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The measurement of professional nursing governance

Hess, Robert G., Jr., Ph.D.

University of Pennsylvania, 1994

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THE MEASUREMENT
OF
PROFESSIONAL NURSING GOVERNANCE

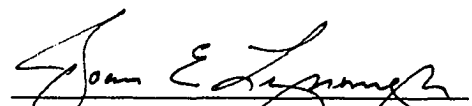
Robert G. Hess, Jr.

A DISSERTATION
in
Nursing

Presented to the Faculties of the University of Pennsylvania
in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

1994


Supervisor of Dissertation


Graduate Group Chairperson

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Robert G. Hess, Jr.

1994

DEDICATIONS

To my wife, Evamaria,
for her love and support;
to my son, Rob,
who died in the service of his country
during my doctoral studies,
for his respect and beliefs;
to my parents,
for their constant approval;
to my parents-in-law
for their faith in me;
and to the rest of my family and friends
for their encouragement.

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ABSTRACT

The Measurement of Professional Nursing Governance

Robert G. Hess, Jr.

Florence S. Downs, EdD, FAAN, Supervisor of Dissertation

The purpose of this study was to develop and psychometrically test an instrument, the Index of Professional Nursing Governance (IPNG), for measuring professional nursing governance by hospital-based nurses. A six dimensional model included: (a) professional control over practice, (b) organizational influence of professionals over resources that support practice, (c) organizational recognition of professional control and influence, (d) facilitating structures for participation in decision-making, (e) liaison between professional and administrative groups for access to information, and (f) the alignment of organizational and professional goals and negotiation of conflict.

In Phase One, items extrapolated from multidisciplinary literature of organizations, management and nursing, were judged for content validity by administrative and hospital staff nurse experts. Total average congruency scores for the resulting 88-item instrument was $\geq .95$. In Phase Two, the IPNG was tested for feasibility with 25 nurses.

In Phase Three, the instrument was tested for reliability with 321 nurses from two hospitals. Cronbach's alphas were .95 for the instrument and from .82 to .90 for

the six subscales; test-retest reliability was .77 over one month. All items were retained.

In Phase Four, construct validity was examined using 816 nurses from ten hospitals. Principal components factor analysis with varimax rotation produced a six factor solution. Eighty-eight items explained 44% of the variance. Three factors closely resembled original dimensions for Information, Participation, and Goals and Conflict; three new factors, Control over Practice, Supporting Resources, and Nursing Personnel, were slightly different than predicted by the original model. Reliabilities ranged from .87 to .91 for factor derived subscales and .97 for the instrument. Subscale intercorrelations were between .43 and .67. Aggregate scores from shared governance and traditionally governed hospitals showed a significant difference ($t=9.56$, $p=.005$). A correlation of $+0.60$ ($n=578$, $p=.005$) was found between the IPNG and the Hague and Aiken Index of Centralization, representing a moderate correlation between the distribution of governance and staff and the degree of centralization in the organizations.

The final 88-item instrument classifies hospital governance based on the governance distribution between nursing management/administration and staff nurses. The instrument can be used for baseline and evaluative data for the implementation of governance innovation and its outcomes.

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CHAPTER 1

Problem

Background

The pursuit of enhanced governance roles by many nursing professionals and their leaders has been shaped by the restrictions on the autonomy of the members of an emergent profession who practice primarily in hierarchical bureaucracies- sixty-eight percent of all working nurses practice in hospitals (American Nurses Association, 1992).

In complex organizations, the degree of professional members' autonomy is a function of whether or not the organization is dominated by that profession and, concomitantly, whether or not the services of those professionals are in short supply (Wilensky, 1964). Despite the fact that hospitals fulfill both conditions, the autonomy of hospital nurses, the largest of full time professional groups, appears variable and situational, and is inconsistently related to personal and professional characteristics (Schutzenhofer, 1992). And, Cleland (1982) took note of the obvious in her observation that most nurses are supervised by nurses whose goals and values about hospital governance are more in line with those of the management of the organization than the goals and values of a professional group whose perspectives have been evolving, especially since the movement to college education for nurses took shape.

Students of organizations have often noted that professional nurses have felt a tension that comes from being organizationally-constrained as employees, while making autonomous practice decisions influenced by allegiance to a greater community of professional nurses. Thus, Scott (1966) identified four areas of conflict for professionals in bureaucracies; (a) resistance to bureaucratic rules, (b) rejection of bureaucratic standards, (c) resistance to bureaucratic supervision, and (d) conditional loyalty to the bureaucracy. For professional nurses, these areas have resulted in incongruent values that are held by nurses in administrative and clinical capacities (Kramer & Hafner, 1989) and conflicting and ambiguous role expectations between nurses and a bureaucratic hospital environment (Bateman & Strasser, 1983; Ketefian, 1985; Hess & Drew, 1990).

Major changes in governance, such as nursing shared governance, have been proposed as vehicles for resolving dysfunctional conflicts evident to professional nurses in their work environment. The involvement of nurses in governance has been implicitly cited as a right of nurses (Fagin, 1975). Professional organizations, such as the American Nurses' Association Commission on Nursing Services (1981), have precisely defined these rights for hospital nursing practice environments.

In 1987, the Secretary's Commission on Nursing (1988),

formed to find solutions to a severe nursing shortage, recommended the maintenance of policies and structures that would include nurses at all levels of organizational decision making, including the board and executive levels, specifically in areas of "strategic planning, quality assurance, and resource allocation" (p. 33). A contributing report (Kusserow, 1988) noted a trend of greater involvement in decision making by hospital nurses. Most chief nurse executives (CNEs) and chief executive officers (CEOs) felt that staff nurses were interested in making decisions about patient and professional practice issues, particularly if they felt that they could make a difference in these areas. Nevertheless, even CNEs rarely acquired voting privileges on hospitals' governing boards, despite frequent allowances (85%) for participation in board deliberations.

In 1989, the National Commission on Nursing Implementation Project endorsed professional practice models that supported authority, autonomy and responsibility for nurses by decentralized management and shared or collaborative governance structures. It was recommended that nurses' involvement in policy decision making for allocation and management of resources that supported nursing care should occur at all levels of the hospital organization through standing committees; this would be augmented by participation of the nursing executive in the medical staff organization and the hospital governing board

(National Commission on Nursing Implementation Project, 1989).

Staff nurses also have voiced concerns about their basic practice as well as about administrative concerns. A national sample of 3500 RNs (with hospital nurses overrepresented) rated being "allowed to exercise nursing judgment for patient care" as the second most important factor in their nursing practice; "support from nurse administrators" and "a sense of being an important member of the health care team" were rated fourth and sixth, respectively, out of a list of the top ten concerns (Huey & Hartley, 1988, p. 182).

A popular representation of organizations successful in nursing can be found in a study of 16 prototypical participative or "Magnet" hospitals that remained virtually immune to the most recent nursing shortage (Kramer & Schmalenberg, 1988a; Kramer & Schmalenberg, 1988b; Kramer, 1990). The characteristics that precluded a nursing shortage in these hospitals were similar to those identified by Peters and Waterman (1982) in their bestselling description of America's best run business firms: (a) bias for action, (b) remaining close to the customer with zealous attention to quality, (c) environment that supports autonomy and entrepreneurship, (d) productivity through respect for the individual worker, (e) creation and clarification of the value system of the company, (f) flat, lean, decentralized

structure, and (g) coexistence of individual autonomy, flexible organizational structure, extensive experimentation, copious feedback, and informality with a remarkably tight, culturally driven, and controlled set of rigidly shared values. In the magnet hospitals, these characteristics were epitomized by structural flatness, self-contained units, self-governance, flexible self-scheduling, salaried status and salary decompression, rejection of traditional roles, specialized practice, support for education and a sense of autonomy (Fagin, 1989).

At the same time that this report appeared, nursing shared governance, a unique nursing management strategy that promoted nurses' participation in organizational governance as professionals, began to emerge in nursing literature. This concept has become one of the most prevalent governance innovations in nursing since its initial popularization during the 1980's by nurses such as Porter-O'Grady and Finnigan (1984). Although there is no definitive form or definition, shared governance can be broadly defined as an organizational innovation in hospitals that legitimizes nurses' decision-making control over their professional practice while extending their influence to administrative areas previously controlled by management. Similar innovations that redistribute control and influence have been alternatively identified as collaborative governance, professional governance, participatory governance, "unit-

based" shared governance, and professional practice models.

Hospital experimentation in governance has been reported either at the nursing departmental level, the nursing unit level, or simultaneously at both (the so-called binary or bilevel model) (Jacoby & Terpstra, 1989; McDonagh, 1990). These innovations have varied widely along a continuum from directed and limited staff involvement in governance (Rudolf, 1989; Ulz, 1989), governance shared between staff and management (Carson & Ames, 1980; Shindler, Pencak, & McFolling, 1989), governance shared exclusively among staff ("Johns Hopkins nurses," 1987; "No head nurses," 1987; "Northside RNs," 1987; Guinn, 1989), and to self-governance which is linked organizationally to the hospital only at the hospital board level (Christman, 1976; Kimbro & Gifford, 1980). Self governance is different from shared governance and even self-management where nurses may manage their own work groups, but retain employee status in the organization (Patterson, 1991). For example, Mitnick and Crummette (1991) described a governance model in which professional nurses contracted their services as entrepreneurs in a group practice; nurses (and physicians) were represented by respective governing boards and had their own administrative structures (because they were not employees of the hospital).

There is a growing shift in hospitals toward innovative situations that increase nurses' power over their practice

and associated administrative areas. While the Center for Nursing Practice at the American Nurses' Association (Perry, 1990) reported that 300-400 hospitals' had implemented shared governance, more recently, Porter-O'Grady (1992) estimated that number at one thousand. Ludemann (1991) stated that shared governance had reached the point where different models should be compared. But without common definitions, it is not possible to make comparisons along quantitative dimensions.

The variety of governance innovations collectively labelled shared governance suggests that it is not a discrete phenomena; rather, there are many different versions that vary on a continuum that ranges from nurses governed by others to nurses governing themselves. Furthermore, wide variations among anecdotal descriptions of differentially specified governance systems also suggest that professional nursing governance is more complex than a simple unidimensional continuum; rather, it simultaneously encompasses multiple continua specific to professional practice and governance in hospitals. These innovations are unable to be evaluated because of a lack of consensus concerning the definition of professional nursing governance in hospitals and its basic dimensions.

Purpose of the Study

The purpose of this study is to develop and test the psychometric properties of an instrument designed to measure

professional nursing governance.

Definition of the Terms

For purposes of this study, the following definitions are proposed.

Formal Organization

A formal organization is a social system contrived to achieve explicit, rational goals as well as implicit, emergent goals that are determined by both internal and external organizational participants.

Organizational Governance

Organizational governance is defined as the structure and process by which organizational participants direct, control and regulate the many goal-oriented efforts of its members.

Professional Nursing Governance

Professional nursing governance is a multidimensional concept encompassing the structure and process through which professional nurses in hospital organizations control their professional practice and influence the organizational context in which it occurs through organizational recognition, facilitating structures, the liaison of information and the alignment of goals.

Significance of the Study

Despite ongoing public and professional concern, nursing governance remains conceptually vague and unmeasured. There is no empirical measure for assessing

governance itself in different hospital environments. Outcome studies of various governance innovations from implementation sites are rarely generalizable beyond the specific institution. Lacking comparable empirical justification, such innovation falls easy prey to controversy. Schwartz (1990), in fact, has claimed that increased nursing governance is a strategy that is being forced on unwilling professional nurses by its leadership.

Neither organizational theory nor the sociology of professions alone adequately describe professional nursing governance situations; nursing literature has borrowed heavily from these disciplines and perpetuated their limitations in application. Despite the importance of structural characteristics such as centralization, professionalization, and participation in governance, professional governance cannot be defined by structure alone. Even nursing's most popular governance innovation, nursing shared governance, has been difficult to recognize by its structure since it is continually "tailored to a specific environment, its employees, and their expectations" (Johnson, 1987, p. 43).

Among all nursing governance innovations, shared governance has dominated the literature and attention of the nursing community. Shared governance (however conceptualized) is firmly situated in nursing's efforts to shape its future. Forty-nine percent of a sample of 987

nurse executives anticipated the use of formalized shared governance with staff nurse-written bylaws and committees by 1992 (Wake, 1990). The New Jersey Hospital Association claimed that 43% of its hospitals already had a "process" for shared governance based on its 1988 survey data; and in 1989, using a smaller sample, it found 37% with such a process.

Nurses have been willing to implement shared governance, even though the benefits of these models are still speculative. As the consequences of early implementation are being evaluated (Porter-O'Grady, 1989), there is still little research outside of single institution-specific studies to support the growing popularity claimed in anecdotal literature. Although several outcome studies have reported favorable changes for nurses in autonomy, job satisfaction, job stress, collegiality, turnover and retention and cost-effectiveness, the governance variables are imprecisely and variously defined, thereby limiting the conclusions which can be drawn from the results.

Research in nursing governance innovation has focused on models that purport to be shared or self governance models. For example, Ethridge (1987) reported higher nurse job satisfaction and less job stress in a model promoting authority, responsibility, and autonomy in decentralized, self-governing environment. In a longitudinal evaluation of a shared governance structure after a year and a half,

Ludemann and Brown (1989) reported that nurses held more positive perceptions of the work environment, felt greater overall job satisfaction, and perceived more opportunities for growth and promotion, as time passed. Smaller studies have reported greater nurse satisfaction associated with a shared governance process for credentialing and peer review (Howard, 1987) and more satisfactory perception of collegial communication on a unit utilizing a professional practice model (Serafini, 1989). However, Pinkerton (1988b) found no change in job satisfaction, professionalism, or control over nursing practices between nurses in a hospital where a shared governance model was introduced and those in a control hospital; the researcher attributed these findings to a short implementation time of nine months (Pinkerton, 1988a). These studies did not share a common measure of their governance phenomena.

In an increasingly cost-conscious health care environment, the issue of the cost-effectiveness of shared governance has not been settled. Shared governance has been associated with cost savings from decreased turnover (Pinkerton, 1988b), restructuring (Jenkins, 1988), and generation of revenue (Ethridge, 1987). However, Pruett (1989) demonstrated a financial liability by positively associating level of implementation with paid manhours per unit of service. Cost benefits of shared governance have yet to be quantified in spite of clear research

opportunities. There is an urgent need to collect such data since researchers speculate that any changes from shared governance are not realized for several years (Eckes, 1988; Ethridge, 1987).

Innovative governance models such as shared governance are appealing to nurses. Nevertheless, nurse executives have little empirical justification to persuade hospital administrators to modify existing governance arrangements in a healthcare climate that is already short of resources to sustain existing programs. There have been no cumulative data that associate professional governance models with consistent outcomes. Without a common measure of governance, it has not been possible to compare models and outcomes. This study proposes to provide this common measure.

CHAPTER 2

Review of the Literature

The literature review for this study addresses several bodies of theoretical literature: (a) the multidisciplinary (management and sociology) study of organization and design; (b) the sociology of professionals in organizations, particularly in health care; (c) authority and power in organizations, and (d) nursing governance innovations in hospitals. This review links six theoretical themes from professional and organizational literature as a conceptual basis for measuring professional nursing governance that include: (a) professional control over practice, (b) organizational influence of professionals over support for that practice, (c) organizational recognition of professionals' formal authority, (d) facilitating structures for participation in decision-making processes, (e) liaison between professional and administrative groups for access to information, and (f) the alignment of organizational and professional goals.

Organizational Governance

Organizations

Governance, the structure and process of directing the activities of a formal organization, is dependent on the view of an organization as a rational, emergent and/or an open system. In a classic analysis, Gouldner (1959) traced the conceptual lineage of these systems through several

grand theorists. During the eighteenth century, Saint-Simon noted the development and rising prevalence of organizations in modern society where administrative authority was based on expertise, not heredity, the "rational" view later developed by Max Weber. Subsequently, August Comte, Saint-Simon's student, offered a much different emphasis on the spontaneous or unplanned aspect of social order, the "natural" view of organizations later espoused by Talcott Parsons and Philip Selznick.

A rational system view of organizations has predominated the literature. For example, in defining an organization, Daft (1989) stressed the activities that are deliberately directed and structured toward goals. Organizations become formal because of the coordination of collective efforts toward a particular purpose (Blau & Scott, 1962); organizations are instruments to achieve explicit goals. Structures are legally prescribed as means to these ends and the organization operates like a machine; when deviations occur, they are simply mistakes or miscalculations (Gouldner, 1959).

Gouldner (1959) stated that organizations can also be viewed as natural systems where rational goals are just one of many types of goals that emerge from components striving for equilibrium. Organizations can even become ends in themselves in a quest for survival, sometimes precluding espoused rational goals. This is an organismic model that

defines the organization on the basis of the interdependence of its parts. Thus, to fully understand an organization, its informal structures or groups must be considered along with the formal "rational" structure. Groups that spontaneously emerge from within the organization cannot be dismissed as mere deviations from formal structure, since they may be important adaptive changes to the environment for maintenance of the organization's equilibrium.

Scott (1981) added an open system perspective to this taxonomy in order to stress that organizations are continually influenced by resources and participants that flow in and out from the environment. As an open system, an organization is subjected to conflicting interests of different groups in both the organization and the environment, and its many goals are the result of constant negotiation. In a formal organization with large professional groups, goals are profoundly influenced by these professional participants.

Based on this review, it is suggested that governance may be comprehensively inferred only by synthesizing these paradigms that define organizations as rational, natural or open systems.

Governance

Governance is a multidimensional, complex phenomenon of government (Dahl, 1961; Peters, 1988), corporate boards (Zald, 1969; Mace, 1971; Tricker, 1988), universities

(Baldrige, 1971; Birnbaum, 1991) and hospitals (Flarey, 1991; Judge & Zeithaml, 1992). Organizational governance is "the means through which an organization is directed, controlled and regulated" (Daft, 1989, p. 489). Nursing literature concurs with a broad conceptualization by referring "to the apparatus or structure through which a body that governs exercises its authority and performs its functions" (McDonagh, 1990, p. 1). The members of this body, in most cases, are called managers.

Reflecting a rational systems perspective, one view of governance stresses the goals of management. Governance has been traditionally enacted and managed by management, a prerogative evoked as if in the best interest of the organization (Scott, 1988). This proclivity has been evident in organizational theory for various reasons. The American tradition of Scientific Management (Taylor, 1947) assigned authority for controlling such decisions in the organization to administrators because of expertise. Weber (1947) assigned this function to bureaucrats through the legal authority of their office because of anticipated efficiency; Simon (1957) continued this inclination, though recognizing that rational effectiveness of managers was limited or "bounded" by limited information and resources. Despite Barnard's (1938) position that such authority would be dependent on the acceptance of subordinates, management's control of governance has not only been preserved (Perrow,

1986), but used to widen accepted areas of control over organizational participants.

Scott, Mitchell, & Peery (1981) interpreted governance as a "vehicle which management uses to promulgate acceptable value structures... by obtaining consensus on essential resource allocation decisions" (p. 137). This orientation stresses a rational systems perspective. Rationality, making decisions relative to the likelihood of achieving particular goals, can be a determinant of governance design. Scott et al. described three rationalities by their distinct objectives and means: (1) technical rationality to achieve efficiency through specialization and motivation, (2) organizational rationality to promote coordination through integration and control and, (3) political rationality to maintain justice and the status quo through common values. They theorized that governance is a rational process that predetermines how priorities are assigned to decisions in terms of efficiency, coordination, and justice. Four ideal governance types of autocracy, totalitarianism, democracy, and federalism were proposed, based on governance processes, structural contingencies, integration and control, power motives and the definition of moral motives.

A rational portrayal of organizations can be found in a structure that depicts intended governance by formally designating work groups and reporting relationships. A traditional bureaucratic structure has been simply

represented by a chart that shows the plan of hierarchical relationships of control and authority between individuals and their work processes (Weber, 1947/1958). Blau (1970) emphasized this differentiation among the ways in which organizational participants were arranged in positions, ranks, and subunits, isolating formal structure from emergent groups and the behavior of the members. His empirical measures consisted of counting these units. Theorists have attributed governance design (governance embedded in formal structure) as rationally evolving in response to efficiency (Weber, 1947/1958), task interdependence and complexity (Thompson, 1967), environmental uncertainty (Lawrence & Lorsch, 1967), resource dependency (Pfeffer & Salancik, 1978; Burt; 1983) and legitimacy (Meyer & Rowan, 1977). However, an examination of commonly-cited structural characteristics with the help of factor analysis revealed the importance of distinctions between what is structurally expected, on one side, and the ways in which organizational participants perceive and define those expectations (Pugh, Hickson, Hinings & Turner, 1968).

Management control that is institutionalized in formal structure has been challenged by the democratic aspirations of industrial humanists and human relations theorists (MacGregor, 1960; Likert, 1967; Argyris, 1964). They have advocated the participation of other organizational members

in administrative spheres previously reserved for managers. This advocacy evolved from an assumption that "those who are in organizations should be, in the last analysis, the source of consent for those who make policy and establish controls" (Scott, 1969, p. 45). Even though these theorists still reserved ultimate control for management, they introduced the importance of emergent groups, a natural systems perspective.

A natural system perspective of governance emphasizes emergent groups that gain informal power through "the effects of information and communication structures" (Pfeffer, 1981, p. 38) and may even transcend the authority derived by formal structure to create a different picture of organizational governance. Fombrun (1984) also noted that the "governance structure of the organization... may or may not coincide with the formal structure and control systems of the organization" (p. 222). By surveying the interaction of professionals in a research organization, he found power concentrated in an elite cadre of individuals who were both experts and managers; this group was superimposed on the formal governance structure. Thus, the presence of powerful professional groups can mitigate attempts to define a simple governance taxonomy proposed in the past (McGregor, 1960; Michels, 1961; Bennis, 1966; Scott, Mitchell, & Peery, 1981).

An open systems view of governance emphasizes the

interaction of organizational members within the context of the environment. Olsen (1988) included these factors in two dimensions to derive decision making models of governance. In one dimension, decisions were either voluntarily made by rational members in pursuit of their goals or determined by environmental or situational forces that rendered the members' decisions irrelevant. In the other, decisions were made either among members with shared goals and values or among members with conflicting interests. These dimensions, although limited to decision making, complement and extend rational and natural systems' views by emphasizing the influence of the environment and diverse interest groups on governance.

All three views assume a dependence on access to information appropriate to governing the organization. For instance, information is used by a rational system to provide feedback on official goals, by a natural system to assess power beyond formal structure, and by an open system to evaluate its environment. However, Olsen (1988) has pointed out that such information can overwhelm decision makers who may be already restricted by their own understanding, so-called "bounded rationality" (Simon, 1957). Or information may be intentionally used to justify the appropriateness and legitimacy of actions already taken (March & Simon, 1958), the "garbage can tradition" of strategic choice (March & Olsen, 1976). Thus, access to and

communication of organizational information can reflect the distribution of governance.

The governance perspective for this study incorporates rational, natural, and open systems models to acknowledge co-existing and sometimes conflicting goals of diverse groups within the organization. These groups compete within formal and informal structures for essential human, material, and informational resources to achieve their goals.

Measurement

Governance is rarely measured since the literature is mainly theoretical. Normative definitions lack a unifying conceptual framework, and substantive definitions do not provide indicators for identifying organizational governance beyond the occasional listing of activities (Mace, 1971; West & Wind, 1990; Flarey, 1991) or structural dimensions (Dahl, 1961; Peters, 1988). These attempts to define governance are scattered throughout diverse literature.

Zald (1969) measured "governance power" in corporations by examining participation, control of important participative structures, and information necessary for decision making. He stated that the purview of governance is the utilization of resources appropriate to the goals of the organization.

The measurement of the influence of professionals over the use of resources has been studied in samples of nursing

faculty (Dimond, 1991) and of nursing executives (Havens, 1991). University faculty governance has been examined through both formal and informal faculty structures for decision-making process (Baldrige, 1971; Birnbaum, 1991). The process was found to be typically participative (that is, involving organizational members other than just managers): The National Center for Postsecondary Governance and Finance reported that ninety-one percent of a 1989 sample (n=402) had a structure for participative governance (Gilmour, 1991).

Governance in nursing literature specific to academe has referred to participation in decision-making in specific areas, measured in terms of degree of perceived authority. Perceptual measures of governance and related concepts such as authority and power are common and have been consistent across informants and have correlated with other measures (Pfeffer & Salancik, 1974; Pfeffer, 1981). Bahrawy (1992) reviewed previous nursing faculty governance literature that measured perceived authority to participate in discrete areas of governance (i.e. none, discussion, consultation, joint action, determination) and found that faculty had little authority over fiscal matters.

Faculty governance was cited in early innovative hospital nursing governance literature (Cleland, 1978) and paralleled its subsequent development. However, additional understanding of governance can be gained by reviewing the

literature of two similar concepts, authority and power.

Authority and Power

Some organizational concepts, such as governance, are "fused with related phenomena" (Peabody, 1964, p. 3). Since authority and power (sometimes used interchangeably or with control and influence) frequently appear in governance literature, these concepts must be briefly reviewed; more extensive reviews of authority and power are available elsewhere (Peabody, 1960; Dornbusch & Scott, 1977; Bacharach & Lawler, 1981; Pfeffer, 1981). Selected studies addressing these concepts will be presented later to support the delineation of dimensions of professional nursing governance.

Legal-Rational and Value-Rational Authority

Weber (1947) provided a broad definition of authority: "the probability that certain specific commands (or all commands) from a given source will be obeyed by a given group of persons" (p. 324). Blau and Scott (1962) separated authority from power, persuasion, and personal influence, associating authority with "voluntary compliance with legitimate commands and suspension of judgment in advance of command" (p. 28). Two components of authority resemble governance: (a) the ability to make certain decisions (Simon, 1953), and (b) a condition where, because of shared values and beliefs, these decisions are "accepted by a contributor to or 'member' of the organization as governing

the action he contributes...so far as the organization is concerned" (Barnard, 1938, p. 163).

Weber's (1922/1969) proposed three types of authority-traditional, charismatic, and legal-rational- each with its own basis for legitimacy. Traditional authority derives legitimacy through a particular person, such as a hereditary king or chief, who occupies a traditionally-sanctioned position; on the other hand, charismatic authority is enacted by a person who elicits obedience by virtue of extraordinary personal qualities. However, only a third type, legal-rational authority, was linked by Weber to the modern bureaucratic organization. Representing a rational systems view, this authority was deemed legal because of its association with an official position or office in an organization (rather than the people that occupy those offices), and rational in its instrumentality toward rational goals. Weber also implied that this authority was rational because he assumed that the officeholder would possess associated expertise and technical knowledge about the organization.

Satow (1974) added a fourth type of authority, value-rational, that she attributed to professionals in organizations. This authority derives legitimacy from a shared belief in a common, absolute ideology; it is rational by orientation toward the attainment of professional goals, which may be emergent and different from those of the

organization- a natural systems view. This authority is also rational due to the expertise of professionals, though perhaps in service to professional goals.

The value-rational authority of professionals may conflict with the legal-rational authority of bureaucrats. Both types of authority, when considered together, offer an explanation of conflict in governance in organizations with large professional groups.

Legitimate, Expert, and Informational Power

French and Raven (1959) described three types of power, legitimate, expert, and information, that conceptually overlap with authority, contributing to the interchangeable use of authority and power in organizational literature. Power was defined in terms of influence, rather than control, in order to acknowledge the many forces that compete with one another to induce change. Control would be used to describe the strongest instance of force (influence).

As in authority, legitimate power is "valence in a region which is induced by some internalized norm or value" (p. 264). Here, the influencer (O) has power over the influenced (P) in that O has a legitimate right to influence P, and P recognizes an obligation to accept that right. In the individual, the basis for this power stems from cultural values, social structure, or designation by a legitimizing agent; in an organizational group, legitimate power may

claim the legitimacy from either the organization (legal-rational authority) or a professional group (value-rational authority).

Expert power is derived from "the extent of the knowledge or perception which P attributes to O within a given area," that is, the credibility and not necessarily the information possessed by the power holder (French & Raven, 1958, p. 267). However, information power, as an extension of French and Raven's (1958) original power taxonomy (Raven & Kruglanski, 1975; Hersey, Blanchard, & Natemeyer, 1979; Pfeffer, 1981), refers to the actual expertise or knowledge that the powerholder possesses as another relevant basis for power in organizations. Both expert and information power is rational and may also parallel Weber's types of authority, depending on whether the credibility and expertise is associated with the organization or the professional group.

A Weberian bureaucracy assumed a correlation between legal-rational authority or legitimate, expert, and information power with position in the organizational hierarchy. However, Blau and Meyer (1971) noticed that increasing specialization within organizations has upset this relationship: managers often supervise workers who possess more expertise than their managers. Thompson (1961) also noted that this expertise can become a basis for legitimacy or a "non-hierarchical authority," upsetting the

congruence between "expected authority and actual authority" (p. 100). In organizations mostly composed of professionals, the decision to recognize this order by merging types of power or authority becomes a basis for altering the decision-making processes of governance (Meyer, 1988) and supplanting hierarchical authority with the collegial authority of professionals (Blau & Meyer, 1971). In describing this new order, the similarities between concepts of governance, authority and power have resulted in studies that appear to address the same phenomena, only through different language.

Professional Governance

Raelin (1986) synthesized a large body of organizational literature and characterized the relationship between professionals and managers as a "clash of cultures," noting conflict between professional autonomy and managerial control. Such autonomy has been conspicuous in classic models that have defined occupational groups as professionals (Greenwood, 1957; Goode, 1960; Kornhauser, 1962; Wilensky, 1964; Hall, 1968).

Conflict between professionals and administrative personnel has been well documented (Corwin, 1961; Scott, 1966; Hall, 1968; Mantagna, 1968; Engel, 1970; Benson, 1973; Sorenson & Sorenson, 1974), as well as theoretical descriptions of professional organizations that structurally promote cooperation between these groups (Litwak, 1961;

Montagna, 1968; Bucher & Stelling, 1969; Mintzberg, 1979, 1983). More recently, health care professionals, such as nurses (Shamansky, 1989), have challenged the exclusive control of governance by administrators and have encouraged the development of new organizational governance models specific to their work situation.

Hospital Governance Models

Although many recent innovative models of hospital governance involve only physicians (Stemmler, 1985; MacLeod & Schwartz, 1986; Shortell, 1989; Stoeckle & Reiser, 1992), Scott (1982) proposed three governance models that can be applied to hospital nurses. Each discrete model depicts a structure that supports a different involvement in governance by professionals:

1. The heteronomous professional organization resembles a traditional bureaucracy, subordinating professional groups to the control of an administrative structure. Professionals are organized into multidisciplinary teams that permit discretion over individual tasks, while constraining them as autonomous professionals. Responsibility for the work of the team is assigned to team leaders and their position in the hierarchy. A large, elaborate hierarchy is required to maintain communication, coordination, and overall control. Scott stated that many hospital nurses work in such a situation.

2. The conjoint professional organization is structured so that influence is shared between professional and administrative personnel; the two groups are interdependent and have equal power and importance. Scott illustrated such a situation with physicians as a professional group that had become increasingly involved in administrative concerns, while hospital administrators had become equally interested in issues of professional practice. Although each group retained primacy in their own areas of expertise, potential conflict from overlapping concerns could be institutionalized within a collaborative and pluralistic structure.

3. The autonomous professional organization is characterized by organized groups of professionals that, in lieu of the administrative group, define their own goals as well as define and control their work. Control occurs through internal peer (collegial) groups and external regulatory groups; these groups tend to affect work performance before and after the work has occurred, thus preserving professional autonomy.

Although Scott joined others in using physicians as the prototypical professional group in hospitals (Engel, 1970; Fogel, 1989), he explicitly recognized that nurses were moving out of heteronomous organizational forms and into conjoint and autonomous situations.

Professional Nursing Governance in Hospitals

Scott's (1982) organizational models somewhat parallel traditional, shared and self governance models that have appeared in administrative nursing literature, anchored on a continuum of professional nursing governance.

Traditional Hospital Governance of Nurses

The traditional hospital governance of nurses can be conceptualized at the restrictive end of a governance continuum where: (a) the nursing staff does not exercise individual professional control or autonomy over nursing practice; (b) the allocation of resources is centrally-determined by bureaucratic mechanisms with no staff participation; (c) the absence of staff empowerment is accepted and rigidly maintained by the organization; (d) a formal hierarchical bureaucracy dominates and enforces the work of nursing; and (e) professional nurses are connected to the organization and each other only through the formal bureaucracy.

Until recently, hospital nursing was characterized by this bureaucratic structural orientation. The bulk of hospital nursing care in the 1940's was provided by private duty nurses who were independently contracted by individual patients; these nurses were centrally governed by hospitals that controlled the environment and access to patients. Student nurses were similarly subjected to the strict supervision of the hospital through its nursing administration which controlled the school of nursing.

Due to a nursing shortage following World War II and the inability of patients to afford individual private nurses, a concept of group nursing evolved that heightened bureaucratic governance. Here, in an early version of professional group practice, a group of independent private duty nurses cared for several patients on a particular ward; however, their work and scheduling remained controlled by the hospital nursing administration (Mustard & Gates, 1960). An examination of one hospital's "Revised Rules Governing Group Nurses" (Mustard & Gates, 1960) reveals a governance situation that embodied Weber's (1947/1958) bureaucratic model.

The structured regulation of nurses within a hierarchical bureaucracy was perpetuated, by commendations, throughout the nursing administrative literature of the 1950's (Donovan, 1957; Bredenberg, 1957). Regulation was enforced through nursing's commitment to Fayol's (1949) classical management functions of planning, organizing, commanding, coordinating, and controlling (Donovan, 1957). These functions were enacted exclusively by nursing administration in governing nurses.

Administrative control of nurses was augmented by the school of "Scientific Management" promoted by Frederick W. Taylor (1947). Taylor advocated task analysis that resulted in standardization and rigidity that precluded innovation. Nurses became subjugated to their own policies and

procedures in the name of efficiency. "Schedules were set up for routine activities; tasks were defined in step-by-step detail; training programs were based on these orderly procedures and tasks. More than half a century later, this approach still prevails in many hospitals..." (Hegyvary, 1990, p. 675). This traditional governance is analogous to Scott's (1982) heteronomous model.

Nursing Shared Governance

Nursing shared governance represented a radical break from traditional governance (Porter-O'Grady & Finnigan, 1984). The concept was first suggested (though labelled differently) in nursing literature as early as 1976 by Christman. The phrase, shared governance, was introduced to nursing literature in Cleland's (1978) adaptation of a university model for governance (Baldrige, 1971); Cleland proposed a model that reconciled the interests of different organizational groups through the distribution of power to formulate policy.

Research has been sparse from the 35 hospitals that have reported their implementation of shared governance in the literature (Hess, 1994b). An operational definition of nursing shared governance is almost nonexistent, although some reports resemble Scott's (1982) conjoint model for professional organizations. However, six common themes that emerged from the anecdotal reports of these hospitals are examined later in this chapter.

Variation in reports also precludes a definitive model. During the past 10 years, some major hospital implementation sites included St. Joseph's Hospital in Atlanta (On the Scene, 1982; McDonagh, Rhodes, Sharkey, & Goodroe, 1989), St. Michael's Hospital in Milwaukee (Pinkerton & Schroeder, 1988; Pinkerton et al., 1989), Carondelet St Mary's Hospital in Tucson (Ethridge & Lamb, 1989; Ethridge, 1991), and Rose Medical Center in Denver (Johnson, 1987). The dynamic nature of these models seem to hamper simple definition. Stichler (1989) noted in the only qualitative report found in the literature that shared governance changes traditional roles by shifting power and authority from management to staff. Nevertheless, shared governance hospital reports are a rich source for generating items that represent common dimensions of professional nursing governance.

Nursing Self Governance

The use of self governance has been reported in some nursing literature. Kerfoot, a nurse executive at a shared governance hospital in Houston, (Curran, 1991) has described some unit-based shared governance models that have evolved into self-managing, "self-governing" units where nurses participate in running each aspect of the units. Self governance has been reported at Johns Hopkins Hospital in Baltimore (Johns Hopkins Nurses, 1987) and Northside Presbyterian Hospital in Albuquerque (No Head Nurses, 1987). However, nurses in these self governing units, as employees

of the hospital, may be subjected to the governance of others in selected areas.

Another self governance model, still largely speculative, describes an organization of self-employed nurses that would provide services to a hospital through a negotiated contract (Mitnick and Crummette, 1991). These nurses as a professional group would exercise control over both practice and resources similar to Scott's (1982) profile of an autonomous model.

Professional Governance by Hospital Nurses

The many varieties of models of professional nursing governance often defy categorization and suggest a continuum of innovation by hospital nurses. Perry (1990) has described these varieties as

ranging from something as simple as adding a committee in each unit to oversee scheduling to spinning off the entire nursing department from the hospital...[where] a hospital signs a contract with its former nursing department for nursing services; the department through a series of committees, governs itself. (p. 90)

Wake (1990) surveyed "centralized, bureaucratic structures to increased committee participation, formal shared governance, or self-managed units" (p. 47). These examples suggest a continuum that ranges from a Weberian bureaucracy to numerous forms of shared governance to complete self governance by independent contractors, a continuum roughly

corresponding to Scott's (1982) heteronomous, conjoint, and autonomous models of professional organizations.

Only two measures that approximate professional nursing governance in hospitals were found in the literature. Pruett (1989) devised the Shared Governance Survey based on Likert's System Four Theory (Likert & Likert, 1976) to measure the level of implemented shared governance based on committee activities and other selected process and unit/staff characteristics. The instrument was limited by a single-hospital survey. Validity and reliability were not reported and the tool has not been used since (L. L. Pruett, personal communication, November, 1992).

Havens (1990; 1991; 1992) developed several indices to measure the extent of staff nurse influence on practice and nursing department involvement with hospital governance; her instrument was confined to measuring the perceptions of chief nurse executives (CNE).

Neither instrument was intended to measure nursing governance as a concept and both proved inadequate for this study because of conceptual incongruity. To fully explicate the concept of professional nursing governance, six dimensions are proposed, with supporting literature.

Professional Control

Governance can be represented by professional control, i.e., who has control over professional work in a formal organization. Control by professionals and administrators

is distributed along a continuum: at one extreme, professionals have little control and are governed by administrators and the rules of the bureaucracy; at the other, professional work is controlled by the professional group.

Control is analogous to power. Mechanic (1962) noted that the formal structure is not the only source of power in an organization. Power can be accrued from specialized knowledge unavailable to bureaucrats. When that power is legitimized by professional structure, it has been called autonomy, the control over work activities (Alexander, Weisman, & Chase, 1982). In organizational literature, autonomy has been described as a structural component, measured by determining the concentration of authority (Pugh et al., 1968; Inkson, Pugh, & Hickson, 1970).

Control over professional work activities, described by Havens (1990) as the content of practice, is a dominant theme in nursing governance literature. Activities indicative of professional control, cited by hospitals reporting governance innovation, include: (a) policies, procedures, and standards of practice relevant to clinical decision making (Eckes, 1988; Pinkerton, 1988a; Liggon, 1990; Jacoby & Terpstra, 1990; Dugger, 1991; Hibberd, Storoz, & Andrews, 1992); (b) quality assurance activities (Thrasher et al., 1992); and (c) staff competency, credentialing, promotions and continuing education (York &

Fecteau, 1987; Patterson, 1988; Guinn, 1989; Perry, 1990; Porter-O'Grady, 1991; Khan & Katsones, 1992).

A continuum of control from administrative and staff perspectives is represented by the following examples from nursing literature:

1. Professional practice is controlled exclusively by hospital or nursing administrative personnel through direct supervision or rules and regulations (Donovan, 1957; Bredenberg, 1957; Mustard & Gates, 1960; Aydelotte, 1983; Hegyvary, 1990).

2. Professional practice is controlled mostly by nursing management with some staff input (Jones & Ortiz, 1989; Rudolf, 1989; Ulz; 1989).

3. Professional practice is controlled jointly by professional nursing staff and administration, cited by nearly all shared governance hospital implementation sites.

4. Professional practice is controlled exclusively by staff nurses who are self managing within a hospital bureaucratic structure or through contract as cited by self governance sites.

Organizational Influence

Governance can be represented by organizational influence, who has influence over the resources that support professional work in a formal organization. Material and human resources contribute to the context of professional work, as opposed to its content (Aydelotte, 1983; Havens,

1991). Influence by professionals and administrators over the allocation of resources is distributed along a continuum similar to that of professional control. This dimension assumes that the resources of formal organizations are finite and groups within the organization must compete for influence over their distribution.

In their comprehensive analysis of power literature, Bacharach and Lawler (1980) suggested that some groups depend on expertise, personality, and opportunity to influence the organization, engaging in informal political processes that operate outside of official channels. While professional control is legally sanctioned and circumscribed by agencies external to the organization, control of organizational resources that are tangential, but necessary to practice, is not; in this domain, professionals must rely on influence. Organizational influence is a weak proxy for control, because it is structurally less legitimate than professional control and is based on group size, history, credibility and expertise in manipulating the organization.

In her follow up to the "magnet hospital" survey, Kramer (1990) noted that staff nurses had extended their influence into finance and personnel. Finance, previously the exclusive purview of management, involves management of material through planning and monitoring capital and operating budgets. Personnel areas mentioned in recent nursing governance literature include staffing, staffing

levels and scheduling (Ethridge, 1987; Johnson, 1987; Patterson, 1988; Perry & Code, 1991) and case load assignments (Patterson, 1988).

A continuum of influence, paralleling that of professional control, is represented by the following examples:

1. Influence over resources is restricted to management (On the Scene, 1982; McDonagh et al., 1989; Havens, 1991).

2. Managers and staff share influence over resources (Milton, Verran, Murdaugh, & Gerberet, 1992).

3. Self governing staffs maintain exclusive influence over their resources (No Head Nurses, 1987).

Organizational Recognition

Governance can be viewed as organizational recognition, who is empowered by the formal structure. Regardless of who exercises control or influence, specific levels of control and influence are assigned to various groups within an organization by its structure; this distribution becomes an accepted status quo that is recognized by all organizational members. This recognition is similar to legal-rational authority (Weber, 1922/1969; 1947/1958) or legitimate power (French & Raven, 1959).

Organizational recognition occurs through hierarchical offices that stipulate administrative roles (and commensurate control and influence) of its officeholders.

Policies, rules, regulations, and systems are also used to assign official expectations of governance (Scott et al., 1981); these are structural sources of organizational power (Pfeffer, 1981; Biggart & Hamilton, 1984). Written personnel policies and bylaws, organizational charts, employee handbooks, and other official practices also indicate the legitimately recognized distribution of governance.

Many organizational mechanisms that establish the recognized distribution of control and influence have been reported in recent nursing governance literature, including: (a) hospital policies, procedures and protocols (Marcouiller, 1988; Jacoby & Terpstra, 1990; Ligon, 1990; Wake, 1990); (b) written group contracts (Johns Hopkins nurses, 1987; Mitnick & Crummette, 1991) and collective bargaining (Cleland, 1978, 1982; Lockwood, 1990); and (c) staff bylaws, either within the nursing department (Carson & Ames, 1980; Eckes, 1988; Lyons, 1991) or adopted at the board level (Johnson, 1987; Jones & Ortiz, 1989; McDonough, Rhodes, Sharkey & Goodroe, 1989; Taylor, 1990). Formal recognition can also be assigned by philosophy statements (Cody, 1990; McDonough, 1990), job descriptions, performance measures, or any rules and regulations that formally designate staff and management roles (By Whatever Name, 1987; Arford & Olson, 1988; Houston & Bevelacqua, 1991; Koerner, Bunkers, & Nelson, 1991; Patterson, 1991; Porter-

O'Grady, 1986).

Unlike the continua of the first two dimensions, organizational recognition is identified by the many mechanisms that constitute the formal organizational structure for distribution of control and influence between staff and administrators, ranging from those that subordinate staff to the decisions of hospital administration (Aydelotte, 1983) to a those that empower staff to make final practice decisions as well as operational decisions regarding the organization (Betti, Livingston, & Hoffenberg, 1981).

Facilitating Structure

Governance can be revealed by facilitating structure, who determines and participates in structures that facilitate governance activities in the organization. These structures are usually committees, observable mechanisms for coordinating and maintaining formal and informal governance processes over time. Although European studies of nonprofessional work groups have suggested that mere participation does not guarantee empowerment (Mulder, 1971), there is some support for structures that facilitate participation in governance as a dimension of governance. Brass (1984) demonstrated that one must at least be in the right place to have influence in an organization, while Tannebaum (1962) found a positive correlation between control and participation in his study of labor unions.

Within facilitating structures, professionals learn to govern by gaining experience in decision making roles and leadership (Haley & Black, 1988).

Identifying who determines these structures may be as important as participation, since the degree of participation alone may not indicate the distribution of control and influence. In hospital nursing literature, structures that appear similar from organization to organization may facilitate different levels of control and influence for different groups depending on whether they are: (a) determined by management (Martin, Wynne, & Pesce, 1990), (b) established within a traditional bureaucracy (Mealy, Mann, Simandl, & Kiener, 1976; Caramanica & Rosenbecker, 1991), (c) established within a flat, team-oriented environment (No Head Nurses, 1987; Patterson, 1991), or (d) created through independent contract (Johns Hopkins Nurses, 1987; Perry, 1990; Mitnick & Crummette, 1991).

A continuum of facilitating structures can be extrapolated from Wake's (1990) survey of nursing governance: (a) an absence of facilitating structures so that decisions are made centrally by administration without staff input; (b) minimal facilitating structures so that decisions being made centrally by administration with minimal staff input; (c) limited facilitating structures allowing unit-specific decisions to be made by management

collaboratively with staff input, while departmental policy is made by administration with staff input through standing committees; (d) staff-directed facilitating structures for formal shared governance; and (e) structures that facilitate self-governance by staff.

Liaison

Governance can be represented by liaison, who maintains communications in order to access information necessary for controlling practice and influencing the allocation of resources within the organization. The distribution of governance is reflected in those who possess vital information about the organization, such as the organization's direction (strategic plan, goals and objectives), viability (financial status and distribution of resources), and relationship to the environment (government and regulatory agencies). Liaison is used as a descriptor to emphasize that this information is acquired through connections within and between administrative as well as professional groups. This dimension is similar to the information power and the expert power implied in Weber's legal-rational authority, that is, expertise about the organization.

March and Simon (1958) theorized that any decision in an organization is dependent on effective communication channels and information. Brass (1984), analyzing the perceptions of 140 employees at all levels of a publishing

firm, found that access to communication networks for information was a strong predictor of influence. The acquisition of organizational information is a recurrent theme in both theoretical (Porter-O'Grady, 1986; Allen, Calkin, & Peterson, 1988) and anecdotal nursing governance literature (Arford & Olson, 1988; Pinkerton, 1988a; Guinn, 1989; Roberts, 1989; Kahn & Kotsones, 1992).

A continuum of liaison information can be extrapolated from nursing literature that ranges from information that is isolated inside top management and not available to staff to information that is freely shared between administration and staff to information that is held exclusively by staff nurses.

Alignment

Governance can be represented by alignment, who has the ability to promote, negotiate, and align conflicting goals within the organization. Alignment is used to label this dimension in that professional and administrative groups sometimes have inherently different goals that may be brought into agreement or simply remain a source of conflict within the larger organization.

Scott, Mitchell and Peery (1981) have maintained that governance design is determined by organizational goals or, in Scott's (1981) words, the "authority of goals." However, organizational groups may claim authority based on different goals. An organization is not only an instrument for

realizing its own rational goals, but also an end in itself, its own emergent goal (Gouldner, 1959). Also, groups within the organization may promote their own goals even if they diverge from explicit organizational goals (Pfeffer, 1981). In professional organizations, conflict in governance may be associated with the tension between professionals' commitment to ideological goals and administrators' orientation toward goals of organizational adaptation and survival (Satow, 1974).

In nursing governance literature, goals are discussed in terms of those who set them and at which organizational level the goals are applied. Goals of hospital nurses have been reported to be: (a) formulated by management for nurses (Libreton, 1981; Peterson & Allen, 1986) or with nurses (Trofino, 1989), (b) subsumed only under those of the larger organization (Khan & Kotsones, 1992), or (c) restricted to operational matters (Guinn, 1989). Nurses' authority to establish goals has been cited at the nursing unit level (Fagan, 1991; Patterson, 1991), at the divisional nursing specialty level (Hess, 1991), and at the nursing department (Pinkerton, 1988a; McDonagh et al., 1989). Despite ongoing advocacy for more participation (Porter-O'Grady, 1986; 1991), Havens (1990) concluded from a national survey that staff nurses are not usually involved in the hospital board, the usual goal-setting group of the hospital.

Nursing governance literature suggests a continuum of

alignment that includes: (a) administratively imposed goals that subordinate professional goals, (b) mutually negotiated goals that are shared between professionals and administrators, and (c) separately conceived professional goals that supersede those of the organization.

Conclusion

A multidimensional model of professional nursing governance has been derived from several related bodies of literature, linking specific dimensions to concepts of governance, authority and power. The six dimensions include professional control, organizational influence, organizational recognition, facilitating structure, liaison, and alignment. These dimensions are formulated along continua derived from theoretical and anecdotal hospital nursing accounts and parallel the discrete models of professionals in organizations described by Scott (1982). This study will evaluate these dimensions as a conceptual model for an instrument to measure the distribution of professional nursing governance among hospital nurses.

CHAPTER 3

Methodology

The purpose of this study was to delineate dimensions of professional nursing governance and to generate and psychometrically test an instrument to measure professional governance as perceived by hospital nurses based on these dimensions. Validity and reliability of the instrument was tested in selected hospital settings. The study was conducted in four phases.

Phase One

In the first phase items were generated for an initial instrument, which represented six conceptual dimensions of professional governance derived from a review of multidisciplinary literature. The items were then tested by nursing administrators and hospital staff nurses for content validity.

Identification of Dimensions

Professional governance pertaining to professional nurses was defined from the survey of literature cited in the previous chapter and from examples of governance found in government, corporations, universities, and hospitals. The following six conceptual dimensions or domains emerged from the literature and from conversations with hospital nurses involved in governance innovation: (a) professional control; (b) organizational influence; (c) organizational recognition; (d) facilitating structure; (e) liaison; and

(f) alignment.

These dimensions were reflected in six corresponding subscales forming a composite instrument, the Inventory of Professional Nursing Governance (IPNG):

1. The Professional Control subscale assesses to what extent a group has control over and assumes responsibility for professional nursing practice and development.

Professional practice includes professional standards, the delivery of care, and the credentialing, education, and promotion of professional nurses.

2. The Organizational Influence subscale assesses to what extent a group has influence over the organizational context of professional nursing practice. The context of professional practice involves the allocation of human and material resources that support the delivery of professional hospital nursing care.

3. The Organization Recognition subscale assesses to what extent the authority of a group to exercise professional control and organizational influence is formally recognized and accepted by the hospital organization. Formal authority is recognized through official written documents, standard procedures, and routine practices (such as methods for daily staffing and patient care assignments) that are contrived and supported by the organization and reinforced as status quo by its members.

4. The Facilitating Structure subscale assesses to what

extent a group determines and participates in committee structures that facilitate decision making processes for control and influence in the organization. Committee structures include nursing and multidisciplinary groups at the unit, departmental, and hospital level.

5. The Liaison subscale assesses to what extent a group has information necessary to control practice and influence its context. Such information, including fiscal status, planning, regulatory compliance, and evaluative data, is communicated through liaison between various groups within the nursing department and the hospital organization.

6. The Alignment subscale assesses to what extent a group has the ability to resolve conflict and align professional goals and values within the organization, both nursing and nonnursing departments. Activities include negotiating and resolving conflict among various groups (e.g. professional groups, support services, hospital administration), influencing philosophy and mission, participating in strategic and operational planning, and determining organizational goals and objectives directly and indirectly through policy formulation.

Item Generation

Representative activities characterizing each dimension were derived from further examination of the literature and more conversations with selected nurse administrators and staff nurses who are considered experts in hospital nursing

governance innovations. These activities were used to generate a preliminary list of specific items to construct the separate subscales for the measurement of each dimension of professional nursing governance. Scores from the six subscales were to be additive, thereby yielding separate subscale scores and a total score for each respondent. Subscale scores and total score for the final instrument would depend on the number of items accepted, although about 10 items per subscale were anticipated.

Each item on the IPNG was to indicate how governance in a particular dimension is distributed among staff and management groups in the hospital. The responses of the group would be represented on a five-point Likert-type scale with the following choices for each item: (1) nursing management/administration only, (2) primarily nursing management/administration with some staff nurse input, (3) equally shared by staff nurses and nursing management/administration, (4) primarily staff nurses with some nursing management/administration input, and (5) staff nurses only (Havens, 1990). Subjects would be asked to respond on the basis of their perception of the overall situation in their hospital.

Content Validity

The initial instrument was tested for content validity as outlined in Popham's (1978) average congruency procedure with a criterion of .90 for an acceptable level of content

validity. Initial content validity of dimensions and items was assessed by six nurse administrators who had experience and recognized expertise with professional nursing governance innovations in hospitals. Five nurses had master's degrees and one was doctorally prepared; judges were employed as either a chief nurse executive (CNE) (2), director of nursing (DON) (1), nurse manager (NM), (1), or a consultant (2). Most had published articles addressing governance innovation and all had experience with the implementation of innovative hospital governance models.

Judges were asked to determine the relevance for each item relative to the definition of its subscale by assigning values of +1 (relevant), 0 (cannot decide), or -1 (not relevant). In addition to judging relevancy, the experts had an opportunity to comment on the wording of items and suggest additional items. An average congruency score for both the subscales and the total score were calculated and items eliminated, reworded and/or added as suggested by the judges.

Following this initial review, all items (including revised and added items) were submitted to six additional similar experts: four CNEs and two professors. Three judges were doctorally prepared and three had masters degrees. Because the majority of the study subjects in future phases would include staff nurses, items were also reviewed by seven hospital staff nurses from five nursing specialties in

five hospitals. Based on the review of these two panels, the items were assessed for validity, and the instrument was revised for feasibility testing in phase two.

Phase Two

During the second phase the instrument was refined for clarity and ease of administration in advance of the larger samples of phases three and four. Individual items were to be revised, reordered, eliminated, or added based on feedback from the sample.

A convenience sample of 25 staff nurses was obtained from a local acute care, teaching, university-affiliated hospital, where the researcher had expeditious access through professional contacts. The researcher met with the director of surgical nursing to determine the best way to select a staff nurse sample in that particular hospital; consequently, distribution occurred through the nurse managers of the surgical nursing units.

Survey packets, consisting of a short demographic questionnaire, the Phase Two version of the IPNG, the Index of Centralization (IC), and a preposted return mailing envelop, was distributed to the sample. With a demographic questionnaire information was collected about the participant's age, sex, basic and current education, certifications, employment history, and current position.

The IC (Appendix D), consists of nine items measuring two dimensions of centralization: allocation of decision-

making and hierarchy of authority. Centralization scores were calculated by summing scores of 5- and 4-point Likert-type responses from the two respective subscales. Lower scores indicate a higher degree of centralization. Although the IC has been used in several published studies (Aiken & Hage, 1966; Hague & Aiken, 1967a, 1967b), its psychometric properties have not been reported in organizational literature. However, in a recent study of 292 nurse managers, Ringerman (1988; 1990) reported reliability coefficients ranging from .67 to .83. Low scores on either the IC or the IPNG represent a dominant management presence.

A cover letter contained instructions for returning sealed, completed material to the researcher through a central hospital location within one week. Space was provided on the IPNG for comments about the clarity of the items, the elimination or addition of items, the organization of the instrument form, and ease of completion, so that items could be revised on the basis of sample response. Participants were advised of human rights according to the "Human Rights" procedure outlined below prior to completing the instrument.

The Phase Two subjects were all female surgical nurses with a mean age of 32 years old (range 21 to 45). There were 21 staff nurses, two middle nurse managers, and two clinical nurse specialists. Eighty-eight percent were employed on a full-time basis, and although the average nursing work

experience was six years, 40% had been nurses for three years or less.

Most nurses (52%) reported a baccalaureate degree in nursing as their basic nursing education, with the remainder divided between a nursing diploma (28%) and an associate degree (20%). However, 72% had at least a undergraduate degree as their highest level of education.

The resulting instrument was professionally typeset and printed for Phase Three.

Phase Three

During the third phase the instrument was evaluated for internal consistency and test-retest reliability.

Sample

A convenience sample of 743 full and part-time nurses was obtained from two acute care community hospitals, Hospitals A and B, again identified through the researcher's professional contacts with local CNEs. The CNEs of the chosen test sites appointed nurse liaisons from their respective institutions to facilitate this phase of the study after submission and approval of a formal proposal.

Hospital A is a 350-bed, acute care, community hospital in an urban area in the mid-Atlantic region of the United States. Permission to conduct this study was approved by the CNE and the nursing division's committee on research and was facilitated by a member of that committee. Survey packets were distributed to the nurses by nurse managers,

after a presentation by the researcher at a monthly nursing management meeting.

Hospital B is a 417-bed, religiously affiliated, acute care, community hospital in an affluent suburban area also in the mid-Atlantic region of the United States. Permission to conduct this study was approved by the CNE and facilitated by a director of nursing; survey packets were distributed to the nurses by nurse managers, after a presentation by the researcher at a monthly nursing management meeting.

Because no changes were made in the instrument as a result of Phase Two testing, Phase Two and Three samples were combined for data analysis. A demographic profile of the combined sample (n=321) of nurses from Hospitals A and B and the Phase Two hospital follows (one survey was returned without demographic information).

Subjects, predominantly female (97%), had a mean age of 39 years with a range of 20 to 70 years. Seventy-five percent of the sample (241) worked full-time. The average work experience of the total sample was 14 years as a nurse with a range of less than one to 48 years; 61% reported an average of five years work experience outside of nursing, with a range of less than one to 35 years.

Most subjects were staff nurses (70.4%) (see Table 3-1) and represented all nursing specialties (see Table 3-2).

Table 3-1

Hospital Positions, Phase 11 & 111 Sample

Position	N	(%)
Staff	226	(70.4)
Middle management (e.g. unit managers, shift supervisors)	44	(13.7)
Support (e.g. recruiters, nursing systems coordinators, consultants)	17	(5.3)
Clinical nurse specialist	12	(3.7)
Executive	11	(3.4)
Education	10	(3.1)
Missing	1	---
Total	321	(100.0)

Table 3-2

Nursing Specialties, Phase II & III Sample

Specialty	N	(%)
Medical	53	(16.5)
Surgical	51	(15.9)
Critical care	48	(15.0)
Maternity	41	(12.8)
Operating room	31	(9.7)
Psychiatry	23	(7.2)
Emergency	17	(5.3)
Recovery room	15	(4.7)
Clinic	11	(3.4)
Education department	6	(1.9)
Quality assurance	5	(1.6)
Pediatrics	4	(1.2)
Other	19	(5.0)
Total	321	(100.0)

Basic educational preparation is displayed in Table 3-3 and the subjects' highest education in Table 3-4; many subjects reporting "Other" for highest educational level had nonnursing baccalaureate degrees.

Table 3-3

Basic Educational Preparation, Phase II & III Sample

Level	N	(%)
Nursing diploma	126	(39.3)
Associate degree	97	(30.2)
Baccalaureate degree	97	(30.2)
Unreported	1	(00.3)
Total	321	(100.0)

Table 3-4

Highest Educational Preparation, Phase II & III Sample

Educational level	N	(%)
Baccalaureate in nursing	90	(28.0)
Associate degree	81	(25.2)
Nursing diploma	71	(22.1)
Master's degree in nursing	32	(10.0)
Master's degree, nonnursing	10	(3.1)
Doctorate	2	(0.6)
Other	32	(10.0)
Unreported	3	(0.9)
Total	321	(100.0)

Seventy-three subjects (23%) were enrolled in school; of these, 29 (9%) were pursuing baccalaureate degrees in nursing (BSNs), 21 (7%) master's degrees in nursing (MSNs), 13 (4%) nonnursing master's degrees, and 8 (3%) nonnursing undergraduate degrees.

Procedure

In addition to calculating internal consistency reliabilities of the instrument and subscales, test-retest reliability was determined. Approximately one month after the initial Phase Three distribution all subjects who had

returned usable surveys (214 nurses) at that point in time were contacted by mail to complete and return a second survey by mail. The reliabilities demonstrated that the instrument was ready for Phase Four testing.

Phase Four

The resulting instrument was tested for construct validity with a large sample drawn from a population of professional nurses employed by six community non-profit acute care hospitals and one federal hospital, all from the mid-Atlantic region of the United States; none of these organizations had participated in previous phases.

Sample

Six hospitals were chosen from an earlier study of 18 hospitals (Hess, 1994a). Three hospitals with a reputation for shared governance (Hospitals C, D, and E) had received Nursing Incentive Reimbursement Awards (NIRA) from the state of New Jersey (NJ) for implementing governance innovations within the last three years, including a "magnet hospital" with a long tradition of governance innovation. Hospital C is a 182-bed, non-profit, rural, non-teaching hospital; hospital D is a 406-bed, non-profit, urban, teaching hospital; and hospital E is a 558-bed, non-profit, suburban/urban, teaching hospital.

Hospitals C, D, and E were matched with non-shared governance NJ hospitals (Hospitals F, G, and H, respectively) by size (represented by the number of

inpatient beds licensed by the state of NJ), location (urban, suburban, or rural), and medical teaching status (presence or absence of medical residents in the hospital) for a total of six hospitals to obtain more varied responses. Matches in size could only be approximated because of a limited choice of hospitals and an unexpected contingency. The hospital initially matched to Hospital C had to be replaced immediately prior to Phase Four when the hospital's nurse administrators realized that the survey would be conducted during the negotiation of a new collective bargaining contract. Hospital F is a 168-bed, non-profit, rural, non-teaching hospital; hospital G is a 366-bed, non-profit, urban, teaching hospital; and hospital H is a 651-bed, non-profit, suburban/urban, teaching hospital.

A seventh hospital was added because of its availability and unique organizational environment: a 708-bed, urban, federal hospital within the Veterans' Administration (VA) system. It was anticipated that a government hospital, often characterized by reputation by a large, centralized, externally controlled bureaucracy, would produce scores similar to those of the other traditionally governed hospitals.

The sample consisted of all professional nurses who were employed on a full or part-time basis by the hospital as registered nurses (R.N.s) assigned to clinical staff

nurse functions. All such R.N.s were designated as professional nurses regardless of basic or advanced nursing or non-nursing education, although these aspects were considered within demographic items. Nurses on leave and temporary or *per diem* nurses were excluded.

The demographic profile of this sample (n=851) was similar to Phase Three. Subjects were again predominantly female (97%) with a mean age of 40 years. Eighty percent worked full-time with an average nurse work experience of 16 years; half of the sample reported an average of three years of work experience outside of nursing.

The hospital position profile, that of mostly staff (70%) (see Table 3-5) was similar to Phase Three. The specialties of ten percent of the sample could not be classified by the instrument (e.g. long term care, rehabilitation, etc.) (Table 3-6).

Table 3-5

Hospital Positions, Phase IV Sample

Position	N	(%)
Staff	599	(70.6)
Middle management	128	(15.1)
Education	35	(4.1)
Executive	32	(3.8)
Support	31	(3.7)
Clinical nurse specialist	2	(2.5)
Other	3	(.3)
Missing	3	---
Total	851	(100.0)

Table 3-6

Nursing Specialties, Phase IV Sample

Specialty	N	(%)
Medical	183	(21.5)
Surgical	59	(6.9)
Critical care	191	(22.5)
Maternity	99	(11.6)
Operating room	48	(5.6)
Psychiatry	33	(3.9)
Emergency	42	(4.9)
Recovery room	35	(4.1)
Clinic	25	(2.9)
Education department	15	(1.8)
Quality assurance	4	(.5)
Pediatrics	29	(3.4)
Other	87	(10.2)
Total	321	(100.0)

The sample was evenly distributed between all three educational entry programs (see Table 3-7). Most subjects identified their highest education as a baccalaureate associate degree (37.4%) in nursing (see Table 3-8). Eighteen percent of the subjects (n=156) were enrolled in

school; of these, 65 (7.6%) were pursuing BSN and 58 (6.9%) MSN degrees.

Table 3-7

Basic Educational Preparation, Phase IV Sample

Level	N	(%)
Nursing diploma	303	(35.7)
Associate degree	236	(27.8)
Baccalaureate degree	302	(36.5)
Other or Missing	10	(1.1)
<hr/>		
Total	851	(100.0)

Table 3-8

Highest Educational Preparation, Phase IV Sample

Educational level	N	(%)
Baccalaureate in nursing	317	(37.4)
Nursing diploma	188	(22.2)
Associate degree	181	(21.4)
Master's degree in nursing	81	(9.6)
Master's degree, non-nursing	34	(4.0)
Doctorate	7	(0.8)
Other	9	(4.6)
Missing	4	----
Total	851	(100.0)

Procedure

Contact via telephone was made with the CNEs of the respective facilities to present the purpose of the study and the data collection plan, and to identify ways to facilitate the study within particular agencies. A liaison person was designated by the CNE at each site to facilitate the research, and time frames and mechanisms for the distribution of survey material were negotiated. After meeting presentations by the researcher, survey packets were distributed by nurse managers on their respective units

(with the exception of two hospitals, F and H, where surveys were mailed to the institutions); all individual packets were returned by mail to the investigator.

The survey packets contained a cover letter, demographic data questionnaire, a single IPNG, an IC, and a pre-addressed stamped envelope. The cover letter explained the intent to measure staff perceptions regarding their work environment; the governance instrument was titled the "Professional Nursing Governance."

Human Rights

The cover letter distributed to all participants in this study explained that participation was voluntary and that consent was implied by returning the completed questionnaire. Subjects were assured that their job status would not be affected in any way by their participation and that there were no known risks or benefits involved in participating. Confidentiality of participating staff and their responses was be assured by having all instruments completed anonymously, returned directly to the investigator through the mail and ultimately retained by the investigator only. Materials were precoded for hospital and unit only, except for Phase Two where surveys were coded for reestablishing contact with subjects to assess test-retest reliability. Reports of the results represented groups only. This study received prior approved from the Committee on Studies Involving Human Beings, Office of Research

Administration, University of Pennsylvania (Protocol #2733-0).

Chapter 4

Results

The purpose of this study was to generate an instrument for measuring the professional nursing governance of hospital-based nurses, based on a six-dimensional conceptual model of governance. The dimensions included: (a) professional control over practice, (b) organizational influence of professionals over support for that practice, (c) organizational recognition of professionals' formal authority, (d) facilitating structures for participation in decision-making processes, (e) liaison between professional and administrative groups for access to information, and (f) the alignment of organizational and professional goals.

A four phase study to test the instrument included: (a) Phase One - nursing administrators and staff nurses assessed items generated from the literature for content validity; (b) Phase Two - items were organized into an instrument with subscales and hospital staff nurses tested the instrument's feasibility; (c) Phase Three - the revised instrument was tested for reliability with a nurse sample from two community hospitals; (d) and Phase Four - the instrument was subjected to four tests for construct validity, using samples from seven hospitals.

Phase One

During the first phase the investigator tested the items of the IPNG that had been generated by the researcher

from the literature for content validity by using nurses who were recognized experts in governance and by hospital staff nurses.

Items for the IPNG were tested for content validity as outlined in Popham's (1978) average congruency procedure through two rounds of experts. In round one the initial content validity of dimensions and items were assessed by six nurse experts (Appendix A). Average subscale congruency scores based on their responses are shown in Table 4-1; the congruency score for the total instrument was .88, failing to achieve the goal of .90.

Table 4-1

Average Congruency Scores (ACS), First Round, Nurse Executives

Subscale	Number of Items	AVS
Professional Control	10	.83
Organizational Influence	11	.97
Organizational Recognition	20	.84
Facilitating Structure	12	.84
Liaison	14	.92
Alignment	11	.90
TOTAL	78	.88

At the suggestion of the judges, thirteen items were added, fourteen revised, and two moved to different subscales (Appendix B).

A second content validity round used six additional nursing administrative experts. Survey items were also submitted to a panel of seven hospital staff nurses. The average congruency scores are shown in Tables 4-2 and 4-3. At the suggestion of the judges, one item was split into two separate items and the wording of eleven other items were revised (Appendix C).

Table 4-2

Average Congruency Scores (ACS), Second Round, Nurse Executives

Subscale	Number of Items	AVS
Professional Control	14	.98
Organizational Influence	16	.97
Organizational Recognition	23	.92
Facilitating Structure	10	.90
Liaison	15	.98
Alignment	12	.97
TOTAL	90	.95

Table 4-3

Average Congruency Scores (ACS), Second Round, Staff Nurses

Subscale	Number of Items	AVS
Professional Control	14	.96
Organizational Influence	16	.96
Organizational Recognition	23	.94
Facilitating Structure	10	1.00
Liaison	15	1.00
Alignment	12	1.00
TOTAL	90	.97

The average congruency score was $\geq .95$ for each group, thereby indicating that a satisfactory level of content validity had been achieved.

Phase Two

The ninety items derived from Phase One formed the IPNG that was tested for feasibility by surgical staff nurses from a large, urban, teaching university hospital. Ease and clarity of administration were assessed on the basis of their completed surveys; the nine-item Index of Centralization (IC) was also administered along with the IPNG to assess the feasibility of simultaneously using this instrument's items during subsequent phases.

Initially, fifty surveys were distributed by a clinical nurse specialist to several nurse managers within the surgical nursing division, who, in turn, distributed them to staff nurses; only 5 were returned (10% response rate). Twenty five additional surveys were distributed by the director of nursing of the division through the nurse managers to different staff nurses; 20 usable surveys were returned plus one incomplete survey (the nurse explained she had not worked in the hospital long enough to assess its governance).

Subjects had no apparent difficulties in completing the questionnaires. Based on 25 surveys, no substantive changes were made in the IPNG or the IC in Phase Two.

Phase Three

Four hundred and two surveys were distributed at Hospital A to unit managers and directors after a presentation at a management meeting; the researcher met with various nurses after the meeting on units and in offices to promote the response rate. After one month, 148 surveys had been returned with a 37% response rate. Three hundred and forty-one surveys were similarly distributed at Hospital B. After one month, 149 surveys had been returned with a 44% response rate (see Appendix D for Phase III/IV survey instruments with cover letter).

Responses from all full and part-time registered nurses from the two hospitals in phase three (A & B) were combined

with the 25 subjects from phase two to evaluate the reliability of the IPNG.

Internal consistency reliability was determined by calculating Cronbach's alpha coefficients for each subscale and total scores. Based on 231 usable cases from hospitals A, B and the Phase Two sample, an overall alpha coefficient of .95 was obtained. Subscale reliabilities, ranged from .82 to .90 (see Table 4-4). Subscale reliability scores did not markedly improve with the deletion of any items, so all items were retained.

Table 4-4

Reliability Coefficients, Phase II & III Sample

Subscale	# Items	Alphas	Mean	S.D.
Professional Control	14	.82	25.10	5.73
Organizational Influence	16	.82	33.11	7.87
Organizational Recognition	23	.83	39.14	8.48
Facilitating Structure	10	.86	20.45	5.36
Liaison	15	.90	31.63	8.02
Alignment	12	.90	25.53	6.86
TOTAL	90	.95		

For test-retest reliability, the 106 nurses who had responded from hospital A were resurveyed about one month

later; 43 returned the second packet (40% response rate). The 98 nurses from hospital B were similarly resurveyed; 38 returned packets (39% response rate). Test-retest reliability was determined by calculating the Pearson product-moment correlation coefficient between the two sets of total IPNG scores and respective subscale scores. Only 39 surveys from the 81 returned packets could be used to calculate test-retest reliability; cases were eliminated if any item was unanswered. From completed surveys (n=39), an overall test-retest reliability of .77 was calculated.

Nine items from four subscales demonstrated marginal stability ($r < .20$) (see Appendix E), but were retained for Phase Four testing as potential discriminators between professional nursing governance situations. Other items demonstrated limited variability from scores skewed toward management. However, because it was unclear whether these distributions represented homogeneity of the organizational structure of the Phase Three sample, they too were retained for further testing.

Phase Four

In Phase Four the construct validity of the instrument was evaluated by: (a) factor analysis, (b) correlations among subscale scores, (c) correlations of the IPNG scores with the results of the IC, and (d) contrasting scores from shared and nonshared governance hospitals.

Surveys packets were distributed to 2981 RNs at seven

hospitals - shared governance hospitals C, D, E, matched with non-shared governance hospitals F, G, H, and a VA hospital I. After 60 days, 851 had been returned for an overall response rate was 29%; of these, 551 were usable for the first test. Distributions and response rates by hospital are shown in Table 4-5.

Table 4-5

Phase 1V Response Rate By Hospital

Hospital	Distributed	Returned	Response Rate (%)
C	239	85	36
D	347	61	18
E	576	163	28
F	172	92	53
G	628	150	24
H	642	186	29
I	377	114	30
Total	2981	851	29

Factor Analysis

First, construct validity was assessed by comparing the six hypothesized dimensions of professional nursing governance to a factor model derived from IPNG items using principal components analysis with varimax rotation.

Because all items were retained in the instrument from Phase Two and Three to Phase Four, samples from the ten Phase Two, Three and Four hospitals were combined for this analysis to increase the subject-to-item ratio to a total number of 816 surveys. The number of usable questionnaires was far less than the 1148 surveys returned between the two phases because any missing item responses eliminated a case from factor analysis; there were no typical item responses missing.

Based on the hypothesized model, six factors were forced on a subsequent factor analysis. The first factor accounted for 25 percent of the variance. Six factors with eigenvalues greater than 2.0 accounted for 42% of the variance and were identified by the pattern of skree plot; factor characteristics are reported in Table 4-6.

Table 4-6

Characteristics of Six Factors After Varimax Rotation

Factor	Eigenvalue	Pct of Variance	Cum Pct
1	22.11	24.6	24.6
2	4.27	4.7	29.3
3	3.76	4.2	33.5
4	2.92	3.2	36.7
5	2.71	3.0	39.8
6	2.3	2.7	42.4

A six factor matrix was obtained by varimax rotation. All items loaded on one of the six factors with loadings of at least .30 (most item loadings were greater than .40) and loading higher on one selected factor than on other factors with two exceptions. Two items, item 15, "Influence to schedule RNs and other nursing staff," and item 44, "Official Authority to regulate cross-coverage of other units (i.e. floating)," loaded on two factors, and were therefore deleted from the instrument and omitted from further tests.

Scores from nine items that had demonstrated marginal stability during Phase Three all had factor loadings of at least .42 and were therefore retained. These items additionally were tested for their ability to discriminate

between shared governance and non-shared governance hospital groups; scores for each of these were significantly different between the two groups by t-tests. Other items that had demonstrated limited variability during Phase Three were also retained since all five response choices were represented in the Phase Four sample responses.

The relationships of the factor subscales and the originally hypothesized subscales are shown in Table 4-7, and the groupings of items with loadings are depicted in Appendix F. The new six factor model for professional nursing governance had both important similarities and differences from the model that was originally hypothesized from the literature.

Factor Subscale One - Nursing Personnel

Factor One, Control over Nursing Personnel, was unexpected as a separate dimension of governance. A subscale of 24 items from originally proposed dimensions of control over practice, influence over organizational resources, and formal authority formed this new factor, accounting for 24% of the variance. The primary theme among most items was the management of nursing personnel: hiring, transferring, promoting, and firing personnel; performance appraisals and disciplinary actions; salaries and benefits; and the creation of new positions. Two items that complemented this theme included organizational charts showing lines of authority and the ability to form hospital

administrative committees or recommend new services. Other related items addressed units' budgets for personnel, supplies, equipment and education; office space; cross-coverage of personnel between units; and restricting or limiting patient care.

Items from original professional control and organizational influence dimensions loaded on this factor with identical items from the original authority dimension, suggesting that in many areas addressing governance, the sample perceived their own control or influence and the formal authority granted to them by the organization to be similar. Seven areas of congruence were clearly identified (see Appendix G); for example, similar items from subscales for professional control, control over promotions and formal authority to regulate promotions of nursing personnel, loaded on this factor. In all areas but one (items addressing budgets), items from the original authority subscale had slightly higher loadings.

Factor Subscale Two - Information

Items loading on factor two, Access to Information, one of two factors that accounted for four percent of the variance, exactly matched items of the originally proposed dimension of access to information relevant to governance. All initially proposed 15 items loaded clearly on this factor with factor loadings of .46 and above, except for an item about access to resources concerning recent advances in

nursing practice (.36). This factor confirmed liaison between professional and administrative groups for access to information about governance activities as a dimension of governance.

Factor Subscale Three - Resources Supporting Practice

Factor three, Resources Supporting Practice, also accounting for four percent of the variance, was comprised of 13 items addressing organizational resources that supports professional nursing practice. This factor was similar to the originally proposed dimension of organizational influence of professionals over support for professional practice in that eight out of sixteen items from the original subscale were included. All items for the new subscale were derived from subscales representing organizational influence over resources and formal authority. As in factor one, there was congruence between influence and authority with similar items addressing the same areas loading on the same factor. Congruent items were identified in areas representing hospital services outside of the nursing department, regulating patient flow, nursing supplies, nursing services outside of the unit, and regulating patient care assignments and factor loadings ranged between .55 and .63. In this factor, the magnitude of factor loadings of items from original subscales for perceived influence over resources and the formal authority over resources granted by the hospital were similar (See

Appendix G).

Other items indicative of supportive resources included making recommendations about other departments' resources, determining cost-effective measures, and access to office equipment.

Factor Subscale Four - Participation

The 12 items loading on factor four, Participation, one of three factors accounting for two percent of the variance, included most items from the originally proposed dimension that represented participation in committee structures for making governance decisions. Eight of ten originally proposed items were retained. Most items from the initially proposed subscale that represented participation in hospital administration committees (except for the ability to determine hospital-wide policies and procedures), did not load on this factor, suggesting that participation at an administrative organizational level was perceived differently than at the unit or nursing departmental level.

Items typically addressed participation in committees for clinical practice and administrative matters, policies and procedures at the nursing departmental and unit level, including the ability to write goals and objectives for the unit. Items were also characterized by participation in committees that deal with nursing and multidisciplinary professional groups, also at the unit and departmental level. The one exception was a grouping of items that

addressed the ability to write policies and procedures at all three organizational levels (e.g. the unit, department and hospital-wide levels); the ability to write policies and procedures was seen as an aspect of participation regardless of the organizational level.

Factor Subscale Five - Professional Practice

Factor five, Professional Practice, accounting for two percent of the variance, was comprised of 16 items that addressed control over professional practice. This factor was similar to the originally proposed dimension, professional control over practice; eight of 14 items from that subscale were retained, and the rest were derived from the authority subscale. As with factors one and three, many similar items from originally proposed subscales for professional control and formal authority loaded on this factor. Similar items addressed direct patient care activities, standards of care, professional development, and setting routine staffing levels and adjusting them for contingencies (Appendix G).

Other items represented control over ancillary nursing personnel, methods of nursing care delivery, products used in care, and incorporating research into practice, and the authority to schedule nurses also loaded on this factor. All but three items had factor loadings greater than .40.

Factor Subscale Six - Goals and Conflict

Items loading on factor six, Goals and Conflict

Resolution, the last factor accounting for two percent of the variance, included eight of 12 items from the original subscale representing the alignment of organizational and professional goals. Item loadings were .44 or above and no items from other subscales loaded on this factor. Items described the ability to negotiate conflict between professional nurses and other hospital groups, as well as formulating goals at the nursing departmental and hospital level, and creating a formal grievance procedure. This grouping of items demonstrated a connection between the ability to negotiate conflict between intraorganizational groups and the ability to determine the organization's goals.

As mentioned above, items from the original subscale for goals and conflict that addressed the ability to write goals for a nursing unit and determine policies and procedures at any organizational level, loaded on factor four, participation in governance structures.

Table 4-7

Relationships of Factor Subscales & Hypothesized Subscales

Factor Subscales, Total # Items	# Items From Hypothesized Subscales
Nursing Personnel, 24 items	Professional Control (6), Organizational Influence (6), Formal Authority (10), Participation (2)
Access to Information, 15 items	Liaison for Access to Information (all 15)
Resources Supporting Practice, 13 items	Organizational Influence (7), Formal Authority (6)
Participation, 12 items	Participation (8), Alignment of Goals/Conflict Resolution (4)
Control over Practice, 16 items	Professional Control (8), Organizational Influence (2), Formal Authority (6)
Goals and Conflict, 8 items	Alignment of Goals/Conflict (8)

The overall alpha coefficient of .97 of the seven-hospital sample was slightly higher than the .95 reliability of the previous phase. Reliabilities of subscales derived from factor analysis ranged from .87 to .91 (see Table 4-8).

Table 4-8

Factor Subscale Reliability Coefficients

Factor Subscales	# Items	Alphas
1. Nursing Personnel	24	.91
2. Access to Information	15	.91
3. Resources Supporting Practice	13	.87
4. Participation	12	.90
5. Control over Practice	16	.90
6. Goals and Conflict	8	.87
TOTAL	88	.97

Subscale Correlations

Correlations between the new subscales were examined by calculating Pearson correlation coefficients. As in the factor analysis, total hospitals' samples from Phase Three and Four were used. Intercorrelations among the six new subscales ranged from .43 to .67 (see Table 4-9), indicating moderate independence.

Table 4-9

Intercorrelations Between Factor Subscales

	2	3	4	5	6
1	.51	.47	.59	.67	.47
2		.44	.62	.56	.54
3			.47	.52	.43
4				.66	.60
5					.50
n= 816					

Convergent Construct Validity

Convergent construct validity was assessed by correlating IPNG scores with scores of the Index of Centralization (IC) (Aiken & Hage, 1968), using responses from the seven Phase Four hospitals. The Pearson correlation coefficient was .60 (n=578), demonstrating a moderate correlation between the balance of management and staff influence in governance and centralization.

"Known Groups" Construct Validity

Construct validity was further assessed by comparing professional governance between hospitals with and without a reputation for shared governance by aggregating IPNG scores of the two groups. As hypothesized, hospitals with a reputation for shared governance had a significantly higher

score than those without such a reputation (df=312, p=.0005) (see Table 4-10).

Table 4-10

t-Test Between Shared and Non-Shared Governance Hospitals

Group	N	M	SD	t
Shared Governance Hospitals	204	188.48	39.86	9.56*
Non-Shared Governance Hospitals	308	156.49	32.37	

*p=.0005, one-tailed

Governance scores among hospitals were further examined by analysis of variance (ANOVA) and Scheffe' post hoc test. Two of the three shared governance hospitals had significantly higher scores (p<.05) than non-shared governance hospitals as expected; however, one shared governance hospital had a score within the range of the non-shared governance facilities. Results are displayed in Tables 4-11, 4-12, and 4-13.

Table 4-11

Mean Scores by Phase Four Hospitals on IPNG

Hospital	M	SD
C*	208.06	39.81
D*	161.11	29.69
E*	190.75	37.43
F	165.55	40.48
G	159.46	31.14
H	149.47	27.23
I	154.58	31.38

*Shared Governance Hospitals

Table 4-12

Summary of Analysis of Variance Between Hospitals on Governance Scores

Source	df	SS	MS	F
Between groups	6	206848.42	34474.74	30.77
Within groups	577	853305.26	1120.38	

p=.0005

Table 4-13

Comparison of Significant Differences Among Hospitals'
Governance Scores - Scheffe' Test

Hospitals	D*	E*	F	G	H	I
C*	X		X	X	X	X
D*						
E*	X		X	X	X	X
F						
G						
H						
I						

X Significant difference between hospitals (p<.05)

* Shared Governance Hospital

The final 88-item instrument classifies the distribution of professional nursing governance of hospital-based nurses into one of five categories (based on total score): (1) nursing management/administration only (88-176), (2) primarily nursing management/administration with some staff nurse input (177-263), (3) equally shared by staff nurses and nursing management/administration (264), (4) primarily staff nurses with some nursing management/administration (265-352), and (5) staff nurses only (353-440).

Chapter 5

Summary, Discussion, Implications, and Further Research

Innovations in nursing governance over the last twenty-five years have been touted as panaceas for solving problems related to nursing shortages, staff morale, cost, multidisciplinary collaboration, and even clinical patient outcomes. However, without a method for measuring governance, models have not been differentiated from one another, outcomes have not been empirically linked to any particular model, and justification has not been provided to generalize any programs beyond initial implementation sites.

The purpose of this study was to generate an instrument for measuring the professional nursing governance of hospital-based nurses. The instrument was constructed and tested in four phases: (a) in Phase One items were generated and tested for content validity, (b) in Phase Two feasibility was assessed, (c) in Phase Three reliability was assessed, and (d) in Phase Four construct validity was tested.

In this chapter a summary and discussion of the findings, implications for nursing administration, and recommendations for additional research will be presented.

Summary

Although the literature of professional nursing, management, and organizations failed to reveal any instrument for measuring governance, a review suggested six

dimensions that contributed to a comprehensive definition of governance in organizations in which professional groups worked. Representative items were extrapolated from this literature and applied to hospital-based nurses. In Phase One, items were judged for content validity by administrative nurses who were experts in innovative hospital-based governance models as well as nurses who worked as hospital staff nurses. After two rounds, the total average congruency score was judged to be .95 for the nurse administrators and .97 for the staff nurses.

In Phase Two, items were combined into a single instrument, the Index of Professional Nursing Governance (IPNG) with six subscales that reflected governance dimensions: (a) professional control over practice, (b) organizational influence of professionals over support for that practice, (c) organizational recognition of professionals' formal authority, (d) facilitating structures for participation in decision-making processes, (e) liaison between professional and administrative groups for access to information, and (f) the alignment of organizational and professional goals. Twenty-five staff nurses from a large university-affiliated medical center completed the two instruments and a demographic questionnaire to test feasibility. Only editorial revisions were necessary.

In Phase Three, the survey instrument was tested for reliability with 321 nurses from two community hospitals.

Cronbach's alphas were .95 for the total instrument and ranged from .82 to .90 for the six originally proposed subscales; the test-retest reliability was .77 over a one-month period. No items were dropped or modified.

In Phase Four, the instrument was examined for construct validity by four methods using a sample of nurses from seven hospitals. Construct validity was assessed by: (1) factor analysis that forced a six factor model, (2) factor subscales' intercorrelations, (3) known groups technique that compared shared and non-shared governance hospitals aggregate scores, and (4) convergence of scores between the IPNG and a measure of a related organizational concept, decentralization. Results were as predicted except for the extracted factor model. Principal components factor analysis with varimax rotation produced a six factor solution. The combined sample from Phases Two, Three and Four (ten hospitals) for this analysis totaled 816 nurses. Two items that did not clearly load on single factors were eliminated. Three factors closely resembled originally proposed dimensions for information, participation, and goals; three other factors, relating to control over practice, supporting resources, and nursing personnel were slightly different than predicted by the original model. Most variance was explained by a new factor, nursing personnel. Cronbach's reliability for the overall instrument was .97 and the new subscales representing the

extracted factors ranged from .87 to .91.

Other tests for construct validity were as predicted. Intercorrelations between the subscales were between .43 and .67 (n=816). A t-test between aggregate scores from the hospitals with a reputation for shared governance and those with traditional models demonstrated a significant difference (p=.0050). The IPNG and the Index of Centralization (IC) had a correlation of +.60 (n=578, p=.005) between the distribution of governance between management and staff and the degree of centralization in the organizations.

Discussion

This study produced a reliable and valid instrument, the Index of Professional Nursing Governance (IPNG), for measuring the professional nursing governance of hospital-based nurses. However, the resulting factor model differed in several aspects from the originally proposed dimensions. This model suggested possibilities for refinement of the instrument.

From the data the most variance in professional nursing governance was ascertained through items representing resources of nursing personnel and organizational support, and access to information, and to a lesser extent, professional practice, committee participation, and the negotiation of goals and conflict. The factor model calls attention to three areas of organizational theory: (1) the

importance of resources, (2) the persistence of rational versus natural models of organizations, and (3) the relevance of organizational levels in explicating governance.

Organizational Resources

The factor model underscores the importance of resources in determining the distribution of governance in that items addressing control or influence over resources accounted for the most variance in measuring professional nursing governance. These items were divided between two factors or dimensions - organizational resources that support professional nursing practice and, more importantly, the nurses themselves as resources. This is not surprising, because hospital nursing is labor-intensive, and much of the hospital's product, patient care, is derived from the work of its nursing professionals. For the hospitals in which they work, nurses are an important organizational resource.

The importance of the control of resources in measuring governance demonstrated by this study is consistent with several traditions of organizational research, notably, resource dependency theory. Resource dependency asserts the primacy of the external environment in an organization's acquisition and maintenance of resources, and its survival; studies have examined governing boards of directors of organizations, their occurrence, board composition and size, how formal and informal memberships interlock between

organizations, and the effect of those memberships on the acquisition and distribution of resources (Zald, 1969; Pfeffer, 1972; Allen, 1974; Pfeffer & Nowak, 1976; Pfeffer & Salancik, 1978; Burt, Christman, & Kilburn, 1980; Burt, 1983; Burt, 1992). The significance of resources in an organization's external environment is also a recurrent theme in other popular organizational theories, such as population ecology (Hannan & Freeman, 1983).

The results of this study complements the external perspective of resource dependency by focusing on the internal terrain of organizations and demonstrating that the control of resources is also an overarching element to governance within the organization. However, the distribution of governance between only two groups, nursing staff and administration, was considered in this study. An assessment of governance that included other stakeholders or interacting groups within a hospital would probably reveal a more complicated internal profile that might reflect the external complexity of interlocking directorates so often described in resource dependency research. In that literature as in this study, the importance of formal structure in controlling resources and ultimately, governance, suggests a rational view of organizations.

Rational Versus Natural Systems Models of Organizations

The congruence between perceived control and influence (i.e. perceived power) and formal authority lends more

support for the formal order described by rational systems models than a natural systems perspective that predicts that professional groups create their own picture of governance. For this sample of professional nurses, their perception of governance was similar to what they perceived to be prescribed by the organization. Factor loadings of items representing authority usually loaded equally or greater on the same factors as similar items representing power. Contrary to past studies of professionals that have discovered informal power structures superimposed on formal structures (Mechanic, 1962; Fombrun, 1984), the factor analysis model supported a rational system bias of governance - that the distribution of governance is what the formal organization says it is.

One unlikely alternate explanation of the congruency between power and authority would assume that nurses had previously influenced the formal authority structure of the hospital to coincide with their own power base. This would support a natural systems model.

However, a rational model is further supported by aggregate governance scores from individual hospitals. An organization that represents a rational system model is one that is enacted by management. According to the IPNG, hospitals reporting scores between 88 and 176 are organizations governed by nursing management/administration; eight of ten hospitals' scores fell within this range. The

scores of the other two hospitals with a reputation for shared governance still reflected organizations governed by primarily nursing management/administration with some staff nurse input. Even the two progressive shared governance hospitals, with mean scores of 190 and 208, did not approach the instrument criterion of a score of 265 for a hospital where governance is equally shared by staff nurses and nursing management/administration.

Authority, defined in this study as the organizational recognition of professional formal authority, did not constitute a separate dimension of governance, as hypothesized. Rather, according to the data, authority is important to many activities in several dimensions of governance and perceived to be similar to an individuals' perceptions of their control or influence. The nurses recognized that the authority granted by the organization in which they work is congruent with their own perceptions power in organizational governance. This tacit acceptance supports the persistent relevancy of Weber's legal-rational authority, while deemphasizing the effect of increasing specialization by professionals often stressed by other organizational theorists (Blau & Meyer, 1971; Thompson, 1961; Meyer, 1988). For this sample, authority, control and influence were a fused phenomena.

Differences In Organizational Levels

The factor model also demonstrated that structural

levels of organizations' levels are important in delineating dimensions of governance. Items assigned to each of the originally proposed dimensions addressed three levels of analyses - the nursing unit, the nursing department, and the hospital administrative level. These levels, alluded to by Parsons (1960), correspond to widely accepted qualitative breaks that occur in decision making on different hierarchical levels and the different concerns of professionals and their managers in organizations.

The inclusion of all three organizational levels in the measurement of professional nursing governance is important because models reported in administrative literature tend to emphasize different levels. As a popular organizational concept, governance refers to the overall control of organizations, such as hospitals, by boards of directors. Nursing professionals have accepted this application, while simultaneously including nurses at the work group or unit level within the concept.

Complementary notions of governance in nursing literature relate to organizational levels. Organizational literature has traditionally treated governance as a macro phenomena, that is, a concern of directorates and sometimes, upper management, controlling the organization as an entity in relationship to its environment. As such, governance has recognized by lists of gross activities (Mace, 1971; West & Wind, 1990; Flarey, 1991) or structural dimensions (Dahl,

1961; Peters, 1988). Even when defined by proxy, such as "governance power" (Zald, 1969), the concept is indicated through participation, control and information in corporate structures involving the entire organization. Nursing has accepted a similar notion by associating governance with the board and macro organizational activities (Shamansky, 1989; Flarey, 1991; Porter-O'Grady, 1991).

Another version of nursing governance focused on the unit level, describing the control or management of professional work at the microlevel (Caramenica & Rosenbecker, 1991; Davis, 1992; Elpern, While, & Donahue, 1984; Mixon, 1992; Patterson, 1991). The final, most popular, nursing governance innovations have simultaneously encompassed all organizational levels, emphasizing the interaction of the individual with the organization, the so-called meso level (House, 1991). Literature from many hospital implementation sites of nursing shared governance models represent this tradition (Pinkerton et al., 1989; McDonagh, 1990). Because hospital nursing governance literature has included all three versions, items for measurement in this study represented all organizational levels.

Many items of each original subscales were duplicated on the nursing unit, nursing department, and hospital-wide level. In most instances, similar vertical groupings of the items were preserved in the factor subscales. For example,

the Participation subscale included similar items that addressed policies and procedures at all three organizational levels, and items for administrative matters and forming new committees that were duplicated both the nursing unit and nursing departmental level. Similarly, in subscales dealing with resources, Nursing Personnel and Resources Supporting Practice, and Practice, items encompassed any organizational level that had an explicit connection to these themes. Subscales items addressing conflict management and access to information also represented all organizational levels within subscales. The importance of accessing information concerning governance on multiple organizational levels is consistent with all organizational paradigms. Information provides feedback to a rational organization regarding progress toward official goals; it guides the assessment of both informal and formal power structures within the natural system; and it aids the open system to evaluate the environment.

Discrimination Between Nursing Governance Situations

The aggregated scores of shared governance and non-shared governance hospitals were significantly different. Shared governance hospitals' scores were higher, indicating greater staff governance than in the traditionally governed hospitals. Nevertheless, as mentioned above, administration dominated governance in all hospitals.

Individual hospital IPNG scores were congruent with the reputational governance situations of the hospitals with the exception of one shared governance hospital. But reputation alone can be a poor indicator; hospitals may have an undeserved reputation for shared governance, while traditionally governed hospitals may actually be empowering organizations for their staff. Rather than diminishing the validity of the instrument, this exception illustrated the ability of the instrument to discriminate between governance situations and emphasized the need for such a common measure. The low score from the alleged shared governance hospital along with other hospitals' scores were congruent with the researcher's personal knowledge of the studied organizations gained through personal contacts, interactions at professional organizations, and published literature.

The case of the low scoring shared governance hospital suggests that governance innovation might not always involve sharing at all, but merely a change in the name of the game (Hess, 1994b). While it was beyond the scope of this study to investigate this idea further, the poor response rate of this hospital as well as other factors raise suspicions that traditional governance still reigns at this organization. Observing as an outsider, it seemed that a major feature of the hospital's initial shared governance model involved unit-based self-scheduling, a chronic administrative problem that was transferred to the staff. Two other major

innovations, case management and patient-focused care, were being simultaneously implemented. However, even the managers seemed stressed when the investigator visited. In addition, changes in personal and sick time benefits utilization had recently been announced; the new policies appeared to be misunderstood and unacceptable to staff. One nursing director at the hospital, when the results of the study were shared, revealed a great deal by insisting that a low score seemed odd because control over practice had been turned over to the staff (S.T., personal communication, March 24, 1994). But control over practice was identified by the sample as a factor accounting for only two percent of the variance; factors addressing personnel and resources, which accounted for the greater portion of variance, might be playing only a minor part in this hospital's governance model. In this case, administrators seemed to be sharing only what staff perceived to be minor areas of governance.

Anecdotally, other hospital scores reinforced the instrument's discriminatory abilities. The VA hospital, with a long history of rigid governmental bureaucratic control produced low, traditional governance scores, as expected. Another traditionally governed hospital with low scores and a low response rate, had become the target of a concentrated union attempt at takeover during the study. On the other hand, the shared governance hospital with the longest participative management tradition, and whose

history included participation in the "Magnet" hospitals study, and a well-documented shared governance implementation history (Magliaro, 1991; McMahon, 1992), generated the highest score. The other high-scoring shared governance hospital also had a longstanding reputation that lent credence to its score (Betti, Livingston, & Hoffenberg, 1991).

Finally, the scores of the two Phase Three hospitals, Hospital A (M=169.75, SD=28.92) and Hospital B (M=172.57, SD=32.22), placed their institutions somewhere between shared governance and traditionally governed hospitals. As it turned out both Phase Three hospitals were in the early stages of implementing their own shared governance programs.

Congruence with Related Phenomena

The IPNG scores demonstrated a moderate positive correlation with scores of the IC, a measure of a related organizational phenomenon. Centralization, a structural property of formal organizations, refers to the degree to which organizational members participate in decision-making. As a measure of both the hierarchy of authority and the degree to which members participate in goal setting for the organization (Aiken & Hage, 1966) the IC reflects the concentration of selected aspects of power within the hierarchy; a highly centralized organization concentrates power in a single individual or office, whereas an extremely decentralized one would distribute power among all of its

members. In evaluating organizational measures, Price (1972) relates the concept of centralization to power stratification, hierarchy of authority and participative management. Decentralization has even been cited synonymously with shared governance in some nursing literature (Meyer, 1988; Allen, 1990; Thomas, 1990; Wake, 1990); however, the IPNG examines subjects' perceptions of the organization in general, while the IC concentrates on subjects' individual job situations.

Decentralization, the converse of centralization, in this study was hypothesized to be positively correlated with professional governance by hospital staff nurses, because as staff nurses are able to make more decisions in more areas, the distribution of governance would include more staff influence. The moderate positive correlation supported this, while demonstrating that the two concepts are different.

Relationships of the Subscales

Subscale scores of the six factors demonstrated moderate positive correlations. These correlations provided some evidence for the multidimensionality of the concept of governance. It is expected that the scores of separate dimensions will vary in some degree, but in the same direction. Other studies have demonstrated that organizations often vary independently on separate dimensions of the same concept (Hall, 1963; Pugh, Hickson, &

Hinings, 1969).

Response Rate

The overall response rate of 29% in this study was within the expected range. Previous response rates from professional nurses in shared governance hospitals have been reported in longitudinal studies as 28% and 37% (Ludemann, 1989; 1991), and as 47% and 35% (Pinkerton, 1988b). Mancini (1990) reported response rates of 33% and 39% in a matched sample of shared versus non-shared governance hospital samples, respectively. These have all been smaller studies, including one or two hospitals.

There were obvious factors in some hospitals that may have influenced some response rates. In one traditional hospital with a 24% response rate, the timing of a union takeover attempt and the presence of an unrelated, concurrent study during this survey might have had an impact on the response; nevertheless, with this hospital sample excluded, the response rate would still be only 30%. In the VA hospital (30% response rate), the survey was entirely conducted through the mail without personal appeal or appearance from the researcher, which may have increased the response rate to 40% as in the cases of the two Phase Two hospitals where the investigator was more visibly involved.

The 18% response rate in one shared governance hospital might have been affected by the simultaneous implementation of several hospital-wide programs; also, the initial

distribution of the surveys was disrupted by an unexpected major survey of nursing units by a state health inspection team. And the "Magnet" shared governance hospital had been extensively researched on an ongoing basis by other researchers immediately prior to this survey. On the other hand, the high response rate (53%) of the smallest hospital remains unexpected and surprising, but might have been a result of no competing studies, state inspections, or unionization attempts occurring simultaneously with this study.

Implications

This study has contributed an instrument for measuring the professional nursing governance of hospital-based nurses. The instrument can provide baseline data before the implementation of governance innovations and evaluative data afterwards. The IPNG provides a means of comparison and verification of governance situations among hospitals and among nursing groups or units within a hospital. Because these comparisons include six areas of governance, the IPNG may be useful in establishing benchmarks during organizational change.

Numerous quantifiable outcomes, such as increased nurse, patient, and physician satisfaction, decreased job stress, improved morale, decreased turnover, and more cost-effective patient care have been attributed to nursing governance innovations in hospitals. Governance studies

involving a wide variety of outcomes, reported by hospital nursing personnel from implementation sites and students of nursing administrative academic programs, have continued to proliferate since the inception of this study; in particular, researchers have attempted to demonstrate the cost-effectiveness of shared governance programs (Daly, Phelps, & Rudy, 1991; DeBaca, Jones, & Tornabeni, 1993; Iacobellis, 1993; Minors, 1993; Wong, Gordon, Cassard, Weisman, & Bergner, 1993). However, as with past studies, none of these reports have defined or described programs in measurable terms. In the absence of a measure, information on relationships between innovations in governance and resulting outcomes are limited to single sites and a matter for speculation. Governance innovations claimed to be highly effective cannot be replicated or compared in the absence of a common measure. The IPNG provides the first possibility to measure governance as an independent variable that may affect outcomes.

By providing the means of demonstrating an empirical linkage between certain governance innovations and positive organizational outcomes, data can be derived from the IPNG to delineate replicable governance models. As patterns or demarcated categories of scores emerge from the six factor dimensions, the IPNG may guide the development of a taxonomy for classifying types of organizational governance.

Recommendation for Future Research

As with any new instrument, an initial study such as this is only the first step in instrument development. Secondary analysis of the present data would provide an opportunity to identify characteristics of individuals and units that are outliers; correlations between demographic variables and governance profiles also need further study.

Perceptions between organizational levels of executive, middle management, staff, and support personnel should be explored for differences. In addition, although the governance and decentralization scores were moderately correlated, the validity of the quantitative IPNG scores would benefit from a triangulated study with additional quantitative measures of related concepts, such as power and autonomy, and qualitative data derived from structured and unstructured observations and solicited comments.

Other structural organizational characteristics must be considered in future research. For example, Diamond (1991) suggested that governance can be assessed by noting organizational members' representation on particular committees or by directly measuring resources that are acquired through that participation. In shared governance hospitals, perception of governance may be influenced by whether or not a nurse is actively participating in the governance structures. This information might be considered in future research.

Hospital organizations are not homogeneous, but are

composed of many different groups. Concurrent assessment of other professional and nonprofessional factions by versions of the governance instrument normed to those groups would enhance the validity of the assessment. IPNG measures the relative governance by groups only within nursing. However, there are actually multiple stakeholder groups in hospital governance. The possibility of a generic instrument that simultaneously includes all stakeholders must also be considered.

The present instrument contains 88 items - too many for practical use in hospitals. Redundant items must be eliminated or combined as a part of further study. This would probably improve response rates. Several items not answered by 3-4% of the combined Phase Three and Four sample may also be examined for future elimination or the use of substituted mean scores considered. At the same time, a reduction of items necessitates further tests for reliability, since the large number of items may have artificially enhanced the reliability of the present instrument.

Finally, longitudinal studies, particularly before and after the implementation of governance innovations, will be necessary to demonstrate the utility of the instrument. Successive scores may provide evidence for identifying stages of the implementation of governance innovations over time. This would provide an opportunity to link governance

scores to outcome variables.

Conclusion

The healthcare environment has reportedly changed during the limited time since this study's inception: the hospital nursing shortage has abated; nurses' job market is shifting to home health, long term, and primary care; health insurance has moved toward managed care; and the federal government has intensified its pursuit for a universal healthcare program that will require cost-effectiveness and efficiency. Nursing governance innovations will no longer be judged in terms of staff recruitment and retention, nurse morale or satisfaction, or any other outcome unless they save money. The instrument generated in this study may offer a means to demonstrate such an effect and the evidence to justify continued innovations in governance.

Appendix A
Phase One Sample Packet

Index of Professional Nursing Governance - Phase One

A. The following items are designed to represent Professional Control, i.e. areas of control that nurses exercise over hospital nursing practice and professional development.

Please rate each item according to the following scale:

+1 I think this is relevant to professional control

0 I cannot decide if this is relevant to professional control

-1 I think this is not relevant to professional control

A1. Activities nurses can independently do at the bedside.	+1	0	-1
A2. Developing and evaluating patient care standards and quality assurance activities.	+1	0	-1
A3. Setting levels of qualifications for nursing positions.	+1	0	-1
A4. Evaluating (performance appraisals) nursing personnel.	+1	0	-1
A5. Determining activities of ancillary nursing personnel (aides, secretaries, etc.).	+1	0	-1
A6. Conducting disciplinary action for nursing personnel.	+1	0	-1
A7. Assessing and providing for the professional/educational development of the nursing staff.	+1	0	-1
A8. Making hiring decisions about RNs and other nursing staff.	+1	0	-1
A9. Promoting RNs and other nursing staff.	+1	0	-1
A10. Appointing nursing personnel to management and leadership positions.	+1	0	-1

What other items would you suggest for this category?

B. The following items are designed to represent Organizational Influence, i.e. items that represent the influence that nurses have over the allocation of resources (people, supplies, money) which support their hospital nursing practice.

Please rate each item according to the following scale:

- +1 I think this is relevant to organizational influence**
- 0 I cannot decide if this is relevant to organizational influence**
- 1 I think this is not relevant to organizational influence**

B1.	Scheduling RNs and other nursing staff.	+1	0	-1
B2.	Determining how many and what level of nursing staff is needed for routine patient care.	+1	0	-1
B3.	Adjusting staffing levels to meet fluctuations in patient census and acuity.	+1	0	-1
B4.	Making daily patient care assignments for nursing personnel.	+1	0	-1
B5.	Regulating cross-coverage of other units (i.e. floating).	+1	0	-1
B6.	Monitoring and procuring supplies for nursing care and support functions.	+1	0	-1
B7.	Regulating the flow of patient admissions, transfers, and discharges.	+1	0	-1
B8.	Recommending and formulating annual unit budgets for personnel, supply, major equipment and education.	+1	0	-1
B9.	Recommending nursing salaries, raises and benefits.	+1	0	-1

Organizational Influence - Cont.

- | | | | |
|--|----|---|----|
| B10. Consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical). | +1 | 0 | -1 |
| B11. Consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy). | +1 | 0 | -1 |

What other items would you suggest for the organizational influence category?

C. The following items are designed to represent Organizational Recognition, i.e. mechanisms that designate nurses' formal authority over professional practice and its supporting resources that is recognized and accepted by the hospital organization.

+1 I think this is relevant to organizational recognition

0 I cannot decide if this is relevant to organizational recognition

-1 I think this is not relevant to organizational recognition

C1.	Written documents that state what nurses can independently do at the bedside.	+1	0	-1
C2.	Written patient care standards and quality assurance activities.	+1	0	-1
C3.	Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, or promotions and raises.	+1	0	-1
C4.	Written evaluations (performance appraisals) of nursing personnel.	+1	0	-1
C5.	Organizational charts that show who reports to whom.	+1	0	-1
C6.	Written guidelines for disciplining nursing personnel.	+1	0	-1
C7.	Annual requirements for continuing inservices.	+1	0	-1
C8.	Procedures for hiring and transferring nursing personnel	+1	0	-1
C9.	Policies regulating promotion of nursing personnel to management and leadership positions.	+1	0	-1
C10.	Prepared schedules for RNs and other nursing staff.	+1	0	-1

Organizational Recognition - Cont.

C11. Acuity and patient classification systems for determining how many and what level of nursing staff is needed for routine patient care.	+1	0	-1
C12. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity.	+1	0	-1
C13. Procedures for determining daily patient care assignments.	+1	0	-1
C14. Procedures for regulating cross-coverage of other units (i.e. floating).	+1	0	-1
C15. Daily methods for monitoring and obtaining supplies for nursing care and support functions.	+1	0	-1
C16. Procedures for controlling the flow of patient admissions, transfers and discharges.	+1	0	-1
C17. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education.	+1	0	-1
C18. Procedures for adjusting nursing salaries, raises and benefits.	+1	0	-1
C19. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	+1	0	-1
C20. Formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy).	+1	0	-1

What other items would you suggest for the organizational recognition category?

D. The following items are designed to represent Facilitating Structure, i.e. committee opportunities that are available to staff nurses for participating in governance activities.

+1 I think this is relevant to facilitating structure

0 I cannot decide if this is relevant to facilitating structure

-1 I think this is not relevant to facilitating structure

D1. Participation in unit committees for clinical practice.	+1	0	-1
D2. Participation in unit committees for administrative matters such as staffing, scheduling and budgeting.	+1	0	-1
D3. Participation in nursing departmental committees for clinical practice.	+1	0	-1
D4. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting.	+1	0	-1
D5. Participation in multidisciplinary professional committees (physicians, other hospital professions and departments) for collaborative practice.	+1	0	-1
D6. Participation in hospital administration committees for matters such as salaries and benefits, and strategic planning.	+1	0	-1
D7. Forming new unit committees.	+1	0	-1
D8. Forming new nursing departmental committees.	+1	0	-1
D9. Forming new multidisciplinary professional committees.	+1	0	-1
D10. Forming new hospital administration committees.	+1	0	-1

Facilitating Structure - Cont.

D11. Creating new clinical positions.	+1	0	-1
D12. Creating new administrative or support positions.	+1	0	-1

What other items would you suggest for the facilitating structure category?

E. The following items are designed to represent Liaison, i.e. the things that nurses need to know about in order to control practice and exert influence over the resources that support that practice.

+1 I think this is relevant to liaison

0 I cannot decide if this is relevant to liaison

-1 I think this is not relevant to liaison

E1.	The quality of hospital nursing practice.	+1	0	-1
E2.	Compliance of hospital nursing practice with requirements of surveying agencies (Joint Commission, state and federal government, professional groups).	+1	0	-1
E3.	Unit's projected budget and actual expenses.	+1	0	-1
E4.	Hospital's financial status.	+1	0	-1
E5.	Unit and nursing departmental goals and objectives for this year.	+1	0	-1
E6.	Hospital's strategic plans for the next few years.	+1	0	-1
E7.	Results of patient satisfaction surveys.	+1	0	-1
E8.	Physician/nurse satisfaction with their collaborative practice.	+1	0	-1
E9.	Current hospital status of nurse turnover and vacancies.	+1	0	-1
E10.	Nurses' satisfaction with their general practice.	+1	0	-1
E11.	Nurses' satisfaction with their salaries and benefits.	+1	0	-1

Liaison - Cont.

E12. Management's evaluation of an individual's nursing practice.	+1	0	-1
E13. Physicians' evaluation of an individual's nursing practice.	+1	0	-1
E14. Nursing peers' evaluation of an individual's nursing practice.	+1	0	-1

What other items would you suggest for the liaison category?

F. The following items are designed to represent Alignment, i.e. areas that are important to nurses for promoting or resolving conflict in professional goals and values within the professional group or within the hospital organization.

+1 I think this is relevant to alignment

0 I cannot decide if this is relevant to alignment

-1 I think this is not relevant to alignment

F1. Conflicts among professional nurses.	+1	0	-1
F2. Conflicts between professional nurses and physicians.	+1	0	-1
F3. Conflicts between professional nurses and other hospital services (respiratory, dietary, pharmacy, etc).	+1	0	-1
F4. Conflicts between professional nurses and nursing management.	+1	0	-1
F5. Conflicts between professional nurses and hospital administration.	+1	0	-1
F6. Writing the goals and objectives of the unit.	+1	0	-1
F7. Writing the philosophy, goals and objectives of the nursing department.	+1	0	-1
F8. Formulating the mission, philosophy, goals and objectives of the hospital.	+1	0	-1
F9. Writing unit policies and procedures.	+1	0	-1
F10. Determining nursing departmental policies and procedures.	+1	0	-1
F11. Determining hospital-wide policies and procedures.	+1	0	-1

What other items would you suggest for the alignment category?

Please rate the categories proposed above according to the following scale and rank the categories in order of importance for professional governance (1=most important; 6=least important):

- +1 I think this deals with professional nursing governance
- 0 I cannot decide if this deals with professional nursing governance
- 1 I think this does not deal with professional nursing governance

Rank:

—	Professional Control , control that nurses exercise over hospital nursing practice and professional development.	+1	0	-1
—	Organizational Influence , influence that nurses have over the allocation of resources which support their hospital nursing practice.	+1	0	-1
—	Organizational Recognition , nurses' formal authority over practice and supporting resources that is recognized and accepted by the hospital.	+1	0	-1
—	Facilitating Structure , committee opportunities that are available to nurses for participating in governance activities.	+1	0	-1
—	Liaison , things that nurses need to know about in order to control practice and exert influence over the resources that support practice.	+1	0	-1
—	Alignment , the promotion and resolution of conflict in professional goals and values by nurses within the professional group and the hospital organization.	+1	0	-1

What other general categories would you suggest?
 What other items would you suggest that are not covered by the proposed categories?

Sample Cover Letter - Phase One

Dear :

I am a doctoral candidate in nursing administration at the School of Nursing, University of Pennsylvania. I am investigating hospital nursing practice.

Professional Nursing Governance is the process and structure through which professional hospital nurses control their professional practice and influence the hospital organization in which their practice occurs. The attached survey is a preliminary effort to construct a questionnaire that measures six different aspects of governance as perceived by hospital nurses.

Although the following materials came from nursing literature, they may or may not be representative of governance. In order to select the most valid and meaningful items, I am enlisting the aid of nurses who are experts in this area, i.e. you.

Please do not respond as if this were a survey of how governance ought to be for hospital nurses. Rather, please indicate which items are relevant for the measurement of professional nursing governance. I would like you to answer honestly according to your perceptions; feel free to write in comments. Your responses will remain anonymous and confidential with myself.

Thank you for your participation. I am available by phone for any comments or questions you may have (609/424-4270).

Sincerely,

Robert Hess
M.S.N., R.N., CCRN, C.N.A.A.
Doctoral Candidate
School of Nursing,
University of Pennsylvania

Appendix B
Items Added, Revised, and Moved Between Subscales -
Phase One, Round One

Items Added To Subscales After Content Validity Round One -

Phase One

Subscales:

Professional Control

- * Selecting products used in patient care.
- * Incorporating research ideas into nursing care.
- * Determining methods of nursing care delivery (e.g. primary, team, case management).

Organizational Influence

- * Making recommendations concerning other departments' resources.
- * Determining cost effective measures such as patient placement and referrals (e.g. placement of ventilator-dependent patients, early discharge to home health care).
- * Recommending new hospital services or specialties (eg. gerontology, mental health, birthing centers).
- * Creating new clinical positions.
- * Creating new administrative or support positions.

Organizational Recognition

- * Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass).
- * Location of and access to office space.
- * Access to office equipment (e.g. phones, personal computers, copy machines.)

Liaison

- * Access to resources concerning recent advances in nursing practice (e.g. journals and books, library).

Alignment

- * Create a formal grievance procedure.

Items Revised By Subscales After Content Validity

Round One - Phase One

Subscales:

Professional Control

- * Determining what activities nurses can ~~independently~~ do at the bedside.

Organizational Influence

- * Consulting and enlisting support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, ~~physical therapy~~, **finance, human resources.**

Organizational Recognition

- * ~~Written documents~~ **policies and procedures** that state what nurses can do in direct patient care.
- * ~~Written patient care standards and quality assurance activities/improvement programs.~~
- * ~~Prepared Procedures for generating~~ **schedules** for RNs and other nursing staf.

Facilitating Structure

- * Participation in hospital administration committees for matters such as ~~salaries and benefits~~, **employee benefits** and strategic planning.

Liaison

- * ~~Management's evaluation opinion of an individual's bedside~~ nursing practice.
- * ~~Physicians' evaluation opinion of an individual's bedside~~ nursing practice.
- * ~~Nursing peers' evaluation opinion of an individual's bedside~~ nursing practice.

Alignment

- * **Resolving** conflicts among professional nurses.
- * **Resolving** conflicts between professional nurses and physicians.
- * **Resolving** conflicts between professional nurses and other hospital services (respiratory, dietary, pharmacy, etc.).
- * **Resolving** conflicts between professional nurses and nursing management.
- * **Resolving** conflicts between professional nurses and hospital administration.

Items Moved Between Subscales After Content Validity

Round One - Phase One

- * Creating new clinical positions moved from "Facilitating Structure" to "Organizational Influence"
- * Creating administrative or support positions moved from "Facilitating Structure" to "Organizational Influence".

Appendix C
Items Revised -
Phase One, Round Two

Items Revised After Content Validity Round Two - Phase One

~~Making hiring decisions about RNs and other nursing staff.~~

- * **Making hiring decisions about RNs.**
- * **Making hiring decisions about supportive nursing staff.**

- * **Selecting products used in nursing patient care.**

- * **Recommending and formulating annual unit budgets for personnel, supplies, major equipment, and education.**

- * **Consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).**

- * **Consulting and enlisting the support of hospital services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance).**

- * **Written policies that state what nurses can do at the bedside in direct patient care.**

- * **Organizational charts that show job titles and who reports to whom.**

- * **Resolving Negotiating solutions to conflicts among professional nurses.**
- * **Resolving Negotiating solutions to conflicts between professional nurses and physicians.**
- * **Resolving Negotiating solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, pharmacy, etc.).**
- * **Resolving Negotiating solutions to conflicts between professional nurses and nursing management.**
- * **Resolving Negotiating solutions to conflicts between professional nurses and hospital administration.**

Appendix D
Phases Two, Three, & Four Sample Packet

BACKGROUND DATA QUESTIONNAIRE

Please provide the following information. The information you provide is IMPORTANT. Please be sure to complete ALL questions. Remember confidentiality will be maintained at all times.

Today's Date _____

1. Sex: Male Female
 2. Age: _____
 3. Please indicate your BASIC nursing educational preparation:
 - Nursing Diploma
 - Associate Degree in Nursing
 - Baccalaureate Degree in Nursing
 - Other (please specify): _____
 4. Please indicate the HIGHEST educational degree that you have attained at this point in time:
 - Nursing Diploma
 - Associate Degree in Nursing
 - Baccalaureate Degree in Nursing
 - Master's Degree in Nursing, Specialty _____
 - Doctorate, Specialty _____
 - Other (please specify): _____
 5. Please indicate the HIGHEST educational level that your MOTHER attained:
 - High School
 - Some College
 - College Degree
 - Some Graduate School
 - Masters Degree
 - Other (please specify): _____
 6. Please indicate the HIGHEST educational level that your FATHER attained:
 - High School
 - Some College
 - College Degree
 - Some Graduate School
 - Masters Degree
 - Other (please specify): _____
 7. Please specify your MOTHER'S occupation _____
8. Please specify your FATHER'S occupation _____
 9. Are you currently enrolled in school?
 - Yes No
 - If YES, please indicate number of credits that you are currently taking _____
 - If YES, please indicate the degree that you are pursuing:
 - Baccalaureate Degree in Nursing
 - Master's Degree in Nursing, Specialty _____
 - Doctorate, Specialty _____
 - Other (please specify): _____
 10. Employment Status:
 - Full-time, 36-40 hours per week
 - Part-time, less than 36 hours per week
 - (please specify the number of hours per week): _____
 11. Please specify the number of years that you have been practicing nursing _____
 12. Please specify the number of years that you have worked OUTSIDE of nursing _____
 13. Please indicate the title of your present position _____
 14. Please indicate the type of nursing unit that you work on:

<input type="checkbox"/> Medical	<input type="checkbox"/> Emergency Room
<input type="checkbox"/> Surgical	<input type="checkbox"/> Recovery Room
<input type="checkbox"/> Intensive Care Unit	<input type="checkbox"/> Maternity
<input type="checkbox"/> Coronary Care Unit	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Operating Room	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Recovery Room	<input type="checkbox"/> Other (please specify): _____
 15. Please specify the number of years you have worked in this institution _____
 16. Please specify the number of years you have been in this present position _____
 17. Have you received any specialty certifications in advanced practice?
 - Yes No
 - If YES, please specify the type of certification and year received _____
- THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY ADDRESSING NURSES AND THEIR HOSPITAL WORKING ENVIRONMENT.**
- Code# _____

PROFESSIONAL NURSING GOVERNANCE

In your hospital, please circle the group that CONTROLS the following areas:

- 1 = Nursing management/administration only
- 2 = Primarily nursing management/administration with some staff nurse input
- 3 = Equally shared by staff nurses and nursing management/administration
- 4 = Primarily staff nurses with some nursing management/administration input
- 5 = Staff nurses only

PART I

- | | | | | | |
|---|---|---|---|---|---|
| 1. Determining what activities nurses can do at the bedside. | 1 | 2 | 3 | 4 | 5 |
| 2. Developing and evaluating patient care standards and quality assurance/improvement activities. | 1 | 2 | 3 | 4 | 5 |
| 3. Setting levels of qualifications for nursing positions. | 1 | 2 | 3 | 4 | 5 |
| 4. Evaluating (performance appraisals) nursing personnel. | 1 | 2 | 3 | 4 | 5 |
| 5. Determining activities of ancillary nursing personnel (aides, unit clerks, etc.). | 1 | 2 | 3 | 4 | 5 |
| 6. Conducting disciplinary action of nursing personnel. | 1 | 2 | 3 | 4 | 5 |
| 7. Assessing and providing for the professional/educational development of the nursing staff. | 1 | 2 | 3 | 4 | 5 |
| 8. Making hiring decisions about RNs. | 1 | 2 | 3 | 4 | 5 |
| 9. Making hiring decisions about supportive nursing staff. | 1 | 2 | 3 | 4 | 5 |
| 10. Promoting RNs and other nursing staff. | 1 | 2 | 3 | 4 | 5 |
| 11. Appointing nursing personnel to management and leadership positions. | 1 | 2 | 3 | 4 | 5 |
| 12. Selecting products used in nursing care. | 1 | 2 | 3 | 4 | 5 |
| 13. Incorporating research ideas into nursing care. | 1 | 2 | 3 | 4 | 5 |
| 14. Determining methods of nursing care delivery (e.g. primary, team, case management). | 1 | 2 | 3 | 4 | 5 |

In your hospital, please circle the group that INFLUENCES the following activities:

- 1 = Nursing management/administration only
- 2 = Primarily nursing management/administration with some staff nurse input
- 3 = Equally shared by staff nurses and nursing management/administration
- 4 = Primarily staff nurses with some nursing management/administration input
- 5 = Staff nurses only

PART II

- | | | | | | |
|---|---|---|---|---|---|
| 15. Scheduling RNs and other nursing staff. | 1 | 2 | 3 | 4 | 5 |
| 16. Determining how many and what level of nursing staff is needed for routine patient care. | 1 | 2 | 3 | 4 | 5 |
| 17. Adjusting staffing levels to meet fluctuations in patient census and acuity. | 1 | 2 | 3 | 4 | 5 |
| 18. Making daily patient care assignments for nursing personnel. | 1 | 2 | 3 | 4 | 5 |
| 19. Regulating cross-coverage of other units (i.e. floating). | 1 | 2 | 3 | 4 | 5 |
| 20. Monitoring and procuring supplies for nursing care and support functions. | 1 | 2 | 3 | 4 | 5 |
| 21. Regulating the flow of patient admissions, transfers, and discharges. | 1 | 2 | 3 | 4 | 5 |
| 22. Formulating annual unit budgets for personnel, supplies, equipment and education. | 1 | 2 | 3 | 4 | 5 |
| 23. Recommending nursing salaries, raises and benefits. | 1 | 2 | 3 | 4 | 5 |
| 24. Consulting nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical). | 1 | 2 | 3 | 4 | 5 |
| 25. Consulting hospital services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance). | 1 | 2 | 3 | 4 | 5 |
| 26. Making recommendations concerning other departments' resources. | 1 | 2 | 3 | 4 | 5 |
| 27. Determining cost effective measures such as patient placement and referrals (e.g. placement of ventilator-dependent patients, early discharge of patients to home health care). | 1 | 2 | 3 | 4 | 5 |
| 28. Recommending new hospital services or specialties (e.g. gerontology, mental health, birthing centers). | 1 | 2 | 3 | 4 | 5 |
| 29. Creating new clinical positions. | 1 | 2 | 3 | 4 | 5 |
| 30. Creating new administrative or support positions. | 1 | 2 | 3 | 4 | 5 |

PROFESSIONAL NURSING GOVERNANCE

According to the following indicators in your hospital, please circle which group has OFFICIAL AUTHORITY (i.e. authority granted and recognized by the hospital) to control practice and influence the resources that support it:

- 1 = Nursing management/administration only
- 2 = Primarily nursing management/administration with some staff nurse input
- 3 = Equally shared by staff nurses and nursing management/administration
- 4 = Primarily staff nurses with some nursing management/administration input
- 5 = Staff nurses only

PART III

- | | |
|--|---|
| <p>31. Written policies and procedures that state what nurses can do in direct patient care. 1 2 3 4 5</p> <p>32. Written patient care standards and quality assurance/improvement programs. 1 2 3 4 5</p> <p>33. Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises. 1 2 3 4 5</p> <p>34. Written process for evaluating nursing personnel (performance appraisal). 1 2 3 4 5</p> <p>35. Organizational charts that show job titles and who reports to whom. 1 2 3 4 5</p> <p>36. Written guidelines for disciplining nursing personnel. 1 2 3 4 5</p> <p>37. Annual requirements for continuing inservices. 1 2 3 4 5</p> <p>38. Procedures for hiring and transferring nursing personnel. 1 2 3 4 5</p> <p>39. Policies regulating promotion of nursing personnel to management and leadership positions. 1 2 3 4 5</p> <p>40. Procedures for generating schedules for RNs and other nursing staff. 1 2 3 4 5</p> | <p>41. Acuity and patient classification systems for determining how many and what level of nursing staff is needed for routine patient care. 1 2 3 4 5</p> <p>42. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity. 1 2 3 4 5</p> <p>43. Procedures for determining daily patient care assignments. 1 2 3 4 5</p> <p>44. Procedures for regulating cross-coverage of other units (i.e. floating). 1 2 3 4 5</p> <p>45. Daily methods for monitoring and obtaining supplies for nursing care and support functions. 1 2 3 4 5</p> <p>46. Procedures for controlling the flow of patient admissions, transfers and discharges. 1 2 3 4 5</p> <p>47. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education. 1 2 3 4 5</p> <p>48. Procedures for adjusting nursing salaries, raises and benefits. 1 2 3 4 5</p> <p>49. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical). 1 2 3 4 5</p> <p>50. Formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy). 1 2 3 4 5</p> <p>51. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass). 1 2 3 4 5</p> <p>52. Location of and access to office space. 1 2 3 4 5</p> <p>53. Access to office equipment (e.g. phones, personal computers, copy machines). 1 2 3 4 5</p> |
|--|---|

PROFESSIONAL NURSING GOVERNANCE

In your hospital, please circle the group that PARTICIPATES in the following activities:

- 1 = Nursing management/administration only
- 2 = Primarily nursing management/administration with some staff nurse input
- 3 = Equally shared by staff nurses and nursing management/administration
- 4 = Primarily staff nurses with some nursing management/administration input
- 5 = Staff nurses only

PART IV

- | | | | | | |
|---|---|---|---|---|---|
| 54. Participation in unit committees for clinical practice. | 1 | 2 | 3 | 4 | 5 |
| 55. Participation in unit committees for administrative matters such as staffing, scheduling and budgeting. | 1 | 2 | 3 | 4 | 5 |
| 56. Participation in nursing departmental committees for clinical practice. | 1 | 2 | 3 | 4 | 5 |
| 57. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting. | 1 | 2 | 3 | 4 | 5 |
| 58. Participation in multidisciplinary professional committees (physicians, other hospital professions and departments) for collaborative practice. | 1 | 2 | 3 | 4 | 5 |
| 59. Participation in hospital administration committees for matters such as employee benefits and strategic planning. | 1 | 2 | 3 | 4 | 5 |
| 60. Forming new unit committees. | 1 | 2 | 3 | 4 | 5 |
| 61. Forming new nursing departmental committees. | 1 | 2 | 3 | 4 | 5 |
| 62. Forming new multidisciplinary professional committees. | 1 | 2 | 3 | 4 | 5 |
| 63. Forming new hospital administration committees. | 1 | 2 | 3 | 4 | 5 |

In your hospital, please circle the group that has ACCESS TO INFORMATION about the following activities:

- 1 = Nursing management/administration only
- 2 = Primarily nursing management/administration with some staff nurse input
- 3 = Equally shared by staff nurses and nursing management/administration
- 4 = Primarily staff nurses with some nursing management/administration input
- 5 = Staff nurses only

PART V

- | | | | | | |
|--|---|---|---|---|---|
| 64. The quality of hospital nursing practice. | 1 | 2 | 3 | 4 | 5 |
| 65. Compliance of hospital nursing practice with requirements of surveying agencies (Joint Commission, state and federal government, professional groups). | 1 | 2 | 3 | 4 | 5 |
| 66. Unit's projected budget and actual expenses. | 1 | 2 | 3 | 4 | 5 |
| 67. Hospital's financial status. | 1 | 2 | 3 | 4 | 5 |
| 68. Unit and nursing departmental goals and objectives for this year. | 1 | 2 | 3 | 4 | 5 |
| 69. Hospital's strategic plans for the next few years. | 1 | 2 | 3 | 4 | 5 |
| 70. Results of patient satisfaction surveys. | 1 | 2 | 3 | 4 | 5 |
| 71. Physician/nurse satisfaction with their collaborative practice. | 1 | 2 | 3 | 4 | 5 |
| 72. Current hospital status of nurse turnover and vacancies. | 1 | 2 | 3 | 4 | 5 |
| 73. Nurses' satisfaction with their general practice. | 1 | 2 | 3 | 4 | 5 |
| 74. Nurses' satisfaction with their salaries and benefits. | 1 | 2 | 3 | 4 | 5 |
| 75. Management's opinion of bedside nursing practice. | 1 | 2 | 3 | 4 | 5 |
| 76. Physicians' opinion of bedside nursing practice. | 1 | 2 | 3 | 4 | 5 |
| 77. Nursing peers' opinion of bedside nursing practice. | 1 | 2 | 3 | 4 | 5 |
| 78. Access to resources concerning recent advances in nursing practice (e.g. journals and books, library). | 1 | 2 | 3 | 4 | 5 |

PROFESSIONAL NURSING GOVERNANCE

In your hospital, please circle the group that has the ABILITY to:

- 1 = Nursing management/administration only
- 2 = Primarily nursing management/administration with some staff nurse input
- 3 = Equally shared by staff nurses and nursing management/administration
- 4 = Primarily staff nurses with some nursing management/administration input
- 5 = Staff nurses only

PART VI

- | | |
|---|-----------|
| 79. Negotiate solutions to conflicts among professional nurses. | 1 2 3 4 5 |
| 80. Negotiate solutions to conflicts between professional nurses and physicians. | 1 2 3 4 5 |
| 81. Negotiate solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, etc). | 1 2 3 4 5 |
| 82. Negotiate solutions to conflicts between professional nurses and nursing management. | 1 2 3 4 5 |
| 83. Negotiate solutions to conflicts between professional nurses and hospital administration. | 1 2 3 4 5 |
| 84. Create a formal grievance procedure. | 1 2 3 4 5 |
| 85. Write the goals and objectives of a nursing unit. | 1 2 3 4 5 |
| 86. Write the philosophy, goals and objectives of the nursing department. | 1 2 3 4 5 |
| 87. Formulate the mission, philosophy, goals and objectives of the hospital. | 1 2 3 4 5 |
| 88. Write unit policies and procedures. | 1 2 3 4 5 |
| 89. Determine nursing departmental policies and procedures. | 1 2 3 4 5 |
| 90. Determine hospital-wide policies and procedures. | 1 2 3 4 5 |

PART VII

Please circle the number which most closely characterizes your job:

- | | Never | Seldom | Sometimes | Often | Always |
|--|-------|--------|-----------|-------|--------|
| 91. How frequently do you usually participate in the decision to hire new staff? | 1 | 2 | 3 | 4 | 5 |
| 92. How frequently do you usually participate in the decisions on the promotions of any of the professional staff? | 1 | 2 | 3 | 4 | 5 |
| 93. How frequently do you usually participate in decisions on the adoption of new policies? | 1 | 2 | 3 | 4 | 5 |
| 94. How frequently do you usually participate in the decision on adoption of new programs? | 1 | 2 | 3 | 4 | 5 |

Please circle the answer that best characterizes your job:

- | | Definitely True | | Definitely False |
|---|-----------------|---|------------------|
| 95. There can be little action taken here until a supervisor approves a decision. | 1 | 2 | 3 4 |
| 96. A person who wants to make decisions would be quickly discouraged here. | 1 | 2 | 3 4 |
| 97. Even small matters have to be referred to someone higher up for a final answer? | 1 | 2 | 3 4 |
| 98. I have to ask my boss before I do almost anything. | 1 | 2 | 3 4 |
| 99. Any decision I make has to have my boss's approval. | 1 | 2 | 3 4 |

Appendix E

Test-Retest Reliabilities of Unstable Items - Phase Three

Test-Retest Reliabilities of Items With Poor Stability

r Scale/Items

Professional Control

.09 Promoting RNs and other nursing staff.

Organizational Recognition

.11 Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions, and raises.

.13 Written guidelines for disciplining nursing personnel.

.04 Procedures for adjusting nursing salaries.

.07 Location of and access to office space.

Facilitating Structure

.14 Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting.

.18 Forming new hospital administration committees.

Alignment

.08 Nurses' satisfaction with their general practice.

.05 Managements' opinion of bedside nursing practice.

Appendix F
Items and Factor Loadings - Phase Four

Items & Factor Loadings - Factor One

Item #	Items	Loading
38.	AUTHORITY according to Procedures for hiring and transferring nursing personnel.	.65
36.	AUTHORITY according to Written guidelines for disciplining nursing personnel.	.61
30.	INFLUENCE to Create new administrative or support positions.	.60
29.	INFLUENCE to Create new clinical positions.	.60
39.	AUTHORITY according to Policies regulating promotion of nursing personnel to management and leadership positions.	.59
22.	INFLUENCE to Formulate annual unit budgets for personnel, supplies, equipment and education.	.56
48.	AUTHORITY according to Procedures for adjusting nursing salaries, raises and benefits.	.55
35.	AUTHORITY according to Organizational charts that show job titles and who reports to whom.	.54
47.	AUTHORITY according to Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education.	.52
23.	INFLUENCE to Recommend nursing salaries, raises and benefits.	.50
11.	CONTROL over Appointing nursing personnel to management and leadership positions.	.50
6.	CONTROLS Conducting disciplinary action of nursing personnel.	.46
63.	PARTICIPATES in Forming new hospital administration committees.	.45
10.	CONTROLS Promoting RNs and other nursing staff.	.44
9.	CONTROLS Making hiring decisions about supportive nursing staff.	.44
33.	AUTHORITY according to Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises.	.42
52.	AUTHORITY according to Location of and access to office space.	.42

Items & Factor Loadings - Factor One

59.	PARTICIPATES in hospital administration committees for matters such as employee benefits and strategic planning.	.42
34.	AUTHORITY according to Written process for evaluating nursing personnel (performance appraisal).	.41
8.	CONTROL over Making hiring decisions about RNs.	.41
51.	AUTHORITY according to Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass).	.40
19.	INFLUENCE over Regulating cross-coverage of other units (i.e. floating).	.38
4.	CONTROL over Evaluating (performance appraisals) nursing personnel.	.36
28.	INFLUENCE over Recommending new hospital services or specialties (e.g. gerontology, mental health, birthing centers).	.34

Items & Factor Loadings - Factor Two

Item #	Items	Loading
75.	ACCESS TO INFORMATION ABOUT Management's opinion of bedside nursing practice.	.75
76.	ACCESS TO INFORMATION ABOUT Physicians' opinion of bedside nursing practice.	.73
73.	ACCESS TO INFORMATION ABOUT Nurses' satisfaction with their general practice.	.69
74.	ACCESS TO INFORMATION ABOUT Nurses' satisfaction with their salaries and benefits.	.68
71.	ACCESS TO INFORMATION ABOUT Physician/nurse satisfaction with their collaborative practice.	.63
72.	ACCESS TO INFORMATION ABOUT Current hospital status of nurse turnover and vacancies.	.62
77.	ACCESS TO INFORMATION ABOUT Nursing peers' opinion of bedside nursing practice.	.59
70.	ACCESS TO INFORMATION ABOUT Results of patient satisfaction surveys.	.55
67.	ACCESS TO INFORMATION ABOUT Hospital's financial status.	.52
65.	ACCESS TO INFORMATION ABOUT Compliance of hospital nursing practice with requirements of surveying agencies (Joint Commission, state and federal government, professional groups).	.52
69.	ACCESS TO INFORMATION ABOUT Hospital's strategic plans for the next few years.	.51
66.	ACCESS TO INFORMATION ABOUT Unit's projected budget and actual expenses.	.50
64.	ACCESS TO INFORMATION ABOUT The quality of hospital nursing practice.	.49
68.	ACCESS TO INFO ABOUT Unit and nursing departmental goals and objectives for this year.	.46
78.	ACCESS TO INFO ABOUT Access to resources concerning recent advances in nursing practice (e.g. journals and books, library).	.36

Items & Factor Loadings - Factor Three

Item #	Items	Loading
25.	INFLUENCE to Consult hospital services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance).	.63
21.	INFLUENCE to Regulate the flow of patient admissions, transfers, and discharges.	.62
46.	AUTHORITY ACCORDING TO Procedures for controlling the flow of patient admissions, transfers and discharges.	.62
50.	AUTHORITY ACCORDING TO Formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy).	.62
45.	AUTHORITY ACCORDING TO Daily methods for monitoring and obtaining supplies for nursing care and support functions.	.60
24.	INFLUENCE Consult nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	.59
49.	AUTHORITY ACCORDING TO Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	.57
20.	INFLUENCE TO Monitor and procure supplies for nursing care and support functions.	.57
43.	AUTHORITY ACCORDING TO Procedures for determining daily patient care assignments.	.57
18.	INFLUENCE TO Make daily patient care assignments for nursing personnel.	.55
26.	INFLUENCE TO Make recommendations concerning other departments' resources.	.50
27.	INFLUENCE TO Determine cost effective measures such as patient placement and referrals (e.g. placement of ventilator-dependent patients, early discharge of patients to home health care).	.45
53.	AUTHORITY ACCORDING TO Access to office equipment (e.g. phones, personal computers, copy machines).	.31

Items & Factor Loadings - Factor Four

Item #	Items	Loading
56.	PARTICIPATES in nursing departmental committees for clinical practice.	.62
60.	PARTICIPATES in Forming new unit committees.	.62
88.	ABILITY TO Write unit policies and procedures.	.60
54.	PARTICIPATES in unit committees for clinical practice.	.56
61.	PARTICIPATES IN Forming new nursing departmental committees.	.54
89.	ABILITY TO Determine nursing departmental policies and procedures.	.53
85.	ABILITY TO Write the goals and objectives of a nursing unit.	.51
58.	PARTICIPATES in multidisciplinary professional committees (physicians, other hospital professions and departments) for collaborative practice.	.51
55.	PARTICIPATES in unit committees for administrative matters such as staffing, scheduling and budgeting.	.50
62.	PARTICIPATES in Forming new multidisciplinary professional committees.	.49
90.	ABILITY TO Determine hospital-wide policies and procedures.	.44
57.	PARTICIPATES in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting.	.42

Items & Factor Loadings - Factor Five

Item #	Items	Loading
1.	CONTROLS what activities nurses can do at the bedside.	.61
2.	CONTROLS Development and evaluation of patient care standards and quality assurance/improvement activities.	.58
31.	AUTHORITY ACCORDING TO Written policies and procedures that state what nurses can do in direct patient care.	.53
32.	AUTHORITY ACCORDING TO Written patient care standards and quality assurance/improvement programs.	.52
7.	CONTROLS Assessing and providing for the professional/educational development of the nursing staff.	.48
14.	CONTROLS Determining methods of nursing care delivery (e.g. primary, team, case management).	.48
13.	CONTROLS Incorporating research ideas into nursing care.	.46
5.	CONTROLS Determining activities of ancillary nursing personnel (aides, unit clerks, etc.).	.45
17.	INFLUENCES Adjusting staffing levels to meet fluctuations in patient census and acuity.	.45
40.	AUTHORITY ACCORDING TO Procedures for generating schedules for RNs and other nursing staff.	.45
3.	CONTROLS Setting levels of qualifications for nursing positions.	.44
16.	INFLUENCES Determining how many and what level of nursing staff is needed for routine patient care.	.44
42.	AUTHORITY ACCORDING TO Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity.	.43
37.	AUTHORITY ACCORDING TO Annual requirements for continuing inservices.	.40
41.	AUTHORITY ACCORDING TO Acuity and patient classification systems for determining how many and what level of nursing staff is needed for routine patient care.	.39
12.	CONTROLS Selecting products used in nursing care.	.37

Items & Factor Loadings - Factor Six

Item #	Items	Loading
80.	ABILITY TO Negotiate solutions to conflicts between professional nurses and physicians.	.77
81.	ABILITY TO Negotiate solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, etc).	.75
82.	ABILITY TO Negotiate solutions to conflicts between professional nurses and nursing management.	.75
83.	ABILITY TO Negotiate solutions to conflicts between professional nurses and hospital administration.	.74
79.	ABILITY TO Negotiate solutions to conflicts among professional nurses.	.66
87.	ABILITY TO Formulate the mission, philosophy, goals and objectives of the hospital.	.48
84.	ABILITY TO Create a formal grievance procedure.	.44
86.	ABILITY TO Write the philosophy, goals and objectives of the nursing department.	.44

Appendix G
Similar Items Loading On Factors
Phase Four

Similar Items- Factor 1

Item #	Items	Loading
<u>Hiring</u>		
*38.	AUTHORITY according to Procedures for hiring and transferring nursing personnel.	.65
8.	CONTROL over Making hiring decisions about RNs.	.41
9.	CONTROLS Making hiring decisions about supportive nursing staff.	.44
<u>Promotions</u>		
11.	CONTROL over appointing nursing personnel to management and leadership positions.	.50
*39.	AUTHORITY according to Policies regulating promotion of nursing personnel to management and leadership positions.	.60
10.	CONTROLS Promoting RNs and other nursing staff.	.44
33.	AUTHORITY according to Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises.	.42
<u>Disciplinary action</u>		
*36.	AUTHORITY according to Written guidelines for disciplining nursing personnel.	.59
6.	CONTROLS Conducting disciplinary action of nursing personnel.	.46

* Highest factor loading among similar items

Similar Items - Factor 1, Continued

Item #	Items	Loading
<u>Performance appraisals</u>		
*34.	AUTHORITY according to Written process for evaluating nursing personnel (performance appraisal).	.41
4.	CONTROL over Evaluating (performance appraisals) nursing personnel.	.36
<u>Salary adjustment</u>		
*48.	AUTHORITY according to Procedures for adjusting nursing salaries, raises and benefits.	.55
23.	INFLUENCE to Recommend nursing salaries, raises and benefits.	.50
<u>Unit budgets</u>		
*22.	INFLUENCE to Formulate annual unit budgets for personnel, supplies, equipment and education.	.56
47.	AUTHORITY according to Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education.	.52

Similar Items - Factor 3

Item #	Items	Loading
<u>Hospital support outside of nursing department</u>		
*25.	INFLUENCE to consult hospital services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance).	.63
50.	AUTHORITY according to formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy).	.62
<u>Regulating patient flow</u>		
21.	INFLUENCE to regulate the flow of patient admissions, transfers, and discharges.	.62
46.	AUTHORITY according to procedures for controlling the flow of patient admissions, transfers and discharges.	.62
<u>Nursing supplies</u>		
*45.	AUTHORITY according to daily methods for monitoring and obtaining supplies for nursing care and support functions.	.60
20.	INFLUENCE to monitor and procure supplies for nursing care and support functions.	.57
<u>Nursing support outside unit</u>		
*24.	INFLUENCE to consult nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	.59
49.	AUTHORITY according to formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	.57

Similar Items - Factor 3, Continued

Regulating patient care assignments

- | | | |
|------|---|-----|
| *43. | AUTHORITY according to procedures for determining daily patient care assignments. | .57 |
| 18. | INFLUENCE to make daily patient care assignments for nursing personnel. | .55 |

Similar Items - Factor 5

Item #	Items	Loading
<u>Direct patient care activities</u>		
*1.	CONTROLS what activities nurses can do at the bedside.	.61
31.	AUTHORITY according to written policies and procedures that state what nurses can do in direct patient care.	.53
<u>Standards of care/Quality Improvement activities</u>		
*2.	CONTROLS development and evaluation of patient care standards and quality assurance/improvement activities.	.58
32.	AUTHORITY according to written patient care standards and quality assurance/improvement programs.	.52
<u>Professional development</u>		
7.	CONTROLS assessing and providing for the professional/educational development of the nursing staff.	.48
37.	AUTHORITY according to annual requirements for continuing inservices.	.40
<u>Adjusting staffing levels</u>		
*17.	INFLUENCES adjusting staffing levels to meet fluctuations in patient census and acuity.	.45
42.	AUTHORITY according to mechanisms for determining staffing levels when there are fluctuations in patient census and acuity.	.43

Similar Items - Factor 5, Continued

Setting routine staffing levels

- | | | |
|------|---|-----|
| *16. | INFLUENCES Determining how many and what level of nursing staff is needed for routine patient care. | .44 |
| 41. | AUTHORITY according to acuity and patient classification systems for determining how many and what level of nursing staff is needed for routine patient care. | .39 |

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