfaction. Because the nursing group reported moderate to low levels of work satisfaction, Mottaz says these results support the interactionist argument that workers assess their jobs primarily in terms of what they consider important in their jobs.

Mottaz (1988) believes that the outcomes of limited autonomy are twofold: (a) excessive reliance of nursing staff on daily supervision, and b) more time spent doing non-nursing tasks. The nurses in this study were very dissatisfied with the quality of supervision they received, the lack of management and leadership skills, lack of support available, little follow-through, and the abuse of authority. They attributed this situation to a failure of most educational programs and hospitals to provide nurses with the necessary management training. Johnston, cited in Mottaz (1988), determined that
nurses spend only one-third of their time on health-related activities, the rest is devoted to non-nursing activities. The result of less time spent on nursing activities is that nurses have less task involvement which in turn leads to decreased job satisfaction. Other reasons for limited autonomy are that most nurses work in hospitals where there are bureaucratic principles where division of labor is based on functional specialization, and a hierarchy of authority—a system of rules, regulations, and procedures tend to govern the task activities.

Hinshaw et al. (1987) believe that hospitals cannot continue to attract professional nurses to an environment in which control over practice and professional autonomy are not part of the system. Ashley (cited in Stamps & Piedmonte, 1986) even goes so far as to say that limiting nurses' autonomy is a classic case of the oppression of women. She notes that the prevalent misuse of nurses has been a major contributing factor to the widespread problems in the health care system, and she also gives a warning of exploitation of female labour. A doctoral thesis by Cahn (1987) asks the fundamental question: whether it is philosophically and ethically justified that professional nurses are prevented from practicing autonomously in health care institutions. Cahn states that the present structure of hospitals results in nurses experiencing “moral distress”—knowing the right thing to do, but being unable to do it because of institutional constraints. Nurses are required either to act unethically or to act ethically with some degree of risk. Cahn believes common constraints of practice to be illegitimate and unjust.

Autonomy in nursing practice ultimately requires an organizational environment that fosters those values of respect, trust, and recognition for a job well done (Benner, 1982; del Bueno, 1984; Kramer, 1990; Seebold, 1984).

Image of Nursing. The negative image society has of nursing and the poor image nurses have of their profession appear to be closely related to nurses' job satisfaction. Todd (1989) says that in the mid-1800s, society perceived nursing as a noble, religious
calling. This image peaked between 1930 and 1945 when nurses were seen as brave, rational, decisive heroines and portrayed in glamorous settings. Once women were not needed on the warfront, nursing was seen as excellent preparation for marriage and motherhood, until the mid-1960s. Kalisch and Kalisch (1985) found in the 1970s that society's television image of nurses tended toward more negative than positive. Nurses were portrayed as self-serving, demanding salary increases or better benefits. They were often being cast as sex objects—big-chested and empty-headed. There were few images found of nurses as dedicated, serious professionals, championing consumer rights to quality care.

By the late 70s, Chaska (1978) found that nurses' positive perceptions of themselves were withering. Porter, Porter, and Lower (1989) also identified that nurses had lower opinions of themselves than did either physicians or the general public. When the three groups were asked: "In a word, define your image of nursing," most nurses scored less on positive responses (72 percent) than did physicians (100 percent), and the general public (84 percent). Nurses' comments are worth noting: "overworked, underestimated, ignored, underrated, underpaid, disillusioned, indifferent, oppressed" (Porter et al., 1989, p. 38).

One of the supporting theories as to why this is so comes from Taves, Corwin, and Haas (1963). They believe that our vocational image is a by-product of: certain expectations we personally value, how we internalize those expectations into a particular role or vocational position, and how we perceive our occupation is endorsed by society. Based on this theory, Benne and Bennis (cited in Taves et al., 1963) found incongruence between the ideal image and the actual behaviour of nurses in their roles. Chaska (1978) says that role inconsistencies occur when either personal or societal expectations are incongruent.
Consideration must be given to why there are incongruencies among nurses’ self-image, job realities, and societal images of nursing. Chaska (1978) found that people in service occupations developed more idealistic expectations of performance than those in other occupations and that the type of basic nursing education program influenced how nurses perceived their image. Those from technical hospital programs had lower self-image, while those from the less technical college system maintained a positive orientation toward nursing. Chaska (1978) and Kramer (1982) also decided that nurses have been effectively socialized in their education program to develop almost a dual image of the role of the nurse, first what the education program wanted to portray, and then the reality of the job.

Taves et al. (1963) state that when similar role conceptions are not held by everyone, there is no clarity. This leads to self-conceptions that are ambiguous and ultimately, dissatisfaction results. Taves et al. contend that occupational images have played an important part within the culture for men at the expense of women. They believe that the male-dominated cultural “norm” has caused the women’s occupations to be considered lower status, therefore the power and prestige derived from women’s occupations is low.

Nursing is also in a serious internal conflict revolving around the definition of the field itself. Stamps & Piedmonte (1986) observe that although the nursing field defines itself as a professional one, many of these conflicts project a semi-professional character. Another reason Stamps and Piedmonte give for this semi-professional character is that in the 1960s and 1970s, various technicians took over some nursing tasks. They believe that for this reason and for reasons already stated, the role of the hospital nurse remains ambiguous—as a relatively subservient worker in the hospital bureaucracy with little control over his/her practice.
As the profession has struggled with its image, perception and role inconsistencies, socialization processes, nursing education and practice discrepancies, and role conflicts, the impact has been felt in recruitment of students and retention of nurses (Haines, 1990; Pringle, 1989). Aiken and Mullinex (cited in Porter et al., 1989) observe that interest in nursing as a career has fallen dramatically in the United States.

The two positions exist as they have for years: society has an ambiguous perception of nursing, and nursing has a poor perception of itself. The public is not going to appreciate or understand what nurses do if nurses cannot identify and verbalize their role (Porter et al., 1989), and, nurses must improve their own image as a group before they can move to a more professional position in health care.

Summary Statement

This review of literature on nurses' job satisfaction has not uncovered definitive answers; it has only uncovered some of the issues. While the existing literature contains many valuable clues regarding the nature and sources of job satisfaction among nurses, the findings tend to be inconsistent and confusing. The reasons for these inconsistent results are many: incomplete theoretical frameworks; faulty development of job satisfaction models; "thousands" of important variables identified; lack of universal definitions and meanings of job satisfaction; too much concentration on individual rather than organizational problems; narrow and simplistic explanations; differing philosophies of how work should be conducted; the conflict and turmoil resident in the nursing profession; lack of standardized or consistent measurement procedures; analysis done in a bi-variate manner when multivariate techniques would be of more benefit; the diverse frames of reference from which nurses come; and the varieties of organizational structures in hospitals.

A few conclusions can be stated from this review, however. One is that significant numbers of nurses have relatively low levels of job satisfaction compared to other
professional and non-professional occupational groups (Mottaz, 1988). Job satisfaction appears to be multifactorial, where all of the variables, whether they are called incentives, rewards, motivators, or satisfiers have to be tailor-made according to each individual nurse, based on the expectations nurses have of nursing and the value systems they bring with them (Hinshaw et al., 1987; Larson et al., 1984; Mottaz, 1988; Prescott & Bowen, 1987).

Job satisfaction and turnover specifically are more often related to organizational problems, than to individual employee problems, and turnover is controllable by the organization (Stamps & Piedmonte, 1986). The concept of autonomy appears to be extremely important to nurses' job satisfaction. Enhancing autonomy of nurses in the health care system will help keep hospitals well-staffed. Autonomy will only become reality in an organizational environment that fosters the values of respect, trust, and recognition for a job well done (Benner, 1982; del Bueno, 1984; Hinshaw et al., 1987; Kramer, 1990; Seebold, 1984; Stamps & Piedmonte, 1986).

One of the ways to achieve increased job satisfaction, less turnover, and more autonomy is to enhance the image of nursing. The profession's actions toward these goals must include nurses taking control of their destiny and deciding what they want nursing to be all about (Porter et al., 1989; Taves et al., 1963).

Clinical Competence

The AARN (1985) believes that as a discipline, nursing is dedicated to the advancement of knowledge that contributes to the pursuit of excellence of care. To that end, clinical competence, along with provision of safe and ethical care, is considered one of the main goals of organized nursing (AARN, 1984).

Butler (cited in Boss, 1985) defines competence in an objective way, as an ability to meet or surpass prevailing standards of adequacy for a particular activity. The notion of
competence for Butler includes not only job-related psychomotor skills, but also a well-rounded education that teaches nurses to apply integrated theories in a critical, scientific manner. In addition, Butler also includes values, critical thinking, clinical judgement and formulation of attitudes in the overall outline of what it means to be "clinically competent." For Benner (1982) competence is not necessarily a state of being or an outcome, it is a constantly evolving entity where the most important factor becomes how a nurse perceives his/her competence. To tie these two points together, Benner (1982) defines competence as a feeling of mastery and the ability to cope with and manage many contingencies of clinical nursing.

Benner's (1982) process-oriented model for competence development provides a workable and practical base from which to examine influencing factors of clinical competence as well as the issues involved. Benner describes clinical competence as a process of moving from a "novice practitioner," through "advanced beginner," "competent," to "proficient" and "expert." In Benner's model, the higher the level of performance, the greater the quality of care afforded to patients.

According to Benner (1982), the "novice nurse" or the "advanced beginner" lacks a significant amount of competence. She states these nurses are often: a) hired directly from their basic education program, or b) not had a great deal of experience, or c) treat their work as a job or task to accomplish, or a means to others' ends. Novice practitioners tend to have limited experience with the situations in which they are expected to perform. Benner states that both novices and advanced beginners usually carry out the psychomotor skills of nursing tasks in an acceptable manner, but this is where their competence ends. They require support in the clinical situation, not only in setting priorities, but also in using discretionary judgement for recognition of characteristic patient problems. Their patient care must be backed up by more competent nurses to ensure that important patient needs do not go unattended. In order to proceed
on the competence continuum, not only do advanced beginner and novice nurses have to perform psychomotor skills well, but they must also develop an organized approach to their work.

Nurses working at a competent level are starting the transition from advanced beginner to proficient level. Competency for this level is typified by the nurse who has been on the job for two to three years, and develops when the nurse begins to see his/her actions in terms of long-range goals, not simply a series of tasks to be performed. Competent nurses can organize their work, have some discretionary judgement ability, and recognize patterns with their patients, so they can start to anticipate future patient problems. The competent level is supported and reinforced institutionally, and many nurses may stay at this level because it is perceived as ideal by supervisors. Nurses can be "managed" at this level because they work within the rules set out through policies and procedures developed as standards of performance. Most inservice education is aimed at the competent level of achievement; few inservices are aimed at the proficient or expert level of performance.

Proficient and expert practitioners are nurses who have been nurses for a number of years, and have had experience with many patients and patient care situations. For these people, recognition and action come together, a skill developed from extensive experience (Benner, 1982). They develop a sense that not all patient situations "fit" into the rules set out in the established policy and procedure manuals. Intuition is something that these two levels of nurses have refined and upon which they rely—the expert nurse to a significant degree. Nurses at these levels of performance can problem-solve and make decisions easily; from past experience they can accurately choose what aspects of a situation upon which to spend the most energy. Because of the intuition and problem-solving skills these nurses have developed, individual patient care needs can be more effectively met. Benner contends that in order to develop enhanced levels of
competence, nurses need: a sense or perception of "where they are at," new challenges with patient care situations, professional issues, and/or ongoing education.

Factors Influencing Competence

Many factors affect clinical competence of nurses, among them: nurses' basic preparation and education, routinization of nursing practice, and changing demands of patient care situations on nursing skills and knowledge. According to Benner (1982), these issues relate to learning the practice of nursing and progressing through the levels of performance: learning the difference between being a technician and a clinician, becoming a practicing physiologist, becoming expert caring practitioners, and overcoming learning challenges.

Nurses' Basic Preparation and Education. The educational base for all nurses is not the same with respect to theory and practical components. Ritchie (1988) quotes Kitson on the importance of sound basic nursing education:

Of supreme importance is the educational preparation of the nurse. We are talking about practitioners who need to be able to analyze complex situations, who know how to integrate large chunks of information about different people and still be able to see the person at the other end. We are talking about autonomous practitioners, decision-makers, people who can change situations and improve quality of life for those with whom they come in contact (p. 35).

One of the nursing profession's difficulties is the great variation in the organization of basic educational programs (Pickett, 1990; Stamps & Piedmonte, 1986). For example, each province in Canada has developed nursing education programs reflective of its own post secondary structure as well as national trends (Richardson, 1988; Shantz, 1985). Despite the variations in the type and length of prelicensure programs, all graduates are expected to pass the same national examination, usually begin their nursing careers in the same kinds of nursing practice environments, and are required to perform similar duties (Richardson, 1988). These factors encourage the belief that there is no difference in the
competence of nurses prepared at various levels (Pickett, 1990) and that division of labour for nurses is drawn along educational lines, rather than functional arrangements (Stamps & Piedmonte, 1986).

A key component of nursing practice is the nurse’s ability to process information and make decisions, no matter where the nurse works. A number of researchers have found that there are profound differences in abilities. The National League of Nurses Task Force on Competencies of Graduate Nurses (1979) conducted a study of cognitive skills development and concluded that differences exist among graduates from different programs. The greatest differences were found to be in the cognitive domain; the greatest similarities in the psychomotor domain.

Results were interesting in an exploratory study regarding problem-solving skills related to the nursing process between two-year-prepared students and baccalaureate-prepared students (Orders, 1988). Orders compared 38 associate degree and 46 baccalaureate degree students on their individual performance using a case study, basing the evaluation on student choices in 22 predetermined competencies. The two groups scored comparatively on 16 of the 22 competencies, one competency was relatively the same in both groups, and of the remaining five, the baccalaureate students scored significantly higher in basic assessment, advanced nursing diagnosis, basic teaching, basic discharge planning, and basic identification of psychosocial planning competency. When the results were compared to similar information in the literature, neither group applied three of the four steps of the nursing process in ways that were congruent with the competencies expected. This information highlights another example of differences in basic nursing preparation that may have impact on nursing practice, and also further points to the gap between how experienced nurses use the nursing process problem-solving approach and how students use it.
Pardue (1987) examined differences in critical thinking abilities and decision-making skills among 121 associate degree, diploma, baccalaureate and masters'-prepared nurses. Decision-making skills were measured against: a) frequency of making decisions, b) difficulty in making decisions, and c) factors which affect decision-making. Pardue found no difference among the various levels of preparation. When decision-making skills were evaluated, she did find differences in critical thinking ability among nurses prepared at various levels of education, however, with the four-year-baccalaureate and the masters prepared nurses scoring higher than the two-year-college nurses and the two to three year hospital diploma nurses. In addition, when asked what the most important factors affecting decision-making skills and critical thinking ability were, most nurses from all of the groups commented that clinical experience experience was the first factor and knowledge was the second in helping them with their problem-solving skills (Pardue, 1987). These findings support Benner's (1982) ongoing research that: a) nurses at different levels of education and experience process information for patient care decisions differently, and b) that clinical experience is a prerequisite to expertise.

Routinization of Nursing Practice. Benner (1982) tells us that one of the threats to enhancing perceived clinical competence is routinization. Routinization can stifle and kill the inherent responsiveness that clinical competence requires. The standardization and routinization of procedures, geared to manage the high turnover of nurses, most often reflect Benner's competent level of performance. Kramer and Schmalenberg (1988a) observe that routinization occurs when rules are substituted for nursing judgements. They say that this causes a self-defeating cycle, since judgement can only be developed by using it.

Mauksch (cited in Yonge, 1985) wrote about a trend in nursing practice taking place in the late 1960s and early 1970s. At that time, nurses were told by others external to the
profession that their care was mechanistic, unfeeling and routine-oriented. According to Yonge (1985), after the shock has subsided nurses began to critically examine their role, the results of which were: a rise in primary nursing care, development of patient advocacy functions, use of the nursing process of problem-solving, development of the clinical nurse specialist role, and realization that nurses must use their nursing judgement and be accountable for their actions. Many of these functions have now become accepted aspects of nursing practice.

However, as recently as December, 1990, 20 years later, the routinization issues again became a topic. An editorial by Judith Banning appeared in the December issue of *The Canadian Nurse* regarding a recent nursing administration conference. Banning quoted Dorothy Wylie, who stated that she had serious concerns about the quality of nursing practice because too many nurses were practicing in a rule-driven, routinized manner, not always knowing the "why" behind their actions.

Further, Wylie (cited in Banning, 1990) noted that the structures of many nursing departments had changed to decentralization in an attempt to offer an alternative system to the overbearing bureaucratic routinized structure. With decentralization, systems of primary care responsibility, patient advocacy, and accountability can allow bedside nurses more autonomy and less routine. However, Wylie cited some serious effects for nurses from this move. She stated that unless nurse managers in decentralized systems had managerial and/or educative assistance, there was no time to offer educational opportunities to their staff and little time for coaching the professional nurses. With the absence of support for the nurses, bureaucratic routines, rituals, and protocols resurfaced. Some bedside nurses continued to feel isolated, unappreciated, and frustrated. Wylie went on to say that nurses in some settings were being dehumanized and treated as clones. For example, nurses may have been legislated onto hospital committees, where hospitals continue to pay lip service to nursing requests for input into decisions that affected them.
Allen et al. (1988) agree with Wylie and state that people have to perceive that their participation in decision-making in the organization has an impact. Role conflict and role ambiguity resulting from decentralization should be discussed and resolved constructively, not through increased routinization—an all too common tendency. Routinizing work leads to less variety, difficulty, and autonomy to the work and ultimately defeats the central purpose of decentralization (Allen et al., 1988).

Workload Demands on Nursing Skills and Knowledge. Benner (1982) states that increased acuity levels of patients, decreased length of hospitalization, and the proliferation of health care technology and specialization have increased the need for highly experienced, effective nurses. Moss and Curran (1987) state that on average patients admitted to hospital are more acutely ill than those treated on an outpatient basis. Accompanying the rise in severity of illness is the demand for highly skilled nurses to deliver complex nursing care. Boss (1985) states that today's nurses not only need knowledge and skills, but they must also be able to think critically, make important clinical decisions, and solve highly complex problems. As a registering and disciplinary body for nurses, the AARN (1985) has set an expectation for professional nurses to be committed to personal accountability, to the maintenance of high standards of performance, and to continued learning, because professional practitioners of nursing hold primary responsibility and accountability for the nursing care clients receive.

Gamble (1989) observes that while organized medicine will control what goes into the parameters of patient care, operation of the established parameters will largely be in the hands of nurses. He states nurses have done a very professional job of back-filling most of the vacuums left by advanced technology and specialization, yet the health care system has failed to recognize or reckon with nurses' expanded, changing roles.

McCloskey and McCain (1988) stated in their exploratory research that little attention has been paid in the literature to variables related to overall nurse competence.
In their research, which examines variables for newly employed nurses, they found that different types of variables affected perceptions of competence. Amount of experience was the best predictor of critical care skills, but the amount of education best distinguished top and medium performers. Career commitment, continuing education, job satisfaction and feedback were also determinants of overall perceptions of clinical competence. Short-staffing and the illness level of the patients negatively affected the nurses’ perceptions of their performance.

In another study, McCloskey and McCain (1988a) compared head nurses’ ranking of staff nurses' scores to the staff nurses' own rankings on 52 specific skills. There was remarkable correlation between the rankings, and one of the areas in which both groups needed improvement was with teaching/collaborating skills.

The teaching role in nursing is becoming more and more important. Many nurses in the magnet hospitals (Kramer & Schmalenberg, 1988a; 1988b) viewed teaching other nurses, patients, and other health care professionals as a fulfillment of their professional obligation; they saw teaching as an occasion for advancement of their own growth and perceived competence. In many of the magnet hospitals, teaching was one of the criteria for promotion in nursing.

Benner’s (1982) competence model is illustrated by Kramer and Schmalenberg (1988a) who found an interesting phenomenon. Among units with nurses who were stable, well-educated and possessed highly perceived levels of competence and confidence in themselves, the need for supervision was markedly decreased. In hospitals where the nursing practice environment was facilitative, more competent staff were able to work with fewer staff and often produced more and better quality nursing care because they were confident in one another’s abilities and trusted the work of their colleagues (Kramer & Schmalenberg, 1988a). Morath (1983) agrees and states that a “short-staff” stands a better chance of maintaining its integrity with a “real pro” working alongside and providing support.
Ethics. One of the aspects of perceived clinical competence that has become increasingly important in nursing is ethical reasoning. In the future nurses will find themselves relying more and more on their ethical decision-making skills. Crowley (1989) states that this is because of: a) increasingly complex patient care situations, increased technology, drugs, and procedures bring on more ethical and moral dilemmas, and b) the nursing profession is demanding more accountability, responsibility, and autonomy and with that comes more direct involvement with ethical and moral situations.

Interest in ethics for the nursing profession has been building over the years; however, the development of nursing ethics has not grown fast enough to keep pace with the changes in health care (Thurston, Flood, Shupe, & Gerald, 1989). Most professional nursing organizations have a group of ethical guidelines for their members, but these are usually general and need updating regularly. Johnstone (1989) conducted an analysis of the literature from 1966 to 1988 and noted that a paradigm shift is taking place; the scientific model has gradually been replaced by a model based on the concept of holism. Johnstone noted that the ideas representing a holistic paradigm of health appear with increasing frequency in the journals in the nursing field, demonstrating the diffusion of a new, refreshing, and different perspective in the practice of nursing. Along these same lines, Raatikainen (1989) is concerned that if nursing ethics are not examined quickly, and a nursing theory of ethics is not designed and used by nurses, the technology, the hospital bureaucracy, and specialization in nursing may curtail the observance of humanness in nursing.

Johnson (1990) and Omery (1989) caution that despite receiving some educational background in ethics, some nurses may still not be clear on the important differences among values, moral reasoning, and ethics. In Omery's view, values and moral reasoning reflect the "is" of everyday situations with which nurses are faced in their practice,
whereas ethics represents the "ought" or "should" of ideal nursing practice. Lyneham (1988) states that nurses need to first examine personal values and then develop professional values; moral and ethical reasoning can take place after values have been examined.

One of the larger problems reported in the literature now is that theory development in ethics is lacking. Many writers speak of the urgency in addressing this issue. Nursing has always had a moral foundation, but Crowley (1989) for one, believes that the profession has to clarify this again and develop a theory of nursing ethics. Fry (1989) believes that nursing ethics are necessarily different from medical ethics and the nursing profession needs to clarify and solidify them as a means of accountability in the profession, and that the development of nursing ethics may not progress along the same lines as biomedical ethics, because the value foundations of nursing ethics are derived from the nature of the nurse-patient relationship. Since professional ethics leads to integrity of nurses as practicing health professionals, ethics specific to nursing must be developed (Fry, 1989).

Fenton (1985) states that nurses in clinical practice are frequently confronted with situations that challenge personal moral beliefs and their perceived clinical competence in dealing with ethical dilemmas. Life and death events, sudden unexpected emergencies, and professional role conflict have been identified as some examples of the kinds of situations that are most difficult with which to cope. Johnstone (1989) also relates that in nursing practice there are instances where the nurse may not agree with a given medical order or prescribed treatment. In such instances the nurse may: a) refuse to carry out orders, b) decline to care for that patient, or c) go along with it. Justification for refusing to carry out such orders may not seem defensible given the hierarchy of the hospital. Declining to care for the patient is not favoured either by nursing colleagues or the hospital bureaucracy.
Fenton (1985) talks of the consequences for nurses who are in these awkward positions. Moral distress results, identified as the feelings of emotional distress that may occur as a result of participation in a patient care situation involving an ethical issue. Personal and professional wholeness may be significantly compromised by an ineffective resolution of such issues. This lack of resolution may even affect the nurse's perceived competence in caring for the patient. In fact, Fenton says that these moral dilemmas are also identified as one of the reasons that nurses choose to leave their jobs and occasionally leave the profession. The situation will only be made worse if nurses do not feel they are competent in dealing with moral and ethical situations and if the professional issues such as autonomy are not examined carefully.

Summary Statement

The section on clinical competence in this literature review has only touched the surface, simply opening the windows to much more nursing literature in the future. Old assumptions still prevail about clinical competence and nursing practice. The biggest assumption is that a nurse is a nurse is a nurse. Hand in hand with this goes the assumption that nurses at all levels process information and problem-solve in the same manner. Another major issue highlighted in this section is the notion of perceptions of clinical competence versus actual clinical competence, and the fact that evaluation of clinical competence is often based on subjective, perceived levels, rather than on standards-based evaluation. The literature also states that some people leave their jobs on the basis of perceived competence.

Conclusions drawn from this section of the literature review are important. Nursing is indebted to the research conducted by Benner (1982); it is becoming more apparent that clinical competence is a process of development, that no new nurse possesses expert nursing skills immediately, and that "proficient" and "expert" nurses can offer more effective care to patients. Benner (1982) believes that with enough determination,
education, and experience, we will one day be able to more clearly understand and share information from "expert nurses" and how they carry out their valuable work.

The question then becomes one of how to develop more nurses at the "proficient" and "expert" levels. The problem is that there are a number of factors that impede this process from occurring. The first is the differences in basic education that nurses receive, for no two basic nursing programs in Canada are the same (Pickett, 1990). Although the written examinations for nursing graduates are the same across Canada, the educational and experiential preparation are not consistent. Second, in bureaucratic organizations it is relatively easy and efficient to routinize the tasks of nurses. Rules are quickly substituted for nursing judgements, and a relatively non-progressive level of nurse competence is perpetuated, allowing little if any room for the more expert nurse to develop. Third, the scope and area of nursing practice is changing. This change requires nurses to deal with increased acuity levels, increased technology, and specialization. These kinds of situations require more and different education including a solid background in patient teaching skills, a self-awareness, and a close examination of personal values in order to develop sound ethical reasoning.

Based on the clinical competence information and associated problems outlined in this section, effective ongoing education is desperately needed to help nurses provide high quality of care to their patients.

**Patient Satisfaction**

Perceptions that patients obtain appropriate care to meet their needs is one definition of patient satisfaction that Ferguson and Ferguson (1983) use. Thorpe (1981) defines patient satisfaction much like Kramer and Hafner (1989) define job satisfaction as: "A relative sense of well-being, contentment or pleasure with regard to an individual's subjective experience which may be intrinsically or extrinsically stimulated" (p. 96).
Pelliter's (1985) definition of patient satisfaction refers to an individual's attitudes toward the health services in which he or she has been involved. Its measurement assesses the extent to which such services gratify the wants, wishes, and desires of patients.

Patient satisfaction can be viewed as one facet of the overall quality of care a patient receives, and for this project, will be the focus. As the assessment of quality care has become increasingly important in health care, patient opinions have increasingly been sought.

Contextual Background for Patient Satisfaction

The concept of patient satisfaction with care has evolved from two main directions, that of the quality assurance movement, making quality of care the most important goal and secondly, the increasing economic imperative that service driven operations become "more businesslike." These two perspectives logically focus significance on the consumer of the health care system—the patient.

A clear, concise definition of quality of care is hard to find. Most often quality of care is either an assumed entity or is referred to indirectly in the literature (Simpson, 1985). Hinshaw, Schofield, and Atwood (1981) provide seven characteristics of quality care: a) personalized care, concern for feelings, reaction to patient condition, b) source of information, c) competency with technical skills, d) competency with medications, e) cooperation with others, f) creativity, and g) personal liking for colleagues. Wilensky (cited in Hinshaw et al., 1981) adds that quality of care uses characteristics that reflect a valuing of competency in the health care field, based on a systematic knowledge acquired through professional education as well as adherence to a specific set of professional norms.

In the document, *A Long Range Plan For Quality Assurance In Nursing*, the AARN (1986) outlined the significance of quality in care by referring to the increasing complexity and diversity in trying to meet client needs. The AARN (1985) states that an
adequate quality assurance program for any health care institute requires a mechanism by
which patients can subjectively report and evaluate the basic nursing care they receive. 
Although patient perceptions are naturally only one of many considerations in a quality 
assurance program, the area is supported by more and more authors as a valuable part of 
a well-planned and integrated quality assurance program (Ferguson & Ferguson, 1983). 
Carey and Posavac (cited in Levin & Devereaux, 1986) support the validity of patient 
perceptions of care as main variables in programs and services.

Similarly, economic growth and opportunity in the United States now resides with 
service industries (Allanach & Golden, 1988). Service management is an extremely 
important element; the demand for services to be run like businesses is growing due to 
the finite amount of fiscal resources available in health care. This situation is projected 
to become more acute as we face the twenty-first century. In business, the rules are 
simple: “the customer always comes first” and to give the customers what they want, 
you have to know them very well; if you define your business too broadly, you lose 
touch with your customers’ needs and you soon lose you customers (Tarkenton & Boyett, 
1990).

The motto “make meeting or exceeding you customers’ expectations of your service 
the one a-d only definition of quality” (Tarkenton & Boyett, 1990, p. 18) has become 
increasingly important in the health care service. From the research done on the 
excellent companies in the United States (Peters & Waterman, 1982), quality requires the 
placement of all company resources behind the customer service. In the hospital, Parrish 
and Cleland (1981) believe that support to enhance “customer service” comes from 
nursing department efforts to create a facilitative nursing practice environment.

Kramer (1990) found that in the magnet hospitals there was an all-encompassing 
zeal for quality. A number of areas stood out with respect to quality: a) these hospitals 
were known for giving “good patient care,” b) there seemed to be a fanatical zeal for
caring about nurses; the staff nurses were treated like the one essential, irreplaceable link in delivering quality patient care, c) excellent employee relations mirrored excellent customer relations, and d) the immediacy of cooperative, goal-directed problem-solving was apparent at all levels of nursing.

As an example, in interviews with nursing department personnel at the magnet hospitals, staff nurses referred to quality of patient care as “planned, competent, effective, high standard, comprehensive, and personalized, continuity of care for each patient” (Kramer & Schmalenberg, 1988b, p. 14). Kramer stated in her 1990 follow-up article, quality of patient care, as described above, was evident as one of the core institutional values. Kramer (1990) found that the definition of quality of patient care often described by the staff was clarified as quality through: a) creativity, b) innovation, c) autonomy, d) competence, e) pride in themselves, and f) pride in their work. Hinshaw et al. (1987) agree with Kramer and state that quality of care depends to a large extent on the knowledge, skills, and attitudes of practicing nurses.

Quality of care is affected by many variables. Besides the variables of institutional values, attitudes of nurses, and nursing department commitment outlined previously, Mottaz (1988) found that if nurses lack experience, quality of care is seriously decreased. Turnover of staff also affects quality (Kramer, 1990). Hinshaw et al. (1987) believe that an environment where nurses can grow and thrive professionally will positively impact quality of care and how nurses perceive themselves and/or are perceived by others. This situation is exemplified in the magnet hospital research.

Research has also demonstrated a direct link between nurse autonomy and quality of care (Brook, Kumar, & Brown, 1986; Knaus, Draper, Wagner, & Zimmerman, 1986). In addition to this, Hinshaw et al. (1987) believe that dissatisfied nurses negatively affect patient compliance with teaching, linking the concepts of job satisfaction and patient satisfaction.
Patient Satisfaction Issues

A general increase in concern for accountability and efficacy in the provision of health care services has led to recommendations that patient satisfaction with such services be systematically monitored (Pelliter, 1985). There are a number of issues related to patient satisfaction. Three will be addressed here: the nature of the helping relationship, communication, and methodological issues.

The Helping Relationship. For Gilpatrick (1989), comprehensive management of health and illness includes focusing on the physical, emotional, psychosocial, and spiritual aspects of the individual. A significant degree of patient satisfaction with nursing care then means that nurses must possess good skills in dealing with all of the needs of the patient.

Just as job satisfaction is an individual concept for nurses, patient satisfaction is very much individual for patients. Some patients take serious responsibility for their state of health, while others prefer to have health care professionals direct them through the system. Some patients take no responsibility for their state of health, because they cannot or do not want to do so. Each patient perceives the health care system and their role in it differently.

Allanach and Golden (1988) examine how patients’ perceptions are affected by their ability to understand the uncertainties of health care or their lack of general information related to their own care. They identified 14 categories from the literature by which patients perceive care: accessibility, amount of care and time spent with the patient, assistance with pain or mood, availability, communication of information related to the patient condition, continuity, efficacy, physical environment, professional knowledge, promotion of autonomy, reassuring presence, recognition of individual qualities and needs, surveillance, and technical quality. The nurses in Allanach and Golden's study
met patient expectations on only two points: “knows how to give shots, start IV lines, manage equipment” and “knows when to call the physician,” highlighting the importance patients place on technical quality and surveillance.

One of the more interesting aspects of the Allanach and Golden (1988) study is the patient selection criteria. They screened out everyone except those who had: full pay coverage by comprehensive health care plans, the ability to read and to write in English or other languages, evidence of high school education or an equivalent level of knowledge, physical and mental capabilities to complete the survey, adult patients who were not transferred from ICU, who were not neurologically, psychologically, or chemically impaired. This results in almost 69 percent or 60/110 patients who were excluded from the study criteria. These criteria are often typical of patient satisfaction surveys, but as evidenced, do exclude a significant amount of the health care consumer population.

One other point may have affected the results: many of the 26 patients had had numerous previous hospital admissions and could compare this last admission with a nursing shortage to the pre-shortage era. Another significant finding was that most of the patients could not identify the nurse caring for them on the evening and night shifts, but could identify the head nurse and their primary nurse, mainly because the nurses did not introduce or identify themselves to the patients.

From their research Allanach and Golden (1988) recommend that nursing administration decisions in relation to nursing care should be based on patients' valuing of nursing care and their perceptions of these behaviours as meeting their expectations. They found that the value patients assign to the care they receive is of paramount importance in how the patients perceive quality of care. Allanach and Golden advocate the need for instruments that measure both patient perceptions of caregiver behaviour and patients' current frameworks of expectations concurrently, so that quality of care can
be congruent with patient values. This knowledge may have a great influence on the hospitals of the future. Doering noted (cited in Allanach & Golden, 1988) that patient satisfaction with nursing care was more strongly associated with overall satisfaction with the hospital than any other aspect of hospitalization.

In a patient satisfaction survey done by Simpson (1985) both age and sex of patients affected levels of satisfaction. Simpson reported on the results of the last 12 months of a two-and-one-half year study on whether the acquisition of patients' perceptions of nursing care would aid the assessment of the quality of care delivered. She designed a 27 item questionnaire, with each question on a four-point Likert scale with unequally weighted numerical values. Eight hundred and fifty questionnaires were sent out and although there was only a one-third return rate, Simpson found that in addition to a sex difference, the youngest age group (15 to 30 years) perceived the highest quality of nursing care and the oldest age group (76 years and over) the lowest.

Elfert and Anderson (1987) found that parents of sick children expected the nurses to do for their children the things they were not able to do for themselves. For this study 31 families in the Vancouver area with children having long-term problems were surveyed. Parents of these families were interviewed on a wide range of topics such as: the process of diagnosis, treatment, management, and the effects on the child and the family. One hundred and eleven statements about nurses and nursing were identified and grouped into major categories and fit under the following three headings: a) provision of direct care or assistance, b) giving information or teaching, and c) provision of emotional support.

Families felt best about nurses when nurses initiated contact with families and then became aware of the problem. Assistance was viewed as positive by families especially when they perceived nurses as knowledgeable and helpful. The largest group of positive statements about nurses (40) was in the category of giving information and teaching.
The families often used nurses to help clarify what physicians were saying (Elfert & Anderson, 1987).

The biggest area for patient dissatisfaction with nurses came with the nurses being too busy for the patients, with patient comments that there were too few nurses to do the work. The patients did not appreciate the results of short-staffing either: the occasional non-supportive attitudes of the nurses, their short tempers, how insensitive they seemed, and how they sometimes argued with the patient on how the patient was feeling. In addition, the families expected to be listened to sympathetically, but stated the nurses were too busy for that.

Elfert and Anderson (1987) also found that paradoxically, families of these pediatric patients had a view that the support from nurses was considered an unusual nursing function yet they valued and cherished the personal relationships they developed with some nurses and reported increased satisfaction with these nurses. Some parents also considered certain nurses to be more knowledgeable and better resources, while there were others whom they considered did not know much. This finding was attributed to the educational backgrounds of the nurses in the study who ranged from staff nurses to clinical nurse specialists.

As patient satisfaction surveys have become more and more common, it has been noted that there are significant differences between patient perceptions of quality care and provider perceptions of quality of care (Allanach & Golden, 1988). Despite the individual differences among nurses and among patients, one of the key factors necessary for positive patient satisfaction is the relationships patients have with nurses.

Communication. One of the big issues in patient satisfaction is communication. Few studies have assessed the communication process with respect to information needs, expectations, and requests of patients. When the communication process is examined with respect to patient satisfaction some interesting discoveries are made. Despite the
lack of sound methodological inquiry, a common discovery of many studies is that patients have not been given information about their health status and nursing care measures (Thorpe, 1981), which can lead to patient dissatisfaction (Altschul, 1983). According to the Consumer Rights in Health Care (1974), patients have an unquestionable right to the very information they may not receive.

It also appears that a smooth communication process on the part of the nurses is altered depending on the topic of conversation. Altschul (1983) describes the paradox of patients wanting to talk, but staff being reluctant to listen, especially where emotionally charged topics are concerned. She speculates on a few reasons for that situation: a) nurses have noble intentions of not wanting to bring up painful subjects, so that the patient does not have to suffer, b) nurses would like patients to talk freely, but have not learned how to encourage patients to do so, c) nurses are still struggling with the old myth that feelings are unimportant and that patients' opinions are not valid, and d) the nurses themselves may not be comfortable talking about painful subjects. With respect to nurses' learning about good communication, Altschul finds that nurses are also more dissatisfied with their own communication skills in recent years.

Altschul (1983) reports on another paradox on the part of the patients. Even though patients experience high levels of dissatisfaction with communication from nurses, they are also very conscious of nurses' situations and will do their utmost to protect the nurses whom they like and respect. When asked about their levels of satisfaction, patients will choose concrete objects like nursing unit noise, meals, privacy, and clothes to blame for their dissatisfaction instead of the real issues—the level of psychosocial nursing care they are receiving. When questioned about why they criticize the physical amenities, the patients state that they are reluctant to criticize the nursing staff because of fear of retaliation, so they choose something else less threatening to blame.
For example, in one of the studies on patient rights, Pankratz and Pankratz (1974) investigated nurses' views regarding autonomy for themselves and their patients. This study was replicated later in Canada by Green (1978) and the results of both studies are similar. Those nurses who worked in administrative positions or in educational/community settings and who had completed a university degree appeared to be more assertive regarding patient rights than those nurses without a university degree and who worked as staff nurses in a hospital setting. In fact, Green (1978) reported that the staff nurses were in need of role models and much support if they were to actively maintain patient rights within the hospital setting.

In her article, The Consumer's Voice: Nursing Implications, Altschul (1983) states that nurses think they know what patients need, but if nurses are to plan care of high quality, they need to consult the patient. Altschul (1983) reports that patients listed "not being given an opportunity to voice an opinion" as their biggest dissatisfaction (p. 180). She concludes that patients need to tell their story and finds, for example, that people learn to cope with losses of any kind by talking about their feelings.

This finding fits with Herzberg's (1976) Dual Factor theory, where people who express satisfaction tend to talk about feelings of personal growth, achievement, and belonging. People who talk about the causes of dissatisfaction often mention such things as physical amenities, working conditions, and environmental factors. According to Herzberg, to improve physical amenities does not increase satisfaction, but to increase opportunities for personal growth causes complaints of physical condition to disappear. These findings add complexity to the nurse-patient relationship, and to the methodological challenges required in obtaining accurate data about patient satisfaction.

Tabak (1987) conducted a review of the literature, examining information exchange between health care providers and patients and found that exchange to be very important. She found that the ability to receive and provide information during health care visits
affected patient satisfaction with care more than any sociodemographic characteristics of patients.

Lau (cited in Tabak, 1987) interviewed 44 parents of pediatric patients; she found that 94 percent of parents expected the physician to discuss psychological information. Their expectations of receiving information about physical symptoms were met 98 percent of the time as demonstrated by tape recorded visits, while only 29 percent of the expectations of psychosocial discussions were met. Lau found that while a small amount of unfulfilled expectations about physical/biological information was not related to patient satisfaction outcomes, the unfulfilled psychosocial expectations correlated significantly with patient dissatisfaction on post-visit questionnaires.

Tabak (1987) states that at its best, the information exchange between patients and caregivers may result in close adherence by the patient to treatment or behavioural guidelines. The more serious consequences can result in fair or poor patient compliance. As Tabak (1987) puts it, when patients choose not to follow medical advice, it is often because they feel their own perceived needs are not being met.

There are also some extremely critical implications regarding communication. One current aspect in health care that underscores the critical need for accurate and timely information exchange is the availability of technological alternatives for patients. Patients may have clear opinions and concerns on which they base their preferences and choices. Yet they frequently do not provide information regarding their preferences to health care professionals or their families before decisions are made. Bedell and Debanco (cited in Tabak, 1987) examined the issue of cardiopulmonary resuscitation (CPR) in hospital. Many patients state, before the fact, that they would prefer not to be resuscitated. In a study of 157 physicians of 154 patients who had been resuscitated after cardiac arrest, 68 percent of the physicians had decided for their patients about resuscitation; some patients were resuscitated against their previous wishes. Only 19
percent of those patients had previously stated their wishes to the physician about not wanting resuscitation. As evidenced here, the differences in perceptions of patients and physicians about information exchange can clearly affect the course of treatment.

**Methodological Issues.** Thorpe (1981), Pelliter (1985), Tabak (1987), and Allanach and Golden (1988) expressed concerns with both the theoretical and methodological aspects of patient satisfaction. Conceptualization of satisfaction appears to have been, and remains, a difficult task for researchers. From a theoretical point of view, Thorpe (1981) states that even the construct of "satisfaction" does not appear to have been well formulated and measured in health care research. She speculates this is partly due to the complex nature of the construct. Thorpe found that, with few exceptions, researchers in the health care field(s) seldom offered a definition of the term "satisfaction" in their work. When a definition was included, Thorpe (1981) and others (Locker & Dunt, 1978; Tabak, 1987; Ware, Davies-Avery, & Stewart, 1978) noted a general lack of consistency in labelling the concept. Pelliter (1985) agrees and advocates conceptualization and operationalization of the term patient satisfaction before any measurements are done.

Thorpe (1981) furthers her point regarding poor conceptualization by saying that the lack of theoretical development for patient satisfaction may be at least partially explained as a consequence of the ongoing argument of whether or not patient opinion is important, as long as health care meets at least minimal requirements and standards. Much criticism has been voiced by health professionals about the patients' "technical competence" to assess nursing care or health services. Indeed, the concern is central to the determination of validity of a measurement device. The problem seems to be with the philosophical positions people hold, whether they be paternalistic or consumer-driven. The trend since Thorpe's work in 1981 has been to include the patient or consumer opinion.

As the years go by, despite lack of conceptual consistency, more and more literature is supportive of the value of patients' perceptions (Carey & Posavac cited in Levin &
Devereux, 1986; Ferguson & Ferguson, 1983). Thorpe (1981) feels that patients are entitled to comment on the expected relationship between the nurse and the patient, especially in the area of patient rights. Patient rights focus on four areas: the right to be informed, the right to be respected, the right to participate and the right to equal access to health care (Consumer Rights in Health Care, 1974). Further rationale for this position is that if a patient's rights are maintained, it is anticipated that the patient would be satisfied with the nursing care provided (Thorpe, 1981).

Pelliter (1985) concurs with the validity of assessing patient perceptions about their care, but also cautions researchers or program evaluators about some conceptual and methodological barriers to the collection and interpretation of patient satisfaction information. These barriers include: carefully describing and operationalizing the particular definition they are using, constructing valid and reliable questions, standardizing measures for comparison purposes, obtaining representative samples of patients, dealing with clients' reactivity and researcher demand effects, and interpreting statistical and/or qualitative findings. Pelliter (1985) states that from his search of the literature, specific measurement applications have developed along three lines: a) a narrow stance, using a single question or a few questions to capture a global rating of overall satisfaction, of all patient care generally; b) multi-term questionnaires which include a wide range of factors assumed to be indices of satisfaction; c) both specific multi-faceted rating as well as global ratings. Pelliter observes that patient satisfaction may indeed mean something different in each study done.

With respect to a standard approach to the measurement of patient satisfaction, Lebow (1974) and Linn (1975) suggested that several issues have hindered the development of a standardized approach to assessing patient satisfaction. First, the populations studied have varied from in-patient, to out-patient, to community populations. Closely linked, yet distinct from the different populations studied are the
diverse settings within which health care services were provided (Lebow, 1974, p. 328). The dissimilarities among populations and settings appear to greatly impede construction of a universally adaptable patient satisfaction measurement tool.

Many studies which examine an "overall satisfaction" rating have found a consistently high positive response rate, despite the methodological problems. Results have ranged from 67 to 100 percent (Thorpe, 1981) and 75 to 100 percent (Pelliter, 1985), indicating satisfaction. Pelliter recommends that if a program or service does not achieve that traditional high degree of approval from patients, it should be examined more closely for its impact on patients.

Thorpe (1981) found that the traditionally expected responses of high satisfaction were found on the written survey she did, although patients stated verbally that they were dissatisfied with certain aspects of the care they received. This corresponds with the paradox Altschul (1983) described earlier. Thorpe recommends that specific instances of satisfaction/dissatisfaction be examined to provide more helpful feedback.

Pelliter (1985) raises another very important point with respect to patient satisfaction, that satisfaction may be unrelated, or in some instances, negatively related to therapeutic effectiveness. Very little research has been undertaken in this area, yet despite this gap, it does appear that how much patients take advantage of the treatment, or conversely, prematurely terminate the treatment regime are at least partly the result of perceived levels of patient satisfaction (Tabak, 1987).

Summary Statement

Consumer satisfaction, whether it be from a business perspective or a health care perspective has become a major focus, however, patient satisfaction (on the health care side) is as complex and multifaceted as job satisfaction.

The fact that the concept of patient satisfaction is so complex is a contributing factor in the theoretical and methodological difficulties that many researchers have faced,
particularly with conceptualization and operationalization (Pelliter, 1985; Tabak, 1987; Thorpe, 1981). In addition, many people in the health care system still believe that patients are not competent to assess nursing care. There is a persistent developmental lack of valid and reliable questions to measure the concept of patient satisfaction, and for standardized measures to compare and interpret results. Patient satisfaction may indeed mean something different in each study.

Patient satisfaction may also be internalized differently for each patient, because of the value each patient places on their care (Gilpatrick, 1989). For example, Tabak (1987) found a link between patients terminating or taking advantage of treatment in the health care system and their level of satisfaction with the professional care they either perceived or had experienced in the system.

The helping relationship between the patient and the nurse is so important. Nurses are the first line of help for patients in hospitals and have a significant position in the lives of patients for emotional, physical, and educational support. The goal of quality care for patients is to enhance “customer services.” This process comes from nursing departments’ efforts to create a facilitative nursing practice environment, so that patients will be cared for in a nurturing manner. Patient perceptions and nurse perceptions about care of patients and their needs may be different, therefore communication becomes a very important issue (Allanach & Golden, 1983; Altschul, 1983; Tabak, 1987).

There are some conclusions that we can extract from this section of the literature review. One is that far more work is necessary on the concept of patient satisfaction. The literature also identifies a relationship between quality of care and the experience levels of nurses (Benner, 1982; Mottaz, 1988). Similarly, there is also a connection between quality of care and turnover (Hinshaw et al., 1987) and quality of care and nurse autonomy (Broten et al., 1986; Knaus et al., 1986). Indirectly, Hinshaw et al. discovered a relationship between patient satisfaction and job satisfaction of nurses. Further investigation may illuminate the exact nature of these relationships.
An Overall Picture: Quality of Work Life

The topic of quality of work life encompasses each of the three main issues of this research project: job satisfaction, clinical competence, and patient satisfaction with care, and affords an excellent way to tie these three issues together. Canadian studies in particular have focused on the umbrella term “quality of working life” more often than the separate issues of job satisfaction and turnover. This section will also highlight some studies from the Canadian perspective.

The term “quality of work life” refers to “systems, programs, or techniques through which organizations and jobs are designed to give workers more autonomy, responsibility and authority, and to make their work more satisfying” (Jenkins, 1981, p. 7). The quality of work life concept strives to balance the needs of the employee with the needs of the organization (AARN/AHA, 1985). According to Bowditch and Buono (1982) a number of diverse and complex themes fall under the general title “quality of work life”: a) adequate and fair compensation, b) safe and healthy working conditions, c) opportunities to use and develop personal capabilities, d) opportunities for continued growth and security, e) social integration in the work organization, f) constitutionalism in the workplace, g) work and total life space, and h) social relevance of work to life.

The Canadian Nurse (1991, p. 4) reports that the issue of quality of work life for nurses looms as one of the most significant management issues today, and that there is now a large body of research findings that reveal that professional nurses’ quality of work life has direct correlation with their job satisfaction, work production, recruitment, retention, and ultimately, the quality of patient care.

The Professional Practice Environment

One theme that has surfaced in the literature not only on clinical competence but also on job satisfaction is the extent to which the work environment permits nurses to use
their professional knowledge and skills. In 1990, the Canadian Nurses’ Association (CNA) and the Canadian Hospital Association (CHA) undertook a large research project to analyze 23 reports dated from 1987 and 1989 on quality of work life issues from provinces across Canada. The purpose of research was to synthesize data to provide a national perspective on professional practice environments and identify areas for action. British Columbia offered six studies, Alberta three, Ontario submitted five, Quebec had four, New Brunswick contributed two, and Newfoundland one.

All of the studies agreed that poor working conditions were (and still are) driving nurses out of the profession. The findings clearly indicated limited attention has been paid to the growing dissatisfaction among nurses over the past decade. From the analysis, factors causing dissatisfaction were: lack of adequate staffing, too many non-nursing tasks, lack of involvement in organizational decision-making, lack of educational opportunities, and lack of flexible work schedules. Other key issues were inadequate compensation, limited autonomy in professional practice, and lack of respect from other health care professionals for nursing’s contributions to the care of patients. A notable observation was made that across Canada the 1987-1989 studies reported few differences from the reports in 1980 and 1981, except that the frustration level of nurses was greater.

Data gathered from the CNA/CHA (1990) sources indicate that an environment which enhances the quality of work life for nurses promotes: a) collegiality between nurses, other health care workers, and administration; b) recognizes and respects the contribution of nurses; c) involves nurses in decision-making; d) fosters a spirit of inquiry; e) protects and promotes health care of clients; f) supports quality nursing care; g) fosters professional growth; and, h) facilitates continued learning. Research also denotes that the specific conditions in work environments necessary for nurses’ personal and professional quality of life, health and wellness, occur when management philosophies are participatory in nature, compensation is commensurate with experience
and responsibility, schedules are flexible, and adequate support services are available to enhance nursing services (Canadian Nurse, 1991, p. 4; CNA/CHA, 1990; Cuddy, 1990). These findings concur with the work of Hinshaw et al. (1987) and Mottaz (1988) related to autonomy.

There were a number of recommendations made in the CNA/CHA report (1990). One of the major recommendations called for was improved communication, specifically to keep all staff informed and to delete the hospital hierarchical culture of lines of communication, paying more attention to two-way communication.

In another study, Spicer and Macioce (1987) agreed that if communications travel through many levels, there is danger of considerable distortion. Harrison (1987) also agrees that flattening the nursing organization would give those at the operating level greater freedom and discretion in scheduling their work activities and in deciding how to most effectively and efficiently meet their challenges. Porter et al. (1989) advocate development of programs to enhance communication skills for nurses with patients and other health care team members.

Effective communication skills held by nurses and managers are also a high priority within organizational structures that allow decentralized decision-making, facilitating valid, reliable exchanges (CNA/CHA, 1990). This finding is illustrated in a study done by Peck (1988) to explore the concept of “fit” and the role of the head nurse in unit performance and staff satisfaction. Peck found that a relationship style of leadership was associated with units that performed well. Mottaz also reported this management issue in his research and stated that nurses were very dissatisfied with the quality of supervision they received. They attributed this situation to a failure of most education programs and hospitals to provide nurses with necessary management training.

The CNA/CHA (1990) research recommended, as did that of Mottaz (1988), that there be more time available for nurses to do direct patient care. This reality was
envisioned through: pilot projects on clinical laddering, exploration of independent consultants in the nursing practice, health insurance expansion to pay for nurses' services, nurses becoming members on hospital boards, mandatory internship for all nursing graduates, and a more realistic base for nursing education. Stamps and Piedmonte (1986) agree, but caution that nurses then often find themselves supervising ancillary staff rather than performing skilled tasks. They cite Christman and Jelinek who state that an estimate of only 25 to 50 percent of nurses' professional skills are ever used.

In examining the quality of work life relationship between job satisfaction and competency or productivity, Kramer and Hafner (1989) compared the impact of shared values among different levels of nurses in the nursing departments of several United States hospitals. Significant findings were: (a) staff nurses needed as clear a picture as possible of their role and responsibilities, so that they could do their jobs efficiently and in turn have job satisfaction; b) where staff nurses were highly respected and acknowledged for their own unique contribution to patient care, job satisfaction increased; and c) reported important factors in the staff nurse role by the head nurses, clinical experts, and top managers did not match or even come close to what staff nurses thought was important. Unlike the others, the staff nurses unequivocally listed working with competent staff at the top of their list. Many of them wrote that there was no way to explain how important that factor was. The conclusion that Kramer and Hafner (1989) came to was that the nursing departments would have to focus their efforts into areas that the staff nurses identified as extremely important, such as clinical staff development; otherwise their efforts would be ineffective.

The research from Larson et al. (1984) and Mottaz (1988) highlight the same point as in the Kramer and Hafner (1989) research, that when hiring, nurses need clear role and responsibility guidelines. They say that every nurse should be made fully aware of all of the duties required, responsibilities and authority associated with the job, in order to avoid unrealistic expectations that lead to job dissatisfaction.
The literature abounds with articles on how specific nursing care delivery systems enhance job satisfaction for nurses, because they enhance autonomy (Harrison, 1987; Jones, 1986; Morath, 1983; Mottaz, 1988). For example, in the magnet hospital study, nurses were in favour of primary nursing concept, or total care of a group of patients (McClure et al., 1982). McClure et al. report nurses wanted and accepted the concept of 24-hour accountability for their patients in a setting where they could exercise their responsibility for meeting the total needs of patients and could evaluate the results of their practice. This was certainly a recommendation in the CNA/CHA (1990) report.

Some people advocate a clinical laddering system as part of a professional practice environment (Barhyte, 1987; Krawczyk, 1988; Sanford, 1987). Without an accepted professional development model, Sanford (1987) warns that nursing has left itself vulnerable to institutional definitions of competence or clinical expertise in practice. Nursing excellence is then made to fit with institutional goals.

From the CNA/CHA (1990) analysis it is believed that job satisfaction and quality of working life are closely related. Without exception, the studies from coast to coast concluded that the single most influential issue related to nurse retention and perceived high levels of quality working life is job satisfaction and its determinants.

Continuing Education

Continuing education is another area of connection among job satisfaction, clinical competence, and patient satisfaction. Education was found to provide nurses with a challenge, stimulation, instilled confidence and competence, and afforded status. Tobin, Yoderwise, and Huel (1979) say that the fostering of innovative and creative approaches to nursing care of patients and can be undertaken through continuing education, resulting in achievement of more effective competence in nursing practice, which improves patient satisfaction with the care they receive and leads to increased job satisfaction for the
nurse. Professional practice is based on the acquisition of knowledge and on the professional responsibilities in the light of that knowledge. In an area such as health care where new knowledge and technology are always developing, and given the reality of continuing social change, it is essential that professionals keep up to date if they are to provide the highest standard of care possible (Cox, cited in AARN/AHA, 1985).

The CNA/CHA (1990) report shows that generally in Canada there is limited access to education for nurses, despite the increased need for levels of preparation. There is reported low satisfaction with the inservice structure many agencies have, mainly because the inservices usually do not involve certification and sessions are not transferable from agency to agency. Inservices alone, however, are not the answer, they cannot develop the insights and judgements clinical practice requires; nor is inservice instruction always applicable to patient care (Morath, 1983). Morath advocates more a specialist or preceptor in the clinical setting to help nursing staff refine skills and develop judgement.

The CNA/CHA report (1990) also recommended that support for development and maintenance of practitioner competence must be shown through: a) institutional policies regarding shared responsibility between the institution and the individual nurse; b) recognition for nurses' educational preparation, prior professional experience, and level of clinical competence, as well as length of service; and c) program and budget planning reflective of variable levels of patient needs and requisite levels of staff competence. The report found that nurses wanted paid educational leave, distance education to be more accessible, joint hospital and academic programs, and more funding.

Continuing education at all levels provides an excellent medium for job satisfaction and clinical competence (CNA/CHA, 1990). This fits with the study done by Kramer and Hafner (1989) who found that increased levels of education led to higher levels of job satisfaction. Moss and Curran (1987) believe that adequate numbers of educated,
clinically competent nurses are absolutely essential if hospitals are to continue to provide high quality patient care. Sovie (1982) pointed out the experienced nurses, enriched by continual clinical experience were satisfied with their work and available to deliver quality care at controlled costs. Morath (1983) also believed that by developing collegial relationships between specialist nurse and staff, job satisfaction would increase. Dalton (1990) wrote about how having confidence in their own clinical competence improved levels of job satisfaction, empowered nurses to grow politically and socially in attaining higher levels of decision-making, and created an environment for valuing health. Ghiglieri, Woods, and Moyer (1983) found that competency development boosted the morale among staff nurses whose expertise was recognized and utilized in determining nursing standards for their hospital. It was McCallum and Wright's (1979) belief that seeing oneself as competent and performing up to one's potential had a positive influence on job satisfaction.

The logistics of providing continuing education opportunities are many. Among the provincial studies analyzed by the CNA/CHA (1990), there were major disagreements over the need, form and format, funding, and access to education. CNA/CHA (1990) state that basic nursing programs cannot be expected to prepare nurses for lifetime practice. Morath (1983) observes that due to the costs involved, hospitals have been very slow to recognize the advantages of staff development strategies to enhance motivation and job satisfaction. She says that the traditional way to deal with a shortage of qualified nurses is to hire more new staff which only makes the situation worse. Tobin et al. (1979) examined through the literature a number of ways to enhance ongoing clinical competence development, among them, peer review, nursing practice audit, reexamination, and continuing education. Each of the areas examined showed advantages and disadvantages. They concluded that no matter what form of clinical competence enhancement, the program would have to be individualized and planned
with each nurse through a staff development approach. One of the biggest frustrations they found was that there had been little documented evaluation of any competence enhancement strategies.

**Application to the LRH Project**

A number of useful research findings and recommendations have come out of this review. Some of the findings could be useful to the LRH Project and the role of the staff development nurse.

Jones (1986), Morath (1983), and Hamilton, Murray, Lindholm, and Myers (1989) advocate a mentor role for specific nurses to hold. They believe that this is one of the better ways to develop professional role identity and professional interest, enhance pride in new skills, facilitate acquisition of a professional ideology, invest in the profession, and internalize practice motives. The mentor model dictates that learning occurs by: observing and comparing student to mentor, coaching, inspiring, supporting, fostering happiness, competence, and self-assurance. Vance (1982) conducted research on mentoring, using new nursing graduates as the study population. Vance reported that mentoring affected the novice nurse by: a) accelerating and intensifying development, b) promoting career development, c) increasing personal satisfaction, and d) increasing self-confidence and self-esteem. The results of Vance's study show that new nurses were more satisfied being able to use their abilities and had increased feelings of accomplishment and ability to assume more authority.

According to the original LRH Job Enhancement Proposal (Appendix A), the Staff Development Nurse would have the mandate of enhancing both individual and group levels of clinical competence with the hope that job satisfaction of the unit nurses and patient levels of satisfaction would increase. Based on the information from this literature review, the researcher concluded that part of the SDN mandate might include a plan to: enhance group cohesion, team respect, and feelings of competence among the
staff; decrease job stress; and add the humanistic perspective to nursing. Functioning in a mentoring or precepting role, the SDN could work with the staff on: increasing professional recognition through delivery of quality of care, developing effective communication skills, and becoming better patient educators. The SDN could offer: support to staff, expert care for patients, expanded clinical nursing knowledge to the unit staff, direct care assistance during peak loads or critical short staffing, and creative clinical problem-solving (Morath, 1983). If the SDN could accomplish these tasks, new nurses with strong growth needs might want to stay and progress to become expert practitioners, possibly leading to enhanced job satisfaction and increased patient satisfaction. Other experienced nurses might feel more respected and enjoy their jobs to a greater degree.

The SDN could also be involved in orientation programs based on individually defined learning needs. This involvement could enhance quality of work life for nurses and increase autonomy. New nurses might benefit from enhanced clinical competence, adjust to clinical practice sooner, and experience increased morale (Peitchinis, de Hamel, & Kober, 1976).

Gamble (1989) believes that we must recognize that most nurses enter and want to stay in nursing to care for patients; therefore, we must admit that our current system thwarts good nurses from building a career around caring for patients, we must create a professional patient care environment for nursing that starts with entry level requirements and defines the education, training, and credentialling process by which a nurse can qualify for increased levels of patient care authority and responsibility up to and including that of medical doctor. Continuing education through staff development activities such as the one proposed for the LRH may help to create that positive professional environment. This Project offered an excellent opportunity to monitor and evaluate this staff development process.
CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

Introduction

This study was primarily an 18-month evaluation research study, on the impact of implementing a Staff Development Nurse position on one focus unit and evaluating the effects on job satisfaction and perceived clinical competence of nurses and satisfaction of patients.

Implementing this SDN position at the Lethbridge Regional Hospital represented a difference from the traditional method of addressing ongoing nursing education—a deliberate introduction of change and innovation. Therefore, this chapter also presents information on the process of change, the notion of evaluation and how it relates to this study, and the setting where the study was conducted, as well as general background information about the participants. Information on the underlying process of change was thought to be helpful in understanding the Project as it unfolded and also in deciding its merits and disadvantages. Information on evaluation also aided in understanding the context of the study and helped to develop methods of analysis and interpretation.

This study incorporated both quantitative and qualitative methodologies to gather as much data as necessary to provide an accurate picture of the focus unit, the staff, the patients, and the work life issues involved. Babbie (1983) states that the most complete way to do research is to employ a number of different research techniques to study a given topic, because this tends to balance many of the disadvantages and advantages of individual research techniques in relation to the research needs and resources. Howe (1988) indicates that triangulation, combining both quantitative and qualitative methods, is encouraged and often required by demands of research practice and problem comprehension. A description of the methods and procedures employed in accomplishing the purposes of the study is also provided in this chapter.
Studying and Evaluating Change Processes

Change and Innovation

Instituting a Staff Development Nurse position within the system of nursing at the Lethbridge Regional Hospital constituted a major change in the system's operation, potentially impacting the lives of all persons within that system. Prior to this innovation, continuing education for the nursing staff had been conducted from a central department, under separate management. The clinical educators from the central education department had hospital-wide responsibilities in addition to clinical education responsibilities on at least four nursing units. The SDN role did not include hospital-wide responsibilities; the continuing education of the nursing staff on one nursing unit was the only focus for the SDN.

The Rand Corporation Study (Berman & McLaughlin, 1978) is often cited as the classic example of an attempt to understand the complexities of establishing, maintaining and evaluating change. The Rand Corporation Study focussed on the phenomena of change by examining 293 American federally funded change agent projects. Although this study was focussed on education and teachers in schools, the guiding principles elicited are helpful to any situation of planned change. In the Rand Study, change was viewed as a series of events moving from initial stages of securing support right through to implementation, by way of a confirmation process based on mutual adaptation. By definition, mutual adaptation occurred when both the project and the setting were changed; a change from idealistic project goals and changes in behaviour as staff tried hard to make the project work (Berman & McLaughlin, 1978, pp. 16-17). Success was defined within the unique context of each project and was measured by whether or not the project continued to be a major undertaking once federal funding ended and the project had to be supported locally.
Based on the Rand Study conclusions, decisions and choices (whether explicit or implicit) on how to put the innovation into practice turned out to be the most important; strategies chosen could spell the difference between success or failure, despite the type of innovation or the educational method used. Ineffective strategies were ones that never became part of regular life or dominant user needs. These ineffective strategies were often related to bringing in outside consultants (due to lack of internal ownership); packaged management approaches (with inflexible rules); one-shot, non-individualized, preliminary training sessions; paid for training (with an associated user lack of interest in the project); formal evaluation (replete with political pressures and agendas); and comprehensive over-sized projects. In contrast, effective strategies promoted mutual adaptation. The opportunity for necessary and timely feedback for the stakeholders to clearly understand their project's goals and objectives were the most positive factors and encouraged commitment to the project (Berman & McLaughlin, 1978, p. 28).

Change is often perceived to threaten stakeholders, to invalidate their experience, to take away learned skills, and to confuse. Effective strategies from the Rand Study outlined below were found to be particularly successful in decreasing resistance to change when they were applied in concert:

a) concrete, teacher-determined, teacher-specific, extended training, to translate the fuzzy guidelines into clear expectations;

b) one-to-one, responsive assistance from the project staff;

c) user observation of similar projects in other settings;

d) regular project meetings that focused on feedback and opportunity to share successes, problems, and suggestions, and ways to build staff morale and cohesiveness important to effective implementation;

e) user participation in project decisions because of their proximity to the problem;
f) local materials development, showing that the staff were valued; and,

  g) administrative participation in training related to the change, supporting and
      valuing the staff efforts. (Berman & McLaughlin, 1978, pp. 29-30)

Three other factors affected the results of the projects in the Rand Study. These
factors included the organizational climate and leadership, characteristics of the
institutions and users, and administrative support. Organizational climate and leadership
encompassed the quality of working relationships, effective project directors, how users
learned new behaviours and attitudes, clarification of goals and operations, minimizing
day-to-day difficulties, and furnishing concrete information to the users. Characteristics
of institutions and users included years of teaching (the longer a person taught, the less
likely the project achieved its goals) and attitudes of professional competency.
Administrative support included constant and active attention at every stage. The
administrators had to be gatekeepers of change, giving legitimacy to the project and
moral support to the users.

Evaluating Change

Evaluation research is one method used for judging the impact of a change or
innovation. Smith and Glass (1987) define evaluation as the process of establishing
value judgements based on evidence about a program or product.

From their observations, Tobin et al. (1979) determined that for continuing nursing
education programs, evaluation was often just a word, an intention, but was rarely
effectively addressed or carried out beyond cursory attempts. Bignell and Crotty (1988)
and Greene, Paul, and Redlich (1989) state that from an educational point of view,
despite the number of evaluation projects being conducted, few programs have
conclusive evidence of the impact of their efforts on changing teacher and other staff
behaviour or increases in student learning.
One of the reasons for difficulty in discovering causal relationships, or making decisions based on evaluation results is that there is little appropriate methodology for the exact tracking of complex relationships (Howey & Vaughan, cited in Greene et al., 1989). Another reason is that evaluation is inextricably tied to certain philosophical positions that people hold to be true. These positions can then dictate a specific method of evaluation, which may not necessarily be the most effective. Greene et al. (1989) report that, from their experience, “the traditional evaluation designs using pre-post measures, or attempting to relate outcome measures to established goals are at present not only impractical and unrealistic but minimize the complexity of the phenomena being examined” (p. 39). With respect to change in schools, they suggest that “it has not yet been possible (nor is it likely ever to be possible) to establish a direct causal relationship between the implementation of large scale change and increased student learning” (p. 39). The research Project proposed here includes working with active, thinking, independent and willful individuals and this fact makes the investigation of causality very difficult.

Griffith (cited in Greene et al., 1989) states that the most common form of evaluation is to assess perceptions, which are valuable, informative and immediately apparent, but which do not answer the most difficult evaluation issue—assessing the effects upon practice. It is one thing to evaluate learner satisfaction with continuing education programs, but yet another to know if the program is effective.

Tobin et al. (1979) evaluated a number of continuing education change processes in nursing. They determined that the most effective way to deliver continuing education programs was to be flexible and to offer a variety of ways to learn material based on individual preferences; they also stated that evaluation had to take place in the context of where the individuals functioned.
The change process itself can be monitored and evaluated. Berman and McLaughlin (1978) and Howarth (1984) argue that summative evaluation may not be the most effective way to evaluate and that summative data rarely serve the intended purpose and function, and the findings may not necessarily be the most important factors in decisions to continue funding projects. There is also a huge risk of local bureaucratic and political concerns significantly influencing evaluation decisions of projects. Howarth (1984) and others (Greene et al., 1989) argue that the best way to evaluate is formatively as the process of change takes place. Formative evaluation serves to help clarify what is being learned and monitor how it is being applied.

Once the questions of when to evaluate has been determined, what to evaluate becomes the next priority. Suggested areas include: the perceptions of adequacy of training and communication between staff (Berman & McLaughlin, 1978), effects of the change upon participants and apparent influence on the organization itself (Griffith, cited in Greene et al., 1989), perceptions of stakeholders included in the implementation phase because they give some of the most helpful information about effectiveness (Howarth, 1984), cost efficiency, fairness, benefits to society (Smith & Glass, 1987), the rationale for which decisions, choices, and strategies were used, and whether or not the users had opportunity for regular feedback and a chance to examine their situations (Berman & McLaughlin, 1978).

In addition, Berman and McLaughlin (1978) advocate evaluating: the nature of administrative support, organizational climate, and leadership, quality of working relationships, interface of the project director and the users, how users learn new skills, behaviours and attitudes, and other major organizational changes such as hierarchical management shifts, characteristics of institutions and users, and how the change affects staff members' sense of competence, occupational identity, and self-concept.
From a methodological point of view, Clark (cited in Greene et al., 1989) supports the documentation method as a way of providing more useful information compared to other methods. Clark believes that “documentation is a recognized mechanism for capturing the events that facilitate and hinder the accomplishments of major educational innovations” (cited Greene et al., 1989, p. 41). Documentation implies capturing, monitoring, and recording the program components, processes, and interactions as the program is implemented. It is essentially a “dynamic, evolutionary activity that provides for broad, continuous data collection ..., data analysis, and feedback ... . The primary goal is to help personnel in the innovating system become more reflective about the improvement process as it is occurring”. Clark stresses that it is important in using such an evaluation approach to be methodologically eclectic and to employ a wide variety of data collection methods including document review (such as proposals, minutes, correspondence), observations, interviews, site visits, surveys and questionnaires, demographic analyses, and review of student tests.

Based on the information gathered above, the complexity of the phenomenon of change precludes the use of simplistic evaluation models or processes. Identification of direct causal relationships is acknowledged to be difficult no matter what evaluation method is used. Methodological eclecticism and dynamic, evolutionary documentation and interpretation may offer more appropriate means to evaluate this Project.

Methodological Considerations

Selection of the Focus Unit

The selection process for the focus nursing unit spanned a number of months from the inception of the Project through the hiring of a Staff Development Nurse. Based on information from the literature, organizational considerations, input from the original Job Enhancement Committee, and the present Advisory Committee, the field of possible units gradually narrowed to one of the four Medical/Surgical (Med/Surg) nursing units.
This decision process was based on: the recommendations from the nursing department for ongoing education for nurses on the Med/Surg units, organizational changes to the Maternal-Child program with the transfer of services from another local hospital, the satisfaction and staffing issues, decisions about whether or not to include a control unit, and consideration of the functional stability of the nursing units. The control unit idea was dropped because no two overall nursing unit satisfaction scores were comparable when nurses completed the initial questionnaire run.

The four Med/Surg units at Lethbridge Regional Hospital were all stable with a core of staff members on each unit who had been at LRH since November, 1988, the NUMs were reasonably established in their roles, and the nature of the work on these units was anticipated to remain relatively static.

The final choice of focus unit was based on demographic information gathered on types of patients admitted, length of stay, and the SDN candidate interview process. The final decision was to implement the Project and conduct the research on Unit 4C, a general surgical 32-bed unit.

Participants

All of the nursing staff on Unit 4C were targeted for particular involvement. Nursing staff had as their nursing responsibility the care of pre- and post-surgical patients. Their work involved the assessment of patient care needs, planning the day-to-day care, implementing various nursing care strategies, carrying out medical orders, conducting discharge planning, and evaluating the care given.

Specific participants among the nursing staff targeted for more indepth involvement included six people representing the following groups: new orientee, someone who worked mainly nights and/or weekends, someone who had worked on the focus unit for a number of years, someone who worked mainly day shift, LPN, and RN. The justification of purposely including these specific participants was the fact that functionally, these
groups represented nurses who conceivably had varying degrees of involvement with the SDN.

In addition, the NUM, SDN, and patients who stayed on the focus unit during the study were also considered participants. The NUM had responsibility for the efficient overall functioning of the nursing unit. She coordinated the nursing care of 32 patients, liaised with the surgeons and general practitioners in charge of the patients, oversaw any problems with patient situations or hospital functioning that affected the unit, and conducted regular performance evaluations of the staff members. This person also hired her own staff and had the authority to discipline and dismiss staff as necessary. The NUM reported to the Director of Surgical Nursing.

The Staff Development Nurse was hired in December, 1991 and began her assignment on February 17, 1992. According to the job description specifically designed for this Project, she was to provide assessment, planning, implementation, and evaluation of those educational strategies that on both an individual and group basis would assist nurses in attaining higher levels of clinical competence. It should be noted that a conscious decision had been made by the Hospital Advisory Committee to have the SDN work in a union position, not outside of the union. This decision was one of many options, chosen so that the SDN was truly unit-based, and reported to only one person, the NUM of Unit 4C. Performance reviews of the SDN were conducted by the NUM throughout the Project, according to union policy.

Procedures

Questionnaires

Questionnaires are very useful when assessing perceptions of many participants and when information about trends is sought. The particular questionnaires used for this
Project concentrated on job satisfaction and clinical competence for the nursing staff on the focus unit, and patient satisfaction surveys.

**Nursing Staff Questionnaires.** The nursing staff questionnaire consisted of four parts: a demographics section; a Likert scale job satisfaction component; a Likert scale clinical competence component; and an open-ended written component on the perceptions of levels of job satisfaction of peers, the influence of the Staff Development Nurse, and the process of implementing such a position. Questions validated by other researchers were used, particularly for the job satisfaction and clinical competence components (Stamps & Piedmonte, 1986; Wandelt, 1974). The job satisfaction component, for instance, was developed from a questionnaire used extensively over the last ten years with a variety of workers and occupations (including nursing) by Stamps and Piedmonte (1986). The clinical competence section was derived from the work of Wandelt (1974), keeping the basic intent of the items intact, and changing the purpose from outsider observations of clinical competence to self-perceptions of clinical competence. The fourth set of items focused on how the SDN influenced the staff. These items were designed specifically for this study. (See Appendix C for a copy of the nursing staff questionnaire).

The entire questionnaire was tested and piloted in a setting similar to the Project setting. Six staff members from the Pediatrics Unit at the LRH tested the first draft of the questionnaire and gave valuable feedback to the researcher on the demographic items, the use of two computer answer sheets and the references to unfamiliar terminology. Changes were made and twelve staff member from a medical / surgical unit (not included in the unit selection process (11 RNs and two LPNs) completed the pilot questionnaire. Final revisions were made to the demographic items and eight items in the clinical competence section were deleted. The questionnaire was accepted by the LRH Job Enhancement Advisory Committee.
The same questionnaire was administered to the participants initially when the SDN started work, one year later, and at the end of the Project. Questionnaires were hand delivered in brown envelopes to the intended participants by the researcher and returned via the regular mail or personally by the participants to the researcher. Every participant was requested to complete the questionnaire and return it in the mail to the researcher. A cover letter accompanied each questionnaire, explaining the procedure of completing and returning the questionnaires.

Five persons who left the participant group (for example, because of relocation or pregnancy) were replaced in the sample with the person who replaced them on the nursing unit roster, and the researcher documented this change. This move was deliberate in that the perceptions of job satisfaction and clinical competence may be different for them, compared to the perceptions of their colleagues. This group included: two RN maternity leaves, one resulting in one RN going to relief and the other RN going to a part-time position on another unit; one RN displaced from 4C because of staff bumping; one RN displaced from another surgical unit to 4C because of staff bumping; other internal rotation changes because of bumping or maternity leaves; one LPN off for considerable time for back pain; one LPN quitting to go to RN school; one RN transferring off to the Pre-op Assessment Clinic; and one RN being dismissed. A total of five RNs and one LPN left the focus unit during the research time frame and five RNs and two LPNs arrived or took over part-time or full-time positions.

Patient Satisfaction Surveys. A patient satisfaction survey was used to gather information from the patients who stayed on Unit 4C during the 18 month period. This was a Likert scale questionnaire consisting of 20 positively-worded items addressing patient rights as outlined by the Consumers' Rights in Health Care (1974). These surveys were different in format and content from the hospital-wide forms and were designed to provide more specific information about the nursing care that patients received. In addition, pertinent demographic data and additional written comments were gathered on
each survey. (See Appendix D for a copy of the patient satisfaction survey). These surveys were offered to patients prior to discharge, with an invitation to complete them before they left. The completed surveys were sent in the hospital mail system to the researcher. Initially, a group of hospital volunteers was enlisted to give the surveys out at 11 a.m. every week day. Within five weeks, this changed to having one volunteer take on this responsibility. This situation lasted for 11 weeks at which time the researcher shared the responsibility of giving out the surveys for 16 weeks and eventually became totally responsible for this task for the last 36 weeks of the Project. The distribution rate increased when the researcher took this task over. Patient satisfaction data was collected once the SDN started, and gathered by the process described, compiled, and analyzed on an on-going basis.

Interviews

Gorden (1989) argues that it is usually possible in an interview to get more complete and thoughtful responses than can be obtained from a questionnaire. These particular interviews served as an adjunct to the questionnaires to expand on some of the issues identified. They were intended to provide a richer interpretation of the data, provide feedback as to what and why certain trends were developing, and potentially increase awareness of important new variables operating in the situation being studied.

Nursing Staff Interviews. These interviews were semi-structured with a certain number of pre-determined, open-ended questions derived during the questionnaire design phase. The six targeted staff were asked to participate in one to two formal interviews spanning the course of the study. These interviews were supplemented by informal interviews as issues related to the research or the continuing education of staff arose. Formal interviews for the staff usually lasted about one hour. It is likely that those who returned the questionnaires were different persons than those who were interviewed, as determined by the differences in demographic data given. (A list of interview questions
and cover letter is included in Appendix E.) Interviewees were randomly selected from within the categories outlined by a person unrelated to the nursing profession.

Formal interviews with the six key participants started in July, 1992 and continued until August, 1993. An initial set of four interviews was done between July and September of 1992 and then another six interviews were done between June and August, 1993. Many informal interviews and conversations were held between the researcher and these six participants throughout the 18-month time frame. Many of these conversations were reported in the researcher's documentation data. Formal interviews with the six key participants numbered 10. Two interviews were taped and for the other eight interviews, the researcher had prepared worksheets with the interview questions printed on them. The researcher then made notes during the interview and spent on average one hour detailing the interview notes, making connections between items, writing quotes from the participants, and writing interpretations. Any clarifications or discrepancies discovered in the data were followed up with a clarification question to the participant from the researcher, either in a telephone conversation or in person at the next most convenient time. Thirty-eight pages of notes were transcribed from the taped interview data, and 55 pages were completed from the notes of the other eight interviews.

Staff Development Nurse and Nursing Unit Manager Interviews. The SDN was interviewed many times during the 18-month Project time frame. The SDN and the researcher met formally almost every two weeks during the Project, with a major formal interview in two segments done at the end of the Project and many informal interviews during the time frame. These meetings and informal interviews were documented in the researcher's journal. The formal interview was not taped—extensive notes were made from brief notes taken during the interview. The researcher made the detailed notes immediately following the interviews. The notes were returned to the SDN and NUM for confirmation.
Formal interviews with the NUM numbered four. A set of taped interviews was done in August, 1992, and then two more interviews were conducted in July, 1993. Numerous informal meetings and conversations were held between the NUM and the researcher and were documented in the researcher's journal. Conversation topics ranged from volunteer motivation to deliver the patient satisfaction surveys to the rate of medication errors, physician/nurse relations, stress in the workplace, and telephone communication. Transcribed data from the taped and the additional interviews totalled 48 pages.

Exit Interviews. Exit interviews were conducted by the researcher with staff who transferred from the unit, to learn about some of the staff members' perceptions related to job satisfaction. One formal and four informal interviews were done. In all cases but one, staff were contacted by the researcher either just before they left the unit or after they had left. A list of exit interview questions is included in Appendix F.

Other Procedures

Robbins (1979) states that ethnographic procedures such as direct observation of the participants on the unit may be a superior technique of data collection and usually will provide better evidence about behaviour than a questionnaire or an interview.

Staff Development Nurse Journal. The SDN was also requested to keep a journal for the duration of the Project. She was encouraged to write about whatever seemed important or significant. Topics included: the events that occurred on the unit, how the SDN perceived her role working in relation to the staff and the unit, interactions with others, what she did and why, what she thought at the time of some of these events, changes in policy, events from outside the unit that were perceived to impact the study, and any learned insights or reflections. These guidelines were derived from conversations with the Thesis Committee, the SDN, and some research done on journal writing (Dewey, 1990; Honey, 1988). The journal documentation was used by the
researcher to supplement, to clarify, to provide a context for, and to give meaning to the
data analysis and interpretation of the data from the questionnaires and the interviews.
The SDN wrote in her journal almost every day when she was on the unit. The SDN
journal generated a very large volume of data.

**Researcher Documentation Data.** As a participant observer, the researcher
observed and documented activities and behaviours during a number of different events
such as: staff meetings, inservices that the SDN gave, activities as nurses carried out
their daily responsibilities, and interactions with other staff. The researcher also attended
inservices presented by the SDN and informally interviewed staff afterwards to gather
their opinions on how useful they found the inservice and how the information given
could be applied to their daily work. Data collected included: minutes of staff meetings,
field notes, notes from specific inservices given and responses of staff, notes from
bulletin board messages, information from staff meetings, and information from the
unit's communication book (unit thank-you cards, incident reports, major letters of
patient concern). Notes were also gathered from informal conversations with the staff,
SDN and NUM. This process of gathering data and documentation generated a
substantial amount of data. The researcher's documentation data served a number of
purposes. The data provided the context of some information derived from the
interviews, a sequence of events "calendar" upon which to tie various reactions of the
participants, a separate point of view on events from the other participants, and most
importantly, a forum for the researcher to vent frustrations during the research process.

As in any other situation, change was constant. Other issues related to the unit were
anticipated to arise over the 18 month period, such as unit and organizational structure,
or role changes that required consideration of how they impacted the research. Thus the
researcher endeavoured to document and describe any such issues in her own journal,
and as much as possible amalgamate them into the overall picture of the unit.
Documentation focused on the components and process of this Project from the
implementation of the Advisory Committee right through the course of the research, and the interactions observed, with highlights on the opportunities for feedback, sharing, support among the nursing staff, and any changes decided upon by the focus nursing staff, SDN, and/or NUM as the Project unfolded.

Research Process and Related Issues

This section covers topics such as: validity and reliability, ethical considerations, confidentiality, communication, generalizability, and bias. Each of these will be addressed separately.

Validity and Reliability. It is well established that a major difficulty with attitude measurement centres on the question of validity (Smith, Kendall, & Hulin, 1969). Validity, according to Stufflebeam, McCormick, Brinkerhoff, and Nelson (1985) is defined as "how truthful, genuine, and authentic data are in representing what they purport to measure" (p. 205).

Specifically related to this Project were concerns with eliciting valid data regarding job problems if the nurse was unsure of how the information would be used. Nurses had to be assured that the information they supplied would not be associated with, or harmful to, them as individuals, or harmful to their unit. During this study, these issues did surface from some staff members.

To increase the validity of the data obtained from the questionnaires and interviews, the following steps were taken in selecting and designing questions that truly addressed the research focus of the study, for example: a) by developing items from issues identified in the review of the literature, b) carefully reviewing existing research instruments and matching the appropriate instrument with the nature and intent of this study, c) seeking expert research and educational opinion and input through consultation with both the Hospital Advisory Committee and the Thesis Committee, and d) utilizing previously tested questionnaire items and interview questions. Also, the questionnaires
and interview questions were pre-tested and piloted with a group of staff nurses who were similar in characteristics to the nursing staff on the focus unit. To the highest degree possible, the data collection was carried out the way it was intended and was consistent from instance to instance.

The issues of questionnaire testing effects is often thought to be one threat to validity in that sensitization through previous test experiences may increase the next test scores. For example, the same questionnaire was given to the participants three times during the Project time frame. The issue of testing effect was hopefully compensated for by conducting interviews to address the issues of job satisfaction and clinical competence from another perspective.

The researcher was also well aware of the potential for Hawthorne Effect from the nursing staff on the focus unit related to the questionnaire and the interview results. This effect was possible simply because of the extra attention the staff on unit 4C potentially received by virtue of being the only nursing unit with an SDN, the additional educational interest and time afforded them because of having a full-time educator on their unit, and also because the staff were asked more frequently about their reaction to the process through the questionnaire and interviews. These issues were raised during the interviews. None of the staff members reported any "specialness" related to the Project. The only mention of the issue came from an SDN journal category; for example, "Other areas want our educator", and feedback the NUM received from other NUMs, who remarked on the positive difference of having the SDN.

Borg and Gall (1983, p. 281) define reliability of an instrument as the degree of consistency with which it measures the variables it is supposed to be measuring. In other words, the less variation an instrument produces in repeated measurement, the higher the reliability. In an effort to increase reliability, participants were also encouraged to complete the questionnaires at a time and in an environment free from distraction. Even though the questionnaire had previously been tested for reliability, because of the small
number of questionnaires returned, no statistical measure of reliability was calculated for this Project.

**Ethical Considerations.** Since this was also a university thesis study, the standards regarding the procedures for human subjects research, adopted by the University of Lethbridge Faculty of Education, were utilized for the thesis. The study had to undergo the rigor of the procedures set out in the human subjects document. From the hospital perspective, once the entire Project was ready to be piloted, the Vice President-Nursing took it forward to the Senior Management Committee and Ethics Committee for their review.

Greene et al. (1984) noted that evaluation of staff is best done in an environment of trust, support, and clearly defined guidelines. Although the involvement of staff in this research was purely voluntary, there were feelings among some staff nurses that they "ought to" participate, although they did not particularly want to; therefore, every effort was made by the researcher (and through the Project, ultimately by the SDN) to introduce the Project, and explain the research to the people involved, so that they did not feel threatened. One of the more interesting areas of resistance from the staff was the fact that they may have liked to participate, but were not hopeful that any positive change for their work situation would be forthcoming. Another issue arose when a few focus unit staff members stated that, throughout the Project, they still did not understand the role of the SDN. Throughout the Project, there also remained a small number of staff who did not trust their relationship with the SDN because of her perceived close ties to the NUM. This concern was also expressed by some staff in relation to the Project leader and the NUM.

Part of the trust-building the focus unit staff had to do was with the SDN, in order to realize mutual professional development and enhancement of job satisfaction or clinical competence. The SDN also went through an orientation period on the nursing unit where
she learned how the focus unit functioned and to get to know the staff. An attitude of openness, trust, and respect at the outset from the Project director and the SDN, and support from the NUM, created an atmosphere where the nursing staff felt “cautiously” comfortable participating in the Project.

In addressing the concern for confidentiality with all participants, consent from the participants was required before any information obtained could be used for the Project. Initial group and individual meetings with the nursing staff on the focus unit were done, where the researcher outlined the process of the research and discussed the issue of consent with the staff. Each questionnaire package given out was individually explained by the researcher, in person. Consent was assumed if the nursing staff completed the questionnaires, and verbal consent (at least) was required for interviews. Individual results were excluded or, in the case of a concern of the staff or patients about the information they gave, attempts were made to secure a more specific consent. One person interviewed on a number of occasions would not consent to give information related to specific staff members. She would either answer “no comment” or would request that the information be “off the record”. This request was honoured, but it did raise ethical issues for the researcher.

Code numbers were assigned by the researcher for both the questionnaires for patients and staff, and for nursing staff interviews. References to individual responses on questionnaires or interviews were made by code number or by number of like responses. Any reports of the research identify individuals by title only, focusing on the process primarily, not the individuals themselves. Responses to questionnaire items were released by summary only. All data was shredded and tapes (used for some interviews) were erased at the end of the Project.

For the patient satisfaction surveys, patients were invited by way of verbal
introduction (by a volunteer or the researcher) to fill in their survey for the purposes of the Project. Consent was assumed if the patients completed the survey.

The SDN was hired knowing that she was part of a research study and required to give information. The NUM was also aware of the fact that her identity could not always be concealed, since she was often referred to by others or requested to give information from her perspective. With the NUM, information was asked of her mainly related to her perceptions of the working relationships of the unit, with no repercussions to performance appraisals of the staff. The SDN and the NUM had opportunity to read the draft copy of the report where they were mentioned, and to clarify and comment on the accuracy of the report.

Many of the issues related to confidentiality were included in the cover letters for the questionnaires and in the introduction process with the interviews. (See Appendices C and E for copies of the cover letters).

Communication. There were a number of different stakeholders in this Project for whom communication was important. These stakeholders included the participants, the Advisory and Thesis Committees, the total hospital organization, the researcher, and various departments within the organization, all of whom had potential to affect the implementation of the Project, or the research process and results.

In traditional research, findings often remain confidential until the final report is released. More recent research acknowledges the fact that not sharing research findings during the study may indeed be detrimental to the very process and purpose of the research (Berman & McLaughlin, 1978; Bogdan & Biklen, 1982; Greene et al., 1989). For this Project, the Hospital Advisory Committee stated that it believed its role was to ensure that the research adhered to the original intent, to act as a consultant to the researcher, and to provide opinions and perceptions about the research. They did not want any direct contact with the focus nursing unit as a whole group; a core group of
management personnel within the Advisory Committee offered consultative services to both the SDN and the NUM of the focus unit in the event that the need arose. Committee members believed as well that the researcher should function somewhat at a distance and not have direct contact with the nursing staff on the nursing unit in the study outside of the administration of the questionnaires and conducting interviews with the NUM, SDN, and other key people. The researcher was requested not to give advice or to discuss findings with the participants until the Project was over. The researcher therefore found the requirements of her role to be somewhat "at odds" with the formative type of research in which she believed.

The researcher was a member of the Advisory Committee, and in some situations, was faced with the decision of whether to share research findings with the nursing staff or not. In some instances, because the study was examining issues related to job satisfaction and clinical competence, there appeared to be great advantage in sharing information; for example, the SDN could make use of the questionnaire results as part of her learning needs assessment or sharing some patient satisfaction survey data with the 4C staff. The issue then became one of whether to share the findings and improve job satisfaction and/or clinical competence, or to withhold that information until the end of the study. A decision regarding whether or not to share findings was to be made jointly by the Hospital Advisory Committee and the researcher. Further, the extent to which findings were to be shared was also a joint decision. In the event that general information was shared with any of the participants, documentation of the situation and of the specific information was carried out by the researcher and was accounted for in the analysis process.

There were also situations where the nursing staff, unprompted, shared information with the researcher that had significant impact on the findings. Important information like this was used only with permission. In order to get as accurate and complete
information as possible and to enlist the cooperation of participants, the researcher held informal meetings (often individual) to inform the staff of the process and progress of the research; however, specific findings of the researcher were not discussed on those occasions.

Generalizability. The extent to which the results of this study can be generalized to other situations and settings is limited by the extent to which other settings are similar with respect to: a) characteristics of the focus unit, b) nursing staff experience and education levels, c) patient and physician populations, d) nursing care delivery systems, e) focus unit relations with the larger organization, and f) present structure of the nursing department. For example, job satisfaction is often used as an outcome measure of the success of various program changes or interventions (Larson et al., 1984). In this Project an attempt was made to evaluate the influence of the SDN, however the separate and combined influences of other factors may have masked any effect that person had. The evaluation tools may also have been too insensitive to detect change, so that an improvement in only one of a host of other job dissatisfiers might not produce enough change in job satisfaction to be statistically significant even though the factor might be extremely important to a number of nurses.

Stamps and Piedmonte (1986) also argue that due to the lack of consistent theories and standardized, or even widely accepted, methods of determining job satisfaction, important variables are hard to identify. The results of the research may also be limited simply by the nature of the questionnaire items listed. The results of this study may have uncovered or partially reflect an unusual historical process or event affecting participants; and therefore, may not generalize to groups not experiencing the same process or event (Farrow, 1986).

Researcher Involvement and Bias. One of the reasons the researcher became interested in this research Project was the SDN/education focus. The researcher has been a clinical educator with a broader mandate than that of the SDN position, and believed
that the best way to address ongoing nursing education was through a role such as the SDN. For these reasons, the outcome of the Project had both personal and professional implications for the researcher. The researcher had a strong desire for the Project to be successful. As the Project leader, the researcher also naturally wished to conduct the research in the best way possible, with the outcomes being positive for the organization.

Having stated the apparent biases from the researcher point of view, and having outlined areas of potential conflict between the researcher's opinions and the opinions of the Advisory Committee, the researcher endeavored not to lead participants on and induce them to think certain answers were right or wrong. Every attempt was made to guard against the researcher unintentionally creating a bias. One of the best ways discovered to guard against bias was full disclosure, by documenting extensively. Another way was to have a means established by which the researcher could go back to the participants to confirm interpretations of the data and trends that came up. The results of the Project were at times, frustrating, disconcerting, and depressing for the researcher. Members of the Hospital Advisory Committee and Thesis Committee provided avenues for the researcher to vent feelings.

**Analysis of the Data**

Components available for analysis included:

a) demographic data of the nursing staff on the focus unit,

b) job satisfaction and clinical competence item results from the focus unit (at the start of the Project),

c) open-ended answers from the staff questionnaires on the focus unit,

d) interview data from key staff participants,

e) interview data from the SDN and NUM,

f) patient satisfaction survey results,

g) data gathered from the researcher's field notes,
h) exit interview data (reasons for leaving),

i) journal entries from the SDN, and,

j) minutes from the Advisory Committee.

All of the above data were available over time and on a number of occasions.

Statistical Methods and Procedures Used

A variety of both quantitative and qualitative methods were used to analyze the data. Because of the large volume of information generated, each of the procedures—questionnaires, interviews and other procedures—will be addressed separately.

Questionnaires. Thirteen out of 27 questionnaires (48.13 percent) sent were completed by the 4C staff in the initial round when the SDN started, and six of 27 questionnaires (22.2 percent) were returned at the one-year mark of the Project. Only one of 27 questionnaires was returned to the researcher at the end of the Project and it was only partially completed. A discussion of the low return rate over the span of the Project period is included in Chapter Four.

The SPSS statistical package was used to analyze the data. The participants filled out computer response sheets and these were scanned electronically. Each of the initial and one-year round questionnaires was analyzed separately to provide total number of responses, frequencies and percentages for the 17 demographic items, the 35 job satisfaction items, and the 34 items each on clinical competence for “self” and for “peers”. For frequency distribution of job satisfaction items, Stamps and Piedmonte (1986) recommended that the seven point Likert scales be collapsed into three to help with the interpretations. These three groups were: 1) disagree, 2) neutral, and 3) agree.

The initial and one-year round questionnaires were analyzed further by grouping items in the job satisfaction component into the six categories, recommended by Stamps and Piedmonte (1986) and illustrated in Figure Three.
Figure 3: Job satisfaction component groupings. Source: Stamps & Piedmonte, 1986.

A third analysis was done on the six nurses who returned completed nursing staff questionnaires at the one-year round with their questionnaires from the initial round.

Responses to the open-ended questions, interviews, and field notes were tabulated and ranked following the guidelines in Bogdan and Biklen (1982, pp. 156-169): developing general coding categories, scoring information items based on the predetermined codes, reading the data in its entirety two times, developing a list of further coding categories, assigning numbers to the last list of codes, reading through the data again, assigning code numbers, changing the list and retesting data against it, reviewing the data a fourth time and finally cross referencing all of the data. Analysis then took place, based on the final coding system set up. Most of these interpretations and analyses are presented in narrative form, with direct quotes used to explain interpretations.
Patient Satisfaction Surveys. Two thousand, three hundred and forty-five (2,345) patients were eligible to receive surveys on 4C during the Project time frame. Patients were initially deleted from this original list who: a) had already left the unit before the survey was given, b) were unable to fill the survey out due to physical or emotional impairment, c) were unwilling to fill the survey out, d) forgot to fill the survey out, or e) were transferred off to Intensive Care Unit of another floor before they were discharged. The number of eligible patients also quickly fell in relation to how often the surveys were given out. Of the remaining patients, 917 (43.6 percent) surveys were actually given out, and 501 (278 males and 223 females) surveys were completed in some fashion and returned to the researcher. This constitutes a return rate of 54.6 percent based on the number of surveys distributed. The age range of patients was from 16 to 94 years. The largest number of returned surveys were from males and females in the “66 to 81 years old” category. Additionally, fifteen people did not wish to fill out the survey when it was offered to them; they preferred to give the researcher a verbal summary. This group included nine women and six men. Six women were in the 50 to 65 year age range, one woman was in the 66 to 81 years range (could not see), one woman was in the 34 to 49 year range stated that there was no change from her last stay when she completed a questionnaire, and one woman was 94 years old and just preferred to give the researcher a summary of her stay. Of the males, four men were in the 50 to 65 year range, one was in the 34 to 49 year range, and one was in the 66 to 81 year range.

Eleven people out of the 501 surveys returned preferred to have the researcher read the survey questions to them and they would choose the category they wanted for each of the Likert scale items. Some of this group of 11: a) could not read (illiterate - 2), b) could not read English (3), c) had poor eyesight to read (2), d) preferred to hear the questions and answer them (4).

Out of 486 patient-completed surveys, 178 people did not comment at all in the open-ended section, but 308 took the time to write comments, some of them one or more entire pages long. Responses to the open-ended items on the patient satisfaction surveys
were tabulated and ranked following the guidelines in Bogdan and Bicklen (1982) outlined above for the written contents on the nurses' questionnaires. Patient quotes are used throughout Chapter Four. Categories derived from the analysis numbered 18 and were labelled: teamwork and communication amongst nurses, students, service and attention from nurses, clinical competence, specific staff members (19 different staff were named; some many times), altered perceptions between patients and nurses, "bad apples", general courtesy of staff, care of patients in general, other departments mentioned (Nutrition Services, ICU, Emergency, Administration, Housekeeping, Maintenance, X-Ray), teaching from nurses, thanks to all, return guests, specific doctors (six different physicians were named), keep up the good work (encouragement from patients to staff), observations of job satisfaction of nurses (workload, administration, facility and services), observed professionalism (profanity, individual attention, being treated with respect, privacy, nursing strikes, human rights, being treated like a person—not an object, "going that extra mile", patient dignity, handle difficult situations with ease), and efficiency of staff.

The patient satisfaction survey data were analyzed using Paradox, a database product for the P.C. The Likert scale data from the patient satisfaction surveys were analyzed in the same manner as the nursing staff questionnaire items. Total numbers of responses for the 20-items were determined, with frequencies and percentages of responses. The data were further analyzed for differences in demographic data: total numbers of responses between males and female, age categories, length of stay on the unit (five days or less, six to 10 days, 11 to 45 days, over 45 days), and for various points in time when staying on 4C during the 18-month period.

A few (less than 10) surveys had two responses per item. With the exception of one survey, the two responses were side-by-side. The side-by-side quality did provide a fair amount of information, so datum selected for entry was the most-often-selected response category. For example, if the the multiple response was "2 and 3", and the patient selected "2" as a response more often than "3" for other items, the value of "2" was
entered as datum. Except for two items, this criterion was satisfactory, and in these two
items, the higher of the two responses was entered.

Interviews. Nursing staff responses to the interview questions were all tabulated
and ranked again following the guidelines in Bogdan and Biklen (1982, pp. 156-169).
Demographic data for the six nursing staff included: two males; four females; one LPN;
five RNs; four of the five RNs graduated from a two-year college program; three nursing
staff worked full-time and three part-time; one RN worked mainly nights, the other five
worked mainly days/evenings; one RN had less than one year experience, one had less
than three years experience, two had three to five years experience, and two had over 10
years experience. Although two of the nursing staff interviewed had worked on other
units at LRH, the other four had started on 4C after they graduated. The remainder of the
demographic information for this particular group of staff will be highlighted in Chapter
Four.

Preliminary coding categories included: background, general satisfaction, 4C
workload, group cohesion, unit description, patients, nursing role in society, clinical
competence-self, clinical competence-peers, changes to make, your future, advice for
NUM, advice for nursing administration, role of SDN, and nursing unit manager.
Analysis then took place, based on the final coding system set up. Most of these
interpretations and analyses are presented in either grouped responses or narrative form,
with direct quotes used to explain interpretations.

The data from the SDN and NUM interviews were analyzed by the same method as
for the nursing staff interviews. Many of the same topical categories were generated
from these data, and allowed the researcher to examine various issues from three
different perspectives. Particular areas of interest were differences in opinion on a few
key issues which will be highlighted in Chapters Four and Five.

Exit interview data finishes out this section of analysis information. Larson et al.
(1984) caution that the mere decision to terminate a job will result in attitudinal change
that would be reflected in the job satisfaction measurements. Therefore, exit interview
data were compared with the last questionnaire results of that particular person whenever possible. This occurred in three instances. Details of the results of exit interviews are included in Chapter Four.

Again, the data from the exit interviews were analyzed in the same manner as the previous interview data. Some of the resultant coding categories were: internal rewards, working group cohesion, bumping, maternity leave, family priorities, career advancement, job challenge, workload frustrations and continuing education.

Other Procedures. Again, the SDN Journal data were analyzed according to the Bogdan and Biklen (1982) system of categorization. The SDN journal proved to be the most work in the analysis phase, as the most information was generated here. In the SDN Journal, preliminary analysis categories numbered 48 and included: professionalism, resources for the SDN-library, 4C nursing care delivery system, 4C workload, NUM/SDN relationship, typical day, needs assessment, NUM/Staff rapport, perceptions of nursing administration, SDN's own professional development, 4C staff relations with other units, patient satisfaction, nurse/physician relations, staff morale, other floors want our educator, SDN educational strategies, surgical nurse committee, staff development needs assessment, new staff orientation, preparatory work, unit changes, SDN and Project leader, reflections of role-SDN, SDN networking with other departments, SDN/staff cohesion, SDN support outside of 4C personnel, ERC relations and 4C working group cohesion. Individual staff members were also referred to in the journal—22 staff in all. The amount of journal space used referring to a specific staff member was reflective of the amount of time the SDN reported spending with that particular person.

Documentation data which the researcher gathered were analyzed after all of the other analysis had been categorized and completed. Then the established categories were used to analyze the researcher's documentation data. The only additional documentation category was that of "Researcher Reflection on the Process".
CHAPTER FOUR
RESULTS OF THE STUDY

Introduction

In this chapter the results of the data collection, analysis, and interpretation phases of the research study will be described. The chapter is organized into four main sections: 1) focus unit contextual background, 2) the work context of the SDN, 3) research question number one, and 4) research question number two.

Both of the research questions chosen for this project must be considered in the context of the focus unit and the work of the SDN. It has been stated that if research in education is to be meaningful, it must capture and convey the frameworks of meaningful purpose within which both the researcher and subjects operate (Tobin, 1979). During the course of the analysis and interpretation, the importance of the context for this Project became increasingly apparent. In the researcher's opinion, the results, interpretations, and recommendations of this study cannot be considered except in terms of this particular context, due the unique events that occurred during the Project time-frame.

Focus Unit Contextual Background

The information contained in this section was obtained from documentation data the researcher gathered from: the 4C Unit Specific Manual, discussions with the NUM, interviews with key staff members, the initial and one-year 4C staff questionnaires, and the patient satisfaction surveys. It is intended to provide a context, to “give a flavour” of the unit that was the focus of the study.

One nursing unit at the Lethbridge Regional Hospital was the focus of this study. Unit 4C is a 32-bed general surgical nursing unit. It is one of three surgical units in the hospital. It contains one four-bed ward, 10 semi-private rooms, and eight private rooms. Unit 4C shares a floor with another general surgical unit and a cardiac/medical unit. The unit is designed so that both long rows of patient rooms either have a window facing
outside, or facing the atrium on the inside. There is a core area on the unit which runs
the length of the unit that houses the supply rooms, tub room, storage rooms, and the
nursing unit desk area. The nurses' desk area is situated halfway down the length of the
unit.

Background of the Staff Nurses

The staff come from a variety of backgrounds. There were 25 females and two
males (one LPN and one RN) on staff during the study period. There were nine full-time
RNs, four full-time LPNs, nine part-time RNs, and five part-time LPNs. The range of
nursing experience was from 23 years for one nurse down to less than one year for
another. The majority of the RNs (14 of 27) had fewer than five years of nursing
experience (many had fewer than three years), while seven RNs had over five years of
nursing experience. Three of the seven RNs with over 10 years experience obtained the
majority of their experience in areas other than surgical nursing. Of the nine LPNs, six
out of nine had over 10 years experience, five of whom had worked on surgery for a
lengthy amount of time. Ages of staff ranged from: over 45 years—nine of 27 staff, 35
to 44 years—three of the staff, 25 to 34 years—nine staff, and less than 24 years—six staff.
This is clearly a diverse staff in terms of age and experience.

For the most part, none of the 4C staff had worked together before the new hospital
opened. Two LPNs with a number of years experience requested specifically to work on
4C, looking for a change from previous work; one RN and one LPN who always worked
nightshift on surgery continued together on nightshift on 4C. Two other LPNs who had
worked at LRH for a long time were also happy to work on 4C. At the time of the 1988
LRH opening, there were many new RN graduates who got their first jobs on 4C, or were
beginning practitioners, and some nurses who "settled" for 4C because they either could
not get jobs or appropriate schedules on the other units.
Relief staff who worked on 4C varied greatly. Most of the relief staff also held temporary and part-time positions on 4C and wanted extra shifts (seven people). Other relief staff came from the casual pool of nurses for the entire hospital, and nurses who floated to 4C from other units in the hospital. Relief staff were used sparingly during the Project (under budget constraints) to cover sick calls, to augment staff on extremely busy days, and to replace staff going to continuing professional education activities.

In addition to the regular staff, first- and second-year nursing students from the Lethbridge Community College two-year Diploma Nursing Programme (eight to 10 at a time) and their instructors rotated through Unit 4C on a regular basis for three- and six-week postings. The focus unit staff were expected to teach, facilitate, and support the learning of the students.

When the unit first opened in 1988, physicians did not have much confidence in the 4C staff as compared to those on other units; other nurses did not like to float to 4C because of how confusing it was to work there; some staff on 4C were thought by the NUM to be inexperienced. Unit 4C had become known as the busy, disorganized, inexperienced, confused, stressful unit with little routine or predictability; clearly the 4C staff had many challenges to overcome.

The years of turmoil lasted from the 1988 opening to August, 1992. As the years after 1988 unfolded, the staff, reportedly eager and enthusiastic, struggled through two leadership changes which had profound effects on them all. A large number of RNs left for other units with more predictability, other kinds of work, different leadership, and a less stressful work environment.

The staff and NUM on 4C declared the exodus of staff officially over in August of 1992 (six months into the Project), at which time a core group of staff had settled in with the general view that 4C was “their home” and that they had a stable working group.
The staff who remained, aided by the positive attitude of the third NUM, adopted the philosophy of "we can try, we can do".

A chart is included here on staff information comparing the 18 month study time-frame with the 18 month period immediately prior to the study time-frame (see Figure 4). Note the fact that fewer staff transferred to or from the unit during the study period.

<table>
<thead>
<tr>
<th>18 months prior to the study</th>
<th>18 months during the study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18 months prior to the study</strong></td>
<td><strong>18 months during the study</strong></td>
</tr>
<tr>
<td>September, 1990 to January, 1992</td>
<td>February, 1992 to August, 1993</td>
</tr>
<tr>
<td><strong>Transfers off 4C</strong></td>
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</tr>
<tr>
<td>RN</td>
<td>8</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>LPN</td>
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<td><strong>Position Vacancies</strong></td>
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</tr>
<tr>
<td><strong>Transfers onto Unit 4C</strong></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>4 (2 — from Auxiliary Hospital)</td>
</tr>
<tr>
<td></td>
<td>(2 — results of St. Michael's Maternity Transfer)</td>
</tr>
<tr>
<td>LPN</td>
<td>1 (back trouble)</td>
</tr>
<tr>
<td><strong>Short-Term Disability</strong></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>1 (pursuing BN)</td>
</tr>
<tr>
<td></td>
<td>(obtained BN)</td>
</tr>
<tr>
<td>LPN</td>
<td>0 (pursuing RN diploma)</td>
</tr>
</tbody>
</table>

**Figure 4:** Unit 4C staff activity prior to and during the study.
Background. The most recent NUM started in March 1991, one year before the Project started. The NUM had been a part-time staff member of 4C. She had attended university and earned a BN in 1990. She stated that she is proud to be a nurse, and wanted the challenge of trying a new position. The NUM stated that she loves her job as leader on a surgical unit and would want no other. She still likes the challenge of the job—the coordination of care for 32 patients on a 24-hour basis.

Goals. The goals the NUM set out to achieve were described as ongoing. One of her goals was to build a consistent, experienced complement of staff, giving high quality of care to patients. Wholistic care of the patient was another of the goals set by the NUM for 4C, where not only were the physical needs met, but so were the emotional, and psychosocial needs. The NUM made one of her other goals to develop and stabilize the unit, so that it was well-respected by others in the hospital.

The NUM reported that her expectations of herself and the development of the unit had been met and exceeded. She stated that the continuity of a longer-term NUM has had a stabilizing and maturing effect on the unit. She also believes that there is more continuity of patient care because of the NUM being there for a longer period of time, compared to the two previous NUMs. She measures her success by the fact that she sees progress of the staff in their competence and also relies on feedback from staff, physicians, other NUMs, patients, and others in the organization to confirm what believes is happening. Admittedly, she says, the feedback is sparse, mainly due to the fact that people do not often think to give feedback, but what she has received has been positive. She reports that patients tend to give the most positive and consistent feedback.

Leadership. The NUM reported spending considerable time helping staff gain experience and more knowledge so that they could hone their judgements and become independent thinkers, resulting in more continuity of care. She believes that her extensive surgical experience has helped her in her leadership role.
The NUM ascribes to a democratic style of leadership where the staff have a great amount of input in decisions which affect their work. Time is used frequently to talk and to discuss issues. The NUM tries to hold formal staff meetings once a month which have proven to be a positive democratic forum. Many people commented on the staff meetings as a positive arena for change, throwing around ideas and suggestions, as illustrated in the following excerpt from the SDN journal. (Names and sexes have been changed to protect the identity of individuals as much as possible; when appropriate, titles are used.)

02/10/92. Staff meeting in the afternoon. NUM does that so well. She turns things back to the group, "What are your solutions?" "How do you see this working?" and follows through on it!

The NUM is described by staff members as being direct and purposeful in her written and verbal word, and in her actions. Her communication is "to the point", her approach is business-like. She can be judging at times; staff feel like they do not want to "make her mad". She is described as a "smart woman", a good advocate for the staff and patients, and for this particular research project. Performance appraisals are done on time and thoroughly, with opportunity for staff input. She is also described as "responsible, careful, so serene, so objective, does not blame, always listens, does not really put people down, but gives suggestions; she comes to our defense". The NUM "answers a lot of our questions". She is "quick to give feedback" (usually in the form of compliments) and to "follow through on a promise".

Nursing Unit Manager/Staff Relations. The staff report that the NUM requests that any conflicts between staff members and others--staff members, patients, physicians, or other health care professionals--are to be dealt with at that level quickly so that the business of patient care can continue. If negotiating does not settle things at that point, the NUM will then step in. This staff level of negotiation does not always occur in reality, according to both the NUM and the SDN, but it is encouraged.
The staff report that they have grown to “lean” on the NUM’s presence to make sure nothing goes wrong and sometimes they find themselves using her just because she is there, when they actually could use their own judgement. They attribute this situation to the need of the NUM to be in control and also a habit on everybody’s part. The NUM reports that the staff do lean on her and that change from mutual dependency is a long process, as the following excerpts from the SDN journal, spanning a nine-month period, illustrate:

1. 10/07/92. One Friday, the NUM was gone..., which left the RNs in charge—they had to look things up, do things, find out where their resources were, etc. Comment was made, “We sure find out a lot of information ourselves now that the NUM isn’t here to answer all our questions.”

2. 30/09/92. Multidisciplinary meeting today. The NUM primed E.N. and L.I. before going in. She went in as well, but had them do it. I think she is going to get everyone going!

3. 06/01/93. NUM told me that she made a conscious effort to stay away from the action and not to interfere. Somebody went “downhill” and H.C. and K.C. did just fine.

4. 13/03/93. Came in late this a.m., as did the NUM and everything seemed chaotic. Relief staff on, doctors running around, not able to find things without the NUM.

The process of rapport between the NUM and staff has evolved gradually over time; as one staff member put it: “We get more support and trust from her than in the past; she is extremely supportive now and she sure tries to acknowledge our work”. Most staff members feel positively supported by the NUM and have a high level of trust and respect for her.

There were comments made throughout the Project that the nightshift typically does not receive nearly as much attention and support as the other shifts; “nights are just expected to manage”—they “always get the short end of the stick”, as one nurse who works some nights stated. This issue comes up later in this chapter.
The Patient Population

General surgical patients were admitted to Unit 4C. Over the Project time span, surgeries included: urological, abdominal, bowel, ears/nose/throat, orthopedic, plastics, vascular, breast, thoracic, eyes, and gynecological. Patients were admitted who needed total parenteral nutrition as well. According to the patient satisfaction surveys returned, ages of the patients ranged from 16 up to 94 years of age, with the majority of patients being in the 66 to 81 age group and male (285 of 516).

There was a certain population of patients on the unit who were waiting for auxiliary or nursing home beds. These patients may have been surgical patients at one time, but could not care for themselves. Lethbridge is no different from many Canadian cities in that there is a shortage of long-term care beds and so people are waiting for placement and require rehabilitative or auxiliary level care and are on active surgical units. Of note is that before the research project started there were two patients waiting for placement, and during the Project the number increased to three. All three of these patients were still waiting for a bed elsewhere as the 18 month Project ended. Patients with medical conditions were also occasionally admitted to 4C when medical beds could not be found elsewhere. This was reported by both patients and staff to be a compromised situation. As one patient put it, "I feel a bit neglected being a medical patient on a surgical floor".

Staff and Patient Interactions. Based on comments from the NUM, staff are reported to be conscious of patient privacy and dignity on 4C. Staff on 4C do not usually knock on doors before entering a patient room, but sometimes acknowledge their arrival by saying "hi" before they come into the room, or will call the patient by name. Staff usually pull the curtains and direct their conversations with the patient as they carry out the nursing care for that patient. Sometimes with less alert patients, privacy issues are not adhered to as well as they could be, and staff tend to talk socially with each other.
while giving care. Some patients, during conversations with the researcher, also reported a tendency for the staff to spend as little time as necessary with patients who were angry or "too demanding" or behaved angrily toward the staff. When asked about this observation, one staff member commented during an interview that she thought that sometimes staff were either afraid of the patients, or decided that they did not need to be treated poorly by the patients, so they avoided some of the angry ones. On one other occasion, when the researcher commented that a particular patient was an acquaintance of hers, one staff member urged the researcher to go and visit with the patient, because she was behaving angrily toward the staff, and they were not sure what was wrong. The researcher did visit this particular patient on three occasions and the patient finally shared that she was so scared of her diagnosis and her future life, that she reacted angrily to most of the staff. The situation was then quickly resolved.

The staff reported, and the NUM agreed, that as much as possible is done to recognize the patient's past experience and family backgrounds when caring for the patient. The long-term patients on the unit have the staff involved more than the shorter stay patients. With the long-term patients, the staff get to know the patient and family well. They discuss the patient's heritage and former occupation with the patients if they know some of the patient history or have talked with visitors.

SDN Journal, 29/10/92. One RN and one RNA had all of the patients in 438 going this morning. They were singing some songs and before you knew it all three men were singing as well—then the folksongs came along. Some physicians that came by stopped dead in their tracks, making comments. NUM said, "Yes, this is a very happy floor!" Seemed to lift everyone's spirits. The RN singing was embarrassed about it but I told her they probably made the patients' day.

Figure 5 compares patient activity for the 18 month study period and the 18 months prior to the study period on Unit 4C and its "sister" surgical unit, 4A, to give the reader an illustration of the nursing unit context.
Prior to study | During study
---|---
(Sep 90-Feb 92) | (Mar 92-Aug 93)

<table>
<thead>
<tr>
<th>4C</th>
<th>4A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions (average/month)</td>
<td>138.17</td>
</tr>
<tr>
<td>Discharges (average/month)</td>
<td>137.20</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>5.48</td>
</tr>
<tr>
<td>Percent occupancy</td>
<td>83.45%</td>
</tr>
<tr>
<td>Deaths</td>
<td>27</td>
</tr>
</tbody>
</table>

* (dropped due to pre-op assessment clinic and transfers from 5A)

Figure 5: Patient activity on 4C.

The Work Situation

The unit is fondly referred to by some staff members as "the Zoo". Despite this title, during the Project, most 4C staff members described the unit as a good or even great place to work. One of the staff interviewed stated that she wanted to work on 4C because the staff were not so set in their ways and that she liked the active surgery from which to learn. She also wanted the technical side of nursing—the procedures—and the busy workload. Other staff members interviewed commented that they especially liked the area of surgical nursing.

Nursing care was delivered through a team nursing format according to the following guidelines set out in the 4C Unit Specific Manual for the majority of the Project time-frame:

- Nights - 1 Registered Nurse per 16 patients and 1 Licensed Practical Nurse per 32 patients,
- 1 Registered Nurse is designated charge;
Days - 2 Registered Nurses per 16 patients and 1 Licensed Practical Nurse per 16 patients,
- 1 Registered Nurse is designated charge; and.

Evenings - 2 Registered Nurses per 16 patients and 1 Licensed Practical Nurse per 32 patients,
- 1 Registered Nurse is designated charge.

The jobs on 4C were described by the staff interviewed as "Basic routine, with exceptions for different surgeries"; "Quite a lot of routine"; "Routine, but the turnover is fast, but you never know what will come your way next"; "There are routine hours and report times, but things change all of the time"; "Once you master some things, then it is routine, but it depends on the patients"; "It is different all of the time, every person reacts differently to every surgery they have".

The nature of the workload on 4C is characterized by the following typical excerpts from the SDN journal.

1. 19/03/92. Chaotic day, lots of staff and nursing students, ORs went early, staff getting flustered, rooms really hot, staff getting even more flustered, more talk of how 4C gets the worst air of the entire hospital, no wonder there is so much sickness... .

2. 12/05/92. So many people on today, nobody really knows what is going on, everyone hangs around the desk. I hate days like this.

3. 20/08/92. It just does not stop! For days, two RNs phone in sick—no replacements found! What a horror story. So NUM and I both decided to work on a side. Night staff had already done lots of bed baths which helped tremendously. I thanked them profusely after we got out of report. (They had worked short as well). There was no replacement on nights for the LPN. So T.B. stayed until 0300 hrs and I.P. came in at 0500 hrs. During the morning NUM hired someone else to help. At coffee break people were talking about burnout. These days have been quite an eye-opener for Nursing Administration. They cannot believe what is going on. Then as the day progresses, we get two transfers from another unit.
(after we had done all of our work, all of discharges), an lo and behold, neither of their patients had had a.m. care. That didn't sit very well!

4. **28/01/93.** Busy day on the floor, helped out with some things. One of the patients went sour real fast, diagnosis of septic shock, took him back to the O.R., then to ICU. That kept people busy for awhile.

5. **18/05/93.** Things don't change much on the floor, we might as well face it—the population isn't getting any younger and we're stuck with the waiting-for-placements patients. They are so time consuming and demanding of your time, holler and yell if they don't get attention. The noise level is so high—everyone is more irritable.

6. **05/07/93.** Apparently had been a busy weekend, lots of relief staff. This morning took awhile to get organized.

7. **15/07/93.** Been helping more on the floor today—we have an extra person from 4A and 3 preceptees on but it's still crazy. Very time consuming patients: older people with fractured hips, people needing a lot of teaching with self-catheterization and colostomies, and then of course the waiting-for-placement patients.

Overall the staff are not very impressed with the short stay unit and the gyn. patients. In itself, the gyn. patients aren't bad but it used to be that Monday, Tuesday, Wednesday were busy, then things would slow down for the weekend. Now Thursday and Friday are getting busier than the beginning of the week and the weekends are hell. Patients on the short stay unit don't go home so we have to accommodate another 14 patients by Friday, leaving no emergency beds whatsoever. NUM has been augmenting (cost her double time on the weekend, but now she is pre-booking). Staff are starting to hate working on weekends. It used to be kind of relaxing; not so anymore. I wonder what will happen; something has to give.

**The Staff Development Nurse Work Contextual Background and Roles**

It is also important to consider the nature of the work of the SDN in the contextual background of this study. The SDN carried out her interpretation of the mandate she was given from the job description. She had her own unique educational style and her own philosophy about nursing and patient care. Once again, in order for interpretations to be
accurate and meaningful, they must be made within this context. Data for this section came primarily from interviews with the SDN and the NUM, interviews with the staff, the one-year 4C staff questionnaires, and observations and informal interviews the researcher documented.

Background

Clinical competence of the eventual SDN was considered to be of paramount importance for the Project. The interview process sought to find a candidate with high levels of clinical expertise, as well as a solid teaching background. The candidate chosen had an extensive nine-year nursing background in emergency, flight, and intensive medical care nursing. She also possessed a background in the technical aspects of nursing care with IV pumps, IV lines, chest tubes, drug administration, and patient monitoring devices. The SDN came with a high level of skill in patient physical assessment, which all but two of the staff formally interviewed reported as helpful to them. There was no mention by anyone interviewed or surveyed that the clinical competence and skill level of the SDN was at anything other than a high level.

The SDN had not worked in this particular kind of educational capacity before. She had limited previous experience with teaching student nurses in the clinical setting, and had done presentations in front of small groups on occasion. To give herself an orientation to staff education, the SDN visited her staff development colleagues in Calgary, Alberta at a large teaching hospital for a two-day span, and kept in contact with other staff development colleagues in Alberta, Ontario, and Saskatchewan. During her time on 4C, the SDN attended two staff development conferences, a team-building experience, and kept current in her knowledge by reading professional journals and books. She also kept up her yearly required certification and became a CPR instructor.
The SDN stated that for her, 4C was the best place to work, and she was glad that she was on that unit. At the time of the job interview, she felt that she had more medical skills than surgical, but that did not seem to be an issue for the Project on Unit 4C. The SDN indicated that the hospital was good place to work, although she had worked in more positive, administratively-supportive environments. Despite her perceptions, she shared that she had received a good amount of positive feedback from Nursing Administration during the Project, not only from the NUM, but also from the Director of Surgical Services and the Senior Nursing Director.

The SDN position was a union position, under the direct supervision of the NUM. Opting for a union position was an important philosophical choice. It was hoped that with the position being within the union, staff would not perceive the SDN to have any influence over their performance appraisals, or perceive that the SDN was a “manager”.

Goals

When the SDN started, she was looking for a number of opportunities: 1) to have a new challenge in staff education; 2) the opportunity “to explore something where I could learn also”, and 3) prove to herself that she could actually work in staff nursing education. The SDN had previously had a disappointing experience teaching college students—her disappointment was mainly due to the lack of support and guidance from the college program with which she was affiliated. The SDN thought she would give nursing education another try, but this time from a staff educator perspective. A formal set of goals and objectives were jointly drafted by the NUM and SDN and presented to Nursing Administration.

Relationships with Others

The Nursing Unit Manager. The relationship between the SDN and the NUM was regarded, even from the planning stages of this Project, to be one of crucial importance.
The relationship with the NUM was reported by the SDN to be very strong. Indeed, through the course of the Project, both the SDN and NUM reported that a real bond was formed between them. The SDN spoke positively about the NUM, stating that she was very happy to be able to work with her. She realized the positive aspects of working together as a manager and an educator, and appreciated the fact that she did not have to run back and forth all of the time to make sure that what she was doing was acceptable to the NUM.

The NUM reported that an open, candid rapport quickly developed between the two and a healthy working relationship resulted. The NUM and the SDN treated each other as mentors, and often discussed openly the frustration and rewards of the job, providing a therapeutic environment for both when reliance on a peer level was needed. The SDN indicated that for many of the conversations between herself and the NUM, the SDN could say whatever she wanted and it would be accepted and understood. The following excerpts from the SDN journal illustrate the significance of the relationship:

1. 21/05/92. NUM asked me whether I could give her feedback on her role/staff’s perception, etc. I told her that in the beginning, I heard more of “Management isn’t supportive”, etc. I always countered that by explaining in which ways NUM was supportive of the staff; “But she’s management”. Well, yes... . I suggested to her that maybe she should promote herself more—4C staff don’t have any idea what she does for them, don’t appreciate it, don’t see it. Also, maybe it’s time to let go of some of the control—it’s actually a normal flow in the Team Leading process, for staff to take on more responsibilities (i.e., do rounds with the physicians for their own side). NUM seems to have a hard time of letting go but it’s a growing process and maybe it is time. I told her as well that I get feedback like “going to the O.R. is the greatest idea” or “visiting all these different areas is just such a good idea”. I respond to the staff, “It was not my idea, you know, it was NUM’s”. They are usually flabbergasted.

2. 19/06/92. I think that NUM and I should write a paper on our relationship and how it in turn influences so many other factors. I think that we not only complement each other, but that we enhance each other as well.
3. 21/06/92. In the afternoon, NUM and I worked on putting the binders together for parenteral/enteral nutrition. We talked about all sorts of things. How she liked her job—well, that opened a gate... I suggested to her to bounce some frustration off of another NUM, because she had had similar episodes and seemed to have found an effective way of handling these issues.

4. 21/06/92. NUM and I both decided that both of us need more feedback and that we will use each other more in regard to this.

5. 16/07/92. Talked with NUM re: my concerns. She gave me some good feedback... She herself had had a similar situation with a staff member. NUM even gave me some examples to go with her feedback.

6. 21/08/92. At coffee overheard people talking about burnout and no wonder. I brought this up with NUM. She has been augmenting evenings and nights, but not days. I suggested to her that maybe day staff needed a break as well. At first she was not too keen on it but a little later she came up to me and said that she had gotten an augment for tomorrow. It's issues like this; I don't feel that I'm attacking her and I believe that she doesn't feel threatened by me. We can suggest things to each other, knowing that it'll be taken in light of things that are happening. We both want what is best for staff/unit and we'll try to obtain that. In the process, neither one feels hurt/attacked or any other feelings by the other.

7. 09/09/92. That's one thing I really appreciate with NUM, and she and I can talk about things, letting our feelings be known. Trying to figure out what things happen/didn't happen, do some soul-searching, etc. Very beneficial for both of us.

The NUM was reported by the staff, the NUM herself, and the SDN to support the educational activities of the SDN, as evidenced by these excerpts from the SDN journal:

1. 04/10/92. NUM bought me some fluorescent posters—she was on a shopping spree yesterday and got them for me.

2. 26/10/92. The NUM negotiated with another floor to send some staff up to cover so 4C's staff can go to the case study that I had arranged. Unit 3A had sent a computer message offering help.
The SDN also reported that there were areas, mainly focused on staff management, which she and the NUM could not discuss in detail. These areas were: 1) issues of unit/staff control, b) perceptions of how work was done by the staff, and c) professionalism of the staff. Regarding issues of unit/staff control, the SDN perceived that the NUM needed to be in control of the unit, because she felt responsible for the patient care outcomes on the unit. The SDN also reported that her own primary concern was education and that management decisions were for the NUM to make.

As the Project progressed, when conversations between the SDN and NUM turned to leadership, the SDN perceived that was where the discussion ended. The NUM reported that indeed unit leadership was the focus of conversation on a number of occasions while the SDN was on Unit 4C, but the NUM wanted it to be clear that she was the manager, and that the SDN was the educator. The following SDN journal excerpt gives clues to this aspect of the relationship:

14/05/93. NUM is very much like that, building up, not blaming, always listening, always objective. Then later that day something else occurred (I would have handled it so differently, but NUM just leaves everything open). I find it awkward though—to complement NUM; maybe because she is my supervisor and I hate brownnosing—guess I do not want to leave that impression.

Another area was the difference between how the NUM perceived how work was being done by the staff and how the SDN perceived it was being done. The NUM was perceived by the SDN to understandably "protect" the staff to a certain degree. For example, the SDN commented that the staff did not always work well as a team. This situation was thought by the SDN to be a management responsibility by the NUM, but she reported that even at the end of the Project, the NUM did not see the team work format as a problem at all; the NUM did not think the floor was still disorganized, the SDN did.
With respect to professionalism of the staff or when the SDN was critical of someone who the NUM held in high esteem, the SDN stated that she had to be careful of how she worded her part of the conversation:

19/05/93. There are some things that I cannot talk with NUM about—a while ago I mentioned something about professionalism (which I think needs improvement on 4C). NUM gets quite defensive then. And rightly so, it's her job to support and build up staff (so is mine) but I have to bitch about it at times. Flirting and professionalism don't go very well together and 4C has a long way to go.

The NUM and SDN were both enthused about working together, but by the end of the 18 months, had agreed to disagree on a number of items. The NUM also shared that if the Project had not ended, she would have needed to have had a major philosophical discussion with the SDN about issues of control of the unit, and handling of some staff situations. Despite these differences, both women reportedly enjoyed working together.

The Staff. Relations with staff were reported by the SDN to be generally positive. The SDN was described by staff interviewed as: having appropriate experiential and educational background, as being fairly flexible (became more flexible over time), and being resourceful. Two staff interviewed stated that the SDN sometimes had a different point of view from them, but that this was not necessarily positive or negative.

When asked to comment on the role of the SDN, most staff described her a resource person to go to, a teacher who followed up on past learning experiences, there basically for those who had started recently to increase their confidence levels. There pervaded throughout the Project an uncertainty on the part of the staff about the role of the SDN. This issue will be highlighted later in the chapter.

There were about four or five staff nurses who, the SDN commented, were quite distant and non-committal throughout the Project. Some staff the SDN believed she never reached; others she was involved with extensively. Here are characteristic comments 12 different staff members had about their involvement with the SDN during the first six months of the Project:
1. I have no contact with her, sometimes I feel that the permanent night nurses are ignored.

2. I have attended one inservice. (two nurses)

3. I have gone to the O.R., and have discussed the possibility of going to other inservices. (two nurses)

4. I have discussed ideas for inservices—more information for staff and patients on the unit (i.e., written materials).

5. Basically I have had nothing to do with her. I talked with her for five minutes once.

6. She gave me assistance transferring patients, and some advice on organizing the team.

7. We've talked personally; I've asked to help with friction between myself and the NUM.

8. She is easily approachable for questions and a good listener.

9. Have not been involved yet.

10. She has been very helpful for staff on: procedures, good with bedside demonstration of technique, and is a good communicator.

11. We did an interview on goals and objectives and I shared with her my frustrations. I have approached her several times with questions about certain procedures and things that I would appreciate inservicing on. She arranged for several of our staff to observe in the O.R.

12. She helped out on the floor, covered for nurses in the O.R. She is very willing to answer questions or find the answers.

The SDN felt earlier in the Project, that one particular nurse with a considerable amount of experience did not trust her. The SDN commented that she was increasingly frustrated because she "could not reach" this particular nurse. She shared her problem with a colleague, where they brainstormed ways to work with this nurse. The eventual way that was successful, which brought this nurse around to be a true support for the SDN, was to acknowledge her education and experience, ask for her opinions on various issues, and get her involved in some program planning.
The SDN got somewhat involved with the staff on a social basis. She brought a birthday calendar back from a trip to Holland and the unit clerk put everyone’s birth dates on it. This action then led to cakes being brought for staff members on their birthdays, and this activity was enjoyed by all. The SDN also had a small Christmas party at her house which was attended by some of the staff, and went to a baby shower of one of the people on the floor. The staff held a going away/baby shower for her when she left.

The fact that the SDN became pregnant affected the staff and NUM in interesting ways. The staff were initially shocked, because they reportedly viewed the SDN almost solely in the context of her position, as a career person, not interested in “regular things”. She appeared to them as a somewhat aloof, formal person, and her pregnancy made her seem more “human”. One of them stated in the interviews that “the pregnancy was good for her; we could relate to her more easily”. The NUM also reported a positive difference as the staff started making sure that the SDN was asked to lunch, dropped by her office more often, and the night staff even made a care package to help her “get through pregnancy”.

On the other hand, the pregnancy also created a definite time limit to the project, as the baby was due to be born at the end of August, 1993. Knowing this, some staff simply delayed any involvement with the SDN. The SDN also found that because of the extra energy requirements pregnancy takes, her own enthusiasm waned during the last few months.

One of the areas of conflicting perceptions reported by the staff was the nature of the relationship between the SDN and the NUM. Some staff members interviewed shared that the SDN was perceived to be spying and telling the NUM some privileged information. Some staff were reportedly wary of becoming too involved with the SDN, because of what might be reported to the NUM. Excerpts from the SDN’s journal explain this issue and how it eventually affected the SDN/NUM relationship:
1. **05/11/92.** It is true that NUM and I discuss a lot but not in detail of who did what, when, and where but rather in general terms and solidifying what we as individuals think. This is really too bad and I hope that it won't taint further relationships.

2. **07/12/92.** ...and she mentioned that staff believe that NUM and I “talk about” everything. I explained to her that NUM and I do talk a lot but I never present things such as “she did this, or she doesn’t know that, with names and everything”. I do present categories to NUM, just to bounce off ideas. There have been times that I did have to tell her something specific, but then the person involved did know about it—that I was going to take it further because of patient safety. Staff don’t believe that things are confidential between them and me. This really upsets me. I can understand that they view it as such—I’ve been used by some staff in the past; that may have something to do with; people see and hear us talk a lot; NUM confides in me, etc. I explained my position to another staff member as well; hopefully with the help from two nurses things will filter to the rest.

3. **11/01/93.** NUM and I still talk a lot, but maybe unconsciously I’m not seeking her out as often (after staff mentioned confidentiality).

4. **21/02/93.** Commented to NUM that I thought there was an underlying event—staff not trusting confidentiality between NUM and SDN. NUM thought about it for awhile but then remarked that maybe what I was feeling had something to do with me not being that visible lately—and that is true; I’ve kept a low profile on the floor, working on the workshop, etc. She suggested that I hang around more again.

When asked if she had noticed any changed behaviours from the staff about the confidentiality issue, the SDN noted that some staff had pulled back; they were not as “chatty”. They still came to the SDN for professional items, but not so much with personal items. Both the SDN and the NUM reported that this situation had resolved itself somewhat by the end of the Project.

**Physicians.** The SDN reported her relationships with the physicians in general, as professional. She reported that while some physicians were good at communicating with her in a professional manner, others would either ignore her or make negative comments about her position. She interacted with them from an educational point of view,
arranging for presentations, gathering information for her own preparatory work, and following up on physician presentations. The SDN stated that she preferred to remain somewhat aloof from the physicians, not getting caught up in what she described as “the social, flirtatious atmosphere that characterized some nurses’ relationships with physicians”.

Nursing Administration. The SDN was in a unique position in relation to the hospital nursing administration, as she had been part of that group prior to becoming the SDN. This is her impression of Nursing Administration from “the other side”:

1. 27/05/92. I was thinking over the weekend as well how strange this organization is. Not any stranger than other organizations, mind you, but still strange. Take attitudes, change in behaviour for example, or just plain gossiping. While I was supervisor, I talked with K.Q. and K.M. (two members of Nursing Admin) on a daily basis, same as with other people. Now, as an SDN, in a different rank, you get a completely different tone of response. Even with S.G., now I have the feeling she talks to me out of courtesy, rather than interest.

2. 07/8/92. One of the directors dropped by this afternoon. She was quite interested in the roster, talked a bit about differences in approaches in education. She is actually a good support.

Other Areas in the Hospital. During the 18 month time-frame, the SDN had contact with almost every nursing unit and support service in the hospital. The rapport built between the SDN and various members of these other areas was reported by the SDN as positive. The SDN also felt that as a representative of 4C, she established a more positive rapport for Unit 4C than had previously occurred with some areas. Contacts with other areas ranged from gathering information for her own presentations and setting up visits for the staff, to giving other areas helpful hints and suggestions regarding educational issues. The SDN also had involvement with various sales representatives and supply companies who deal with LRH.
**Education Resources Centre.** The relationship that existed between the SDN and the LRH Education Resources Centre (ERC) was an interesting one. Historically, the ERC was a department of its own, where the educators carried out hospital-wide education and also had designated nursing areas as their individual educational responsibilities. ERC also was the central area within the hospital responsible for library resources, certification manuals and equipment, audio-visual production, audio-visual equipment loaning, and adult education resources.

Within one month of the SDN introducing herself to the staff in ERC, a meeting was called to deal with some issues. The Project leader, SDN, NUM and all of the staff in the ERC were to attend. According to the ERC staff, they had not been briefed at all on the role of the SDN, and felt that because of their perceived vulnerable position within the institution, the SDN was a threat to the future of ERC. The purpose of the Project was outlined and the research methodology discussed. The issue for the ERC staff was even more intense, because at the time of the SDN being hired, there was no ERC educator for any of the surgical nursing areas.

It was clarified that once the ERC educator was hired, she or he would provide educational support for all of the surgical areas except 4C. The SDN would network and support the resources of the ERC, like hospital-wide orientation, the general nursing certification sessions, but would also be responsible for unit-specific orientations required by 4C staff. The ERC staff also requested that for the purpose of the research, for all research project successes, the resources from ERC be fully acknowledged.

From this uneasy beginning, relations with some members of ERC grew strong, while with others relations remained distant. The SDN utilized resources from the Library, the audio-visual studio, the CPR dolls, and IV manuals.

The new ERC educator for the other surgical areas started in June, 1993, some five months after the SDN started on 4C. The relationship between the SDN and ERC
educator evolved into a tenuous one at best. They did have some joint projects and presented some inservices together, but their working styles were reportedly different. There were reported competition issues from both the SDN and the ERC educator, not only for ideas, but for staff, equipment, and for rooms to do inservicing. The two had different personalities, philosophies of education and of human nature, and coupled with inherent differences in their respective roles, the surgical education scene made for some interesting times. In short, the SDN and the ERC educator "rubbed each other the wrong way", as the SDN says. This uneasy relationship did result in many many "frustration-release" entries in the SDN journal.

Since the closure of the Project, and unrelated to the Project results, the clinical educators have been removed from ERC and now work under the direction of their respective Nursing Directors. The ERC, as such, is no longer a separate department.

The Role of the Staff Development Nurse

When she first started on the job, the SDN conducted individual needs interviews and assessments with almost all the staff members. Staff were asked about: the clinical skills they were interested in learning (a list of 35 items was provided and staff could list other items as well); about their interests (educational, professional, and personal); committee, conference, or workshop interests they had in either planning or presenting; whether or not their annual required certificates were up-to-date; how they liked to learn best (by lecture, hands-on, discussion, or with video); their goals and objectives for the next six, 12, and 18 months; and, how the SDN could best help them.

The formal staff needs assessment was conducted from April 7, 1992 until the third week in May, 1992. The SDN reported that a portion of every needs assessment interview was used to clarify her position for the staff and describe the Project.

The SDN indicated that initially she found a large degree of mistrust among some of the staff. She discovered that there was actually a large pervading perception among the
4C staff that they were “hopeless” and needed help; that they were not good nurses and that the SDN was “sent to make them better”. The SDN speculated that the staff had been through so many leadership changes in the past that they were unsure of who to trust. The SDN tried to quell their fears by stating that 4C had experienced some rough times, through no fault of their own, and that the intent of the Project was meant to be positive for the staff, and that one of the reasons their floor had been chosen was because the 4C staff were known for their enthusiasm. The SDN also perceived that the staff on 4C had “bought into” the “disorganized” label that had been given to their floor from other nurses who had floated to their unit.

In order to increase their trust in her, the SDN promised that she would keep the needs assessment information to herself, use the ideas they gave her for education, and give each of them their interview information when she finished the job. She followed through on her promise. Neither the NUM or the Project Leader saw the data.

The formal staff needs assessment interviews were followed up by the SDN with a set of interviews at the 10-month mark, as well as at the end of the Project, to see how the needs had been met.

The SDN also derived information for her needs assessment from other sources. These included: the NUM of Unit 4C, her own observation and documentation of patient care on the floor, requests from other departments or units, reviewing the required yearly certification requirements of the staff, requests from patients, family and physicians, organizational priorities such as accreditation, the Director of Surgical Nursing Services, nursing students and instructors, and staff requests. These kinds of needs assessments were conducted virtually from the first minute the SDN appeared on the floor, and continued to the end of the Project time-frame.

The next thing the SDN did with the educational information from the staff was to assess the data, determine commonalities, prioritize, and then she began to implement the plans for teaching. The SDN utilized flex time so that she could reach all shifts.
Planned Educational Activities and Events

Many formal educational sessions were planned. For example, some surgeons who
admitted patients to 4C were approached by the SDN to talk about various procedures.
The SDN got other staff on 4C involved in doing presentations. Five RNs and one LPN
did inservice presentations on their own after attending a workshop in another centre or
did case study presentations with some of the surgeons. Most of these presentations were
open to any staff member in the hospital, and staff from many other areas did attend.
During the 13 months, over 40 inservices were presented to large and small groups either
by the SDN herself or by others she had asked to present.

Other activities planned by the SDN included: facilitating development of standard
care plans for surgical patients at LRH; developing an enteral/parenteral nutrition manual
for use at LRH; developing a manual for Patient-Controlled Analgesia (PCA); reviewing
all policies and procedures drafted for 4C and facilitating staff review of these
documents; conducting mock codes; and teaching the yearly certifications such as CPR,
unit fire protocol, blood glucose monitoring, and IV therapy. Audits were done on PCA,
where the SDN got the patient charts from the Health Records Department, and the staff
audited the charts for adequate nursing documentation. IV audits were also done where
staff would audit the other team's IV tags, charting, and sites.

Almost all 4C staff members were scheduled to visit the O.R., Medical Imaging
Department, ICU, Post-Anesthetic Recovery Room, Pharmacy, and the Laboratory for
either tours, or actual observations of procedures. Some staff also went to the Morgue.
The intent of these visits was three-fold: it was perceived as a great opportunity to
conduct positive public relations with other departments; it allowed 4C staff to see how
other departments worked in relation to themselves; and, it was a good way for staff to
gather useful information to then teach their patients in preparation for various
procedures.
SDN Journal, 07/05/92. Took two RNs on a tour through the Lab—they were so impressed. After you have seen chemistry/bloodbank/hematology—then you go into histopathology/microbiology/toxicology, isotope and fluoroscope. Quite overwhelming. “I'll never phone the data centre any more if I need the bloodbank! I never knew it was so huge! We don’t see half the people who work here! They’re always so patient with us when we phone the wrong number, but they always help us to the right place”.

The SDN also set up some “Multipurpose Session Teaching Rooms” in three vacant patient rooms on 4C during the 1992 summer bed closures). Staff were invited to travel from station to station, gaining experiential learning from the activities at each station. There was a station on WHMIS and hazardous workplace materials, which involved a “Wheel of Fortune” game, a mock cardiac arrest room, a mock isolation room, a policy and procedures “Jeopardy” game, and a section of one room devoted to “Did You Know?” in which all sorts of hospital supplies and services were costed-out so the staff could become more knowledgeable about hospital economics. The SDN eventually wrote an article on this type of learning for staff nurses, because of its positive feedback. The SDN journal gives a good account of this planned activity:

13/07/92. Took the first three people through the rooms—more a type of hostess/facilitator—explained what has to be done and they do it. Except for the “Jeopardy Game” where you actually have to ask questions, they wanted more of it! (Competition—“I got more right than they did!”) The WHMIS wagon was a success as well—using the wheel to find out what to look up in the MSDS for a certain product. The unit economics part was enlightening and the mock isolation room was skill-testing. One of the nursing directors came through—was really impressed. She mentioned that she would suggest it to other nursing managers—so they could test their skills.

The SDN was also influential in getting more 4C staff involved as: members of unit and hospital committees, LRH representatives to various association and interest groups, and participants in interesting workshops. In addition to their previous memberships, Unit 4C staff were represented in: the Patient-Controlled Analgesia program (a trial and pilot implementation program were held on Unit 4C in the summer of 1992), “Patients
Walking to the O.R. program, the Orthopedic Interest Group, Canadian Society of Gastroenterology Nurses, Urology Interest Group, the Surgical Nurses Committee, and the Pre-Op Assessment Clinic Planning Committee. The SDN would often see brochures for interesting workshops and forward them on to staff whom she knew were keen on certain issues.

The Surgical Nurses Committee (SNC) was resurrected when the SDN came, with the SDN as chair. Nursing staff from all of the inpatient and outpatient surgical areas of the hospital were recruited to represent their area on the committee. The SNC met almost every month, accomplishing a great deal of work. For example, that committee redrafted the old Terms of Reference, rewrote the standard nursing care plans for all surgical patients admitted to LRH, reviewed discharge education materials and rewrote them, organized and presented a workshop on “The Acute Abdomen”, directed to LRH and rural hospital nursing staff on April 1 and 2, 1993 (staff from LRH and physicians presented), and developed a new pre-operative teaching video along with staff on 4C. The SDN reported that this committee gave her a great deal of satisfaction because of all of the work that was accomplished, but was also a great source of frustration because of some lack of motivation on the part of some members.

Unit orientation sessions were designed and coordinated by the SDN for eight (mostly casual) staff during the course of the Project. The SDN drafted a standard unit orientation package to be used on 4C as well.

The other activity of note was that of a picture that the SDN constructed to display photographs of the staff on Unit 4C. The SDN took pictures of each of the staff members, mounted them, framed the whole thing, and placed it on the wall outside the conference room. This generated much pride, and a sense of professionalism, among the staff as reported by both the SDN and the NUM.
Spontaneous Educational Activities and Events

The notion of immediacy was also utilized in that questions on the floor from staff were handled by the SDN usually at the time of asking. If the question required further research, the SDN would do that in a timely manner. Other educational sessions were not planned; either the need came up quickly, such as a patient who was discovered to have gas gangrene (a condition rarely seen), or when a staff member called the SDN to help with a patient situation and some teaching was carried out on the spot. When pertinent articles could be found, the SDN placed them in a binder (FYI Binder) in the conference room so that all staff could benefit from the information.

The SDN stated that she had to adopt an attitude of “going with the flow”. She commented that she responded to immediate staff needs rather than what needs they may have outlined in their needs assessment interviews weeks earlier, or what she had wanted to cover. For example, the SDN wished she could have done more demonstration format or individual staff nurse sessions with total parenteral nutrition (TPN) and central lines complications, but the other immediate patient/staff needs often took precedence.

The SDN’s favourite kind of presentation turned out to be “show-and-tell”, where she would go to a patient with a chest tube or an A/V fistula for dialysis. (This learning opportunity was planned ahead; there was no immediate patient crisis.) Right at the bedside, the SDN would then teach the staff about various aspects of care and safety factors. As the SDN was explaining something to the staff nurse, the patient listened as well. Often the patient would comment on how they actually managed something related to their own care or explained aspects of their condition. Regrettably, the SDN reported these show-and-tell sessions did not happen a lot because the staff were busy most of the time.

When asked what educational format was most often used, the SDN commented that over time it became apparent that the one-to-one informal, “spur-of-the-moment”
education was the most often used, followed by a demonstration format, where two or more people would be shown a particular item or procedure, such as chest tube drainage, or TPN set-ups. The third most often used was the lecture/inservice format, interestingly, the way the SDN had initially though her role would be, and which she arranged in the beginning of the Project.

When asked about the kinds of roles she found herself in during the Project, the SDN replied: "When I look at various roles as an educator, I thought at the beginning that I would be a presenter of lectures more often, but I turned quickly into being a facilitator and a conversationalist, where education took place in small conversations while doing other things, and by debriefing informally with staff when they would make comments about patient care situations that had happened".

Outcomes of Educational Strategies

The SDN kept documentation of all of the educational activities that the staff on Unit 4C were involved in during the 18 month period of the Project. She recorded attendance for each staff member and kept track of the dates for certification renewals as well.

Some planned inservices were well-attended, others were not. The NUM also reported that the SDN had informal power, that addressing the staff got the process of education going, but that the formal part, the set-up inservices, really "turned people off". Staff attendance at inservices presented or organized by the SDN decreased but staff attended in greater numbers when physicians presented. Some excerpts from the SDN journal highlight the difficulty in conducting planned educational inservices:

1. 23/04/92. The NUM, six second-year students, and one LPN stayed behind on the floor. During the inservices I was presenting it became apparent that people were watching the clock, shifting, etc. Afterwards, I talked about it and: 1) too many nurses off the floor (all four came),
2) thinking about what is happening on the floor, 3) it was a good inservice, learned a lot. I discussed this with the NUM, apparently the unit clerk was really upset as well. Anyway, if this is a problem, it may be to my advantage to approach this differently.

2. 19/11/92. Did some floating on the floor picking up little things. Even with the students on, it's hard to really accomplish anything with the staff.

3. 24/04/93. I'm not sure these inservices are ever going to work out again. Staff are working on the new NISS (charting system) now between 10 and 11 o'clock (one of my favourite time slots), and then between one and two o'clock, patients come back from the O.R. and admissions arrive. It almost seems hopeless. With the new Pre-operative Assessment Clinic (PAC), it might get a bit better in the afternoon. Even the short, 10 minute inservices staff don't always get a chance to attend.

4. 20/05/93. Haven't been able to do CPR at night, not due to lack of trying, just too busy.

5. 21/05/93. Had to cancel my plans re: PCA inserviceing. Everything looked fine this a.m., then around 10 o'clock things got pretty chaotic.

6. 19/07/93. Been too busy today to do more mock code principles with the students. That's too bad.

Other people in the institution also commented on various educational activities that the SDN conducted. Most of the comments were very positive and almost envious. For example, the SDN shared that it was noticed by the Fire Marshall that inservices on fire drills were going so smoothly on Unit 4C, that he wished all floors were like that unit. A senior nursing person also commented to the SDN, saying that she was hearing so many wonderful things about the SDN; how other floors were commenting on how relaxed the NUM was looking since the SDN has been around.

The SDN actually became a kind of local celebrity for designing the multipurpose rooms, and often had people comment to her directly or to the NUM about how interesting and useful staff from all units had found them. The same theme was used during an LRH atrium display in recognition of International Nurses' Week. The pre-op
video done by the Surgical Nurse Committee was also a great hit. The entire Nursing Administration, the Director of Development and Communications, the Medical Director, Hospital President and Board, and the hospital Accreditation teams visiting at the time all came to see it. The video was also highlighted at the hospital telethon as a promotional tool, and copies were given to the Lethbridge Public Library and to Cable TV.

The involvement the SDN had with staff members ranged from working on clinical skills, to organizational skills, to helping with presentations, providing emotional support, giving information through the educational process, getting staff to do proofreading, helping staff prepare for job interviews, writing care plans with staff, working on communication skills, working on team building, and gaining moral support from some of the staff.

The SDN reported that she did learn a great deal about group dynamics and human relations, being able to use those dynamics in a positive manner, and about "turning energies around". She also learned to emphasize the quick "bottom line" as she got more comfortable with educational sessions of various formats. She learned about the politics of the nursing department and the fact that they were always there. She felt that the politics affected her and her work. She also stated that she had not learned as much as she had hoped. She had wanted to do more one-on-one education sessions and would like to have been questioned more by staff. She often felt conversations with staff were one-way—from the SDN to the staff member—but that two-way would have been better; she felt she always had to take the initiative.

One of the greatest learning experiences reported for the SDN was the writing of the journal. The SDN wrote almost everyday for 18 months. The journal became a significant form of continuous follow-up for her, as she was able to read back in time and compare aspects of her mandate. For example, in the area of expectations of herself, the
SDN indicated that she was often too hard on herself; when she looked back in her journal, often situations for which she had chastised herself had turned out positively anyway:

1. 16/07/92. Now, I discovered something else—it wasn't M.N. who gave me the low evaluation, it was her student. Maybe I'm looking for things or maybe I'm negative... . The other two students gave me high evaluations....

2. 24/07/92. I guess I'm approaching everybody in the same manner, this doesn't work with M.N.—will have to change my approach/attitude.

3. 01/10/92. Did evaluations of last month's activities—on paper doesn't seem like I did a lot. Luck of the draw, I guess.

The journal was also found to help delay some of her reactions until after she had thought about things and become more objective, and thus more able to determine a solution. Conversely, the journal allowed her to be more proactive; by writing things down, the course of action for a given situation became clearer:

13/8/92. NUM and I will both do some thinking on the subject of CPR. I tend to favour my initial thoughts again. Take 10 minutes after report to do a short blurb on something that has come up. Then no one feels they're pulled away. Night staff will have to stay longer but maybe they can be reimbursed. Or even five to 10 minutes, twice a week. I think it is worth a try. If the predominant feeling is that it is too disruptive to go away, then this could be an alternative. Going away for breaks is not seen as disruptive. Once people are conditioned that, say each Thursday afternoon, we will have a short inservice then it just becomes part of the routine. That is actually a frightening, but understandable concept. The staff have to be so flexible already that the routine they have is very important.

The journal also provided the opportunity for the SDN to evaluate her educational strategies, based on how well the information she passed on was integrated into practice. She wrote about both aspects of education in her journal:

1. 16/07/92. That's my other point—am I losing the individual needs because I'm doing too many projects (O.R., PARR, Lab, MI)? NUM and I agreed
that I may need to focus in a bit more on the individual. Once these multipurpose sessions are over, I’ll start working on the roster (taken from the needs assessments). That will meet the personal needs more I hope.

2. 24/07/92. One soon realizes their errors. When I handed out the six-month evaluations, I did some things on purpose: i.e., the scale 1-5 (I hate 1-7), but now I’m getting the first evaluations back and some areas only have a “3”. Now I want to know why. But I didn’t leave any space for comments or suggestions either. Next time will be better, I hope.

3. 29/07/92. Interesting to see that the inservices done already (i.e., hips, CBI/TUPR, tube feeds) rank low on the interest according to the needs assessments. Yet so many people showed up and the feedback was—that was exactly what we wanted to know, that was great, that really helped, etc. Shows very little correlation then with what they wanted. Or is that a reflection of not having put a lot of thought into the needs assessment, or that physicians did a lot of the presenting?

4. 06/07/92. More on the Policy and Procedures inservices. I find that presenting in the morning at report is no longer effective. I will now leave shortened versions on the computer (generic password to access all staff)—we’ll see how that works.

5. 05/08/92. NUM had mentioned to me as well that I should make a note in my journal re: Policy and Procedures; how the first idea (posting) did not work well and that the second idea (presenting one or two after morning report) seems to work much better.

In summary, the SDN came to her position with a rich experiential background. Together with the NUM, the SDN set out goals and objectives to use as guidelines for her activities during the 18 month Project.

The SDN had positive working relations with most of the staff, physicians, nursing administration, and other areas within the hospital. The nursing staff on 4C were fairly open to working with the SDN, but some staff members were perceived by the SDN not to understand her role. Also the issue of breech of staff confidentiality between the SDN and the NUM was perceived to be a threat by some staff nurses. Some staff nurses were worried that SDN would talk to the NUM about clinical competence levels. The SDN
also had an uneasy relationship with her counterpart in the Education Resource Centre, reported by the SDN to be due to differences in personalities and philosophies of education.

The SDN started her position by working with the staff of 4C firstly to get an orientation, then she conducted an educational needs assessment with them. Based on the information given to her, the SDN planned many educational events. Gradually, the SDN found that although the planned educational activities were generally helpful, they were not welcomed by the staff or as conducive to learning as she had originally thought. The spontaneous educational activities (demonstrations, one-to-one short learning sessions) turned out be more acceptable to the staff nurses and effective for the SDN. The NUM and the staff interviewed indicated that during her 18 month time-frame, the SDN had increased the level of educational opportunities for staff nurses on 4C.

The researcher visited the unit on a regular basis for most of the Project and almost daily for the last 36 weeks of the Project. Looking back over the researcher's journal and her categories of staff morale and SDN/staff cohesion, some trends were observed with respect to job satisfaction. The researcher always found some of the staff on 4C smiling and fairly positive no matter what was happening.

The researcher observed that the SDN spent a few weeks after she initially started orienting and getting to know the staff. Once that phase was over, it seemed as if the SDN got busy with educational activities in a big way. It appeared to the researcher that in those first few months, the staff on 4C were amazed at the speed at which the SDN made things happen. Within a few months of starting, the SDN had involved many people in the educational activities and it almost seemed as if they got caught up in the opportunities available. On all accounts—from the SDN, NUM and staff interviewed—staff morale seemed to be high over July and August, 1992.
The staff appeared more comfortable with the SDN within two months of starting, once they had ascertained the SDN's personality and educational style. The individual needs assessments were noted in the researcher's journal to be almost all completed by March 24, 1992 and, looking back, this strategy appeared to be a positive one for starting working relations between the SDN and the staff on 4C.

However, there were still challenges for the SDN in reaching some of the staff on 4C, as evidenced by this excerpt from the researcher's journal:

1. **14/07/92.** Went to visit the multipurpose rooms the SDN had set up. I travelled through a few of the stations with the SDN and we finally came to the "mock code" room. One of the 4C nurses and her preceptor student were just going to proceed with a mock code. The SDN offered to help. I sat and watched and bit my lip for fear I would say something out of turn. What ensued was a "tug of war" between the SDN and this particular nurse over what and how to teach the student about how to handle a cardiac arrest. The SDN wanted to go through the procedure from start to finish; the nurse wanted to highlight each step along the way. The student was getting visibly frustrated. The encounter ended in a stand off between the RN and the SDN; the SDN and I left the RN and the student to continue.

2. **05/08/92.** M.N., the same nurse who had the student preceptee a couple of weeks ago came up to me as I was talking at the desk with the SDN. In front of the SDN, this nurse asked me if I had any articles about the care of patients with gas gangrene! The SDN was wondering why this nurse was asking me and not her; I felt uncomfortable, and this nurse seemed quite angry. What!!!

Under the category of "SDN/staff relations", the researcher made notes on various times when the SDN was observed in educational activities with the staff where the nurse would ask the SDN about a certain piece of equipment and a new technique and the SDN would explain whatever the topic was and they would go off to see that patient, or the staff and the SDN would be coming from a patient's room after an educational event and debrief at the desk. There always seems to be an air of respect for the SDN and a politeness when the staff interacted with her.
It also appeared to the researcher that the staff became calmer and generally more confident and relaxed with their daily work gradually over the Project time-frame. Two particular journal entries are recalled, one in April, 1993 and another in July, 1993, where the researcher wrote that the staff seemed more "well-rounded" and "solidly confident" than they had been in the early days of the Project, where often they were seen "wide-eyed" and appeared stressed and "strung-out".

Research Question Number One Findings

The first specific research question was: "What is the Impact of Implementing a Full-time, Unit-based Staff Development Nurse Position on: a) nurses' perceptions of their own job satisfaction, b) nurses' perceptions of their peers' job satisfaction, c) nurses' perceptions of their own clinical competence, d) nurses' perceptions of their peers' clinical competence, and e) patients' levels of satisfaction with their nurse care? Each component of this question will be addressed in order.

It is extremely difficult to isolate the issues of either job satisfaction or clinical competence, and harder still to relate them to the influence of the SDN. During the analysis of the data, it was difficult to determine at times where the information on job satisfaction ended and the information on clinical competence began.

Although it was intended initially that certain data collection techniques would be the primary sources of data for specific components of the research questions, it quickly became apparent that data from many or all sources had relevance for many, if not all of the research questions. For example, it was anticipated that staff questionnaires and interviews would be the major data sources for the questions on staff perceptions of their job satisfaction. However, the question was also addressed through the SDN journal, the
NUM interviews, the researcher's own journal and even the patient satisfaction surveys. Therefore, rather than discussing the results according to procedures, they are discussed by research question and most of the relevant data are considered in attempting to address each question.

Impact on Nurses' Perceptions of their own Job Satisfaction

Nursing Staff Questionnaires. The demographic information for the 13 people who completed the initial nursing staff survey and the six people who completed the one-year nursing staff survey are included in Figure 6. The job satisfaction scores for the 13 people who completed the nursing staff questionnaires initially were compared to the job satisfaction scores for the six people who completed the nursing staff questionnaires at the one-year round. There were six people who completed the questionnaires in both the initial and one-year round. Stamps and Piedmonte (1986) developed an Index of Work Satisfaction for their calculations of total job satisfaction scores. Their formula was used for the initial and one-year job satisfaction results. Stamps and Piedmonte calculated the highest possible total job satisfaction score to be 245. The score of 245 meant that the nurse had a high level of job satisfaction. The scores for the 13 nursing staff on the initial questionnaire range from 101 to 144, with the average score being 122.8, equal to Stamps and Piedmonte's "50 percent satisfied" mark. The Index of Work Satisfaction scores for the six people who completed the one-year round nursing staff questionnaire ranged from 121 to 158 with the average score being 142.5. This represented an increase of 19.7 points overall for the two times the questionnaires were completed. When the scores of the same six people who completed both the initial and one-year round of
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Figure 6: Comparison of demographic data for respondents from the initial and one-year round of nursing questionnaires.
nursing staff questionnaires were compared, increase in every index was noted. Their indices of work satisfaction are shown in Figure 7.

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<th>Staff Nurse</th>
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<th>One-Year Round</th>
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Figure 7: Comparison of index of work satisfaction scores from initial round to one-year round on the six people who completed both rounds.

The information analyzed from the job satisfaction nursing staff questionnaires does not show the SDN having a positive influence on the increased scores at the one-year round. The indices increased, but who or what is responsible for this increase is not known. The information obtained from the open-ended portion on the one-year round nursing staff questionnaires referring to the SDN did not confirm the changes in that the six staff who completed it were either not supportive of the SDN or had had little to do with her.

Interviews. The interviews with nursing staff were not conclusive with respect to their perceptions of what job satisfaction meant. During the final interviews conducted with the six key 4C informants, nursing staff revealed that often when they were asked about job satisfaction, they would answer with evidence tied directly to clinical competence. When asked directly, two of the six nurses interviewed indicated that the SDN had no positive impact on their own job satisfaction; one nurse said that it was hard to say if the SDN had an impact on her job satisfaction. The other three nursing staff stated that the SDN had a positive impact on their job satisfaction. When asked for details, these three offered the following comments:
1. “She encouraged me to look at different things, like how to approach a patient situation, and to look at things differently, like how to do our work to get more patient time and still get the work done; I liked that.”

2. “She increased our awareness of things. She had lots of things for us to see and try that made me feel good about my job, like the tours to other areas; I had no idea.”

3. “She helped me to look at different areas of interest (assessments) and helped me increase my knowledge. I felt better because I could do better patient assessments.”

Interestingly, despite vague answers about the SDN having increased their own job satisfaction, the six nurses, during the final interviews, reported an increase in job satisfaction indirectly related to the SDN. One of the six nurses who had been on the unit for less than three years, stated that for her, increased job satisfaction came from feeling a part of the unit and the staff on 4C. Part of this nurse’s feeling a part of the unit came from being involved in inservices that the SDN had organized; she liked the fact that she was labelled as “4C staff” when she attended these inservices. Another of the six nurses stated that she was proud of the Pre-op video that their floor had done (the SDN had coordinated that video). A third of the six nurses liked the visits that the SDN had scheduled—the O.R. especially—because it was great to see how the hospital worked in relation to 4C. Finally, a fourth nurse interviewed spoke about learning new procedures, some of which the SDN had been involved in.

Initial perceptions by the nursing staff of the SDN were reported by the SDN, the NUM, and staff informally interviewed, to be tentative and unsure of the role of the SDN. In one initial meeting, two nurses actually told the researcher that they must be considered “bad nurses” by administration and the SDN was sent to make them “good nurses”. Other nurses welcomed the SDN, but there appeared to be a general sense of doubt among the nursing staff that the SDN would increase their job satisfaction.
The written feedback on the six one-year round questionnaires regarding an increase in staff job satisfaction with the influence of the SDN were diverse. Two nurses had no comment to make. One nurse stated that the SDN did CPR recertification with her, and this nurse had asked the SDN questions about certain concerns she had with policies and procedures. A fourth nurse stated that the SDN was a resource person for her, who helped her with clinical questions that came up, and at other times was just a “figure on the floor”. A fifth nurse was of neutral opinion about the influence of the SDN on her job satisfaction. She stated that she went to the Recovery Room for a few hours (which the SDN scheduled her for) to observe, and that this nurse often found that the SDN would pull people off the floor when “we were very busy”. The sixth nurse was very clear on how the SDN had influenced her job satisfaction. She stated, “Personally, do not see the need for SDN—except that it helps to increase the budget deficit”.

Impact on Nurses' Perception of their Peers' Job Satisfaction

Nursing Staff Questionnaires. There was no particular information contained in the nursing staff questionnaire items on job satisfaction that addressed this question. The staff were asked on the one-year round nursing staff questionnaire to comment on the job satisfaction of their peers. None of the comments referred to the SDN, so the details of their comments are included in Research Question Number Two.

Interviews. The interviews with the six key informants were again not conclusive on this subject. The same two RNs and one LPN who reported increased self-satisfaction, stated that the SDN had a positive influence on the job satisfaction of their peers. However, one of these RNs commented that even though the SDN had spent a considerable amount of time with one particular RN to help with competence and team working skills, it was not successful; that the “ease” of working with this particular RN was no better. Alternatively, the other RN supportive of the SDN’s impact on the job
satisfaction of the other staff spoke quite positively of the improvements noticed in the one particular staff member, attributing some of the improvement to the SDN.

It was also difficult to separate the key informants' comments about themselves from their impressions of their peers. For example, one nurse interviewed stated that the SDN had helped her do better assessments; she also stated that the SDN had helped to increase her peers' knowledge and assessments too, and had helped them look at different areas of interest.

The other three nurses interviewed did not believe that the SDN had any impact on job satisfaction of their peers. One of these three nurses stated she had not had much time with the SDN, nor had some of the people with whom she worked.

Impact on Nurses' Perceptions of their own Clinical Competence

Nursing Staff Questionnaires. Information on the clinical competence scores for the 13 nursing staff from the initial questionnaire and from the six nursing staff who completed the one-year questionnaire were separately totalled to give a summative picture of the nurses' perceptions of their own clinical competence. The 34 items included in this section of the questionnaire were considered by Wandelt (1984) to be indicators of clinical competence. Nursing staff were asked to estimate how often in the last month they completed each particular item. The seven choice responses on the Likert scale were collapsed for analysis into four categories: a) not applicable or "had no opportunity", b) less than 1/2 the time, c) about 1/2 the time, and d) more than 1/2 the time. These four categories were compared between the initial round (n=13) and the one-year round (n=6) questionnaires for the items labelled "myself" (see Figure 8).

When this questionnaire was being drafted, it was expected that the "non-applicable" answer would rarely be used. It was a surprise to discover that for the initial round, 12 items had a "non-applicable" answer. This number dropped with the one-year round questionnaires.
Figure 8: Responses for "myself" scores between the initial and one-year rounds.

A total of 17 items were reported by at least 80 percent of the respondents to be done "more than half of the time" in the initial round and this number jumped to 29 items for the one-year round respondents. Items reportedly done "less than half of the time" numbered 14 for the initial round respondents. This number dropped to one item for the one-year respondents.

It would appear from the overall response rates between the initial and one-year round nursing staff questionnaires, that perceived levels of clinical competence had been increased. Information from the initial round questionnaires was further analyzed to isolate the same six respondents as the one-year round questionnaires. These data were compared for response rates on the clinical competence items.

When the same six respondents from the one-year round were isolated out of the initial round of 13 people, some contrasts were made. These six people in the initial round indicated five items that were not applicable (77, 83, 97, 101, 107), compared to
four items in the one-year round (59, 83, 101, 105). Only two items (83, "Carried out safe administration of medication" and 101, "Participated in ward conferences") were common to both times.

The six staff isolated from the initial round of questionnaires listed seven items that they did "less than 1/2 the time", compared to one item on the one-year round. These same six respondents indicated 16 items which 100 percent of them did "more than 1/2 the time" compared to 15 items on the one-year round. Five of the six (80 percent of the respondents) also indicated that for an additional nine items on the initial round, they did "more than 1/2 the time" for a total of 25, compared with 14 on the one-year round for a total of 29.

From these data, it would appear that perceived clinical competence increased slightly over time for these six people who completed both the initial and one-year round questionnaires. However, this change in perceived clinical competence cannot be attributed specifically to the SDN, for the simple reason that most of the questionnaire respondents reported spending little time with the SDN.

Interviews. When asked if the SDN had influenced their own clinical practice, five of the six nursing staff formally interviewed commented in the following ways:

1. "She helped me a lot, answered questions and worked with me. She did things with me, like techniques and helped with job interview questions".

2. "The inservices were helpful and going to the O.R., so that what I saw I could then teach to my patients. It was nice to be able to do CPR right on the floor. I also worked with her on the nurses' workshop where I gained some teaching skills".

3. "She is very knowledgeable, helped me do better assessments and increased my knowledge of treatments from the Lab, O.R., and ICU".

4. "She caused me to step back and look at what I do and to be able to assess why I do it. There is a lot out there to learn about and I have been encouraged by her to do that. The one-to-one time was great!"
5. "I did ask her for material for the floor that was more advanced, for large laproscopic abdominal surgeries. She declined, stating that because we do not do those specific kinds here, that would not benefit the floor. She did CPR with me and did an interview with me, but I was not sure what she wanted".

When asked what situation(s) posed the biggest clinical challenge for themselves, nurses interviewed spoke candidly. One relatively new nurse commented that her own competence as well as her peers' competence had improved over time. She still found challenges in handing equipment to the doctor when putting in a central line, and handling "codes" (cardiac arrest situations). Another nurse spoke of being challenged when she had to something she had never done before without adequate practice, although she stated that did not happen often. She also spoke of situations in which patients were dying, and stated that it was a personal challenge; in her mind, when people were dying—"you have to sit and wait"—but when they were dead, "you could do lots of things", like resuscitate. She did not like the "waiting" part.

Two of the six nurses interviewed, one an RN and one an LPN spoke of the challenges from a workload standpoint. They felt that they could not get "all of the work done" with different types of heavy surgeries and "lots of tubes". The LPN commented that, "I feel frustrated with patients who are angry; I try to look at their situation, but it is hard". The RN referred to above added that respiratory arrests were still a challenge for her, and generally any change from normal work, because she would worry whether she would know what to do. The NUM was also asked what situations she found caused staff the greatest challenges. She indicated that such situations were ones where patients were very sick and situations of patient crisis, for example, blood pressure dropping before their eyes, or respiratory failure or arrest.

When nurses were asked if they would comment on how the SDN may have helped them increase their own clinical competence for some of these clinical situations, their comments were tentative. They admitted the SDN had spent time with some of them on
cardiac and respiratory arrests, or on new procedures, but were not convinced that she had helped them in developing clinical competence. Comments from three of the six nurses interviewed indicated that the SDN had shown them things, but "playing with CPR Annie" was not the same as a real cardiac arrest, that they had been shown new techniques, but the true learning came when they had to do it on their own.

Impact on Nurses' Perceptions of their Peers' Clinical Competence

Nursing Staff Questionnaires. The nursing staff questionnaires, given out for both the initial and one-year rounds, contained 34 items for which respondents indicated perceived levels of clinical competence in their peers. Each round the questionnaire results in this category were analyzed separately to give an overall picture of the nurses perceptions of their peers' clinical competence. These results appear in Figure 9.

<table>
<thead>
<tr>
<th>Category</th>
<th>Initial Round</th>
<th>One-Year Round</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=13)</td>
<td>(n=6)</td>
</tr>
<tr>
<td>&quot;Peers&quot; scores same as &quot;myself&quot; scores on more than half of the time</td>
<td>12 items</td>
<td>19 items</td>
</tr>
<tr>
<td>&quot;Peers&quot; scores lower than &quot;myself&quot; scores on more than half of the time</td>
<td>12 items</td>
<td>7 items</td>
</tr>
<tr>
<td>&quot;Peers&quot; scores higher than &quot;myself&quot; scores on entire survey</td>
<td>10 items</td>
<td>6 items</td>
</tr>
<tr>
<td>&quot;Peers&quot; did &quot;more than half of the time by 100 percent of the respondents</td>
<td>2 items</td>
<td>12 items</td>
</tr>
<tr>
<td>&quot;Peers&quot; did &quot;more than half of the time by over 80 percent of the respondents</td>
<td>16 items</td>
<td>17 items</td>
</tr>
<tr>
<td>Total *7 items less than how respondents scored themselves</td>
<td>18 items*</td>
<td>29 items</td>
</tr>
</tbody>
</table>

Figure 9: "Responses for Peers" scores between initial and one-year rounds.
The "peers" items labelled "same" as myself increased over time, and items where the "peers" items labelled "lower" decreased over time, indicating that respondents felt that their peers had gained some competence. The total number of items where over 80 percent of the respondents indicated peers did "more than half of the time" also increased.

It would appear that perceived levels of competence among peers had been increased. However, this change cannot be attributed to the SDN for the same reasons as previously stated.

Interviews. The interviews done with the six key informants focused in part on the opinions of whether they had noticed any change in their peers in the areas of keeping current, being accountable, and increasing their clinical competence while the SDN was on the unit. Four out of six nurses thought that the SDN had helped everyone keep more current; one staff member thought that the SDN had helped staff be more accountable; the other nurse had no comment. Three nurses indicated that the SDN had increased clinical competence on the unit, with one other nurse stating that she had seen improvement, but was not sure of the reason. A fifth nurse commented that clinical competence was an individual thing and that to assess peers was very hard.

Only one nurse interviewed stated that she felt comfortable commenting on her peers in the area of improving clinical competence. She recalled a situation with a diabetic patient, when his glucometer reading was high, but the staff did not get a lab sample of blood to compare the results.

Staff interviewed were asked to give an overall impression of the atmosphere of their unit while the SDN was there. Four of the six staff said that the atmosphere was different, that there was more an atmosphere of learning. One of the nurses stated that there were many good things that happened and that there was a sense of increased awareness among the staff generally. Two of the four nurses were especially enthusiastic about the SDN.
1. "The learning environment was good for everyone, with all of the posters and learning materials, updated information and the pre-op video; she really tried to meet our interests."

2. "She asked for input from every one of us, she planned ahead, so that we could all participate in what was going on if we wanted to. She was definitely a great help to me."

Two of the six nurses interviewed were more skeptical about the idea of the SDN. One RN shared that sometimes she did not like the "nagging", almost like a "a monkey on your back" or trying to make people do activities which seemed like doing education was more important than patient care. She added, "My priority was patients". The other nurse stated that some staff did not care for the SDN, that they felt she should, "Help with patient care, and were not sure what she did everyday, would often sit at the desk when the patient call bells were ringing. Sometimes she did help".

Since the Project has ended, three of the six nurses interviewed were invited to comment on what their floor is now like. Typically, their comments were mixed:

1. "There are definitely less inservices, and less talk about new procedures or up-to-date information, I don't miss her, though".

2. "We need a committee now to organize and continue all of the good things she started".

3. "The floor is going to miss her".

Impact on Patients' Levels of Satisfaction with their Nursing Care

From the 486 patient satisfaction surveys completed by the patients, there were 272 (56 percent) responses from males and 214 (44 percent) from females. The following figure gives a graphic illustration of the total numbers and percentages of respondents according to age group (see Figure 10).

The patient satisfaction survey Likert scale items were then analyzed. The five point Likert scales of "effective", "usually effective", "occasionally effective", "not
null
females was in 81 and over age group (59.8 percent), and for males was in the 66 to 81 age group (69.7 percent).

When the percentages of “above average” scores were examined for all respondents, males and females across all age groups, it appeared that for females, over 74 percent scored their care “above average” until the age group reached over 81 years, then the percentage of women who scored “above average” dropped by more than 15 percent. For men, “above average” scores dropped by over eight percent in the 66 to 81 age group. Generally speaking, scores for “above average” drop as the respondents get older.

When the individual items on the survey were considered in terms of the total number of responses in the “very/usually effective”, “about average”, and “occasionally/not effective” categories, the majority of the responses fell into the “very/usually effective” category, as indicated in Figure 12 (see Figure 12). The largest number of “very/usually effective” responses came from item 20, “Gave my medications skillfully”. The largest “average” and “occasionally/not effective” scores came for item six, “Informed me of my rights as a patient”. Item eight, “Taught me how to cope with changes in my daily activities after leaving the hospital” scored the lowest on the “very/usually effective” category with the only other item referring to discharge planning—item four, “Discussed how I could take care of myself after leaving the hospital”—scoring second lowest in the “very effective/usually effective” category.

Overall, according to the patient satisfaction Likert scale data, the patients who responded to the survey on 4C were satisfied with the care they received.

Although 501 patient satisfaction surveys were completed, and there were 372 written comments from individuals, no comments were made by the patients about the SDN. When the data were analyzed on the patient satisfaction surveys, no differences could be found in levels of patient satisfaction clearly related to the influence of the SDN. The patients, however, indicated other areas in which they noticed influences on
<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Very/Usually Effective</th>
<th>About Average</th>
<th>Occasionally/Not Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Encouraged me to ask questions about my care.</td>
<td>361</td>
<td>69</td>
<td>26</td>
</tr>
<tr>
<td>2. Protected my privacy.</td>
<td>409</td>
<td>48</td>
<td>12</td>
</tr>
<tr>
<td>3. Carried out my treatments skillfully.</td>
<td>428</td>
<td>28</td>
<td>7</td>
</tr>
<tr>
<td>4. Discussed how I could take care of myself after leaving the hospital.</td>
<td>297</td>
<td>61</td>
<td>30</td>
</tr>
<tr>
<td>5. Responded to my calls for assistance without delay.</td>
<td>374</td>
<td>61</td>
<td>21</td>
</tr>
<tr>
<td>6. Informed me about my rights as a patient.</td>
<td>274</td>
<td>74</td>
<td>69</td>
</tr>
<tr>
<td>7. Met my needs for personal care.</td>
<td>418</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>8. Taught me about how to cope with changes in my daily activities after leaving the hospital.</td>
<td>241</td>
<td>63</td>
<td>47</td>
</tr>
<tr>
<td>9. Addressed me by my name.</td>
<td>431</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>10. Conveyed genuine concern for me.</td>
<td>420</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>11. Discussed my health needs.</td>
<td>350</td>
<td>58</td>
<td>21</td>
</tr>
<tr>
<td>12. Considered my opinion worthwhile.</td>
<td>328</td>
<td>61</td>
<td>31</td>
</tr>
<tr>
<td>13. Allowed me to make decisions about my health care.</td>
<td>317</td>
<td>64</td>
<td>28</td>
</tr>
<tr>
<td>14. Explained the procedure(s) while treating me.</td>
<td>406</td>
<td>34</td>
<td>13</td>
</tr>
<tr>
<td>15. Informed me about the progress I was making while I was in the hospital.</td>
<td>364</td>
<td>44</td>
<td>34</td>
</tr>
<tr>
<td>16. Showed concern about my emotional needs.</td>
<td>341</td>
<td>51</td>
<td>37</td>
</tr>
<tr>
<td>17. Provided instructions that I could understand.</td>
<td>407</td>
<td>34</td>
<td>6</td>
</tr>
<tr>
<td>18. Treated me as a unique person.</td>
<td>350</td>
<td>66</td>
<td>17</td>
</tr>
<tr>
<td>19. Left the call light in a convenient place.</td>
<td>423</td>
<td>27</td>
<td>13</td>
</tr>
<tr>
<td>20. Gave my medications skillfully.</td>
<td>441</td>
<td>18</td>
<td>9</td>
</tr>
</tbody>
</table>

Figure 12: Total patient satisfaction survey responses by item number.
the job satisfaction of nurses. These will be highlighted in Research Question Number Two.

Remarks in the SDN's journal relating to patients were sparse. The following excerpt gives a flavour of the relationship between the staff and patients through the eyes of the SDN:

09/09/92. During report this morning a note was passed around re: upset family. This dates back to when it was very busy and the family was very upset with care, etc., etc. Some of the staff were rather shocked because they (family) were going to write an angry letter to administration. Staff were saying how horrible that would be. I responded from another focus: let them write, let them tell that nursing care was inadequate. Admin. had been up here, they've seen how busy it was, they commended you for your efforts.

The researcher conducted most of the delivery and introductions of patient satisfaction surveys during the study period. There was no mention of the SDN's role in any of the conversations between the researcher and the patients.

Others' Perceptions of the Impact of the Staff Development Nurse on Nurses' Job Satisfaction and Clinical Competence

The effects of instituting an SDN on a nursing unit were far more involved than is apparent from the preceding section. Although it appears that neither nurses nor patients perceived any definitive effects on nurses' job satisfaction or clinical competence, the nursing staff questionnaire and interview data provide an incomplete picture. In hindsight, it appears that there might have been a more general research question referring to the "quality of working life", as referred to in Chapter Two. Therefore, this section explores the impact of the SDN more generally from the point of view of other stakeholders.

Staff Development Nurse's Perceptions of Impact. During the Project, the SDN developed her teaching skills and gained some experience in staff development. She described her job as anything but routine until the last few months before it ended. The routine of the last few months came into play when she felt she could no longer take on any new projects because she could not follow through.
The SDN believed she had very little impact on the lives of the nurses on 4C. The SDN describes the 18 month time-frame in the following way:

1. I was very excited to get started on this new job in the beginning. Things seemed to go slowly at first as I was meeting with everyone on their needs assessments. The getting into it was hard and feeling everyone out. Then I started planning and getting good responses from staff after the first four months. It took the staff a long time to figure out what I was doing on the unit. August of 1992 was one high point for me and for the staff where the education was concerned; we were all familiar with each other and we were getting the kinks worked out of the staff development process. October, 1992 was a very low point because I started hearing from others that the end of the Project was nearing (only 10 months away) and others were asking what I was going to do afterward. January and February of 1993 were also a bit dreary, as it was wintertime and cold and everyone was low. After I had been there for one year was another high point, because I got into a lot more one-to-one sessions with some staff that had previously been distant, and I was able to help them and give them a sense of “ah-ha!” These last few months have been a bit of a downer too, as I am gearing down. Sometimes I still get responses that we still do not know what you are doing here, and that is depressing after all of this time. I am not getting into anything exciting lately either, because I will not be able to do all of the follow through. I sure did like the planning, for example, the Acute Abdomen Workshop; doing the planning was fun, the follow up after the workshop was alright, but I did not really want to be there the day of the workshop because I thought, “What else can I do?”

2. SDN Journal. 09/07/92. NUM mentioned that she finds the morale very high at the moment, staff are excited about projects and involvements. There is not a great difference in clinical skills yet, but she sees progress.

3. 16/07/92. I did discuss with NUM the competency versus insecurity issue of the staff. She agrees with the observation but not the severity. As she can compare the RNs with say, two years ago, they have improved much so she sees a confidence level that is increasing. It seems as well that NUM is taking more office and days and leaving the RN in charge.

The SDN felt that her impact was directly related to the NUM because the NUM was the leader of the unit. The staff were very quick to go to the NUM for educational questions, but when she was gone from the unit, people increasingly sought out the SDN. However, the SDN believed that her impact would show up sometime in the future. She
gave an example: the staff might take care of certain patients about whom the SDN had taught them regarding a new procedure, and then they would remember. She believed that overall, she had had a positive effect on about 45 percent of the staff.

Some staff were referred to frequently in the SDN journal, others were included rarely, if ever. When asked about four RNs who were rarely referred to in the journal, the SDN reported that one had no interest in being involved with the SDN; one indicated she had to have all of her work done to spend time with the SDN and consequently those times were rare; another nurse would come to the SDN occasionally with questions, but mostly the questions were related to where to look for more information (assessed by the SDN to be a self-directed learner). The fourth nurse worked mostly nights, moved from a casual to a part-time position; she was a newer graduate who was assessed as very strong clinically by the SDN, had a lot of common sense and spent time occasionally with the SDN.

There was a coding category identified from the SDN journal called, “Other floors want our educator”. This category gives some clues as to how other nurses in the hospital viewed the benefits of the SDN to the staff of 4C. Under this category, there were 20 different entries and this represented six areas who wanted some assistance from the SDN. Many other nursing units and departments saw the SDN as a positive resource to the staff on 4C and would often ask the SDN for ideas and suggestions. The requests, as reported by the SDN, ranged from advice on educational promotion of the Nursing Department Quality Assurance activities and Nurses’ Week Planning Committee, to advice on various classes in the Nursing Program at the University of Lethbridge and information on new procedures in other nursing areas, and requests to do new staff orientations on other units. Staff on other units were also reported by the SDN to be upset because they wondered why they did not get the same “treatment” as the 4C staff. There were even people who were reportedly “mean” to the SDN and the NUM, the SDN ascertains out of jealousy.
When asked whether or not she would take a staff development nurse position again if it were offered to her, the SDN responded by saying that she may or may not do this job in the future, because of facing extreme staff frustration all of the time. Staff frustrations reported by the SDN included: the floor and the work not being organized enough to allow for more specific times for education; not always enough staff; not always enough time. The SDN commented that she wished that there would have been more situations where the one-to-one communication happened, but it was not always important for the staff to come to her with questions; she felt that she was more “helping out”, rather than being a resource person.

When asked what changes she would make if she were to do the Project over, the SDN would definitely ask for more time to be set aside for education; she did not like feeling rushed. She also wished for more involvement from staff. She and the staff really liked the different educational tools available, and she believed that nurses would learn more if inservices were to utilize “entertainment”, such as videos, overheads, computer technology, and the wonders of CDROM. The other idea the SDN had for continuing education was that certain staff would be sent to workshops and seminars for one to two days to update or to gain new knowledge. The positive aspects viewed by the SDN were that the staff were away from the work responsibilities and worries of the unit. These staff members would be enthused by outsiders, and then feel some sense of ownership when they brought the information back to their colleagues.

Nursing Unit Manager's Perceptions of Impact. The information outlined here was derived from numerous information interviews; formal interviews with the NUM in August, 1992 and in August, 1993; and a written evaluation of the Project that was requested from the NUM by the researcher.

The NUM commented that involvement with projects the SDN had worked on with the staff, had made the staff more well-rounded to a small extent. The NUM reported
that the staff "get things" ahead of the other units because they had an educator that "does that for them"; they were aware of hospital changes and new policies and procedures earlier than their counterparts.

It was reported by the NUM that staff morale had increased as of August, 1992, about six months after the SDN had started. A number of reasons were given for this situation, among them the fact that the complement of staff had remained the same for a longer period of time and the staff enjoyed the stable atmosphere of the unit. The SDN had also been requested by the NUM to work with one nurse who was struggling with the move to a surgical floor and the SDN spent many hours one-on-one with this nurse. The situation with the nurse was a definite issue among the rest of the staff. At that time, the NUM reported seeing improvement in the skills of this particular nurse and in her job satisfaction, and that in turn, gave the other staff who worked with her increased job satisfaction.

According to the NUM, the SDN has changed the culture of the unit. The NUM said that the staff seemed more at ease with the SDN there and they could call on her if they needed clinical help. The NUM reported that, for the most part, the staff enjoyed having the SDN around: "She opened them up to being idea-oriented and to look at their own self-development". The NUM also commented that new staff had received a more intensive orientation than had previously occurred, and that was seen by her as a benefit.

The new Total Parenteral Nutrition manual was introduced on 4C and taught by the SDN, which was reported by the NUM to have answered many specific questions for the staff. There were also presentations on patient case studies that the staff on 4C attended; the NUM believed they benefitted from these presentations in that she noticed their skills in handling these types of patients increased. Enteral feeds was another area that the NUM noticed a great deal of improvement in following an inservice done by the SDN.

The NUM added that the SDN had enhanced her own job satisfaction. One of the biggest advantages as reported by the NUM was that the SDN took over responsibilities
for mandatory inservices. The SDN had also suggested many new ideas to the NUM; they became mentors for each other.

Job satisfaction was not enhanced, according to the NUM, when the SDN attempted to conduct a CPR recertification and pulled a staff member or two off the floor. Other staff members were not happy because they were busy and said that this disrupted the work. The staff who went to do the recertification were distracted, not able to concentrate on what they were doing, and impatient to get back to help. The number of heavy or sicker patients on the unit was also a predictor of how much staff education went on, because available time was whittled away with heavy patient loads or unpredictable situations. The NUM also commented that there were not as many opportunities as anticipated for the SDN to work with staff members on a one-to-one basis.

The NUM summarized her evaluation of the impact of the SDN by stating that the SDN was an advantage for her, a provider of more intensive education to the staff, but not a factor in job satisfaction. The NUM hopes that competence of the staff will slowly continue to evolve from their work with the SDN. She also knows that the staff are taxed, because of their small number. As staff take on more responsibility with discharge planning, do more problem-solving, and grow as independent thinkers, the NUM hopes that they will increase in their competence as well.

Two influencing themes affecting the process of staff development were identified by the staff, NUM, and SDN as operating during the 18 month Project. One of these themes was the fact that the Project was for 18 months; it had a finite time limit. From the researcher observations, the staff knew it, the SDN knew it and the NUM knew it. As far as the NUM was concerned, the idea was to keep the momentum of the Project going for as long as the SDN was there. However, even as late as May, 1993, three months before the Project was due to end, more assignments for longer term or later in
the year were passed on to the ERC educator who would absorb 4C educational responsibilities along with her own once the SDN was gone. From the staff point of view, some were reportedly eager to be involved with the SDN, while others were not too interested, because they knew that the SDN would not be there to "bug" them after 18 months.

The second notion which affected staff, SDN and NUM, was that the SDN became pregnant, being due at the end of the Project, August, 1993. The normal emotional and physical changes with pregnancy affected the SDN, not only in her priorities and physical energy, but also it put a mental end to her involvement with the staff of 4C.

Research Question Number Two Findings

The second specific research question was: "What are nurses' perceptions of other factors affecting their job satisfaction, for example: the support or resistance from other staff; the Nursing Unit Manager (NUM); and/or the organization; changing workloads; changes to nursing care delivery systems; patient perceptions of nurses meeting their needs; and, change in patient service?"

Nurses' Perceptions of Other Factors Affecting Their Job Satisfaction

While the SDN may have had a positive influence on job satisfaction and/or clinical competence for some staff members, it became apparent that there were many factors in addition to the SDN that were affecting perceptions of satisfaction and clinical competence. Similarly, there were a number of factors that had substantial effect on the extent to which the SDN could have impacted on job satisfaction and competence. For example, the six staff interviewed were asked about any restraining forces they saw as decreasing the effectiveness of the SDN. One nurse suggested that the SDN should align herself more with the staff than the NUM, adding that she thought the SDN project was a
useful thing to do, but that it was not necessary to have one SDN on each unit. Another RN stated that there was some staff reluctance to indicate areas of clinical weakness, because of the fear that it would get back to the NUM. The other four staff nurses indicated that it was other forces beyond the control of the SDN that decreased her effectiveness, like attitudes of some and staff and some staff being "set in their ways".

This section will address some of these other factors. Some of the categories of factors listed below were identified from the early literature review, and were included in the second research question. Others were identified in the later literature review and still others were developed during the coding phase in the analysis of the staff interviews, SDN and NUM interviews, the initial and one-year staff questionnaires, the SDN journal, the patient satisfaction surveys, and documentation data from the researcher. These categories also seem to represent what has come to be known in the literature lately as components of nurses' "Quality of Working Life".

Staff Relations. A variety of issues contribute to nursing job satisfaction and every person interviewed for this study reported that they were happy in their role; however, there were varying degrees of satisfaction. For instance, one nurse said that she liked what she did 90 percent of the time; another found her role fulfilling some days, but found job dissatisfaction came from interactions with others or from the workload; such as when she was being yelled at by doctors, or when patients did not treat her well, or when other staff "wanted you to share their bad day", or on Mondays, trying to buffer the effects of a heavy workload weekend and coping with the transfers to 4C from the short stay unit. One newer nurse also shared that more recently she felt "right" in her role because she felt more clinically competent and was finally comfortable so she could give better quality of care. The LPN interviewed highlighted satisfaction with the type of work and stated that LPNs are bedside people, and that the role LPNs have in this hospital was the most comfortable one to have.
The nursing staff questionnaires had an area where staff could comment on their perceptions of job satisfaction for themselves and their peers. Five out of six staff members responded to this question on the initial and the one-year surveys. Their comments give the reader an appreciation for the wide variety of factors affecting job satisfaction (see Figure 13). These comments appear here, under Research Question Number Two, because all of the comments referred to other issues, aside from the SDN, that created job satisfaction or dissatisfaction. Only one staff member stated that the job satisfaction issue had improved. The other four either determined no change or found that the status was the same for themselves and their peers.

The comments from the other seven staff who responded to this question on the initial nursing staff questionnaire are summarized here:

1. "Room for improvement, communication could be better. Some people bring personal problems to work, or are here and put money as a Number One Priority".

2. "I am generally content, but there is a lot of discontent and frustration with upper management—not the NUM".

3. "Shitty, lots of bitching and complaining about the work. Not enough time and manpower to provide adequate care or time for patients."

4. "Too much stress, too much responsibility".

5. "Frustrated, knowing the type of care we could give and being unable to give it, angry and overwhelmed".

6. "Many people complain about everything from expectations, job descriptions, administration, salaries, which at times is very frustrating to listen to. But this type of communication—sharing—is beneficial to express and realize that others have similar concerns re: the hospital".

This last quotation sums up many of the feelings of those who filled out the questionnaires, touching on the areas of workload, organizational change impact, perceptions of society, and the frustration of trying to do a good job, but not being able to.
<table>
<thead>
<tr>
<th>Initial</th>
<th>One Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Not too many people seem satisfied with their jobs. Everyone seems to complain re: being overworked, underpaid.</td>
<td>I don't always feel as though the staff on our unit feel good about jobs. Staff often feel that they're unable to spend enough quality time with patients. However, I think that if everyone put in the same amount of work--spent less time &quot;hanging&quot; around the desk--that maybe there would be more time spent with patients. This isn't always the case, depends on who is working. Also when things are very busy, people worry that things will get missed or forgotten and that can be very stressful at times.</td>
</tr>
<tr>
<td>2. The kind of nursing we do tends to put more stress on nursing staff, as not all pull their own weight. NUM sometimes too busy to offer support. I, as a staff member, don't know where I stand sometimes due to NUM's reaction to staff members. Makes me paranoid.</td>
<td>Politics between nursing staff, administration and physicians seem to be a big issue. Doctors (not all) aren't always respectful to nursing staff and do not appreciate the 24 hours nurses put in, as opposed to their three to five minute visits. I find it hard to differentiate between management and NUM, but at least our NUM really helps out on the floor where as management is not seen. They have no clue as to what goes on on the units, yet they make all of the decisions.</td>
</tr>
<tr>
<td>3. Job satisfaction among my peers is pretty well nil. We hardly have time to do things we have to, never mind any extras. This makes for some very frustrated people and negative attitudes. As far as morale and job satisfaction, there is none.</td>
<td>Poor.</td>
</tr>
<tr>
<td>4. I feel the staff can't give the patients the best care because of the short staff and busy floor, so I feel the staff are never satisfied because they would like to do more, but can't.</td>
<td>I think that everyone on our floor, no matter what their job duties are, gives 100 percent and is totally satisfied with their jobs.</td>
</tr>
<tr>
<td>5. Discouraged, tired, thankful for a job but don't feel really good about it because I never feel like the job is done well due to the busyness and stress of responsibilities.</td>
<td>Discouraging due to busyness of the floor.</td>
</tr>
</tbody>
</table>

Figure 13: Comparison of five nurses' comments on job satisfaction, self and peers, from initial to one-year questionnaires.
7. I feel most of us enjoy nursing but have a very high level of frustration due to a very high nurse / patient ratio. There just is not enough time to do anything but the bare necessities. This leaves us feeling like we're not doing our job completely. Also a lot of frustration with public ideas and comments that we make too much money. I sometimes wish they would follow us around for a day or two. I'd gladly do with a little less cash and have more staff. As far as general nursing goes, I feel very strongly that the focus is moving further and further away from the patient and more and more to administrative issues. Sometimes I think we need to look at the very basic reason we are all here—the patient. I don't think the patients feel they get all of the attention they used to.

Turnover of Unit Colleagues. One of the factors reported that affected 4C staff before the Project got started and into the first six months of the Project was the turnover of staff. One staff member commented, “For awhile, you never knew who you were working with. When people moved to other units, even if there were no bad feelings about them leaving, it was still a “downer” for the rest of us who stayed. We had to try and put our floor back together again with each other and the new staff”. The low turnover of staff after August 1992, was reported to help the staff in developing a sense of belonging. Those staff who completed the initial and/or one-year questionnaires (with two exceptions) and all six of the people interviewed, saw surgical nursing and 4C as “their career or their area of preference”. When asked about the number of staff on 4C who moved to ICU, the NUM stated that the change was desirable because the staff needed to grow. She also predicted that turnover would happen again when staff needed a change, but commented that the stable workforce was a positive influence on job satisfaction for all the staff, including her.

When asked to list three reasons why they stayed on 4C, the six staff who were interviewed listed the following: four nurses stated that the floor was “their niche—surgery”; four nurses liked the fast pace; three nurses liked their positions, shifts, or security (ie., permanent, full-time); two nurses liked the other staff; one nurse liked working with students; one nurse stayed to gain practical experience and background;
one nurse simply stated, "I always wanted to be a nurse—this is great!"; another nurse commented that, "if the patient is happy, I am happy, I like to take care of patients"; and, one nurse liked learning new things.

The six staff interviewed were asked how long they were planning to stay on Unit 4C. Three staff stated that they had no thought of leaving; one said "Who knows"; another offered, "As long as I can but I am also looking for a degree or to work in a different unit for a different challenge". A fourth nurse was temporary on the unit and hoped for a more immediate goal, that of obtaining a permanent position on 4C, but also wanted to teach after she got her degree. The remaining two staff members were hoping to either get more job security or maintain job security, although they saw many other benefits to staying on 4C such as the surgical nursing focus and the other staff.

The impact of staff turnover was examined with staff who left Unit 4C. Formal and informal exit interviews were done with five of the six staff who left the unit during the study time-frame. The reasons for leaving were varied. One LPN returned to school to become an RN, with hopes of working on 4C again. One RN was transferred off 4C because of budget cuts, a situation beyond her control. Two RNs went on maternity leave; one sought part-time work on 4C, could not get it, so went to another unit. She still socializes regularly with the staff on 4C. The other RN, due to health problems, went from full-time hours to working relief on 4C, and still considers 4C her unit. Another RN had been looking for new challenge, especially since obtaining her degree, and moved to the new Pre-op Assessment Clinic when it opened. She stated that she liked 4C, and would have worked there longer, but wanted a different nursing focus with more teaching. She stated that she was frustrated with 4C in the early months she worked there, but found that as time went by, more and more things got sorted out until the unit was doing quite well. The final RN left 4C with narcotic misuse infractions.
Of the three nurses who left the unit during the Project time-frame and completed the initial nursing staff questionnaire, all three stated that unit 4C was their area of preference. There were no other indications that they were unhappy on unit 4C. Their reason for leaving 4C were more for reasons of circumstance—bumping and maternity leaves.

Working with Competent Staff. Staff interviewed were also asked what adequate staff meant to them in terms of both numbers of staff and in skill levels or competency of staff. With respect to number of staff, those six nurses interviewed had the following to say:

1. "It is now adequate, because we added one more RN to evenings (August, 1993)".
2. "Most times it is pretty fine; who is going to ask for more staff in this day and age? When we get too busy, there is always a question of safety".
3. "It depends on the acuity and the numbers of patients; chronic patients can be heavy. Augments of one or two RNs would make the day go better".
4. "We are short. I would want one RN and one LPN more per shift. On weekends with 5A closing and four RNs and two LPNs in charge, it is hard to be in charge and doing nursing care too".
5. "I would like to see an extra person on each side".
6. "The present staffing may not be adequate with: high acuity, confused patients, and bookwork to do; the patients lose out and do not get the attention they deserve".

The researcher wondered if adequate staffing meant strictly numbers of staff or competence levels of staff. The six staff responses seemed to focus more on competence than numbers of people to work:

1. "The skill level or competence of the staff is generally good".
2. "Pretty good on our floor, however, it depends on who works".
3. “The floor is o.k. We all have little groups we like to work with. More than competence, I think it is personalities--how they communicate. People should try not to become defensive when the team leader is delegating. However, having efficient people sometimes helps”.

4. “The skill level and competence is most important. Some staff you can rely on; some you can’t. We need more numbers of staff working, but if they are incompetent, we need more”.

5. “You have to get someone who is willing to work. Now is o.k., but highly competent staff is best, knowing what their job is and doing it. LPNs need to start prioritizing. There is not enough communication—need some more as a team and prioritizing to patient acuity and do better time management. We need to ask, ‘Who is doing what for whom?’”.

6. “Working only one or two shifts in a row is not good, especially on nights—for staff or for patients—it is a hard shift if you have not worked it before”.

One nurse made an interesting comment during one of the interviews that she found relations with other staff were better “once she herself knew more about nursing care, and became more competent”. This statement again supports the notion that increased competence may enhance job satisfaction for self and peers.

The NUM also reported that staff morale was diminished when 4C staff had to float to other units (a rare occurrence), but not as bad as when they got new relief staff who did not know the unit or the work of surgical nursing. The staff interviewed did not mention anything about them floating to other units. Generally the staff felt that some casual staff, or staff who floated to their unit to help were in one of two categories, the ones who worked, and the ones (as one nurse put it) “who looked”. Some of these extra staff fit in well with the 4C staff, some did not. Most of the nurses interviewed said, that when casuals or floats were on, the shift did not go as smoothly.

Clinical competence can be acquired in many ways, and sometimes simply through personal experience. One interesting item that the SDN noted when she conducted the
formal staff needs assessment interviews, was that there were many staff who had previously experienced serious illnesses or losses themselves. During the interviews the SDN was moved by the fact that these staff commented on how their own illnesses had changed their relationships toward patients. The staff reported they had more understanding, more empathy, and were more willing to discuss serious issues with patients, for example, the whole area of death and dying. Possibly, when a person has more life experiences, they can lend additional support to patients.

**Group Cohesion.** The NUM described the level of support or trust among the staff on the unit as very positive with the exception of one or two staff who were not supported by the others. The staff interviewed were also asked about group cohesion and generally these two themes came up: a) particular staff members who “did not fit”, and b) communication problems among the staff. With respect to one particular staff member, some nurses sounded supportive and thought that this nurse tried hard, that she was a lovely lady, that she had been in nursing for a long time, and that she was working against “stacked odds”. Two others preferred not to work with this nurse, and when they did, they would keep careful watch for safety, or use careful communication—sit down with her at the beginning of the shift and set out specific tasks for everyone to do and request her feedback often. Three other staff nurses were in-between, and put “the work situation” up to lack of skills, other staff not helping her, or simply different personalities. It should be noted here that although one particular staff member was referred to often during the 18 month study, many staff members had “their favourite” colleagues with whom they liked to work and others whom they liked to criticize.

Before the Project started, there was a situation where narcotics were found missing from Unit 4C. The RN allegedly responsible had been off for drug rehabilitation and was just returning to 4C with rules and guidelines for her future work conduct. She had worked on the unit previously, but as described in the SDN journal, there was definitely
an "air of mistrust" on the part of the other staff when she arrived back on the unit. Some staff rallied to support this RN when she returned; others were outwardly blaming. Relations among the staff settled down after a number of weeks, until the second infraction occurred.

Some of the staff had difficulty adjusting following the second incident, mainly because they reported that they were given little information about the entire story. One nurse interviewed stated that the staff were not sure if this nurse was going to come back to work with them again, and there were fears about how they would handle such a tense situation. Two staff members were documented as saying that they felt embarrassed when others in the hospital and in other agencies apparently knew more about the situation than they did. As well, they did not like the tarnished reputation that the whole situation had created for their unit. This lack of information resulted in a great amount of staff job dissatisfaction, because most of the staff felt accused, too. If the narcotic count was out on any shift, they panicked for fear that they would be accused of an infraction. Group cohesion was particularly affected in this instance, as noted in the following comments from the four of the staff interviewed:

1. "They tried to keep the situation 'hush, hush', it just built up problems among the staff. Then she came back!! The NUM should have kept us informed. We are punished of that now; we only get to have one key".

2. "That was a serious lesson for us. We are all more cautious now, and you don't trust everyone, the onus is on you. If the count is out, nobody leaves. Some of us are worried that she will come back—but now NUM says she won't".

3. "You were never sure if the incidents were taking place when you were there or not; the atmosphere was uneasy. The look on NUM's face was serious all of the time. The nurse denied, we mistrusted; it is hard to trust someone again. She is not coming back, and that is good".

4. "I do not know what to say. I feel sorry for her; she needs help. Neither do I have anything to do with making it better. Everyone is left in the dark".
In the area of communication, staff interviewed generally indicated that some staff worked well together and some did not, that there were definite "groups", and personal matters of some staff got in the way of work. One staff member interviewed stated that the group only worked well together when they kept making connections with each other or the "desk" (the unit clerk, charge nurse, or the NUM) because of the possibility of missing out on O.R. times and scheduling changes.

Patients also commented on the teamwork and communication among the nursing staff. In the patient satisfaction surveys, teamwork was mentioned six times. Some comments were positive:

Patient 053, "... their positive attitude and teamwork was noted and is also very important to us patients".

Patient 479, "... they were all very friendly, gentle and seemed to have excellent rapport with each other, and worked well as a team."

Some comments were not as positive. Patient 061 stated, "... the organization of management can be noticed between shifts. The teamwork is not here for some; my two previous stays have been more pleasant than this one". All that Patient 302 had written on the comment portion of the survey was, "Not enough communication between the nurses." Patient 261 commented that, "... my first night here I had problems with a nurse. I had requested to have the intravenous changed as I was having trouble with swelling in the hand it was in. She did not want to do this, then went to a different nurse and was told it had to come out. A lot of time and frustration for all three of us could have been saved had it been done properly the first time, and it would have saved the hard feelings that went with it".

The SDN was reportedly very frustrated at times with the lack of group cohesion among the staff on 4C. As an outside observer and one that did not work daily within the team concept, she admitted that she could see areas where improvement could be made. Sometimes her suggestions were appreciated; other times she felt that they were not.
Another thing I have noticed—we organize the day around the times that the O.R. and Medical Imaging give us, then they show up an hour ahead of time and it throws everything off. I wonder if these changes cannot be communicated back to the floors somehow or other. The O.R. does it sometimes, but not always.

With respect to group cohesion, the SDN was also acutely aware of the fact that some people worked well together and others did not. She commented in her journal about differences of opinion between RNs and LPNs, among RNs, among LPNs, and the fact that people were not as happy at work when they had to cover up for someone and make sure that their work was getting done too. The SDN was of the opinion that often staff did not efficiently plan their work at the beginning of the shift. The SDN said and three of the six people interviewed agreed that certain staff did not like to work together, so did not talk to each other. Sometimes the "med nurse" was just that—the nurse giving out medications—often contributing little to the team. The SDN speculated that the problems with the team format may have been partly due to the immaturity of the group, and therefore workstyle priorities were not set, and that the staff were into completing tasks as opposed to looking at “the big picture”.

The SDN commented as well that when the night staff came to work dayshift for a couple of shifts, there were differences in opinion, and a bit of defensiveness from everyone. One staff member who works mostly nights had some interesting observations about the dayshift. She said, “It was confusing, it was noisy, there was a lack of organization and teamwork. The med. nurse only does meds and the LPNs only do vital signs and outputs. Nightshift often has to ‘pick up the pieces’ from what did not get done on days and evenings”.

The SDN also commented in her journal about how some staff got along so well, that they were concerned with each other and how efficiently the work got done. The SDN even commented that on days when there were two teams that got along, people said that they had fun and were happy to be at work—that they liked their jobs.
A description of most-liked staff reported by the six nurses interviewed, the SDN
and other comments found in the researcher's journal might look like this: "ones who
pull their weight, outgoing, friendly, sense of humor, keen, workers, get the work done
closer, professional in appearance, positive manner, professional attitude".

A description of staff who were most disliked, again gathered from the same
sources might look like this: "a couple who arc buddies with NUM and get special
treatment, people who are not team players, those with negative attitudes, ones who
constantly complain, and "lookers" ". It was also noted by one staff member interviewed
that staff who are really 'up and hyper' were not always good for the patients either.
Another staff nurse interviewed noted that there were good and bad traits in everyone, so
you had to work with each other in the best way you could.

The SDN also found that staff did not compliment each other very often. Again,
staff interviewed gave their impressions of this aspect of group cohesion. They were
asked what they heard staff on their unit praise each other about and what they heard
others complain about. One nurse said she noted that towards the end of the Project,
staff talked more to each other, and "if you have a disagreement, you just settle it".
Another staff member said they did not pay attention to staff compliments, with two
others interviewed adding that only certain staff compliment others--some people are
consumed with jealousy and personal troubles. Another stated that compliments happen
sometimes related to new things done properly or when someone handles a situation
well. The fifth staff nurse summed it up by saying that if you go that extra mile,
compliments sure help out.

When the conversations during the interviews turned to complaints, staff seemed to
be more vocal:

1. "I usually hear complaints about things not being done, with a lot of back
biting and not confronting the person".
2. "I usually hear about time and lack of it, not knowing enough information ahead of time, like someone is not telling you the plan. I hate it when O.R. times change and I don't know about it".

3. "Staff love to talk when things are not good; misery loves company. They complain about each other, not to their face, however".

4. "I hear more about lack of staff and more work".

5. "Oh, all kinds of things in all kinds of places (cafeteria, on the floor, at the desk)—gossip, budget cuts, especially when the NUM is not around". (The sixth nurse interviewed had no comment here).

As an indicator of group cohesion, the six staff participants were asked to reflect on a time when they had tried to introduce change on the unit, and the outcome of that introduction. One nurse stated that she had tried to make suggestions, especially when she saw discrepancies on nights. She said her suggestions have not been well-received, and that she had given up. If there is a problem with patient safety, she still makes an issue of it, but not otherwise. One LPN stated that she did not usually make suggestions, but if she did, it would probably be received positively. Two nurses commented that at staff meetings they work many things out, and that the meetings are very open. Two other nurses reported that their suggestions have been well-received in the past.

Aside from the issue of working group cohesion, there was also the issue of social group cohesion. The SDN noted in her journal changes in a number of people over time, not in a clinical sense, but in a social sense. One staff member in particular was thought by the SDN to be enjoying herself at work more; the SDN believed that it was the nurse's personal life that was pleasing her more, and therefore, she was happier at work. One of the staff interviewed also commented in general terms, that if everything was fine at home, then work would be fine too.

The staff got together socially outside of work for various functions such as wedding showers, weddings, baby showers, unit Christmas parties, and other events.
Staff described these events as a positive addition to the work situation, but added that the unit focus was not the highest priority and was estimated to be no different than on the other surgical units by the staff questioned. Two staff members interviewed found that these staff social gatherings were good places for staff to "talk about the ones who were not there", especially if the NUM was not around to monitor the conversation.

Support or Resistance from the Nursing Unit Manager. As outlined in the work context section previously, the NUM was perceived by most staff to be a positive support to them. The NUM reported that she supported the staff, especially with physicians. She tried to give positive feedback immediately when she found that the staff handled a crisis or a patient well (notes of praise often appeared on the conference room board) and also tried to make note of it for their performance appraisals.

Reported elsewhere was the staff's tendency to lean on the NUM for decisions. One area that the staff leaned on the NUM was to settle staff to staff personality conflicts. This was reported through the interviews where two staff nurses felt that the NUM should act as "den mother" and stop people from gossiping. However, two staff nurses interviewed perceived the NUM "played favourites", but the others generally reported the NUM to be objective, coming to their defense when needed, and growing to be more supportive as time went by.

The researcher did notice a trend toward the end of the Project that the staff were leaning less and less on the NUM and relying more on their own nursing judgements, as noted from the differences in responses in the interview data with the same people over time. The SDN believed that the "leaning on the NUM" exemplified the feeling of helplessness that the staff had adopted. She stated that it was almost as if they did not see that they could plan and see what other possibilities were available to them to help them with their daily work.

"Advice" to the NUM from staff interviewed was as follows:
1. "Decrease or stop the gossip, and some staff who are two-faced".

2. "Work on attitudes—have more positive thinkers and motivational speakers. Decrease the whining and complaining. A positive attitude snowballs and is infectious".

3. "Sort out what to do with one particular staff member. Decrease the gossip".

4. "Get rid of two staff members in particular".

5. "Keep being supportive".

6. "Get staff to increase their competence would help—NUM tries but it does not make any difference".

Administrative Relations. Lack of organizational support was one area where there seemed to be staff consensus. Nurses often commented that no one asked them about anything, and that their opinions only counted on their own unit. The area of organizational support appears to be an interesting one in that staff reported feeling distanced from "admin", but believed that administrative decisions affected them acutely.

Just prior to the study starting at the end of 1991, budget cuts occurred to the long-term care wing of the hospital by government decree and staff union bumping into the main hospital occurred. Unit 4C therefore acquired two RNs from this part of the hospital in the original staff bumping process. Adjustments for these two nurses were reportedly not easy, moving from long-term care to an active surgical unit.

A year later, in January 1992, a neighbouring hospital's maternity service and staff were transferred, with seniority intact, to LRH. Bumping of union positions again occurred throughout the hospital. 4C was affected by having to transfer one of the unit's RNs and then received another in her place. The bumping was completed just after the SDN started on 4C. The results of both of these "bumping episodes" contributed to the staff dissatisfaction, as evidenced by their interview reports and many SDN journal entries referring to her staff development endeavors with these particular staff members.
Discussions about summer bed closures as a way of saving money happen every year. The result of hospital administrative decisions for the closure in 1992 was particularly traumatic to the staff on 4C as evidenced by an excerpt from the SDN journal.

08/09/92. Apparently the weekend was a very nice one. You can even tell by today. Very relaxed, patients getting more attention. One RN especially was talking about the two to three most horrible weeks that she had ever had. She was referring to the weeks during summer bed closures. At Nursing Council, it was brought up that the summer bed closures will not happen again—admin saw the error. The hospital President actually did come up to the floor as well to express his appreciation. NUM had written a little note on the blackboard pertaining to same.

On yet another decree from the Government of Alberta, budget cuts were looming by the summer of 1993, just as the Project was ending. Four staff members from Psychiatry and others were laid-off. Many nurses were glum.

Many 4C staff reported just prior to this announcement that they had positive job satisfaction. With the final interviews, some of the more junior staff stated that the issues of job satisfaction did not matter anymore; they were more concerned with whether they had a job. One of the staff members who was upset by the talk of budget cuts stated that it did not matter what kind of job she had, so long as it was a job and she could make a living. These are examples of how quickly and intensely positive job satisfaction can be wiped out by forces beyond the nurses' control.

Many other events occurred within the organization, specifically within the Nursing Department. As many of these events as possible were documented in the researcher's journal. Reactions of the 4C nurses were also documented as much as possible. Although, looking back, the events may not have seemed important at the time, they did affect the staff on 4C, both directly and indirectly.

Nursing Administration underwent a change in administrative format in May 1992, when one structure, consisting of Associate Director of Nursing and a Director of
Nursing, was changed to Directors of Nursing, a Senior Nursing Director and a Vice-President-Patient Care Services. The NUM reported that in the beginning much grumbling was heard from the staff about the fact that the unit needed more staff and that they were not getting it, but they saw another layer added to Nursing Administration with the Director positions. However, the NUM perceived no effect as of August, 1992 on the staff or their jobs as a result of the change. The six nurses in the interviews commented little, if at all, about Nursing Administration. They said they did not have contact with "admin", and were aware of very little of what Nursing Administration did. The notion of distance between Nursing Administration and the staff nurses on 4C, however, becomes extremely important when the overall job satisfaction situation is examined. This notion is reflected in the scores of the initial 13 and the six one-year round responses to the items in the organizational polices category on the nursing staff questionnaire. These respondents seemed to be more in agreement about unit policy statements, but on the items related to administrative decisions, 12 out of 13 people on the initial round and five out of six people on the one-year round nursing staff questionnaire agreed with the following statement: "There is a great gap between the administration of this hospital and the daily problems of the nursing department".

Most of the staff interviewed mentioned that they felt a great distance from Nursing Administration. They reported that they rarely saw anyone from Administration, let alone were consulted by Administration. They did mention that they had seen Nursing and/or Hospital Administration "coming around occasionally", and usually when there had been a crisis. One of the nurses interviewed stated that she saw the Director of Surgical Services coming to talk to the NUM and that she would say "hi" when she is on the unit, and that this nurse feels quite supported by Nursing Administration. There were also comments that the LPNs were getting more contact with the Nursing Administration since they they started sitting on more committees. One nurse saw the Director of Surgical Services almost every day, but did not see other administrative staff often.
Other staff perceived that they do not really have anything to do with the other levels of nursing, little contact with the Director, some contact with the secretaries in Nursing Administration when they needed staff, and that was it. One nurse said that she had a problem with a doctor, and the Director was called and to look after it, but otherwise she did not really deal much with Nursing Administration.

The NUM reported that her own chain of command had changed with the new nursing administration changes. The chain of command was simplified; she had worked with the new Director of Surgical Services before. The change did cause the NUM more work, but she reported seeing the benefits over time, mostly related to the decentralization of surgical services, where the NUM had potential for more autonomy.

In March 1992, an interesting and unique event occurred. Twenty-three nurses on the LRH Maternal-child unit won $256,000 each in a unit ticket 649 draw. In a curious reaction, staff from all other areas, including 4C, rallied to start buying tickets to “win” also. As time went by, laments were heard from 4C--staff reported feeling depressed over this whole experience—not winning themselves, being jealous, fighting over how to set up a unit pool, and being aware that their chances of winning were very slim.

In May 1993, a decision was made by the Administration and Nursing Administration to open a five-day-a-week short stay unit on 5A to accommodate uncomplicated surgical and medical cases. The six nursing staff interviewed commented on the fact that the workload was twice as heavy on weekends for them as compared to during the week when this new program started. There were usually less staff on 4C on the weekends and many of the patients from 5A were transferred to 4C on Fridays because they were not ready to be discharged. The decisions of which surgeries went to 5A and which went to either 4A or 4C left some of the staff wondering about the cost effectiveness of the short stay unit. It appeared to one staff nurse interviewed that more
of the familiar prostate surgeries were going to 5A, and that left a worry that 4C staff would lose their skills in this area, while 5A staff then had to learn new skills. Two other nurses commented on the fact that sometimes big surgeries would get admitted to 5A, although it was well-known that they would not go home before the end of the week, so the patient was then transferred onto the 4C for the rest of their post-op course. This shuffle of patients was thought by the two staff members to cause extra use of housekeeping services, nursing time, harder on patients to move to a different floor with different staff, and did not make for consistent nursing care in the system. Shortly after 5A opened, one nurse recalled a particular patient who was moved four times during their stay. Another staff nurse commented that if the way the short stay unit was operating was saving the hospital money—well fine—but it was not helpful to the staff and especially not helpful to the patients.

SDN Journal. 17/05/93. Staff are really bitching and complaining about it being so busy and 5A “is just sitting around”. Rumours are flying that people will just call in sick. (And it has already been noticed, more sick calls on the weekend and it is hard to find replacements). I suggested to staff to bring their concerns to NUM.

Staff interviewed indicated a few different areas of job dissatisfaction related to the workload on 4C. The dissatisfaction was mainly due to the perceived nursing department and organizational changes that took place during the Project. One staff member noted the higher acuity, not only because of the decisions to open the short-stay unit, but because of the types of problems that patients had (ie., bigger bowel surgeries). During the course of the Project time-frame, it became apparent to the researcher that many other areas and people made changes and decisions that caused extra work or stress for nursing staff.

New charting standards, lidocaine initiated IVs, “lap choles”, gyne patients, “lap hernias”, “endoscopic vag hysters”, central line removal, blood drawing—these are just a
few of the new programs or changes that the staff mentioned during their many interviews, in all of which, they were expected to become clinically competent. The new forms that were introduced, revised, inserviced, or deleted during the 18 month Project were enough to cause stress; the changes included fluid balance, blood component administration, census sheet, physician order form, pre-op checklist, consent policy, post-op assessment sheet, medication administration sheet, patient-controlled analgesia record. At least five new programs were instituted during the same time-frame. When one considers the time it takes to learn a new form or a program, then to integrate it into practice, and to document correctly, it is no wonder that some days seemed “crazy” to the staff. Staff interviewed felt varying degrees of involvement with new programs, ranging from taking a big part on the planning committee, to introducing speakers, to no involvement at all. The staff who had little involvement in the planning of the new programs would hear about them at staff meetings or inservices and be expected to integrate the new program into their nursing care. Some staff reported that it was nice to be involved, both the SDN and one staff member mentioned that the Patient-Controlled Analgesia pilot project was done on 4C, an achievement in itself.

Students were reported to help at times and to hinder at other times, depending on the personalities of the students, their instructor, and how well everyone communicated. Student/staff relations and working group cohesion had a great deal to do with what tone was set for each shift. For two of the staff members interviewed, it enhanced their feelings of job satisfaction and as one nurse put it, “Percepting was good, I like teaching and taking pride in our students”.

Toward the end of the Project, the Housekeeping Department also went through some work format changes. Two nursing staff interviewed, and many patients commented after the change, on how unclean the unit was. This was described as embarrassing and more disheartening to one staff nurse in particular.
When asked whether the hospital was a good place to work, staff were not as positive as they were in their descriptions of what a good place 4C was. With respect to the hospital as a good place to work, three of the six staff interviewed replied, “Well, I think so, some days, it depends”; “I do not like the attitude the hospital has about nights”; “At times, yes”. Three other staff members interviewed thought the hospital was an “o.k.” place to work, and one of these commented that the hospital had no control over what the government decides, so you cannot blame the hospital for loss of jobs.

Although these events may seem disconnected and unrelated, they each appear to have varying degrees of positive or negative impact on the job satisfaction for those nurses interviewed on 4C. The events generally represent more change nurses on 4C had to deal with during the Project.

Staff achievements recognized by Nursing Administration are considered by the NUM to be very important, but she perceived that beyond the long service awards, little else was done by anyone outside 4C, including Nursing Administration. When asked what type of staff achievements were acknowledged, some of the replies of the six nurses interviewed were: “discharge planning that went well, being efficient and using your time wisely, if you do extra research”; “patient surveys with names of staff are brought to our attention”; “written feedback on the board of the conference room, inservice participation”; “getting a degree in nursing, moving to a new position on the floor, welcoming new staff”; “long term service”, and “patient care situations handled well”. Interestingly, only one of the above sources of achievement recognition referred to the hospital, the other five sources came from the unit setting. One nurse spoke specifically about being proud of the Pre-op video that was done by 4C and of the workshop that was done for their colleagues at LRH and outside the hospital. One nurse asked sarcastically if there were any acknowledgements made to the staff.
There was also a perception from one staff nurse that any contact with Nursing Administration was not done on nightshift. Her point was that management decisions affect the whole hospital, and that since nightshift represents one third of the nursing responsibility, nightstaff should be consulted more.

The staff interviewed also had advice for Nursing Administration. Some of the advice was admitted by the staff to be unrealistic, but they felt they wanted to say it anyway:

1. “Give us your support daily, and guarantee us safety from bumping, give us job security. It is nice when people come around and acknowledge our hard work”.

2. “Get some motivational speakers, show your faces and show your support”.

3. “Come to the floors, make an appearance, ask how it is going—show your support. When that newspaper article came out, someone from Administration came around, but I did not see anyone from Nursing Administration”.

4. “I'm not sure what they do, so I cannot give advice”.

5. “They make all of the decisions, but they should learn how their decisions impact on staff (i.e., IV sheets and ‘In and Out Record’). Those forms are not filled out properly because they are hard to understand—they are confusing). Decrease the unit by five beds—close 438, and keep same number of staff.”

Relations with Others in the Health Care System. This section will cover reported relations with other members or departments of the hospital, such as other nursing units, support services, and the physician group.

There was a reported attitude of conflict on 4C with the other surgical unit, 4A, that existed throughout the Project time-frame. This conflict was reported by two staff nurses interviewed and by the SDN. The researcher inquired about this and was told by the NUM, the SDN, and by various staff members on 4C that there had been conflict
between the two units since the hospital opened. Toward the end of the Project, staff reported the relations between the units to be improving. The SDN and two staff nurses commented that possibly the Surgical Nurses' Committee activities had allowed the two nursing units to cooperate with each other.

As reported by the NUM, relations with the Operating Room, Intensive Care Unit, and Medical Imaging were still a bit uneasy, but the trips the staff made to those areas had made a positive difference to relations. Most of the conflict between 4C and the O.R., according to the NUM, seemed to be centered around the lack of control that the staff on 4C felt over "scheduling whims and changes of the surgeons and the O.R.". This situation did not allow for much planning or control for the 4C staff. Relations with other units, including Nutrition Services and Occupational and Physical Therapy, were generally deemed positive by the NUM, SDN, and those six staff interviewed.

Relations with the physicians, however, seemed to be an intense issue. Staff interviewed were asked about relations between themselves and the physicians that came to their unit, and relations between their peers and the physicians. The following comments illustrate the nature of this vital relationship. There also appears here a sense of nurse having to "put up" with the behaviour of some physicians:

1. "Good, there is one I don't like."
2. "They know you by name now. It was hesitant in the beginning, but I have gotten used to them".
3. "Most treat me well, I have never had a doctor yell at me. They are good once they see you are there for the right reasons".
4. "They are friendly. They are pretty good. They often get mad at a situation, but get mad at you. They blow up at a nurse, but not at the situation".
5. "I am at a different level (LPN), probably some doctors do not even know who I am. I do not like to be singled out with any special status".
6. "I have never had a problem, I usually get a positive response. They figure if I am concerned enough to phone, I get the orders I want. They extend a certain level of courtesy to me and I do to them."

When the staff interviewed talked about their peers and the physicians, generally the responses were that there were uneasy relations in the past, but improving relations with the physicians as time went by. There were some doctors whom staff commented on as not liking, and that there were a few nurses who were apparently not liked by the physicians because it was thought that they "had not earned the respect". The SDN was perturbed one day about the relationship between the staff and physicians and commented that nurses have always had a certain level of respect for doctors, that they intuitively (or from indoctrination) know this "fine line" that they don't cross. This is not reciprocated by physicians, according to the SDN, and that leads to a double standard between physicians and nurses.

One observation was made by the researcher and confirmed by two of the staff interviewed, the NUM, SDN, the admission/discharge statistics obtained, and surprisingly, by the nursing students. This observation centred around the fact that the physicians had slowly changed their attitudes about the staff on 4C. More of the physicians were admitting their acute patients to 4C. The NUM added that around August 1992, she noticed the 4C staff receiving more respect from the physicians.

The SDN commented on the staff-physician relations in her interview also. She described nurses in general as being like a minority group, that they set themselves for being treated as a minority group. She asks, "Why can't the doctors pull their own charts, go into the computer themselves?" Nurses do not see their role in the relationship in a negative way. They almost see it as a way to prove to the doctor that they are 'smart'. It is almost a status thing to go on rounds with the doctor.

The SDN also stated that the 4C staff had a higher profile in the O.R. and Recovery Room since 4C staff tours. The staff on 4C saw the surgeons in a different light—realized
that they actually worked and sweated and worried over patients they were operating on.
Some of the physicians reported to the SDN that they liked the staff tours of the O.R.,
and encouraged the staff to do more, so that they could teach the staff more, and the staff
could be more aware of what happened to the patient during surgery.

Two incidents are highlighted here to illustrate the unique nature of the relationship
between staff and physicians and will give possible clues as to why this relationship is so
significant to job satisfaction. The first incident is regarding a newspaper article from a
Lethbridge physician making judgements about nurses who work at LRH. The excerpt is
from the researcher's documentation data.

I came onto the unit this morning and one of the LPNs stopped me, waiving a
newspaper clipping in my face. She said, "Do you want to know why we have
no job satisfaction? It's this! How dare he say we do not care and we are not
good nurses! What does he know; whenever he has a patient here he never
comes to see them. We have to call him to come in because we care about the
poor patient. The next time I see that little man, I am going to tell him how I
feel."

Another incident came up in the interviews where the staff were blamed by a
surgeon (known for his anger and rage) for not preparing a patient properly for bowel
surgery. When the patient got to the O.R. and the surgeon got started, he found that the
patient's bowel was not empty. There ensued an incident where the surgeon passed word
through the O.R. reception that he was not pleased and was determined to make his
point, he was so enraged with the 4C staff. The NUM calmed the situation down to a
degree, and later the surgeon came on the floor to show his displeasure. He called one
LPN into the office and closed the door. The rest of the staff would not settle for the
situation, and opened the door and entered the conversation as well. Their wish was to
defend their position and support their co-worker. They stated that they had followed the
preparation protocol to the letter; there was nothing more they could have done, and they
fully understood the repercussions of sending anyone to the O.R. for such surgery
without being fully prepared. The surgeon eventually became more calm and they ended up having an amicable outcome.

Changing Workloads / Changes to Patient Care Services

When asked what activities they found most rewarding, the six staff interviewed had many patient care examples:

1. “Being busy, doing physical assessments on patients, making patients comfortable, seeing patients getting better and going home”.

2. “Being busy, the technical aspect of nursing (IVs), opportunities to deal with patients one-to-one, developing a sense of knowing when to speak with a patient about his/her life-threatening illness, and when to wait for the “right moment”.

3. Patient teaching, spending time talking to patients, meeting new people, gaining confidence from the job”.

4. “I get rewarded every day by the positive patient responses. Not only do you get paid, but you give to someone who cannot give to themselves”.

5. “Taking care of patients, having a routine and knowing it well, doing somethings important”.

6. “Having a job”.

It should be noted here that compared to the other surgical unit (as noted in the patient activity chart from the unit context) during the Project time-frame, 4C was busier. This fact holds true for average monthly discharges; 4C had shorter average length of stay and a higher percent occupancy than 4A.

The other issue for almost every staff member interviewed, the SDN, and the NUM, was that they knew on days when they were really busy, patient care suffered. The staff reported feeling badly but also helpless, because they could not do any more with the time and resources they had. The researcher got the impression that some of the staff often felt like leaves on a lake, with little control over or defense against the weather condition on that lake; they just hoped that they would make it through.
Five of the six nurses interviewed commented that some days their goal was to simply get through the day, get all of the work done and have "nothing go wrong". They did not talk of lofty goals to conduct good patient care planning, or preventative health teaching for a patient; their main focus was on the immediate physical needs of the patient, to have everything coinciding with the O.R. times and diagnostic tests.

The long term care patients were also a focus of three staff members interviewed. Their view was that medical and surgical patients do not mix well, that trying to rehabilitate someone on a surgical floor does not make sense, especially when there were better facilities elsewhere. A comment also came from a patient about this issue. She felt, as a medical patient, she was neglected on a busy surgical floor.

Traditionally at LRH, gynecological surgery was handled on a separate unit from general surgery. There was a change to this in the spring of 1993, when gynecological patients were no longer admitted elsewhere, they came to 4C. Staff had to learn about other types of surgeries, and get used to more female patients. The return on the patients satisfaction surveys also showed the increase in female patients starting in April of 1993.

Job satisfaction was referred to by some 12 patients. An older man (Patient 031) commented that he noticed that the nurses seemed like they cared and took interest in their jobs.

1. Patient 052 wrote, "I am always interested in how deeply staff enjoy their work. I am impressed by attachment of nurses for this caring service and am impressed by the replies to the effect that full enjoyment of the service is hampered by inadequate staff and heavy workload".

That patient was very observant and talked to the staff about their work. Others also noticed how the workload affected the staff morale and subsequently their care.

2. Patient 058 noted that, "The nursing staff and assistants are great, only they are expected to cover too large an area, so therefore the patient suffers. Administration or someone should hire more staff. Health care shouldn't be the first to suffer".
3. From Patient 059, "I felt too often when you needed personal service it was so rushed; I'd hesitate to ask for help—nurses didn't have any time".

4. Patient 061 states, "I understand that the staff is very busy with their nursing duties and that they are not happy about the workload, but I don't believe that they should tell a patient that they are too busy to help that patient. My needs to recovery were met more from my family than the nursing staff (ie., help with bath after surgery, going for walks, getting juice or water)".

5. Patient 171, "The nursing staff was very efficient, for the amount of patients they are handling or caring for. The nursing staff has been so very busy running back and forth from patient to patient. I am very pleased with the staff because they were able to keep very pleasant attitudes... It was very understandable if they did not get to you right away".

6. Patient 174, "I can appreciate why we need more nurses, because they have a great deal of work. They are still able to treat you with a smile, even with a heavy workload".

7. Patient 234, "A lot of time taken for bookkeeping records by nurses. Would be nice to free up time for personal care and allow time to respond to concerns".

8. Patient 290, "Only concern is that no staff on weekends. If you have more than two high risk patients at the same time, all other patients wait".

9. Patient 355, "The staff of this unit were consistently caring and helpful. They were obviously doing the best they could with very limited staff. I noticed significant change in levels of service since my stay 12 years ago. Please don't let things deteriorate any more; you have very dedicated, efficient staff. Please take care of them!!".

10. Patient 427, "In general, the nurses seem to be working at a very high level of workload, many details, many pressures to get the job done well. The cut-backs must be starting to show up".

11. Patient 437, "The nurses are always too busy, everything is rushed. Possibly the nurses are understaffed".

12. Patient 480, "Nurses are caring, but overworked. Friendly and happy which really helps".
13. Patient 480, "The nurses on this floor seem to be constantly busy—a lot busier than on the last surgical ward I was on. They seemed to be rushed a lot".

One patient who stayed two weeks in July, 1993, ends this section:

14. "I can't say a negative word against any of the staff encountered during my lengthy stay... At times the floor seemed to be short-staffed, probably due to holidays and cut-backs".

The patient comments above were numbered sequentially, according to when they were discharged from the unit. It is apparent from the long list of comments about workload above, that the staff were working hard throughout the study time-frame, and that patients did notice and they were affected by the workload of the staff.

The tone on the unit was different on different days. Most of the staff interviewed stated that when they were short-staffed (due to any number of reasons), the level of normal humor in the staff decreased. The following excerpts from the SDN journal give an idea of how variable the days were.

1. 25/03/92. Hectic day. Two of the regular staff phoned in sick and two casuals were found to replace. In the morning during report, you could see the regular staff rolling their eyes, not looking forward to another busy day with inexperienced casuals. Same refresher grad as yesterday was on too. Still not being organized, she did not have a grip on things—glucometers have to be done, orders have to be received, insulins had to be given, and she was only concerned with 0800 meds.

2. 16/04/92. Whole day was upset by a code 999 on floor. Apparently patient was found during med rounds by K. Patient was on the toilet slumped against wall (patient never made it). Would be the type of thing that would haunt you for awhile.

3. 15/01/93. This is the third day we had second-year students on—doesn't seem to make an impact on the patient care though (doesn't get any lighter). We do have some heavies—lots of ostomies and hips.

4. 17/8/92. This was one hellish day. NUM asked if I had a free moment to help out on the floor. They had an extremely busy weekend and even today was just crazy. It was a great team on: K., T., J., T., S., and B. The
patients required so much time and they weren't very motivated to help themselves. Even people who could get up would just hang around, not initiating anything.

5. 08/09/92. Apparently the weekend was a very nice weekend. You can even tell by today. Very relaxed, patients got more attention, etc.

6. 02/02/93. Very nice day on the floor, hardly any call bells. Things were in control; everyone relaxed.

7. 02/11/92. Some things just don't change and staff must get so frustrated, not having the time to do things thoroughly. I encouraged an LPN to spend extra time with one patient while I did the rest.

8. 18/12/92. It was just a day that dragged on. A lot of discharges, getting ready for Christmas, weekend coming up, etc.

9. 30/06/93. Pretty busy still, helped out on the floor. Lots of heavy patients, elderly, time-consuming, some of the staff were dragging their feet as well...

Patient care was also acknowledged by the staff interviewed and the SDN to suffer at times, especially when the students were starting their preceptorship in June of every year. The students are to do all of the work, with the staff member overseeing. The following written comment from a patient's family member is a reflection of those unfortunate first days for preceptors:

As a nurse member of the family, I have grave concerns over lack of basic care, illustrated by two open areas developed in three days!! I arrived 19 hours after my aunt was returned from O.R. and she had not been washed, turned, anything! I also had to pursue every bit of information, she received no teaching about post-op plans or care (ie., I had to chase down physio to learn exercises, etc. before her transfer to facility where no physio available). My aunt had no input in discharge planning. She often had student nurses who appeared to have no RN or instructor assisting them at all. A student told me she learned more in four hours with me than the rest of her rotation. I spent many hours on your unit and never saw anyone sit down with patient or family to discuss discharge planning or her hospitalization. My aunt was afraid to move in bed because that's how she dislocated the new ball and socket, but even though I made staff aware of it, no one spent a moment reassuring her or
teaching her. A knee immobilizer was put on my aunt with no teaching and the staff seemed unable to answer my questions about purpose, when to wear, etc., etc.

1. Patient and family teaching was poorer than I have ever experienced in 25 years of nursing.

2. *Basic care very minimal.*

*Is morale that low?*

In January and February 1992, the unit tried out two kinds of nursing care delivery systems, team and primary. A vote was taken, further discussions ensued, and in May 1992, a decision was made to go with team nursing. The workload was set up so that there were three people on each of two teams for 32 patients: two RNs, one to act as team leader and give medications out to all of the patients and do assessments, one RN to do treatments, dressing changes, for all of the patients and split the personal care work with the LPN. The NUM was still doing most of the discharge planning for patients until about the last six months of the Project, when she gradually got the staff to do more.

From all the reports of the six nurses interviewed, they liked team nursing, saying that team nursing was better for the nurses and the patients, although “any system would work if you get everyone into their job”, they noted that the med carts were helping, and more people were working together for the team. The big issue for staff did not seem to be the system used, but how well the caregivers communicated.

On busy days, the researcher was often tempted to get a video camera and film the “proceedings” on unit 4C, because the real picture was only evident to the people on the unit at the time. Staff would often carry on three conversations at a time: one to the doctor, another to someone on the other end of the phone, and still another to answer a question for a family member or try to soothe an agitated patient. Frequently, the NUM found herself in these triangular conversations. The researcher wondered how staff could cope at times. There was a steady din of noise coming from the desk: laughing, lecturing, soothing, teasing, talking and questioning. Suddenly, a staff member would
race from the desk to answer an emergency call bell or to change an IV bag or in
response to a changed O.R. time. The air often felt full of tension, action and urgency.

The Image Nurses Hold and Others Hold of Nurses

Because job satisfaction issues are individual, as evidenced by the variety of
responses from the staff during the Project, the researcher asked staff what they thought
of themselves as nurses. When asked about their motivation for being a nurse, staff who
completed the job satisfaction questionnaires replied with the following:

1. Caring about people (five nurses).
2. To help others (three nurses).
3. One nurse each for: Need to have a career; Self-fulfillment; and, 
   “Satisfaction obtained from patients' appreciation, procedures are
   fascinating”.
4. I get a good pay cheque.
5. Sharing experiences with clients in a hospital setting.

Of the 13 staff who either returned the one-year questionnaire (six) or were
interviewed during the study (six), 11 people stated that Unit 4C was their area of
preference. One stated that she did not know if it was an area of preference or not, while
another wanted a change.

Professionalism. The notion of professionalism came up often during the Project.
The SDN noted several concerns in her journal about how professionalism was
interpreted by the staff; staff interviewed commented on it; the NUM was asked about it;
the staff questionnaires referred to it; and the patients commented on it. Staff interviewed
were asked where they thought the future of the nursing profession would head; they
were asked what they considered a career advancement opportunity within nursing; to
comment about professionalism related to patient confidentiality (from their own
perspective and from an organizational point of view); and, if they were ever asked to do anything that was against their better nursing judgement. There were also questions on what constituted unprofessional behaviour, their perceptions of the level of respect nurses on 4C received for their contributions to patient care, and their own professional goals.

Three people commented on the future of nursing. One nurse, who is presently completing her nursing degree, said that she thought that eventually there would be a lot more community health nurses, and that all nurses were going to be required to have their degree. One nurse spoke negatively about the amount of paperwork that has crept into the duties of nursing and predicted that there would be less hands-on for nurses and more paperwork in the future. Another nurse took a completely different view. She stated that the future of nursing was scary; nursing was not looked at as a prestigious occupation anymore, there were cuts to nursing occurring daily. She wondered who would take care of the older generation in the near future, and the baby boomers in later years, with a definite lack of facilities for older people and the already large number of elderly increasing each year.

In the area of career advancement opportunities, the people interviewed indicated a wide range of areas, often tied to their clinical experience and present employment. Responses ranged from getting a permanent job and full-time status, to a degree, a teaching position, a "nine to five" job. Two of the six staff asked this question were not looking for any different positions, instead they were looking at a different dimension within their present positions.

1. "This is my career, although when you work full-time you get burned out. I try to get better at my job every day, though. I try harder to prioritize my activities, and get faster at some of the things I do, so that I can spend more time talking and listening to patients".

2. "I like becoming more aware of things and I am motivated".
When asked if they were ever asked to do things that were against their better nursing judgement, five of the six staff interviewed said no. One staff member, who is relatively new, stated that she had been. Apparently a doctor told her to take out some suture line clips on a large lady. “He didn’t look at the patient before he wrote the order. I took them out and taped the incision up well. She dehised (the suture line opened). What would I have done differently?: 1) tell the doctor to have a look with me before I removed them, 2) refuse to carry out the order, or 3) talk to the NUM before I took the sutures out”. This situation for the nurse represented a time when she was asked to do something she did not think was right. Not only is competence an issue here, but so is professionalism in the sense that nurses must question the extent to which they must do everything that doctors tell them to do.

The researcher wondered how often these nurses interviewed were asked to use their nursing judgement. Most of the staff interviewed responded that they used it every shift, frequently, or quite often. One said she used it intuitively; another stated, “it is the nurse who takes care of the patient and tells the doctor what we need—the doctors leave it up to us”.

With respect to professionalism and patient confidentiality and privacy, four staff members of the six commented:

1. “Depending on the staff member; some sit at the desk and talk about the patients”.

2. “Part-time people seem to be happier, you are really there for the patients, so you do not gossip about them”.

3. “Yes, I think that nurses here respect patient confidentiality”.

4. “Sometimes confidentiality leaves something to be desired. There is a general attitude here that you do the basic labwork and basic care that is necessary, and then you can talk about anybody and anything. I have a good rapport with patients”. 
One patient even wrote on his/her survey that the nurses were, “Helpful, protect your privacy more than you do!”

When asked who were the most popular patients, one nurse commented that the young, healthy ones, as well as the old grannies and grandpas (because they were “cute”), were the most popular. The less popular patients were the whiney, irritable ones that “the nurse cannot do anything with”. Another staff member commented on conflicts with patients or families. She stated that the most important goal was to get the patient home, but in the meantime with conflicts, it is best to go in and talk to the patient about why they are so angry, support the patient, and tell them that you will try to meet their needs. If that did not work, “you deferred to the NUM”.

The issue of professionalism was an important one for the SDN, and one that she believes contributes to job satisfaction. In the SDN journal, she described an incident in the cafeteria among staff at lunch time one day. She was the object of sarcasm that day from a nurse who worked on another floor. The situation revolved around the close relationship that was evident between the SDN and the NUM. The SDN went on to talk about how professionalism is so important to job satisfaction.

29/07/92. Things can be said in a joking way but nobody should end up feeling hurt—there is a fine line. It’s this sort of thing I find so frustrating. What kind of system is this? It seems that as long as nurses find themselves secure with a job, their seniority, and their union, they can analyze others, criticize them, complain and bitch about things, and focus on what is either not being done or what is lacking rather than looking at the positives. What a stifling, suffocating environment.

The SDN had a number of examples of professional issues that caused her concern on 4C; on two occasions nurses made comments or asked physicians what they thought of other physicians. These situations caused uneasiness on the part of physicians, the other nurses who were within earshot, and did not bring positive feelings from others towards the staff on 4C.

Unprofessional behaviour was described by the staff interviewed as:
1. "Giddiness, loud around the desk (especially at shift change)".

2. "It’s fun to giggle to relax, but when you have shifts and students at report, it gets loud".

3. "Rough handling of a patient".

4. "Jokes at the patient’s expense; disrespect for patients (especially minority groups)".

5. "Loud talk at the desk".

6. "One unit pitted against the other (some doctors perpetuate it as well); gossiping and being ‘two-faced’".

On one occasion in the fall of 1992, the researcher overheard a conversation among 4C nursing staff at the desk related to an admitted male patient and his sexual orientation. The conversation was loud and just then the NUM came by. The researcher mentioned to the NUM concerns about how staff talk about some patient and wondered if that then was reflected in how they cared for some patients. The NUM did speak about how minorities are treated in the following staff meetings. No further conversations were overheard on 4C by the researcher related to homosexuality.

The other significant aspect of professionalism seems to be the image that nurses hold of themselves. The six staff interviewed were asked the following question: "To what extent do you feel that your day-to-day activities have substantial impact on the lives of others?" One answered, "I think so—working with others and patients, families, and their well-being". Others commented:

1. "It is my professional and personal belief that I do make a difference".

2. "Yeah, at times".

3. "Absolutely".

4. "Depends on the patients and how long I am there; on a busy day I don’t make a difference. If I am there for a few days, yeah, someone reaches out to you".
5. “Every shift”.

When asked how they measured their own success, those interviewed said things like:

1. “How well the shift goes, how in control I am, that I do proper assessments, that things that I pick up are followed through”.

2. “If the patients are happy, I am happy. It is nice to hear positive feedback when it happens. You hope you are always doing a good job”.

3. “By other staff comments and by performance appraisals”.

4. “What you hear about yourself outside of work (or your floor). At the end of the day if it went smoothly, communication was good with staff and you have not left any work for the next shift. I do not feel successful when we do not work together and have poor communication”.

5. “I go home and think, did I do good job or not; did I do 100 percent, did I do my best? Being involved without interfering with families”.

6. “If I can do my job properly, efficiently and get through the day and feel good about what I have done. They keep asking me to apply for more positions, so that must be good”.

Both the NUM and the SDN commented that professionalism had increased throughout the course of the Project. They seemed to think that this was because of a combination of factors, increased staff involvement on committees, being part of the Abdominal Workshop to some extent, and because of the Pre-op video production.

The staff interviewed were more skeptical about what opinion society had about nurses. Two nurses said that society had a high level of respect for nurses, with one adding that the public is more educated and the respect is improving all of the time. Four staff members held the position that societal respect for nurses is less than perfect. One nurse commented, “People say we make too much money”; another said that it was a toss up as to whether society was supportive or not, based on their knowledge; another still
that, "Lots of people do not know what nurses actually do—they think of General Hospital—we don't sit at the desk all of time; we have less appreciation and more responsibility these days!"

Most of the patient satisfaction surveys written comments conveyed a high level of respect from patients toward nurses. One comment only was written stating, "Don't go on strike, be smart and stay at the job".

An interesting comment was made by one staff member, a male. He stated that it was different being a male nurse—that some patients love having a male nurse, others not at all, so he was therefore not sure what sort of respect society had for nurses. The SDN commented during one of her interviews that she found the male staff were treated differently from the female staff, especially from doctors, but also from patients and their families. Some patients even commented that they were uncomfortable with a male, others did not care.

Patients' Perceptions Of Nurses

As outlined in Research Question Number One, a number of patients wrote comments about how impressed they were about the professionalism of the staff. Patients 043 and 410 were chosen to illustrate the nature of the comments patients had about how professional nurse were. These comments represent times from the beginning and the end of the Project.

1. Patient 043, "I personally found the entire nursing staff to be very professional in their treatment while being personable and pleasant. They treated me like an equal human being, not an object. All nursing staff were attractive and neat in appearance and dress. They never put me before other patients but still made me feel somewhat special. Although I am somewhat phobic about hospitals, I enjoyed my stay at this facility. Thank you very much."

2. Patient 410, "Found the staff on 4C to be extremely friendly and
Job satisfaction of nurses was mentioned by some of the patients in their written comments, but related to a workload context, rather than to the SDN, so their comments will be discussed here.
While on the Likert scale items, the patients appeared to score clinical competence items of great importance (i.e., giving medication and doing treatments skillfully), they also scored the general courtesy item, "Addressed me by my name" high. The researcher was impressed by the kinds of written comments patients had about the nursing staff. The written comments appeared to move away from issues of clinical competence of nurses to the interaction issues which occur between nurses and patients.

Clinical competence was referred to by eight patients, six which were positive and two that were questioning the competence of some nurses. Patient teaching, another aspect of clinical competence, was referred to by five patients, two were positive about the teaching they received, three wished for more.

The patient comments also supported the service and attention received from nurses (11 people) and some even noted the nurses' professionalism (13 people). Some patients were critical about either the uncaring attention they received (17 people) or not enough attention (six people).

Despite these more negative comments, they pale in comparison to the numbers of positive, appreciative comments for specific staff nurses. In total, there were 62 positive comments about the care and treatment patients received during their stay on 4C. The following comment is typical and sums up most of the comments from the other patients:

Patient 50, "There is no place where I feel more pampered than in a hospital and this hospital is no exception. The staff have been so nice to me and treated me with kindness and compassion. The people here are true caregivers."

In addition to the many comments about specific staff nurses and the caring attitude, 42 comments were written about general courtesy of the staff on 4C—friendliness, helpfulness, smiles, words of encouragement, cheerful, happy, and polite. All of these qualities appeared to be almost essential for the patients who wrote about them. Patient 240 speaks about coming into hospital and appreciating the nursing staff on 4C:
In my estimation, there is no one who enjoys staying in the hospital for any length of time for any reason. That was my state of mind when I was admitted. All the nurses and staff of Floor Four did a very commendable job of making my stay as painless and enjoyable as possible. If my stay was any indication of the type of care given on a regular basis, then nobody should have any worries at all. Hats off!!

Five patients wrote that they had been admitted to 4C previously, and four of them had return admission during the Project. All five wrote that they had requested to be admitted to 4C again, because they liked the staff so much, that they were treated very well, and they were familiar and comfortable with the staff. Nine patients also wrote thanks to the staff and encouraged the staff on 4C to "keep up the good work".

Many patients who wrote comments thanked the staff for their care during their say, but a group of 33 comments were especially heartwarming and, without question, overshadowed the number of critical comments from patients. The following five comments offer a selection of this type of heartwarming gratitude patients can feel for nurses. These comments span the time-frame of the Project. The first is from an 81 year old woman and appears here in her own writing. She told the researcher that she could barely write anymore, but she wanted to write her thanks to the nurses.

The nurses are just wonderful try go out of their way to help you. God bless them all.

The next comments are from an older husband and wife from an outlying town, who were unfortunately admitted to hospital within a few days of each other. They were admitted to the same unit and actually stayed in the same room for part of their stay. The wife writes the following:
Patient 325 wrote:

I would like to express how very pleased I was with all the nurses I came into contact with. I was on the 4th floor in the surgical unit and had many student nurses whom I felt gave me exceptional care and was very impressed with their knowledge and genuine concern for me. It is very nice to go to a hospital and feel like you are special. I cannot tell you how much it means to someone who is sick and its very hard to express that when you are feeling so bad. At this time, I would like to personally thank all the nurses on the 4th floor surgical unit for your excellent care.

The following comments is from a patient and a family member:

I would like to thank the nurse and staff on floor 4C for all of their kindness shown me while my husband was here. I would like to thank each and every staff member who was in contact with me for their care and kindness. God bless every one.

The fifth comment sums up the appreciation some patients found with the 4C staff:

Patient 481, "There could be no rainbow without them (nurses)."
Summary Statement

In an attempt to summarize the information contained under Research Question Number Two, possibly the questions the researcher asked the six staff interviewed about barriers and enhancers to their own job satisfaction might provide a short answer. Of course, there is little consensus on either barriers or enhancers from this group of nurses. Their responses are summarized in Figure 14.

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Barriers</th>
<th>Enhancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Short staff numbers</td>
<td>Add one RN to evenings</td>
</tr>
<tr>
<td></td>
<td>Short competent staff</td>
<td>Decrease use of casual staff</td>
</tr>
<tr>
<td></td>
<td>Group cohesion.</td>
<td>Work at getting along</td>
</tr>
<tr>
<td>2</td>
<td>Job cuts/bumping</td>
<td>Send long-term patients to an appropriate floor</td>
</tr>
<tr>
<td></td>
<td>Heavy workload, doing the work, but not having time to be a good nurse</td>
<td>being involved in educational events with staff and patients in a meaningful way</td>
</tr>
<tr>
<td>3</td>
<td>Gossip and back biting</td>
<td>Staff rapport/positive group cohesion</td>
</tr>
<tr>
<td></td>
<td>(Social group cohesion)</td>
<td>Making each work day count</td>
</tr>
<tr>
<td>4</td>
<td>Poor group cohesion</td>
<td>New education for patients - pre-op video</td>
</tr>
<tr>
<td></td>
<td>(Mistrust of some staff [drugs])</td>
<td>PCA pumps - patient comfort</td>
</tr>
<tr>
<td></td>
<td>Organizational decisions (SA)</td>
<td>Give more control to the patient</td>
</tr>
<tr>
<td></td>
<td>Short of competent staff</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Physician/nurse interactions</td>
<td>Seeing different departments in the hospital, how we all work together</td>
</tr>
<tr>
<td>6</td>
<td>Working group cohesion</td>
<td>Technical aspects of nursing (IVs)</td>
</tr>
<tr>
<td></td>
<td>Cleaning up after previous shifts</td>
<td>Learning new procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See patients comfortable</td>
</tr>
</tbody>
</table>

Figure 14: Barriers and enhancers for job satisfaction.

Ten different aspects of job satisfaction came up for these staff as barriers to job satisfaction. Eleven areas came up as enhancers for staff job satisfaction. While some of the job enhancement aspects mentioned were related to the SDN (educational events, learning new procedures), many enhancers were not related to the SDN at all. They were
related to aspects of organizational changes and decisions, unit working and social group cohesion, and workload.
CHAPTER FIVE
DISCUSSION AND CONCLUSIONS FROM THE STUDY

Introduction

The purpose of this chapter is to discuss the two research questions, examine the methodology, reflect on the whole process, and forward recommendations. The information here will be addressed in four sections: impact of the SDN on job satisfaction of nurses, other factors affecting job satisfaction of nurses, methodology, and recommendations.

The Impact of the Staff Development Nurse

The original purpose for the SDN being on Unit 4C was to increase staff levels of clinical competence, which would hopefully result in increased levels of staff job satisfaction.

The nursing staff questionnaires conducted on 4C were to provide valuable information to track the progress of nurses' perceptions of their own and their peers' job satisfaction and clinical competence. Although both the job satisfaction and clinical competence indices increased for the six staff nurses who completed both the initial and one-year round questionnaires, when further data were examined, it could not be determined whether the institution of the SDN was responsible for this change or not. The open-ended answer portion on the one-year nursing staff questionnaires referring to the SDN was not able to confirm the changes, in that the six staff who completed that portion were either not supportive of the SDN or reported having little to do with her.

It was clear to the researcher from the interviews that some of the staff saw a benefit to the SDN role. Three of the staff interviewed did not feel that the SDN played a role in their own job satisfaction, but did feel that she had helped them with their clinical competence. Two nurses said that the SDN did not have much influence on their clinical competence or job satisfaction, and one saw the SDN as an added pressure, even though
the SDN had helped her with clinical skills. A few reasons for this situation come to mind: possibly the work and positive influence of the SDN did not reach these staff members; possibly it takes a large amount of time until enhanced clinical competence results in increasing job satisfaction; that the efforts of the SDN do not affect job satisfaction; or that job satisfaction is always tenuous, varying widely over time and with situational variables.

The SDN saw a benefit to her role, in small ways and small steps, not only in increasing staff clinical competence but in a number of professional issues where more 4C nursing staff presented inservices and conducted background research for case studies. She could not be sure if these small steps had influenced job satisfaction with the staff or not. The conclusion to which the SDN arrived was that she was a positive influence for some staff some of the time. Through some of the work the SDN did, the staff gained better relations with other departments in the hospital, became more knowledgeable about certain procedures so that they were ready to carry them out when asked, and gained some clinical skills.

The NUM saw a benefit especially for herself and for the staff from the SDN role. As the NUM stated, although 18 months was a short time in which to expect major changes in attitude and behaviour in a project of this magnitude, the SDN position had a significant positive impact on the quality and quantity of educational opportunities for the staff on 4C, and the NUM hoped that in the future, those opportunities would lead to enhanced feelings of job satisfaction and clinical competence for the staff.

Through the Project, it was also originally hoped, based on research by Kramer (1990), that having competent staff nurses would prove more important than having sheer numbers of staff. The information gained from the staff nurses in this study was not completely supportive of this notion. All of the nursing staff interviewed agreed that having competent staff with whom to work was a very good thing, but they stated that
even with competent staff, additional numbers of staff were still needed, and that everyone still had to communicate and work well together, regardless of competence.

Based on Fleming's (1989) report, Lethbridge Regional Hospital recommended that ongoing education and staff development of nurses be addressed. This was carried out for 18 months on 4C with a substantial increase in all of the staff on 4C engaging themselves in ongoing education. The researcher believes that clinical competence has been enhanced for some of the 4C staff through the SDN, as evidenced by both patient and nursing data. Because of the SDN, at the very least, the researcher believes that nurses on 4C were made aware of organizational changes and decisions. Some staff were even prepared for the changes when they occurred, thanks to the SDN.

From the literature review, Benner (1982) believed that one of the things that stifled competence was routinization. Routinization was referred to by all six staff nurses interviewed as being part of the job and a way to manage the workload. Wylie (cited in Banning, 1990) warned that when decentralization occurred in a nursing department, routinization was often a result, mainly as a means of coping. To counter the tendency to move towards routinization, Wylie recommended intensive educational support be available to both the managers and the nursing staff to help them cope. The SDN appears to have been particularly valuable as a support the NUM.

The researcher believes that the SDN may have become a mitigating factor or a buffering agent for the staff to cope with their workload as well as they other myriad of factors influencing their job satisfaction. Indeed, the staff on 4C "heard it or got it first" and they liked the fact that they were kept up-to-date. If that is true, then the SDN played a very important role in the lives of the staff on 4C. It must be noted here that the NUM played a mitigating role as well in buffering the pressures for the staff, but was able to buffer more effectively through the help of the SDN.
In conclusion, the institution of the SDN position was perceived by some staff involved in the study as enhancing of individual and group levels of clinical competence, and in turn it possibly enhanced perceptions of job satisfaction among some of the staff on 4C. Competence had increased over time for some of the staff on 4C, and it was very likely due to the presence of the SDN (who reportedly created an atmosphere of learning), if not the actions of the SDN.

The relationship between nurses' perceptions of clinical competence of nursing peers to job satisfaction is evident in this study, based on the increased scores on the nursing staff questionnaires from the initial to the one-year round, but it is not clear who or what was responsible for those increases. It is also evident that there are many other job satisfaction factors besides clinical competence which were important for the 4C staff.

Summary Statement: Research Question Number One

The researcher concluded that the SDN did enhance some clinical competence for some nurses, but that the connections between clinical competence and job satisfaction could not be clearly demonstrated for all staff in this study. The SDN brought many "subtle" positive aspects to the environment on 4C, some of them educational and some of them social. Two factors are apparent to the researcher in examining the conclusions from this study: one, that ongoing education and support such as that demonstrated by the SDN in this study are vital for the nursing staff and the NUM; and two, that the situation for nurses and for nursing education will not change until the working environment for nursing changes.

Other Influencing Factors for the Staff

Based on the information gathered from the data outlined in Chapter Four, there are many other factors influencing the job satisfaction for nurses on 4C.
Aside from their involvement with the SDN, the nursing staff on 4C had many other daily challenges with which to cope. Prior to the study, the staff on 4C also experienced many personnel changes during their relatively short history in the new Regional Hospital building. Numerous colleagues and two nursing unit managers had left the unit; new people came and adjustments had to be made. The staff, many of them newer nurses, had to: 1. gain clinical experience, 2. hone their own organizational skills, 3. work cooperatively with others to get the work done, 4. accommodate newcomers or casual staff, and 5. cope with the heavy, heavy workload. All of these necessary adjustments occurred during the 18 month Project and are still going on. It may very well be that because staff were working on these adjustments on a daily basis, their clinical competence would automatically increase, and in turn, so might their perceptions of job satisfaction. Conversely, these factors might very well reduce competency and inhibit job satisfaction.

For many of the 4C staff, these realistic adjustments may have had to have been made before they could incorporate the services the SDN was offering. Although the SDN worked with some of the staff on the adjustments, when the small areas of progress were added to the other great challenges with which the staff were faced, their perceptions of positive progress with the SDN might have become overshadowed.

Working group cohesion on 4C did improve as reported by many of the staff who responded on the nursing staff questionnaire and for all six of the nurses interviewed, although the staff interviewed admitted that there was still progress to be made. The area of group cohesion also seemed to be the biggest dissatisfier for many of the staff interviewed. It appeared that once the bulk of the staff who were not happy on 4C left the unit, the remaining staff were motivated to invest and trust in each other and make their own nursing unit. Trust was challenged on two occasions in the initial stages of the Project with the narcotics situation and then with a staff member who was not keeping up
with the job requirements. Trust was again an issue when some staff felt that the NUM and the SDN were breaking staff confidences.

Once the bulk of personnel changes was over, the challenge then became one of figuring out ways to get all of the work done as a team. One of the side effects of trying to get all of the work done was that some people worked and communicated well with each other, and some did not. The issue of miscommunication as a job dissatisfaction remained for many of the staff through the Project ending.

The heavy workload was acknowledged by all staff but one who completed the questionnaire and by all staff interviewed. Because the workload was so great for the staff, there was little room for “lookers” simply because the work would not get done. Neither did the staff need colleagues who were confused, slow, disorganized, or lazy. The issue of working with competent staff and more numbers of staff were important for the staff on 4C; in fact, they depended on others who were available to help and could handle the workload. The staff had to reckon with the heavy workload most days; very little time was free to think about other aspects of nursing.

There occurred a vicious cycle where the workload demanded staff to be quick, skilled, and energetic. Some of the staff lacked in expertise, speed, or energy, so the workload became heavier, and demanded more from the rest of the staff.

Patient satisfaction and nursing satisfaction have been shown to link directly to each other (Allanach & Golden, 1988) and positive nursing environments produce better quality of care for patients (Kramer, 1990). From the information in Chapter Four, overall patient satisfaction on the surveys done in this study ranged from 65.1 percent for the 81 and over age group, to 81.6 percent for the 50 to 65 age group. Thorpe (1981) found that in other studies, “overall satisfaction” rates ranged from 67 to 100 percent. Pelliter (1985) found that in other studies “overall satisfaction” ranged from 75 to 100 percent, and recommended that if a service does not achieve that traditional high degree
of approval from patients, it should be examined more closely for its impact on patients. The range given for overall patient satisfaction from this study was a little low from what was recommended by either Thorpe or Pelliter. Possible further investigation is needed, to determine whether other mitigating variables were influencing patients' levels of satisfaction.

The impact of organizational change was a tremendous challenge for the staff on 4C. They had to deal with staff bumping two times; with the added workload of summer bed closures, and many relief staff; stress of possible job cuts; additional adjustments when the short stay unit opened; and changes to patient care services.

The part the researcher believes was and still is so tough for the staff is that they perceive that they have little input or involvement in the organizational decisions, but most importantly, they are expected to deal and cope with the organizational changes. This situation simply adds to the sometimes overwhelming responsibilities they already have. The nurses interviewed often did not perceive these changes as helping either themselves, or more importantly, the patients.

Administrative decisions were perceived by the staff to be made without them, in some distant place, often without regard for how the decisions would impact on their own workload. New forms, policies, programs, and demands for staff time or attention would appear from administration almost weekly. As perceived by the 4C staff interviewed, any sign of support or teamwork from administration was absent.

In many ways, the group of nurses on 4C was typical of groups of nurses elsewhere when job satisfaction issues were considered. The staff on 4C might as well have been part of the research done by CNA/CHA (1990), because the same issues came up during this study. For example, the staff on 4C in the LRH Project were asking for closer, more personal communication from Nursing Administration. They perceived that there was still a “chain of command” and that there was a great distance between them and the top.
As another example, the general sense of powerlessness was apparent for many of the nursing staff interviewed. "Powerlessness" occurred over changing O.R. times, Medical Imaging time changes, and over nursing department or organizational changes. The staff on 4C, again no different from other staff in other hospitals (if the literature on job satisfaction is accurate), were socialized into their subservient role, as were the physicians and Administration socialized into their more "powerful" roles. The notion of autonomy did not come up at all in the staff interviewed and for the six people who completed the nursing staff questionnaires, five of the six staff felt that they had autonomy and control over the program of care for each of their patients on the unit, but when questions about other aspects of autonomy were asked (i.e., supervision, responsibility), the answers given did not reflect a wish on the part of the respondents for autonomy and independence. The sense of powerlessness related to issues outside the nursing unit, seemed to pervade the staff.

From the literature review, Mottaz (1988) stated that outcomes of limited autonomy (exemplified from this study) were twofold: excessive reliance of nursing staff on daily supervision (as evidenced by "nurses leaning on the NUM"), and more time spent doing non-nursing tasks. Mottaz stated that when nurses spent less time on direct patient care, they had less job satisfaction. Other reasons Mottaz gave for low autonomy were related to nurses working in hospitals where bureaucratic principles of division of labor with a system of rules, regulations, and procedures existed. This situation sounds very similar to the one on Unit 4C.

The nursing staff interviewed said they wished that they were consulted more about decisions for their floor by those outside the unit. There was not very much evidence from those interviewed to indicate that Administration consulted with 4C staff before they put changes into place. There were two "Town Hall" meetings scheduled during the 18 month Project to which all staff were invited. Administration delivered a presentation
and the staff had opportunity to respond. Staff from 4C did not attend and did not use that forum to state their concerns, commenting that Administration “never listens to us anyway”. Kramer and Hafner (1989) have observed such situations before and state that they have found that nursing departments must focus their efforts into areas identified by nurses as important, otherwise their efforts are ineffective.

In their working life paper, the CNA/CHA (1990) wrote about nurses needing an environment which enhances the quality of working life, an environment that promotes collegiality among nurses, other health care workers, and Administration. The staff of 4C certainly got the opportunity and did develop more collegiality with other health care workers through the tours to other areas and working on the Surgical Nurses Committee with nurses from other units. Two staff nurses interviewed, the SDN, and the NUM believed that the SDN activities had helped promote that collegiality. The staff interviewed did say that they got along better with each other towards the end of the Project, as compared to its start, and have better relations with other departments.

The staff on 4C had their trying moments with staff from other units and departments, with physicians, and with patients. However, a potential source of support and positive job satisfaction were the other staff who worked on 4C. For two staff interviewed, the co-worker support reportedly helped increase their levels of job satisfaction. For the four others, some days the other staff were perceived as supportive and enhancers of job satisfaction; other days, job dissatisfaction was the theme. The unit appeared to provide a number of positive aspects for people, as identified from the staff interviews on their reasons for staying on 4C, ranging from social and emotional to vocational.

The patients were often a source of satisfaction for the staff, and gave them a reason for being there, along with the nature of nursing care those patients required. Three staff members interviewed reported that taking care of patients was their source of job
satisfaction. All but one of the staff who completed the questionnaires (12 of 13) and all of the staff interviewed chose a nursing career to take care of patients.

From the literature review, Gamble (1989) warns that if staff state that they went into nursing to care for the patients, then the current system thwarts good nurses from building a career around caring for patients. Gamble gives reasons like organizational changes, taking nurses further away from the bedside, and adding more to their workload as factors that keep nurses from doing the thing they like most. The researcher was acutely aware of this phenomenon on 4C during the Project time frame.

Job satisfaction has been shown in this study to be a very individual issue as well. A different profile was drawn up for each staff member interviewed on 4C related to barriers and enhancers they perceived affecting their own job satisfaction, based on information gathered during the interviews. Some aspects were the same, while some were quite unique.

The best way to address the more individual aspects of job satisfaction might be through some of the theories outlined in Chapter Two. For example, Herzberg, Mausner, and Snyderman (1959) developed the Two-Factor Theory where intrinsic factors related to job satisfaction were: achievement, growth, work itself, responsibility, and advancement; the separate extrinsic factors of job dissatisfaction were: policy, administration, security, salary, interpersonal relations, and working conditions. Most of the staff interviewed and those who completed the nursing staff questionnaires liked the work itself, and the sense of achievement they sometimes felt from it. They also liked the responsibility, but were divided as to whether they had too much or too little. Some were dissatisfied with some interpersonal relations on the floor (one of Herzberg's dissatisfiers).

Interestingly, Herzberg et al. suggested that positive intrinsic factors were seen as able to prevent job dissatisfaction, but not able to create job satisfaction. They believed
that only when the actual tasks of a job were stimulating to a worker, would positive job satisfaction occur. If this theory is followed, then some of the staff on 4C may have gained positive job satisfaction through stimulation by the SDN to learn additional interesting skills, such as physical assessments.

Maslow's Need Hierarchy Theory (1943) had five "need" categories: 1. physiological (food, shelter), 2. safety and security, 3. affection and need to belong, 4. self-confidence and competence, and 5. self-fulfillment. In his theory, Maslow stated that every category operates at all times. This issue of constant fluctuation was evident as one nurse interviewed toward the end of the Project shared that even though previously she had other job satisfaction issues, lately she was simply glad to have a job, that the other issues did not matter. This theory also possibly explained the needs of nursing staff on 4C to develop positive group cohesion and a sense of belonging to the unit before they could address clinical competence. Larson et al. (1984) stated that what one person views as highly desirable for job satisfaction another may not. This notion is certainly true from the evidence in this study. Also, Larson et al. add that one factor may have varying effects on each employee's satisfaction, depending on their expectations and the importance they place on that factor.

Professionalism was one of the areas of job satisfaction where there was a wide difference among perceptions of all participants interviewed and those who completed questionnaires. The SDN did not perceive that professionalism on 4C was always high. The NUM disagreed. The staff interviewed believed that professionalism was present on 4C, but not always. From the patient satisfaction surveys, generally speaking, the patients found the staff professional, outside of a small number of comments about profanity, or treating patients less professionally than they might have. The times when there were more written complaints from the patients, the researcher found the staff interviewed or the SDN also talked about busy times on the unit, changes to workload, preceptors on their first shifts, or higher numbers of inexperienced casual staff.
Summary Statement: Research Question Number Two

The researcher concluded that there were many other factors in this study affecting the job satisfaction among the nursing staff on 4C. These factors included: working group cohesion, the heavy workload, organizational change, the images nursing holds of itself, and relations with others in the hospital.

Methodology Revisited

The original Project premise that the SDN role was pivotal to enhancing job satisfaction through clinical competence among the staff may have been optimistic in that most literature and the results of the Project data have determined that there are multiple factors influencing the job satisfaction of the nursing staff on 4C and nursing in general. The SDN did not have control over or influence on many of the more pressing job satisfaction factors for the 4C staff although she might have been a mitigating force, helping nursing staff cope with their pressures.

Because of its use of diverse methods, the case study was especially helpful in discovering and gathering pertinent information. As it turned out, the quantitative information from the nursing staff questionnaires was small and not as revealing as the qualitative information from the case study approach. (The huge amount of data derived from the qualitative methods used were overwhelming for the researcher many times; results and conclusions may indeed reflect that fact.) Perhaps an action research or complete case study approach may have been more useful for this Project.

The case study allowed the researcher and ultimately the reader to understand behaviours of the staff from their own frames of reference. An attempt was made to understand how the participants thought and came to develop the perspectives they held.

The case study also allowed the researcher to observe that the work situation was different for each staff member, based on their background and experience. The replies
from those staff who had worked for less than three years, for example, seemed different in attitude and character than those who had four to five years experience, and those with over ten years of experience.

Related to the quantitative data, thirteen of 27 nursing staff questionnaires were completed at the initial round of the Project and six out of 27 were completed at the initial round of the Project and six out of 27 were completed at the one-year round. This return rate was enough to give an initial and a small updated picture of what job satisfaction and clinical competence were like for those people who returned the questionnaires. The interview data from the staff, the SDN journal, and the documentation data from the researcher provided a larger volume of useful data and additional information beyond the questionnaires to answer the research questions.

At the time of the final questionnaires, not one nursing staff questionnaires was completed. As outlined previously, some of the staff stated that they were reluctant to fill out another survey, because they felt they had “been evaluated to death”. Some people said that they had set out their goals with the SDN, worked on them during the 18 months, and did not want any more work related to the Project. The researcher also suspected that by the time the Project was over, the staff knew the SDN was gone, they were again burdened with other more pressing issues such as job cutbacks, bumping, and could not comfortably think about “extra issues”. Some staff even admitted that they would rather talk to the researcher in person than put pencil to paper. The researcher found most staff who were asked were willing to meet for an interview.

It might be useful to address the process and progress of the Project to examine any of those factors that may have affected the results. In evaluating the change process that the implementation of the SDN represented, some components of the RAND study could be used as a guide (Berman & McLaughlin, 1978). This process may give some clues to where improvement to the research process could have occurred and therefore the outcome of the SDN project might have been different.
The RAND study defined the concept of change as a series of events moving from initial stages of securing support, through to implementation and a state called "mutual adaptation". Mutual adaptation was noted to be a situation where both the setting and the project were changed as staff tried hard to make the project work. Success in the RAND study was defined as to whether or not the project continued to be a major undertaking once central support ended. Ineffective change was when the change never became part of regular life, characterized by lack of internal ownership, or inflexible rules. At present, this Project has not been incorporated as part of the regular education scene at LRH, nor have many of the activities initiated by the SDN continued.

The interface between the Project directors and the users was one area of consideration for the RAND study. For this particular Project, there was interface between the researcher and the SDN regularly; the researcher ad the NUM less frequently, yet still almost daily; and between the researcher and the staff almost daily after the researcher started to give out the patient satisfaction surveys. The researcher believes that there was more staff acceptance of the researcher and possibly the Project after she started giving out the patient satisfaction surveys. There was not contact between the Hospital Job Enhancement Advisory Committee and the participants on 4C. Organized meetings between the researcher and the Advisory Committee occurred at the beginning of the Project and then very infrequently until the end when there was a series of summative meetings proposed to give results of the research. This lack of integration between the Job Enhancement Advisory Committee and the 4C staff may have been a factor in the staff reluctance to embrace the Project.

The RAND study also evaluated whether the stakeholders were given opportunity for necessary and timely feedback, to clearly understand the project goals and objectives, through update meetings or extended training sessions. In this Project, participants were initially introduced to the Project just before it started. The 4C staff members were not
involved in the choosing of the unit for the Project, neither were they given opportunity for formal feedback during the Project time frame. The exception was when one of them would ask the researcher how things were going with the research. The researcher would reply in generalities, as instructed by the Advisory Committee. During her time on the unit, the SDN did try to clear up some issues about the research and her role, but as evidenced by the comments from the staff, even at the closing of the Project, they were not sure what the role of the SDN was.

The researcher believes that it would have been more appropriate to share findings with the staff after the initial and one-year round nursing staff questionnaires were completed, and every month or two during the study to discuss the patient satisfaction surveys received. The researcher feels that if she had shared the results of the nursing staff questionnaires with the 4C staff after the initial round and one-year round, the staff might have been more open to completing more questionnaires.

The patient satisfaction surveys were given out daily, and results were available daily. Some of the information might have been useful for the NUM, the SDN, and the staff to use to improve their care or change some educational focus. The researcher felt compelled at times to share information with the NUM, the SDN, or the staff. These times were when the trend about “terrible food” went on and on, or when a patient would explain to the researcher why they were behaving they way they were and the staff were not aware of the circumstances, or when the trend on the survey question related to discharge planning was showing a “not done” score. If the researcher had been able to fully share all of the results of the patient surveys, possibly some aspects of patient teaching, patient orientation to the unit, and individualized care would have been addressed. Additionally, the overall satisfaction scores might have increased and the patients might have felt they had higher quality of care.
Looking back, the researcher feels that it was a significant disadvantage not to have shared the patient satisfaction surveys more frequently, because they may have contributed to the quality of care for the patients. The NUM speaks of working on quality of care now that the Project is over; that may have been possible with the benefit of these particular patient surveys during the Project. The researcher feels that using the first person would have been more appropriate and honest and helpful, however, that did not seem acceptable at the time the research was being completed.

Recommendations

Pringle (1989) states that job dissatisfaction can have serious consequences for both the organization and the individual. If job satisfaction is to be viewed as a desirable organizational and humanistic outcome, as well as a determinant of organizational effectiveness, the issues raised here need to be addressed.

Recommendations will be concentrated in two areas, the role of the SDN and creating positive working environments for nurses.

The Role of the Staff Development Nurse

Suggestions were requested from those nursing staff interviewed for future use of the SDN role. A wide variety of responses were given, from deleting the position forever to having an SDN on every unit. The following recommendation is selected after carefully considering the suggestions made by the participants.

1. **Incorporate the SDN role into the unit working life of 4C.**

   This recommendation supports the notion that ongoing education of nursing staff is vital for patient care, for job satisfaction of nursing staff, and for the “health” of the organization.
Even though complete support for the SDN role in this particular study was not apparent, the "subtle" advantages of the SDN role during this short 18-month period should not be ignored. Education is often not perceived as an important factor in the whole picture, however it is vital to many aspects of our daily working lives. Some of these aspects of the SDN role are highlighted here.

In his examination of bureaucratic systems, Friere (1984) was quite adamant that freedom was won through one's own efforts in self-liberating education. One wonders if nurses continued to have intensive staff development such as that displayed on 4C during this Project, if increased autonomy of nursing staff would occur. Autonomy has already been identified elsewhere as vital to higher quality of care for patients, and job satisfaction for nurses (Benner, 1982; Mottaz, 1988).

Benner (1982) has spent the better part of her nursing career researching how enhancement of clinical competence occurs. She observed that increased acuity levels, decreased length of hospitalization, and the proliferation of health care technology have increased the need for highly competent clinical nurses. Benner believes that nursing experience is an important factor, but must be accompanied by a reflective educational component in order for learning and advancement of nursing practice to occur. Benner (1982) also warns that the third of five levels of competence is the level that is often supported and reinforced institutionally, centralized, non-individualized education is often aimed at this level, and this level is perceived as ideal by supervisors because nurses can be "managed"; however, routinization of patient care occurs, autonomy decreases, and patient care suffers. This level is not ideal for high quality of patient care, because nurses are not encouraged to use creative problem-solving. Benner's competency model is illustrated by Kramer and Schmalenberg (1988, Part II) who found that among units with nurses who were stable, well-educated, and possessed high levels of competence, the need for supervision was markedly decreased, because staff could
problem-solve for themselves. The role of the SDN outlined in the job description for this study is an excellent role to facilitate increased clinical competence to the two higher levels, by providing that reflective educational component. Some of the staff interviewed experienced the benefits of such a role, as did the NUM in both a personal and professional manner.

Perhaps the role of the SDN could be viewed differently than it was demonstrated in the study as well, so that more clinical development could take place as the work on the unit was being carried out. The SDN in this study did possess a large volume of information and expertise, yet with the time constraints, that resource was sometimes not utilized or considered, and she often felt like she was merely “helping out”. To capitalize on this situation, for example, the days when the floor was very busy and the SDN “helped out” could be viewed as exceptional opportunities for learning, where education could occur in very brief “bottom line” conversations and by role modeling from the SDN. Additional information could be supplemented later, individually or in small groups, when the pace was slower. Education in this form might be viewed as more informal, but the advantages are that it is clinically-based, very practical, and by the responses from staff interviewed, well-received. The role of a clinical nurse specialist might be worthy of consideration also, combining patient and family care with staff education responsibilities.

The results of this study also highlighted the fact that the SDN role was viewed as that of a buffering or mitigating force for the nursing staff on 4C. The value of this aspect of the SDN role should not be underestimated. The NUM found the SDN to be an immense support both personally and professionally, and stated that she could do her own job more effectively, because she could delegate some of her continuing education responsibilities to the SDN, who would carry them out. The staff nurses on 4C reported liking the fact that they were warned or “heard it first” regarding any changes coming to
them. The SDN role was an excellent one to fulfill this information gap in the system. Wylie (cited in Banning, 1990) noted that when nursing systems change to decentralized structures (like the one at LRH), unless nursing unit managers have educational support, increased routinization of patient care occurs in an attempt to manage all of the work, and bedside nurses continue to feel isolated, unappreciated and frustrated (like the nurses on 4C). Interestingly, Wylie even states that although nurses may be legislated onto hospital committees, they still perceive that the hospital is paying lip service to nursing requests for input into decisions that affect them.

The fact that the Project ran for an 18-month time limit may also have set the impression in many nurses’ minds that education was only done for short periods of time, but if there was a continuous established educational position on 4C, the staff may have viewed the value of education differently. Despite the fact that there may not have been obvious, measurable, quantifiable evidence to support the SDN role, the positive impact of the SDN role may have been overshadowed by the nurses’ negative perceptions of other areas affecting their job satisfaction.

The SDN also brought up another important point, and one that supports Benner (1982), Kramer and Schmalenberg (1988, Part II), and Mottaz (1988). The SDN believed that if education of staff was important, provisions should be made for it in the nursing shift. She believed that education in the particular hospital setting did not have a high profile, that the floor and the work could be reorganized to allow for more specific times for education. The situation of little time for education was noted by the SDN and the researcher to be no different than many other institutions in the country, where the budget cuts have eradicated many different continuing education programs for nursing staff. Possibly the issue of little time for vital education through the role of the SDN can be addressed in the following recommendation.
Creating Positive Quality of Working Life Environments for Nurses

Positive working environments have been described by many writers and researchers as places where: recognition and respect for the contributions of nurses are demonstrated, nurses are involved in decision-making, management philosophies are participatory in nature, a spirit of enquiry is fostered, professional growth is fostered, health care of clients is protected and promoted, and quality of care for clients is supported (Canadian Nurse, 1991; CNA/CHA, 1990; Cuddy, 1990; Hinshaw et al., 19487; Mottaz, 1988). The NUM certainly tried to foster these ideas on 4C. The staff also perceived the NUM to be very supportive of them. Based on what the nursing staff on 4C shared, the following recommendations are made with respect to enhancing the working environment for nurses.

1. **Improve communication to keep all staff informed and delete hierarchical, cultural lines of communication.**

The staff of 4C perceived that there is still a "chain of command" despite the nursing department changes and that there was great distance between themselves and the "top". They wanted to see more of Nursing Administration and Administration coming to their unit to consult and discuss with the nurses about organizational change and decisions. This move is supported in the literature by the CNA/CHA (1990), Kramer (1990), and Harrison (1989). Harrison adds that flattening the nursing organization gives those at the operating level greater freedom and discretion in scheduling their work activities and deciding how to most effectively and efficiently meet their challenges. McClure, Poulin, Sovie, and Wandelt (1983) defined part of their Magnet Hospital "culture of excellence" as having a management style where the visible head nurse, supervisor, and clinical specialists were identified as key supports and resource persons. Stamps and Piedmonte (1986) supported this move and stated that the organization must
change to meet the needs of the staff, not the other way around, because nurses are the connective tissue of the hospital.

2. Establish more available time for nurses to direct patient care.

Nurses in the study suggested adding more staff to the unit, decreasing the unit by four beds with the present staffing component, enhancing clinical competence of the existing staff, decreasing the amount of paperwork, allowing more time for planning of care with provisions for discharge planning, and redefining the admissions and transfers that go to 4C. The CNA/CHA (1990) and Mottaz (1988) both state that in order to achieve greater autonomy for nurses, which is believed to lead to higher quality of care, nurses need to spend more of their daily time doing direct patient care. McClure et al. (1983) found that in the Magnet Hospitals there was nurse-to-nurse consultation, a low nurse-to-patient ratio compared to other hospitals, nurses did not feel overwhelmed and overworked and had opportunity to care for all patient needs, efforts were directed at making work life easier for the nurses, and staffing was based on adequacy, quality, and patient need. In the Magnet Hospitals, the nurses had higher job satisfaction and the patients felt they received higher quality of care. Benner (1982) and del Bueno (1984) add that autonomy requires an environment that fosters values of respect, trust, and recognition for a job well-done. These factors are included in the first recommendation.

3. Make patient care the highest priority.

Patient satisfaction surveys show that during the study the patients were not at the 100 percent satisfaction level and that there was room for improvement. Medication errors on 4C are higher than on the other surgical unit. The nurses in the interviews and in the questionnaires spoke of the patients being the reasons that they were working as nurses at LRH. There was also a concern that sometimes it did not seem as if the patients were the main focus within the hospital. This related again to the positive
working environment for nurses. Kramer (1990) found that in the Magnet Hospitals, there was an all-encompassing zeal for quality. According to Kramer, these hospital were known for giving "good patient care". There seemed to be a fanatical zeal for caring about nurses—the staff were treated like one essential, irreplaceable link in delivering quality patient care, excellent employee relations mirrored excellent patient relations, and the immediacy of cooperative, goal-directed problem-solving was apparent at all levels.

In conclusion, to better serve the needs of the nurses and patients, the role of the SDN could be reexamined to include a patient care component and a staff education component, and the quality of working life environment could be supported in a more concrete manner. In reflecting on the flavour of the study, the notion of a "classic functionalist study" comes to mind. In rereading the study, it appears that the nurses in the questionnaires and the interviews did not or could not speak personally about their work or what the meaning of nursing was to them. This situation may also be a result of the nature of the questionnaire items and interview questions, but it appears that there were very few accounts of passions about the work of nursing or no reflections on the sensibility of nursing and how important nursing is to the health and healing of patients. Perhaps that is one of the problems the nursing profession faces—of having to deal with workload and tasks and not the "essence of nursing", that of caring for patients.
REFLECTIONS

The Project is over; the research is completed. As I reflect on the process, I think of Unit 4C as a lake. On that lake are leaves (the nurses). The lake is part of an environment and subject to all sorts of weather patterns—the sunshine (steady, reasonable workloads); rainbows (the patients); clouds (heavy workloads), which can either produce rain storms (busy days), or snow storms (hectic days); the winds or gales (organizational change) can blow at any time without warning, producing a drizzle (new programs and forms), or thunder and lightning (doctors). There are some buffers to shield the leaves from the weather. One of these shields is the mist (NUM). The other was the SDN. The NUM creates a soft mist, hoping to protect the lake and the leaves from too much disturbance.

The Leaves

As the weather patterns change, the surface of the lake ripples and swells; the leaves have little control over their destiny. These leaves are beautiful, each one contains colours like no other. Some are older, while some are still quite fresh, and together they have found themselves on the lake. They have hopes, dreams, ideals, and promise. They have arrived on the lake by various routes. Some have decided that this lake is the best place for them to be, and they travelled great distance to get there. Others have simply fallen into the lake. Most of them like it on the lake; most of them are happy there.

The leaves are there to watch out for rainbows. They have been trained and educated to do that very thing. It makes them happy to do that. When they provide special care for a rainbow, they feel so rewarded and satisfied.

The leaves also know that they all have to deal with the weather patterns which occur on this lake. Some of the weather patterns are to be expected, like the sunshine. Even so, the leaves know that they have to work together, because even the sunny days
can be less fun and more taxing if they are at odds with each other. There are, of course, different ways to stick together, and there is always at least one leaf that wants to be something different, or a leaf that does not want to part of the group. When the group weakens, sun can beat down and drain and dry out many of the leaves. They do not work well if they are dried out. The leaves also need the other inhabitants on the lake, because it is a big job looking out for rainbows, and if one is missed, it may be disastrous for everyone involved—the leaves, the rainbows, and the lake.

Some leaves are better at watching out for rainbows than others. Maybe they are more experienced; maybe they have developed better skills, maybe they just "have a knack" for it. Others are learning, and still others have lost interest in even looking any more. Some have been weakened by the temperamental weather patterns. But all of the leaves are still necessary and important.

The Rainbows

Rainbows are so very interesting. They can be seen in all shapes and sizes, from very big ones that take over the entire sky, to softer, smaller ones that are almost hidden in the hills beside the lake. No matter what the size of shape of the rainbows, the leaves know that the rainbows become more brilliant whenever the leaves smile at them, and show that they are important. For the most part, the rainbows feel that the leaves do an excellent job of watching out for them, which in turn makes the rainbows feel safe, protected, and important.

The Sunshine and Clouds

Sunshine and clouds always work in combination over the lake. They are the major consideration with which the leaves must deal every day, for the sunshine actually permits the leaves to watch out for the rainbows. If it is a sunny day, there are many rainbows, but if the clouds come rolling in, the rainbows are harder to find. The clouds
can obscure the sun, and make it really hard for the leaves to do their job the way they believe it should be done. Sometimes these clouds disperse showers; sometimes they spew out lightning, thunder and driving rain; sometimes they cause a heavy wet snow to fall all over the lake; and sometimes they can create a steady, cold drizzle that lasts for days at a time. The surface of the lake becomes ripply and stone cold.

The lightning and thunder are sometimes frightening and intimidating. The leaves have been exposed to thunder and lightning many times, and some leaves even say they get used to them, but the leaves also know that of all the weather conditions, thunder and lightning can be the most alarming and intense weather conditions around these parts. Thunder and lightning can also be the most impressive weather patterns, and often, if they feel safe, the leaves especially like to watch the lightning doing its work, and listen to the thunder tell about its power.

The Wind

Without question, the wind is the most puzzling weather condition for the leaves to understand. The wind is often seen by many leaves as an essential weather pattern, because it can thaw out the frozen lake, and provide a reassurance and an energy that helps the leaves to do their important work. But whoever controls the wind is sometimes thought by the leaves to be “out of control”. The wind can begin without warning and mess up everything on the lake; it can send a blast of cold air down onto the lake that takes the leaves many days to get over; it can create big waves, or even tidal waves. The wind can blow steadily for days, weeks, or even months. It almost seems that sometimes someone turns on the wind full blast and goes on vacation for a few weeks, leaving no one to turn the wind off or down. So the leaves find themselves being flitted around, being blasted from one side of the lake to the other, or even seriously hurt by the effects of the wind. Some leaves have even been blown off the lake and have had to find somewhere else to settle. None-the-less, the leaves have to somehow stick together and
keep up their job of watching out for rainbows, even when the wind blows rain their faces, changes direction suddenly, creates a rough surface to balance on, or blasts snow into their eyes. The wind drains the leaves of their energy. Part of the reason it is so taxing, some leaves say, is that it has a tremendous force generated far away from the lake, and it almost seems as if it has no mercy, or no sense of the amount of destruction it sometimes causes to the leaves and the lake. The leaves often talk about their wish to somehow get word back to the source of the wind that there are grave consequences related to the sheer force of the wind.

The Mist

The mist was a protection for the leaves from the weather patterns, and the mist tried hard to shield the leaves from the bad storms. The leaves were so grateful for the mist, especially after a drying wind. The mist did a good job in many instances. For awhile, the mist had some assistance, from a different kind of mist. This special kind of mist was able to get closer to some of the weather patterns and given the leaves at least some warning so that they could get prepared. This special mist also took some leaves along on trips with her to visit some of the areas where some parts of weather patterns were created. This helped the leaves to understand a little more about the areas around the lake. Sometimes when the special mist took leaves travelling with her, the sun or the clouds would get especially intense, and the other leaves were afraid that they did not have enough leaves to stick together or to carry out their important job of watching out for the rainbows. Sometimes, some of the leaves even said that the special mist blurred the sky so that the sun was hard to see.

Reflections from a Distant Leaf

It was so easy to become mesmerized by the reflections, to get caught up in the colours, in the depths of the lake, and in the ripples and waves that each of the weather
patterns created on the lake. It was also hard to clearly see what had happened beyond those reflections. At a glance, I saw and experienced some joyous and serious isolated times in the lives of the leaves, the lake, the rainbows, the mist, the special mist, and the sunshine, the clouds, the thunder and lightening and the wind. Some glimpses lasted a few minutes, some days—others lasted only seconds before the next weather pattern came in. Some days it was hard or almost impossible to keep up; on other days, I wished for time to pass quickly, because I had too much time to think and the events of the day were too painful to watch.

Many, many days I wanted to save, or at least bolster those poor, fragile, delicate, beautiful leaves from the the oppressing wind, the terrible rain and snow storms, the tremendous lightening and thunder, and the freezing drizzle. I became depressed for long stretches, knowing that I was neither capable nor strong enough on my own to make any difference... because I am one of them. Some days, like the leaves, I have more energy to start trying to make work for leaves on the lake easier, but there is so much to do. Where do we start?

So, we go back to the place where we get some comfort—to each other—because we are all on the same lake. That is what we have in common. And we work... and we wait... and we work, and we hope that the sun will peek through and we will get a chance to do the other thing we all have in common, the thing we most cherish—enjoying the glorious rainbows. Maybe we can linger with the rainbows a bit longer... may we can just be content... Here comes the wind again.

I look back over the three years of this Project from start to finish: the more than 2000 hours of research, the hundreds of conversations (some sane, some not), the thousands of pieces of paper, the millions of words on paper.

In the beginning, wondering if this Project was worthwhile, wondering if the mechanics of making it happen were too great, hoping I could make a difference for
nurses, yet knowing that I probably would not and neither would this idea, but that something had to be done, doubting if anything would help, yet hoping that maybe somewhere during the time frame something would jump out and I would find the answer.

Living through the Project, living with the doubts, the depression, the moments of joy, the depths of despair, and the weird feelings that come with doing qualitative research, the agonizing logistics of doing quantitative research, knowing that probably all of this would make very little difference, yet hoping against hope that it would be great news for some nurses.

Being on the home stretch and knowing that there was so much work done, so much time spent, that three years of my life has been focussed on this, such important information, wanting to delve into it deeper to discover more secrets or find more hope, but knowing that it probably was not there, and that what I had “found” was what many others had already found, only I found it here where I work. Feeling sad about that, I want passionately to help ease things for those who keep trying to be nurses. Knowing that someone has to do something soon, and realizing that the timing is not right for me to do it. But I could try... I'm so tired though...

As the Project is coming to a close, and the presentation to “4C outsiders” looms ahead, the issue of trust again arises. The nature of the research created a “fish bowl” situation where a number of people unrelated and removed from 4C are to examine each detail of the research carefully. I feel trepidation over a number of issue: that authority figures within the hospital organization will take offense at some of the information, either dismissing it or ignoring it; or that disciplinary action would be levied at some staff on 4C because of the nature of the information divulged; and the NUM and the SDN and certainly the staff nurses might be angry and more importantly, feel betrayed because they had shared information that would become “incriminating”. I feel totally
responsible for this situation, for I was the one they trusted enough to tell their stories; I
did not even have to prod them; they trusted that I would not “make it worse” for them.
The only scrap of comforting thought that I have is that documentation was done over an
18-month period on one nursing unit only, and that the information found was typical of
many other findings from other researchers in other studies; that these people who had
trusted and shared part of their lives were suffering and enjoying the same issues of job
satisfaction as other nurses in other places. I can only hope that maybe this time
something will be done to positively impact the quality of working life for the strong,
Wonderful, hard-working, precious nurses on 4C and for other nurses at LRH.
WINDS OF ORGANIZATIONAL CHANGE

VARIABLE WEATHER OF WORKLOADS

SOME CLOUDY DAYS

SOME SUNNY DAYS

DRIZZLE OF NEW PROGRAMS AND FORMS

THE PATIENTS

RAINBOWS OF HOPE AND PURPOSE

THUNDER AND LIGHTNING

THE UNITLAKE

THE STAFF

REFLECTIONS OF THE RESEARCHER
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APPENDIX A
PILOT PROJECT PROPOSAL
FOR SUBMISSION TO
THE JOB ENHANCEMENT FUND COMMITTEE
OF THE PREMIER'S COMMISSION

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January 23, 1990
THE JOB ENHANCEMENT FUND:

In 1988, the Premiers' Commission on Future Health Care for Albertans released a interim report on "Concerns of Nurses in the Hospital and Nursing Home System". The report clearly vocalized the concerns of nursing personnel in the province regarding their low morale and high levels of job dissatisfaction. As result, two actions were introduced by the government: (1) actions to address immediate concerns of nurses, and (2) developmental actions to begin laying the framework for improving nursing morale and satisfaction.

The job enhancement fund was established as one of the developmental actions. It is a fund of $2.0 million that will flow monies on a cost-shared basis to institution initiated pilot projects. The pilot projects are required to demonstrate initiatives or benefits that will accrue to nurses or add to our knowledge of job enhancement and thus, job satisfaction of nurses.

LETHBRIDGE REGIONAL HOSPITAL NURSING DEPARTMENT PROFILE:

Approximately 350 registered nurses, 80 registered nursing assistants and 90 nursing attendants are employed in the nursing department. Nurses employed here deliver care in high risk, specialty, general care, extended and geriatric care settings. Although no specific job satisfaction studies have been conducted, an acute staffing crisis in early 1989 sparked a close review of nursing recruitment and retention issues. A major report was issued in May of 1989 that examined these concerns in light of the profession generally and then specifically for this institution.

An exploration of the antecedents to job satisfaction was a major thrust of the report. Five major recommendations and twenty-one sub-recommendations regarding management implications and specific measures the nursing department could implement were made. They addressed the departments' needs in: developing a strategic plan, changing organizational structure and function, clinical nursing practice issues, quality of work life and ongoing educational and staff development needs. Recommendations of the report will be further discussed at an upcoming Nursing Department Planning Meeting.

ACTIVITIES UNDERTAKEN TO IDENTIFY POTENTIAL JOB ENHANCEMENT PROJECTS FOR SUBMISSION TO THE JOB ENHANCEMENT FUND

In January of 1990, a voluntary committee of nine nurses representing several areas of staff within the nursing department was formed and examined current issues in job satisfaction for nurses. Components of job satisfaction for nurses were identified, as were strategies that could provide them. Possible projects for each component and strategy were brainstormed. Finally, a list of thirteen potential projects was compiled. Three successive rounds of nominal group technique yielded three possible projects most desired by the group. The project in first position was ranked first by every member of the committee in each of the nominal three rounds. Thus, the project ranked as most desirable, was done so by a significant margin. It is also noted that the proposed project is of similar intent as one of the major recommendations of the recruitment and retention report. Thus, there is strong nursing department support and belief in the value of the proposed project.
DESCRIPTION OF THE PROPOSED JOB ENHANCEMENT PROJECT

Numerous links between job satisfaction in nurses and turnover, quality of care and job performance have been reported. Two well understood phenomenon related to nurses' satisfaction is that first, intrinsic incentives and rewards have a longer and stronger effect on job satisfaction than extrinsic ones. Second, job satisfaction is not a single barometer that goes up or down, but rather an interplay of the balancing and buffering effects of "satisfiers" and "disatisfiers". Over the past several years, job satisfaction studies on studies on nurses have identified essentially similar findings as to what elements comprize "satisfiers" and "disatisfiers". However, a recent finding in a study conducted of nurse staffing patterns revealed an unexpected result that may impact our knowledge of job satisfaction in nurses. This finding was that nurses' perceptions of adequate staffing were totally unrelated to actual numbers of staff, but significantly related to the nurses' perception of the clinical competence of their nursing unit peers.

Armed with this finding, the next logical relationship to explore is how significantly does the clinical competence of a nurses' peers impact her own job satisfaction? Although correlations have been found between job satisfaction and group cohesion of members of a nursing unit, its' relationship with clinical aspects of peer behavior have never been explored. The proposed project aims to answer this question and provide adjunctive information regarding how clinical competence of nurses and their peers is best attained.

It is proposed that a selected nursing unit undergo pre-trial measurements of job satisfaction, perceptions of clinical competence of self (by the R.N.), perception of clinical competence of peers (by the R.N.), general levels of motivation and patient satisfaction scores. At the same time a "control" nursing unit with appropriately matched characteristics will undergo the same measurements.

The trial unit will then have a "clinical development nurse" specifically assigned to the unit on a full-time basis and the control unit will have access to a nurse educator on a shared basis with several other nursing units, as currently reflects the method of nature and nursing staff development operationalized in this institution.

The clinical development nurse's role will be to assess, implement and evaluate those educational strategies that on both an individual and group basis will assist nurses to attain a specified level of clinical competence on the trial nursing unit.

Following a 12 month (minimum) to 18 month (maximum) trial period, the trial and control units will undergo post-trial measurements of the same pre-trial tests. The results will be specifically analyzed to determine:

1. How successful the institution of an on-unit, full-time clinical development nurse was in enhancing individual and group levels of clinical competence, and

2. The correlation of nurses' perceptions of the clinical competence of nursing peers to job satisfaction.
The potential of this study is not only that new correlations regarding nurses' job satisfaction may be discovered, but more importantly, that should a positive correlation be found, a specific strategy, namely the institution of full-time, unit based clinical development nurses, may be indicated as a proven job enhancer for staff nurses. This finding will hold true to the original intent of the job enhancement fund and provide this nursing department with a clear image of how clinical competence can be obtained, not only for the satisfaction of our nurses, but also for the quality of care afforded to our patients.

COST AND RESOURCE REQUIREMENTS OF THE STUDY

The appendix identifies the resource and increased cost requirements of each phase of the project.

Summarized, the cost is as follows:

For 12 Month Trial:

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project leader hours (900)</td>
<td>$16,020</td>
</tr>
<tr>
<td>Clinical development nurse hours (2000)</td>
<td>$40,000</td>
</tr>
<tr>
<td>Use of statistical instruments, computer analysis, statistician, paper</td>
<td>$6,000</td>
</tr>
<tr>
<td>Word processing support hours (200)</td>
<td>$2,000</td>
</tr>
<tr>
<td>Clerical Support hours (80)</td>
<td>$640</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$64,840</strong></td>
</tr>
</tbody>
</table>

For 18 Month Trial:

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical development nurse hours (3000)</td>
<td>$60,000</td>
</tr>
<tr>
<td>Other costs as above</td>
<td>$24,840</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$84,840</strong></td>
</tr>
</tbody>
</table>

Guidelines from the government regarding the submission of proposed projects state that approval will be granted on cost shared basis with the requesting institution.

Deadline for the submission is January 30, 1990.
### Planning
- Develop research hypothesis.
- Set research design.
- Consultation with Alberta Nursing Research Foundation (ANRF) Scholar(s) re integrity of research design.
- Identify setting, subjects, sample.
- Choose research measurement tools.
- Written development of role (job description) of clinical development nurse.
- Collaboration with NUM and ADON re implementation of project.
- Selection of candidate to perform clinical development nurse role in the study.
- Consent/ethics need for research committee.

### Implementation
- Pre-trial measurements of trial and control units' job satisfaction, scales perceptions of clinical competence, motivation and patient satisfaction scores.
- Fees paid out for use of research measurement instruments.

<table>
<thead>
<tr>
<th>PROJECT PHASE</th>
<th>TIME FRAME (months)</th>
<th>RESOURCE REQUIRED</th>
<th>APPRAH. COST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MIN TIME</td>
<td>MAX TIME</td>
<td></td>
</tr>
<tr>
<td>1. Planning</td>
<td>1</td>
<td>1.5</td>
<td>Nurse project leader time</td>
</tr>
<tr>
<td></td>
<td>80 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>concurrent with next stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Implementation</td>
<td>12</td>
<td>18</td>
<td>CDN Salary</td>
</tr>
<tr>
<td></td>
<td>20 hours</td>
<td>$18 per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>concurrent with next stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40 hours x $10 per hour</td>
<td></td>
<td>$400</td>
</tr>
<tr>
<td></td>
<td>Consultation statistician</td>
<td></td>
<td>$2000</td>
</tr>
<tr>
<td></td>
<td>Computer time run on SPSS and other statistical analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Word processing support</td>
<td></td>
<td>$320</td>
</tr>
<tr>
<td></td>
<td>40 hours x $8 per hour</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clerical support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40 hours x $5 per hour</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statistical analysis of pre-trial results</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concurrent with next stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Placement of clinical development nurse (CDN) on unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 months</td>
<td>18 months</td>
<td></td>
</tr>
<tr>
<td>PROJECT PHASE</td>
<td>TIME</td>
<td>RESOURCE REQUIRED</td>
<td>APPROXIMATE COST</td>
</tr>
<tr>
<td>---------------</td>
<td>------</td>
<td>-------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Post-trial measurements</td>
<td>1</td>
<td>Fees for use of scales.</td>
<td>$1000</td>
</tr>
<tr>
<td>Post-trial data</td>
<td>0.5</td>
<td>Clerical support</td>
<td>$320</td>
</tr>
<tr>
<td>Pre and post trial data</td>
<td>0.5</td>
<td>Consultation</td>
<td>$2000</td>
</tr>
<tr>
<td>Analysis</td>
<td>0.25</td>
<td>Statistician</td>
<td>$2000</td>
</tr>
<tr>
<td>Computer run</td>
<td>0.25</td>
<td>Time of stats analysis</td>
<td></td>
</tr>
<tr>
<td>Analysis</td>
<td></td>
<td>160 hours x $18 per hour</td>
<td>$2880</td>
</tr>
<tr>
<td>Report</td>
<td>1</td>
<td>Project leader time</td>
<td>$2880</td>
</tr>
<tr>
<td>Evaluation</td>
<td>2</td>
<td>Word processing support</td>
<td>$800</td>
</tr>
<tr>
<td>Evaluation of project</td>
<td></td>
<td>160 hours x $18 per hour</td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
<td>80 hours x $10 per hour</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td></td>
<td>$64,840</td>
</tr>
<tr>
<td>(12 month trial)</td>
<td>29.5</td>
<td></td>
<td>$84,840</td>
</tr>
<tr>
<td>(18 month trial)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
JOB DESCRIPTION

STAFF DEVELOPMENT NURSE
NURSING DEPARTMENT

JOB SPECIFICATIONS

Education and Training
Graduate from an approved School of Nursing.
Baccalaureate degree in nursing required; Master's degree in nursing preferred.
Eligible for registration with A.A.R.N.

Experience
Minimum of three years of recent clinical practice experience in medical or surgical nursing.
Previous staff development and/or teaching experience highly desirable.

Special Skills and Knowledge

Essential
Expert nursing skills in medical or surgical nursing.
Excellent verbal and written communication skills.

Desirable
Knowledge of adult learning, principles and teaching methods.
Current knowledge of concepts and applications of work satisfaction, group dynamics, change and conflict resolution.
Basic computer literacy.
Personal Attributes (Job Related)
Decisive and able to function with minimal supervision.
Capable of working independently as well as within a team.
High level of initiative and self-directedness.
Flexible.

Physical and Mental Abilities
Good intellectual skills of analysis, synthesis and problem solving.
Good abstract reasoning skills, understands models and theories.
Able to organize complex tasks and determine priorities given multiple demands.

SPECIAL JOB CHARACTERISTICS
Unique Working Conditions
Fluctuating workload.
Flexible hours.
Some evening, night and weekend work will be required.
Work is active and indoors.

Special Equipment and Work Aids Used
Computer terminals and printers.
Teaching and demonstration materials.
Audiovisual equipment.
JOB SUMMARY

The Staff Development Nurse is a unit-based nurse educator who is responsible to the Nursing Unit Manager for the assessment, planning, implementation and evaluation of staff development activities on the nursing unit; the provision of educational and procedural support in the development of new nursing practices and standards for the nursing unit; and liaison with the Educational Resource Center for meeting joint responsibilities for orientation and selected continuing nursing education activities.

RESPONSIBILITIES AND DUTIES

The staff development nurse will:

1. Assess, plan, implement and evaluate staff development activities for staff of the nursing unit.

2. Provide educational and procedural support in the development of new nursing practices and standards for the nursing unit.

3. Liaise with Educational Resource Center in joint responsibilities for orientation and selected continuing nursing education activities.

4. Be responsible for own professional self-development.

5. Perform other related duties as requested by the Nursing Unit Manager.
STANDARDS OF PERFORMANCE

STAFF DEVELOPMENT NURSE

The staff development nurse will:

1. Assess, plan, implement and evaluate staff development activities for the staff of the nursing unit.

Assessment

1.1 In consultation with the Nursing Unit Manager, the staff, and her/his own observations identifies the professional learning needs of the nursing unit staff.

1.2 Conducts formal assessments of the staff from time-to-time to further assess learning needs.

Planning

1.3 Forms a realistic set of learning objectives based on the assessments.

1.4 Develops a teaching plan based on principles of adult learning to facilitate the acquisition of skills and knowledge.

1.5 Establishes priorities for educational activities.

1.6 Utilizes relevant research findings and incorporates them into the teaching plan where appropriate.

Implementation

1.7 Together, with the Nursing Unit Manager and staff, determines scheduling for unit orientation, specific orientation sessions and other formal offerings.

1.8 Uses a variety of instructional methods such as demonstration, one-to-one instruction, role modelling, conferences, workshops, seminars, handouts, posters, etc. to meet the diverse and ongoing educational needs.

1.9 Demonstrates sensitivity to individual learning needs and implements special strategies where required.

1.10 Maintains a flexible schedule to be available to all shifts, depending on the educational needs and the best way to meet them.

Evaluation

1.11 Evaluates the educational activities through a variety of evaluation methods within the context of the helping relationship, and based on learner outcomes.
1.12 Shares results of educational activities with staff and Nursing Unit Manager.

1.13 Documents staff development activities according to the format developed jointly with the Nursing Unit Manager.

2. Provides educational and procedural support in the development of new nursing practices and standards for the nursing unit.

2.1 Participates in the identification of policies, procedures, standards and their related skills required for safe and efficient patient care.

2.2 Participates in the development of policies, procedures and standards for the nursing unit.

2.3 Responsible for the development of teaching strategies required for staff to integrate knowledge and skills in order to carry out policies, procedures and standards of care.

2.4 Acts as a change agent to facilitate the implementation of new concepts related to nursing and educational processes.

3. Liaises with Educational Resource Center in joint responsibilities for nursing orientation and selected continuing nursing education activities.

3.1 Works cooperatively with Education Resource Center and participates in the delivery of general nursing orientation.

3.2 Plans, in conjunction with the standards set by the Educational Resource Center, for the delivery of relevant formal educational offerings for nursing unit staff, (i.e. conferences, workshops).

3.3 Utilizes the resources of the Educational Resource Center (library, audiovisual services) to maximize educational outcomes.


4.1 Assumes responsibility for learning by seeking opportunities for continuing education and self-development.

4.2 Maintains current and competent nursing skills in area of specialty.

4.3 Engages in self evaluation of performance and sets developmental goals.

4.4 Maintains membership with appropriate professional associations.

4.5 Keeps abreast of new developments in nursing profession and in area of nursing specialty.

5. Performs other related duties as requested by the Nursing Unit Manager.
APPENDIX C
January 16, 1992

Dear Nursing Colleague,

As you may have heard, a Staff Development Nurse has been hired for 18 months through the provincial Job Enhancement Fund to coordinate the ongoing educational activities on unit 4C. As part of the evaluation of this new position, I (Sharon Prusky) am conducting some research. The research project includes involvement of the staff on unit 4C (with the Staff Development Nurse) and staff on units 4A, 4B and 5B, who will continue to share the services of a clinical educator from Education Resources. I would like to request your participation in this study.

One of the evaluation methods proposed is a questionnaire (enclosed). You are requested to complete this questionnaire now, and again in six to nine month intervals throughout the next 18 months. Information obtained will be used to assist Lethbridge Regional Hospital Administration with job satisfaction and ongoing nursing education decisions.

Participation in this study is completely voluntary, but it is important to obtain responses from as many participants as possible if the results are to be meaningful. The questionnaire will take approximately 45 minutes to complete and completion of the questionnaire implies consent. All responses will remain anonymous. When responses are analyzed and released, they will be reported in summary form or by number of like responses.

The results of this study will also become part of a Master of Education thesis. Following completion of the study, results will be available upon request.

For further information, please contact me at the hospital, at 382-6224 or page me through the switchboard, or at home 381-7821; Dr. Myrna Greene, Chair of the Thesis Committee, University of Lethbridge, 329-2424; or Dr. Jane O'Dea, Chair of the Human Subjects Review Committee, University of Lethbridge, 329-2458.

Please complete the enclosed questionnaire within one week, return it in a brown interdepartmental envelope and send it in the hospital mail c/o Sharon Prusky, Nursing Administration.

Thank-you in advance for your time. I appreciate your input.

Sharon Prusky, R.N., B.N.
M.Ed. Candidate
Lethbridge Regional Hospital
JOBS SATISFACTION AND CLINICAL COMPETENCE QUESTIONNAIRE

PLEASE USE THE COMPUTER ANSWER SHEET FOR ALL OF YOUR ANSWERS, UNLESS OTHERWISE INDICATED.

A. Under the area "Birth Date", in the lower half of the left hand side of your answer sheet, please code in TODAY'S DATE. For example:

<table>
<thead>
<tr>
<th>BIRTH DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD.</td>
</tr>
<tr>
<td>O</td>
</tr>
<tr>
<td>O</td>
</tr>
<tr>
<td>O</td>
</tr>
<tr>
<td>O</td>
</tr>
<tr>
<td>O</td>
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<tr>
<td>O</td>
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<tr>
<td>O</td>
</tr>
<tr>
<td>O</td>
</tr>
<tr>
<td>O</td>
</tr>
</tbody>
</table>

B. Beside the vertical green bar on your answer sheet under "SEX", please code in whichever you are. "m" male or "f" female.

C. Please answer the items directly below, using the spaces provided:

1. Have you ever had experience on a nursing unit before where there was a unit-based educator?
   
   Yes ___ No ___

   a) What title did that person have?

   b) What was your opinion of that experience?

2. My main motivation for being a nurse is ...

3. My main motivation for working is ...


JOB SATISFACTION AND CLINICAL COMPETENCE QUESTIONNAIRE

PART A: BACKGROUND INFORMATION

PLEASE ANSWER THE FOLLOWING ITEMS AS HONESTLY AS YOU CAN. USING YOUR COMPUTER ANSWER SHEET PLEASE.

1. The type of basic nursing program I graduated from was:
   1. RNA/LPN School.
   2. 2 or 3 year hospital school.
   3. 2 year college program.
   4. 4 or 5 year BN/BSN program.
   5. Other (please specify) ____________________________

2. I am an:
   1. RN.
   2. LPN.

3. My position is:
   1. Regular full-time.
   2. Regular part-time.
   3. Casual (Number of days per month you work) ____________________________

4. I work mainly:
   1. 8 hour shifts.
   2. 12 hour shifts.
   3. 10 hour shifts.
   4. Other (please specify) ____________________________

5. The shift/rotation I work most often is:
   1. Days/evenings.
   2. Evenings only.
   3. Nights only.
   4. Days/nights.
   5. Other (please specify) ____________________________

6. I have practiced Nursing a total of:
   1. Less than 1 year.
   2. From 1 year to less than 3 years.
   3. From 3 years to less than 5 years.
   4. From 5 years to less than 10 years.
   5. 10 or more years.

7. I have worked at Lethbridge Regional Hospital now for:
   1. 0 - 6 months.
   2. Over 6 months to 1 year.
   3. From 1 year to less than 3 years.
   4. From 3 - 5 years.
   5. Over 5 years (please specify) ____________________________

8. I have worked on this particular nursing unit now for:
   1. 0 - 6 months.
   2. Over 6 months to 1 year.
   3. From 1 year to less than 3 years.
   4. From 3 - 5 years.
   5. Over 5 years (please specify) ____________________________
9. This nursing unit: (circle one only)
   1. Is my area of preference.
   2. Is not my area of preference.
   3. Is all right for now, but I want a change.
   4. May or may not be my preference; I am undecided.
   5. Other (please specify) ________________________________

10. The highest level of NURSING education I have attained since graduation is:
    (Please check all that apply)
    1. Post-basic baccalaureate. 2. Master’s degree.
    3. Certificates and Diplomas (please list) ________________________________
    4. Other (please specify) ________________________________
    5. None of the above.

11. Education I have attained in a field OTHER THAN NURSING is: (please check all that apply)
    1. Nothing else.
    2. Bachelor’s degree (please specify) ________________________________
    3. Master’s degree (please specify) ________________________________
    4. Certificates and Diplomas (please list) ________________________________

12. I am currently enrolled in:
    1. Baccalaureate degree (please specify) ________________________________
    2. Master’s degree (please specify) ________________________________
    3. Certificates and Diplomas (please list) ________________________________
    4. Other (please specify) ________________________________
    5. None of the above.

13. My age range is:
    1. 18 - 24 years. 2. 25 - 34 years.
    3. 35 - 44 years. 4. 45 - 54 years.
    5. 55 or older.

14. Partner status. My partner:
    1. I do not have a partner. 2. Works full-time.
    3. Works part-time. 4. Is not working right now.
    5. Cannot work.

15. How many dependents are you financially supporting?
    1. No dependents. 2. One dependent only.
    3. 2 dependents. 4. 3 dependents.
    5. 3 or more dependents

Please go on to the next page ....
PART B: JOB SATISFACTION

Instructions for Scoring

Starting with number 16, please code the number on your computer answer sheet that most closely indicates how you agree or disagree with each statement. "1" = strongly disagree, "2" = moderately disagree, "3" = somewhat disagree, "4" = neutral (use as little as possible), "5" = somewhat agree, "6" = moderately agree and "7" = strongly agree.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

16. My present salary is satisfactory.
17. Most people do not sufficiently appreciate the importance of nursing care to hospital patients.
18. The nursing staff on my unit do not hesitate to pitch in and help one another when things get in a rush.
19. There is too much clerical and "paperwork" required of nursing staff in this hospital.
20. The nursing staff have sufficient input and control over scheduling their unit rotations.
21. Physicians generally cooperate with the nursing staff on my unit.
22. I feel that I am supervised more closely than is necessary.
23. Nursing is a long way from being recognized as a profession.
24. New employees are not quickly made to "feel at home" on my unit.
25. I think I could do a better job if I did not have so much to do all of the time.
26. There is a great gap between the administration of this hospital and the daily problems of the nursing department.
27. I feel I have sufficient input into the program of care for each of my patients.
28. There is no doubt whatever in my mind that what I do in my job is really important.
29. There is a good deal of teamwork and cooperation between various levels of nursing staff on my unit.
30. I have too much responsibility and not enough authority.
31. There are not enough opportunities for advancement of nursing staff at this hospital.
<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

32. There is a lot of teamwork between nurses and doctors on my unit.
33. On my unit, my supervisors make all of the decisions, I have little direct control over my work.
34. I am satisfied with the types of activities that I do on my job.
35. I have plenty of time and opportunity to discuss patient care problems with other nursing staff.
36. There is ample opportunity for nursing staff to participate in the unit and nursing department decision-making process.
37. I am satisfied with the level of independence I have in my job.
38. What I do in my job does not add up to anything really significant.
39. There is a lot of "rank consciousness" on my unit. Nursing management seldom mingles with others of lower rank.
40. I have sufficient time for direct patient care.
41. I am sometimes required to do things on my job that are against my better professional nursing judgment.
42. Administrative decisions at this hospital interfere too much with patient care.
43. It makes me proud to talk to other people about my job.
44. I wish the physicians here would show more respect for the skill and knowledge of the nursing staff.
45. I could deliver much better care if I had more time with each patient.
46. Physicians at this hospital generally understand and appreciate what the nursing staff does.
47. If I had the decision to make all over again, I would still go into nursing.
48. Nursing management generally consult with the staff on daily problems and procedures.
49. I have the freedom in my work to make important decisions as I see fit, and can count on my supervisors to back me up.
50. An upgrading of pay scales for nurses is needed in this province.

*Please go on to the next page...*
Please answer the following question in the space provided below:

Thinking about job satisfaction and about your nursing unit peers, generally, how would you describe the levels of job satisfaction among your peers? Use any descriptive words you feel appropriate.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please go on to the next page ...
PART C: THE SELF-PERCEIVED COMPETENCY SCALE

This portion of the questionnaire asks you to assess your own as well as your peers' levels of competence against several categories.

Instructions for Scoring

1) For this section, please continue to use the computer answer sheet starting with number 51.

2) Please code the number on your computer answer sheet that most closely indicates the extent to which WITHIN THE LAST MONTH a) you, and b) your nursing unit peers did the following.

"1" = never, "2" = about 1/5 of the time, "3" = about 1/3 of the time, "4" = about 1/2 of the time, "5" = about 2/3 of the time, "6" = about 4/5 of the time and "7" = always. The numbers closer to "1" indicates either a) you, or b) your nursing unit peers rarely do the items listed below.

<table>
<thead>
<tr>
<th>Timefactors:</th>
<th>1/5</th>
<th>1/3</th>
<th>1/2</th>
<th>2/3</th>
<th>4/5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Always</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On the answer sheet, the ODD numbers represent "you" and the EVEN numbers represent "your nursing unit peers".

IF AN ITEM DOES NOT APPLY TO YOU, LEAVE IT BLANK. OR IF YOU HAD NO OPPORTUNITY YOURSELF OR DID NOT OBSERVE YOUR PEERS CARRYING OUT ANY OF THE FOLLOWING ITEMS, PLEASE CODE IN THE "0" SPOT ON THE ANSWER SHEET BESIDE THE ITEM.

<table>
<thead>
<tr>
<th>Myself</th>
<th>My Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.</td>
<td>52.</td>
</tr>
<tr>
<td>53.</td>
<td>54.</td>
</tr>
<tr>
<td>55.</td>
<td>56.</td>
</tr>
<tr>
<td>57.</td>
<td>58.</td>
</tr>
<tr>
<td>59.</td>
<td>60.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Timefactors: | 1/5 | 1/3 | 1/2 | 2/3 | 4/5 |

<table>
<thead>
<tr>
<th>Myself</th>
<th>My Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.</td>
<td>62.</td>
</tr>
<tr>
<td></td>
<td>Created an atmosphere of mutual trust, acceptance and respect, rather than showing concern for power, prestige and authority.</td>
</tr>
<tr>
<td>63.</td>
<td>64.</td>
</tr>
<tr>
<td></td>
<td>Demonstrated professional demeanor when caring for an unconscious or non-oriented patient as when caring for a conscious patient.</td>
</tr>
<tr>
<td>65.</td>
<td>66.</td>
</tr>
<tr>
<td></td>
<td>Adapted nursing procedures to meet the needs of individual patients for daily hygiene and for treatment.</td>
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<td>Used procedures as opportunities for communication and interaction with patients.</td>
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<td>Identified physical symptoms and physical changes.</td>
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<td>Recognized physical distress and acted to provide relief for the patient.</td>
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<td>Encouraged patient to get adequate rest and exercise.</td>
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<td>Encouraged patient to take adequate diet.</td>
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<td>Responded appropriately to drug side effects.</td>
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<td>Demonstrated proper sterile technique when necessary.</td>
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<td>Recognized hazards to patient safety and took appropriate action to maintain a safe environment and gave the patient a feeling of being safe.</td>
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<td>Carried out established technique for safe administration of medications and parenteral fluids.</td>
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<td>Used patient teaching opportunities appropriately.</td>
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<td>Involved patient and family in planning for care and treatments.</td>
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<td>Allowed patient freedom of choice in details of daily living whenever possible and within patient’s ability to make choice.</td>
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<th>Timefactors:</th>
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When the person is not performing the task, or when the task is not relevant, do not apply.
Please answer the following question in the space provided below:
Can you describe your involvement with the Staff Development Nurse since she started on
February 17, 1992?
Please be as descriptive as you wish.

Please go on to the next page ...
119. Compared to most days, my day today is/has been:
1. Unusually good.
2. Good.
4. Bad.
5. Unusually bad.

120. I completed this questionnaire:
1. All at one time.
2. Bit by bit whenever I had time.

Thank-you very much for your time.

Sharon Prusky
PATIENT SATISFACTION SURVEY

Dear Patient,

The nursing staff on this unit strive to meet the physical and emotional needs of our patients. Please assist us in this goal by completing the following survey. It will only take a few minutes to complete. Please remember that completing this survey is completely voluntary.

Your responses will remain completely anonymous and will be handled in a confidential manner, therefore there is no need to identify yourself.

Part A

Please check (✓) the following items that pertain to you.

1. You are a:
   a) male √
   b) female

2. How long was your stay on this unit? ________________

3. Your age range is:
   a) 18-33 years
   b) 34-49 years
   c) 50-65 years
   d) 66-81 years
   e) 81 or older

4. Date today ________________

Part B

Directions

The following statements, written in terms of yourself, refer to the nursing care you received during your hospital stay.

For each statement, please check the appropriate phrase (phrase categories are provided) that best describes your nursing care. It is important that you respond to the statements according to how you actually do feel with regard to your nursing care.

Example:

HOW EFFECTIVE WERE THE NURSES WITH WHOM I CAME IN CONTACT IN THAT THEY:

1. Introduced themselves to me? [✓]

This response would indicate that you felt nurses usually introduced themselves.
If you would like to make any comments or suggestions, please use the space provided below.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________


PLEASE PUT YOUR COMPLETED QUESTIONNAIRE IN THE ENVELOPE PROVIDED. SEAL IT AND RETURN IT TO THE NURSING DESK.

THANK YOU VERY MUCH FOR YOUR COOPERATION.
January 16, 1992

Dear _______________________

As you know, a Staff Development Nurse has been hired through the provincial Job enhancement Fund for 18 months to coordinate the ongoing educational activities on unit 4C. As part of the evaluation of this new position, you were asked to complete a questionnaire about your perceptions of job satisfaction and clinical competence. I would also like to interview a few of the staff members on unit 4C to obtain perceptions of the influence of the Staff Development Nurse, follow-up on some of the questionnaire results, and obtain more detailed information about some of the issues of job satisfaction and clinical competence.

I am requesting your participation in a brief one-half hour interview, at a time and place that is mutually convenient. I will be the only person able to identify specific individual’s comments. All information will be treated in a professional and confidential manner.

I will be contacting you within the next week to request your willingness to participate. I hope you will take advantage of the opportunity to participate in this research, but if you decline, I would accept that decision.

Sincerely,

Sharon Prusky, RN, BN
Project Leader

I understand the purposes of the evaluation of the new Staff Development Nurse position on unit 4C, and agree to participate in an interview. I also understand that I may withdraw my participation at any time.
INTERVIEW QUESTIONS

Job in General

1. How did you come to work on 4C?
2. What were you looking for in this job when you started?
3. Could you list three reasons why you stay on this job?
4. Is this unit a good place to work?
5. Is this hospital a good place to work?
6. How long are you planning to stay on this unit?

Job Satisfaction

1. How routine would you say your job is? Why?
2. What do you like best or find important in your job? Which activities do you not find satisfying?
3. How often are you required to use your own nursing judgement?
4. To what extent do you feel your day to day activities substantially impact upon the lives of others?
5. What is the nature of the relationships with physicians on this unit for:
   a) you?
   b) other staff?
6. What is the level of support and trust you receive from your NUM?
7. What kind of support do you receive for your work from nursing administration?
8. What types of staff achievements are most awarded:
   a) on your unit?
   b) within the nursing department?
9. How do you measure your own success?
10. What contributes to your own job satisfaction? Any events in the last six months or so that have created job satisfaction for you and/or your peers?
11. What creates job dissatisfaction for you? Any events that you remember?
12. What small piece of advice, designed to enhance job satisfaction on your unit and/or in the hospital, would you give:
    a) your NUM?
    b) senior nursing administration?
13. Can you reflect on a time when you tried to introduce change for your unit? What was the outcome?
14. Do you feel that unit 4C has received special attention because of the fact that the SDN is here?
Unit Environment

1. What does adequate staffing mean to you in terms of:
   a) numbers of staff?
   b) skill level or competence of staff?
2. Tell me about your quality of working life with respect to your:
   a) role.
   b) relations with other staff.
   c) recognition.
   d) society in general.
   e) other floors or professionals outside your unit.
3. What trends do you notice on your unit in the last six months or so with:
   a) nursing care delivery systems.
   b) organizational changes.
   c) new procedures.
   d) changing workloads.
   e) professionalism.
   f) other.
   What have some of the consequences of these changes been?
4. Describe your, or your peers', involvement on your unit in the organization of various programs related to quality of care:
   a) patient controlled analgesia.
   b) patients walking to the OR.
   c) Staff Nurses Committee, i.e., NCPs, workshops, video presentations.
   d) other, i.e., QA Committee.
6. What do the staff praise/support each other about?
7. What do the staff complain to each other about?
8. What rules and regulations does the staff ignore?
9. What rules and regulations seem important to the staff?
10. What is the nature of relations between different groups on 4C? Do some like to work together? Do some not?
11. What kind of staff are the most liked on your unit? Why?
12. What kind of staff are the most disliked on your unit? Why?
13. Is the tone on your unit different on different days? Explain. What are the effects of those differences?
Nursing Profession

1. What is your opinion of the profession of nursing?
2. Where do you think the future of nursing is heading?
3. Are you ever asked to do things that are against your better nursing judgement? If so, what is one example?
4. Are you asked to participate in decision-making for your unit? Please give an example.
5. What would you consider a career-advancement opportunity for you?
6. Do you think staff nurses on 4C are highly respected and acknowledged for their contributions to patient care?
7. What do you define as unprofessional behaviour? Do you see that very often?
8. What are some of the goals you are striving towards?

SDN Role

1. The SDN has been on your floor for a number of months now. How would you describe her role, from your point of view?
2. What is your opinion of how well the SDN role meets the ongoing educational needs of the staff nurses, in terms of keeping them:
   a. current?
   b. accountable?
   c. clinically competent?
3. What effect has the SDN made to your:
   a. practice?
   b. you and your work?
   c. your peers?
4. What do you think makes a good clinical teacher?
5. Do you think that the SDN has influenced staff levels of job satisfaction? To what extent?
6. Can you outline an example of where this has happened?
7. Can you think of an example where this did not occur or could have occurred, but did not?
8. How has the 4C setting been changed by the SDN?
9. Can you identify any restraining forces that have decreased the effectiveness of the SDN?
10. Can you think of any driving forces that have influenced the SDN role and its success?
11. How do you view the relationship between the SDN and the NUM?
12. What stands out in your mind as the most significant thing the SDN has done for:
   a. you?
   b. your peers?
   c. the Unit?
14. Do you feel that there is a real atmosphere of learning on this unit?

Clinical Competence
1. Could you describe what makes a staff member clinically competent?
2. How would you rate yourself in overall competence?
3. How would you rate your peers in overall competence?
4. Which clinical situations pose the biggest challenges for:
   a. you?
   b. your peers?
5. Would you comment on the methods used to evaluate nurses on your unit?

Patient Satisfaction
1. Who seems to the most popular of patients on your floor?
2. Who seems to be the least popular of patients?
3. To what extent do you think a patient's privacy is respected on this unit?
4. To what extent does the staff recognize a patient's past experience and family backgrounds in their care?
5. How do you think patients view nurses on this unit?
6. Do you think patient have a problem keeping a sense of dignity while on this unit?
7. How are patient/family complaints handled on your floor?
8. How well do you think the organization meets the needs of the patients?
9. What do you think is the most important part of patient care?
10. Would you estimate what you think the quality of care on this unit is right now? What do you think has influenced this estimate?
EXIT INTERVIEW FORMAT

Date: ____________________________

Staff Member: ____________________

Demographics

1. Role: ____ RN? ____ LPN?

2. Number of years on 4C. ______

3. Numbers of years at LRH. ______

4. Position you hold on 4C. ____ Shifts? ____ Hours?

5. Is this unit your area of preference?

6. What is your highest level of education achieved?

7. What is the reason for your leaving 4C?

8. Where do you plan on going now?