University of Alberta

Fostering Quality Work Settings For Nurses

by

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Dedication

To my husband Doug who encourages me in all that I do and to my three boys Trevor, Matthew, and Jason who know my quest for learning is never ending.

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CHAPTER ONE: INTRODUCTION

This thesis is the culmination of a comprehensive doctoral program of education and research. In recent years nursing workplaces have generated a great deal of public and professional interest. Quality work environments have been found to be essential to the delivery of quality care, yet are not widely found in contemporary health care settings. Recent changes in nurses' work have generated issues related to shortages, effective and efficient use of human resources, and resiliency of staff. Research has identified factors that influence health, job satisfaction, and clinical outcomes, however, how to accomplish these improvements is more obscure. Reconceptualizing work as a "practice" setting where various actors interact based on their interpretations allows nursing workplaces to be reconsidered. The overarching purpose of my research is to generate new insights into how nursing work settings can be improved.

Concern about nursing work conditions

Nursing work environments are troubled and have been described as one of the three causal factors in the current nursing crisis (Canadian Nursing Advisory Committee, 2002). Lowe (2002) has characterized recent Canadian health reform as "hyper-change" with dramatic and constant reconfigurations since the 1990s. Nurses, the largest group of health workers, have taken the brunt of turmoil. They have experienced widespread layoffs, unrequested role transfers (sometimes outside of their expertise), and sometimes have been reassigned to work areas that are not their preference. This has resulted in personal distress and feelings of disempowerment and disenchantment with employers, as well as disruption of work groups. With these working conditions, it is not surprising that nurses have the distinction of being the sickest workers in Canada with "absenteeism rates 80% higher than the average worker (Statistics Canada, 2002).

Beyond the compelling human rationale for addressing nursing work settings, there are business reasons why the current state of affairs must be addressed. First, if absenteeism rates fell to the Canadian average it would add the equivalent of 3500 full time nurses to the system at a time when staffing shortages are adding to the burden of work overload (Canadian Nursing Advisory Committee, 2002). Secondly, nurses have reported leaving patient care needs unmet because there is too much to do and research has found linkages from staffing ratios to job satisfaction and to patient health outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Sloane, & Sochalski, 1998; Aiken, Smith, & Lake, 1994; Canadian Nursing Advisory Committee, 2002).

Nursing work issues are embedded in a global context of worldwide healthcare human resource shortages and job dissatisfaction among nurses (Aiken et al., 2001). Within Canada, strong currents of fiscal prudence characterize a growing knowledge-based economy that extends beyond health care to all sectors. Reliance on innovative and learning driven workers in many sectors will drive labour demand and exacerbate human resource shortages forecasted because of the large number of projected baby boomer retirements. (C.D. Howe Institute, 2001; Conference Board of Canada, 2001; First Consulting Group, 2001; The Laurier Institution, 2000). Retaining and attracting nurses in this milieu of competitive labour demand will also be challenged by the Canadian context, which broadly defines quality of life to embrace not only work, but also education, family, community and personal components (Pal, 2001). A recent Canadian work-life conflict study (Higgins & Duxbury, 2002) found healthcare workers the most work-life unbalanced of all workers; they had the most onerous workloads. Lowe and Schellenberg (2001) similarly found that health professionals had the weakest employment relationships with their employers of any occupational group. Furthermore, nurses tend to retire earlier than other professionals, between ages 56 and 58, (O'Brien-Pallas, 2003), this will contribute to forecasted shortages unless measures to retain existing nurses longer and attract new recruits to the profession are undertaken. Actions to sustain the healthcare system and compete with a growing number of employers for knowledge-based workers will necessarily include addressing the nursing work environment issues.

Problem

These concerns have been described as a health human resource crisis (Commission of the Future, 2002; Premier's Advisory, 2001; Standing Senate Committee, 2002) that must be addressed through workplace improvements to benefit both nurses and their health care organizations. Quality work characteristics have been identified, but how to implement and sustain them is less well understood. Nursing workplaces have not been examined as social contexts, where "people dynamics" influence perceptions and interactions. Few qualitative studies have examined nursing work settings in order to understand the social meanings and their influence on organizational policymaking. Achieving quality workplaces for nurses is problematic without better understanding of the social setting and dynamics therein.

My orientation to research

A web of education, work, and personal experience has shaped my research orientations. These views and values shape and have been shaped by the way I see,

interact, and make sense of the world. I view the role of research as a way to be in the world so that what we learn can inform and involve others in the process of incorporating the best understandings and knowledge into practice. I believe knowledge is gained by interacting with people in the environment, furthered by experience/reflection, and informed by working in concert with others. Further, I see knowledge as complex and context laden and constantly under modification as things change. Reality becomes clearer when critically examined and considered from multiple perspectives since interactions define, reinforce, and influence our views of reality. Therefore, I view knowledge as always tentative and truth as probable, influenced by context and in constant flux. These views are compatible with Lincoln and Guba's (2000) description of postpositivism as a belief in an imperfect and probabilistic reality, characterized by objective knowledge and "probably true" findings that are achieved through rigorous investigation. Further, Lincoln and Guba also describe various paradigms as beginning to "interbreed" (p.164) such that some meshing is apparent, evidenced by the inclusion of mixed methods such as critical multiplism and qualitative within postpositivistic methodology. These mixed methods work best when the elements fit within the same axiomatic framework, a position adopted by Lincoln and Guba (2000) and Letourneau and Allen (1999). This means that in naturalistic studies there may be opportunities to blend elements of qualitative and quantitative methods if they resonate with the other elements of the investigation.

I believe that the researcher interacts throughout the research process and therefore is not independent of the study. The researcher reflects her values through the questions asked, approaches employed, and the acknowledgement of values embedded in the context. I attended a workshop about personal values/work congruence, which clarified my priority values: to continue to learn and develop as an individual, to work intellectually in partnership with others to make a difference, to be healthy and foster health in others, to have integrity, and be trustworthy.

I see research as a call to action and loathe the thought of new knowledge sitting on the shelf collecting dust. I believe that acting on research results is a natural and important next step. I identify with the participatory action research view that there is value in community-based analyses of social problems based on the assumption that knowledge is local and embedded in organizational life. Existing practices and current thinking need to be periodically scrutinized to see if they fit in terms of assumptions and context, then appropriately reconfigured if required.

Decter and Villeneuve (2001) allege that factors known to affect job satisfaction, turnover and clinical outcomes have been recognized for over 20 years with little new evidence, just more of it with only incremental refinements gained. Therefore, they advocate taking action to improve nursing workplace issues, believing that although the issues are systemic and complex, the most successful solutions will be local in nature. Although participatory action thinking influences me, in my discussion with leaders in health regions there was a lack of readiness for this approach, making it not feasible for my dissertation research. Therefore, I have opted to do exploratory research that emerged as an opportunity to provide the partnering organization with information to inform policy development and improve their readiness for future participatory orientated studies. I selected a research site where there was first, general agreement on the approach for the study and second, interest in considering the findings.

I decided to collect a variety of perspectives and give voice to nurses and their union representatives who usually are not part of organizational policy decisions. My own democratic style of leadership and multidisciplinary team experience informed this decision. Working with multidisciplinary perspectives has sensitized me to diversity in thinking and multiple understandings of the same data. I have also witnessed the transformation in plans, which emerge from an interdisciplinary discussion where the client/family focus pulls clinicians out of their discipline frames. Involving a variety of stakeholders in the research process can enrich the research findings, thereby improving the core nature of changes needed, people's transition during change, and the implementation success.

My observations and concerns as a health leader in a variety of work environments has sparked my interest in the dichotomy between what we know from research about positive work setting characteristics and the experiences of work by contemporary nurses. As a critical thinker, I continually compare what is to what could be, see questions to ask and ways to improve, and want to involve others who can bring diverse opinions and enrichment to my own thinking. The aim of my inquiry was to develop an understanding of one social setting, in a way that described or explained how a work environment issue, improving front line management, might be framed to inform policy formulation. Although I am keenly interested in views regarding causes, desired actions and results, and barriers and facilitators in the setting, I was also concerned about the meanings attached to these concerns. Therefore, my research design adopted a post-positivistic critical multiplism methodology.

Methodology

Post-positivistic critical multiplism is a unifying research methodology that assumes that there are multiple ways of knowing; therefore, allowing rival theories and methods to be integrated and eliminating forced choice between quantitative and qualitative methods (Letourneau & Allen, 1999; Lincoln & Guba, 2000). Besides pluralism in methods, there is openness to multiple perspectives, multiple data manipulations and multiple interpretations that can be scrutinized by a variety of theoretical perspectives. Inherent to post-positivistic critical multiplism is critical thought and debate that considers multiple stakeholder input, critique and research direction to improve knowledge claims and utilization (Miller & Crabtree, 2000). It is within this methodological framework that I designed this investigation of nursing work environments.

Although the factors that influence personal and organizational outcomes have been studied repeatedly, few studies have used a qualitative lens to examine the nursing workplace to understand the social meanings at play and how they might relate to appropriate mechanisms for enacting improvement. In exploring the "social context" of nursing work, I am referring to the process aspects of organizations --communication, decision-making, etc. -- viewed from a public discourse vantage point. Of particular interest are the meanings surrounding "social dynamics" or the interactions among individuals, groups, and events that color human work experiences. By reconceptualizing work as a "practice" setting where various actors interact based on their interpretations allowed me to consider nursing work settings in new ways. Some of my underlying research assumptions included:

- Work structures and social processes shape problems, involvement, options, and solutions.
- Work understandings arise from interactions between individuals, groups, and events.
- People individually and collectively act on their interpretations.

This study was designed to gain insights into how quality work settings could be fostered. Accordingly, the research principles employed were directed by this exploratory, discovery purpose. This meant setting aside a range of applicable theoretical frameworks regarding people in organizations (e.g. Herzberg, 1982; Blau, 1964), job

design (Hackman & Oldman, 1980), personal health at work (e.g. Karesek & Theorell, 1990; Siegrist, 1996), and so on, as organizing frameworks for data collection and analysis. This was done to allow the data to be considered inductively and then to be reconsidered in light of the previous theoretical work. However, I did build on previous work factor studies that empirically established work dimension indices related to individual and organizational outcomes (e.g. Rucci, Kim, & Quinn, 1998; Buckingham & Coffman, 1999; Health Canada: The survey, 2002). I adapted one of these tools not to replicate previous instrument development research but to explore its practicality as a benchmark and process tool in health care organizations. The results also allowed me to describe the study site with regard to nurses' views about the importance and state of enabling factors.

The understandings of "knowing" nurses and managers regarding how work experiences can be improved and particularly collective views on this issue are not available in the literature. Focus groups were chosen as a data collection strategy based on the advantages of group conversation as a collective process of sharing and comparing. The group exchange facilitates exploring and discovering new understandings that are unavailable in individual data collection techniques. However, the collective nature of focus groups can also have disadvantages if the topic under discussion is sensitive, the participants are fearful of sharing their views, or "group think" emerges as opposed to a discussion of divergent opinions. As well group dynamics can be problematic if member behaviors include domination, belittling or silencing. Several strategies can be employed to mitigate against these issues; they include suitable topic selection, explicit ground rules, and having a skilled facilitator to manage group dynamics.

The process of focus groups also provides a means of community negotiation and judgement about what is "real", "useful" or relevant for action (Lincoln & Guba, 2000). This tends to add credibility to the findings and allows the researcher to combine observational information like body language to the verbal data collected. Focus groups can be a source of rich data by using collective thinking to explore shared problems and generate new insights.

An electronic data-organizing program, Atlas-ti, was used to facilitate data analysis.

Measures designed to scrutinize the research findings and add to the overall trustworthiness included: audit trail reflections, supervisory committee consultations, literature rechecks, and broad based discussions of preliminary findings in the research site.

Overview of the thesis

This section provides an overview of the thesis document itself. First I provide background to why I chose a paper thesis format and the broad guidelines shaping the work presented. Then I describe the investigation site and highlight some of the challenges impacting the work. Finally a short overview of the three papers is provided. Although I do not elaborate further here, the final chapter of the dissertation provides a conclusion to sum up the work and reflect on the research experience and learning this work has had for me.

Paper format thesis

In pursuing my goal to generate new insights into how nursing work settings can be fostered, I have organized my dissertation as a set of three papers in preparation for journal publication. This approach is congruent with my belief that new knowledge needs to be disseminated into practice and journal articles are a key strategy to do this. Practically it has required that I translate my research findings into consumable written communication. This has further developed my academic skill through supervisory committee mentorship.

The Faculty of Graduate Studies (University of Alberta, 1997) guidelines and regulations were followed for preparing a paper thesis. The major difference from a traditional thesis is the body of the text. In a paper format the body of text is composed of the introductory chapter (with its own bibliography), each subsequent chapter is a separate paper (with bibliography but without a separate abstract), and the final chapter is a conclusion (with its own bibliography). In addition to the dissertation guidelines the papers themselves were written with an audience and target journal in mind. Each journal provided guidelines for submitting authors governing length, format and referencing, and special considerations (e.g. language use - avoid personal pronouns). Therefore some differences between papers will be discernable in style and format. The greatest challenge in meeting many of the journals targeted to nursing leaders were length criteria established to accommodate busy professionals.

Contextual orientation to the study site

In selecting the research site, my primary consideration was the interest of the chief nurse in the topic and commitment to improving nurses' work life. One of the sites with strong interest was an organization where I had recently worked as the chief nurse to cover a one-year educational leave. I explored the potential benefits and risks with both people at the site and my supervisory committee, which is described in detail in the concluding chapter. In the end there was agreement by all parties that there was comfort with me as the researcher and that the research should proceed. Being an insider allowed me to consider the study evidence in the larger context of my experience, however, it also represented a potential bias to the research. Again in the concluding chapter I describe more fully the experience and the use of an audit trail and other approaches to manage this challenge.

The investigation was conducted in 2003, within one institution residing in the Canadian health care scene. Both national and provincial health care reform has been characterized by dramatic fiscal constraints, nursing lay offs, and institutional/regional reorganizations for almost a decade. Despite the uncertainties and budget challenges, this institution has not undergone major nursing layoffs or been part of organizational mergers typical for many Canadian nurses during this time frame. Therefore, there has been relative stability of nursing staff and managers in the setting. Altogether over 150 registered nursing staff, were employed in inpatient and outpatient care areas and a small number of these nurses reported to departments outside nursing. Structurally, nursing unit managers reported to a chief nurse who also had responsibility for other departments.

Challenges In the study site

Multiple challenges emerged in conducting the research in the reality of a contemporary health care organization. First, the pace in the organization was hectic and it proved difficult to arrange a time for managers to have their group interview. In the end a second group was set up for them to ensure everyone had an opportunity to participate. Second, provincial bargaining with the nurses' union had just gotten underway at the time of survey distribution and. was not progressing well in the union's opinion at the time of focus group data collection. As described in the second paper, the union and staff attitudes about surveys may have influenced the low return rate. However, the union focus group participation and discussion was very valuable. In some ways the challenges in conducting the research seemed to mirror some of the challenges people talked about in trying to improve their work environments. These included busyness,

attitudes and conflicting goals.

Outline of the thesis

Three papers prepared as manuscripts for publication are presented and reflect my exploration into understanding how nursing workplaces might be improved. Each has a unique focus and therefore, employed distinct concepts and methods. In them I argue that understanding social dynamics in workplaces is needed, that acknowledges human agency as one key to making and sustaining improvements.

Paper 1: Improving nurses' work through focus group research

In the first paper, "Improving Nurses' Work Through Focus Group Research," I address the following research questions:

- What is known from the literature on nursing work environments?
- What gaps in information need to be filled in order to improve nursing work?
- How can the missing information be best acquired?

In this paper I argue that new understandings are required if we are to reverse current trends that jeopardize health care system sustainability and nurses' personal health. Over twenty years of research has created a consensus about quality work characteristics; however, a major gap exists in knowing how to accomplish work environment improvements. Often the literature reflects bureaucratic and corporate management philosophies, wherein systems, not people, are the focus of improvements. Absent in most of the literature is information about "knowing nurses and managers" whose interpretations of work interactions and events is central to meaningful and sustainable change. Also missing is nursing work group interpretations to help us understand the social dynamics within settings, which shape and are shaped by interactions and local circumstances. Focus groups are explored as a method to generate specific understandings that frame nursing work problems, policy formulations and improvement possibilities.

Paper 2: Nurses' views on enabling factors at work

In the second paper, "Nurses' Views on Enabling Factors at Work," I answer the research questions:

- How do nurses rate enabling characteristics in their current work environments, the importance of these characteristics to them, and their levels of stress and satisfaction?
- What work issues do nurses identify as priorities for improvement in their

work setting?

- How do nurses' personal characteristics, work environment ratings, stress levels, and top priorities for improvement relate to each other?

In this paper I report on the first phase of data collection aimed at obtaining a snapshot of the nursing setting under investigation. Building on previous research that found common factors in the immediate workplace influence both personal and organizational outcomes, I conducted a survey (See Nursing Work Survey, Appendix 1). The findings were used to describe and explore relationships between current and desired enabling factors in the work setting, stress levels, and responder characteristics. As well nurses' identified improvement in how they were managed as their highest priority and volunteered for the nurses' focus group to discuss this issue in detail (second phase of the study).

Paper 3: Importance of settings in improving nursing work

In this paper I explore the central research question:

- "How can front line nursing management be improved?"

This issue emerged as problem dimensions, potential improvement strategies, barriers and enablers, and desired outcomes. Perspectives were gathered from three groups: nurses, their managers, and union representatives, as well as an interview with the chief nurse.

In this paper I describe how the nurses' top priority for change, improving management, was framed in order to explore the significance of settings in shaping problems and policy formulations. A qualitative lens was used to explore perspectives from key players so that social dynamics that interact to shape the management issue and proposed solutions could be illuminated. An interview with the chief nurse and focus groups were conducted with: (1) a purposive sample of nurses from across the organization; (2) nurse managers from all areas, and (3) union representatives (see Focus Group/Interview Guiding Questions, Appendix 2). I used open coding to analyze the data and develop understandings of the management problem, potential strategies and desired results. Further analysis of the perspectives permitted reconstruction of the problem into a framework to foster future discussion and action. Implications for nursing leadership, research and education are proposed.

Contributions of the research

A primary goal of this research is to promote further thinking about how to foster quality work environments for nurses. This study adds to the literature by its focus on social dynamics in one organization and by advocating for a reconceptualization of work as a "practice" setting where various actors interact. Sandelowski (1997) suggests that "conceptual utilization" of research findings can inform or emancipate thinking through the power of (re)naming and (re)viewing that allows us to change our views and hence act differently based on our new understandings.

Besides advancing knowledge, this study provides the collaborating agency with specific organizational policy information. The understandings created regarding root causes, desirable actions, expected results, and the meanings various players bring to the discussion, may provide insights for organizational policy formations. Jonathan Lomas (2000) suggested that organizational research will be useful in policymaking to the degree that it resonates with the local context.

This study provides insights that may encourage others to think about nursing workplaces in new ways in relation to defining the nature of organizational policy problems and therefore, the appropriate means of addressing them. Together the three papers contribute to understanding people in context who influence and are influenced by their work settings and who play active roles in discovering and enacting improvements in their working lives.

References

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., Busse, R., Clarke, H., Giovannetti, P., Hunt, J., Rafferty, A. M., & Shamian, J. (2001). Nurses' reports on hospital care in five countries. Health Affairs, 20(3), 43-53.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout and job dissatisfaction. Journal of the American Medical Association, 288(16), 1987-1993.

Aiken, L. H., Sloane, D. M., & Sochalski, J. (1998). Hospital organisation and outcomes. Quality Health Care, 7(4), 222-6.

Aiken, L. H., Smith, H. L., & Lake, E. T. (1994). Lower Medicare mortality among a set of hospitals known for good nursing care. Medical Care, 32, 771-87.

Blau, P.M., (1964). Exchange and power in social life. New York: Wiley.

Buckingham, M., & Coffman, C. (1999). First break all the rules: What the world's greatest manager do differently. New York: Simon & Schuster.

C.D. Howe Institute. (2001). Aging populations and the workforce, challenge for employers. Anonymous.

Canadian Nursing Advisory Committee. (2002). Our health, our future: Creating quality workplaces for Canadian nurses. Ottawa, ON: Advisory Committee on Health Human Resources. Retrieved November, 2002, from Health Canada http://www.hc-sc.gc.ca/english/nursing/cnac

Commission of the Future of Health Care in Canada. (2002). Building on values: The future health care in Canada. (The Romanow Commission). Ottawa, ON: The Commission: Government of Canada. Retrieved December, 2002, from http://www.gov.mb.ca/health/documents/worlife.pdf.

Conference Board of Canada. (2001). Wanted: Skilled workers to fill the upcoming labour shortage in Canada. Conference Board of Canada. Retrieved December, 2002, from http://www.conferenceboard.ca/pandp/documents/pp00rpt.pdf

Decter, M., & Villeneuve, M. (2001). Repairing and renewing nursing workplaces.

Hospital Quarterly, 46-49.

First Consulting Group. (2001). The healthcare workforce shortage and its implications for America's hospitals. (Fall). Anonymous.

Hackman, J.R., & Oldman, G.R. (1980). Work redesign. Reading, MA: Addison-Weley.

Health Canada. (2002). The survey 2001: Origins and characteristics of the workplace health needs and risks inventory 2001. Ottawa, ON: Workplace Health Bureau.

Herzberg, F. (1982). The managerial choice: To be efficient or to be human. Salt Lake City: Olympus.

Higgins, C. & Duxbury, L., (2002). The 2001 national work-life conflict study: Report one. (ISBN: 0-662-32404-8). Ottawa, ON: Retrieved December, 2002, from Health Canada htpp://www.hc-sc.gc.ca/ppphb-dgspsp/publicat/work-travail/index.html

Karasek R., & Theorell T. (1990). Healthy work: Stress, productivity and the reconstruction of working life. New York, New York: Basic Books, Inc.

Letourneau, N., & Allen, M. (1999). Post-positivistic critical multiplism: A beginning dialogue. Journal of Advanced Nursing, 30(3), 623-630.

Lincoln, Y.S., & Guba, E.G. (2000). Paradigmatic controversies, contradictions and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (second edition, pp. 163-188). Thousand Oaks, CA: Sage Publications, Inc.

Lomas, J. (2000). Connecting research and policy. Isuma 1(1), 140-144.

Lowe, G. S. (2002). High-quality healthcare workplaces: A vision and action plan. Hospital Quarterly, Summer, 49-56.

Lowe, G. S., & Schellenberg, G. (2001). What's a good job? The importance of employment relationships. (Report No. ISBN 1-896703-53-4). Ottawa, ON: Renouf Publishing Co. Ltd.CPRN Study No. W/05.

Miller, W. L., & Crabtree, B. F. (2000). Clinical research. In N. K. Denzin, & Y. S. Lincoln (Eds.), Handbook of qualitative research (second edition, pp. 607-626). Thousand Oaks, CA: Sage Publications.

O'Brien-Pallas, L. (2003). Bringing the future into focus: Projecting RN retirement in Canada. (Report No. ISBN: 1-55392-263-8). Ottawa, ON.: Canadian Institute for Health Information; Nursing Effectiveness, Utilization and outcomes Research Unit (University of Toronto), Retrieved July, 2003 from Http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_29jul2003-e

Pal, L. A. (2001). Beyond policy analysis: Public issue management in turbulent times. (2nd ed.). Toronto, ON: Nelson Canada.

Premier's Advisory Council on Health. (2001). A Framework for reform. (The Mazankowski report). Edmonton, AB, Canada: Government of Alberta. Retrieved March, 2002, from htpp://www.gov.ab.ca/home/health_first/documents_maz_report.cfm

Rucci, A. J., Kim, S.P., Quinn, R.T. (1998). The employee-customer-profit chain at sears. Harvard Business Review. January/February, 83-87.

Sandelowski, M. (1997). "To be of use": Enhancing the utility of qualitative research. Nursing Outlook, 45 (3), 125-32.

Standing Senate Committee on Social Affairs, & Science and Technology. (2002). The health of Canadians - the federal role. Volume six: Recommendations for reform (The Kirby Report). Ottawa, ON: Government of Canada. Retrieved December, 2002, from htpp://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm

Statistics Canada. (2002). Canada's labour force survey (2002). Ottawa, ON: Retrieved November, 2002, from htpp://statcan.ca/english

The Laurier Institution. (2000). Renewal and retention: Attracting and keeping faculty and senior administrators at British Columbian universities. June, 2000. Vancouver, BC, Canada: The Laurier Institution.

University of Alberta. (2004). Thesis handbook: A manual of regulations and guidelines for thesis preparation. Edmonton, AB, Canada: Faculty of Graduate Studies and Research: Retrieved April, 2004, from http:gradfile.fgsro.ualberta.ca/current/index.html

CHAPTER TWO: IMPROVING NURSES' WORK THROUGH FOCUS GROUP RESEARCH

There are troublesome symptoms in nursing workplaces that suggest transformative change must be made. For this change to be successful, additional knowledge is needed regarding how nurses understand the issues and believe improvements can be made within their specific settings. Others then can consider these insights for applicability and usefulness in their circumstances. In this paper the nature of contemporary nursing work settings is sketched, major gaps in current understandings are highlighted, and focus groups are explored as a method to generate knowledge for improving nurses' work.

Troubled work settings

Nursing work environments have been described as one of the three causal factors in the current nursing crisis (Canadian Nursing Advisory Committee, 2002). Growing and changing expectations by government and the public have placed new pressures on the health care system and nurses, in particular, have felt the effects. For example, there have been drastic reductions in acute hospital capacity, predicted by some to close one third to one half of all hospitals (Levi, 1999). As well, resources have shifted to community-based forms of care incorporating an emphasis on early screening, detection, and prevention. One result of such changes is that the hospitals left open are serving more complex patients who require more intensive care, thereby, changing the nature of hospital work for nurses. Another result is changed role expectations. As patients and their families take on more active roles in maintaining their health, nurses become partners in behaviour change, facilitators of decision-making, and supporters of people who are going through tough experiences and judgement calls. Further, evidence based management approaches, require nurses to continually realign their professional practices to best practice interventions and care delivery. Constant change has become the norm of nursing work life.

Multiple changes, lack of a coherent plan for health care system changes, and expedited implementation of these major changes, have created uncertainty for health care organizations and the people who work within them. Managers are also working longer hours so as to meet increasing expectations with fewer resources, making it difficult to manage change and lead human resource initiatives. Glouberman (2002) finds that the current instability in nursing work environments is making everyone, "jittery and less

respectful of each other" (p.29). This lack of predictability creates unhealthy working conditions (Bauman, et al., 2001).

The health of nurses is in crisis. "Too few funded nursing care hours for too many nursing care needs," (Canadian Nursing Advisory Committee, 2002, p. 8) has resulted in strained and overworked nurses. Decter and Villeneuve (2001) note that nurses are known to suffer the highest stress of all health caregivers with nearly a tenth of nurses off work each week due to illness. Their absenteeism rate is 80% greater than the Canadian average [8.1% for nurses, compared with a 4.5% average among 47 other occupational groups] (Statistics Canada, 2002). This makes nurses among the sickest workers in the country. Nursing absenteeism adds to work environment problems, as it is difficult to find casual staff, leaving those present with even greater workloads.

Decter and Villeneuve (2001) suggest that the last ten years of downsizing in Canadian hospitals has created, "Unhappy patients, horrific workloads, destruction of organizational loyalty and decaying morale among all healthcare workers" (p.47). Furthermore, they allege that near global discontent among nurses results from a maze of complex, multifaceted, and interwoven issues of gender, power, and economics coupled with broad employee and societal discontent extending beyond nursing. This was confirmed in a recent study that found Canadian workers across all sectors desired more fairness, respect, and supportive work environments, with better communication, pay, and benefits (Lowe and Schellenberg, 2001). Health care professionals were found to have the lowest scores of all occupational groups on all four dimensions of employment relationships (trust, commitment, communication and influence), have job satisfaction lower than the Canadian average, and were the least likely to describe their work environment as healthy.

Worker shortages will cross all employment sectors resulting in a surplus of knowledge intensive jobs like nursing and a scarcity of people who can fill them (C.D. Howe Institute, 2001; Conference Board of Canada, 2001; First Consulting Group, 2001; The Laurier Institution, 2000). These shortages will be exacerbated by the lingering effects of a changed psychological relationship between health workers' and their employers following widespread downsizing and reorganization during the 90s. Decisions implemented during that time, decreased nursing graduates and lay offs caused nurses to leave Canada for employment or to leave the profession entirely. Since then

education seats and graduates have increased, although not enough to meet projected needs (Canadian Nursing Advisory Committee, 2002).

These trends may or may not evolve exactly as suggested, but they do fit with the looming health human resource crisis and the need to address improved work environments as a critical component of health care system sustainability (Commission of the Future, 2002; Premier's Advisory, 2001; Standing Senate, 2002). Improving nursing work settings is imperative to optimize their contributions in health care and to attract and retain sufficient numbers to the profession.

Nursing work environments

For over twenty years the literature regarding nursing work environments has grown. Personal, job, and organizational factors have been identified that influence nurse's work attitudes such as satisfaction, stress and commitment. Further, there has been examination of nurse's attitudes and personal outcomes such as burnout and job satisfaction, as well as organizational outcomes such as turnover, patient satisfaction and mortality. Stressful jobs combine high effort/low reward and high demand/low control with little support from supervisors and co-workers. Research has consistently found that workers' health relates to job design, work control, and related rewards, as well as family friendly management practices, organizational change and job security (Koehoorn, Lowe, Rondeau, Schellenberg, & Wagar, 2002).

Work factors frequently studied include the way nursing jobs are structured and/or characteristics of the organizations including involvement, cohesion, supervisor or administrative roles, autonomy, control over practice, communication with colleagues, resource adequacy, professional development, interesting/responsible work, and lack of recognition (Adams & Bond, 2000; Clarke et al., 2001; Farrell & Dares, 1999; Morrison, Jones, & Fuller, 1997). Research from the 1980s, which investigated hospitals considered to be magnets in their ability to attract and retain staff, found work characteristics such as autonomy and collegial relationships, professional development and supportive, visible nursing leadership were linked to nursing recruitment and retention outcomes (Kramer & Schmalenberg, 1988a; Kramer & Schmalenberg, 1988b; Manley, 2000; McClure, Poulin, Sovie & Wandelt, 1983). More recently this research has been extended to demonstrate linkages between work characteristics and positive performance outcomes such as patient satisfaction, lowered complication and mortality rates, reflecting the contemporary management emphasis on quality and cost effectiveness (Aiken, Smith, & Lake, 1994; Mitchell & Shortell, 1997).

A broader review of literature that extended beyond nursing to consider any health care work environment identified the powerful roles professional associations and unions play in health care settings (Koehoorn, Lowe, Rondeau, Schellenberg, & Wagar, 2002). Canadian labour disputes have been commonplace and complicated by the complexity of players, legislation, range of practice settings and varying bargaining agents (Haiven, 1995). These additional actors and dynamics in health settings need to be considered in generating improvement strategies for nurses' work.

Gaps in knowledge

Although the factors that influence health, job satisfaction, and clinical outcomes, have been studied repeatedly, little is known about nursing workplaces as social contexts. Hence the "people dynamics" that facilitate or hinder improvements and influence perceptions are not well understood. This limitation leads to three major gaps in knowledge. First, there are few implementation or evaluation studies that assess human resource management interventions or organizational changes, in order to learn more about effective mechanisms for achieving work environment improvements. Little industrial relations research has focused on health care and little is known about the introduction of high involvement work practices outside the manufacturing sector (Eaton, 1994). Koehoorn et al. (2002) suggested that a critical factor in the success of new work redesign strategies may be in the "restoration of confidence and trust between management and employees and their unions" (p. 13). Second, there are few studies that include all groups of health care workers including physicians or explore union and professional association influences. Third, despite the number and range of studies few have used a qualitative lens to examine the nursing workplace to understand the social meanings at play and how they might relate to appropriate mechanisms to enact improvement. Without better understandings of the social dynamics in nursing workplaces, making sustainable changes that will result in improvement is problematic.

Most studies of nursing work environments have measured and contributed evidence (on both individual and social aspects) using quantitative and structural approaches. Research exploring values and meanings is sparse and, when available, has tended to focus on the individual as opposed to socially oriented understandings from the group. For example, McGirr and Bakker (2000) found that hospital nurses at all levels could articulate their own contributions to their positive workplaces, however, they did not explore group understandings that related to these contributions. For example unlike previous positive work settings research where directors of nursing were found to be highly visible, in this study the directors did not report having a strong presence on work

units. Since the researchers did not examine nurses' and managers' experience with their Director, it is not possible to know if support was experienced in ways other than "presence", such as through messages from their manager or through positive new initiatives attributed to the Director. In another example, Gaudine (2000) found a lack of control theme ran through individual interviews regarding the meaning of workload and work overload for nurses. Workload issues identified included "simultaneous demands", "anticipation of the unexpected", unrealistic "demands on self", and "interdependence". A number of important implications for practice were suggested based primarily on individual approaches. Interactive group orientated qualitative studies could contribute understandings as to how hospital nurses collectively understand workload issues and could add insights into ways that supportive group actions could address the issues found in Gaudine's study.

The importance of individually based understanding is underscored also by research that shows organizational commitment as an important predictor of retention, productivity, and employee well being. In examining organizational policy development particularly the concepts of justice and fairness and how policies are communicated and accepted, researchers have suggested that it may be the perceptions of these properties that influence individual responses rather than measurable objective factors (Decotiis & Summer, 1987; Meyer & Allen, 1997). Similarly employee perceptions of the motives for implementing desirable human resource management practices were more important to organizational commitment than an objective assessment of their desirability (Koys, 1991). These results may help to explain the variability found across studies in linking particular work experiences and organizational commitment as well as administrators' experiences in trying to implement best practices from other settings. However, we do not understand how the social dynamics in settings help to shape individual perceptions and views on the meanings of work interactions. Notwithstanding the vast body of literature on nursing work, we are challenged to gain further insights and develop knowledge required to improve the current state of nursing work environments.

Filling the gaps

Reconceptualizing work as a "practice" setting where various actors interact based on their interpretations allows us to consider the social dynamics within nursing work in new ways. The foundations for studies investigating socially shaped perceptions are contained in the symbolic interactionist tradition wherein the major assumptions are:

- people individually and collectively act on the basis of the meaning that things have for them;

- meaning arises in the process of interaction among individuals; and
- meanings are dynamically linked to the specific context in which people find themselves (Benzies & Allen, 2001; & Manis & Meltzer, 1978).

Therefore, the symbolic interactionist perspective emphasizes the processual aspects of work settings and the part that individual and collective meaning making plays in influencing behaviour in specific situations.

Practically, the socially based process elements related to implementing change can be mishandled by merely going through the motions of involving others. For example, "Involvement for buy in" or "input so that we can say we did it (without alteration)" quickly alienates and disillusions nurses. Yet in our rush to implement, cynicism is bred by failure to discuss how input fits with bigger picture dimensions or the rationale for decisions taken. When enacted in a way that allows mutual shaping of the understandings, participants naturally engage in actions that evidence the shared understanding and new thinking that has been created.

By valuing subjective information and placing focus on humanistic considerations, qualitative studies are adding a different standpoint to the substantial literature on nursing work environments. They can add the sense of the "knowing nurse" or the "knowing manager" whose experience in interpreting work interactions and events are central to meaningful and sustainable change. This can shift our sense of nursing work as social enactment, wherein people choose to interact in certain ways based on their interpretive decisions about who they are and what they are trying to do (Morgan, G. 1998). Nurses have active roles in the ongoing process of constructing and reconstructing their workplaces and leaders and managers are challenged to create and shape meanings that serve as guides to organized action (Morgan, G. 1998). The concept of organizational change broadens to encompass the importance of images and values in the minds of people as new thinking is required to enact change effectively (Morgan, G. 1998). Even power and conflict can be reframed as energizing or destructive forces depending on the interpretations at play, the impacts realized, and the changing nature of the situation. Understanding the political significance of meanings enacted in the setting may also foster new insights.

There is a chasm between quality work environment knowledge and the reality of work experienced by many contemporary nurses. Polanyi, Frank, Shannon, Sullivan, and Lavis (2000) have suggested that promoting positive psychosocial attributes at work may be seen as a conflict for the organization, as it represents a contradiction between worker

health and broader social goals for productivity and profitability. This may partially explain the discrepancy in research knowledge and its utilization in nursing work settings. However, some contemporary authors suggest that there is hope of mutual benefit, since the same characteristics that foster healthy people, also have been shown to contribute to organizational goal achievement (Pratt, 2001). Work settings are acknowledged as an important influence on personal and organizational health, yet we do not fully understand the meanings at work in ways that allow us to effect positive changes. Qualitative methodologies can address this gap by identifying interpretations that define issues from different perspectives and by developing insights into potential solutions. For example, I (2004) recently studied how interpretations of nurses, managers and union compare regarding ways to improve a top work environment issue in their setting. The research design employed focus groups as a method to gain a social perspective on how the various groups frame the issue and view actions that will bring about results that are important to them. The collective process of generating insights adds a new dimension to our understandings of nursing workplaces.

Focus groups

Focus groups are designed to gather feelings, perceptions or ideas regarding issues or services, from a homogeneous group of people through social interaction. The focus group process of conversation creates a collective process of sharing and comparing that allows the group to construct new understandings unavailable in individual data collection techniques. The focus group participants can build on each other's opinions and thoughts and through questioning can challenge each other's contradictions and responses. Thoughts can then be influenced if they are incomplete, faulty or malformed with false data (Lincoln & Guba, 2000). Data collected in this manner tend to be viewed as credible since members of the community itself judge what is "real", useful, or has meaning especially in relation to shaping action.

Focus groups share three common strengths found in qualitative methods: exploration and discovery, especially in poorly understood areas; context and depth behind people's perceptions; and interpretations, which provide insights into how and why people think and act as they do. Focus groups combine two elements frequently used in qualitative data collection, that is participant observation and interviews in a uniquely collective manner. During the group the researcher is able to observe the horizontal interaction of participants in social interaction. Focus groups do allow for the collection of a large amount of verbal communication, body language and self-report data in a relatively short amount of time.

While comprehensive resources such as the, "The Handbook for Focus Group Research" (Greenbaum, 1998) and "Focus Group Kit" (Morgan & Krueger, 1998) are available, a few important considerations in planning focus group data collection are essential. First, the research purpose and questions must be clear in order to determine the degree to which participants will be directed by questions or will have freedom to explore issues and direct their own conversation. One of the advantages often attributed to focus groups is the possibility of maximizing participants influence over the direction and process of discussion and minimizing the influence of the researcher's preconceived ideas and opinions (Madriz, 2000). Second, the choice of participants is not to achieve statistical "representativeness", but instead is guided by the specific research aim and related questions. Therefore, the sample is not random but selected on the basis of participant experience and expertise related to the research question. However, the collective nature of focus groups can be limiting if the individual is not comfortable in group discussion or the topic is sensitive and participants are wary of fully sharing their views. Group member behaviours like dominating or silencing others, can be problematic. As well there is a danger that "group think" will emerge rather than a discussion of diverse opinions. Explicit ground rules and a skilled facilitator in managing group dynamics are measures designed to mitigate against these issues.

Focus groups are a powerful way to collect rich data, to use collective thinking to make sense of the situation and to provide a shared experience of reflection to participants. The group interaction contributes to developing "shared stocks of knowledge," (Holstein & Gubrium, 1995, p.71) and has the "potential to initiate changes in participants' thinking or understanding, merely through the exposure to the interactive process" (Barbour, 1999, p.118). These new understandings can lay a foundation for action. However, if transformative change is to be achieved, a broad based engagement process with staff will need to follow. To be successful the change process must do more than appear to be participative, it must in fact be shaped by those who are affected, in a fashion that uniquely satisfies the dynamic context in which it resides.

Summary

O'Donnell (2000) suggests that the science and art of health and productivity management is so new that basic strategies have not yet been articulated, yet they are key to organizational productivity for the 21st century (Goetzel & Ozminkowski, 2000). There is a need to understand people's experience and sense of work environments as settings that not only contain factors that influence health, job satisfaction and clinical

outcomes, but also influence options and improvement possibilities. Qualitative research findings can frame work environment problems in new ways that allow interpretative understandings to be part of policy formulations and improvement actions. Findings from studies like these combined with the existing literature could assist us in understanding nursing workplaces as constructed dynamically with interlacing facets of both objective and subjective components. Reflecting and considering this broader evidence in work setting dialogue could provide insights into ways that nurses might create and maintain quality nursing work environments in the changing landscape of health reform.

References

Adams, A., & Bond, S. (2000). Hospital nurses' job satisfaction, individual and organizational characteristics. Journal of Advanced Nursing, 32(3), pp. 536-543.

Aiken, L.H., Smith, H., & Lake, E. (1994). Lower Medicare mortality among a set of hospitals known for good nursing care. Medical Care, 32(8), 771-87.

Barbour, R. S. (1999). Are focus groups an appropriate tool for studying organizational change? In Barbour, R. S. & J. Kitzinger. Developing focus group research: Politics, theory and practice. Thousand Oaks, CA.: Sage Publications.

Baumann, A., O Brien-Pallas, L., Armstrong-Stassen, M., Bltythe, J., Bourbonnais, R., Cameron, S., Doran, D.I., Kerr, M., Hall, L.M., Vzina, M., Butt, M., & Ryan, L. (2001). Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system. A Policy Synthesis: The Change Foundation. Retrieved March, 2002, from htpp://chsrf.ca/docs/finalrpts/pscomcare_e.pdf

Benzies, K. M., & Allen, M. N. (2001). Symbolic interactionism as a theoretical perspective for multiple method research. Journal of Advanced Nursing, 33(4), 541-547.

C.D. Howe Institute. (2001). Aging populations and the workforce, challenge for employers. Anonymous.

Canadian Nursing Advisory Committee. (2002). Our health, our future: Creating quality workplaces for Canadian nurses. Advisory Committee on Health Human Resources. Ottawa, ON: Retrieved November, 2002, from Health Canada http://www.hc-sc.gc.ca/english/nursing/cnac

Clarke, H.F., Spence Laschinger, H., Giovannetti, P., Shamian, J., Thomson, D., & Tourangeau, A. (2001). Nursing shortages: Workplace environments are essential to the solution. Nursing Issues, 50-57.

Commission of the Future of Health Care in Canada. (2002). Building on values: The future health care in Canada. (The Romanow Commission). Ottawa, ON: The Commission: Government of Canada. Retrieved December, 2002, from http://www.gov.mb.ca/health/documents/worlife.pdf.

Conference Board of Canada. (2001). Wanted: Skilled workers to fill the upcoming labour

shortage in Canada. Conference Board of Canada. . Retrieved December, 2002, from http://www.conferenceboard.ca/pandp/documents/pp00rpt.pdf

Decter, M. & Villeneuve, M. (2001). Repairing and renewing nursing workplaces. Hospital Quarterly, Fall, 46-49.

DeCotiis, T. A., & Summers, P. (1987). A path analysis of a model of the antecedents and consequences of organizational commitment. Human Relations, 40, 445-470.

Eaton, A. (1994). Factors contributing to the survival of employee participation programs in unionized settings. Industrial and Labour Relations Review, 47, 371-389.

Farrell, G.A., & Dares, G. (1999). Nursing staff satisfaction on a mental health unit. Australian and New Zealand Journal of Mental Health Nursing, 8(2), p. 51-58.

First Consulting Group. (2001). The Healthcare workforce shortage and its implications for America's hospitals. (Fall). Anonymous.

Gaudine AP. (2000). What do nurses mean by workload and work overload? Canadian Journal of Nursing Leadership. Online.

Glouberman, S. (2002). Structure, power and respect: The nurse's dilemma. Ottawa, ON. Canadian Nursing Advisory Committee. Retrieved December, 2002, from Health Canada http://www.hc-sc.gc.ca/english/nursing/cnac

Goetzel, R.Z., & Ozminkowski, R.J. (2000). Health and productivity management: Emerging opportunities for health promotion professionals for the 21st century. American Journal of Health Promotion, 14(4), 211-214.

Greenbaum, T. (1998). The handbook for focus group research. (Second Ed.). London: Sage Publications Inc.

Haiven, L. (1995). Industrial relations in health care: Regulation, conflict and transition to the wellness model. In Swimmer, G. & Thompson, M. (Eds.) Public sector bargaining in Canada. (pp. 236-271). Kingston, ON: Queen's University, IRC Press.

Holstein, J.A., & Gubrium, J.F. (1995). The active interview. Thousand Oaks, CA: Sage Publications Inc.

Koehoorn, M., Lowe, G.S., Rondeau, K.V., Schellenberg, G., & Wagar, T.H. (2002). Creating high quality health care workplaces. Ottawa, ON: Canadian Policy Research Networks Inc. (CPRN). Retrieved October, 2002, from http://www.cprn.org

Koys, D.J. (1991). Fairness, legal compliance, and organizational commitment. Employee Responsibilities and Rights Journal, 4, 283-291.

Kramer, M. & Schmalenberg, C. (1988a). Magnet hospitals: Part I - Institutions of excellence. Journal of Nursing Administration, 18(1), 1324.

Kramer, M. & Schmalenberg, C. (1988b). Magnet hospitals: Part II - Institutions of excellence. Journal of Nursing Administration, 18(2), 11-18.

Levi, P. (1999). Sustainability of healthcare environments. Journal of Nursing Scholarship,31(4), 395-398.

Lincoln, Y.S., & Guba, E.G. (2000). Paradigmatic controversies, contradictions and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (second edition, pp. 163-188). Thousand Oaks, CA: Sage Publications, Inc.

Lowe, G.S., & Schellenberg, G. (2001). What's a good job? The importance of employment relationships. (Report No. ISBN 1-896703-53-4). Ottawa, ON: Renouf Publishing Co. Ltd. CPRN Study No.W/05,

Madriz, E. (2000). Focus groups in feminist research. In N. K. Denzin, & Y. S. Lincolcn (Eds.) Handbook of Qualitative Research (second edition, pp. 835-850). Thousand Oaks, CA.: Sage Publications, Inc.

Manis, J. G., & Meltzer, B. N. (1978). Symbolic interactionsim: A reader in social psychology. (3rd ed.). Boston: Allyn and Bacon.

Manley, K. (2000). Organisational culture and consultant nurse outcomes: Part 1 organisational culture. Nursing Standard,14(36), 34-8.

McClure, M., Poulin, M., Sovie, M., & Wandelt, M. (1983). Magnet hospitals: Attraction retention of professional nurses. Kansas City: American Academy of Nursing.

McGirr, M., & Bakker, D. A. (2000). Shaping positive work environments for nurses: The contributions of nurses at various organizational levels. Canadian Journal of Nursing Leadership. 13(1), 7-14.

McLennan, M. (2004). Importance of settings in improving nursing work. Manuscript in preparation.

Meyer, J.P., & Allen, N. J. (1997). Commitment in the workplace: Theory, research and application. Thousand Oaks, CA: Sage Publications, Inc.

Mitchell, P., & Shortell, D. (1997). Adverse outcomes and variations in the organisation of care delivery. Medical Care,35(11), 19-32.

Morgan, D.L., & Krueger, R.A. (1998). The focus group kit. (Eds.). Thousand Oaks, CA: Sage Publications, Inc.

Morgan, G. (1998). Images of organization. (The Executive Edition). San Francisco, CA: Sage Publications & Berrett-Koehler Publishers.

Morrison, R.S., Jones, L., & Fuller, B. (1997). The relation between leadership style and empowerment on job satisfaction of nurses. Journal of Nursing Administration, 27(5), 27-34.

O'Donnell, M. (2000). Health and productivity management: The concept, impact, and opportunity: Commentary to Goetzel and Ozminkowski. American Journal of Health Promotion,14(4), 215-217.

Polanyi, M.F.D., Frank, J.W., Shannon, H.S., Sullivan, T.J., & Lavis, J.N. (2000). Promoting the determinants of good health in the workplace. In B. D. Poland, L. W. Green, & I. Rootman (Eds.), Settings for health promotion: Linking theory and practice (pp. 138-175). Thousand Oaks, CA: Sage Publications Inc.

Pratt, D. (2001). The healthy scorecard. Victoria, BC, Canada: Trafford Publishing.

Premier's Advisory Council on Health, (2001). A framework for reform. (The Mazankowski report). Edmonton, AB, Canada: Government of Alberta. Retrieved March, 2002, from htpp://www.gov.ab.ca/home/health_first/documents_maz_report.cfm

Siegrist J. (1996). Adverse health effects of high-effort low-reward conditions. Journal of Occupational Health Psychology,1, 27-41.

Standing Senate Committee on Social Affairs, & Science and Technology. (2002). The health of Canadians - the federal role. Volume six: Recommendations for reform (The Kirby Report). Ottawa, ON: Government of Canada. Retrieved December, 2002, from htpp://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm

Statistics Canada. (2002). Canada's labour force survey (2002). Ottawa, ON: Retrieved November, 2002, from htpp://statcan.ca/english

The Laurier Institution. (2000). Renewal and retention: Attracting and keeping faculty and senior administrators at British Columbian universities. June 2000. Vancouver, BC, Canada: The Laurier Institution.

CHAPTER THREE: NURSES' VIEWS ON WORK ENABLING FACTORS

Attracting and retaining high quality staff has become a major strategic issue for health sector employers and improved work environments have been identified as a key strategy for achieving this goal (Canadian Nursing Advisory Committee, 2002). Previous work suggests that nurses will seek to work in settings that enable them to achieve their work goals and that foster personal health (Kramer & Schmalenberg, 1988a; Kramer & Schmalenberg, 1988b; McClure, Poulin, Sovie, & Wandelt, 1983). Yet, troublesome signs continue to plague many workplaces threatening the quality of care and the personal health of nurses. Thus Canadian nurses have been found to be the most overworked, stressed, work-life unbalanced, and the sickest workers in the country with absenteeism rates 80% higher than other workers (Statistics Canada, 2002). This paper provides a snapshot of some nurses' opinions about their work environments in one hospital and recommends that administrators consider using a simple survey as part of a multi-faceted strategy to foster quality work settings.

Background

Twenty years of research on nursing work environments has shown that personal, job, and organizational factors influence nurses' work satisfaction, stress, and commitment. These same factors have also been shown to correlate with organizational outcomes such as patient satisfaction, mortality, and staff turnover rates. Although numerous research instruments have been developed to conduct research (Aiken & Patrician, 2000; Estabrooks, et al., 2002; Kramer & Hafner, 1989; Lake, 2002), little has been available to nursing administrators that allows them to assess the quality of the operating environment quickly and proactively. Consequently, administrators have tended to manage their operations using "trailing" indicators of work environments such as employee absenteeism, turnover, and poor morale rather than "leading" indicators like employees' feelings of being empowered or skilled to achieve work goals. Unfortunately, the usual warning flags appear after damage to health and productivity has occurred. A more proactive approach would be to measure enabling factors that have previously been linked to successful outcomes, align the organization to achieve them, and measure them frequently so that improvement can be tracked and correction made before negative results occur. This logic underpins Rucci, Kim, and Quinn's (1998) research, which demonstrated a causal relationship between a 10-point work index and employee satisfaction, customer loyalty, and financial results. Similarly, Buckingham and Coffman (1999) identified 12 key environmental conditions that great managers used to attract and retain top-notch employees who created successful business outcomes. These popular business indices used factors similar to those in a work index that predicted health

outcomes (Health Canada: The survey, 2002). Accordingly, Pratt (2001) has argued that research has established a common set of factors in work environments relating to employee capability, motivation, and wellbeing. Further, Pratt has advocated using a simple Index of these factors as part of a leadership strategy to enable workers to be both productive and healthy.

Purpose

This study builds on previous conceptual development and research, to explore the utility of an enabling work index survey in a nursing practice setting. As part of a larger research project to explore how to foster quality work settings for nurses, it also provides a snapshot of the study setting by answering the following research questions:

- How do nurses rate enabling characteristics in their current work environments, the importance of these characteristics to them, and their levels of stress and satisfaction?
- What work issues do nurses identify as priorities for improvement in their work setting?
- How do nurses' personal characteristics, work environment ratings, stress levels, and top priorities for improvement relate to each other?

Methods

For this study a descriptive design with a self-report survey instrument was used.

Instrument

A survey was developed for this study and included four components. First a thirteen-item Enabling Work Index assessed factors that were found in a literature review of simple survey indices about worker satisfaction and productivity. This index was first developed for use in consulting practice by the author in collaboration with a group of organizational effectiveness consultants. The psychosocial concepts utilized in the index have also been associated with worker health: Sense of belonging, social support, job clarity, pride in work, trust, fairness, supervisory support, purpose, sense of control and learning and development (Health Canada: The survey, 2002; Pratt, 2001). In this study survey respondents were asked to rate each work characteristic in the Enabling Work Index on (a) how typical it was of the work area ("Actual") and (b) how important it was ("Importance") using a 5-point Likert type scale. Rating choices ranged from 1 = not at all to 5 = highest degree possible and an option to use NA= not applicable. The reliabilities of the "Actual" Index and the "Importance" Index were measured by the Cronbach alpha reliability coefficient and found to be .90 and .89 respectively. (This means that the tool was found to have high correlation across indicators within each of the indices.)

The second component of the survey measured stress and satisfaction levels using a four question Stress/ Satisfaction Offset Score (SSOS) that Shain (1999) has shown to be related to health status, absence from work, and health risk. This measure builds on empirical work that demonstrated too much demand with too little job control (Karesek & Theorell, 1990) and high effort with few rewards (Siegrist, 1996) resulted in stress, numerous illnesses, and injuries. Satisfaction has been shown to offset stressors and the ratio of the two was the factor that best predicted employee health status and absenteeism (Shain, 1999).

Thirdly, the survey collected data concerning six personal characteristics including unit membership. Finally, there were two open-ended questions to identify what nurses felt were current strengths in their workplace as well as priority issues to be changed.

Study sample

One institution was selected for this investigation due to its relation to the second part of the research project, which explored how to foster quality work settings for nurses. The specific organization was chosen based on the chief nurse's expressed commitment to improving the quality of the nursing work environment and its convenient location. Permission to conduct the study was received from administration, the union, and the relevant research ethics boards. All 164 nurses working in the institution were invited to complete a survey. The overall response rate was 37% with 60 useable questionnaires returned. The response rate by work unit ranged from 15%-75%, with the participants in the least responsive unit reporting that the union had advised against participation because it conflicted with bargaining activities then underway. This occurred despite earlier discussion and endorsement by the union representative before site selection. A second round of surveys was distributed in that work area to ensure that anyone wishing to participate had the opportunity. Few additional responses were received.

Approximately half the respondents were 45 years of age or older, had worked in the organization for over 10 years, and were employed full time. Relatively few (7%) had been employed there less than one year, were under the age of 30 (10%), or employed casually (8%). These characteristics are similar to the entire nursing population in this institution except that there was an under-representation of casual nurses, probably reflective of the loose tie to the organization that is typical in these roles. The vast majority (85%) reported their employment status reflected their preferred choice. The responding nurses were well educated -- 75% had education beyond a diploma, 53% had university degrees (provincial average, 29%), and the others had completed specialty

courses. Most (70%) lived with a partner and 55% had responsibilities for children or elderly parents.

Results

Certain contextual factors should be considered when viewing the results of this study. The institution resides in the Canadian health care scene where both national and provincial health care reform has been characterized by dramatic budget reductions, nursing lay offs, and institutional/regional reorganizations for over ten years. Despite the uncertainties and budget challenges, this institution has not undergone major nursing layoffs or been part of major organizational mergers, thereby enjoying relative stability of nursing staff and managers. Surveying occurred in the midst of expected provincial announcements of further regional boundary adjustments and union bargaining for a new provincial nursing contract.

Data analysis was conducted on an overall institutional level to describe the enabling conditions, the levels of stress and satisfaction, and nurses' views on the best things about their work environment as well as the priority items to improve. Results were also analyzed by nursing unit as a meaningful level of workplace information for local interpretation and action. Finally multiple regression analysis was used despite the small sample size to explore associations between study variables and to encourage other research.

Enabling conditions

For the thirteen enabling factors, scores were calculated for how characteristic they were of the current work area ("actual"), their "importance", and the "discrepancy" between ratings of "actual" and "importance". Findings for the institution are illustrated in Table 3-1 and are reported with the highest "actual" mean at the top and listed in descending order to the lowest mean at the bottom. Also included in Table 3-1 are three cumulative scores: the "Actual" Index (sum of current ratings), the "Importance" Index (sum of importance ratings), and the "Discrepancy" Index (total of discrepancy scores). The three index scores indicate the overall perceptions of the current environment, level of importance of these factors, and the degree of difference between these two views.

All the enabling factors were found on average to be "somewhat to greatly" present in work areas and all were rated highly for importance. The actual conditions with the highest mean were the ability to use skills and knowledge, clear roles and responsibilities, and the ability to deliver high quality services. Characteristics with the

lowest mean related to the manager/staff relationship: management seeks my input, provides regular feedback, and takes an interest in me. These last areas were also found to have high discrepancy scores. However, these items were not the items rated as highest in importance. In fact the items rated highest in importance were most often found to rate relatively higher in actual ratings as well. This may mean that the organization was already meeting the most important needs fairly well. Alternatively, it could reflect a tendency for the participants to have diminished expectations concerning areas that were problematic. The data are silent on this.

Next, the Enabling Work Indices were analyzed by work unit, including one unit that captured all nurses employed in a variety of small miscellaneous areas within the institution. To keep respondents and nursing units anonymous descriptive details of the units (including return rates) have not been disclosed, but they do include both inpatient and outpatient units. These findings should be used with caution because of the low return rate in one unit (15%). The results are displayed in Table 3-2 and illustrate a variation in opinions about the presence of enabling conditions even among members of the same nursing unit. The greatest range of opinion was expressed in Unit B where the "Actual" index scores ranged from 30 (indicating few enabling factors were perceived to be present in the work environment) to 62, (indicating many factors were perceived to be present to the greatest degree possible). In all 5 units, some nurses expressed high enabling conditions while in 3 units some nurses indicated conditions were not enabling. Two of the latter units also had the highest discrepancy scores.

Stress/satisfaction offset score (SSOS)

The overall organizational stress/satisfaction offset score, which is the mean SSOS for the nursing workforce as a whole, was +0.3 reflecting a slightly more satisfied than stressed workforce. A negative score means that stress outweighs satisfaction; a positive score that satisfaction outweighs stress; and a zero score that stress and satisfaction cancel one another out (Shain, 1999). Individual scores were calculated and aggregated by unit and are presented in Table 3-2. Those units with the highest "Actual" Enabling Work Index, Units C and D, also had the most satisfaction. Less satisfaction was expressed in the other three units, where the enabling factors were also rated lower. On an individual basis, over three quarters of the nurses reported being balanced or more satisfied than stressed. However, 10% were slightly more stressed than balanced, and an additional 14% indicated even more stress.

Strengths

When asked to identify the best thing about their workplace, "colleagues" were identified

by one third of respondents. Examples of the accompanying comments include: "Nurses I work with are competent", "sense of equality in our work team", "laughter and happy coworkers", and "supportive camaraderie". Next most frequently listed strengths were "patients" and "pride in the workplace", as indicated by such comments as "patient outcomes observed as a result of what I do", "not having to cut corners", "available to assist more junior inexperienced nurses", and "reputation of place of work".

Priority changes

Thirty-five percent of respondents identified the highest priority for change as improvement in management and leadership. The comments reinforced many of the "importance" ratings reported earlier. Examples of comments included: "More communication and collaboration between staff and management", "more active involvement in decisions", "free to vocalize and make improvements", and "more feedback on work". Mentioned slightly more frequently (37%) but weighted less in priority were workload concerns, such as "work assignments too heavy", "need better provision for coverage/ extra help", "too overbooked", and "taking breaks (requires) change in workplace culture". The next three priority areas --equipment/space, job design, and professional development -- were each raised by approximately one quarter of respondents.

Relationships between factors

Survey responses were analyzed by length of service, age group, education background, care-giving burden, work unit and preference for current employment status. Stepwise multiple regression analysis was then conducted to explore the relationships between those personal characteristics, index scores (Actual, Importance, Discrepancy), and Stress/Satisfaction Offset Scores, and priority improvement issues. Significant findings are presented in Table 3-3, which highlights those variables that were found to best predict stress/satisfaction and priorities for change. The small sample size and particularly the Unit findings should be used with caution because of the low return rate in one unit (15%). Twenty-six percent of the variability in the satisfaction scores (SSOS) was related to the presence of enabling factors in the work environment and an additional six percent was accounted for by membership in Unit D. Using each improvement priority as a criterion, forty – two percent of the variability in improving management was accounted for by high discrepancy scores, and Unit C membership accounted for ten percent of variability in workload and Unit E membership for eight percent in equipment/space. Unit A membership accounted for nineteen percent of variability in improving recognition and lower levels of education for an additional six percent. Being

stressed accounted for ten percent of the variability in professional development improvement. The small sample size makes the regression analysis results at best tentative and causes concern that findings may not be replicable in other samples.

Discussion

Poor survey response rates make it difficult for organizations to collect and respond to employee concerns. In this study it was suggested that the union negatively influenced one unit's particularly low response rate (15%). However, other factors may have contributed to this such as responder fatigue, due to a unit generated survey circulated one month prior to this one, and organizational history, because recent surveys were reported to be a waste of time since few results emanated from them. Although it is widely acknowledged that staff opinions about their workplace are valuable, there are multiple challenges in collecting them even when the survey is short and easy to fill out.

Enabling factors

Recent studies in Canada and Western countries have consistently found deterioration in working conditions for nurses and growing levels of job dissatisfaction and poor morale (Aiken et al., 2001; Burke & Greenglass, 1999; Clarke et al., 2001; Corey-Lisle, Cohen, & Trinkoff, 1999; Laschinger, Finegan, Shamian, & Casier, 2000; Shindul-Rothschild, Berry, & Long-Middleton, 1996; Sochalski, 2001; Spence Laschinger, Sabiston, Finegan, & Shamian, 2001). Similar to findings in this study, participation in decisions, feedback, and relationships with managers have been found to be among the most problematic of conditions. Positive relationships with colleagues was one of the best features of this workplace and has been broadly reported in other studies particularly relationships with physicians (Aiken, et al., 2001; Clarke et al., 2001; & Sochalski, 2001). The most frequently cited concern in this study, workload, and the highest priority, improving management, have also been reported in other recent studies and policy reviews (Aiken et al., 2001; Baumann, O'Brien, et al., 2001; Canadian Nursing Advisory Committee, 2002; Clarke et al., 2001; Koehoorn, Lowe, Rondeau, Schellenberg, & Wagar, 2002; Laschinger, et al., 2000; Shindul-Rothschild, et al., 1996; Spence Laschinger, et al., 2001).

Unlike many of the studies mentioned above, job insecurity and trust issues were not found, possibly influenced by the organizational history of managing fiscal challenges without major layoffs and restructuring of nursing staff. This may also partially explain the positive stress/satisfaction balance in the overall organization. Baumann, Giovannetti, et al (2001) found that although those whose job was restructured had the most stress, all nurses were affected. However, the most striking finding from this study is the prevalent

view that quality care is provided (greatly or to the highest degree possible) by 92% of the nurses and reinforced by comments, such as "personal fulfillment in providing excellent patient care". In contrast quality of care concerns were raised in all of the foregoing studies. For example Aiken et al. (2001) in a five-country study conducted in 1998-1999 found one in nine German nurses and one in three nurses in Canada, the United States, Scotland, and England rated the quality of care as excellent. Likely the strong enabling conditions that were found here: having a clear nursing role that used their skills and knowledge, good levels of trust and respect, and reasonable resources to do the job, played a part in nurses' perceptions of being able to provide quality care. These factors were also the most important to nurses in this setting. Although measuring quality of care through the lens of the professional nurse lacks the precision of a common objective standard, it does capture many intangible aspects of quality that are difficult to measure (Sochalski, 2001).

The nursing unit as a physical and social organizational unit is a significant unit of analysis for examining nurses' experience of work and designing improvement activities. The fact that opinions about the presence of enabling factors varied widely in some of the nursing units raises interesting questions such as, " How can the same work environment be experienced so differently?" The experience of work clearly has a unique personal interpretation attached. For example, low scores may reflect personality conflicts with manager and/or co-workers, job mismatches, stress or illness, or various other reasons. Each case can be understood fully only in the particular, and managers therefore, need to invest time with the individual nurse to gain better understandings and develop effective strategies.

The unit mean, can also be misleading if it is associated with a large range of individual responses. Nonetheless, in the business sector it is common for managers to be evaluated and compensated on their work area index results (Buckingham & Coffman, 1999; Rucci & Kim, 1998). While this practice emphasizes the importance of enabling environments, it also may lead to leadership actions that eliminate or avoid dissonant opinions in an attempt to homogenize the work group. For example, leaders may delay or evade necessary change if they feel it will be unpopular within the work group. Over time, this practice can erode individual and unit performance. Still, there is a role for unit and organizational analyses. These can be useful in benchmarking against others, or to self over time and are particularly helpful in evaluating change efforts.

Pratt (2001) argued that top scores in all enabling factors should be the goal as these conditions are fundamental to satisfaction, productivity, and health. Alternatively,

discrepancy scores in combination with mean scores may identify priority areas that are lacking and important to people. These measures serve as a focus for action and are best understood in discussions about what and how changes could be made to make a meaningful difference for nurses.

In this study nurses were found to value the same work characteristics that have been found to be important to contemporary workers in a variety of other North American settings (Buckingham & Coffman, 1999; Rucci & Kim, 1998). These work dimensions reflect democratic ideals of free and open dialogue coupled with egalitarian views of fairness and equal participation in a humanistic social environment of shared purpose and supportive relationships. In other cultures nurses may have different values and consequently, have different opinions regarding power relationships, for example. Therefore, further study is required to determine if there are cultural differences in the factors that are enabling for nurses.

Stress/satisfaction

The best predictor of satisfaction in this sample was the perception of enabling factors that accounted for twenty-six percent of the variance. However, none of the personal characteristics, priorities for change, or enabling indices predicted work stress levels, not even the discrepancy scores. Because discrepancy in expectations is commonly understood to be a source of stress, it had been expected to be significantly related to stress levels. One explanation may be that other factors not measured in this study -- such as home stress or social support or personal choices-- acted as mediating factors (Health Canada, The survey, 2002; Karesek & Theorell, 1990; Shehadeh, Shain, 1990).

Shain (1999) has recommended that individual SSOS scores be aggregated to the organizational level because it has been demonstrated to be an important indicator of business objective achievement. In this study, the organization's +0.3 score indicated that satisfaction was slightly ahead of stress. Unfortunately, at present there are no published SSOS results for organizations to use as benchmarks for assessing performance. Although dissatisfaction and burnout have been widely reported in recent nursing studies.

Achieving a more positive organizational SSOS depends on increasing satisfaction, decreasing stressors, or a combination of both. The practice implications for improving the stress satisfaction ratio is illustrated by considering the most frequently mentioned issue in this workplace, workload. Gaudine (2000) studied nursing workload issues and

found that a lack of control theme ran through nurses' experience. This would be expected to add stress unless mechanisms allow nurses to take charge of their work, manage workload fluctuations, and receive support in difficult circumstances from colleagues and managers. Besides adding support and control, work effort can be reduced through proactive education. Not having required skills or knowledge diminishes confidence and increases effort. Education in an atmosphere that promotes ongoing learning and development, rather than crash courses to survive the next change process, builds capacity. Feeling capable and ready can help mitigate difficult work and change efforts. Increasing satisfaction through meaningful rewards means employing strategies that consider personal motivators and the context. Frequently, simple things such as noticing extra effort, personal accomplishment, or teamwork (either orally or in a written note) are effective. Interesting work assignments, opportunities for personal development, and experiencing an enabling work environment that supports quality patient care are other ways that contribute to nurses feeling valued and rewarded.

Priorities for change

Improving management was identified as the top priority for change, congruent with the three lowest characteristics found on the actual enabling index related to management/staff relationships. Leader empowering behaviors have been previously identified as significantly influencing employee perceptions of workplace empowerment (Morrison, 1996; Morrison, Jones, & Fuller, 1997; Spence Laschinger, Wong, McMahon, & Kaufman, 1999). The survey comments reflected a common opinion that managers have responsibility to make changes in work environments when they are viewed as poor. In other workplace research, this same opinion was found among university administrators, academics and support staff who wanted work environment improvements (McLennan, 1999). More broadly, Shain (1999) argued that discretionary managerial decisions to increase employee control and rewards can relatively quickly influence health outcomes as evidenced by reduced injury rates and decreased absenteeism. Others concur that how managers decide to design and organize work are key influences on employee experiences of work (e.g. Buckingham & Coffman, 1999; Rucci & Kim, 1998). However, it is not clear from my findings how managers should improve, what setting factors play a part, and what benefits are expected from improvement. Further exploration of how the issue of management was defined and seen to foster better workplaces for nurses is needed -- and such exploration was conducted in the second phase of this research.

Study limitations

This study is limited insofar as it relied solely on data generated through a written self-report survey without any other collaborating evidence for measures such as stress levels or quality of care. The small number of respondents within one unit, the one-site focus, and volunteer bias also limits generalizability. The study does, however, add to the body of knowledge that suggests that it is valuable for administrators to know what their nurses think about their work environments.

Conclusion

Interactions with people were found to be the greatest source of strength among the nurses, but also the top priority for improvement in the case of managers. Koehoorn et al. (2002) have proposed a multidimensional "High-Quality Workplace Model" for health care that emphasizes human relations and leadership. All of the enabling factors were found to be important to nurses and, when they were seen to be deficient, there was a tendency to call for improvement in management. Enabling work environments were found to be associated with greater satisfaction and none of the variables tested predicted work stress levels. Perceptions of high quality care may have related to the high enabling factors that allowed nurses to use their knowledge and skills in a trusting and respectful atmosphere with reasonable resources to do their job. Further research is needed to better understand the relationship between quality care, the work setting conditions, and staffing levels particularly in light of the predicted nursing shortages.

The importance of enabling factors in work settings extends beyond their direct relationship to outcomes -- it extends to their role in creating resilient people who are able to manage continual change. When present, enabling factors facilitate workplace change; when absent, they act as barriers. Therefore, efforts to improve nursing work environments should take into consideration the state of enabling conditions.

In light of these findings, a simple enabling index and survey tool may elicit important feedback to trigger learning about how work settings can become healthy, productive, and rewarding places for nurses. A survey can provide an opportunity for nurses to assess their work environments and identify change priorities, which in turn can lead to discussions about how to achieve improvements. To be useful, the results need to be integrated into a human resource system and strategy that is truly responsive and accountable. Providing quality work environments is one piece of the puzzle of recruiting and retaining nurses. Will we soon have potential recruits asking for the results of work environment surveys before they decide whether to accept or reject the jobs we offer?

References

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., Busse, R., Clarke, H., Giovannetti, P., Hunt, J., Rafferty, A. M., & Shamian, J. (2001). Nurses' reports on hospital care in five countries. Health Affairs, 20(3), 43-53.

Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: the revised nursing work index. Nursing Research, 49(3), 146-53.

Baumann, A., Giovanetti, P., O'Brien-Pallas, L., Mallette, C., Deber, R., Blythe, J., Hibberd, J., & DiCenso, A. (2001). Healthcare restructuring: The impact of job change. Canadian Journal of Nursing Leadership, 14(1), on-line.

Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Irvine Dornan, D., Kerr, M., McGillis Hall, L. Z. M., Butt, M., & Ryan, L. (2001). Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system. A policy synthesis. The Change Foundation. Ottawa, ON: Canadian Health Services Research Foundation. Retrieved on March, 2002, from htpp://chsrf.ca/docs/finalrpts/pscomcare_e.pdf

Buckingham, M., & Coffman, C. (1999). First break all the rules: What the world's greatest manager do differently. New York: Simon & Schuster.

Burke, R. J., & Greenglass, E. R. (1999). Work-family congruence and work-family concerns among nursing staff. Canadian Journal of Nursing Leadership, 12(2), 21-9.

Canadian Nursing Advisory Committee. (2002). Our health, our future: Creating quality workplaces for Canadian nurses. Ottawa, ON: Advisory Committee on Health Human Resources. Retrieved November, 2002, from Health Canada http://www.hc-sc.gc.ca/english/nursing/cnac

Clarke, H. F., Spence Laschinger, H., Giovannetti, P., Shamian, J., Thomson, D., & Tourangeau, A. (2001). Nursing shortages: Workplace environments are essential to the solution. Hospital Quarterly, 50-56.

Corey-Lisle, P., Cohen, M. Z., & Trinkoff, A. M. (1999). Healthcare reform: Its effects on nurses. Journal of Nursing Administration, 29(3), 30-37.

. Decter, M., & Villeneuve, M. (2001). Repairing and renewing nursing workplaces. Hospital Quarterly, 46-49.

Estabrooks, C. A., Tourangeau, A., Humphrey, C., Hesketh, K., Giovannetti, P., Clarke, H., Acorn, S., Wong, J., Thomson, D., & Shamian, J. (2002). Measuring the hospital practice environment: A Canadian context. Research in Nursing and Health, 25, 256-268.

Gaudine A. P. (2000). What do nurses mean by workload and work overload? Canadian Journal of Nursing Leadership. Online.

Health Canada. (2002). The survey 2001: Origins and characteristics of the workplace health needs and risks inventory 2001. Ottawa, ON: Workplace Health Bureau.

Karasek R., & Theorell T. (1990). Healthy work: Stress, productivity and the reconstruction of working life. New York, New York: Basic Books, Inc.

Koehoorn, M., Lowe, G. S., Rondeau, K. V., Schellenberg, G., & Wagar, T. H. (2002). Creating high-quality health care workplaces. Ottawa, ON: Canadian Policy Research Networks Inc. (CPRN). Retrieved October, 2002, from http://www.cprn.org

Kramer, M., & Hafner, L. P. (1989). Shared values: Impact of job satisfaction and perceived productivity. Nursing Research, 38(3), 172-177.

Kramer, M., & Schmalenberg, C. (1988a). Magnet hospitals: Part I - Institutions of excellence. Journal of Nursing Administration, 18(1), 1324.

Kramer, M., & Schmalenberg, C. (1988b). Magnet Hospitals: Part II - Institutions of excellence. Journal of Nursing Administration, 18(2), 11-18.

Lake, E. T. (2002). Development of the practice environment scale of the nursing work index. Research in Nursing and Health, 25, 176-188.

Laschinger, H. K. S., Finegan, J., Shamian, J., & Casier, S. (2000). Organizational trust and empowerment in restructured healthcare settings: Effects on staff nurse commitment. Journal of Nursing Administration, 30(9), 413-25.

McClure, M., Poulin, M., Sovie, M., & Wandelt, M. (1983). Magnet hospitals: Attraction and retention of professional nurses. Kansas City, MO: American Nurses Association.

McLennan M. (1999). You said," workplace wellness..." we listened. [Research Report]. Edmonton, AB, Canada: University of Alberta.

Morrison, P. (1996). Issues for clinical leaders in nursing development units. Nursing Times, 92(12), 36-9.

Morrison, R.S., Jones, L., & Fuller, B. (1997). The relation between leadership style and empowerment on job satisfaction of nurses. Journal of Nursing Administration,27(5), 27-34.

Pratt D. (2001). The healthy scorecard. Victoria, BC, Canada: Trafford Publishing.

Rucci, A. J., Kim, S.P., Quinn, R.T. (1998). The employee-customer-profit chain at sears. Harvard Business Review. January/February, 83-87.

Shain M. (1999). Satisfaction and health at work: Tuning for high performance. Occupational Health and Safety Canada. April/May, 38-47.

Shehadeh V., & Shain M. (1990). Influences on wellness in the workplace: Technical report. Ottawa, ON: Health and Welfare Canada.

Shindul-Rothschild, J., Berry, D., & Long-Middleton, E. (1996). Where have all the nurses gone? Final results of our patient care survey. American Journal of Nursing, 96(11), 24-39.

Siegrist J. (1996). Adverse health effects of high-effort low-reward conditions. Journal of Occupational Health Psychology,1, 27-41.

Sochalski, J. (2001). Quality of care, nurse staffing, and patient outcomes. Policy, Politics, & Nursing Practice, 2(1), 9-18.

Spence Laschinger, H. K., Sabiston, J. A., Finegan, J., & Shamian, J. (2001). Voices from the trenches: Nurses' experiences of hospital restructuring in ON. Canadian Journal of Nursing Leadership, 14(1), 6-13.

Spence Laschinger, H. K., Wong, C., McMahon, L., & Kaufman, C. (1999). Leader behaviour impact on staff nurse empowerment, job tensions, and work effectiveness. Journal of Nursing Administration, 29(5), 28-39.

Statistics Canada. (2002). Canada's labour force survey (2002). Ottawa, ON: Retrieved November, 2002, from htpp://statcan.ca/english

Table 3-1 Institution Enabling Factors and Work Indices

Enabling Factors	Actual		Importance		Discrepancy	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Use skills/knowledge	4.5	0.7	4.7	0.5	0.3	0.6
Clear role/responsibility	4.4	0.8	4.7	0.5	0.4	0.7
Quality service provision	4.3	0.7	4.9	0.3	0.7	0.7
Trust and respect	4.1	0.8	4.9	0.4	0.7	0.8
Resources to do job	3.8	1.0	4.7	0.6	1.0	1.0
Fair, respectful practices	3.7	0.9	4.7	0.5	1.1	0.8
Ongoing training	3.7	0.9	4.7	0.5	1.0	0.9
Raise workload concerns	3.7	1.3	4.7	0.5	1.1	1.2
Disagreement management	3.6	1.1	4.5	0.6	1.0	1.0
Readily ask for help	3.5	1.0	4.4	0.7	1.0	0.9
Management seeks input	3.2	1.1	4.3	0.6	1.2	1.1
Receive regular feedback	3.1	1.1	4.4	0.7	1.4	1.1
Management takes personal interest	3.1	1.3	4.2	0.9	1.2	1.1
*** Enabling Work Indices**	**48.7**		**59.8**		**11.2**	

* Each index is the sum of the 13 individual factors; maximum score in each case is 65. When a respondent left 1 or 2 items blank the mean score from the completed items was used to substitute a value for the missing item.

Table 3-2 Unit Indices and Stress Satisfaction Offset Score Results

UNIT	Actual			Importance		Discrepancy		SSOS	
	Mean	S.D.	Range	Mean	S.D.	Mean	S.D.	Mean	S.D.
A	46.4	5.4	39-57	58.6	6.2	12.2	4.4	-0.4	1.4
B	43.3	8.9	30-62	60.5	4.6	16.6	8.6	-0.3	1.2
C	55.3	7.1	47-65	58.1	4.5	4.4	4.3	1.2	0.8
D	55.0	5.0	48-65	61.9	3.6	6.9	3.6	1.4	0.8
E	50.9	10.2	33-60	58.8	5.5	7.9	9.5	0.6	0.7
Overall	**48.7**	**9.0**	**30-65**	**59.8**	**4.9**	**11.2**	**8.1**	**0.3**	**1.3**

Note: "Highest degree possible" enabling factors yield a 65 index score for Actual and Importance Indices.
Positive (1, 2) SSOS score indicates satisfaction offsets stress,
Negative (-1, -2) scores indicate stress offsets satisfaction.

Table 3-3 Results of Stepwise Regression Predicting SSOS and Priority Change Areas

Criterion Variable	Step	Variable	Multiple R square	F change	Beta	P
SSOS	1	Actual Index	0.262	19.145	.407	.002
	2	Unit D	0.325	4.940	-.272	.031
Priorities for Change						
• **Management**	1	Discrepancy Level	0.417	38.587	.646	.000
• **Workload**	1	Unit C	0.099	5.938	-.315	.018
• **Equipment/Space**	1	Unit E	0.077	4.496	-.277	.039
• **Professional Development**	1	SSOS	0.102	6.165	-.320	.016
• **Recognition**	1	Unit A	0.185	12.266	-.451	.000
	2	Education	0.246	4.286	-.248	.043

CHAPTER FOUR: IMPORTANCE OF SETTINGS IN IMPROVING NURSE WORK

Looming nursing shortages and residual effects from downsizing and reorganization activities in the 1990s have drawn attention to human resource issues in health care. Specific concerns include nurses' high absenteeism rate and growing recognition that health care workers are the most overworked, stressed and work/life-unbalanced-workers in Canada (Decter, & Villeneuve, 2001; Higgins & Duxbury, 2002; Lowe, 2002). Recent policy documents paint the situation as a crisis (Canadian Nursing Advisory, 2002; Lowe, 2002) with three root causes: insufficient numbers of nurses, inadequate operating funds, and poor work environments that are characterized by overwork, damaged relationships, loss of control, and minimal leadership. Over twenty years of research on nursing work environments, has produced a well-established consensus regarding the factors that relate to job satisfaction, stress, turnover, personal health, and more recently clinical outcomes. These studies emphasize the importance of visible, accessible and empowering front line leaders to organizational and individual outcomes. Yet, little is known about how social dynamics shape the issues and problem solving in nursing work environments. Viewing work as a setting where various actors interact based on the meanings that things have for them creates an opportunity to generate needed knowledge. This study contributes by exploring one work issue from a variety of perspectives to determine how various groups within a setting frame the problem and view actions that will bring about outcomes that are important to them. The chief aim of this research was to gain a better understanding of the workplace as a social setting, so as to suggest how nursing workplaces may be improved.

Setting

The investigation was conducted in 2003, within one Canadian health care organization in order to ensure that common policy and administrative structures and interactions framed the research. This decision was based on the assumption that work issues are defined and meaningful within their contexts and also that keys to making policy improvements are likely to be strongly related to local circumstances. This assumption is congruent with the Determinants of Worker Health model (Polanyi, Frank, Shannon, Sullivan, & Lavis, 2000). In this model the setting is conceptualized as the "knowledge and understanding of the workplace as a social organizational context," (173) that influences both the health and productivity of the target population (registered nurses), as well as conditions that enable or hamper improvement efforts. This assumption also fits with Decter and Villeneuve's (2001) advice that the most successful solutions to nurses'

work issues will be local in nature even though they are complicated and intertwined with broader system, societal, and global concerns.

The organization chosen for study had just over 150 registered nursing staff, deployed in inpatient and outpatient care areas with approximately 20% reporting to departments outside nursing. Structurally, nursing unit managers reported to a chief nurse who also had responsibility for other departments. A typical nurse in this institution was over the age of 45, employed in the organization over 10 years, worked full time, and was likely to have a specialty certificate or university degree. Historically, the institution had a reputation for excellent patient care quality and for being a good place to work. Due to the small size of the organization and stability of staff, nurses reported knowing each other and described their workplace as having a "friendly, small town atmosphere", which meant "loyalty" to some and "cliques" and "stagnant thinking" to others. Health reform and budget reductions to the organization had impacted nursing minimally over the last ten years with a sizeable reduction of inpatient beds achieved with no lay offs of nurses or managers. However, worries had arisen in the organization over additional bed closures, a potential take-over by another health region, and insufficient funding to meet escalating demands that had been fuelled by ongoing provincial health system changes and stresses.

Findings from a survey collected in an earlier phase of this research found that overall the group of nurses in this setting were slightly more satisfied than stressed, "somewhat happy" with the work setting characteristics measured, and the nurses were unified in their desire to see further improvements in all those dimensions (McLennan, 2004). Improving management was found to be the number one issue and served as the focal point of investigation for this second phase of study.

Methods

Data collection

The central question for participants was: How can front line nursing management be improved? This issue was explored in terms of problem areas, potential improvement strategies, barriers and enabling factors, and desired outcomes. Perspectives were gathered from three groups -- nurses, their managers, and union representatives -- as well as an interview with the chief nurse. Managerial focus group participants were chosen on the basis of their position. In the union focus group two executive members of the provincial union joined the local union representative to further clarify local experience and illuminate local circumstances. The nurses' focus group was composed of

volunteers solicited in the earlier survey supplemented by some invited participants to ensure that all work areas were represented. This was done because the earlier survey findings suggested that work environment opinions were partly related to work area membership (McLennan, 2004). All participants were chosen based on their interest and ability to be thoughtful, active group participants. Final selection of participants was based on key informant input or personal knowledge gained from having worked in the organization. This purposive sampling has been acknowledged as critical to collecting rich qualitative data (Patton, 1990) and encouraging differing viewpoints to be present in the conversation.

Data analysis

All interviews were audio taped – and, in the case of focus groups, key points were also noted on a flip chart to encourage group checks on understandings, agreements and differences. Transcribed audiotapes were combed for categories, themes, and patterns. Further review of the data was made to assess what was missing or had been left out, to make linkages and connections, and to develop support for the description and comparison of perspectives. This content analysis was then set aside and another review conducted to discover what was underlying the discussion. Paying particular attention to feelings, the original audiotapes were played again to note tone, inflections of speech, choice of words, and repetitions by the speaker or by other group members. This was supplemented with a record of nonverbal responses collected by the research assistant, who recorded group member and speaker behaviors. Asking, "What is important to people, what underlies this view?" allowed various perspectives to be blended into a reconstruction of the problem.

Having worked in the setting and knowing some participants allowed data to be considered in the larger context of my experience, but also represented a potential interpretive bias. An audit trail of notations that captured my thoughts, ideas, and discussions with others allowed reflection on ethical and bias dilemmas. Devers (1999) advised that bias could be minimized by always being mindful of how your personal characteristics and role in the research setting may possibly affect research findings. Discussion, review and scrutiny from three other seasoned researchers added to the trustworthiness of the interpretations.

Findings

Participants across all the groups had similar perspectives regarding the changes in management that were needed and desired. However, there were differences in

suggested improvement strategies because views on underlying causes varied. The findings in each of these areas are highlighted next and then synthesized in a framework designed to foster future discussion and policy formulation.

Problem dimensions

Problems in nursing management were found to cluster into several interrelated themes: role clarity, fostering clinical excellence, giving strategic direction, collaborative relationships, communication, decision-making, and managing change.

Role clarity

It was agreed that a lack of clarity surrounded the manager role. In part, this lack of clarity was related to the differing responsibilities assigned to the various manager positions, which ranged from a "working supervisor with a hand full of staff" to " one with a hundred nurses and twenty-four hour responsibility." Second, expectations for managers were not explicit or necessarily shared among the players. For example, nurses pointed out that staffs' expectations for managers range from interdisciplinary diplomat to clinical expert. Third, the union suggested that there was nonmanagerial work mixed into the manager role, which should be reassigned to free up time for other priorities. Yet nurses reported little willingness from managers to delegate responsibility or allow staff to do things to take pressure off the manager. For the chief nurse clarifying manager's roles was not just rewriting the job description, but also included ensuring partnership behaviours with staff were implemented. Study participants agreed that front line staff do not fully appreciate or understand the managerial role. Participants acknowledged - being a nurse manager is a challenging job, but advocated a different leadership approach was needed.

Fostering clinical excellence

Fostering clinical excellence by supporting staff learning and development was another theme in the discussions of the managerial role. How best to do this was contentious even within groups. Some managers and nurses felt nurses who were given protected time could foster clinical learning and would feel rewarded by being involved in best practice and clinical education initiatives; others felt only dedicated roles could accomplish this. Nurses who advocated for incorporating clinical education and research expertise into nursing practice roles, suggested managers were reluctant to delegate this work to staff. Embedding the expectation solely within the manager role was no longer feasible in the opinion of the chief nurse because spans of control had increased, specialty knowledge and skills have short half-lives, and the complexity of administrative

operations had grown. Thus, there was agreement among study participants that dedicated time to foster clinical excellence outside the nursing manager role was needed either delegated to selected nurses with assigned time or developed into a special role.

Strategic direction

Another important aspect of the manager's role raised in all the focus groups was the need to provide staff with a sense of strategic direction and focus. Nurses "need to have a sense of direction, to know where we are going as an institution. It feels like we are always reactive without a plan." Nurses said they could "contribute more and be innovative" if there were opportunities to talk about ideas and make links to the strategic direction. They also noted it was difficult to speak only about the nursing work area because changes in the broader organization impacted their views -- for example, physician and senior leadership changes and health reform uncertainties.

Collaborative relationships

Another theme was the need to develop a new way for managers and nurses to work together. This was being modeled in some areas of the institution and those nurses who were familiar with this suggested it had allowed their work area to cope successfully with large workloads. In other areas, a norm of griping and gossiping had negatively influenced not only the manager/staff relationships but also those among nurses and other multidisciplinary team members. Examples of misunderstandings and symptoms of relationship problems included: a manager asking about a staff member's health was labelled "harassment"; a nurse asking for flexibility of vacation time during a family health crisis was refused (resulted in sick time); staff received mixed messages when they were told new beds were opening soon when beds had been closed on the weekend because of a lack of staff; and other department leaders were reported to have been allowed to stop a nursing initiative. Part of the concern seemed to relate to diminished trust and mutual respect, with an underlying concern about fairness, as demonstrated by the following union comments: "Nurses are the most trusted occupation by the public yet they are not treated that way at work." "It's bizarre that you're making life and death decisions every day, you're a highly skilled professional, highly educated -- and you don't know when you're sick, when you shouldn't be at work?" "We make [critical health] assessments at work and yet [we] are questioned about whether our family is really that sick and require our attention."

The way managers and nurses work together is evidenced through a number of key processes and those that were identified as problematic are described next.

Communication

As might be expected communication was key among the concerns and included aspects such as feeling on the periphery -- not in the know, being afraid to raise concerns or new ideas, and not feeling valued as an individual. Nurses said, "Tell us what you're doing so we can work at it [brace self, work with others on solutions]"; "[It is difficult to] raise new ideas or be critical"; and "Our concerns need to be heard, listened to, and acted upon". A union group member said, "Communication needs to be ongoing. If staff can't raise issues, rumours get started." "There is a need for managers to get to know who staff are as people, to have a 'personal' relationship." Managers' chief concern was not having information or not knowing how to share it with staff. The chief nurse felt that informal interchanges with nurses were needed to bridge gaps between work areas, to respond to staff concerns and questions, and to provide organizational updates.

A special type of communication discussed by nurses and managers was performance feedback. There was agreement that this was an area that did not receive enough attention and was contentious. Nurses were not receiving enough spontaneous feedback nor were they receiving regular performance appraisals. The union was supportive of performance appraisals done by management but did not agree with peer input into evaluations as it - "puts staff in an unfair position". Managers reported little time or opportunity to make clinical observations of nurses and yet older staff had been resistant to self-appraisal, and the union's resistance to peer involvement was well known.

Decision-making

All participants raised decision-making as another key process requiring attention, but individuals varied in the degree of change envisioned. A missing element was a feedback loop after involvement for outlining the rationale for the decision taken. Sometimes nurses doubted their input was used in making decisions and they felt new ideas got lost. Part of the problem, as nurses expressed it, was that managers did not always know when to ask for other opinions and when to just get on with things. Nurses described budget considerations and "bottom line" thinking as overriding other considerations in decisions made by managers. They identified assessing impacts and identifying implications for areas, as well as generating alternative solutions as fruitful areas for nurses' involvement. The union described many decisions as "reactive," made to manage short-term budget goals and not addressing longer-term implications. On the other hand, managers talked about making joint decisions with their staff, but felt group decisions were not always honoured, as some nurses disregarded them and continued to

act autonomously. They said that staff frequently "consider only the personal impact, not the bigger picture" and "belly ache, expecting the boss to solve." They also said that nurses frequently "don't want to consider new realities - like budget." The chief nurse articulated a vision wherein nurses would be key participants in deciding how care would be delivered. This would enact an important dimension of their professional practice. Traditionally, practice decisions across settings have been in the sole domain of the manager. The new vision would see the manager as supporter of a group of nurses who would together decide how best to manage circumstances to achieve the best care possible.

Managing change

Managing change was another key process identified by most participants as difficult due to change fatigue and resistance to new ideas. One nurse suggested, "We need a month where everything stays the same, so you can catch your breath, and then we'll go on." Managers reported that long-term staff especially wanted guarantees of success before making a change, while younger nurses, particularly those who had worked elsewhere, were more open to changes. Staff and managers identified studying an issue and piloting a solution as approaches, which had been successful in the past -- particularly so when coupled with staff-generated modifications based on their experience and feedback. Some managers reported making a conscious effort to create a working environment of learning from change experiences.

Desired results/outcomes

There was agreement among participants regarding the short-term results and longer-term outcomes that could be achieved from managerial changes. Tangible results were seen to be interactive with one another. For example, clearer role expectations would help to establish priorities, which would assist in workload management, and the process of clarifying expectations was seen to foster more open back and forth communication between managers and nurses. Opening communication up, down, and across organizational areas was seen as a way to improve connectedness, promote innovation, and assist in making better decisions. Allowing nurses to solve issues and supporting them in decision-making, was seen to add to their professional development – and, in turn result in increased confidence and ability to influence care. Working within a strategic plan especially during times of uncertainty, would provide a framework for understanding ones' own contributions and a focus for thinking about the future. Participants suggested an improved managerial approach would lead to personal outcomes such as feeling valued, increased work satisfaction, and better opportunities to

grow and contribute. The organization would also benefit from managerial changes by realizing improved patient care, increased innovation, better use of nursing skills, enhanced ability to attract and retain nurses, and improved morale.

Barriers

Barriers to management improvement were found to be of three types: resources, multiple priorities, and attitudes. Nurses and the union voiced the issue of resource constraints most strongly because they believed additional managers and supports for managers such as administrative assistants and education programs were necessary. Nurses' heavy workloads and the need for more relief were also described as compounding the front line manager issue. The participants also mentioned competing priorities, citing various legislative changes impacting operations, care innovations, and staffing shortages as examples of issues, that distracted managers from doing things differently with their staff. Although managers acknowledged resources and multiple priorities as issues, they framed the barrier for them as time and therefore, saw making changes as "small successes, baby steps." They also connected the nurses' workload problems to their own, because working managers felt pressured to relieve overburdened staff by sacrificing their managerial time to meet clinical staffing needs. When doing that, they often felt their managerial role was not valued or understood by staff.

All groups raised attitudes as a major hurdle. Everyone referred to "ingrained practices." Depending on the speaker's perspective these were attributed to nurses or managers, sometimes both. Nurses and the union felt some managers might prefer meetings and budget tasks to what they were proposing - a more involving style with staff. The chief nurse pointed out that the attitude barriers extended beyond nursing to the broader organization, because some of the attitudes in nursing that needed changing were reflections of the broader organization. Therefore, making changes in nursing behaviours and attitudes would be counter-cultural to the broader organization.

Enablers

It was easier for the groups to pick out barriers than facilitating factors. Existing strengths included having nurses, who understand nursing work and patient care demands, fill leadership roles. Also identified was the on site shift supervisors who support nurses around the clock. However, the most prominent enabling factor was, "we share a common goal: excellent care" and "[we all] have a strong commitment to the organization and mission." As well informal leaders and enthusiastic young people were seen to "cheer others" and "bring energy." A union group member suggested that, "Nurses are

resilient and any sign of improvement, even if it's little, will help a lot;" and "they will be encouraged by any positive change."

Causes and solutions to the management issue

Most participants identified the same range of causal factors for the problem: overload, unclear role expectations, isolation, multiple leadership changes, culture, and lack of knowledge. Differences related to perceptions of root cause or the relative importance of the factor. The chief nurse described organizational history and culture as the major factor shaping the leadership issue. Many of the managers and their staff had spent entire careers of twenty to thirty years together at work in a hierarchical bureaucracy. The ways leaders and staff interacted were embedded in years of common history and cultural understanding. However, participants in this study identified the need to change, although staff and chief nurse identified this more strongly than front line managers.

Workload and role clarity were linked as another causal theme shared among all groups. The nurse and union groups described managers as having "undoable jobs" and "unmanageable workloads" with no increase in the number of manager positions, even though staff numbers and patient loads had doubled in some areas. For managers the key underlying cause was not knowing what staff expected because they were previously unaware of the management problem, had not discussed it with staff, and wondered if nurses' expectations were realistic.

Across all the groups a theme of isolation dominated as a key cause in the management issue. Nurses described work group isolation. They believed they never got the "big picture" with little subcultures isolated from each other; some felt disadvantaged, "country cousins," to the others. Managers described role isolation feeling like the "sandwich filling" squeezed from those above and those below. The union echoed both views, adding - "nurses are tight among themselves in their work area, sometimes drawing a line between themselves and management." The chief nurse reported – that "separateness" created difficulty in working across work areas and noted the challenge new people and new ideas have in breaking into the tight sub-systems. Obviously, multiple causes are interwoven in the management issue and differing root cause perspectives add to the complexity of making and achieving improvements.

Multiple strategies for amelioration were suggested reflecting the range of opinions on causation. Further analysis indicated that the two dominant causes -- work overload and isolation -- were linked with the two predominate strategies. First, clarify the manager

role so that reasonable expectations can be identified and a clear focus for success set. Second, establish a new partnership between nurses and their managers in order to change everyday interactions that will lead to better work processes and experiences.

Discussion

Findings will now be considered first - in how they relate to nursing leadership knowledge, second - how they may inform organizational policy formulation, and third- paradoxes and conditions found in the workplace. Overall, the study findings suggested there was a tangled web of understandings that interact to maintain things as they are within the setting. Yet, the commonalities that surfaced may serve as a catalyst and unifying force to move forward on the shared issue of improving management.

Leadership needs and strategies

The findings regarding the nature of the problems with nursing management were congruent with contemporary research that differentiates between managing things and leading people (Covey, 1989). Leading people requires a release of power to provide guidance that will assist the nurse in being successful. Substantial research on nursing work environments has utilized Kanter's (1977, 1993) model of work empowerment, which identifies 3 structural organizational factors (1) opportunity – access to challenge, growth and development, (2) power – access to resources, information and support, and (3) social composition – isolation. In the setting studied all three were found to need improvement.

Laurent (2000) proposed a "leader-follower relationship" model based on Orlando's nursing theories (1961, 1972) regarding the "dynamic nurse-patient relationship". Conceptually Laurent's model shifts the nurse manager's role from director and controller to facilitator and guide in partnership with the employee in the same way that Orlando transferred control of the patient's care to the patient. The staff/manager partnership strategy recommended by the nurses in this setting fits with Laurent's model and with other research that found leaders' empowering behaviours influenced positively employees' perceptions of workplace empowerment, job tensions, and work effectiveness (Spence Lashinger, Wong, McMahon, & Kaufman, 1999; Morrison, Jones, & Fuller, 1997). However, leadership styles tend to match organizational designs (Paware & Eastman, 1997) and in hierarchical, bureaucratic healthcare organizations, the natural tendency is toward transactional leadership. This style focuses on directed tasks and decision-making by upper management, resulting in staff disempowerment and reduced creativity. Thyer (2003) contended that transformational leadership -- through

vision, team development, and involving communication -- ideologically fits better with the transforming nature of professional nursing practice. The chief nurse highlighted the challenge and potential tensions between the extant culture and the new management approaches desired by nurses. Dixon (1998) argued that to deal with staff and senior management effectively, both transactional and transformational leadership are essential. Work settings will need to balance these requirements through manager role statements and clear expectations that satisfy their unique contexts.

Several recent studies on Canadian work environments highlight the critical nature of relationships at work. In this study concern was raised about implementing constant change. Relationships play a large part in shaping how managers and staff interact in change processes (Reay & Golden-Biddle, 2003). They found that middle managers successfully implement healthcare changes through the following organizing practices: building high quality connections that foster openness and creativity, fortifying expertise and the development of others, facilitating agentic (front line workers) involvement in the change process, negotiating the boundaries of change (timing and cultural meanings) with senior management and maintaining identity throughout. From my research the ability to work together rests on the relationship building blocks of trust, fairness and purpose (linking to strategic plans). My findings mesh with core components of Shain's model (Health Canada, 2000) around which working conditions influence stress (thereby health) and work satisfaction. They also link to other research findings where employment relationships were found to be important to individual and organizational outcomes (Lowe & Schellenberg, 2001). Koehoorn, Lowe, Rondeau, Schellenberg, and Wagar (2002) singled out trust between managers, employees, and unions as the most important factor in making successful work redesigns. My study sought out perspectives from these key stakeholders to develop problem understandings that could lead to collaborative policy formulations designed to improve management in this work environment.

Policy formulation

Defining policy issues in ways that achieve positive results is challenging because they are entangled with other problems, causal forces may be complex and difficult to address, and links to other issues influence solutions available (Pal, 2001). Jonathan Lomas's (2000) model for understanding the context of decision-making illustrates three interrelating domains that influence policymaking: institutional structure for decision-making, values, and information. According to Loma's framework there is an opportunity for research to influence policy decisions by providing information about the causal

assumptions that relate to how changes address problems. This study generated information from stakeholders such as nurses and union representatives who frequently are silent or relegated to a secondary role in policy decisions. Further analysis and blending of perspectives permitted reconstruction of the problem and solutions into a contextually specific framework. Understanding the setting in this way by integrating key players' perspectives, lays the foundation for a change process that makes sense to local actors and considers local circumstances. In another setting, participants exploring the same problem might frame the issue quite differently, focus on the same or differing elements, and might work toward other strategies -- such as education or structural change – even while desiring outcomes similar to those in this study.

By paying attention to the process of decision making rather than merely providing technical advice - "policy researchers who work with policy makers and their staffs over time to create a *contextual* [emphasis added] understanding about an issue and build linkages that will exist over time...," positions them to serve an enlightenment function (Rist, 2000, p.1003). Both nurses and managers in this study suggested that the focus group conversations gave them a unique opportunity to reflect and share perspectives on how nursing management could be improved. In a similar vein, Webber (1993) has asserted that in our changing world conversation is essential to allow knowledge workers like nurses and their managers to share ideas and refine thinking.

Paradoxes/conditions in the setting

A number of paradoxes in this context pointed out how strengths can be both barriers and facilitators in making changes. For example, the small staff size created familiarity and stability that made it difficult for new people and new ideas to be fully considered and embraced. As well, a tradition of autonomy and excellence fostered feelings of separation and being outside changing circumstances such as resource scarcity. This made it difficult to creatively manage the new realities and could lead to mediocrity or organizational demise in the future.

Images and descriptions portrayed conditions within the study setting. Feelings like "family" in the organization can lead to problems and issues being delegated to the manager - "parent", thereby unfairly burdening them with solving issues and leaving nurses feeling like "children" who have no power or resources to effect needed changes. Both nurses and managers used the images of battle and survival. The chief nurse described both groups as often "making heroic recoveries" to ensure that excellent care was maintained. Such descriptions of the workplace - "The drowning" manager in a

"mash unit" at the "edge of chaos" do not fit with the images of a "small town family". These contrasting thoughts possibly reflect the fact that participants hold two conflicting views concurrently. If this is true, then the importance of influence and collective meaning-making activities becomes prominent. Osborn, Hunt, and Jauch (2002) describe leadership as more than "the incremental influence of a boss toward subordinates, but most important it is the collective incremental influence of leaders (and followers) in and around the system" (p. 798). In this study the union suggested that nurses understood - "Hard decisions have to be made but [they're] easier to take when management is seen and trusted." Likely part of this trust and the ability to influence opinions lies in the attribution of intent, which can be classified as the use of power for personal gain or to facilitate group goals -- "social power" (McClelland, 1975). For example, if the leader is believed to be benefiting personally through his/her actions instead of acting in the best interests of patients, staff, and the organization, it will be difficult for them to influence others and gain their trust. In contrast, leaders who are understood to be promoting the goals of the organization and the best interests of constituents will be able to mobilize social power to influence those with contrasting thoughts. Alternatively, another explanation for contrasting images in this setting may simply be that major players were frustrated and chose language that placed urgency on their issues.

Implications for practice environments

Previous research has clarified what needs to change in nursing work environments, but it has been less clear about how to achieve those changes, in part due to a lack of information on how the "knowing nurse" and the "knowing manager" understand their issues. For example one manager in the study suggested - "It doesn't sound right, but without the staff being first then patients won't get the care. I have to have my staff happy, educated, and comfortable." However, changes on both sides of the relationship will be required. Nurses need to be accountable for being informed and involved in not only making decisions that impact their work but in enacting those changes that make the whole work area function better. Managers need more "face time" with staff to turn attention to collecting and understanding varying perspectives, and then determining how best to support nurses' work in the organization. This would also allow the manager to refocus on the uniqueness of each nurse as a person with a life and roles beyond the workplace. These examples illuminate the active human nature involved in interactions and the mutuality of influence that spins a work environment toward improvement or dysfunction. One nurse described a potential cycle of "betterment" where choices made by individuals and groups improve the working environment, which feeds into additional

positive decisions that, in turn, lead to an even better place to work. The idea of cycles in change is not new; however, here the speaker was referring to a self reinforcing system whereby well intentioned actions are perceived well and reinforced, thereby encouraging further positive actions. This thinking suggests workplaces are not only systems with feedback loops, but more importantly that players are active in observing and judging events and that they tend to align their own and collective actions.

Implications for research

Health work settings have been recognized as complex, sometimes chaotic, and under tremendous pressure to transform in order to remain sustainable as health care reform proceeds. Applying a fundamental principle of complexity theory to organizations, -- that order naturally emerges in open systems through self-organization, -- has profound implications for management (Lewin, 1999). If structures, processes, and self-adjustments occur in response to external or internal challenges, then the role of managers becomes one of guiding, influencing through rewards and incentives, and setting the boundaries for change (Anderson, 1999; Lewin, 1999). Bottom-up processes, empowerment strategies, and mutual shaping of change are congruent in this approach to reframing organizational life (Lewin, 1999). These ideas open new frontiers for research into complex organizations like health care institutions where dynamics inside and outside the organization drive constant change and co-evolution. New theoretical models and measurement tools that capture the dynamics of interaction, changing interpretations over time, and non-linear relationships between actions and outcomes are needed.

Implications for education

The emerging understanding that leadership in nursing is embedded in context and not amenable to simple action-result thinking has profound implications for existing leadership preparation programs and prevalent practices. Both leaders and nurses will need information that assists them to work together in less certain environments that they co-own. Organizational leaders can play a central role in building knowledge by being "conveners and connecters" of both people and ideas" and fostering shared meaning (Brown & Isaacs, 1996, p.4). The strategy of creating time and opportunities for learning conversations is worthy of consideration, especially in light of an escalating demand for nursing knowledge generation, diffusion and application.

Conclusion

Nursing workplaces are complex social entities where local circumstances and perceptions are critical to meaningful work environment improvements. Understanding work issues within their unique settings allow problems and solutions to be framed to fit both the actors in the setting and the multiple levels of context that exist. Behavioural expectations for managers should emphasize that fundamental relationship building is needed to foster a more involved and engaged nursing work force. Incremental changes made in collaboration with the key players in the setting, can diminish perceived barriers and enable nurses and their managers to create the environments where they and their patients will flourish.

References

Anderson, P. (1999). Complexity theory and organization science. Organization Science, 10(3), 216-232.

Brown, J., & Isaacs, D. (1996). Conversation as a core business process. The Systems Thinker. 7(10), 1-6.

Canadian Nursing Advisory Committee. (2002). Our health, our future: Creating quality workplaces for Canadian nurses. Advisory Committee on Health Human Resources. Ottawa, ON. Retrieved November, 2002, from Health Canada http://www.hc-sc.gc.ca/english/nursing/cnac.htm

Covey, S. R. (1989). The seven habits of highly effective people: Powerful lessons in personal change. New York: Simon and Schuster.

Decter, M. & Villeneuve, M. (2001). Repairing and renewing nursing workplaces. Hospital Quarterly, Fall, 46-49.

Devers, K.J. (1999). How will we know "good " qualitative research when we see it? Beginning the dialogue in health services research. Health Services, 34(5), 1153-1188.

Dixon, D.L. (1998). The balanced CEO: A transformational leader and capable managers. Healthcare Forum Journal.43(2), 26-29.

Health Canada. (2000). Best advice on stress risk management in the workplace. (Cat. No. H39-546/2000E, ISBN 0-662-29236-7). Ottawa, ON: Minister of Public Works and Government Services.

Higgins, C. & Duxbury, L., (2002). The 2001 national work-life conflict study: Report one. (Report No. ISBN: 0-662-32404-8). Ottawa, ON: Health Canada, Retrieved December, 2002, from htpp://www.hc-sc.gc.ca/ppphb-dgspsp/publicat/work-travail/index.html

Kanter, R.M. (1977). Men and women of the corporation. New York: Basic Books.

Kanter, R.M. (1993). Men and women of the corporation. (Second Edition) New York: Basic Books.

Koehoorn, M., Lowe, G.S., Rondeau, K.V., Schellenberg, G., & Wagar, T.H. (2002) Creating high quality health care workplaces. Ottawa, ON: Canadian Policy Research Networks Inc. (CPRN). Retrieved October, 2002, from http://www.cprn.org

Laurent, C. L. (2000). A nursing theory for nursing leadership. Journal of Nursing Management, 8, 83-87.

Lewin, A. Y. (1999). Application of complexity theory to organization science. Organization Science, 10(3), 215.

Lomas, J. (2000). Connecting research and policy. Isuma 1(1), 140-144.

Lowe, G. S. (2002). High-quality healthcare workplaces: A vision and action plan. Hospital Quarterly, Summer, 49-56.

Lowe, G.S., & Schellenberg, G. (2001). What's a good job? The importance of employment relationships. (Report No. ISBN 1-896703-53-4). Ottawa, ON: Renouf Publishing Co. Ltd. CPRN Study No.W/05.

McClelland, D.E. (1975). Power: The inner experience. New York: Irvington.

McLennan, M. (2004). Ready and able: Nurses' views on work enabling factors. Manuscript in preparation.

Morrison, R.S., Jones, L., & Fuller, B. (1997). The relation between leadership style and empowerment on job satisfaction of nurses. Journal of Nursing Administration,27 (5), 27-34.

Orlando, I. J. (1961). The dynamic nurse-patient relationship. New York: Putnam's Sons.

Orlando, I. J. (1972). The discipline and teaching of nursing process. New York: Putnam's Sons.

Osborn, R. N., Hunt, J. G., & Jauch, L. R. (2002). Toward a contextual theory of leadership. The Leadership Quarterly, 13, 797-837.

Pal, L. A. (2001). Beyond policy analysis: Public issue management in turbulent times, (2nd ed.). Toronto: Nelson Canada.

Paware, B.S., Eastman, K.K. (1997). The nature and implications of contextual influences on transformational leadership: A conceptual examination. Academy of Management Review. 22(1), 80-109.

Patton, M. (1990). Qualitative methods in research and evaluation. Newbury Park, California: Sage.

Polanyi, M.F.D., Frank, J.W., Shannon, H.S., Sullivan, T.J., & Lavis, J.N. (2000). Promoting the determinants of good health in the workplace. In B. D. Poland, L. W. Green, & I. Rootman (Eds.), Settings for health promotion: Linking theory and practice. Thousand Oaks, Ca.: Sage Publications Inc. (pp. 138-175).

Reay, T., & Golden-Biddle, K. (2003). Organizational change in health care. Presentation at the meeting of the Canadian College of Health Service Executives, Edmonton, AB, Canada.

Rist, R. C. (2000). Influencing the policy process with qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), Handbook of qualitative research (second edition, pp. 1001-1017). Thousand Oaks, CA: Sage Publishing Co.

Spence Laschinger, H.K., Wong, C., McMahon, L., & Kaufman, C. (1999). Leader behaviour impact on staff nurse empowerment, job tensions, and work effectiveness. Journal of Nursing Administration, 29(5), 28-39.

Thyer, G. L. (2003). Dare to be different: Transformational leadership may hold the key to reducing the nursing shortage. Journal of Nursing Management, 11, 73-79.

Webber, A. (1993) What's so new about the new economy? Harvard Business Review. January-February, 24-42.

CHAPTER FIVE: CONCLUSION

This dissertation examined how nursing work environments could be improved. Each paper has described the study's findings in light of previous research and drawn implications from the insights gained. In this final chapter, key points from each paper are highlighted in order to generate overall implications for practice, education, and research; then reflections on the research process are shared, which lead to additional recommendations for future researchers.

Paper one: Improving nurses' work through focus group research

The first paper, "Improving Nurses' Work Through Focus Group Research," deals with findings pertaining to the following research questions:

- What is known from the literature on nursing work environments?
- What gaps in information need to be filled in order to improve nursing work?
- How can the missing information be best acquired?

Constant change and high degrees of uncertainty characterize contemporary health care settings. Nursing work environments are known to be troubled with large numbers of nurses absent due to illness and experiencing low job satisfaction and diminished morale. Workplace improvements are needed not only for nurses themselves, but for patients who need quality healing environments as well.

Previous research has established a number of things. First, personal, job, and organizational factors have been identified that influence nurse's work attitudes such as satisfaction, stress, and commitment. Further, nurses' attitudes have also been examined as they relate to personal outcomes such as burnout and job satisfaction, and organizational outcomes such as turnover, patient satisfaction, and mortality. Second, the research shows that stressful jobs combine high effort/low reward and high demand/low control with little support from supervisors and co-workers. Third, research has consistently found that workers' health relates to job design, work control, and related rewards, as well as family, friendly management practices, organizational change, and job security (Koehoorn, Lowe, Rondeau, Schellenberg, & Wagar, 2002).

A convergent of research findings has established what needs to be fostered within work environments; however, how to accomplish these improvements is less clear. Moreover,

the literature often reflects bureaucratic management thinking that positions people as an element of the "system" and not as an integral active part of the improvement process.

My review of the literature on nursing work environments identified a major gap in information: Very little is known about "knowing nurses" and "knowing managers" whose experience in interpreting work interactions and events are critical to improving nurses' work. Also missing are collective interpretations that help us understand the social dynamics that shape interactions and nursing work experiences. Little research is available regarding values and meanings and, when available, reflects individual rather than group oriented findings. Therefore, focus groups were proposed as a method to collect information needed for improving nurses' work. Viewing work as a setting where various players interact based on their own and others' interpretations of events and alternatives available to them was viewed as an opportunity to gain new insights. These additional understandings are necessary if we are to reverse current trends and accomplish needed changes that will sustain our health care delivery system and the nurses' who work in it.

Paper two: Nurses' views on enabling factors at work

The second paper, "Nurses' Views On Enabling Factors At Work," deals with findings related to the following research questions:

- How do nurses rate enabling characteristics in their current work environments, the importance of these characteristics to them, and their levels of stress and satisfaction?
- What work issues do nurses identify as priorities for improvement in their work setting?
- How do nurses' personal characteristics, work environment ratings, stress levels, and top priorities for improvement relate to each other?

My survey results indicated that enabling factors, colleagues, reputation of the organization, and involvement in quality patient care contributed to nurses feeling enabled at work and added to their work satisfaction, confirming previous research (e.g. Kramer & Schmalenberg 1988a; Kramer & Schmalenberg 1988b; Koehoorn, Lowe, Rondeau, Schellenberg, & Wagar, 2002; & McClure, 1983). Ninety-two percent of nurses rated their unit's quality of care highly. This varied remarkably from other studies, for example Aiken et al.'s (2001) international study found that 33% or less nurses (on a country level) reported excellent nursing care. I have suggested that the strong enabling conditions reported (having a clear nursing role that used the nurses' skills and good

levels of trust and respect, and reasonable resources to do the job) may have contributed to my finding.

Over three quarters of the nurses reported being balanced or more satisfied than stressed. However, none of my survey variables predicted stress. This might be because mediating factors such as social relationships and other sources of stress outside work were not examined.

My findings regarding the most prevalent concern, workload, and the top change priority, improved management, confirmed other recent study findings about issues that confront contemporary nurses (e.g. Baumann, et al., 2001; Canadian Nursing, 2002). In the workplace I studied, characteristics relating to the manager/staff relationship were rated the lowest. Furthermore, nurses experiencing the most dissonance in their work environment tended to identify management improvement as a priority. These findings are congruent with research that points to the critical role of front line leaders in work environments (Blegen, 1993; Irvine & Evans, 1992; & Thomson, Dunleavy & Bruce, 2002). Further exploration of the issue of front line nursing leadership and how it might be fostered was recommended.

The findings in this study are limited because of small sample size, one site focus and the voluntary bias of surveys. The study does contribute to a growing knowledge base that places importance on nursing leaders knowing what their nurses think about their workplaces. As well it provides important contextual information for the next phase of my research.

Paper three: The importance of settings in improving work environments

In the third paper, "The Importance of Settings In Improving Work Environments," I explored the central research question:

- "How can front line nursing management be improved?"

I used a qualitative lens to identify key players' perspectives, so as to illuminate the *social dynamics* that shaped the management issue and proposed solutions. Focus groups (drawn from a purposive sample of nurses from across the organization, nurse managers from all areas and union representatives) as well as an interview with the chief nurse were conducted. Content analysis was used to develop understandings of the management problem, potential strategies, and desired results.

Perspectives on the dimensions of the management problem and desired outcomes were similar across all the groups, although differences in improvement strategies were found. Further analysis and blending of the perspectives permitted reconstruction of the problem into a framework of local understandings. The framework describes the dimensions of the problem, underlying causes, viable actions (considering the perceived barriers and facilitators), and expected results. This interpretation based on multiple perspectives lays the basis for future discussion and action. The degree of similarity in the perspectives that I found was not expected, and comparable studies examining all levels of nursing in the organization and union perspectives were not found. However, findings have been mixed in studies that have compared nursing staff and management perspectives on various issues. For example, Martinus, Royle-Cummings, Baumann, Oolup, Smith, and Blythe (1995) found similar perspectives regarding nursing roles during change; but others have found significant differences in areas such as performance appraisals (McLennan, 1983).

Understanding how work issues relate to their unique settings allows problems and solutions to be framed that better fit both the actors and local circumstances. Social dynamics influence understandings and therefore can play a key role in improving nursing workplaces. Clear expectations for managers that emphasize leadership and manager/nurse relationship building are needed to foster a more involved, engaged nursing work force. Additional qualitative studies are needed to further examine my study's findings and to better understand the social dynamics and key player perspectives that interact in nursing work settings.

Implications for leadership practice

Treating and assessing enabling factors in nursing work settings as leading indicators for individual and organizational health and performance can provide valuable feedback. Previous research has shown these enabling conditions influence individual and organizational outcomes, and that they can act as either facilitators or barriers to people being resilient and able to accomplish needed changes. The meaning of survey findings in a particular setting will best be understood in local conversations where issues can be framed and solutions developed that make sense to the specific players and situation. Notions of "buy in" and involvement become richer when understood as shaping processes. In doing so there is room to reach new understandings and mutually influence the future. Partnering relationships between managers and nurses lead to co-ownership of work environments and the changes that occur in them. Time and opportunities for learning conversations need to be created. The resulting dialogue can

provide a fuller understanding than any one person can bring to an issue, reinforces connectedness, allows free exchange of ideas, and provides opportunities to learn and grow as people who are engaged in the practice of nursing. Actions such as these foster positive social dynamics that enrich work settings.

This investigation provided an opportunity for nurses, their managers, and the union to participate in framing an organizational policy problem. The study findings suggest that both managers and nurses need to adjust behaviours if a new partnership is to be established. The magnitude of the needed adjustment was illustrated in an exchange with the audience where the preliminary results of the study were shared. One of the managers commented that survey results can be difficult for administrators to interpret and act upon, and "that's why people can expect to see delays in follow-up actions". This comment was in keeping with the norm in this particular setting, where administrators decided what survey results meant and what actions were to be taken. I responded that involving staff from a variety of levels in the organization might improve that process and result in actions that would be better aligned to achieve meaningful results across the organization.

Keeping in mind Lomas's model (2000), which describes contextual influences on organizational decision-making processes, my findings suggest that those who are frequently silent (nurses, midmanagers and union representatives) can add to interpretative understandings that influence beliefs about causal relationships between problems and solutions, and, therefore, policy decisions. The social dynamics illustrated in this study suggest that the benefits of their involvement is likely to be related to the perception of genuine opportunities to influence and shape the future. My study highlights the active role of people in observing, judging, and aligning their own and collective work actions, and thereby influencing the course of change.

The key implication for leaders is a reorientation of nurses and managers as joint owners of the workplace. This fundamentally alters the manager/nurse relationship by valuing the different contributions each brings as active participants in a constantly changing landscape.

Implications for leadership education

If leadership is embedded in context and not amenable to simple linear action-result thinking, then how we cultivate leadership and educate leaders must change. Preparing leaders to manage in less certain environments that are co-owned requires new

knowledge, skills, and attitudes. It means that the role of manager becomes one of coaching, influencing, and setting the boundaries for change. Reframing leader-follower relationships in this way leads to mutual shaping of changes, empowerment strategies, and encourages bottom-up processes. How a contemporary leadership expectation translates into different learning needs can be illustrated by considering the expectation that leaders support the escalating demand for nursing knowledge generation, diffusion, and application. One leadership strategy to do this might be to build shared knowledge among team members by creating time and opportunities for learning conversations. Through dialogue, inquiry can be fostered, ideas exchanged, and creative responses generated. The implication of this strategy for leadership preparation is knowledge and skill development in asking strategic questions, fostering collegial discussions, encouraging divergent opinions, providing linkage to sources of research evidence, supporting experimental learning, and fostering collaborative decision-making.

Implications for research

Regardless of the improvement required in a nursing work environment, a better understanding of how to foster and achieve quality workplaces is needed. Collaboration between researchers and practitioners could help, particularly by studying knowledge dissemination and use, implementation strategies and their results, and the dynamics of change both within and beyond unit and organization walls. Action research could engage participants actively in making desired improvements, while also supporting new knowledge generation. Further research could also determine the effects of multidisciplinary roles, professional associations and unions, as well as local, provincial and federal governments in developing quality nursing work settings.

Holding contradictory views at the same time (a finding from my study) is not uncommon for an individual, especially during times of change when people are trying to make sense of the situation. Further research is needed into the nature of this phenomenon, to identify mechanisms that facilitate meaning-making, and to define relationships between such things as personal and organizational characteristics, time, and impacts.

Specifically I would recommend that future research examine multidisciplinary perspectives in additional institutions, particularly those thought to be more characteristic of typical health care experience. As well action research could be used to test implementation strategies. This work is needed to allow concepts such as those found in my study -- dynamics of interaction, changing interpretations over time, and non-linear relationships between actions and outcomes -- to be compared and contrasted in a

grounded theory development process (Glaser & Strauss, 1967). Creating new theoretical models is necessary, as current organizational theories do not adequately address these matters.

Reflections on the process of research

I conducted my research (1) with a commitment to creating a better understanding of the social dynamics involved in improving nursing workplaces, and (2) by valuing and respecting a variety of perspectives and meanings. Therefore, I worked to share authority, to provide voice in policy-making, and to be collaborative with the participants so that they might benefit from the research process. This influenced decisions about where and how the investigation was conducted. A process of reflecting on my research decision-making and personal learning has generated some recommendations for future researchers.

Investigation decisions

First, in selecting the research site, my primary consideration was the chief nurse's interest in the topic and commitment to improving nurses' work life. One of the sites with strong interest in these matters was an organization where I had recently worked as the chief nurse to cover a one-year educational leave. I explored the potential conflicts – such as compromised confidentiality for participants and potential of personal bias – as well as the benefits of personal knowledge of the site, in a number of ways. First, I collected views from my supervisory committee, which allowed me to formulate a plan to determine the likely impact. This included, for example, the chief nurse meeting with the nurse managers to collect opinions and provide a recommendation on involvement in the research. The managers endorsed the study and later met with me to advise on timing, logistics, and ways to generate interest and participation in the study. I also met with the union representative and asked for an informal poll of constituents to gauge interest and identify any concerns about my role as researcher. It was indicated that about one third of nurses were keen, one third wanted to think about it and one third said they had no interest or would not participate. In addition, the representative was aware that collecting the union perspective through an interview was part of the research design and voiced no reasons to not proceed. This preliminary checking was valuable and provided confidence that people in the site were comfortable with me as the researcher and wanted to proceed. Accordingly, I would strongly recommend that researchers who have previous relationships with research participants find ways to determine any concerns prior to site selection decisions.

Second, being an insider allowed me to consider the study evidence in the larger context of my experience, however, it also represented a potential bias in the research. For example, being an insider helped me make sense of why nurses might be feeling uncertain, even when the discussion did not touch on that explicitly. Also, insider information sometimes allowed me to probe a topic and analyze some comments differently due to my broader frame of reference. On the other hand, I believe being an insider required additional reflective work and scrutiny in my efforts to avoid interpretive bias. To this end, I adopted several strategies:

- An audit trail of notations captured thoughts, ideas, and discussions with others not only to inform the coding and analysis process, but also to promote reflection on ethical and bias dilemmas. I discussed these deliberations with my committee members and looked for confirming evidence for interpretations.
- I found it helpful to use internal questioning, "Why do I believe an interpretation is true? What evidence supports my view or alternative explanations? Is there an external source (committee member, focus group) to verify my interpretation?"
- Being constantly mindful of how you as a person and how your role in the research setting might potentially affect research results, is one way to minimize bias (Devers, 1999). For example in the nurses' focus group one of the participants asked if the results of the study would influence the senior administration to accept their focus group suggestions. Knowing I had a consulting contract with senior administration was confusing to the participant. I explained that the research project was separate from my consulting work and that I had not been retained to advise the organization on this topic. As well, I let them know that one criterion for selecting that organization for my study had been the chief nurse's interest in improving the nursing work environment, and that I was therefore confident there was interest in receiving the findings.

In sum, I would recommend that other researchers who have insider relationships consider these and other techniques to manage ethical issues that emerge and to improve the trustworthiness of their interpretations. Furthermore, I urge qualitative researchers to be prepared to describe these strategies with participants who are more familiar with empirical methods and question the "objectivity" of the researcher who has insider experience.

Third, in designing the study I used a survey to assess enabling factors that had previously been found to relate to personal and organizational outcomes, but I did not consider the measurement as an end in itself. I believed to be most useful the collective results should go back to unit staff for discussion and decisions on how to make

improvements. However, to encourage participation it was decided to forego this and keep the units anonymous. The survey also broadly engaged nurses in defining *in their own words*, workplace strengths and the top priority for change to be explored in the second part of the research. Therefore, the survey findings were important to provide context and direction for the next phase of data collection. In addition, the survey served as a mechanism for soliciting volunteers for the focus group discussions. Finally, it was thought that the collaborating institution could potentially use the overall survey results (baseline) and re-administer the survey as a simple self-benchmarking measure of enabling conditions and stress/satisfaction levels. This would provide useful feedback in evaluating improvement efforts and progress.

Preliminary data analysis occurred concurrently with data collection throughout the study. Thus, ranking of issues allowed the identification of the priority issue to be studied in the second phase of the investigation. As well, multiple regression analysis was used to determine the direction and size of the effect of personal characteristics on opinion results (There are important caveats associated with this procedure; that are described in [Chapter 3, page 32]). In addition, the significant relationship found between unit membership and different change priorities influenced the nurses' focus group decision to include at least one nurse from each unit. Finally in this connection, later focus group data collection and analysis influenced my earlier interpretations of this survey finding. For example during the nurses' focus group, participants expressed surprise at and affirmation of their substantial agreement on concerns and perspectives, even though they worked in different units. This led me to believe that the unit differentiation survey finding might be related to "top of the mind" thoughts on issues rather than substantial differences. The insight shared by the nurses in this latter phase of data collection influenced my earlier impression. Preliminary data analysis also influenced future data collection. For example nurses from the first focus group identified the issue, how best to foster "best practice," that I then brought to participants in subsequent interviews.

In light of these experiences, I would recommend that in studies similar to this researchers keep an open mind not only to identifying further data collection requirements as the study unfolds, but also the possibility that later data analysis may alter earlier impressions.

I also had to make adjustments in the focus group phase. When at the last minute almost half the nurse managers were unable to attend their scheduled focus group, I established a second group rather than attempting to solicit the missing views through

solo interviews. My decision allowed the data to continue to be collected in a collective conversation where participants could negotiate the completeness and accuracy of expressed thoughts, and reach "consensus on what was real, useful and meaningful" (Lincoln & Guba, 2000 p.167). Further, because members of one unit had reported that the union had recommended against completing the survey (because of ongoing bargaining activities), I also decided to create a focus group that included provincial union members rather than conduct an individual interview with only the union representative. I did this so that information regarding the union perspective might be vetted and negotiated in a public conversation. This action clarified local circumstances further and fostered additional examination of the information provided. In hindsight, I could have worked more intensely with the union representative at the time of survey distribution, which might have diminished the reported negative interactions that decreased the return rate in at least one of the units.

Accordingly, I would recommend that in collaborative research special consideration be given to groups that are known to have competing interests –such as unions and employers. In data collection too often the interests of all parties are not considered or their interests are assumed to be different than they are when verified. In this instance, for example, a second consultation with the union representative closer to the survey distribution might have resulted in a higher survey response rate.

Personal learnings

Writing a paper-based dissertation presented challenges I did not foresee. Meeting the word length parameters for contemporary nursing journals was the most difficult task and resulted in many rewrites. Capturing the essence of a major component of the work in a short journal-length article took additional contemplation and discipline. It does, however, focus the scholar and provides rich feedback and support from the supervising committee members.

Accordingly, I recommend that those who consider a papers dissertation allow additional time in their plans to achieve the needed synthesis, reduction, and refinement.

Conclusions

I have grown personally and professionally in my doctoral studies. I have gained research and academic skills that have strengthened my abilities to analyze, critique, and communicate. My humanistic approach to work and leadership has been reaffirmed and

my understandings of what it means to improve nursing work settings have grown. My commitment to collaborative efforts between research and practice is renewed and I will continue to foster initiatives and learning that connect both endeavours.

Nursing work environments have been recognized as problematic and have been the subject of research studies for over twenty years. The three papers presented in this thesis will, I hope, contribute to the understanding that it is indeed important to not only *understand people in context*, but to treat them as active players in discovering and enacting improvements in their working lives. The findings from this research support three key approaches to fostering quality work settings for nurses:

- Strengthen and maintain enabling conditions by measuring and discussing them regularly at the local level.
- Reorient both nurses and leaders to be co-owners of work settings and the changes made there through collaborative relationship building.
- Add additional perspectives to policy formulations by actively engaging organizational stakeholders in framing policy issues.

Each of these strategies recognizes the necessarily active role of people in the workplace. Frontline managers are pivotal in actively engaging nurses in their settings. Working together they are key in creating quality workplaces for nurses. I hope these insights encourage others to think about their nursing workplaces in new ways when defining the nature of organizational policy problems and therefore, the appropriate means of addressing them.

References

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., Busse, R., Clarke, H., Giovannetti, P., Hunt, J., Rafferty, A. M., & Shamian, J. (2001). Nurses' reports on hospital care in five countries. Health Affairs, 20(3), 43-53.

Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Dornan, D.I., Kerr, M., McGillis Hall, L. Z. M., Butt, M., & Ryan, L. (2001). Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system. A policy synthesis: the Change Foundation. Ottawa, ON: Canadian Health Services Research Foundation. Retrieved March, 2002, from htpp://chsrf.ca/docs/finalrpts/pscomcare_e.pdf

Blegen, M. (1993). Nurses' job satisfaction: A meta-analysis of related variables. Nursing Research, 42, 36-41.

Canadian Nursing Advisory Committee. (2002). Our health, our future: Creating quality workplaces for Canadian nurses. Ottawa, ON.: Advisory Committee on Health Human Resources. Retrieved November, 2002, from Health Canada http://www.hc-sc.gc.ca/english/nursing/cnac

Devers, K. J. (1999). How will we know "good" qualitative research when we see it? Beginning the dialogue in health services research. Health Services, 34(5), 1153-1188.

Irvine, D., & Evans, M. (1992). Job satisfaction and turnover among nurses: A review and meta-analysis. Toronto, ON: University of Toronto Faculty of Nursing.

Koehoorn, M., Lowe, G. S., Rondeau, K. V., Schellenberg, G., & Wagar, T. H. (2002). Creating high-quality health care workplaces. Ottawa, ON: Canadian Policy Research Networks Inc. (CPRN). Retrieved October, 2002 from http://www.cprn.org

Kramer, M., & Schmalenberg, C. (1988a). Magnet hospitals: Part I – Institutions of excellence. Journal of Nursing Administration, 18(1), 1324.

Kramer, M., & Schmalenberg, C. (1988b). Magnet hospitals: Part II – Institutions of excellence. Journal of Nursing Administration, 18(2), 11-18.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions and emerging confluences. In N. K. Denzin, & Y. S. Lincoln Handbook of qualitative research (second edition, pp. 163-188). Thousand Oaks, CA: Sage Publication, Inc.

Lomas, J. (2000). Connecting research and policy. Isuma 1(1), 140-144.

Martinus, L., Royle, J., Boblin-Cummings, S., Baumann, A., Oolup, P., Smith, S., & Blythe, J. (1995). Exploring the effects of change on nurse practice in acute ambulatory settings: A qualitative study. (Report No. 95-10). Hamilton, Ontario: Quality of Nursing Worklife Research Unit, McMaster University, University of Toronto.

McClure, M., Poulin, M., Sovie, M., & Wandelt, M. (1983). Magnet hospitals: Attraction and retention of professional nurses. Kansas City, MO: American Nurses Association.

McLennan, M. (1983). Performance appraisal: A description of the current process and recommendations for revision. Unpublished master's thesis. Edmonton, AB.: University of Alberta.

Thomson, D., Dunleavy, J., & Bruce, S. (2002). Nurse job satisfaction-factors relating to nurse satisfaction in the workplace. Ottawa, ON: Can. Nursing Advisory Committee.

APPENDIX 1

Nursing Work Survey

Nursing Work Survey

Please circle your answer to the following questions, leave blank any you prefer not to answer. Overall findings from the surveys will provide input into later focus group discussions regarding how to foster quality work settings for nurses.

1) How long have you worked at the CCI?
   a) Less than one year
   b) 1-5 years
   c) 6-10 years
   d) 11-20 years
   e) 21 years or more

2) How old are you?
   a) Under 30
   b) 30-44
   c) 45-59
   d) 60 or over

3) What is your highest level of education?
   a) Nursing diploma
   b) Nursing diploma plus other _____(specify)
   c) University degree
   d) Post graduate degree

4) What best describes your current family situation? *Circle all that apply.*
   a) Live alone
   b) Live with partner (married, common-law, other)
   c) Responsible for dependent children
   d) Responsible for elderly parents

5) I work primarily in the following area
   a) Inpatients
   b) OPD-Clinics & Chemo
   c) Daycare
   d) Research
   e) Other _____(Specify)

6) My employment status is
   a) Full time regular
   b) Part-time regular
   c) Full time temporary
   d) Part-time temporary
   e) Casual

7) My employment status is my preferred choice?
   a) Yes
   b) No

Enabling Work Index

Circle the number in the ***Agreement column*** which best reflects your work area and second, the number in the ***Importance Column*** which best reflects how important each is to you, using the following scale:

1=not at all 2=a little 3=some 4=greatly 5=highest degree possible N/A=not applicable

Working Condition	Agreement						Importance					
1. I receive adequate ongoing training/education to do my job.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
2. When disagreement arises it is usually resolved through joint problem solving.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
3. Among the people I work with, there is a high degree of trust and respect.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
4. I can raise workload concerns with the person I report to without fear of negative impact.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
5. I use my skills and knowledge in my job.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
6. When I am busy I can readily ask a coworker for assistance.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
7. Management takes a personal interest in me, encouraging work/life balance.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
8. I regularly receive the feedback I need to do my job well.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
9. Management seeks my opinions on important matters.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
10. Overall, work practices are fair and respectful.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
11. Our work area provides quality services.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
12. I understand my roles and responsibilities and what is expected of me in my job.	1	2	3	4	5	N/A	1	2	3	4	5	N/A
13. I have the materials, equipment and information to do my job well.	1	2	3	4	5	N/A	1	2	3	4	5	N/A

This section gives you an opportunity to add comments about work that are important to you.

What are three things that make you feel good about your workplace?

1. _____
2. _____
3. _____

What are three things that you would most like to see changed in your workplace? Rank each as to Importance: #1, most important, #2, second most important and #3, third most important.

1. _____
   _____
2. _____
3. _____

Circle the number, which best describes how you feel about the following statements:

1=Not at all	2=Once in a while	3=Sometimes	4=Often	5=Most of the time	6=Always

I feel I am well rewarded for the level of effort I put out for my job.	1	2	3	4	5	6
I am satisfied with the amount of involvement I have in decisions that affect my work.	1	2	3	4	5	6
In the last (6) months, too much time pressure at work has caused me excess worry, "nerves" or stress.	1	2	3	4	5	6
In the last (6) months I have experienced worry, "nerves" or stress from mental fatigue at work.	1	2	3	4	5	6

Is there anything else you would like to add about your work environment?

_____
_____
_____
_____
_____

VOLUNTEER TO PARTICIPATE IN A GROUP DISCUSSION

Your ideas and opinions are important. Would you be willing to participate in a focus group discussion about how to foster quality (healthy and productive) work environments? A small group of nurses (6-10) will be invited to share their ideas in a 1-2 hour discussion scheduled on Thursday, February 6 from 12-2:00 p.m.

Volunteer by filling in the following:

Name:

Contact Unit: **Phone Number:**

Comments/Questions:

Further information is available from the Primary Investigator: Marianne McLennan dmclenna@shaw.ca or 477-0005.

APPENDIX 2

Focus Group/Interview Guiding Questions

Guiding Questions for Focus Groups/Interview

Guiding questions will provide a general focus to initiate discussion and may include:

1. What words would you use to describe the type of workplace this is?

2. How would you describe supervision in work areas here?

3. What changes in supervision would improve nurses' workplaces?

4. What are two or three important actions that would improve nurse's experience with supervision?

5. For the top actions identified, what is the expected result desired from that intervention?

6. What might get in the way of making the changes suggested?

7. What will facilitate positive change?

8. What other comments about your work life would you like to share?