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**CORRELATES OF STAFF NURSE WORK SATISFACTION
IN HOSPITALS WITH SHARED GOVERNANCE**

By

Mary Kay Flynn

**A dissertation presented to the
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING
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**In partial fulfillment of the
requirements for the degree**

DOCTOR OF NURSING SCIENCE

May, 1997

Dissertation Committee

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CORRELATES OF STAFF NURSE WORK SATISFACTION IN HOSPITALS WITH SHARED GOVERNANCE

Abstract

Mary Kay Flynn, DNSc, RN, CCRN

Lack of staff nurse participation in hospital decision-making has been cited as a major reason for the dissatisfaction in nursing. Shared governance has been proposed as an organizational model that provides staff nurses with both the structure and the mechanism for having increased decision-making authority. The purpose of this study was to investigate the relationship of organizational culture, perceived importance of involvement and actual involvement in decision-making, the discrepancy between importance and involvement, staff nurse years of involvement in shared governance, control over nursing practice, and work satisfaction among staff nurses working in hospitals with shared governance.

A descriptive, correlational design was used to investigate 188 full-time RN staff nurses from three hospitals with shared governance. Organizational culture was eliminated from analysis because of the large amount of missing data. Three multiple regression models were tested. In the final prediction model, control over nursing practice was the strongest predictor of work satisfaction, accounting for 40% of the explained variance. The next most significant predictors were involvement in decision-making, years in shared governance, and years in nursing, for a total of 43 % of the variance. Since the variables in the model only explained 43 % of the variance, other factors need to be identified to further predict work satisfaction. Based on the findings in this study, staff nurse participation in shared governance is a vehicle for control over nursing practice and work satisfaction.

DEDICATION

This dissertation is dedicated to my wonderful husband, Pat, who offered me his constant love and encouragement to complete this project and to my sons, John and Kevin, who provided me with their love and support throughout the entire process.

I would also like to dedicate this dissertation to my mother, Mary, who always praised and encouraged me to pursue my dreams in nursing.

Lastly, I dedicate this research to Almighty God, who enabled me to do his will and blessed me along the way.

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CHAPTER I

Introduction

Job satisfaction and retention in nursing are major concerns for nurse administrators as the supply and demand for nurses continues to fluctuate (Fagin, 1989; Kramer, 1990). According to a recent publication (Dracup & Bryan-Brown, 1997), nurse recruitment is on the rise nationally. As the baby-boom generation continues to age, the demand for healthcare services will escalate. The healthcare industry is projected to have the greatest job growth of all industries across the next fifteen years, and the demand for nurses is expected to increase between now and the year 2005. The combination of decreased enrollments in bachelor's degree programs and increased need is projected to result in a nursing shortage, especially in nurses with bachelor's and master's degrees (Dracup & Bryan-Brown, 1997). Furthermore, the restructuring of healthcare delivery systems and redesign of nursing roles are creating major changes in the work environment that have a direct influence on job satisfaction and retention of nurses (Dienemann & Gessner, 1992). Researchers have reported a multitude of factors within the work environment that influence job satisfaction and the decision of nurses to remain or leave employment (Curry, Wakefield, Price, Mueller, & McCloskey, 1985; Hinshaw, Smeltzer, & Atwood, 1987; Kramer & Schmalenberg, 1991).

Numerous studies have reported lack of participation in decision-making as a major reason for some of the dissatisfaction and turnover in nursing (Hinshaw & Atwood, 1982a, 1982b; Hinshaw et al., 1987; Kusserow, 1988; Orsolitis, 1989). Major studies conducted by the Institute of Medicine (1983) and the National Commission on Nursing (1983) have all recommended greater staff nurse involvement in decisions about patient care, as well as the governance, administration, and management of the work environment.

Numerous reasons have been given for increasing staff nurse participation. Nurses today are more career-oriented, have increased expectations, desire more responsibility, and expect full participation in decisions regarding their work environment and patient care (McClure, Poulin, Sovie, & Wandelt, 1983; Moritz, Hinshaw, & Atwood, 1989). Advances in medical technology, coupled with increased severity of illness and an aging patient population, require that those who are closest to the patient have authority to make decisions and as rapidly as possible (Kramer & Schmalenberg, 1988a, 1988b). In addition, intense competition among healthcare organizations is demanding greater nurse accountability for clinical and financial outcomes which require an active role in decision-making (Porter-O'Grady, 1990; 1991).

Current trends suggest that the governance, authority, and control structures in hospital nursing are shifting from a centralized, bureaucratic model to a decentralized one characterized by increased committee participation, formalized shared governance, and self-managed units (Kramer, 1990; Porter-O'Grady, 1986; Wake, 1990; York & Fecteau, 1987). Furthermore, changes in the healthcare system, coupled with scarce resources and

a growing dissatisfaction among nurses, have stimulated the development of organizational models that emphasize staff nurse participation (Adams & Rentfro, 1991).

The original magnet hospital study (McClure et al., 1983), that reported on hospitals successful in attracting and retaining nurses, and several follow-up studies (Kramer, 1990; Kramer & Schmalenberg, 1988a, 1988b, 1991) identified a definite movement toward a system of autonomous self-governance and increased representative involvement in department-wide governance issues. In a study of nurse executives, Wake (1990) reported that governance was a key issue in evolving nursing care delivery systems and that formalized shared governance within their organizations was projected for 1992 by forty-nine percent of nurse executives.

Shared governance in nursing has been described as both a philosophy and an organizational model for healthcare institutions. It is characterized by a decentralized nursing organization consisting of staff nurse representative group structures (e.g., councils) that have the authority and responsibility for all practice-related decisions (Porter-O'Grady, 1987). Shared governance also has been described as a professional governance model with bylaws that specify the decision-making structures and areas of accountability of its members (Porter-O'Grady, 1983; Porter O'Grady & Finnegan, 1984). Shared governance in nursing developed in response to a changing value system and an identified need to provide hospital nurses with more control over their hospital-based working environment (Ortiz, Gehring, & Sovie, 1987; Peterson & Allen, 1986a; Pinkerton, 1988).

Benefits of shared governance include increased opportunities for staff nurse participation in significant work-related decisions and the enhancement of the professional practice of nursing (Del Tugno-Armanasco, Olivas, & Harter, 1989). Shared governance is viewed as an organizational model that empowers staff nurses (Ludemann & Brown, 1989; Peterson & Allen, 1986a; Pinkerton, 1988). Advocates of shared governance believe that shared decision-making promotes greater professionalism, control over practice, accountability, job satisfaction, and retention of staff nurses (Ludemann & Brown, 1989; Peterson & Allen, 1986a; 1986b).

Although shared governance has appeared in the literature since the early 1980's, few studies have been conducted to investigate its effectiveness. A large scale organizational change, such as shared governance, requires a period of time after implementation before attitudinal changes could be expected (Pinkerton, 1988). Furthermore, it has been assumed that the organizational culture in hospitals with shared governance is participative, yet the specific type of culture and degree of participation afforded by that culture have not been investigated. Another assumption is the universal desire for participation. However, the desire for participation often depends upon the importance of the decision to the individual (Allen, Heidrich, & Peterson, 1987).

Shared governance has been proposed as an organizational model that provides staff nurses with the structure and mechanism for having increased decision-making authority. Involving staff nurses in decision-making related to hospital policies and procedures sends a message that nurses are the primary clinical experts (Jenkins, 1991). An improvement in satisfaction with one's work is expected to result from the nurse's perception of control

over nursing practice. In addition, higher levels of work satisfaction are expected to indirectly contribute to decreased hospital costs, increased productivity, and an improvement in the quality of patient care (Moritz et al., 1989).

By measuring perceived importance of involvement in decision-making and actual involvement in decision-making, the congruency or "fit" between what is desired by staff nurses and what is provided in the organization may be determined. This approach is expected to explicate which types of organizational decisions are important to staff nurses and which are of less concern. By matching importance with involvement for specific decisional areas, nurse managers could involve staff nurses in committees that are of interest to them, resulting in an improvement in work attitudes while avoiding participation for the sake of participation. Intervention strategies could then be designed to match the participative patterns with nurses' specific demographic and/or job characteristics. Lastly, investigating outcomes in terms of staff nurse years in shared governance may offer valuable insight into the need for continued administrative support over a period of years before expecting to see the anticipated benefits of the model.

Purpose

The purpose of the study was to determine the relationship of organizational culture, staff nurse years in shared governance, perceived importance of involvement in decision-making, actual involvement in decision making, discrepancy between importance and involvement, control over nursing practice, and work satisfaction among staff nurses employed in hospitals with shared governance. The research questions are described in the next section.

Research Questions

- What is the relationship between organizational culture and work satisfaction?
- What is the relationship between staff nurse years in shared governance and work satisfaction?
- What is the relationship between perceived importance of involvement in decision-making and actual involvement in decision-making for those same decisions?
- What is the relationship between perceived importance of involvement and work satisfaction?
- What is the relationship between actual involvement in decision-making and work satisfaction?
- What is the relationship between the discrepancy between perceived importance of involvement and actual involvement in decision-making to work satisfaction?
- What is relationship between control over nursing practice and work satisfaction?
- What are the strongest predictors of work satisfaction among staff nurses employed in hospitals with shared governance?

Definition of Terms

Shared Governance

Shared governance in hospital nursing is defined as a nursing organizational model which meets the following criteria: (a) decentralized nursing organizational structure; (b) staff-representative councils with final authority for all practice-related decisions; and (c) bylaws specifying the decision-making authority and accountability of its members (Porter-O'Grady, 1987).

Organizational Culture

Organizational culture refers to the total environment of the organization, including the values/norms and focus of the organization. It is operationalized by ratings given on the organizational culture scale addressing four categories of culture: (a) productivity, (b) quality, (c) creativity, and, (d) cooperation (Boulgarides & Rowe, 1986).

Years in Shared Governance

Number of years in shared governance refers to the period of time in which staff nurses were employed at that hospital under a shared governance model. It does not refer to any previous employment at another hospital with shared governance.

Perceived Importance of Involvement and Actual Involvement in Decision-Making

In this study, involvement in decision-making was conceptualized along two dimensions: perceived importance of involvement in decision-making and actual involvement in decision-making. Importance of involvement refers to the ratings of perceived importance assigned to seventeen organizational and clinical decisional items on the Importance/Involvement scale (Allen et al., 1987). Involvement in decision-making refers to the ratings of actual involvement for those same decisional items.

Discrepancy Between Perceived Importance of Involvement and Actual Involvement in Decision-Making

The discrepancy variable was defined as the absolute difference between the ratings for importance of involvement and involvement in decision-making for those same decisions using the Importance/Involvement scale (Allen et al., 1987). The discrepancy was obtained by measuring the absolute difference between importance of involvement

and actual involvement in decision-making for those same decisions with item scores ranging from -5 to +5.

Control Over Nursing Practice

Control over nursing practice was defined as the freedom to evaluate and modify nursing practice and to influence others and is operationalized by ratings given on the Control Over Nursing Practice scale (Gerber, 1988).

Work Satisfaction

Work satisfaction was defined as occupational satisfaction with one's work in the following areas: (a) pay, (b) autonomy, (c) task requirements, (d) organizational requirements, (e) job status, (f) interaction, and (g) total work satisfaction. It is operationalized by ratings given on the Index of Work Satisfaction (IWS) scale-Part B (Stamps & Piedmont, 1986).

Conceptual Framework

The conceptual framework for the variables related to work satisfaction is depicted in Figure 1. The predictor variables are organizational culture, staff nurse years in shared governance, perceived importance of involvement in decision-making, actual involvement in decision-making, discrepancy between importance of involvement and involvement in decision-making, and control over nursing practice. The criterion variable is work satisfaction.

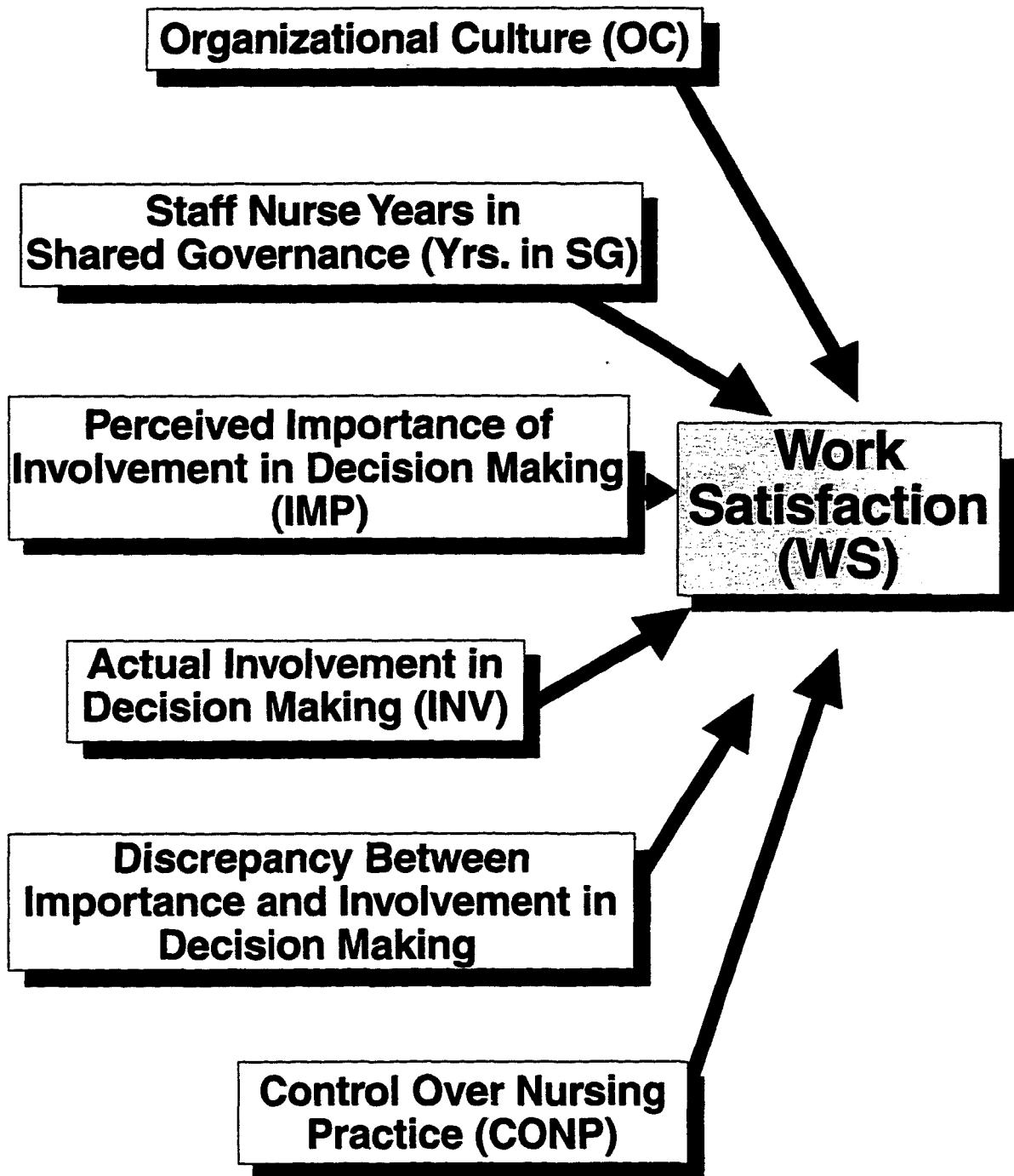


Figure 1. Conceptual model of variables related to work satisfaction among staff nurses in hospitals with Shared Governance.

Organizational Culture

The ability to participate in decision-making often depends on the type of culture created by the organization. A decentralized organizational culture pushes responsibility and authority downward so that decision-making takes place at the point where the work is performed. Several studies have focused on organizational culture as one factor contributing to the dissatisfaction and turnover among nurses (Gray-Toft & Anderson, 1987; Hart & Moore, 1989; Hinshaw, Smeltzer & Atwood, 1987; Kramer & Schmalenberg, 1988a, 1988b). In this study, it was anticipated that nurses who rated their hospital's organizational culture as cooperative (or participative) would report higher levels of work satisfaction than those who did not rate the culture as participative.

Staff Nurse Years in Shared Governance

Based on previous studies, a period of eighteen months to two years of hospital duration of shared governance was needed before significant changes in nurse attitudes or behavior occurred (Ludemann & Brown, 1989; Pinkerton, 1988). It was assumed that hospitals with the greatest number of years of shared governance would have stable, consistent participatory structures, and this would lead to more positive work attitudes than hospitals with fewer years of shared governance. Another assumption was that hospitals would have a representative population of staff nurses who had worked at the hospital since their shared governance began. In this study, it was predicted that staff nurses with a greater number of years employed in a hospital with a shared governance model would report higher levels of work satisfaction than nurses with fewer years of

employment in that hospital. This does not refer to any previous exposure to shared governance in another hospital.

Participation in Decision-Making

Several theoretical frameworks have been used as a basis for research on participation in decision-making: (a) Theory X-Theory Y (McGregor, 1960); (b) System's I-IV (Likert, 1961); and (c) the Human Relations/Human Resources Theory (Miles & Ritchie, 1971). The "traditional" autocratic or non-participatory style of management has existed for many years in bureaucratic organizations. McGregor's Theory X, Likert's System I, and Weber's traditional bureaucratic model all describe an autocratic leadership style in which there is little or no participation by employees. The autocratic style describes a supervisor's assumptions about subordinates as being indolent, self-centered, and having little to contribute to the decision-making process. In contrast, McGregor's Theory Y, Likert's System IV, and Miles and Ritchie's Human Resources Model describe supervisory behaviors that recognize the capabilities of employees, acknowledge the ability to contribute meaningfully to decisions, and involve them in the decision-making process. Proponents of the Human Relations Theory advocate involvement for involvement's sake and participation in routine organizational issues. Proponents of the Human Resources Theory, however, believe in employees' capabilities and involve them in important organizational decisions (Yukl, 1989). The Human Resources Theory of Participation was used to conceptualize participation in important organizational decisions within a shared governance organization. In shared governance, professional nurses are

expected to utilize their full potential and capabilities by contributing to practice-related and organizational decisions (Porter-O'Grady, 1991)

Several major studies have demonstrated the importance of nurse participation in preventing work dissatisfaction (Institute of Medicine, 1983; McClure et al., 1983; National Commission on Nursing, 1983). In other studies, participation in shared governance has been reported to affect the perceptions of control over nursing practice, job satisfaction, and anticipated turnover (Ludemann & Brown, 1989; McClure et al., 1983; Peterson & Allen, 1986a; Porter-O'Grady, 1987).

Perceived importance of involvement and actual involvement in decision-making.

Both importance and involvement were considered important in the measurement of shared governance. This approach was used to determine whether there was a "fit" or "match" between importance and involvement for those same decisions and whether a match resulted in higher levels of work satisfaction than when there was not a match. In this study, nurses were expected to report higher levels of work satisfaction when they were involved in decisions that were important to them and lower levels of satisfaction when the decisions were less important.

Control Over Nursing Practice

Positive effects of participation in decision-making are believed to occur through satisfaction of the employees' need for autonomy and control over their work environment (Sashkin, 1984). Several studies have identified the importance of autonomy as a determinant of job satisfaction and turnover in nursing (Pierce, Freund, Luikart, & Fondren, 1991; Weisman, Alexander, & Chase, 1981). In the literature, control over

nursing practice has been used interchangeably with autonomy, but in this study it is conceptualized as a broader concept. Control over nursing practice has been defined as the freedom to evaluate and modify nursing practice and to influence others (i.e., health care workers) in the work environment (Gerber, 1988).

Involvement in decision-making does not automatically mean influence in those same decisions. Earlier studies have demonstrated that bureaucratic organizations which fostered employee participation continued to maintain final authority for those decisions (Miles & Ritchie, 1971). This implies that employees only gave input into decisions and were not really participating in decision-making. Similarly, hospital organizations encouraged greater staff nurse participation in decision-making, but nurses were not always given final authority (Porter-O'Grady, 1987). Dissatisfaction resulted when staff nurse participation in shared governance did not result in the expected influence and control over nursing practice (Peterson & Allen, 1986a; Porter-O'Grady, 1991). Part of the dissatisfaction with shared governance has been the manner in which participation was operationalized in hospital settings. Administration continued to maintain control for decisions that nurses believed were within their realm of authority. In this study, involvement in decision-making was used to measure actual participation while control over nursing practice was used to measure the nurse's perceived influence in those decisions.

Summary

Theoretically, shared governance addresses many of the issues confronting practicing nurses in hospitals today. It has been proposed as an organizational philosophy

and structure for promoting nurses' control over their practice and work satisfaction. In spite of the interest in shared governance as a strategy for restructuring the nursing organization, little research has been conducted to evaluate its effects on staff nurses (Allen et al., 1987; Ludemann & Brown, 1989; Pinkerton, 1988; Porter O'Grady, 1989). This study proposes to investigate the relationship of organizational culture, staff nurse years in shared governance, perceived importance of involvement in decision-making, involvement in decision-making, discrepancy between importance of involvement and involvement in decision-making, control over nursing practice, and work satisfaction among staff nurses working in hospitals with shared governance.

CHAPTER II

Review of Literature

The review of literature in this chapter supports the selection of variables for this study and is organized around those variables described in the conceptual framework. In each section research studies are summarized. The first section will consist of a synthesis of the descriptive and research literature on shared governance. The succeeding sections will describe the findings for a select group of research studies on organizational culture, importance of involvement and involvement in decision-making, control over nursing practice, and work satisfaction.

Shared Governance

In most hospitals, the organizational structure of shared governance, consists of staff representative councils and unit committees that function to accomplish the goals of the nursing department and the nursing units, respectively. The typical structure consists of the following councils: (a) nursing practice, (b) quality improvement (or evaluation), (c) education and/or research, (d) peer accountability, and (e) coordinating (or management). Unit committees generally mirror the council structure in committee type. Staff nurses from unit committees are elected to represent their respective units on each of the councils. Issues or problems that arise at the unit level are brought to the council meetings by the unit representative if they involve issues other than those related to their unit. All

representative members have a vote on the decisions at the council meetings. Council decisions determine the parameters of nursing practice in the institution. However, unit decisions are made to handle unit-specific issues. Membership in shared governance may be limited to registered nurses (RNs) only or may include all personnel involved in patient care (e.g., LPNs, nurses' aides, respiratory therapists). Those who believe that shared governance is a professional model limit the membership to RNs (Porter-O'Grady, 1987). However, nurse executives have indicated a need to include all care providers in their shared governance models (Pinkerton, 1989).

The majority of literature on shared governance is descriptive, espousing the benefits of shared governance. Only three studies could be found that specifically evaluated the effects of shared governance on staff nurse attitudes (Allen et al., 1987; Ludemann & Brown, 1989; Pinkerton, 1988). The study conducted by Allen and associates will be described in the importance/involvement section of this chapter.

In a sample of 274 staff nurses, Pinkerton (1988) reported that there were no differences in job satisfaction, professionalism, control over nursing practice, absenteeism, and turnover after a nine month period of shared governance in two community hospitals within the same corporation and geographic location. A nonequivalent control group pretest/posttest design was used (Hospital A with shared governance and Hospital B without shared governance). Preexperimental testing for sampling equivalence was not conducted. For the experimental group, shared governance was already in place at Hospital A; hence, it was not randomly assigned. The Nurse Opinion Questionnaire consisted of three instruments. The Occupational Satisfaction scale (Slavitt, Stamps,

Piedmont, & Haase, 1978) measured satisfaction of health professionals in seven areas: pay, autonomy, task requirements, organizational requirements, interaction, job prestige/status, doctor-nurse relationships. Professionalism was measured using an attitude scale to assess the degree of professionalism in five component areas: (a) participation in professional organizations, (b) belief in public service, (c) belief in self-regulation, (d) sense of calling to the field, and (e) feeling of autonomy (Hall, 1968). Control Over Nursing Practice was measured using a tool developed by Horsley and Pelz for the nationally funded Conduct and Utilization of Research in Nursing project (1976-1981). The findings revealed that the rank order for the satisfaction components from least satisfied to most satisfied were (a) task requirements, (b) organizational requirements, (c) pay, (d) doctor-nurse relationship, (e) interaction, (f) autonomy, and (g) professional status. Rank orderings were similar at both hospitals. The t-statistic was used to test mean differences between the dependent measures (time 1 to time 2) at both hospitals. Respondents from both hospitals had similar scores and rankings on all instruments at time 1, so had there been statistically significant differences for Hospital A (from time 1 to time 2), the influence of shared governance would have been identified. No significant differences were found in the 9 month period from time 1 to time 2. The investigator concluded that sufficient time had not elapsed since instituting shared governance for significant differences among hospitals to be found. The most important conclusion derived from this study was the developmental nature of shared governance and the need to investigate outcomes over time. Additionally, lack of random selection of the sample

and failure to insure equivalency of groups may have introduced selection bias into the study.

In a study of 178 staff nurses conducted by Ludemann and Brown (1989), findings revealed significant differences in attitudes towards the work environment, amount of influence, and job satisfaction since implementing shared governance one and one-half years previously. A second survey was done on seventy-four staff nurses because of unanticipated layoffs of nurses and the low response rate in the first survey. Since no differences were found between the two surveys, data from the second survey was used. The findings revealed significant improvements in attitudes toward the work environment, personal power and autonomy, and climate for innovation after instituting shared governance. The highest mean difference was in the influence scale (personal power and autonomy), indicating that staff nurses perceived they had greater ability to influence decision-making within the organization. Significant differences were also found for the subscales of job satisfaction, including intrinsic rewards (feelings of self-respect and prestige), extrinsic rewards (salary and benefits), as well as overall job satisfaction. In addition, significant differences were found for opportunities for personal growth and promotions. Certain staff characteristics influenced the degree of commitment to the Nursing Congress (title of their shared governance model) and the organization. The following demographic variables were significantly correlated with organizational commitment: age, years employed at the hospital, years in nursing, and position. Nurses who worked full time and had more education were more committed to shared governance, but not to the organization. Although professionalism was not directly

measured in Ludemann and Brown's study, the investigators concluded that participation directly influenced professionalism and one's job. Generalizability is limited because of the small sample, lack of random selection, and problems associated with recall.

The original Magnet study (McClure et al., 1983) identified hospitals which were highly successful in attracting and retaining professional nurses and with reputations as good places to work. In a follow-up study, Kramer (1990) reported on trends among the Magnet hospitals, including the governance structures that support participation and empowerment among staff nurses. In a study of sixteen of the forty-one hospitals from the original Magnet Hospital study, Kramer (1990) reported trends and developments between 1982 and 1986 and between 1989 and 1990. In 1989, interviews with nurse administrators identified the themes operating in these highly successful hospitals as experimentation, value formulation, recognition of competence, and power and autonomy. Additionally, these centers were not experiencing a nursing shortage despite the prevalence of one of the most severe nursing shortages in U.S. history. Specifically, the trends consisted of elimination of middle managers from clinical decision-making and recognition of clinical competence and empowerment of staff nurses. The movement toward staff nurse self-governance, which was identified both in 1982 and 1986 and continued in 1989, was defined as a system of autonomous, self-managed, self-governed operations at the unit level. It consisted of the development of participative, representative involvement by unit staff nurses in department-wide governance issues, especially those related to clinical decision-making and nurse-physician collaboration (Kramer, 1990). Nurse executives reported that the most important new things that had occurred in the

nursing department and hospital during the past three years were (a) new nursing care delivery systems; (b) expanded or differentiated nurse roles; (c) programs to empower staff nurses; (d) collaborative practice; (e) flattening of the organizational structure; and (e) computerization programs, especially for documentation.

In summary, only two studies could be found that specifically investigated the effects of shared governance on staff nurse attitudes. In one study, participation in shared governance resulted in increased influence in decision-making and overall job satisfaction eighteen months after implementing shared governance (Ludemann & Brown, 1989). In the second study, however, no significant differences in work attitudes were found nine months after implementing shared governance (Pinkerton, 1988). Kramer (1990) reported on trends in staff nurse self-governance and representative staff involvement in department-wide governance issues in hospitals involved in the original Magnet Hospital study. The majority of nursing studies used instruments developed for organizational research and global approaches to the measurement of participation. None of the studies used a longitudinal design. Factors determining outcomes of shared governance were viewed as complex and involved multiple variables from several domains (individual and organizational), requiring a multi-variate approach to measurement. The paucity of research, small sample sizes, and limitations in designs preclude any generalizations beyond the samples used in these studies.

Organizational Culture and Work Satisfaction

This section presents the research on organizational culture and its relationship to nurses' work satisfaction. The literature includes numerous conceptualizations of

organizational culture (Boulgarides & Rowe, 1986; Gillies, Franklin, & Child, 1990; Van Ess Cooling & Wilcox, 1988). According to Schein (1985), organizational culture is defined as basic assumptions and beliefs shared by members of a group or organization that serve as a basis for expectations to guide behavior. Boulgarides and Rowe (1986) defined organizational culture as shared understandings which include all the norms, beliefs, values, standards, rituals, structure, rewards, climate, and kinds of interactions within the organization. Organizational culture also incorporates all the policies, procedures, goals, strategies, and actions of the organization (Boulgarides & Rowe, 1986).

Numerous studies in the organizational literature have demonstrated the importance of the organizational culture in affecting employee attitudes and performance (Kanter, 1983; Ouchi, 1982; Peters & Waterman, 1982). The nursing literature also addressed the importance of organizational culture in supporting professional nursing practice and improving satisfaction and retention among staff nurses (American Nurses Association, 1979; Kramer 1990; Peterson & Allen, 1986b). In spite of literature proclaiming its importance, few studies investigated the relationship between organizational culture, participation in decision-making, and work satisfaction. Although shared governance is based on a participative culture, no studies could be found that investigated the relationship between organizational culture and work satisfaction in relation to shared governance.

Using an anthropologic, ethnographic method, Van Ess Coeling and Wilcox (1988) reported that a participative management strategy affected two nursing units differently.

The researcher functioned as a participant-observer and conducted semi-structured, taped interviews to obtain data to compare the day shift cultures of two medical-surgical units. One nursing unit preferred an autocratic leader and someone to direct them, desiring policies and procedures which told them what to do. The other unit preferred a more democratic leader, since the staff wanted to make their own decisions based on the needs of their patients. Unit A demonstrated a culture receptive to a more autocratic leader and limited participative management. However, Unit B gave evidence of being more receptive to democratic leadership and participative management. The investigators concluded that work group cultures and differences in the desire for participation should be considered in future studies.

Gillies and associates (1990) investigated the relationship between organizational climate and job satisfaction in thirty-four nursing caregivers from four patient units in an acute care hospital. The Work Satisfaction Questionnaire (Slavitt, Stamps, Piedmont, & Hasse, 1979) was used to measure overall work satisfaction and the following components of work satisfaction: pay, professional status, interaction, administration, autonomy, and task requirement. The Organizational Climate Description Questionnaire (Litwin & Stringer, 1968) was used to measure the following aspects of the climate: structure, responsibility, reward, risk, warmth, support, standards, conflict, and identity. Job satisfaction was significantly correlated with a climate of responsibility ($r=.28$; $p<.05$); warmth ($r=.41$, $p<.007$; support ($r=.60$, $p<.0001$); and identity ($r=.65$, $p<0$). However, when responses to individual climate questionnaire items were analyzed, staff members did not perceive the warmth and support from the administrators. Eighty-eight percent of

respondents disagreed with the statement that administrators demonstrated interest in employees' career aspirations and seventy-nine percent disagreed with the statement that there were warm relations between administrators and nurses. The authors suggested implementing a participative management structure and primary nursing, adopting a relationship-oriented leadership style, providing individual coaching and career counseling for employees, and implementing support groups. Limitations of the study included the small, non-random sample which prohibited generalization beyond the study.

Organizational culture was evaluated in three hospitals to assess the strength of the organizational and work unit ideologies and the extent of cultural homogeneity (Fleeger, 1993). A fifteen item questionnaire was administered to staff nurses to assess the type and distribution of different cultures throughout the hospital, how well nurses know and use informal rules, the overall culture of the hospital, and whether the work unit culture is similar to the overall hospital culture. A qualitative cultural assessment inventory was used to aid in understanding the relationships uncovered by the questionnaire data. The nursing cultures at two hospitals operated in harmony with other occupational cultures and with the overall organizational culture which indicated consonance. However, the third hospital's nursing culture was in conflict with the other professional cultures and also with the hospital's organizational culture, which indicated dissonance. Characteristics of a consonant culture are that members (a) share the same goals and motivations as the organization, (b) are caring and supportive of one another, (c) have frequent management/staff interactions, (d) have clinical expertise that is valued, (e) have high cooperation between units, (f) have independent decision-making and autonomy, and (g)

use formal and informal systems to address conflicts. In contrast, the characteristics of a dissonant culture include: (a) a mismatch between professional and organizational goals, (b) stronger union affiliations than organizational, (c) little staff representation on committees, (d) low staff involvement, (e) competitive spirit, and (f) low staff/management interactions. The investigator suggested the following management strategies to promote consonance: (a) strategic planning sessions promoting employee involvement, (b) increasing both formal and informal interactions, and (c) adapting a nursing care model that promotes autonomy and responsibility.

In summary, the relationship between organizational culture and nurse attitudes is multi-variate and complex. Work group cultures and differences in the desire for involvement vary depending on the leadership and the individuals involved. In one study, satisfied nursing personnel described their organizational climate as high in responsibility, warmth, support, and identity. Similar results were found in another qualitative study. Nursing cultures that were consonant with other occupational cultures and the overall organizational culture shared similar goals with the organization, valued each person's expertise and experience, fostered open communication between management and staff, and promoted autonomy and independent decision-making among professionals. Nursing cultures that were dissonant with the organizational culture did not value or respect the managers, had low staff involvement and representation on committees, and did not work toward the common goals of the organization.

Although only a subset of research studies have been described, a consistent theme in the nursing literature was the positive relationship between a participative

organizational culture and work satisfaction and the harmony (or consonance) between the nursing culture and the organizational culture. Work cultures that fostered warmth and caring, mutual respect and valuing, and employee involvement resulted in higher levels of cooperation and collaboration than environments which did not have those characteristics.

Participation in Decision-Making and Work Satisfaction

Participation in decision-making refers to shared or joint decision-making and infers a shifting of the control for decision-making downward to the employees at the lower levels of the organization (Locke & Schweiger, 1979; Yukl, 1989). The organizational literature has a long history of research related to participation in decision-making (Argyris, 1964; Likert, 1961; McGregor, 1960). The benefits of participation have generally fallen into two broad categories: increased morale or satisfaction and greater productivity or efficiency. Low participation had the greatest harmful effect on job satisfaction. Lack of participation was related to job dissatisfaction, depression, drinking, and overall poor health (Sashkin, 1984). In a major literature review, Locke and Schweiger (1979) concluded that there was equivocal support for both satisfaction and productivity as outcomes of participation, but that the evidence was stronger for satisfaction. However, meta-analytic studies revealed inconsistent findings on the effects of participation on satisfaction and efficiency (Miller & Monge, 1986; Wagner & Gooding, 1987). Participative decision-making is a complex phenomenon and numerous individual (e.g., age, education, experience) and organizational factors (e.g., management style, task requirements, organizational culture) are believed to moderate its effects (Yukl, 1989).

In the organizational literature, the measurement of participation is inconsistent across studies. The amount or degree of participation varies along a continuum from "no participation" to "full participation" (Yukl, 1989). The construct has been measured from the viewpoint of both the supervisor and the subordinate. The subordinate's viewpoint included how frequently individuals participate (Anderson, 1987; Stuart, 1985), the extent to which subordinates are consulted or involved in making a decision (Locke & Schweiger, 1979; Melcher, 1976), and the extent to which subordinates influence decisions (Moch, Cammann, & Cooke, 1983). The majority of instruments used global attitudinal measures (i.e., overall participation in decision-making), which are not sensitive to the variety of decisions that might be used in various nursing situations.

Nursing participation has been studied primarily by using global, attitudinal scales borrowed from the organizational literature (Anderson, 1987; Harrison & Roth, 1987; Kusserow, 1988; Stuart, 1985). In addition, the content domains of decisional participation in nursing (i.e., hiring, staffing, benefits) have virtually been ignored. It cannot be assumed that the decisional domains are equally important to all members of an organization. An assumption in the participation literature is that greater rates of decisional participation are desired by employees and that fulfillment of their expectations leads to greater organizational commitment, job satisfaction, personal growth, and acceptance of change. Further, the desire to participate influences the degree to which individuals will participate. Individual differences in people (i.e., attitudes, values, abilities) will affect their desire for participation (Stuart, 1985).

Another controversy in the participation research is whether influence can be inferred from participation in decision-making. Participation by itself does not necessarily mean influence in decision-making. Similarly, both the levels of participation and influence in decision-making may vary according to the type of decision and status of the group. Influence has been measured as the amount of control that members have over their work (Moch, Cammann, & Cooke, 1983). In this study, participation in decision-making and influence are being viewed as separate variables. That is, participation in decision-making is measured by actual involvement in decision-making, whereas influence in decision-making is being measured by control over nursing practice.

In Price's (1977) landmark study of turnover, centralization was positively related to turnover. Centralization was defined as the degree to which decision-making authority is concentrated in the organization. It concerns both participation and influence in organizational decision-making. If nurses experience a decrease in control over their work and an increase in dependence and submissiveness, a high concentration of decision-making power is in the hands of others. This may lead to alienation and withdrawal, which may result in turnover (Price, 1977).

In a study of nurses in fifteen hospitals, Prescott and Dennis (1985) reported that the chief nurse executive (CNE) was the critical determinant of influence of the nursing department and markedly influenced the department's role in organizational decision-making. In a similar study, Stuart (1985) investigated the decisional behavior of 606 nursing administrators in first-level, middle, and top administration. The most important variables predicting participation among the CNEs were one's preference (or desire) for

participation, committee membership, and position level. Responses indicated that nurse executives desired greater participation and that their expectations were not being met. Although a discrepancy existed between the desired and actual levels of participation, actual discrepancy levels were not reported. Lastly, Stuart reported that participation and autonomy were found to be significant predictors of job satisfaction and commitment.

In a study conducted by the Office of Inspector General (Kusserow, 1988) on nurse participation in hospital decision-making, data were obtained from nurse executives and hospital administrators in ninety-three hospitals. Findings revealed that sixty percent of chief executive officers (CEOs) and eighty-five percent of chief nursing officers believed that input into decision-making had a positive effect on nurse retention, but was not as important as salaries, educational benefits, and autonomy. The majority believed that staff nurses were more interested in serving on patient care and nursing practice committees than those not directly work-related. The survey also revealed that once on a committee, nurses continued to be interested if they believed that their participation could make a difference in the hospital policies and procedures and if they could see positive effects on practice. Most respondents believed that input into decisions provided nurses with a greater sense of control over their work and a stake in the success of the organization. However, none of the data were collected from staff nurses.

Several studies of job satisfaction and turnover in nursing identified lack of autonomy and participation as part of the reason for job dissatisfaction and turnover (Alexander, 1988; McCloskey & McCain, 1987; Prescott & Bowen 1985). In a hallmark study, Price and Mueller (1981) investigated turnover in one thousand registered nurses in

a multistage, causal model. Participation in decision-making was identified as one of the factors influencing job satisfaction. In a study of 320 staff nurses, McCloskey and McCain (1987) reported decreased job satisfaction, organizational commitment, and professionalism over their first year of employment in a large hospital for both new graduates and experienced nurses. The decline occurred during the first six months of employment for all nurses, which suggests that initial expectations were not met. Nurses were most satisfied with social rewards and least satisfied with psychological and safety rewards. Specifically, nurses were least satisfied with their schedules, compensation for weekend work, participation in decision-making, and recognition of work by superiors.

Few studies investigated outcomes of clinical decision-making. However, in a qualitative study of clinical decision-making in staff nurses, head nurses, supervisors, and physicians, nurses were "generally" satisfied with their involvement in clinical decision-making (Prescott, Dennis, & Jacox, 1987). In contrast, nurses were dissatisfied when they were frustrated with their decision-making roles. Seventy-three percent were satisfied with their roles in decision-making, while twenty-two percent were dissatisfied. Nurses on specialized and critical care units were more satisfied than were nurses working on medical-surgical units. A wide discrepancy existed for types of decisions that nurses "want" and types they "have." Staff nurses were described as being interdependent with physicians for many decisional areas, and physicians generally resisted decision-making discretion of nurses. Hospitals with strong administrative support that valued the worth of nursing and fostered physician-nurse communication facilitated nurse decision-making.

The investigators suggested new governance models and delivery systems that encouraged nurses to assume greater decisional roles and accountability for their decisions.

Alexander (1988) used Price's (1977) model of turnover in a study of 1726 RNs and LPNs. Two centralization measures were investigated: staff RN influence in unit-related decisions and decision-making authority of the head nurse. Surprisingly, a moderate positive relationship was found between the degree of RN influence in unit decisions and RN turnover. The predicted direction of centralization was not supported by the data. The more RNs perceived themselves to be involved in unit decisions, the greater the turnover in the unit. Alexander suggested that organizational strategies that focused on providing nurses with more decision-making control may be ineffective in reducing turnover if unaccompanied by other structural changes.

Perceived Importance of Involvement and Actual Involvement in Decision-Making

Allen and associates (1987) investigated importance of involvement and involvement in decision-making in 302 nursing personnel in a hospital with shared governance. The fit (or match) between importance and involvement in organizational decision-making and its effects on job satisfaction, commitment, role conflict, performance reward, and motivation were investigated. Participation in decision-making was measured by two variables: control-authority and the importance/involvement scale. Control-authority was operationalized by the degree of latitude one has in making job-related decisions and was derived from the Job Discretion scale (Van de Ven & Ferry, 1980). Staff nurses rated the following decisional areas: tasks, policies and procedures, handling exceptions, and determining performance criteria. The Importance/Involvement scale (Allen et al., 1987)

used a five-point Likert scale to rate ten decisional areas for importance and involvement. Job satisfaction was measured by using eight items on a five point scale from the Organizational Assessment Index (Taylor & Bowers, 1972) that measured satisfaction with job, pay, supervision, co-workers, past and present career advancement, and future career advancement. The Performance-Reward scale measured the extent to which employees believed their performance would be rewarded if it was good or sanctioned if it was unsatisfactory. Organizational commitment measured the desire or intent to stay in the organization, acceptance of the organization's goals or values, and willingness to exert effort on the organization's behalf. Motivation measured the effort an employee exerted in doing his/her job and the degree to which an employee was self-motivated to perform the job. Subjects were divided into high and low groups on importance and involvement using a mean split on each of the variables. Multi-variate analysis of variance was used to examine the effects of participation (high-matched, low-matched, not-matched) on the dependent variables (job satisfaction, organizational commitment, performance-reward, motivation, and role conflict). A high-matched group indicated high on importance and involvement, whereas low-matched indicated low importance and low involvement. A not-matched group indicated either low importance/high involvement or high importance/low involvement.

Only the findings of the Allen and associates study (1987) that are pertinent to this study, such as participation in decision-making and job satisfaction, will be reported in this section. The findings revealed significant correlations between control-authority and job satisfaction ($r=.37$, $p<.001$). The overall F test was significant ($p=.04$). Results of the

univariate F-tests revealed significant differences for job satisfaction. The highest mean satisfaction score was for the low-matched group (i.e., low importance/low involvement) with a mean of 3.34 on a five-point scale. The lowest mean satisfaction score was for the not-matched group (i.e., high importance/low involvement) with a mean of 3.04. When the not-matched group was compared to the matched group on each of the dependent variables, a significant difference was found for job satisfaction ($t=2.34$, $p=.02$). The not-matched group had significantly lower scores on job satisfaction than the matched group. Consistent with the original hypothesis, nurses whose attitudes concerning participation in decision-making match (or fit) that of the organization will report higher levels of job satisfaction than those who do not match the organization. Findings revealed that the match between importance and involvement significantly influenced job satisfaction. The investigators concluded that individual differences and participation in work-related decisions play a major role in the success or failure of shared governance or any participatory strategy for nurses. Allen and associates' (1987) study helped provide the conceptual framework related to importance/involvement and work satisfaction for this study.

In summary, organizational research demonstrated positive relationships between participation in decision-making and job satisfaction (Ivancevich & Matteson, 1980; Locke & Schweiger, 1979). Most of the earlier studies in nursing involved nurse executives or managers and not staff nurses. However, the few studies that involved staff nurses demonstrated positive relationships between participation and job satisfaction. Weaknesses in the studies included the use of organizational global measures of

participation, failure to measure specific decisional domains in nursing, lack of measurement of desired and actual levels of participation, and lack of attention to the moderator variables that could potentially affect outcomes of participation.

Control Over Nursing Practice and Work Satisfaction

The last section of the literature review describes the research related to control over nursing practice and work satisfaction. The issues of autonomy and control over nursing practice have emerged as significant factors in nearly every major study of nurse satisfaction and turnover in nursing (Blegan & Mueller, 1987; Hinshaw, Smeltzer, & Atwood, 1987; Huey & Hartley, 1988; Price & Mueller, 1981, Roedel & Nystrom, 1988). In the literature, autonomy and control over nursing practice have been used interchangeably. In this study, however, control over nursing practice is being used since it is considered to be a broader concept than autonomy. It is defined as the freedom to evaluate and modify nursing practice and to influence others (Gerber, 1988; Hinshaw & Atwood, 1986).

In a large turnover study of nursing staff members (N=1,597) in fifteen hospitals, Hinshaw, Smeltzer, and Atwood's (1987) five stage theoretical model of anticipated turnover demonstrated that anticipated turnover was moderately predicted by both organizational satisfaction and professional/occupational job satisfaction, group cohesion, and initial expectations of tenure. Sixty-two percent of the sample were RNs, nineteen percent were LPNs, and nineteen percent were nursing assistants. Organizational satisfaction was measured by the Work Satisfaction scale (Slavitt, Stamps, Piedmont, & Hasse, 1978) and was defined as a staff member's positive or negative opinion of the job

in terms of pay or reward, nursing administration style, professional status, and interaction. Professional/occupational satisfaction, measured by the Nurse Job Satisfaction scale (Atwood & Hinshaw, 1980), referred to the nursing staff's opinion of the quality of care they delivered, time to conduct their care activities, and general enjoyment of their position. Both types of satisfaction were expected to influence anticipated turnover (i.e., the higher the job satisfaction, the lower the anticipated turnover). Control over nursing practice was an organizational factor that referred to the concept of centralization and the degree of decision-making allotted to staff members. Autonomy was defined in terms of characteristics of the position that allowed or encouraged individual decision making with daily operational activities. Control over nursing practice and individual autonomy were expected to increase both types of job satisfaction. Fifty-seven percent of the explained variance in organizational job satisfaction was explained by group cohesion ($\beta=.27$), job stress ($\beta=-.34$), control over nursing practice ($\beta=.17$) and autonomy ($\beta=.13$). Also, professional job satisfaction was strongly predicted by job stress ($\beta=-.47$), group cohesion ($\beta=.17$), autonomy ($\beta=.18$) and experience in the agency ($\beta=-.15$). In this study, control over nursing practice and autonomy positively influenced organizational job satisfaction, but not as much as job stress and group cohesion. Autonomy also positively influenced organizational satisfaction, but much less than job stress, group cohesion, and experience in the agency. Baccalaureate nurses valued group cohesion, whereas diploma nurses valued committee involvement and access to ideas. Critical care nurses were more concerned with organizational satisfiers, such as control over practice, than medical-surgical nurses. However, medical-surgical nurses wanted both organizational and

professional satisfiers and strategies for decreasing job stress. Enjoyment of their job, delivery of quality care, group cohesion, and control over nursing practice through committee involvement were important to medical-surgical nurses. Control over professional practice and autonomy within one's professional practice were viewed as "satisfiers" by staff nurses.

Blegan and Mueller (1987) tested a model of job satisfaction using thirteen causal determinants and five correlates in a longitudinal study of 370 RNs in five hospitals. In contrast to Hinshaw and associates' (1987) findings and contrary to Blegan and Mueller's prediction, autonomy had surprisingly little effect on job satisfaction in the three causal models tested. However, the authors suggested retaining autonomy in future studies since other studies have established its importance.

In another job satisfaction study, Roedel and Nystrom (1988) reported that autonomy was significantly related with all aspects of satisfaction (i.e., work, pay, promotion, supervision, co-workers, and the job in general). The highest correlation was between autonomy and satisfaction with the supervisor. Autonomy was defined as the degree to which the job provided freedom, independence, and discretion of the employee in scheduling the work and determining the procedures to be used in carrying it out.

In summary, the studies investigating the relationships between autonomy and/or control over nursing practice and job satisfaction have been contradictory. Most studies have demonstrative positive relationships between autonomy and/or control over nursing practice and job satisfaction (Hinshaw, Smeltzer, & Atwood, 1987; Huey & Hartley, 1988; Price & Mueller, 1981; Roedel & Nystrom, 1988). However, Blegan and Mueller

(1987) found that autonomy had little effect on work satisfaction in three causal models of job satisfaction. One study specifically investigated the concept of control over nursing practice (Hinshaw et al., 1987), but most have used the concept of autonomy and control over nursing practice interchangeably (Blegan & Mueller, 1987; Huey & Hartley, 1987; Price & Mueller, 1981; Roedel & Nystrom, 1988). Therefore, operational definitions must be carefully evaluated, since autonomy may not have the same meaning as control over nursing practice. Autonomy refers to individual freedom to make decisions within one's immediate work environment. On the other hand, control over nursing practice not only refers to freedom to make decisions, but the ability to influence others in the work environment and to make changes in practice. In this study, control over nursing practice was conceptually defined as freedom to evaluate and modify nursing practice and influence others in the work environment (Gerber, 1988).

Summary

Despite the interest in shared governance and the descriptive literature proclaiming its success, there is a paucity of research on the effects of shared governance on staff nurse attitudes. Several studies suggested that future research use a longitudinal or comparative design over a period of years to investigate the long term effects of shared governance on staff nurses. Although there appears to be evidence in the literature pertaining to nurses' desire for greater participative decision-making, few studies have specifically investigated this concept among staff nurses. The empirical findings have revealed a discrepancy between desired and actual levels of participation in decision-making. This discrepancy has not been explored among staff nurses or with specific organizational decisions.

Furthermore, numerous arguments were given for changing the organizational culture towards a more participative work environment and a system of self (or shared) governance for professionals. Also, the literature revealed that autonomy had a significant impact on job satisfaction in several studies. Fewer conclusions can be made regarding the relationships between control over nursing practice and job satisfaction and between control over nursing practice and participation in decision-making. No studies could be found that investigated the relationship between participation in decision-making and control over nursing practice. In the literature, control over nursing practice has been used interchangeably with autonomy, so the conceptual distinction is less clear. Lastly, predictors of work satisfaction are multi-variate and complex and include both individual and organizational factors. Simple correlational techniques are not powerful enough because numerous factors in the work environment interact simultaneously to influence work satisfaction. Therefore, the study of work satisfaction requires more powerful techniques, such as multiple regression, to examine the variables affecting work satisfaction. Organizational culture, staff nurse years in shared governance, perceived importance of involvement and actual involvement in decision-making, and control over nursing practice are the variables believed to affect the work satisfaction of staff nurses within a shared governance framework. Chapter III will discuss the methodology of the study.

CHAPTER III

Methodology

The following sections describe the methodology used in this study. The research design, sample and setting, instruments, procedures for data collection and data analysis, and protection of human subjects are addressed.

Design

A survey approach using a descriptive, correlational design was used to study work satisfaction among staff nurses who were employed in hospitals with shared governance.

A survey approach was used since a longitudinal study was not feasible at this time. A descriptive study was used to describe phenomena as they naturally occurred. No attempt was made to manipulate the variables. A correlational design allowed for the assessment of several variables and their relationships simultaneously in a realistic setting.

Furthermore, this design allowed for the testing of the strongest predictors of work satisfaction. A correlational design was appropriate since the variables were complex and did not lend themselves to the use of more precise experimental methods. The paucity of research on shared governance and staff nurse participation in decision-making prohibited the use of a design with a greater explanatory power. However, this study may provide the framework for a later study in which the testing of cause and effect relationships is possible (Waltz & Bausell, 1986).

Sample

Setting

The study was conducted in three community hospitals located in the southern and western regions of the United States. Hospitals were identified through personal contact with a nationally known consultant in shared governance (Porter-O'Grady, 1988). Hospitals were purposively selected based on duration (years and/or months) of shared governance and the presence of a councilor model of shared governance. Hospital duration of implementation of shared governance ranged from less than two years to greater than twelve years (approximately thirteen years). One large medical center was divided into two study sites because shared governance was implemented at distinctly different times, thus permitting two separate study sites in one hospital. At this medical center, the critical care division implemented shared governance within the past two years; whereas the acute care division implemented their model six to eight years prior to the time of data collection (1992). In addition, these two divisions had distinct organizational structures, further justifying their separation in this study. Three hospitals (four study sites) were purposively selected based on their duration of implementation of shared governance: Hospital 1 (<2 yrs), Hospital 2 (2-4 yrs), Hospital 3 (6-8 yrs), and Hospital 4 (>12 yrs). The rationale for choosing hospitals that were at different stages of implementation of shared governance was based on previous studies (Ludemann & Brown, 1989; Pinkerton, 1988) suggesting that attitudinal changes could not be expected for several years after implementation. It was assumed that nurses would have varying lengths of involvement in shared governance depending on their employment patterns.

Furthermore, attitudes toward work were expected to be more positive for nurses with a longer history of employment under a shared governance model than those with a shorter period of employment.

Criteria for hospital selection consisted of (a) a decentralized nursing organizational structure, (b) a councilor model of shared governance, (c) written bylaws, and (d) council authority for all practice-related decisions. These criteria were based on the defining characteristics of shared governance described in the literature (Porter-O'Grady, 1987). A decentralized organizational structure has been described as one in which decision-making authority has been delegated to employees in the lower levels of the organization and where there are few levels of authority between the top executive and the lowest person in the organization (Price & Mueller, 1986).

The investigator met the nurse executive and validated the selection criteria at that time. A copy of the nursing organizational chart was analyzed at each hospital for evidence of a decentralized nursing organizational structure with no more than three levels between the nurse executive and staff nurse. Decentralization was also measured through evidence of staff nurse representation on the councils, unit committees, and hospital committees. A copy of the bylaws was also inspected to validate the date of approval of the shared governance model. The official date was often much later than the date of implementation because of the slow approval process within the organization. Consequently, the dates of implementation provided by the nurse executives were the dates used in the hospital selection process, not the actual date on the bylaws.

Data on the characteristics of the hospital organization and shared governance model were obtained from the Organizational Profile questionnaire completed by the chief nurse executive at each hospital (Appendix A). All hospitals were non-profit, community hospitals ranging in size from 141 to 523 beds. The two smallest sites (141 and 270 beds, respectively) represented the critical care (Hospital 1) and acute care (Hospital 3) divisions of the same large medical center. Bed sizes for the other hospital sites were 346 (Hospital 4) and 523 (Hospital 2), respectively. Thus, actual hospital size for the three hospitals ranged from 346 to 665 beds. Types of nursing care delivery systems included primary nursing, modified primary nursing, and patient-focused care (or Care 2000).

Hospitals with longer periods of implementation of shared governance reported a higher percentage of RNs. The percentage of RNs to all nursing personnel are listed in descending order: Hospital 4 (81%), Hospital 3 (67%), Hospital 2 (58%), and Hospital 1 (49%). The method for determining the proportion of RNs was obtained by dividing the number of RNs by the number of all nursing personnel (LPNs, nurse aides, or patient-care technicians).

Vacancy rate was defined as the number of available RN positions divided by the number of RN positions required for adequate staffing. Hospitals reported the vacancy rates at the beginning of their shared governance and at the present time. Current RN vacancy rates ranged from five to nine percent and were relatively consistent across hospitals. Vacancy rates decreased from 30% in 1986-1987, when rates were first recorded by hospitals, to five percent in 1992, when the data were collected. Vacancy rates at the beginning of shared governance were lowest in Hospital 4 (23%), followed by

Hospital 3 (25%), and Hospital 2 (30%). The vacancy rate for Hospital 1 was five percent in 1992, when the hospital first began to track this data and when shared governance was begun.

Data on the characteristics of the shared governance model is described in this section. Participation in shared governance was restricted to RNs in all study sites except Hospital 2. This hospital reported an all RN participation from 1989 to 1992, followed by multi-disciplinary participation thereafter, which included all nursing personnel. The structure of the shared governance councils was similar for all sites and consisted of (a) nursing practice, (b) education, (c) quality assessment (improvement/evaluation), and (d) management (or coordinating) councils. The CNEs reported that shared governance councils had final authority for all practice related decisions. Type of unit committees corresponded to the councils except there were additional taskforces to accomplish the work on the nursing units.

Subjects

Demographic data were obtained from the staff nurses who completed the Demographic Profile questionnaire (Appendix B). The sample consisted of all full time (greater than 32 hours per week) RNs who had primary responsibility for patient care and were hospital employees, including pool or per diem nurses employed by the hospital. This excluded nurses hired by an outside agency (or registry). Nurses from all shifts (i.e., day, evening, night) and all shift variations (i.e., eight, ten, or twelve hour shifts) were included in the sample. All clinical areas were included as long as the nursing unit was involved in shared governance.

Simple random sampling was used to obtain the sample. A complete list of staff nurses was obtained from each nursing department manager. After numbering all persons in the target population, subjects were chosen using a table of random numbers. This method eliminated any selection bias or systematic bias imposed by the researcher. Sample size was based on power analysis. Using a power table for Pearson Correlation for a directional test at a 0.05 level of significance and assuming a population correlation coefficient square of 0.1 (moderate simple correlation of 0.3), a minimum of thirty subjects per hospital (or 120 subjects total) was required to achieve a power of 0.8 (Cohen & Cohen, 1975). Questionnaires were distributed to two hundred subjects in each of three settings, while 182 questionnaires (total population) were distributed in the fourth setting (total population) for a combined total of 782. A follow-up distribution of fifty questionnaires per hospital to nonresponders was conducted for a total of 982 for both data collection periods.

Procedure for Data Collection

After the investigator personally contacted the nurse executives by phone, the Nurse Executive Letter of Inquiry was sent to each nurse executive explaining the nature and purpose of the study and to enlist their support (Appendix C). Next, the investigator personally met with each nurse executive to explain the study. A letter of tentative commitment to participate in the research was obtained, pending formal approval by the nursing research councils. Chairpersons of the research councils were then contacted by phone to enlist their support in the study.

After obtaining approval from the Committee for the Protection of Human Subjects at the University of San Diego (Appendix D), a proposal and complete set of instruments were forwarded to the nursing research council at each hospital for final approval. Research packets contained the following: (a) a cover letter, (b) instruments, and (c) a self-addressed stamped return envelope. A Cover Letter to Participants was used instead of a consent form since there was no risk to subjects (Appendix E). The cover letter contained a description of the research, the purpose and benefits, voluntary nature of the study, and measures to protect anonymity and confidentiality. Return of the completed questionnaire signified consent to participate in the study. The completed questionnaire was requested to be returned to the investigator within three weeks of receiving it. Confidentiality of the data was protected by keeping the results in a locked file cabinet for five years before being destroyed.

Several mechanisms were used to ensure a satisfactory response rate. The investigator formally presented the research proposal at a quarterly staff meeting in one hospital. In the other hospitals, the chair of the nursing practice or research council discussed the nature of the research at a general staff meeting. One month prior to data collection, a description of the research study was published in one hospital newsletter to alert the nursing staff to the upcoming research. After receiving approval from the human subjects' committees in each hospital, 782 questionnaires were distributed to staff nurses via the unit mailboxes during the first data collection period. Four to six weeks following the first data collection period, a random sample of two hundred non-responders (fifty per study site) were sent follow-up letters requesting their participation along with another

questionnaire and a self-addressed stamped envelope. The total number of questionnaires distributed was 982. Non-responders were identified by a code number which was placed at the top of the questionnaire. However, confidentiality was protected since only group data were reported in the findings.

Instruments

The staff nurse questionnaire packet consisted of the following instruments: (a) the Organizational Culture (OC) tool (b) the Importance/Involvement (IMP/INV) scale (c) the Control over Nursing Practice (CONP) tool (d) the Index of Work Satisfaction (IWS)-Part B tool, and (e) the Demographic Profile. The chief nurse executives completed the Organizational Profile instruments for their hospitals.

Organizational Profile

The Organizational Profile instrument, developed by the investigator, was used to gather the following information: (a) hospital size, (b) organizational structure, (c) levels in the chain of command between the CNE and staff nurses, (d) nursing care delivery system, and (e) the number of full time and part-time RNs (See Appendix A). The questions pertaining to shared governance included (a) years of implementation of shared governance; (b) date of written bylaws; (c) council structure; (d) type of membership (i.e., RNs only); (e) percent of staff nurse involvement in the shared governance councils, unit committees, and hospital committees; and (f) council authority for decisions.

Hospital size was requested for the purpose of describing the sample only. No data could be found in the literature related to hospital size and outcomes of shared governance. Data on the organizational structure was obtained to provide information on

decentralization which was described as a necessary criterion for shared governance (Porter-O'Grady & Finnegan, 1984). The organizational chart was inspected for levels in the chain of command between the CNE and staff nurse to determine the degree of centralization. Levels in the chain of command have been used to depict centralization of an organization (Price & Mueller, 1986). Three to four levels have been described as a decentralized structure. The shared governance structure also was analyzed for staff nurse representation on the councils and unit-level committees. The hospital and shared governance organizational charts were not collected but were inspected at each hospital to verify the criteria for selection and decentralization. Information related to participation in hospital committees was elicited to determine the degree of participation in hospital committees compared to shared governance committees. Type of nursing care delivery system was requested to determine whether various delivery systems were related to outcomes of shared governance. Previous research failed to find differences in work attitudes related to type of healthcare delivery system (Ludemann & Brown, 1989; Pinkerton, 1988). Type of delivery system was not addressed as a specific variable because of the similarities in systems across sites.

Data on full-time nursing equivalents (FTEs), full-time and part-time RNs, and pool or per diem RNs were obtained to compare the ratio of RNs to total nursing FTEs. This information was used to identify the percent of RN staff employed by the hospital. One study reported greater commitment to the Nursing Congress among the full-time staff nurses (Ludemann & Brown, 1989).

Duration of implementation of shared governance, date of written bylaws, and a copy of the shared governance organizational structure were requested to verify the selection criteria. Date of implementation of SG was identified by the nurse executive since the date on the written bylaws was often later than the actual start of implementation because of the legal approval system. Type of shared governance membership varied across hospitals depending on the philosophy of the hospital. The type of membership was elicited to help identify differences in the sample relative to the outcomes of shared governance. Previous research did not address this phenomenon. Membership that consisted of RNs only has been described in the literature as a more professionalized model (Porter-O'Grady, 1987).

Information on council authority for decision-making and veto power of the CNE was elicited to determine whether the councils had final authority for practice-related decisions. In the literature, one of the criteria for defining a shared governance model is that the councils have final authority for decisions within their scope of authority (i.e., practice decisions) (Porter-O'Grady & Finnegan, 1984).

Organizational Culture

The Organizational Culture scale consists of twenty questions relating to four cultures (productivity, quality, creativity, and cooperation) for a total of eighty items (Rowe & Boulgarides, 1984a). Sample items from the Organizational Culture scale are depicted in Appendix F. Productivity refers to a culture that emphasizes efficiency, consistency, and adherence to procedures. Quality refers to an emphasis on effectiveness, the importance of planning, and problem-solving. Creativity refers to an emphasis on

invention, innovation, entrepreneurship, experimentation, and risk-taking. Cooperation is defined as a culture that emphasizes teamwork, interaction, communication, group processes, support, and reinforcement of fellow workers (Boulgarides & Rowe, 1986).

Subjects were asked to rate the statements related to each of the four cultures with respect to the degree to which they reflect their organizational culture, using a four-point scale: 1 (least), 2 (slight), 3 (moderate), and 4 (most). Each column was summed for a scale score for that culture. A summed total value for all four cultures is not meaningful. The scale score with the highest frequency represents the staff nurse's perception of the culture in that hospital. Since the culture subscales were independent of one another, the subscales were to be entered into the regression formula separately to determine which type of culture explained the most variance in work satisfaction. However, since shared governance is based on a participative work environment, the cooperative (or participative) culture was to be used as the predictor of work satisfaction in the regression analysis.

The organizational culture instrument (OCI) was developed in conjunction with the Decision Styles Inventory (DSI) and the Values Inventory (VI) for a Department of Defense (DOD) study (Rowe & Boulgarides, 1984b). The validation study consisted of correlating the OCI with the DSI and the VI, two similarly designed instruments (Hane, Rowe, & Boulgarides, 1984). The DSI (four styles) was correlated with the VI (four values) and the OC (four cultures) (Rowe & Boulgarides, 1983). The validation study consisted of a sample of 428 DOD and non-DOD managers in eight organizations. The correlation coefficient among the twelve scales (three instruments times four styles)

revealed a consistent pattern for comparable scales. That is, each of the scales had a strong, statistically significant correlation with the corresponding scale on the other two inventories. Correlation coefficients for subscale items ranged from .24 to .49.

Productivity culture correlated most highly with the pragmatist value ($r=.40$) and the directive decision style ($r=.30$). The quality culture correlated most highly with the theorist value ($r=.20$) and analytic decision style ($r=.40$). Creativity culture correlated most highly with the humanistic value ($r=.32$) and conceptual decision style ($r=.41$). The cooperative culture correlated most highly with the humanistic value ($r=.48$) and behavioral decision style ($r=.37$).

Internal consistency reliability was calculated in several ways. The relationship between a scale and each of its component items was calculated as the correlation coefficient between the scale score and the item score. Only ten (4.2%) of the 240 items (twenty items times three scales times four styles) had correlations with their total scale score of less than .15. Only three items (1.2%) had correlations less than .10, and the smallest correlation was .08. These results indicate a moderate-to-high contribution of individual items to scale total scores. Split-half reliability consisting of correlating the odd with the even items ranged from .36 to .73. Sixty-seven percent of the split-half correlations exceeded .50, while forty-two percent were approximately .70 (Hane, Rowe, & Boulgarides, 1984). Given the significant correlations among corresponding scales, the values ranging from .50 to .70 were deemed satisfactory for use of the instrument in this study.

Importance-Involvement Scale.

The IMP/INV scale was used to measure perceived importance of involvement in decision-making and actual involvement in decision-making. The IMP/INV scale consisted of seventeen decisional items on a five-point Likert scale. The IMP scale ranged from one (not important to be involved in this decision) to five (extremely important to be involved). The INV scale ranged from one (not at all involved in this decision) to five (as completely involved in this decision as I want to be) (Allen et al., 1987). Sample items for the IMP/INV scale are presented in Appendix G. Scores were summed and averaged resulting in a mean score for importance of involvement and a mean score for involvement in decision-making. The decisional tool originally was developed by Alutto and Vrendenburgh (1977) for a study of 197 nurses. Responses are dichotomous and refer only to the number of desired and actual decisions. The thirteen decision items were based on a review of research on nursing roles and participation in decision-making. Allen and associates (1987) modified Alutto & Vrendenburgh's tool by changing it to a Likert format, extending it to seventeen items, and changing the name to the IMP/INV scale. Validity was established through a review of the nursing literature, content experts, and interviews with staff nurses in a pilot study. Decisional items consisted of both organizational decisions (e.g., hiring personnel, creating nursing policies) and practice - related decisions (e.g., providing information to patients, determining patients' goals). In a study of 302 nursing personnel, the internal consistency for the IMP/INV scale was .94 and .86, respectively (Allen et al., 1987). In six uses of the instrument, the alpha coefficients ranged from .88 to .96 for a total of one thousand in the nurse sample. The

tool developed by Allen and associates (1987) was used without modification in this study.

A congruence or "fit" between importance and involvement was analyzed by using a discrepancy approach to measurement. A discrepancy score was obtained by obtaining the absolute difference between importance of involvement and involvement in decision-making for each decisional item for each subject. The higher the score, the greater the discrepancy between importance and involvement in decision-making for that item. The discrepancy approach was used since the direction of the difference was not important, but rather the magnitude of that difference. That is, whether the obtained value was plus or minus was not important. For example, an importance score of 4 minus an involvement score of 1 yields a difference score of 3. The reverse is also true. Subtracting a score of 4 from a score of 1 is the same as subtracting a score of 1 from 4. The absolute difference is still 3. The mean discrepancy scores for all items were summed to produce an overall mean discrepancy score. This overall mean discrepancy score was used as the predictor of work satisfaction in the regression analysis. The discrepancy scores represented values per subject and not per site, since the unit of analysis was the individual.

Control Over Nursing Practice

The CONP instrument consists of twenty-three items on a seven-point Likert scale ranging from 1 (disagree) to 7 (agree) (Gerber, 1988). Sample items from the CONP scale are depicted in Appendix H. Item scores are summed and averaged, resulting in a mean score for control over nursing practice. Control over nursing practice is defined as the freedom to evaluate and modify nursing practice and to influence others (Gerber, 1988).

The scale was designed to be used with staff nurses who are employed in hospitals. In the 1970's, Horsley and Pelz measured the concept of control over nursing practice in their study on the conduct and utilization of research in nursing (CURN project) (Horsley & Pelz, 1976-1981). Later, Hinshaw and Atwood (1986) revised the instrument for use in their study of anticipated turnover in nursing. Then Gerber (1988) revised the scale again. Most of the items in Gerber's scale reflect the conceptual orientation of the previous scales, but several new items have been added.

The modified CONP scale (Gerber, 1988) is the most recent version and was used in this study. Gerber's thirty-item scale was pretested on 224 RNs with an alpha reliability of .92. Based on exploratory factor analysis and assessment of item-item and item-total scale correlations, several items were omitted and others rewritten. The psychometric properties were based on baseline data collected in 1989 on 336 RNs in four hospitals in Arizona (Gerber, 1988). The internal consistency reliability using Cronbach's alpha correlation coefficient was estimated at .89. Construct validity was found to be relatively strong. When using confirmatory factor analysis techniques, all items loaded on one factor (coefficient of .40 and at least .20 above any other loading, except for item eleven, "free to decide who was hired to work here.") Discriminant validity was strong when the CONP scale was factor analyzed simultaneously with other scales. When control over nursing practice was entered simultaneously with organizational commitment and the group cohesion scale, each scale clearly loaded on the expected factor. However, item eleven failed to load on any of the factors. Predictive validity of the CONP scale is also relatively strong. Using multiple regression techniques, control over nursing practice was associated

positively with work satisfaction as predicted. In this study, the mean CONP score was used in the regression analysis as a predictor of work satisfaction.

Index of Work Satisfaction-Part B

The IWS-Part B consists of 44 items on a seven-point Likert scale, ranging from strongly disagree (1) to strongly agree (7) (Stamps & Piedmont, 1986). Sample items from the IWS-Part B are depicted in Appendix I. The scale was designed to measure the level of organizational satisfaction in six work components: pay, autonomy, task requirements, organizational requirements, job status, and interaction. Pay is defined as a dollar remuneration and fringe benefits received for work done. Autonomy refers to the amount of work-related independence, initiative, and freedom either permitted or required in daily work activities. Task requirements are those things that must be done as a regular part of the job. Organizational requirements are constraints or limits imposed upon work activities by the organization's management. Job status is the perceived overall importance of the job at the personal level as well as its importance to the organization and community. Interaction refers to opportunities and requirements presented for formal and informal social and professional contact during working hours.

The Index of Work Satisfaction tool was selected over other satisfaction tools because it contained the major components of work satisfaction which were identified in the majority of studies in the literature. More specifically, this tool included the concept of autonomy as a separate component of work satisfaction which is essential to a successful shared governance model. Lastly, the Index of Work Satisfaction has established validity and reliability based on its use in a number of nursing studies.

Since the six components are conceptually separate dimensions of satisfaction, each component yields a separate scale score, as well as a total summed score. The interaction component is divided into two components: nurse-nurse interaction and physician-nurse interaction. Thus, it is possible to separate this component to obtain separate scores for both types of interaction, as well as a total subscale value. Half of the items are positively phrased and half are negatively phrased and are randomly distributed throughout the questionnaire. Responses are reversed in such a way that a higher summed score represents a higher level of satisfaction. The seven-point response scale has a neutral midpoint which represents an undecided option and allows the investigator to differentiate between high and low levels of occupational satisfaction. Only the summated IWS score was used as the criterion measure in this study. Data on the separate subscales were analyzed for descriptive purposes only and not entered into the regression equation.

In the original study, the Cronbach's alpha coefficient of internal reliability for the IWS-Part B ranged from .80 to .90 (Slavitt et al., 1978). In the final validation study on 246 staff nurses, the Cronbach alpha ranged from .52 to .81, with a total alpha of .82, and a Kendall's Tau of .92. Intrascale reliabilities were as follows: pay (.85); interaction (.83), professional status (.76), physician-nurse relationship (.70), task requirements (.70), autonomy (.70), and organizational requirements (.84). Validity of the scale items was assessed using factor analytic techniques, specifically principle component analysis with varimax rotation. Four factor analytic studies were conducted resulting in a reduction from seventy-two to forty-four items. Confirmatory factor analysis supported the revisions made by the investigators.

Demographic Profile Questionnaire

The Demographic Profile questionnaire, developed by the investigator, was used to obtain information on the following: age; sex; marital status; education; employment status; years employed in nursing, the hospital, nursing unit; years in shared governance; clinical area; and type of shift worked (See Appendix B). Validity for obtaining this information was based on two previous studies that investigated outcomes of shared governance (Ludemann & Brown, 1989; Pinkerton, 1988).

Questions were designed to elicit information on participation in shared governance in the following areas: council and unit committees, previous participation in shared governance with positions held, years and/or months of employment under shared governance, and hours per week involved in shared governance activities. Lastly, an open-ended question was developed to elicit information on which types of decisions staff nurses would like greater involvement. Validity for obtaining the above data was established in a previous study that determined individual participation patterns in shared governance (Ludemann & Brown, 1989). In the present study, the investigator attempted to elicit more specific information on involvement in shared governance. The open-ended question concerning types of decisions in which staff nurses would like greater involvement was added because the IMP/INV scale used a structured, pre-coded format that did not allow individual preferences to be identified.

Data Analysis

Descriptive statistics were used to analyze the demographic and organizational data and to describe the sample. Descriptive statistics are used to report what is observed in a

sample (Munro, Visintainer, & Page, 1986). Frequency distributions and histograms of the values of all variables were inspected. This allowed for the calculation of means and percentages on all the demographic variables, such as age, education, and employment status. Frequency distributions were also inspected on all values related to committee participation. Cross-tabulations, scattergrams, and correlations were then examined for bivariate relationships. Bivariate correlations between the predictor variables and the criterion variable were assessed using Pearson product-moment correlation coefficients. This step also included exploring for multi-collinearity among the predictor variables by inspecting the correlational matrix. A high correlation between the predictor variables suggests that the variables are not independent, leading to difficulties in estimating the regression statistic. The problem of potential multi-collinearity will be discussed further in Chapter IV.

Multiple regression was conducted incorporating the conceptual framework of the study. Multiple regression is used when there is a measurable multiple correlation between a group of independent variables and one dependent variable (Munro, et al., 1986). Further, multiple regression allows one to examine the direction and extent of the relationships, as well as the predictive power of the variables included in the research framework. Forward stepwise multiple regression analysis was used to determine which of the predictor variables contributed most to the explained variance in the criterion variable of work satisfaction. With the forward stepwise procedure, the predictor variable that is most highly correlated with the criterion variable is entered first, followed by the one with the next highest partial correlation until all predictor variables have been included in the

regression equation. The predictor variables are years in shared governance, organizational culture, perceived importance of involvement, actual involvement in decision-making, discrepancy between importance and involvement, and control over nursing practice. The criterion variable is work satisfaction.

Testing for assumptions for multiple regression was conducted by analyzing the scatter diagrams. Diagrams of the standardized residuals and normal probability plots provided graphic evidence to support that the errors were normally distributed. Scatterplots were inspected for outliers or extreme residuals. All but one case in 188 provided evidence of a normal distribution. The assumption of linearity was supported when the scatterplots depicted a nearly straight line for all the standardized residuals. Residual statistics were also analyzed to test the assumption of homoscedasticity, or equal variance of errors for all levels of a predictor. Residuals for all levels of the predictor variables were consistent and displayed equal variability as evidenced by the standardized scatterplot. The F -distribution was used in testing the significance of the R^2 change and each of the b -weights. The significance level for the overall F -test was .05. The Statistical Package for the Social Science-Extended Version 2.0 (SPSS-X, 1988) was used to analyze the data in this study. These procedures and the research findings are discussed in more detail in the next chapter.

Summary

Chapter III described the research methodology for the study. The study used a descriptive, correlational design that investigated staff nurses in three hospitals which had shared governance models. Hospitals were purposely selected according to their duration

of shared governance. A total of 782 questionnaires were distributed to staff nurses. An additional two hundred questionnaires were distributed in a follow-up data collection. The research packet for staff nurses consisted of the following instruments: the OC scale, the IMP/INV scale, the CONP scale, the IWS-Part B tool, and the Demographic Profile. The Organizational Profile was completed by the nurse executive at each hospital. Validity and reliability for each of the instruments were discussed. Data analysis consisted of descriptive and correlational statistics which included the Pearson product-moment correlation and multiple regression techniques.

CHAPTER IV

Results

Chapter IV is divided into two major sections: (a) descriptive results pertaining to sample characteristics, participative patterns, and the predictor and criterion variables; and (b) inferential results pertaining to the research questions. A descriptive, correlational design was used to answer the research questions in this study. The predictor variables were organizational culture, staff nurse years in shared governance, perceived importance of involvement in decision-making, actual involvement in decision-making, discrepancy between importance and involvement, and control of nursing practice. The criterion variable was work satisfaction. Organizational culture was not used in the statistical analysis because of the large amount of missing and/or inaccurate data. Data were analyzed through a process of data reduction, data aggregation, and model testing which included regression analysis and the testing of assumptions.

Descriptive Findings

Characteristics of the Sample

Respondents returned 222 questionnaires out of 782 (response rate=28%). However, thirty-four questionnaires were unusable because of incomplete or missing data. Total sample size for data analysis was 188 with a final response rate of 24%. Organizational culture was not included in data analysis because of an inordinate amount of missing data. Forty-eight organizational culture instruments were either incomplete or

inaccurate and could not be used in data analysis. The sample size would have been reduced to an even smaller size if the culture variable had been retained because of the number of unusable questionnaires. Eliminating the forty-eight unusable organizational instruments would have resulted in an 18% response rate. Consequently, this variable was eliminated from the study because of the threats to external validity. Further explanation is provided in the limitations section in Chapter V. Power analysis for the final data set revealed a power at 0.99 for a moderate correlation coefficient of 0.3. Furthermore, the power for a multiple regression four predictor model yielding a moderate R^2 of 0.3 was also .99.

Participant age ranged from twenty-three to sixty-six years with a mean age of thirty-seven years. The mean age was similar for all hospitals, ranging from thirty-five to thirty-eight years of age. Table 1 depicts the frequency distribution for gender, marital status, and highest level of education for the sample. Ninety-seven percent of the sample were female with 65% married, 22% percent single, 12% divorced, and 1% widowed. Forty-three percent of the sample listed a BSN as their basic level of nursing education, followed by ADN (31%) and diploma in nursing (18%). Hospital 1 had the highest percentage of BSN nurses (51%) and Hospital 4 had the lowest (37%). Data on highest level of education for the sample were as follows: master's degree in nursing (2%), master's degree in other field (3%), BSN (45%), ADN (26%), and diploma (18%). Hospital 2 had the largest percentage of nurses with a BS/BSN or above as their highest level of education (64%),

Table 1
Frequency Distribution for Gender, Marital Status, and Education.

Variable	Hospital 1 (SG<2 yrs)		Hospital 2 (SG 2-4 yrs)		Hospital 3 (SG 6-8 yrs)		Hospital 4 (SG>12 yrs)		Total (N=188)	
	(n=55)		(n=41)		(n=32)		(n=60)			
	N	%	N	%	N	%	N	%	N	%
Gender										
Female	53	96	39	95	32	100	58	97	182	97
Male	2	4	2	5	-	-	2	3	6	3
Marital Status										
Married	34	61.8	27	65.9	20	62.5	41	68.3	122	65
Single	14	25.5	7	17.1	8	25	12	20	41	22
Divorced	7	12.7	6	14.6	4	12.5	6	10	23	12
Widowed-	-	-	1	2.4	-	-	1	.7	2	1
Highest Level of Education										
Diploma	10	18.2	8	19.5	7	21.9	8	13.3	33	18
ADN	11	20	11	26.8	7	21.9	19	31.7	48	26
BSN	28	50.9	19	46.3	15	46.9	22	36.7	84	45
BS (other field)	3	5.5	3	17.3	2	6.3	4	6.7	12	6
Master's in Nursing	1	1.8	-	-	-	-	2	3.3	3	2
Master's (other field)	-	-	-	-	1	3.1	4	6.7	5	3
Other	1	1.8	-	-	-	-	1	1.7	2	1

while Hospital 4 had the smallest (55%). Hours per week involved in shared governance activities ranged from zero to ten hours (\bar{x} =1.32 hours). Years employed in nursing ranged from less than one year to thirty-eight years with a mean of twelve. Years employed at the current hospital and nursing unit ranged from less than one year to thirty years, with means of six and five years, respectively. Number of years that staff nurses were employed under a shared governance model (years in shared governance) ranged from less than one year to thirteen years with a mean of three years. Nurses in Hospital 4 reported the greatest number of years in shared governance (\bar{x} =4.0 yrs) and Hospital 1 the least (\bar{x} =1.4 yrs). Lack of variability in mean number of years involved in shared governance had a negative impact on the ability of this variable to predict work satisfaction. Implications of the lack of variance will be discussed in Chapter V.

Staff nurses worked in the following clinical practice areas: critical care (51%), medical-surgical (31%), surgery (10%), emergency/trauma (4%), and pediatrics (1%). When data were analyzed by hospital, respondents in Hospital 1 reported their major practice areas were critical care (82%) and emergency/trauma (11%) since this site is designated as the critical care division of the medical center. In contrast, Hospital 3 reported the major areas of practice were medical-surgical (78%) and critical care (6%), because this site is designated as the acute care division of the same medical center. The other two hospitals had a balanced proportion of clinical practice areas typical of a community hospital setting. Forty-seven percent of the nurses worked straight days, 19% worked nights, and 13% evenings. Another 12% of the sample worked a rotating shift

(i.e., day-evening), 2% worked weekends only, and approximately 1% worked per diem. The remaining 6% did not indicate their shift on the questionnaire.

Decisional Participation

Overall committee participation. Seventy-six percent of the sample served on an average of 1.4 committees per nurse. Not all respondents served on a committee; whereas others may have served on more than one committee. This percentage includes participation in all hospital committees, including shared governance. The rationale for this question was to determine the overall committee participation by staff nurses because some nurses may have served on a hospital committee but not on a SG committee. Also, a high rate of nurse participation in overall hospital committees may help to determine the hospital's commitment to the SG philosophy. Nurses in Hospital 4 had the highest overall rate of participation (1.66 committees per nurse), while Hospital 3 had the lowest (0.96 committees per nurse). Types of committees with the highest level of participation were practice, education, and evaluation (or continuous quality improvement). Committees with the lowest rate of staff nurse participation were credentialing and products. Hospital 1 had the greatest number of committees (n=12) with staff nurse participation and Hospital 3 the least (n=6). Table 2 depicts the frequency distribution for committee participation for all hospital committees.

Shared governance participation. Thirty-two percent of staff nurses served on shared governance councils. Some respondents served on both the council and unit committees, while others served on more than one unit committee. For council

Table 2

Frequency Distribution of Committee Participation for all Hospital Committees

Committee	Hospital 1 (SG<2 yrs)		Hospital 2 (SG 2-4 yrs)		Hospital 3 (SG 6-8 yrs)		Hospital 4 (SG>12 yrs)		Total	
	(n=43)		(n=51)		(n=13)		(n=62)		(N=169)	
	N	%	N	%	N	%	N	%	N	%
Clinical Practice	7	16.2	9	17.6	3	23.0	25	40.3	44	26.0
Education	10	23.2	9	17.6	1	7.6	12	19.3	32	18.9
Evaluation/CQI	2	4.6	7	13.7	3	23.0	8	12.9	20	11.8
Nursing Care Delivery	5	11.6	6	11.7	4	30.7	2	3.2	17	10.0
Coordinating/ Management	4	9.3	4	7.8	1	7.6	1	1.6	10	5.9
Research	4	9.3	1	1.9	-	-	3	4.8	8	4.7
Salary & Benefits	1	2.3	3	5.8	-	-	3	4.8	7	4.1
Policy/Procedure Standards	3	6.9	4	7.8	-	-	-	-	7	4.1
Scheduling	2	4.6	4	7.8	1	7.6	-	-	7	4.1
Multi-disciplinary	2	4.6	-	-	-	-	4	6.4	6	3.5
Miscellaneous	1	2.3	3	5.8	-	-	1	1.6	5	2.9
Products	2	4.6	1	1.9	-	-	1	1.6	4	2.3
Credentialing	-	-	-	-	-	-	3	4.8	3	1.7

participation, Hospital 2 had the highest rate of total participation (44%) and Hospital 4 the lowest (24%) (Table 3). Councils with the highest level of participation were practice, evaluation/CQI, and education. In Hospital 1, research, practice, and education councils had the highest level of staff participation. In contrast, Hospital 4 reported that evaluation/CQI and the nursing care delivery system councils had the highest rate of council participation. All hospitals reported an increase in participation since beginning shared governance, except for Hospital 4 which reported a slight decrease from 25% to 24%.

Forty-seven percent of respondents served on shared governance unit committees. Committees that had the greatest amount of participation were evaluation/CQI, practice, and education. Hospital 2 had the highest rate of unit participation by staff nurses (68%), followed by Hospitals 3 (34%), 4 (33%), and 1 (17%), respectively.

Decisional areas in which nurses desire participation. Decisional areas identified by nurses for increased involvement were staffing, salary and benefits, and practice. Decisional areas in which nurses had the least desire for participation were scheduling, documentation, and working conditions. Similarities were noted across study sites. Respondents in Hospital 1 indicated the decisional areas of salary/benefits, policy/procedures, and hiring as areas for increased involvement, while Hospital 2 indicated salary/benefits, staffing, and finance. Nurses in Hospital 3 identified staffing, practice, and nursing care delivery system; whereas Hospital 4 nurses identified staffing, practice, and policy/procedures as their top choices. In summary, respondents in all four

Table 3.

Frequency Distribution of Participation in SG Councils and Unit Committees

	Hospital 1 (SG<2 yrs) (n=25)		Hospital 2 (SG 2-4 yrs) (n=46)		Hospital 3 (SG 6-8 yrs) (n=23)		Hospital 4 (SG>12 yrs) (n=54)		Total (N=148)		
	N	%	N	%	N	%	N	%	N	%	
Shared Governance											
Councils	16	29	18	44	12	37	14	24	60	32	
Unit-based Committees	9	17	28	68	11	34	40	33	88	47	

sites identified staffing, salary/benefits, and policy/procedures as areas in need of increased participation in decision-making by staff nurses.

Predictor and Criterion Variables

Staff nurse years in shared governance. Years in shared governance were measured by the number of years and/or months that staff nurses were involved in shared governance in that hospital. Staff nurse years in shared governance ranged from 1.4 to 4.9 years with a mean of 3.2 years for the sample. Mean number of years in shared governance by hospital were (a) Hospital 4 (SG>12 years) with a mean of 4.9 years, (b) Hospital 3 (SG 6-8 years) with a mean of 3.5 years, (c) Hospital 2 (SG 2-4 years) with a mean of 2.9 years, and (d) Hospital 1 (SG<2 years) with a mean of 1.4 years.

Perceived importance of involvement in decision-making. Table 4 depicts the descriptive statistics for the predictor and criterion variables, including importance of involvement. The IMP/INV scale was used to measure both the importance and involvement variables using a five-point Likert scale for seventeen decisional items. The importance and involvement items are depicted in Table 5. For importance, the scale ranged from (1) not important to be involved to (5) extremely important to be involved. The mean rating for Hospital 2 was 3.8, while the mean for each of the other three hospitals was 3.7. Decisional areas which were considered to be most important for staff nurse involvement were (a) providing information to patients/families, (b) determining patient goals, and (c) creating nursing policies and procedures for the unit. Decisional areas of least importance to nurses were (a) determining nursing service budget, (b) hiring new personnel, and (c) assigning unit personnel to daily work.

Table 4

Descriptive Statistics for Predictor and Criterion Variables

Study Variables	Hospital 1 (SG<2 yrs) (n=55)		Hospital 2 (SG 2-4 yrs) (n=41)		Hospital 3 (SG 6-8 yrs) (n=32)		Hospital 4 (SG>12 yrs) (n=60)		Total (N=188)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Importance of Involvement (Range = 1-5)	3.7	0.6	3.8	0.6	3.7	0.6	3.7	0.6	3.8	0.6
Involvement in Decision-making (Range = 1-5)	2.5	0.7	2.5	0.6	2.5	0.7	2.6	0.6	2.5	0.6
Control over Nursing Practice (Range = 1-7)	5.1	0.8	5.3	0.9	5.3	0.8	5.4	0.8	5.3	0.8
Years in Shared Governance (Range= 1.4-4.9)	1.4	1.8	2.9	1.1	3.5	2.3	4.9	3.3	3.2	2.7
Work Satisfaction (Range = 1-7)	4.4	0.7	4.3	0.7	4.4	0.5	4.8	0.8	4.5	0.7

Table 5

Descriptive Statistics for Discrepancy Between IMP and INV Scores

	Decisional Item	Discrepancy Score	
		<i>M</i>	<i>SD</i>
1.	Providing information to patients.	0.53	0.67
2.	Assigning personnel to daily work.	0.81	1.01
3.	Coordinating patient services.	0.74	0.81
4.	Hiring new personnel.	1.43	1.22
5.	Determining nursing salaries.	2.65	1.32
6.	Creating unit policies and procedures.	1.36	1.17
7.	Creating policies and procedures for hospitals.	1.64	1.18
8.	Determining unit budget.	1.72	1.34
9.	Determining job security and job issues.	2.11	1.42
10.	Determining patient goals.	0.52	0.73
11.	Assigning patients to nurses.	0.82	1.07
12.	Determining and coordinating discharge plans.	0.73	0.89
13.	Evaluating administrative structures and processes.	1.76	1.31
14.	Evaluating implications of decisions made by other disciplines.	1.86	1.29
15.	Determining education programs.	1.17	1.05
16.	Impacting multi-disciplinary patient care decision.	1.03	1.04
17.	Determining hospital environmental issues.	1.94	1.22

Note: Discrepancy score is the mean of the absolute difference between IMP and INV for each item.

Actual involvement in decision-making. For involvement, the scale ranged from (1) not at all involved in this decision to (5) as completely involved as I want to be (seventeen decisional items) (see Table 5). Subjects in Hospital 4 were only slightly more involved in decision-making with a mean of 2.6, while the other three sites each had means of 2.5. The decisional areas in which nurses were as involved as they wanted to be were providing information to patients and families, determining patient's goals, and determining and coordinating discharge plans. Decisional areas with the least amount of nurse involvement were determining nursing budget, determining nursing salaries, and hiring new personnel.

Discrepancy between importance and involvement in decision making. The discrepancy score was created by subtracting the absolute difference between importance and involvement for each decisional item (see Table 5). The greatest discrepancies occurred in (a) determining nursing salaries, (b) job security/seniority issues, and (c) hospital environmental issues. Respondents whose overall mean scores matched for importance and involvement indicated that they were satisfied with their involvement. When responses to the IMP/INV scale were compared to the open-ended question about the desire for greater decisional involvement, several similarities were noted. For both the IMP/INV scale and the open-ended question, salary, job security, and seniority issues were the areas in which staff nurses desired greater involvement. In contrast, nurses differed in their responses to the question pertaining to patient care issues. On the IMP/INV scale, respondents indicated they were satisfied with their involvement; yet in the open-ended question, nurses indicated they wanted increased involvement in patient

care decision-making. No explanation can be given for the inconsistency between the IMP/INV scale and the open-ended question for the decisional area related to patient care.

Control over nursing practice. Control over nursing practice was measured using a seven point Likert scale ranging from (1) disagree to (7) agree for twenty-three items. The scale scores were summed for all items and an overall mean score was obtained. The mean score was entered into the regression analysis as a predictor. The mean CONP score was 5.3 for the sample. Hospital 4 had the highest mean rating of 5.4 and the lowest was 5.1 at Hospital 1. Areas with the greatest amount of control were (a) practice clinical skills to the best of my ability, (b) consult with others when solving complex problems, and (c) ask assistance from other staff members. In contrast, items with the least amount of control were (a) help decide who to hire, (b) coordinate care between patients and healthcare services outside the hospital, and (c) influence staffing patterns on my unit. Several similarities existed between the CONP and IMP/INV scales. In both scales, staff nurses were as involved as they wanted to be and had control over practice with issues related to patient care and ability to practice clinical skills. Similarly, staff nurses indicated that they had the least amount of control in staffing, which also was identified in the open-ended question. The findings related to these two instruments were consistent, indicating a valid measure of participation in decision-making. However, it implies that staff nurses were dissatisfied with their involvement, resulting in a lack of control over nursing practice in the areas of staffing, hiring, and coordination of care with outside agencies.

Work satisfaction. Table 6 depicts the descriptive statistics for work satisfaction and the component scores. Work satisfaction was measured by the IWS-Part B consisting

Table 6

Descriptive Statistics for Total Work Satisfaction and Component Scores

Work Satisfaction Component	Hospital 1 (SG<2 years) (n=55)		Hospital 2 (SG 2-4 years) (n=41)		Hospital 3 (SG 6-8 years) (n=32)		Hospital 4 (SG>12 years) (n=60)		Total (N=188)	
	M	SD	M	SD	M	SD	M	SD	M	SD
Total Work Satisfaction	4.40	0.70	4.36	0.70	4.42	0.49	4.79	0.77	4.51	0.71
Component Scores										
Interaction	4.81	0.97	5.00	1.01	5.01	0.76	5.13	0.92	4.99	0.93
Phys-Nurse	4.23	1.32	4.51	1.06	4.37	1.28	4.47	1.29	4.39	1.25
Nurse-Nurse	5.37	1.07	5.49	1.23	5.67	0.82	5.79	1.02	5.58	1.06
Task Requirements	3.87	1.19	3.43	1.17	3.31	1.03	3.95	1.03	3.70	1.13
Professional Status	5.47	0.76	5.67	0.64	5.52	0.60	5.76	0.72	5.61	0.70
Organizational Policies	3.76	1.09	3.65	1.14	3.76	0.79	4.25	1.25	3.89	1.13
Pay	3.11	1.29	2.71	1.37	3.37	1.13	3.87	1.44	3.31	1.39
Autonomy	4.91	0.75	4.94	0.93	4.91	0.87	5.31	1.00	5.04	0.91

Note. Scale ranges from (1) Disagree to (7) Agree. Higher scores indicate higher satisfaction in that area.

of forty-four items on a seven-point Likert scale ranging from (1) strongly disagree to (7) strongly agree. The higher the mean score, the greater the level of satisfaction. In addition to the summated score for the total IWS, six subscales were measured: (a) interaction, (b) professional status, (c) autonomy, (d) organizational policies, (e) pay, and (f) task requirements. Overall, respondents were moderately satisfied with their work ($\bar{x}=4.5$). Furthermore, the sample was relatively homogeneous, with Hospital 4 having the highest mean ($\bar{x}=4.8$), followed by Hospitals 3, 1, and 2 ($\bar{x}=4.42, 4.40,$ and 4.36 , respectively). When the satisfaction subscales were analyzed, respondents were most satisfied with professional status, nurse-nurse interaction, and autonomy; they were least satisfied with pay, task requirements, and organizational policies. When the subscales were analyzed across settings, Hospital 4 scored the highest on all satisfaction subscales. No other patterns emerged with respect to the component scores.

Inferential Findings

Testing For Multicollinearity

The correlational matrix was inspected for multi-collinearity. Redundancy (or high correlations) among predictor variables may lead to difficulties in estimating the regression statistics. In this study, multicollinearity was considered a potential problem if the predictor variables were intercorrelated with $r > .50$ (Pedhazur, 1982). In this study, the only correlation among the major predictor variables that was considered a potential problem was the correlation between control over nursing practice and involvement in decision-making ($r = .53$). The conceptual distinction between control over nursing practice and involvement is small in that control over nursing practice is the influence component

of participation in decision-making, whereas involvement refers to the actual participation in decision-making. One possible solution for this multi-collinearity problem was to delete the control over nursing practice variable. However, since control over nursing practice was deemed an important variable, another approach was used to reduce the redundancy. A discrepancy score was created by taking the absolute difference between importance and involvement for each decisional item, thus yielding a mean discrepancy score for each decisional item. The mean discrepancy scores were summed to produce an overall mean score. The mean discrepancy score was then used as a predictor of work satisfaction. The correlation between the discrepancy score and control over nursing practice was $r=.38$, which was not considered to cause a significant problem with multicollinearity.

Several of the demographic variables posed potential problems with multicollinearity. As expected, all the temporal variables were intercorrelated. Age was highly correlated with years in nursing ($r=.73$); years in hospital ($r=.56$), and years on unit ($r=.52$). Years in nursing was moderately correlated with years in hospital ($r=.62$) and years on unit ($r=.53$). Finally, years in hospital was highly correlated with years on unit ($r=.82$). In the following sections, findings related to each of the research questions will be described.

Bivariate Relationships

Table 7 depicts the correlational matrix for the predictor and criterion variables. Using zero-order coefficients (Pearson product-moment correlations), the variables were examined both in relation to each other and to the criterion of work satisfaction. Both

Table 7
Correlational Matrix for Predictor Variables, Criterion Variable, and WS Component Scores

Variable	Variable Number													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Importance of Involvement	—													
2. Involvement in decisions	.35 ***	—												
3. Discrepancy between IMP and INV	.55 ***	-.51 ***	—											
4. Control over practice	.15 *	.53 ***	-.38 ***	—										
5. Years in Shared Governance	.05	.26 ***	-.20 **	.25 ***	—									
6. Total Work Satisfaction	-.03	.42 ***	-.38 ***	.59 ***	.22 ***	—								
Work Satisfaction Component Scores														
7. Interaction	.04	.24 ***	-.25 ***	.40 ***	.16 *	.73 ***	—							
8. Physician-nurse interaction	-.08	.10	-.16 *	.21 **	.03	.50 ***	.84 ***	—						
9. Nurse-nurse interaction	.23	.30 ***	-.26 ***	.48 ***	.24 ***	.59 ***	.77 ***	.31 ***	—					
10. Task requirements	-.06	.15 *	-.20 **	.38 ***	.08	.64 ***	.32 ***	.23 ***	.29 ***	—				
11. Professional status	.008	.19 ***	-.12 *	.27 ***	.14	.47 ***	.27 ***	.13	.32 ***	.15 *	—			
12. Organizational policies	.02 ***	.43 ***	-.39 ***	.50 *	.18 ***	.80 ***	.43 **	.21 ***	.51 ***	.42 **	.21	—		
13. Autonomy	.07	.44 ***	-.31 ***	.65 ***	.23 **	.79 ***	.57 ***	.30 ***	.65 ***	.49 ***	.33 ***	.58 ***	—	
14. Pay	-.09 ***	.25 ***	-.27 ***	.25	.12 ***	.69 ***	.31 **	.21 ***	.28 ***	.31 ***	.27 ***	.62 ***	.32	—

* p<.05 ** p<.01 *** p<.001

total work satisfaction and its subscales were examined using bivariate analyses. Each of the variables was carefully considered from a conceptual and statistical viewpoint. The criterion of statistical significance of $p < .05$ was used to identify which variables were significantly associated with either the criterion or predictor measures. The following section describes the findings related to the research questions based on the conceptual framework.

Relationship between organizational culture and work satisfaction. Organizational culture was deleted from the analysis because of missing/inaccurate data.

Relationship between years in shared governance and work satisfaction. Years in shared governance was measured by years and/or months that staff nurses were employed at the current hospital with shared governance. Years in shared governance was positively correlated with work satisfaction ($r = .22$, $p < .001$). That is, staff nurses with a greater number of years of employment under shared governance also had greater levels of work satisfaction.

Relationship between perceived importance of involvement and actual involvement in decision-making for the same decisions. Importance of involvement was moderately correlated with involvement ($r = .35$; $p < .001$). In other words, high levels of importance of involvement were associated with high levels of involvement in decision-making.

Relationship between perceived importance of involvement and work satisfaction. There was no relationship between importance of involvement and work satisfaction ($r = -.03$). The importance variable was used primarily to obtain the discrepancy between

importance and involvement and was not expected to be related to work satisfaction by itself.

Relationship between actual involvement in decision-making and work satisfaction.

Involvement in decision-making was moderately but positively correlated with work satisfaction ($r=.42$; $p<.001$). Increased levels of involvement in decision-making were associated with increased levels of work satisfaction.

Relationship between the discrepancy between perceived importance of involvement and actual involvement in decision-making and work satisfaction. The discrepancy between importance of involvement and involvement in decision-making was moderately, but negatively, correlated with work satisfaction ($r=-.38$; $p<.001$). The greater the discrepancy between importance and involvement, the lower the level of work satisfaction.

Relationship between control over nursing practice and work satisfaction. Control over nursing practice was positively correlated with work satisfaction ($r=.59$; $p<.001$). Increased levels of control over nursing practice were associated with increased levels of work satisfaction.

Predictors of Work Satisfaction

Regression model testing. Multi-variate analyses of the predictors of work satisfaction were performed using multiple regression techniques. Each predictor variable was regressed on the criterion variable of work satisfaction. The study employed multiple regression first to explore the variance in work satisfaction explained by staff nurse years in shared governance, perceived importance of involvement, actual involvement in

decision-making, and control over nursing practice among staff nurses employed in hospitals with shared governance. A second regression model was tested using the discrepancy between importance and involvement to determine whether a discrepancy approach would have greater predictive ability than using the importance and involvement variables separately. A third regression model was tested using the major study variables and the following demographic variables: years in nursing, years in hospital, years in unit, hours per week in shared governance, and clinical area. This approach was used to determine whether selected demographic variables were able to increase the predictability in work satisfaction over the original regression model developed from the conceptual framework.

The analysis initially generated five regression equations, one for each of the major predictor variables: (a) years in shared governance, (b) perceived importance of involvement, (c) actual involvement in decision-making, (d) discrepancy between importance and involvement, and (e) control over nursing practice. Five additional equations were generated using the following demographic variables: (a) years in nursing, (b) years in hospital, (c) hours per week in shared governance, (d) years in unit, and (e) clinical area.

Two multiple regression approaches were used: forward stepwise regression and forced entry regression. In stepwise regression, the predictor variable with the highest correlation was entered first, followed by the next highest partial correlation until all significant predictors had been included in the regression equation. In contrast, with forced entry regression, the predictor variables were added, based on the theoretical model, and

kept in the final equation even if they were not statistically significant. This approach was used to determine which of the predictors explained the greatest variability in work satisfaction based on the theoretical framework. A forced entry regression approach was used for the demographic variables in order to determine if these variables would contribute to the overall prediction of work satisfaction.

Three models were tested using multiple regression techniques. Model 1 tested the following predictors of work satisfaction: importance of involvement, involvement in decision-making, control over nursing practice, and years in shared governance. Model 2 tested these predictors: discrepancy between importance and involvement, control over nursing practice, and years in shared governance. Model 3 tested the following predictors: importance of involvement, involvement in decision-making, control over nursing practice, years in shared governance, years in nursing, years in hospital, years in unit, hours per week in shared governance, and clinical area.

- **Model 1: Multiple regression for IMP, INV, CONP, and years in SG on WS.**

Table 8 depicts Model 1: Stepwise Multiple Regression for importance of involvement, involvement in decision-making, control over nursing practice, and years in shared governance on work satisfaction. Control over nursing practice was the strongest predictor ($R^2=.35$, $p<.0001$), accounting for 35% of the explained variance in work satisfaction. Involvement and importance were the next two most significant predictors of work satisfaction, increasing the total explained variance to 38% for the three predictor model. Years in shared governance failed to predict work satisfaction. Table 9 depicts Model 1: Forced Entry Multiple Regression for importance of involvement, involvement in

Table 8

Model 1: Stepwise Multiple Regression for IMP, INV, CONP, and Years in SG on WS

Predictors	<i>R</i>	<i>R</i> ²	<i>R</i> ² Chg	<i>F</i>	<i>p</i>	β
Control over Nursing Practice	.59	.35	.35	60.95	<.0001	.59
Importance of Involvement in Decision-Making	.60	.36	.01	4.07	.04	-.12
Involvement in Decision-Making	.62	.38	.02	7.98	.005	.20

Note: Years in Shared Governance was not significant in the Stepwise Multiple Regression Model.

Table 9

Model 1: Forced Entry Multiple Regression for IMP, INV, CONP, and Years in SG on WS

Predictors	<i>R</i>	<i>R</i> ²	<i>R</i> ² <i>Chg</i>	<i>F</i>	<i>p</i>	β
Control over Nursing Practice	.59	.35	.35	60.95	<.0001	.59
Importance of Involvement	.60	.36	.01	4.07	.045	-.12
Involvement in Decision-Making	.62	.39	.03	7.98	.005	.20
Years of Shared Governance	.63	.39	.005	1.46	.23	.07

Note: Years in Shared Governance was not significant in the forced entry model.

decision-making, control over nursing practice, and years in shared governance on work satisfaction. Using forced entry with the predictors, regression analysis was performed to determine whether years in shared governance had a significant impact on work satisfaction based on the theoretical framework. However, years in shared governance again failed to predict work satisfaction. Control over nursing practice explained 35% of the variance, followed by involvement (R^2 chg = .03) and importance of involvement (R^2 chg = .01), for a total of 39% of the explained variance in work satisfaction.

- Model 2: Multiple regression for discrepancy between IMP and INV, CONP, and years in SG on WS.** Table 10 depicts Model 2: Stepwise Multiple Regression for the discrepancy between importance and involvement, years in shared governance, and control over practice on work satisfaction. Control over nursing practice was the strongest predictor of work satisfaction ($R^2 = .35$, $p < .0001$), accounting for 35% of the explained variance. The next most significant predictor of work satisfaction was the discrepancy between importance and involvement, (R^2 chg = .03), for a total of 38% of the variance. Years in shared governance failed to predict work satisfaction. Table 11 depicts Model 2 using forced entry multiple regression for these same variables. Again, years in shared governance failed to significantly predict work satisfaction. The discrepancy between importance and involvement was entered first into the regression equation ($R^2 = .14$), accounting for 14% of the explained variance in work satisfaction. This was followed by control over nursing practice ($R^2 = .23$), accounting for 23% of the variance in work satisfaction. The total explained variance for the three-predictor model was still 38%.

Table 10

Model 2: Stepwise Multiple Regression for Discrepancy Between IMP and INV, CONP, and Years in SG on WS

Predictors	<i>R</i>	<i>R</i> ²	<i>R</i> ² Chg	<i>F</i>	<i>p</i>	β
Control over Nursing Practice	.59	.35	.35	60.95	<.0001	.59
Discrepancy between Importance and Involvement	.62	.38	.03	8.51	.004	-.18

Note. Years in Shared Governance was not included in the final stepwise regression model.

Table 11

Model 2: Forced Entry Multiple Regression for Discrepancy Between IMP and INV, CONP, and Years in SG on WS

Predictors	<i>R</i>	<i>R</i> ²	<i>R</i> ² Chg	<i>F</i>	<i>p</i>	β
Discrepancy between Importance and Involvement	.38	.14	.14	31.53	<.0001	-.38
Control over Nursing Practice	.62	.37	.23	69.41	<.0001	.52
Years of Shared Governance*	.62	.38	.005	1.54	.22	.07

Note: Years in Shared Governance was not significant in the forced entry regression model.

Comparison of the findings for Models 1 and 2 suggest that the two models are similar with respect to amount of predictive ability. Both Models 1 and 2 explained 38% of the variance when forward stepwise and forced entry regression techniques were used. However, contrary to the original hypothesis, the discrepancy between importance and involvement offered no better explanation for the variance in work satisfaction than using importance and involvement as separate variables. In Model 2, using a forced entry technique and controlling for the discrepancy between importance and involvement, control over nursing practice explained only 23% of the variance, decreasing from 35% in the forward stepwise approach. While the discrepancy between importance and involvement was a significant predictor, it appears that control over nursing practice is still the single most important predictor of work satisfaction.

- **Model 3: Multiple regression for CONP, IMP, INV, years in SG, years in nursing, years in hospital, years in unit, and clinical area on WS.** Several of the demographic variables which were significantly correlated with work satisfaction were entered into the regression analysis in an attempt to explain a greater proportion of variance in work satisfaction (Table 12). These variables were years in nursing, years in hospital, years in unit, hours per week in shared governance, and clinical area. Clinical area, a nominal level variable, was categorized according to medical-surgical and critical care units since nearly all nursing units fell into one of these clinical areas. Model 3 depicts forced entry regression for control, importance, involvement, years in shared governance, years in nursing, years in hospital, years in units, and clinical area on work satisfaction (Table 13). Discrepancy between importance and involvement was not used in the final

Table 12

Correlational Matrix for Predictor, Criterion, and Demographic Variables

Variable	Variable Number												
	1	2	3	4	5	6	7	8	9	10	11	12	
1. Importance of involvement	—												
2. Involvement in decisions	.35 ***	—											
3. Discrepancy between IMP and INV	.55 ***	-.51 ***	—										
4. Control over practice	.15 *	.53 ***	-.38 ***	—									
5. Years in SG	.05	.26 ***	-.20 **	.25 ***	—								
6. Total work satisfaction	-.03	.42 ***	-.38 ***	.59 ***	.22 ***	—							
7. Age	-.22 **	.04	.26 ***	.07	.34 ***	.08	—						
8. Highest education	.15 *	-.004	-.15 *	-.03	-.09	-.11	-.05	—					
9. Years in nursing	-.25 ***	.006	-.26 **	.08	.17 *	.04	.73 ***	-.11	—				
10. Years in hospital	-.15 *	.17 *	-.35 ***	.27 ***	.29 ***	.16 *	.56 ***	-.11	.62 ***	—			
11. Years on unit	-.16 *	.12	-.30 ***	.23 **	.22 **	.20 **	.52 ***	-.03	.53 ***	.82 ***	—		
12. Hours per week in shared governance activities	.04	.13	-.04	.17 *	.06	.19 *	-.07	.02	-.07	.05	.01	—	

* p<.05 ** p<.01 *** p<.001

Table 13

Model 3: Forced Entry Multiple Regression for CONP, IMP, INV, Yrs. in SG, Yrs. in Nursing, Yrs. in Hospital, Yrs. in Unit, Hrs/Wk in SG, and Clinical Area on WS

	R	R ²	R ² Chg.	F	p	β
CONP	.63	.40	.40	0.33	<.0001	.63
IMP	.63	.40	0	0.33	<.0001	-.06
INV	.64	.41	.01	20.47	<.0001	.10
Yrs. in SG	.65	.42	.01	15.83	<.0001	.11
Yrs. in Nursing	.65	.43	.01	13.04	<.0001	-.10
Yrs. in Hospital	.65	.43	0	10.75	<.0001	-.01
Hrs/Wk in SG	.65	.43	0	9.11	<.0001	-.01
Yrs. in Unit	.66	.43	0	8.06	<.0001	.13
Clinical Area	.66	.43	0	7.11	<.0001	-.03

model since importance of involvement and involvement in decision-making explained the same amount variance in work satisfaction as the discrepancy variable. The combination of the major study variables and demographic variables explained 43% of the variance in work satisfaction, adding to the 38% obtained in Models 2 and 3. The control over nursing practice variable explained 40% of the variance in work satisfaction. Importance of involvement did not contribute to work satisfaction. Involvement in decision-making, years in shared governance, and years in nursing each added .01 to the R^2 , increasing the total variance to 43%. While the overall model remained significant with the addition of the other four variables, they did not add to the prediction of the model, as noted by the zero R^2 change in the remaining model. No explanation can be given for why years in shared governance contributed to the explained variance in this final model when it failed to predict work satisfaction in the the first two models. It is quite possible that redundancy existed between years in nursing and years in shared governance. That is, years in nursing needed to be in the model before years in shared governance would be significant. However, when tested for multicollinearity, these two variables did not reveal redundancy.

Relationships Between Demographic and Study Variables

The relationships between demographic and study variables were analyzed to help explain the findings based on sample characteristics. Table 12 depicts the correlational matrix for the demographic and study variables.

Age. Age was inversely related to importance ($r = -.22$, $p < .05$), but positively related to years in nursing ($r = .73$, $p < .001$), the hospital ($r = .56$, $p < .001$), nursing unit ($r = .52$, $p < .001$); and with years in shared governance ($r = .34$, $p < .001$).

Education. Education was weakly associated with importance of involvement ($r=.15$, $p<.05$), but not with any of the other study variables.

Years in nursing. Years in nursing was inversely related to importance of involvement ($r=-.25$, $p<.001$) but positively related to years in hospital ($r=.62$, $p<.001$), nursing unit ($r=.53$, $p<.001$); and years in shared governance ($r=.17$, $p<.05$).

Years in hospital. Years in hospital was positively associated with years on unit ($r=.82$, $p<.001$), years in shared governance ($r=.29$, $p<.001$), involvement in decision-making ($r=.17$, $p<.05$), control over nursing practice ($r=.27$, $p<.001$); and work satisfaction ($r=.16$, $p<.05$).

Years in unit. Years in nursing unit was inversely related to importance of involvement ($r=-.16$, $p<.05$), but positively related to years in shared governance ($r=.22$, $p<.01$), control over the nursing practice ($r=.23$, $p<.01$); and work satisfaction ($r=.20$, $p<.01$).

Hours per week involved in shared governance activities. Hours per week involved in shared governance activities was positively associated with control over nursing practice ($r=.17$, $p<.05$) and work satisfaction ($r=.19$, $p<.05$), but not associated with any other study variables.

Summary

The study utilized a descriptive, correlational design to determine the relationship among staff nurse years in shared governance, perceived importance of involvement, actual involvement in decision-making, (or the discrepancy between importance and involvement), control over nursing practice, and work satisfaction in staff nurses working

in hospitals with shared governance. Seventy-nine percent of the sample were involved in shared governance committees: councils (32%) and unit committees (47%). Committees with the highest level of participation were nursing practice, evaluation/continuous quality improvement, and education. Staff nurses desired greater participation in decision making in issues related to staffing, salary and benefits, and practice.

A discrepancy between importance of involvement and involvement in decision-making existed for all decisional items. Staff nurses were most satisfied with involvement in patient care issues and least satisfied with salary, job security, and environmental issues. Control over nursing practice was rated moderately high with a high level of control over patient care issues and low control over issues related to hiring staff, coordination with outside agencies, and staffing. Overall, staff nurses were moderately satisfied with their work. They were most satisfied with professional status, nurse-nurse interaction, and autonomy and least satisfied with pay, task requirements, and organizational policies. Despite the wide range of hospital duration of implementation of shared governance (<2 years to >12 years), years in shared governance for the nurse sample only ranged from 1.4 to 4.9 years with a mean of three years.

When bivariate relationships were examined, involvement in decision-making, control over nursing practice, and years in shared governance were significantly related to work satisfaction. The strongest correlation occurred between control over nursing practice and work satisfaction. The discrepancy between importance and involvement was inversely related to work satisfaction, suggesting that nurses were more satisfied when they were involved in decisions important to them. Although there were several significant

relationships among the demographic and study variables, only years in hospital, years in unit, and hours per week in shared governance were significantly related to work satisfaction.

Several regression models were tested to determine the strongest predictors of work satisfaction. In Model 1, using importance of involvement, involvement in decision-making, control over nursing practice, and years in shared governance as predictors, control over nursing practice was the strongest predictor of work satisfaction, accounting for 35% of the variance. Years in shared governance failed to predict work satisfaction. Importance of involvement and involvement in decision-making each contributed a much smaller amount for a combined total of 38% of the variance in work satisfaction.

In Model 2, using the discrepancy between importance of involvement and involvement in decision-making, control over nursing practice, and years in shared governance, control over nursing practice continued to be the strongest predictor, explaining 35% of the variance. Again, years in shared governance failed to predict work satisfaction. The discrepancy between importance and involvement also significantly predicted work satisfaction, but to a smaller degree than control over nursing practice, for a total of 38% of the explained variance in work satisfaction. Therefore, using the discrepancy between importance and involvement did not improve the ability to predict work satisfaction over using importance of involvement as separate predictor.

In Model 3, using importance of involvement, involvement in decision-making, control over nursing practice, years in shared governance, years in nursing, years in hospital, hours per week in shared governance, years in unit, and clinical area as

predictors, control over nursing practice explained 40% of variance in work satisfaction.

Involvement in decision-making, years in shared governance, and years in nursing increased the total explained variance to 43%, each contributing .01 to the R^2 change.

Years in hospital, years in unit, hours per week in shared governance and clinical area did not predict work satisfaction. Thus, adding the demographic variables to the model increased the overall prediction from 38% to 43%.

CHAPTER V

Discussion

The purpose of the study was to explore the relationships among variables predictive of work satisfaction among staff nurses in hospitals with shared governance. The conceptual framework proposed that organizational culture, staff nurse years in shared governance, perceived importance of involvement, actual involvement in decision-making, discrepancy between importance and involvement, and control over nursing practice would predict work satisfaction among staff nurses working in hospitals with shared governance. Organizational culture was omitted from data analysis because of a large amount of missing or inaccurate data. This chapter includes a discussion of the findings of the study, a comparison of study findings with previous studies, an interpretation of the findings, implications for nursing, and suggestions for further study.

Descriptive Findings

The demographic and organization profile instruments provided information on the nurse and hospital samples, respectively. The typical respondent was thirty-seven years of age, female and married, had twelve years of nursing experience, and had a BSN (43%) or an ADN (31%) degree. Hospital 4 (shared governance greater than twelve years) had the greatest percentage of RN staff. At the time of data collection, the RN vacancy rate ranged from five to nine- percent among the hospitals. However, the vacancy rates

decreased from a high of 30% in 1987 when the nursing shortage was at its peak. The vacancy rate was lowest for Hospital 4. One might assume that shared governance may have affected the drop in vacancy rates in these hospitals, but the organizational tenure among staff nurses was low, suggesting other contributing factors.

Thirty-two percent of the sample participated in shared governance councils and forty-seven percent served on unit committees. An unexpected finding was the high committee participation in Hospitals 1 and 3 (both from the same large medical center). Hospitals 3 and 4 were expected to have the highest participation rates since they had the longest history of shared governance and, thus were expected to have more stable committee structures. No explanation can be given except that perhaps the administrations in Hospitals 1 and 3 were more supportive of shared governance and staff participation compared to the other hospitals. Another possibility is that Hospital 1 was in the 'honeymoon stage' with their newly implemented model. Also, Hospital 4 may not have had as high a participation rate if they had integrated their committee structure so less time and fewer people were needed to do the work. Numerous organizational and individual level variables which were not measured in this study might explain some of the differences in committee participation. Thus, findings must be cautiously interpreted since this study was non-experimental and did not control for extraneous or contextual variables.

Committees with the greatest staff nurse representation were practice, education, continuous quality improvement, and nursing care delivery system. These findings are consistent with the literature in that staff nurses are more interested in participating when

it relates to clinical practice and less interested when it involves business/management issues. Only Hospital 4 had a salary/benefits committee, which rarely is included in shared governance models.

Types of shared governance councils were similar to the unit committees for all hospitals (e.g., practice, education). The similarity in council and unit committees is important since a staff representative from each of the units is elected to serve on the same type of council. However, unit committee structures had multiple task forces to accomplish unit-specific functions. Hospital committees differed from shared governance committees by their multi-disciplinary membership and focus. Only one hospital had a multi-disciplinary membership in its shared governance organization. Hospital 2 recently had established a multi-disciplinary membership structure for its shared governance organization in the same year of data collection. When staff nurses were asked an open-ended question related to the desire for increased participation, they identified the areas of staffing, salary/benefits, and clinical practice. These findings were consistent with those obtained from the IMP/INV scale with the exception of clinical practice, in which nurses indicated satisfaction with their involvement in practice decisions.

Interpretation of Findings Related to the Research Questions

Bivariate Relationships

Years in shared governance and work satisfaction. The relationship between years in shared governance and work satisfaction was weak ($r=.22$), but supported the conceptual framework. A possible rationale for the small correlation may be that respondents only worked in hospitals with shared governance for an average of 3.2 years.

A greater difference between hospital sites was expected, since years of hospital shared governance ranged from less than two years to twelve years. When analyzed across hospital sites, mean years in hospitals with shared governance ranged from 1.4 years (Hospital 1) to 4.9 years (Hospital 4). As expected, respondents with the greatest years in shared governance (Hospital 3 and 4) also had the highest satisfaction scores. The findings are supported in the literature (Ludemann & Brown, 1989), in which eighteen months of implementation of shared governance was needed before positive outcomes could be demonstrated. In another study, no differences in job satisfaction were found nine months after instituting shared governance (Pinkerton, 1988).

One reason why staff nurses were employed at hospitals for only a few years with shared governance may be a function of the duration of implementation of shared governance at each hospital or it could be other factors in the work environment which were not measured in this study. Since shared governance was recently instituted in Hospitals 1 and 2, staff nurses had less opportunity for exposure to the model than nurses in Hospitals 3 and 4. An explanation cannot be given for the smaller number of years nurses worked in Hospitals 3 and 4, since shared governance had been in existence for six to eight years and greater than twelve years, respectively. However, the RN vacancy rate was lowest for Hospital 4.

One possible conclusion from the positive relationship between years in shared governance and work satisfaction is that respondents who worked in hospitals for a greater number of years with shared governance may have had greater opportunity to participate in decision-making because of the committee structure. This may have resulted

in higher levels of work satisfaction than those with fewer years in shared governance. A basis for this conclusion is that continued involvement in shared governance is believed to result in improvements in group decision-making and the ability to influence decisions and quality of those decisions. However, numerous competing explanations are possible when intervening variables cannot be controlled. Alternative explanations may include changes within the organization, leadership, or work environment that could have produced similar findings.

Perceived importance of involvement in decision-making and work satisfaction. No relationship was found between importance of involvement and work satisfaction ($r = -.03$). Theoretically, importance of involvement by itself, was not expected to affect the level of work satisfaction. However, satisfaction of that desire or actual involvement in important decisions was expected to result in higher levels of work satisfaction than decisions which were unimportant. The importance variable was not intended to be an actual predictor of work satisfaction, but was separated from the IMP/INV scale in order to use involvement as a separate predictor of work satisfaction. Since the instrument had two separate subscales, the variables were combined to obtain a single discrepancy score. The rationale for the separation was to obtain the absolute difference between importance and involvement and, thus, determine whether a discrepancy approach to measurement would be a more effective method of predicting work satisfaction than using importance and involvement separately.

Actual involvement in decision-making and work satisfaction. As expected, actual involvement in decision-making was moderately correlated with work satisfaction ($r = .42$).

This finding supports the conceptual framework of the study. Staff nurses with high involvement in decision-making had higher levels of work satisfaction than those with lower levels of involvement. Shared governance is being measured primarily through committee involvement in decision-making. The positive relationship supports the organizational and nursing literature in that involvement in decision-making results in increased work satisfaction (Blegan, 1993; Locke & Schweiger, 1979; Prescott & Dennis, 1985; Sashkin, 1984).

Alternative explanations are likely when intervening variables cannot be controlled. A possible explanation for the findings may be that nurses were involved in significant decision-making because of their clinical experience, expertise, and/or tenure in the organization rather than from participation in shared governance. Moreover, numerous factors unaccounted for in this study may affect one's satisfaction with work. An explanation may be that participation in important decisions that resulted in control over nursing practice led to increased levels of work satisfaction. Therefore, it is possible that control over nursing practice mediates the effects of involvement on work satisfaction. However, the research design did not allow for any conclusions regarding cause and effect relationships or time-ordering of any of the variables in this study.

Discrepancy between perceived importance of involvement and actual involvement in decision-making and work satisfaction. As predicted in the conceptual framework, a negative relationship existed between the discrepancy between importance and involvement and work satisfaction ($r = -.38$). The greater the discrepancy between importance and involvement, the lower the level of work satisfaction. In contrast, a match

(no discrepancy) between importance and involvement (high IMP/high INV) resulted in higher levels of work satisfaction than where there was no match (high IMP/low INV). The findings partially support the existing literature on participation in decision-making. According to Prescott and Dennis (1985), importance of involvement should be combined with the measurement of involvement in order to effectively predict work satisfaction. Allen and associates (1987) also reported that the fit between importance and involvement significantly influenced nurse job satisfaction. These authors concluded that individual differences and participation in work-related decisions play a major role in the success of shared governance. Although the bivariate relationships between importance and involvement and between involvement and work satisfaction were significant, the regression analysis revealed that the discrepancy between importance and involvement in decision-making was no more predictive of work satisfaction than involvement alone.

Control over nursing practice and work satisfaction. The relationship between control over nursing practice and work satisfaction was moderately strong ($r=.59$). The positive relationship supports the conceptual framework and the empirical findings in the literature (Blegan, 1993; Gerber, 1988; Hinshaw & Atwood, 1986; Irvine & Evans, 1995). A comparison of the results of this study will be made with two recent meta-analyses of job satisfaction (Blegan, 1993; Irvine & Evans, 1995).

Blegan's (1993) meta-analysis of nurses' job satisfaction using forty-eight studies (N=15,048) revealed that autonomy was moderately correlated with job satisfaction ($r=.42$) in 27 studies (N=7,927). All studies were performed after 1987 since, according to Blegan (1993), those studies were most likely based on data obtained after the latest round

of nurse shortages noted by the National Commission on Nursing (1983). However, data for this study were collected in late 1992 and a nursing shortage was not evident in the surveyed hospitals based on their report of the nurse vacancy rate. In a more recent meta-analysis of job satisfaction and turnover, Irvine and Evans (1995) reported that autonomy was moderately correlated ($r=.46$) with job satisfaction in twelve studies ($N=5,332$). In comparing the results of the two meta-analyses with the present study, the correlation coefficients were substantially lower than that of the present study. The difference in the correlation coefficient between the present study ($r=.59$) and Blegan's ($r=.42$) was .17; for Irvine and Mueller, the difference was .13. One explanation for the disparity in correlations between the two meta-analyses and this study may be in the definition of the construct. In this study, control over nursing practice was defined as "freedom to evaluate and modify nursing practice and to influence others," a very broad definition. However, in Blegan's study, the term "autonomy" was used along with several different labels (centralization, powerlessness, discretion, personal control, participation). In addition, satisfaction was measured using twenty-one different instruments. Blegan explained that studies were combined when the variables defined conceptually similar phenomena. The differences in how the measure was defined could account for some of the disparity of findings. Another explanation could be in the temporal relationship between when data were obtained in the present study (1992) and date of publication in the studies used in the two meta-analyses. In Blegan's analysis, studies were divided into pre-1987 and 1987 or later. According to Blegan (1993), the pre-1987 studies showed no decrease in variations. Yet, only five variables had homogeneous results when the studies published in 1987 or

later were included in the analysis. The correlation between autonomy and satisfaction in the 18 studies that were published in 1987 or later was only .37, which is substantially lower than in the current study. Blegan's study used published and unpublished studies; whereas, Irvine and Evans used only published studies. Sampling bias could account for the large differences in the correlation coefficients between the two previously reported studies and the present study. Furthermore, the overall response rate in the present study was small (24%), which precludes any generalizations beyond this sample. Also, a potential bias exists when it cannot be determined whether the refusers are different from the responders.

Predictors of Work Satisfaction.

Findings from the regression analyses revealed that control over nursing practice was the strongest predictor of work satisfaction using three different regression models and with forward stepwise and forced entry techniques. Using the discrepancy between importance and involvement as the variable did not add to the predictive value of the model any more than using involvement in decision-making as a separate variable. Both models explained thirty-eight percent of the variance in work satisfaction. Years in shared governance failed to predict work satisfaction in Models 1 and 2. However, in Model 3, when the demographic variables were entered into the regression equation, years in shared governance predicted work satisfaction but to a much smaller degree than did control over nursing practice. Involvement and years in shared governance contributed a small amount to the variance, for a total of forty-three percent of the explained variance in work satisfaction.

Thus, other factors which were unaccounted for in this study need to be identified to offer further explanation for the variance in work satisfaction. Intervening factors (i.e., personal, economic, and organizational) could produce similar findings other than that resulting from shared governance, such as a change in leadership or nursing care delivery system. It was not possible nor was it the intent in this study to determine causality or time ordering of the variables, but a discussion of possible conclusions is justified. Based on the findings, one might speculate that if staff nurses were involved in important decisions, they would experience increased levels of work satisfaction if they perceived that they had greater control over nursing practice. Furthermore, based on the strong contribution of control over nursing practice, it may be that control over nursing practice may intervene in the relationship between involvement and work satisfaction. However, a greater explanation of these findings requires causal modeling techniques in future studies. While years in shared governance was significant in the bivariate correlation with work satisfaction, it was not strong enough to contribute to the variance in work satisfaction in two of the three regression models. One explanation may be the narrow range of years in shared governance for the four sites. Using forced entry regression techniques for years in shared governance, significance was found only in Model 3 in which the demographic variables were added. Years in shared governance lacked variability in the sample to contribute to the explained variance in work satisfaction in all but one model. Perhaps, the measure itself needed to be more specific and sensitive to capture what was intended in the conceptual framework. It was anticipated that increased years of participation in

shared governance would result in increased work satisfaction, but the open-ended question did not ask for this information specifically.

Relationship between demographic and study variables. Demographic variables were not identified in the research questions, but were analyzed to provide additional information about the sample and add to the explanation of findings. The discussion below describes only those variables which were significantly related to the study variables. Gender was weakly associated with nurse-nurse interaction ($r=.25$), but not with any other study variables. In the nursing literature, gender was not identified as a significant variable in the meta-analyses of job satisfaction (Blegan, 1993; Irvine & Evans, 1995). It seems probable, however, that female nurses would have more satisfying interactions with female rather than male nurses because of the socialization process and because nursing is still predominantly a female profession. However, the disproportionate number of females (97%) precludes any generalizations regarding differences in gender.

Age was negatively associated ($r=-.22$) with importance of involvement, but positively associated with years in nursing ($r=.73$), years in hospital ($r=.56$), years in unit ($r=.52$) and years in shared governance ($r=.34$). The average nurse was thirty-seven years old, worked for twelve years in nursing, six years at the current hospital, five years on the nursing unit, and three years in shared governance. The relationship between age and importance may be explained by the fact that younger nurses, who are just starting their careers, tend to be more interested in committees than older nurses. This finding may also be related to changes in their level of education and subsequent expectations for greater involvement. This is partially supported in the literature (McCloskey & McCain, 1987) in

which new graduates were least satisfied with their lack of participation in decision-making. In contrast, older nurses, who may have been more interested in decision-making in the past, may become less interested because of frustration if their previous participation did not result in desired outcomes. The rationale for obtaining high correlations between age and tenure may be explained by the current economic and employment climate rather than by shared governance. The moderate correlation between age and years in shared governance (or years worked at that hospital with shared governance) cannot be explained by the employment climate. One possible explanation may be that older nurses, who generally have greater clinical expertise, are able to contribute to decision-making in shared governance committees more effectively than younger nurses. Moreover, older nurses or those with tenure in the organization have had more opportunity to participate in shared governance than younger nurses. In addition, older nurses are usually more settled with family responsibilities and also have less freedom to move. However, age was not related to work satisfaction in the present study. An explanation may be that multicollinearity existed between age and years in nursing ($r=.73$) and years in hospital ($r=.56$) and years on unit ($r=.56$). Blegan (1993) and Irvine and Evans (1995) reported significant but low correlations ($r=.13$ and $.16$, respectively) between age and work satisfaction. A possible explanation for their findings may have been the large sample size when studies were combined for meta-analyses compared to the much smaller sample size in the present study.

Highest level of education was weakly associated ($r=.15$) with importance of involvement, but not with any of the other variables. That is, nurses with more education

considered it important to be involved in decision-making; yet actually were not more involved than nurses with less education. The importance finding may be related to their socialization during their educational process. In the present study, education was not significantly associated with work satisfaction. The literature is inconsistent in the findings related to education and job satisfaction. In an earlier study of job satisfaction, nurses with a bachelor's degree in nursing valued group cohesion; while nurses with a diploma in nursing valued committee involvement (Hinshaw, Smeltzer, & Atwood, 1987). In a study of shared governance conducted by Ludemann and Brown (1989), nurses with more education were more committed to shared governance, but not to the organization. More recent studies, however, reported very low to no relationships between those variables. Blegan (1993) reported a negative relationship ($r = -.07$) between education and satisfaction. In contrast, Irvin and Evans (1995) failed to find significance in the education-satisfaction relationship.

Years in nursing was inversely related to importance ($r = -.25$) and positively related to years in hospital ($r = .62$), years in unit ($r = .53$), and years in shared governance ($r = .17$). An explanation for the inverse relationship between tenure and importance may be that the desire for involvement may decrease with tenure because of lack of motivation if their previous involvement did not result in achievement of outcomes. Also, this inverse relationship could be a function of the age and prior socialization. However, the strong relationships between years in nursing and years in hospital and between years in nursing and unit tenure may have several competing explanations. Nurses with greater nursing tenure may continue their employment in an institution because they are either satisfied

with their work or because of the need of economic security that continued employment provides. In contrast, nurses may continue their employment even when they are dissatisfied with work because of economic reasons or inability to find another job. Mergers, hospital downsizing, and staff layoffs were just beginning to occur in the early 1990's. In this study, data were collected in late 1992. An explanation of why tenure in nursing was related to years in shared governance is speculative. Perhaps, nurses with greater tenure in nursing have increased clinical knowledge and expertise to influence decision-making through working in the hospital with shared governance. Although tenure in nursing was not significantly related to work satisfaction in the present study, it was a significant correlate in both meta-analyses being used for comparison with this study. In Blegan's (1993) study, tenure in nursing was weakly correlated ($r=.09$) with job satisfaction (30 studies, $N=9,288$). In a later study, Irvine and Evans (1995) reported a similar correlation ($r=.12$) in 12 studies ($N=1,899$). A possible explanation for the correlations in these studies may be the large sample sizes when the studies were combined for meta-analyses.

Years in hospital was inversely related to importance ($r=.15$), strongly related to years in unit ($r=.82$), and weakly correlated with years in shared governance ($r=.29$), involvement ($r=.17$), control over nursing practice ($r=.27$), and work satisfaction ($r=.16$). The same negative relationship was found between tenure in nursing and importance ($r=-.25$) as found between tenure in the hospital and importance ($r=-.15$). This finding was expected since there is a strong relationship between years in nursing and years in hospital ($r=.62$). The strong positive relationship between hospital and unit tenure may be expected

because continued employment requires that a nurse work on a nursing unit or specialty area.

However, the relationship between tenure in hospital and years in shared governance, involvement in decision-making, and control over nursing practice, and work satisfaction cannot be explained so easily. One explanation may be that hospital tenure (or experience) is generally accompanied by increased clinical expertise and knowledge of the system, which could provide the basis for effective staff nurse participation. Extending the rationale further, increased participation could be expected to result in increased control over nursing practice and work satisfaction when nurses perceive that their participation leads to influence in the decision-making process or control over nursing practice.

The nursing literature is inconsistent in the findings related to organizational tenure and job satisfaction. Irvine and Evans (1995) reported a low correlation ($r=.10$) between organizational tenure and job satisfaction in nine studies ($N=4,068$). In contrast, Blegan (1993) found no relationship between organizational tenure and satisfaction in a meta-analytic study of job satisfaction.

Years in unit was inversely related to importance ($r=-.16$), but positively related to years in shared governance ($r=.22$), control over nursing practice ($r=.23$), and work satisfaction ($r=.20$). Contradictory findings related to importance and involvement occurred when years in unit was analyzed by hospital. Nurses with greater years in the nursing unit considered it less important to be involved in decision-making than those with less years. However, nurses with greater years in hospital were actually more involved in decision-making than nurses with less years. A possible explanation may be that recent

graduates or newly hired nurses are usually more interested in being involved in decision-making than nurses with more years in the unit because they are still trying to develop professionally. Based on the findings, it would appear that years in hospital is more important for involvement in decision-making than is years in unit. In addition, years in nursing, hospital, and unit were significantly related to years in shared governance.

Rationale for the findings may be that years in unit is very important to participation in shared governance because experienced staff nurses have greater clinical expertise to effectively participate in the decision-making process. Years in unit was also significantly associated with control over nursing practice and work satisfaction. A rationale may be that experienced unit staff nurses are more satisfied with work because their expectations for involvement in decision-making and control over nursing practice are met.

Hours per week in shared governance were weakly associated with control over nursing practice ($r=.17$) and work satisfaction ($r=.19$). These findings may have several competing explanations other than from involvement in shared governance. Numerous factors in the work environment could account for the increased work satisfaction. Hours per week ranged from one to ten hours (mean=1.32 hours per nurse). For example, a heavy work assignment or lack of relief to attend meetings may preclude staff nurses from attending committee meetings. However, the positive relationships between hours in shared governance, control over nursing practice, and work satisfaction lends support to the conceptual framework. That is, involvement, which is conceptually similar to hours per week in shared governance, is also related to control over nursing practice and work satisfaction. Based on these findings, one might conclude that nurses who are consistently

more active in shared governance on a weekly basis will have higher levels of control over nursing practice and work satisfaction because their expectations for participation and influence are met. Hours per week in shared governance, while similar to years in shared governance, would appear to be a weaker variable as a predictor of work satisfaction. The correlation between years in shared governance and work satisfaction was .22, which is higher than .19 reported above for hours/week in shared governance and work satisfaction.

Limitations

Data from the organizational culture questionnaires were not analyzed because of the large amount of missing data or inaccurate completion of the questionnaire. Some respondents failed to complete any portion of the culture questionnaire. One reason may have been that it was the last instrument to be completed in a large research packet. Furthermore, respondents who did complete the questionnaire either did not understand the instructions for rank ordering or failed to follow instructions. Other respondents left a number of blanks. The tool was either too difficult and/or time-consuming for the majority of respondents. Incomplete or inaccurate completion of the questionnaire invalidated its use. The size of the sample would have been much smaller than was obtained if the organizational culture questionnaire was retained. Complete data sets were needed to analyze the data. The primary reason for omitting the organizational culture variable from the study was based on the serious threats to both internal and external validity that compromised the findings in this study. The number of unusable instruments was forty-

eight out of 222 questionnaires. Because twenty-two percent or nearly one-fourth of the sample did not have data, this variable was omitted from the data analysis.

Another limitation was the low response rate which affected the external validity of the study. One reason for the response rate may have been that several hospitals had recently conducted their own surveys of nurse satisfaction on their shared governance models. This information was conveyed to the investigator during data collection. Another reason, and probably most important, was the length of the research packet which contained four instruments and a demographic profile. Although nurses were asked to complete the questionnaires at home, it took forty-five to sixty minutes of their time to do this. Several respondents indicated that they wanted to complete it at work and simply did not have the time to do this.

Although the staff nurse sample was randomly selected, hospitals were purposively selected based on the desire to have hospitals with progressively greater years of shared governance. Selection bias was inevitably introduced because of this lack of randomization of hospitals. Consequently, any comparisons between hospitals must be carefully evaluated. Although years in shared governance was one of the major variables, the individual was the unit of analysis, not the hospital. Years of hospital implementation of shared governance ranged from less than two years to greater than twelve years. However, the number of subjects for the predictor, years in shared governance, did not have enough variability to significantly predict work satisfaction. This was a methodological limitation, since the investigator expected greater variability in organizational tenure among the nurse sample. Perhaps, incorporating experience with

shared governance at other institutions would have increased the variability in this measure and subsequently predicted work satisfaction.

The manner in which shared governance was measured may be a limitation of the study. Although shared governance involves numerous changes in the organization that can affect all of health care delivery, it was operationalized by staff nurse participation in committee decision-making. It may have been too limiting to capture the essence of how participation in shared governance contributed to one's control over nursing practice and work satisfaction. In addition, other variables which were not measured in this study, may predict work satisfaction to a higher degree than the variables used in this study since only forty-three percent of the variance in work satisfaction was explained. Numerous individual and organizational variables may influence individuals' attitudes toward their work.

Data on decentralization and participation in decision-making obtained from the organizational profile instrument and organizational chart may not represent the true reality in the hospital. However, two self-report measures of participation (the Demographic Profile and IMP/INV scale), may have indicated the degree of decentralization better than that which was identified by the organizational profile and the organizational chart. In addition, obtaining data on individual participative patterns using the demographic profile was believed to enhance the validity of the measured scale values for involvement, as well as provide additional information on the culture of the organization.

Implications

Implications for Practice

Based on the findings in this study, critical interventions aimed at increasing the level of work satisfaction among staff nurses include the following: (a) determining what motivates nurses, (b) identifying which decisions are important to them, and (c) involving them in those decisions whenever possible. Managers need to identify what the nursing staff value, including the personal significance that active involvement will have for them as individuals. Specifically, management has a responsibility to determine which decisions are important for nurse participation and which can be addressed by someone else. Nurse administrators need to help the nursing staff realize that active participation may lead to increased influence over decisions and greater control over practice. Motivational strategies, such as recognition and rewards, education, and demonstration of positive outcomes can be used as mechanisms for empowering nurses through shared governance.

Control over nursing practice within the institution was viewed as very important to staff nurse satisfaction in this study. Shared governance provided opportunities for the nursing staff to become involved in the organization through committee participation at all levels of the organization. Additional strategies may include asking staff nurses to select the committees that are of interest to them to increase their participation and quality of decisional outcomes. Expecting nurses to participate in committees that are of no interest to them only invites frustration and dissatisfaction. Additional mechanisms that may provide nurses with greater control over their practice are including a method for nurses to have control over their schedules, including nurses in the interviewing and hiring

process for prospective staff members, designing and implementing their own staff development programs, and allowing them to chair a committee. Time needs to be provided for this type of involvement and should not be expected to be completed on one's own time.

Furthermore, nurse administrators also need to pay more attention to retaining expert nurses and those with seniority in the system, since they have clinical expertise and the ability to influence decisions at all levels. Although job mobility seems to be decreasing because of job insecurity, providing mechanisms for retaining expert nurses will only enhance the quality of patient care. In a study of the impact of shared values on job satisfaction, Kramer and Hafner (1989) reported that nurses were more job dissatisfied when they perceived their environment as not being conducive to quality nursing care. One of the major factors identified by staff nurses as very important to job satisfaction was working with competent staff.

Administrators throughout health care organizations recognize the value of staff participation but do not always provide the support and resources to allow for the committee work to be accomplished. Furthermore, while many of the nursing staff members believe in a shared governance philosophy, they do not participate because of lack of follow through by management in previous encounters. When nurses are told they have the autonomy to make decisions and control their nursing practice, but are not given the authority to do so, then frustration, anger, and dissatisfaction result. This behavior leads to decreased participation, commitment to the organization, and work satisfaction (McNichols & Miller, 1988).

Results of this study underscore the importance of several factors related to nurse work satisfaction that are clearly under the control of health care administrators and managers. Even in the current health care climate of downsizing, mergers, and loss of nursing jobs, it is important to address the issues that influence nurses' working lives. Shared governance is an organizational model intended to provide a vehicle for staff nurse participation and greater control over nursing practice. Although the majority of work satisfaction studies were conducted in an effort to retain nurses because of the cyclic nursing shortages, shared governance was developed primarily as a means of involving staff nurses in decision-making and fostering professional nursing practice. The issues facing the nursing profession today require an even greater role in nurse participation and collaboration. Although the focus has shifted away from nursing organizational models toward a multi-disciplinary collaborative model, nurse involvement in decision-making is still essential to the delivery of quality patient care. With scarce resources and the need for cost containment, satisfaction with work may be of lesser concern than keeping one's job. Dissatisfaction with work may be present, but one's priorities are different. If nurses could demonstrate their competence in achieving cost-effective, quality patient outcomes and collaborate with other disciplines in solving complex patient problems, then job security might not be the issue. Clearly, nurses must articulate nursing's value to patients and families, other healthcare providers, and organizations if nursing is to survive as a profession. Using mechanisms and vehicles for expression of the nurse's value and worth will clearly send a message to consumers, providers, and employers that nurses are valuable and make a significant contribution in health care delivery.

Even if shared governance is not used as a nursing model, the research findings addressed in this study may provide additional insight into staff empowerment. Shared governance provides the structure and mechanism for nurses to control their practice and, perhaps, enhance nurse satisfaction. Administrators involved in hospital redesign or reengineering need to consider the unique, valuable resources that it has in its professional nurses and invite them to develop a staff empowerment model. The trend towards integrating all disciplines in achieving the best outcomes for patients does not mean that a nursing model cannot also exist. Nursing, however, must maintain its own identity and participate in decisions that are directly related to nursing through councils or similar participative structures. A blending of a professional nursing model with a multi-disciplinary, collaborative model may provide yet another mechanism for nursing to articulate its unique contribution to health care.

Implications for Theory

Numerous models of work satisfaction have been developed to explain the relationship between individual and organizational variables and work satisfaction (Blegan & Mueller, 1987). Both correlational and causal modeling techniques have been used with varying degrees of success in explaining work satisfaction (Hinshaw, Smeltzer, & Atwood, 1987; Mueller & McCloskey, 1990). In addition, two meta-analyses have been conducted in an attempt to understand work satisfaction to improve retention and decrease turnover in nurses (Blegan, 1993; Irvine & Evans, 1995). All have left considerable variance unexplained. Few studies have attempted to link quality outcomes to nurses' work satisfaction (American Nurses' Association, 1995). In spite of the numerous

studies of work satisfaction, no single theory has emerged to explain nurses' satisfaction/dissatisfaction with their work.

Instead of focusing on individual attributes, perhaps the focus needs to be on organizational and environmental variables. In addition, more attention may need to be given to relationship variables. Both organizational variables (e.g., organizational structure, committee participation) and relationship variables (e.g., peer interaction, interdisciplinary collaboration) may need to be considered when developing new models of work satisfaction. Research related to nurses' satisfaction with their professional roles may provide additional insight into attitudes toward their work. Meeting expectations of the professional role (i.e., autonomy and/or control over nursing practice) may provide other areas for theory development. Another approach to the study of work satisfaction would be to focus on patient and nurse outcomes. Nurses are happiest and most satisfied when their patients receive good patient care and dissatisfied when that does not occur. Researchers have found that patients rate the quality of care they receive highest in settings where nurses are most satisfied with work (Hinshaw, Scofield, & Atwood, 1981).

The most consistent finding in this study with implications for theory development is the importance of control over nursing practice to work satisfaction. Numerous mechanisms for increasing empowerment other than staff participation in shared governance committees are possible, but these were not explored in this study. Based on the findings in this study, meeting the nurses' expectations for participation in important decisions is one way of achieving control over nursing practice and work satisfaction.

Shared governance is only one way of achieving staff empowerment. Numerous contextual and relationship variables can also influence the nurse's attitude towards work.

Implications for Research

Measurement of outcomes related to an organizational change, such as shared governance, may require a longitudinal approach to measurement. Using comparative analyses of several hospitals only captures one point in time, not changes occurring over time, which may be extremely important in organizational change. When a longitudinal study is not feasible, pre and post change data are needed to adequately evaluate the outcomes of organizational change. Furthermore, using the individual as the unit of analysis may make it difficult to evaluate the impact of organizational change on staff nurses if they are very mobile. Although the current trends are changing due to layoffs and job loss, job mobility was high at the time of this study as evidenced by the low tenure in the organization among the nurse sample. Control over extraneous variables might be possible if study designs were to follow the same nurses over time, compare similar units across hospitals, or use an outside control group (Jones, Stasiowski, Simons, Boyd, & Lucas, 1993). The investigator was unable to find a control hospital for this study. Perhaps, using the organization as the unit of analysis with a large hospital sample might produce findings of a different nature than those obtained by using the individual as the unit of analysis. Also, a combination of individual and organizational outcomes may contribute most to a greater understanding of the impact that shared governance has on staff nurse attitudes and professional nursing practice.

Future research on shared governance should also explore the impact of the model on nurse-sensitive outcomes, such as quality of care, patient satisfaction, and nursing care costs. Including patient outcomes related to quality and safety may help demonstrate the impact of staff involvement in decision-making in improving patient outcomes. The American Nurses' Association (1996) has developed quality indicators to assess patient safety and quality of care in acute care hospitals. Nurse staff satisfaction is one of the indicators being used to assess the quality of care. Lastly, triangulation of research methods, using both quantitative and qualitative approaches, may offer valuable insights into the complex phenomenon of work satisfaction.

Conclusion

Four variables were initially used to predict nurses' work satisfaction in this descriptive, correlational study: staff nurse years in shared governance, perceived importance of involvement in decision-making, actual involvement in decision-making (or the discrepancy between importance of involvement and involvement in decision-making), and control over nursing practice. In Model 1, control over nursing practice was the major contributor, accounting for thirty-five percent of the explained variance in work satisfaction. Involvement in decision-making and importance of involvement contributed significantly but to a much smaller degree than control over nursing practice, for a total of thirty-eight percent of the variance. Years in shared governance failed to predict work satisfaction most likely because of the small variability in the measure. When forced entry regression techniques were used, years in shared governance still failed to contribute significantly to the variance in work satisfaction.

In Model 2, when the discrepancy between importance of involvement and involvement in decision-making was used as a predictor, along with years in shared governance and control over nursing practice, years in shared governance still failed to predict work satisfaction. However, control over nursing practice accounted for the largest proportion of variance (thirty-five percent) in work satisfaction with a total explained variance of thirty-eight percent for the three predictor model. Forced entry technique also produced a total of thirty-eight percent of the total variance in work satisfaction. However, discrepancy between importance and involvement accounted for fourteen percent of the variance, followed by control over nursing practice with twenty-three percent.

In Model 3, the following demographic variables were included along with the major predictor variables: years in nursing, years in hospital, hours per week in shared governance, years in unit, and practice area. Using forced entry regression techniques, control over nursing practice continued to explain the greatest proportion of variance ($R^2=.40$), with involvement in decision-making, years in shared governance, and years in nursing each contributing a small amount ($R^2\text{change}=.01$, respectively), for a total of forty-three percent of the explained variance in work satisfaction. Only one of the five demographic variables significantly predicted work satisfaction (years in nursing). However, the contribution of the demographics to the major predictor variables increased the total explained variance in work satisfaction from thirty-eight percent to forty-three percent.

As postulated, specific factors in the work environment contributed significantly to the level of work satisfaction among this sample of hospital nurses. Control over nursing practice appears to be a major factor that mediates the relationship between factors in the work environment and work satisfaction. Involvement in decision-making is also a predictor of work satisfaction, but seems to require other factors in the work environment to increase one's work satisfaction. Although years in shared governance was significantly correlated with work satisfaction in the bivariate correlations, it was not a strong enough predictor in most of the regression models. Years in nursing was the only demographic variable that significantly predicted work satisfaction in this study. Staff nurses rated perceived importance of involvement higher than actual involvement for all decisional items. Since matching importance with involvement was a significant predictor of work satisfaction, this approach needs to be considered when trying to involve staff nurses in shared governance committees or any participatory activities on the unit. Staff nurses were moderately satisfied with their jobs in this study. Because of this moderate satisfaction, nurses may tend to focus on the components of the job over which they have greater control, such as relationships with peers, colleagues, and patients. These were the areas in which nurses were most satisfied.

Work satisfaction is a complex phenomenon and multiple factors interact to comprise the predictors of work satisfaction. Personal attributes and personality traits, organizational factors, and job attitudes (e.g., stress and professionalism) may have stronger relationships with work satisfaction than the variables used in this study. Of the variables related to work satisfaction in the present study, those related to work content or

the work environment had the strongest relationships with satisfaction than did individual attributes or economic factors. Although organizational culture was not measured in this study, it is very important to establishing a shared governance model because of the philosophy inherent in shared governance. Therefore, the organization must assess the unique culture of the organization and seek ways to change individual's attitudes or values to help them to "fit" the organization. The "fit" between the shared governance structures and the unique qualities and characteristics of the nursing staff is very important for achieving success of the model.

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APPENDIX A

ORGANIZATIONAL PROFILE

To be completed by the chief nurse executive.

1. **Hospital name:** _____ 2. **Title of nurse executive**
3. **Hospital size (no. of beds):** _____ 4. **No. of yrs. with shared governance?** _____
5. **Date of written bylaws:** _____
6. **Type of membership in shared governance:** 1) RNs only _____
2) RNs & LPNs _____ 3) All nursing personnel _____
7. **Number of nursing FTEs** _____
8. **Number of full-time RN's (at least 32 hours per week)** _____
9. **Number of part-time RNs** _____ 10. **Number of Pool RNs** _____
11. **Current vacancy rate of RN's** _____
12. **Annual vacancy rate since implementing shared governance (please give years)** _____
13. **Type of nursing delivery system:** 1) Team Nursing _____ 2) Total Patient Care _____
3) Primary Nursing _____ 4) Case Management _____
5) Other (describe) _____
14. **Decentralized nursing organizational structure?** 1) Yes _____ 2) No _____
15. **Levels in the chain of command between the chief nurse executive and the staff nurses: (Please describe levels)** _____
16. **Unit-level shared governance committees (list committees):**

17. **Shared Governance council structure (list councils & send diagram of shared governance model):** _____
18. **Percentage of staff nurse participation in shared governance:**
1) Council level _____ 2) Unit-level _____
19. **Percentage of staff nurse participation in hospital-wide committees:** _____
20. **Hospital-wide committees with nurse representation:**

21. **Councils have final authority for practice-related decisions?** 1) Yes _____
2) No _____
22. **Chief executive have no veto power over council decisions?** 1) Yes _____
2) No _____

Appendix B-Demographic Profile cont.

Position on council _____

14. Past participation in shared governance councils

01. Yes _____ 02. No _____

If yes, specify council position & year(s) of involvement:

Council position _____

Year(s) of involvement _____

15. Current participation in unit-level shared governance committees:

01. Yes _____ 02. No _____

If yes, specify committee & position:

Committee _____ **Position** _____

16. Estimated number of hours per week spent in shared governance activities or meetings? _____

17. Current participation in hospital-wide committees:

01. Yes _____ 02. No _____

If yes, specify committee and position:

Committee _____ **Position** _____

18. Total number of committees that you are currently involved in: _____

19. What prevents you from becoming involved in shared governance?

20. What councils, committees, or taskforces would you like to be involved in:

Please add any comments pertinent to the evaluation of shared governance in your hospital.

APPENDIX C**NURSE EXECUTIVE LETTER OF INQUIRY**

Dear _____,

I am a doctoral candidate in nursing administration at the University of San Diego. My dissertation research topic is "Correlates of Staff Nurse Work Satisfaction in Hospitals with Shared Governance." The proposed research will specifically examine the relationship between staff nurse years of involvement in shared governance, perceived importance of involvement in decision making, actual involvement in decision making, discrepancy between importance and involvement in decision-making, control over nursing practice, and work satisfaction.

Few studies have investigated the outcomes of shared governance. Furthermore, few studies have systematically examined specific organizational decisions or compared importance of involvement with involvement in decision making among staff nurses. It is hoped that the results of this study will enable nurse executives to develop nursing organizational models that enhance professional practice and promote job satisfaction and retention among hospital nurses.

I am writing to ask your support for participation in this study at your institution. I have contacted the chair of the nursing research council in each of your institutions and will be submitting my proposal to your institutional review board in the near future.

I am looking forward to working with you and your staff during the data collection process and presenting the research findings upon completion of the study. Please call me at 602-991-8551 if you have further questions or need clarification.

Sincerely,

Mary Kay Flynn, DNS(c), RN, CCRN
University of San Diego

APPENDIX E**COVER LETTER TO PARTICIPANTS**

Dear Nurse Colleague:

I am requesting your participation in a study of shared governance that will form the basis of my doctoral dissertation. The purpose of my study is to investigate the relationship of organizational culture, staff nurse years of involvement in shared governance, perceived importance of involvement in decision-making, actual involvement in decision-making, discrepancy between importance and involvement in decision-making, control over nursing practice and work satisfaction among staff nurses in hospitals with shared governance.

You are included in a group of randomly selected staff nurses working in hospitals with shared governance located in different geographic regions. I am not requesting information about who you are or where your work. You can be guaranteed that your responses are completely confidential. Just detach this letter, complete the instruments as instructed, and return the survey to me via the enclosed self-addressed stamped envelope within three weeks. Do not write any identifying marks on the survey. Your mailing of the completed questionnaire is an indication of your consent to participate. Your decision to participate will in no way affect your employment at the hospital. Participation in this study is completely voluntary and you may refuse to participate or withdraw at any time.

The benefits of this study may include providing valuable information on the impact of shared governance in promoting greater control over nursing practice and satisfaction in the work environment. I know the demands on your time are great. However, I ask that you please take about 45 to 60 minutes to respond to the questionnaire. Your participation and prompt response is greatly appreciated.

The study has been approved by the research committee of your institution and by the University of San Diego Committee on Protection of Human Subjects. The results of this study will be available through the nursing department when completed. If you have any questions, I may be contacted at 602-991-8551.

Thank you for supporting this nursing research.

Mary Kay Flynn, DNS(c), RN, CCRN
University of San Diego

APPENDIX F

SAMPLE ITEMS OF ORGANIZATIONAL CULTURE SCALE

Instructions:

1. USE THE FOLLOWING RATING SCALE TO ANSWER EACH QUESTION:

- 1- When response LEAST reflects your view of your organization
- 2- When response SLIGHTLY reflects your view of your organization
- 3- When response MODERATELY reflects your view of your organization
- 4- When response MOST reflects your view of your organization

Assign a different number to each of the 4 responses (you are, in effect, ranking the 4 responses).

2. Each of the numbers must be inserted in the box following answers to each question. Do not repeat any number in a given line.
3. Example: the sequence of numbers you might use to answer a given question could look as follows: 4 2 1 3

PLEASE SCORE THE FOLLOWING QUESTIONS ON THE INSTRUCTIONS GIVEN. YOUR SCORE REFLECTS YOUR PERCEPTION OF THE CULTURE OR CLIMATE OF YOUR ORGANIZATION. IT DETERMINES HOW YOU FEEL THE ORGANIZATION REACTS TO YOU AND TO OTHERS AT THE PRESENT TIME.

1. In my organization, a leader	directs the organization	establishes objectives	is open to new ideas	respects others
2. My organization has a:	strong work ethic	well defined direction	creative atmosphere	cooperative spirit
3. In my organization, employees are:	reliable	truthful	moral	helpful
4. My commitment is based on	trust in my superior	advancement opportunities	meeting my personal goals	sharing of sentiment
5. My management emphasizes	meeting schedules	quality of work	innovative approaches	employees' suggestions
6. I feel that power is used to	achieve objectives	maintain control	negotiate goals	gain acceptance of programs
7. In my organization, participation	does not work	leads to mediocre solutions	is a desirable process	is always worthwhile

Source: Boulgarides, J. & Rowe, A. (1986)

APPENDIX G

SAMPLE ITEMS OF IMPORTANCE/INVOLVEMENT SCALE

Directions: The next set of questions are about decisional areas that nurses have identified as being important to them. For each decisional area, please indicate both (a) just how important it is for you to be involved in that decision and (b) your present level of involvement in that decision. Please use the following scales:

IMPORTANCE	PRESENT INVOLVEMENT
1 = Not important to be involved in this decision	1 = Not at all involved in this decision
2 = Slightly important to be involved	2 = Slightly involved
3 = Somewhat important to be involved	3 = Somewhat involved
4 = Very important to be involved	4 = Very involved
5 = Extremely important to be involved	5 = As completely involved as I want to be

	IMPORTANCE	INVOLVEMENT
1. Providing information to patients and families.	1 2 3 4 5	1 2 3 4 5
2. Assigning unit personnel to their daily work.	1 2 3 4 5	1 2 3 4 5
3. Coordinating overall patient services (e.g.x-ray)	1 2 3 4 5	1 2 3 4 5
4. Hiring new nursing personnel.	1 2 3 4 5	1 2 3 4 5
5. Determining nursing salaries.	1 2 3 4 5	1 2 3 4 5
6. Creating nursing policies & procedures for the unit.	1 2 3 4 5	1 2 3 4 5
7. Creating policies & procedures for the hospital.	1 2 3 4 5	1 2 3 4 5
8. Determining the overall nursing service budget.	1 2 3 4 5	1 2 3 4 5

Source: Allen, Heidrich, Peterson (1988).

APPENDIX H

SAMPLE ITEMS OF THE CONTROL OVER NURSING PRACTICE SCALE

Instructions: The following items represent opinions about your nursing practice. Circle the number that most closely indicates how you feel about each statement. It is very important that you give your honest opinion.

The left set of numbers indicates degrees of disagreement, while the right indicates degrees of agreement. The center number indicates "undecided". Please use it as little as possible. The more strongly you feel about the statement, the further from the center you should circle, with disagreement to the left and agreement to the right.

	DISAGREE	AGREE
I AM FREE TO:		
1. evaluate current nursing policies & procedures.	1 2 3 4 5 6 7	
2. evaluate the outcomes of nursing care.	1 2 3 4 5 6 7	
3. consult with others when solving complex problems.	1 2 3 4 5 6 7	
4. influence standards of practice in this hospital.	1 2 3 4 5 6 7	
5. modify or adapt patient care procedures and protocols.	1 2 3 4 5 6 7	
6. implement my nursing care in an efficient manner.	1 2 3 4 5 6 7	
7. provide holistic, patient-centered care.	1 2 3 4 5 6 7	
8. plan strategies to meet my own developmental needs.	1 2 3 4 5 6 7	
9. practice clinical skills to the best of my ability.	1 2 3 4 5 6 7	
10. analyze problems critically.	1 2 3 4 5 6 7	

Source: Gerber, R. (1988).

APPENDIX I

SAMPLE ITEMS OF THE INDEX OF WORK SATISFATION SCALE-PART B

Instructions: The following items represent satisfaction with your work. Please respond to each item by circling the number that most closely indicates how you feel about each statement. It is very important that you give your honest opinion. Do not go back and change answers.

The left set of numbers indicates degrees of disagreement and the right set indicates degrees of agreement. The center number means "undecided". Use this number as little as possible.

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

	DISAGREE	AGREE
1. My present salary is satisfactory.	1 2 3 4 5 6 7	
2. Most people do not sufficiently appreciate the importance of nursing care to hospital patients.	1 2 3 4 5 6 7	
3. The nursing personnel on my service do not hesitate to pitch in & help one another out when things get in a rush.	1 2 3 4 5 6 7	
4. There is too much clerical and paperwork required of nursing personnel in this hospital.	1 2 3 4 5 6 7	
5. The nursing staff has sufficient control scheduling their own work shifts in my hospital.	1 2 3 4 5 6 7	
6. Physicians in general cooperate with nursing staff on my unit.	1 2 3 4 5 6 7	
7. I feel that I am supervised more closely that it is necessary.	1 2 3 4 5 6 7	
8. Excluding myself, it is my impression that a lot of nursing personnel at this hospital are dissatisfied with their pay.	1 2 3 4 5 6 7	

Source: Stamps, P. & Piedmont, E. (1986).