INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
Relationships among staff nurses’ beliefs, nursing practice and unit ethos

Byers, Sandra Roberts, Ph.D.
The Ohio State University, 1990
RELATIONSHIPS AMONG STAFF NURSES' BELIEFS, NURSING PRACTICE AND UNIT ETHOS

DISSERTATION

Presented in Partial Fulfillment of the Requirement for
the Degree Doctor of Philosophy in the Graduate School of
The Ohio State University

by

Sandra R. Byers, RN, BSN, MS

The Ohio State University
1990

Dissertation Committee:

B. L. Mitchell, Ph.D., Chair
R. W. Backoff, Ph.D.
V. E. Blanke, Ph.D.
L. L. Cunningham, Ph.D.

Approved by

Advisor
College of Education
Copyright by

Sandra R. Byers

1990
To Linda M. Byers Fontana, RN, BSN
ACKNOWLEDGEMENTS

I am most appreciative of the many patient ways in which my adviser, Brad Mitchell, supported me throughout this study and my doctoral experience. He was always available to gently encourage a new perspective and more than met my many needs for encouragement and growth. Thanks go to the other members of my committee, Drs. Robert Backoff, Virgil Blanke and Vern Cunningham. This committee provided a depth and richness to my education that goes far beyond my courses and this dissertation. Two nursing colleagues, Drs. Edna Menke and Marybeth Mathews were available when needed and were especially helpful. They were able to combine being mentors, colleagues and friends. They are fantastic role models.

The staff nurses in this study are special people. I am most grateful for their cooperation and willingness to be a part of this study. I will always remember their dedication. They are professional nurses of the highest quality. To friends and colleagues in nursing and education, my thanks for your wisdom, encouragement and interest.

I could not have completed this process without the sensitive guidance, support, understanding and love of my husband, Tom. I am blessed with a wonderful partner and friend. Our children and my sisters, near and far, were always faithful in their encouragement and support. Thank you all.

iii
VITA

November 18, 1937.................Born- Rochester, New York

1960..............................B.S.N, Cornell
University-New York
Hospital, School of
Nursing, New York, New
York

1973..............................M.S., Nursing
Administration, School of
Nursing, The Ohio State
University, Columbus, Ohio

1973-1975............................Assistant Director, Staff
Development Department,
The Ohio State University
Hospitals, Columbus, Ohio

1975-1982............................Director, Medical Nursing
Riverside Methodist
Hospital, Columbus, Ohio

1982-1986............................Vice President, Nursing
Services, Health
Management Services,
Inc., Senior Vice
President, Nursing
Services, Grant Medical
Center, Columbus, Ohio.

FIELDS OF STUDY

Major Field: Education, Educational Policy and Leadership,
Nursing Administration

Minor Field: Public Administration
TABLE OF CONTENTS

ACKNOWLEDGEMENTS..................................iii
VITA..............................................iv
LIST OF TABLES...................................ix
LIST OF FIGURES...................................x
CHAPTER PAGE

I. INTRODUCTION...................................1
   Background......................................1
   Problem Statement..............................3
   Purpose and Research Questions................4
   Terms Defined...................................5
   Study Limitations and
   Potential Researcher Bias........................8
   Significance....................................9

II. LITERATURE ...................................11
   Introduction....................................11
   Historical Perspective........................13
   Hospital and Unit Work Context...............16
      The Hospital Context........................16
      The Unit Work Context.......................23
   Beyond Hospital and Unit: External Influences
   on Nursing Practice...........................31
      External Environment........................31
      Professional Organizations and Educational
      Influences...................................33
      Nursing Practice............................36
   The Staff Nurse................................40
      Nurse Job Satisfaction.......................46
   Comments about the Literature and
   Integration....................................51

III. METHODS......................................54
   Research Design................................54
Site Selection.....................................55
Preliminary Background........................55
Initial System Entry and Unit Selection...56
Site of Interviews................................58
Participant Observation Site..............58
Subject Selection................................59
Data Collection Strategy......................61
Researcher Role..................................61
Introduction of the Study to the Staff.....62
Phase I Data Collection: Questionnaires..64
Phase II Data Collection: Interviews......66
Phase III Data Collection: Observation of Unit...........................67
Phase IV Data Collection: Participant Observations........................68
Phase V Data Collection: Unit Documentation..................................71
Data Analysis.....................................72
Interview Data Analysis........................74
Participant Observation Data Analysis....75
Questionnaire Data Analysis..................76
Analysis of Pertinent Documents............76

IV. RESULTS........................................79

Findings from Interviews, Participant Observations and Questionnaires............81

Nurses’ Beliefs Explored by Interviews......81
Nurses’ Beliefs revealed from Interview Data: Beliefs about Nursing Practice......81
The Nurse as the Direct and Primary Patient Care Provider.........................82
The Nurse as a Professional..................85
The Unit Work Environment...................92
Summary: Nurses’ Beliefs about Nursing Practice........................................98
Nurses’ Beliefs revealed from Interview Data: Beliefs about Unit Ethos..........100
Hospital.............................................100
Unit..................................................102
Nurse Peers........................................104
Physicians.........................................109
Support Services...............................110
Patient............................................111
Nurse Manager.................................113
Summary: Nurses’ Beliefs about Unit Ethos............................................115
## LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Observed Nurse Activities</td>
<td>77</td>
</tr>
<tr>
<td>2. Organizational Effectiveness</td>
<td>175</td>
</tr>
<tr>
<td>3. Staff Nurse Characteristics</td>
<td>235</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURES</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategy for evaluating relationships among, beliefs, practice and ethos</td>
<td>6</td>
</tr>
<tr>
<td>2. Average Activity Profile</td>
<td>123</td>
</tr>
<tr>
<td>3. Organizational Effectiveness</td>
<td>176</td>
</tr>
<tr>
<td>4. Nursing Unit Overall Culture Plot</td>
<td>180</td>
</tr>
<tr>
<td>5. Organizational Culture Plots Using Average Nurse Organization Dimension Scores</td>
<td>183</td>
</tr>
<tr>
<td>6. Nursing Division Organization Chart</td>
<td>234</td>
</tr>
<tr>
<td>7. Unit Floor Plan</td>
<td>236</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Background

The American health care system has been shaped by cultural characteristics of modern Western Civilization---expectations for a long and healthy life, belief in technological innovation and the acceptance of bureaucratic organization. The trend toward "big business" practices (mergers, diversification, "down-sizing") in health care persists amid rising costs, declining resources, and consumer concerns about effectiveness, efficiency and quality of life. Clearly, rising health care costs and changing social demographics are reshaping the nature and scope of the health care system.

Hospitals have been the center of the health care industry. Now they are trying to survive in a more competitive and regulated environment with decreasing financial support. This unstable and unpredictable environment is changing how hospitals are organized and run. Characteristics of the health care system having a specific impact on the hospital are: fragmentation of client services between acute care system and community; lack of coordination and inappropriate utilization of hospital resources; and changes in the locus of health care delivery from the inpatient acute care system to outpatient and physician
services, the increasing voice of the consumer in the quality and the amount of services being received, and the ethical issues over the use of complex technology in relation to the meaning of life and death also are contributing to the new realities of hospital life.

The work, organization and environment of the hospital are critiqued by consumers, payors and providers differently than in previous years. Each constituent has unique and sometimes incompatible expectations of the hospital. Hospitals employ a mixture of salaried and non-salaried professionals and non-professionals. They each have their own goals and expectations and are struggling for their own identity, turf and share of shrinking financial resources.

The nursing profession is a hospital occupation struggling to redefine its unique responsibilities and niche in the new hospital care environment. Nursing is a service oriented occupation and nurses are the primary health care providers in the care of acutely ill hospitalized patients. Nursing care is the product delivered to patients by the staff nurse and is an essential service offered by the hospital. Nurses comprise the majority of health care providers in the hospital environment and consume the largest percentage of the budget allocated for employee salaries. Their knowledge, skill and flexibility in providing nursing care to all types of patients increases their value to the hospital. Nurses interface with the patient and family on a twenty-four hour, seven day-a-week basis on the hospital unit.

Nursing, as a service oriented occupation, has supply and demand cycles (Jones, 1988). Most hospitals are experiencing a nurse shortage due in part to the variety of career opportunities now available to
women, the decreasing pool of qualified nurses active in the work force, and the stresses of the hospital environment which encourages nurses to seek other employment settings (Curtin, 1986; Andreoli et al., 1988; Smith and Falter, 1988; Boyar and Martinson, 1990; Maraldo, 1990). With the shortage, the hospital environment quickly becomes a less than desirable place to work. Demands for nurses to do more with less help results in nurses feeling they are providing less than quality care and less nursing care for sicker patients. The increased workload and the need for more nurses to care for an older patient population in the hospital with multiple chronic illnesses, new diseases and the impact of high technology requiring more sophisticated employees adds to the physical, intellectual and emotional demands on nurses. As a result of the nurse shortage and the stressful and changing hospital environment, the nursing unit can experience poor morale, job dissatisfaction and an increase in nurse turnover. Nurses react negatively to their lack of status and power in the hospital environment (Butler, 1989).

Problem Statement

Nurses have been affected by changes in the hospital and health care environment. This complex situation challenges nurses and nursing administrators in their efforts to remain a vital part of the hospital environment. Hospital and nursing administrators must find ways to deliver care efficiently and effectively.

The staff nurse as the primary provider of nursing services is a key actor in the need to realign and redefine nursing's contributions to the hospital. For successful organizational adaptation, it is important
to determine the staff nurses' perspective of how nursing practice is currently implemented on the hospital unit, and what the environment is really like for the nurses employed there. It is important to clarify how nurses' roles are influenced by environmental changes and to identify and understand what staff nurses believe they are doing and ought to be doing in new and complex work environments. Observing what nurses actually are doing and exploring what it is about the work environment that supports or detracts them from accomplishing their tasks will provide information needed to keep pace with health care system expectations, changes, advancements and reconceptualizations of nurses' work.

**Purpose and Research Questions**

The purpose of this descriptive field study was to explore and identify possible relationships among staff nurses' beliefs about their work or nursing practice, what it is they are doing in the work environment and what influences in the environment they believe shape what they are actually doing.

The primary research question was;

What are the relationships among staff nurses' beliefs, nursing practice and unit ethos?

Subquestions were identified to focus the research. The subquestions were:

1. What are staff nurses' beliefs about nursing practice and unit ethos?

2. What is nursing practice on the hospital unit?
3. What is the unit ethos?

4. What are the similarities and differences among nurses' beliefs, nursing practice and unit ethos?

Four data collection methods were used to acquire information necessary to answer the main research question. These methods were interviews, questionnaires, participant observations and unit specific documents. Figure 1 graphically displays the methods and research questions. Area A represents staff nurses' beliefs, area B, nursing practice and area C, the unit ethos. By exploring and describing the similarities and differences between a and b, b and c, and a and c, an attempt was made to discover the relationships among the nurses' beliefs, nursing practice and unit ethos.

Terms Defined

For purposes of this study, the following words were defined; staff nurse, beliefs, unit ethos, nursing practice, and hospital unit. A \textit{staff nurse} is a registered nurse employed by the hospital and working as a floor or unit nurse with no system-identified managerial responsibilities by title. She/he graduated from a two, three or four year accredited nursing education program. The staff nurse is working in the hospital under the direction of a Nurse Manager and has a job description.

\textit{Beliefs} are defined as shared "understandings that represent credible relationships between objects, properties, or ideas" (Sproull, 1981, p. 204). Beliefs are generally consistent over time, and held to
Figure 1. Strategy for evaluating relationships among beliefs, practice and ethos. Relationships among A, B and C are indicated by arrows. The type of study providing information about each relationship is indicated adjacent to the arrows. The arrows indicate the source of information about a particular relationship. For example, participant observations of nursing practice (B) provide information about the relationship between B and C.
be true and in common by members of a profession, group, movement or organization (Webster, 1971, p. 909).

**Unit ethos** is defined as the "distinguishing character, tone or guiding beliefs" of an identified group. (Webster, 1971, p. 285) The guiding beliefs are operationalized in group norms and expectations that influence individual and group behavior.

**Nursing practice** is defined in accordance with the State of Ohio legal definition. The practice of nursing as a registered nurse means:

- providing to individuals and groups nursing care requiring specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, social and nursing sciences. Such nursing care includes:
  1) identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen;
  2) executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions;
  3) assessing health status for the purpose of providing nursing care;
  4) providing health counseling and health teaching;
  5) administering medications, treatments, and executing regimens prescribed by licensed physicians, dentists and podiatrists;
  6) teaching, administering, supervising, delegating, and evaluating nursing practice.

Nursing regimen' may include preventative, restorative and health promotion activities.'

'Assessing Health status' means the collection of data through nursing assessment techniques which may include interviews, observation, and physical evaluations for the purpose of providing nursing care. (The State of Ohio Nurse Practice Act, 1987)

The hospital unit is a 38 bed unit within an over 1000 bed, acute care, multi-service institution located about five miles from the center of a large metropolitan mid-west city on a university campus.

Although "primary nursing" was not a specific concern in this study, it is frequently referred to and is explained for clarification and understanding. Primary nursing is a method for assigning patients to
nurses in the hospital. It was designed to return to the concept of "my patient-my nurse". Each registered nurse is assigned to provide complete care of a group of patients during their hospitalization. The nurse is responsible for planning patients' 24-hour care and writes a care plan for each patient. Primary nursing represents a form of decentralized decision making and is intended to give each nurse more responsibility and authority (Bernhard and Walsh, 1990).

Study Limitations and Potential Researcher Bias

This study was confined to one location at one moment in time. Some time limitations occurred due to work schedules and patient care needs. It is not necessarily generalizable to other locations. The validity of the responses and the nurses' observed behavior were dependent on the openness and willingness of the participants to freely and with independent judgment respond to the data collection methods. The researcher relied on the cooperation of the participants for the quality of the responses and the representativeness of their behavior in comparison to times when they were not being observed.

The credibility of this study was supported by the focus on one unit for a period of time to establish rapport with the participants and the openness with which researcher responded to questions about the study and the sharing of study results. Triangulation of data support credibility (Lincoln and Guba, 1985). Triangulation occurred as the data from each of the collection methods were analyzed. To assure that the various descriptions be as true to the staff nurses' view as possible, actual quotes were reported throughout the results section. Nurse peers
read the data and the conclusions for the purposes of peer debriefing. As described by Lincoln and Guba (1985), peer debriefing is a technique useful in establishing credibility. "It is a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln and Guba, 1985, p.308).

As an instrument in the data collection, the researcher had particular biases which may limit the study results. As a nursing administrator for over 12 years and a registered nurse for 30 years, the researcher believes nurses are the most important health care provider in the hospital. They are the coordinators of care and have not been given the financial and social rewards the majority have earned for their work. The researcher believes baccalaureate education for nurses should be the entry level for the professional registered nurse because of the judgments and the decisions for which that practitioner is held accountable. The assumptions underlying this study focused on the role of the nurse in a hospital environment. They are: (a) the nurse is a key employee in the delivery of the hospital's service; (b) she/he wants to control nursing practice; and (c) a hospital ethos is present, is unique, and is influenced by and influences the nurse.

Significance

Hospital nursing and nurses have been studied through the years in similar ways and with standard variables such as job satisfaction, morale, recruitment, retention, and work productivity. Representative
studies are discussed in Chapter II. This study attempts to contribute a deeper understanding of what nurses' believe about their work in the hospital and about factors which shape their practice in that environment. It explores nursing practice from the staff nurse perspective and in the context where work tensions and problems emerge. The resultant deeper understanding of this context may assist in solving some of nursing's recurring dilemmas as a work force and as a profession. The context in which nurses practice their profession contributes to the reason why nurses leave a particular work setting (Pooyan et al., 1990).

Nurse administrators have tried to create nursing care delivery systems which meet the current nursing needs of patients, anticipate future changes, identify role changes necessary for nurses, and provide a feedback mechanism for the education of nurses. In the past, much of the information used to make decisions about the redesign of the delivery of nursing care has been objective, quantifiable data often lacking in conveying the essence of nursing work. This information has seldom secured the total support and confidence of staff nurses. Complementary information for nursing and hospital administrators searching for creative ways to enhance the nursing profession and to attract and retain qualified nurses may prove helpful. The relationship between nursing practice and unit ethos needs to be described at the "grass-roots" level to facilitate the implementation of change and to enhance policy decision-making at all organizational levels.
CHAPTER II
LITERATURE

Introduction

The purpose of this chapter is to review current literature concerning staff nurses, the practice and profession of nursing, and the hospital and unit environment. There is an extensive literature on each of these topics; only examples important to this study are included. There are few integrated and wholistic studies which strive to situate staff nurses or bedside nurses within personal, professional and hospital contexts.

Styles's (1984) conceptual framework of the nursing universe seemed a good model to utilize in framing the study and literature review. It considers the social context, the practice and the profession, and the individual nurse. Styles's framework cuts across three frames of reference; the individual, group and context. All are viewed as important and integrated. The unit environment is complex and the human interaction of nurse(s) working in the unit is unique. Viewing the world of the nurse from her perspective and trying to understand it the way she understands and makes meaning of it may contribute important understandings about nurses' work to the organization and the nursing community at large.
In addition to the wholistic approach of Styles (1982), the "organization as culture" school of thought from organizational theory provided insights for the study. Morgan (1986) discussed culture as a way of understanding and viewing organizations as distinctive patterns of beliefs or shared meanings supported by various operating norms and rituals. He stated the characteristics of the culture and subculture become evident as the patterns of interactions between individuals, the language used, the images and themes explored in conversation and the various daily rituals are explored. This phenomenon is now recognized as "corporate culture" and "corporate culture develops as an ethos created and sustained by social processes, images, symbols and rituals" (Morgan, p.123). The organization's rules, policies, structure and job descriptions help interpret and express the culture and are avenues to be used in changing an organization. Organizations often have many different and competing value systems that create a "mosaic" of organizational realities rather than a uniform corporate culture (Morgan, 1986). Each subculture has its own reality resulting in difficult communications. Successful organizations find ways to integrate the norms and priorities and avoid the divided loyalties that occur when there are not shared meanings, shared understandings and shared sense making. Successful leaders create this shared sense of meaning and communicate the desired beliefs and values to guide employee actions in the organization. The cultural view of organizational life is not a static view but an ongoing pro-active process of reality construction. People in the organization create, change, and recreate the worlds in which they live. This way of viewing the hospital, the
unit, and the interactions that occur daily between nurses and others seemed very useful and exciting.

The primary logic of the literature review was to capture the central perspectives of how the world of nurses and the work of nursing has been researched in recent years. The literature review includes an historical overview, the hospital and unit work context, pertinent external influences and the staff nurse.

**Historical Perspective**

Nursing research at the beginning of the twentieth century focused on reforming nursing education (Felton, 1989). Studies were based on surveys that explored the variety of educational backgrounds of nurses (e.g. the length of the program and whether it was hospital or university based) and identified critical deficiencies in the practice of nursing (e.g. the need for public health principles and leadership skills). Clinical research prior to 1950 was conducted largely by non-nurse scientists (Ziegler et al., 1986). It focused on specific diseases and the improvement of nursing techniques to inhibit the transfer of diseases.

In the 1950's the need to identify nursing functions to improve clinical practice was the focus of some research and in 1952 the first research journal, *Nursing Research* was published. Two other research journals, *Research in Nursing and Health* and the *Western Journal of Nursing Research* (Ziegler et al., 1986) were initiated in the 1970's.

A federally sponsored Division of Nursing Resources was formed in 1949. Initial studies by this agency investigated nurse supply and
distribution; the quantity, quality and costs of nursing education, job satisfaction and job turnover; and, patient satisfaction with care. The Division produced research procedure manuals which stimulated an increase in nursing research in the 50's and 60's. This research thrust gained momentum in response to support from nursing leaders, professional associations and research organizations. At the same time, an increase in nurses prepared at the masters and doctoral levels prompted greater research efforts. Research during this period reflected the development of specialty groups within nursing; for example community health and medical-surgical nursing. In the 60's, research endeavors focused on educational opportunities, career mobility, and professional advancement. In the 1970's research focused on evaluation of teaching methods, student learning experiences, the use of computer simulation in nursing education and the methods of nursing care delivery. Interest in primary nursing management resulted in studies about nurse productivity and contribution to the quality and cost of hospital care.

Theories and research on nurses and nursing have emanated from scholarly perspectives in sociology, psychology, life sciences, organizational development, and organizational behavior. Abdellah and Levine (1965) recognized the contributions of these sciences to nursing research. For example, in experimental biochemistry facts discovered are applied to dietary regimens for obesity, pregnancy, diabetes, ulcers and cardiovascular disease. In the physical sciences, the importance of oxygen to all body cells for survival has been researched and nurses then apply this information in the development of nursing procedures
which promote the patient's oxygen utilization. An example of a nursing concern studied by many disciplines is pain. Jacox and Stewart (1973) studied pain as a biopsychosocial phenomenon, Johnson and Rice (1974) from the social psychology perspective and Strauss et al. (1974) studied pain as a social phenomenon with organizational and interactional consequences.

Many early studies focused on interpersonal relationships. Burling et al. (1956) studied interpersonal relationships at a total system level in six hospitals. Bennis et al. (1958) have studied the organizational loyalty of groups of nursing personnel in outpatient departments. Whiting (1958) studied the perception of nursing personnel and patients of the relative importance of various facets of the nurse-patient relationship. The Western Interstate Commission for Higher Education (1977) published a compilation of descriptions and critiques of 140 psychosocial instruments and descriptions of 19 instruments that can be used to measure physiological variables of interest to nurses.

McDaniel's (1990) reviewed 28 studies from 1980-84 and 55 from 1985-1989. She found 93% of the studies were from a single site, most frequently a hospital. There were 156 variables; descriptors of "nursing work" represented the largest proportion (50%). The descriptors used were: performance of job responsibilities, the hours worked, the work schedule, retention, and turnover. The second largest category of research variables examined (22%) was "attitudes of nursing work". This included job satisfaction, work perceptions and feelings of power. The majority of studies (40%) used nursing personnel (e.g. those individuals paid through the nursing service budget) mainly nursing staff (nurse
aides, registered nurses and licensed practical nurses). Few nursing research studies have examined the context or nature of health care services (McDaniel, 1990,).

From the historical perspective, nursing research has progressed along two main paths. One path focuses on the research about nursing education; the types of programs and graduates and how the programs should be structured. The second path centers on clinical research. Clinical research has tended to focus on manpower issues (e.g. supply and demand, or job stress) or recent advances in medications or treatments used in specialty areas such as the obstetrical area or intensive care (e.g. medications that affect patients' sense of balance or the physiological changes that occur with endotracheal suctioning of a patient in the intensive care unit). Although strides have been made along both research paths, frequently the research has not been replicated and the clinical research is frequently not implemented in the hospital. Nursing research has been influenced by quantitative research methods and little emphasis has been placed on interpretive understandings of nursing life. Some descriptive work has been published (Frede, 1985 and Heron, 1987) and there is a growing body of work that has been labeled feminist nursing literature. For example, the first 8 volumes of Advances in Nursing Science were indexed and approximately 15% had an identifiable feminist orientation (Wheeler, 1986).

Hospital and Unit Work Context

The Hospital Context. One critical way to understand nurses and nursing is to examine the hospital and unit context. The majority of
nurses (65%) work in a hospital and are assigned to work on a specific clinical unit. Therefore, nurses need to understand the hospital for what it is, a large complex organization with unique characteristics. One of the ways hospitals are unique is that they employ a large number of professionals, namely nurses. Professionals usually think of themselves as highly skilled and expect to make independent decisions based on their unique knowledge. They tend to have loyalties to their professional association outside the hospital. They have a mission which is based in their commitment to society not the organization. Complex organizations are usually bureaucracies characterized by rules, a division of labor, a hierarchy of authority, specialists, line and staff positions, a separately designated administrative staff, records and "closed-systems thinking" (Fuszard, 1983; Daft, 1986). Organizational theorist such as Perrow (1965), Mintzberg (1979), Melosh (1982), Singleton (1984), Strauss et al.(1985), Raelin (1986) and Neuhauser (1987), each offer ideas about hospital organization.

Perrow stated hospitals are complex organizations that deviate in structure and role relationships from the usual bureaucratic organization. He described the hospital as a system of multiple authority or multiple subordination. This impacts nurses because at times they are caught between the administrative and medical hierarchies.

Hospitals have a different relationship with doctors who are approved by their medical peers to be affiliated with the hospital. Physicians are both staff members providing a specialized skill acquired outside the organization and line members doing the work on the "raw
material". Physicians are responsible for productive effort. They are viewed as "guests" who bring patients and use the facilities. However, physicians are not bona fide members of the organization because they do not receive reimbursement from the hospital and are not directly under the organization's authority. However, they do exercise control, have a bureaucratic role, and their interests are tied to the interests of the organization (Perrow, 1965).

Perrow refers to the hospital, as "the product of the interaction between cultural and technological systems" (Perrow, 1965, p.914). The technological systems Perrow refers to are the techniques necessary to execute a task and the cultural system is the values or beliefs about what should be done or goals which are determined by society. In the hospital if a patient comes expecting nurses to care for him or her in a particular way, and the nurse does not have the skill or abilities to do what is expected, a different interaction occurs then if there was a match between the two. The primary task of the hospital is, "to alter the state of human material" which is accomplished by technology or techniques employed for that purpose (Perrow, 1965, p.915). Perrow's view on the interaction and importance of culture and technology is important for nurses. As nurses become increasingly technologically competent through formal education and the performance of health care procedures, the role and authority relationships between nurse, physician and hospital change. Nurses have attained a different level of technology and this must fit with the goals of the organization as the employer. A conflict may arise between the nurses' professional and legal requirements imposed from outside the organization. In these
cases, the conflict is frequently resolved through negotiations and protection of nurse actions by approval from the medical hierarchy. Nurses constantly struggle to be recognized and rewarded for their expertise and their amount of accountability within the hospital.

Similar to Perrow, Mintzberg (1979) emphasizes hospital structure and organization and calls it a professional bureaucracy. In a professional bureaucracy, the operating core, one of the five basic parts of the organization (Mintzberg, 1987), is composed of professionals. In an organization characterized as a professional bureaucracy, the organization may be kept smaller, rules fewer and the employees more autonomous (Daft, 1986). In the primary nursing organization, nurses are accountable for their assigned patients for their entire hospitalization and are expected to develop the patient's care plan. This method emphasizes nurse autonomy and independent decision making within a bureaucratic organization.

Neuhauser (1987) agreed with Mintzberg and characterized the organization of the hospital as being a response to the core relationship of patient-physician-nurse. The hospital's central problem is the "coordination of highly specialized workers around the care of numerous unique individual patients with often unpredictable needs for medical care inputs, within urgent time constraints" (Neuhauser, 1987, p.427). He divided the hospital into two organizational components: the administrative hierarchy which is departmentalized and staffed by full-time salaried employees and the collegially organized medical staff who spend most of their time outside the hospital in fee-for-service office
practices. He described the hospital as a fixed-cost operation with revenues dependent on the number of patients cared for.

Raelin (1986) agreed with Mintzberg and amplified Perrow's notions about culture. He typified the hospital as "the clash of cultures": the corporate culture which captures the commitment of managers, and the professional culture which socializes professionals. He stated both cultures are sustained by the wider social culture (Raelin, 1986). For example, a nurse administrator has first of all been socialized to focus on the patient but in the administrative position is required to focus on the survival of the hospital. Patients expect the nurse administrator to be loyal to both. The clash between patient needs for increasing amounts of nursing care and hospital survival may require the release of nurses to maintain hospital financial stability when the need for more nurses to care for patients is also present. Many professionals are employed and paid by the organization in contrast to having an autonomous business with no employer-employee relationship. In the corporate professional culture, Raelin defined professionals based on what they do and as having the following characteristics:

1. expertise—engaging in prolonged specialized training in a body of abstract knowledge.
2. autonomy—possessing the freedom to choose the examination of and means to solve problems.
3. commitment—shoving primary interest in pursuing the practice of one's chosen specialty.
4. identification—identifying with the profession or with fellow professionals through formal association structures or through external referents.
5. ethics—rendering service without concern for oneself or without becoming emotionally involved with the client.
6. standards—committing oneself to help in policing the conduct of fellow professionals (Raelin, 1986, p.9).
Singleton (1984) contributed a financial perspective to the understanding of hospital structure, organization and relationships. In "big business", usually the consumer is clearly the purchaser and payer of service. In the hospital, the consumer is the patient who must be admitted for the purchase and receipt of services ordered by the physician. The physician is not a formal partner in the business enterprise but is responsible for ordering the product of care for the patient. Nurses and others employed by the hospital are responsible for implementing the care prescribed and the care within their practice domain. The payers, usually government agencies or insurers have a great deal to say about the amount of payment for the health care and the conditions under which the care is provided (Singleton, 1984). Therefore the quantity and the quality of the services provided to patients is influenced and monitored by another body outside of the hospital environment. This kind of control creates a very complex environment for hospitals trying to adjust the numbers of personnel and the programs to fit with the revenue resources.

Strauss et al. (1985) contributed an image of the hospital organization in very practical terms and identifies many complexities in the system. They described contemporary hospitals as:

...variegated workshops-places where different kinds of work are going on, where very different resources (space, skills, ratios of labor force, equipment, drugs, supplies and the like) are required to carry out that work, and where the divisions of labor are amazingly different, though all of this is in the direct or indirect service of managing patients' illnesses (Strauss et al., 1985, p.6).
Melosh (1982), examined the work and the work place of the nurse uniquely. She reviewed nursing in relationship to the physician's role and women's history, labor history and sociology. She viewed nurses as subordinate to physicians by custom and law yet second in command on the hospital unit and closely associated with physicians' prestige and power. She described nurses' occupational culture as "a tradition of pride in manual skills, of direct involvement with the sick, of respect for experience and often a concomitant mistrust for theory" (Melosh, 1982, p.7). She perceived a conflict and a strength between nurses' "culture of apprenticeship" and the traditions of professional ideology in controlling and defining their work (Melosh, 1982, p.207). The apprenticeship approach is the way for nurses to affirm their skills and define their work, and maintain the profession's ideals of the patient as the center of nurses' work and basis for nursing's legitimate authority. From this perspective, nursing autonomy is doomed unless it is linked to broader issues of hospital work.

The work of nurses is imbedded in the structural and role relationships within the hospital environment. Aikens (1983) suggested six fundamental tensions between hospitals, physicians and nurses. These tensions are: 1) The nurses' sphere of authority has not changed since World War II even though nurses are now in command of much of the available clinical expertise to care for the seriously ill and make judgments about appropriate use; 2) Physicians work fewer hours and are available less for consultation. The authority of the nurse to act in the absence of the physician has not been redefined; 3) Nurses have not been recognized for their new level of clinical decision making with the
increase in older and more seriously ill patients; 4) There is an increase in medical subspecialties, resulting in numerous physicians involved in a patient's care, fragmentation of care and the potential of costly and dangerous duplication or omission of services. The role of the nurse to synthesize and monitor multiple diagnostic and treatment regimens has not been recognized; 5) Nurses are the coordinators of all the support services involved with the care and safety of a patient, yet they have no authority to deploy or redirect these services to carry out the responsibilities; and 6) Nurses, largely females and now looking at many professional career options, do not find working conditions in hospitals professionally satisfying. These six tensions, which Aikens terms incompatibilities, are indicators of nurses' lack of recognition and status within the hospital. They also indicate the inadequate job the nursing profession has done to communicate to others about what nurses can and do accomplish.

The Unit Work Context. The clinical unit in most hospitals is defined by a designated physical space and labeled according to a type of medical specialty. Patients admitted for care are placed in private or semi-private rooms. Hospital employees and non-hospital employees come and go on the unit depending on their assigned responsibilities. Each clinical unit is quite isolated and has unique characteristics. Physical structure, organizational structure, management, culture, and work-related variables have constituted the study of the clinical unit in the past.
The work place of the nurse has received national attention from The American Academy of Nursing in its Task Force on Nursing Practice in Hospitals report, *Magnet Hospitals, Attraction and Retention of Professional Nurses* (1983), and the Federal Commission on Nursing document, *Secretary’s Commission on Nursing Interim Report* (1988b). Hospitals which were judged to have outstanding records of nurse recruitment and retention were then labeled "magnet hospitals". This report has been used extensively by nursing administrators in trying to correct their own nurse recruitment and retention problems.

The *Magnet Hospital* report identified characteristics of a positive work environment and encouraged hospitals to design programs which incorporate these characteristics. They are: a visible, accessible and participatory administration; knowledgeable and strong leaders who support their work and care about their working conditions; a collaborative organizational structure with mutual goal setting; staffing patterns that recognize the need for adequate quantity, quality, and mix of expertise of staff; personnel programs and policies with flexible work schedules, competitive salary and benefits; active recruitment and retention programs; professional practice support and a drive for quality with models of delivery that support nurse autonomy, constructive feedback on the quality of care, and knowledgeable nursing care consultants available. Nurses in these hospitals identified for their outstanding recruitment and retention programs are recognized for their contributions to the total care of the patient and family and are consulted by physicians. Professional development is supported and
includes strong orientation programs, inservice and continuing education, formal education and career development.

The Secretary's Commission Report (1988a) contained nine (out of 16) recommendations that address the reorganization of the work place. The emphasis on work schedules, staffing and nurse utilization is similar to the Magnet Hospital report. Briefly the nine recommendations are: health care delivery should preserve the time of the nurse for direct patient care by providing adequate staffing levels for clinical and nonclinical support services; innovative staffing patterns should utilize nurses' different levels of education, competence and experience; automated information systems and other new labor-saving technologies should be developed; methods for costing, budgeting, and tracking nursing resource utilization should be developed; involvement of nurses at all policy and decision-making levels must occur; the decision-making level of the nurse in cooperation with medicine should be recognized; positive and accurate images of nurses' work should be promoted; and, the effects of nurse compensation, staffing patterns, decision-making authority and career development on nurse supply and demand and health care cost and quality should be researched.

Fine (1982) has suggested three practical applications for creating a work place for the professional nurse that are more assertive and aimed directly at the organizational structure than the previous reports. They are: changes in staff nurse participation to include representation at the board and administrative levels of the organization and at the controlling and coordinating levels of nursing service; changes in the structure and the structuring of nursing to two
levels, a coordination and control level and a technological level; and changes in work autonomy to mean that the client-professional relationship incorporates innovation, individual responsibility and communication, and socialization and resocialization efforts as necessary to maintain nurses' professional roles. This would involve examining the orientation programs of new nurses entering the hospital, expecting nurses to be active leaders, and including continuing education programs to enhance the nurses' self-image and confidence. It would mean teaching nurses how to present nursing topics at meetings and encourage their speaking up about the contributions nursing makes to patient care.

Lancaster (1985) suggested impacting the work environment by creating a climate for achievement. The characteristics identified were helping employees feel like somebody, establishing explicit goals, making expectations clear, providing feedback and reinforcement, eliminating threats, encouraging individual responsibility, and creating a climate of open communication.

Nurse retention is frequently used as an indicator of the hospital's and unit's status. J. Alexander (1988) studied voluntary turnover rate in a sample of 1,726 registered nurses and licensed vocational nurses working in 146 units within 17 hospitals. The dependent variable, voluntary turnover rate, was correlated with four unit organizational variables. The first variable was staff integration defined as the ratio of RN's assigned to the unit to total patient care staff assigned to unit, extent of RN rotation among shifts, and ratio of full-time staff to all unit staff. The second variable was
centralization defined as RN influence in unit-related decisions and
decision making authority of head nurse. The third was
communication/coordination defined as the frequency of contact and
communication among nurses during the shift, frequency of patient care
conferences and explicitness of unit policies and procedures. The final
variable was evaluation defined as perceived accuracy of head nurse
performance evaluation and the number of patient care hours performed by
head nurse per week.

The results indicated that four organizational categories are
significantly related to turnover: salience of evaluation, frequency of
patient care conferences, shift rotation and RN ratio. There was a
positive correlation with shift rotations and a negative correlation
with the RN ratio suggesting, "A collegial group of professional workers
and some degree of organizational stability may be necessary to achieve
organizational integration and consequently to reduce turnover" (J.
Alexander, 1988, p.69). He also contended that where there is formal
communication, instrumental communication or informal communication
occurs and positively influences turnover. For example, the planned
meetings and conferences as patient care conferences, increases the
opportunities for staff socialization and thereby positively impacts
retention. The importance of fair and accurate evaluations was seen to
legitimize the role of the RN and thus reduce the role conflict and
alienation that may result in turnover.

Butler (1989) focused on the perceptions of 212 staff nurses
concerning environmental factors that promote job satisfaction and nurse
retention. The findings identified inadequate salary, lack of control
over scheduling and patient care load, lack of recognition for clinical excellence and lack of managerial support as influencing satisfaction and retention.

Pooyan and colleagues (1990) surveyed 1,250 registered nurses working at three private hospitals to examine the relative contributions of work-related and demographic variables to turnover intention. They found demographic variables of age, occupational tenure, education and marital status did not contribute to nursing job changes in ways not accounted for by work-related variables.

Pooyan’s results were consistent with Wiseman (1982) in suggesting that turnover-related variables can potentially be controlled by hospital management. There were three job satisfaction variables: satisfaction with promotion, pay and supervisor; and three work environment variables: role ambiguity, participation opportunity (e.g. how much "say" the nurses perceived they had in making job-related decisions regarding how to do one’s job, the sequence/speed of work, and the division of work responsibility as well as the amount of work), and performance constraints (shortage of nursing staff, unavailability of medical equipment/supplies, lab delays, too much paper work, and not having sufficient instructions). Satisfaction with promotion and perceived performance constraints were the first and second most significant predictors of turnover.

How nurses specifically feel about their jobs is considered an important part of turnover and retention in addition to the variables mentioned previously. C. Alexander et al. (1981) attempted to identify characteristics of the work situation that had a significant influence
on nurses' evaluation of their jobs. The variables studied are nurse autonomy and nurses' opinions about physician task delegation. They interviewed 789 staff nurses at a large university-affiliated hospital. They studied correlations between four personal characteristics; baccalaureate education, first position, length of employment and internal control (degree to which an individual perceives his behavior is controlled by fate or by his own initiative or skill), and seven job-related characteristics: primary nursing, rotating shifts, position level, workload, head nurse scale (staff nurses' attitudes about the head nurse's leadership style and responsiveness), physician task delegation and adequacy of professional time with perceived autonomy.

Autonomy was defined as control over work activities and was measured by a four-item scale on workers' perception of their decision-making power relative to the conduct of their jobs. Five variables significantly predicted perceived autonomy: baccalaureate education, internal control, primary nursing, the head nurse scale, and the adequacy of professional time. The head nurse scale, which measured staff nurses' attitudes toward her head nurse's leadership style and responsiveness, was the strongest predictor of perceived autonomy.

Studies relative to the evaluation of primary nursing, the mode of patient care assignment used on the unit in the present study are sparse. Giovannetti noted:

In spite of the paucity of research evidence suggesting that the implementation of primary nursing will promote professional nursing practice, along with its anticipated benefits in the areas of quality, satisfaction, and costs, the implementation of primary nursing has become widespread. (1986, p.146).
Giovannetti raised the issue that primary nursing is probably in part a philosophy of care and the nurse's role in primary nursing is commonly described as having autonomy, authority and accountability. She suggested evaluation should proceed via philosophic inquiry.

Williams (1988) reviewed the literature on hospital and unit design, spatial environment, sound, color, thermal conditions, and weather. These variables have had limited attention from researchers yet are recognized as influencing the work and therapeutic environment for patients and personnel. Williams encouraged research in the field to improve working conditions.

In summary, the immediate work place of most nurses is a physical unit that is a rather closed sub-system of the larger hospital and houses a variety of workers and clients. Nurses want adequate working conditions, rewards and benefits typical of most other workers in our society. The interactions between the mix of workers are complex relationships influenced by the structure and the expectations of each other. The nurses are torn between professional allegiance and allegiance to the organization as they continually change and reposition themselves in the organization. The degree to which most hospitals have become individual specialty units, triggered by the increase in complex technology and the specialized nursing care that is required, has influenced the structure of the organization in terms of the need for increased communication and integration. An omission in the literature are studies that explore the affect of this structure and what kind of integration and communication might be required at the unit level or in the hospital to achieve patient care and hospital goals. This study
provides an approach to integration at the unit level by exploring and describing nurses’ beliefs and actual practice in the hospital context.

Beyond Hospital and Unit: External Influences on Nursing Practice

Many forces external to the hospital influence its work and the work of nurses. Theorists such as Thompson (1967), Lawrence and Lorsch (1969), Daft and Steers (1986), Pflaum and Delmont (1987), and Bryson (1988) provide relevant statements about the external environment. Nursing professional organizations, various nursing task forces, physician associations, preservice educational institutions and the legal system attempt to influence nursing practice.

External Environment. In recent years, hospitals have been strongly influenced by legal and financial aspects of the external environment. Previously the hospital’s environment could be described as relatively static, resource dependent and mildly complex based on the number and variety of external elements important to its survival. Today, hospitals are faced with rapid and unpredictable changes in government and insurance company reimbursement policies, swings in specific labor force availability, and in technological changes important to the care of large numbers of patients. This is evident in the care of patients with heart disease, kidney disease, and cancer.

Daft and Steers (1986) defined the environment as including all elements outside the boundary of the organization such as competitors in the same industry, government, suppliers, community, natural resources, culture, technology, demography, labor force, customers and economic
conditions. Pflaum and Delmont (1987) advocated monitoring forces and
trends in four broad categories in the external environment: political,
economic, social and technological-designated as PEST's.

Thompson (1967) stated the organization's board is the link to the
external environment and plays a significant role in maintaining the
organization's viability. Lawrence and Lorsch (1969), considered
pioneers in organization-environment interface, recommended boundary
spanning units to assist in matching the organization with its relative
environment. The functions of these units was to check on opportunities
and changes in the environment which might alter the organization's
position on two continuum: certainty vs uncertainty and stability vs
change. Based on this assessment, the organization responds by accepting
various unit differences within the organization, new or different units
or realignment of units to cope with changes in the business. Bryson
(1988) discussed this as a function of strategic planning. "Strategic
planning focuses on achievement of the best "fit" between the
organization and its environment" (Bryson, 1988, p.56).

In summary, the hospital's environment has made its influence
keenly felt. Hospitals now employ lawyers to manage "risk control";
marketing departments survey the latest demographics and the
competition; enlarged public relations departments script the next TV
ad; discharge planners are working closely with the financial
department; and, nurses are being pressured to join nationally
affiliated unions, not previously active in the health care arena.
Hospital administration is faced with a dynamic, complex environment.
Professional Organizations and Educational Influences. The American Nurses Association (ANA) and the National Commission on Nursing (NCN) are two examples of influential external forces. ANA developed standards for the practice of nursing based on the "nursing process": assessing, planning, implementing and evaluating nursing care. This process emphasized the way nursing care should be performed and written standards for all clinical specialties are available. These clinical standards of care are considered appropriate and indicate what society can expect from professional nurses (ANA, 1973).

In 1980, ANA published Nursing: A Social Policy Statement delineating the social context of nursing, the nature and scope of nursing practice and the importance of nursing specialization as a mark of advancement for the profession. The latest Code for Nurses With Interpretive Statements was published by ANA in 1976. The Code provides guidance for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the profession and quality in nursing care. These documents influence members and non-members.

A project of The National Commission on Nursing (NCN) is aimed to support efforts to implement:

...differentiated nursing practice or practice which recognizes the different levels of education, skills and experience of professional nurses; nurse-managed delivery systems; nursing information systems to track quality and cost of care; a process to move the nursing education system toward preparing two categories of nurse, the professional and the technical; ways to foster public understanding of nursing’s contribution to health care research; and, ways to translate project goals to other groups (Nursing’s Vital Signs, 1989, p.13).
As the NCN implementation project activities indicate, the nursing education system is a key concern. Nurse educators have been struggling with this issue. In 1986, the American Association of Colleges of Nursing (AACN) published *Essentials of College and University Education for Nursing A Working Document: February 1986*. This document clearly stated characteristics of the professional nurse in terms of a liberal education; a professional with essential values, attitudes, and personal qualities; and, the essential professional education and skilled practice requirements. It states the major roles of the nurse; a direct provider of care, a planner/coordinator of care, and a member of a profession. The professional socialization process is highlighted. The document also specifies specific nursing intervention and clinical skills to be learned by the professional nurse.

In addition to the professional organizations, studies have explored the relationship between educational background and nurses' clinical expertise. Bottoms (1988) researched the relationship between the intended competency outcomes of liberal education as demonstrated in registered nurse behavior and the type of nursing education program completed by the nurse. She surveyed 565 nurses from all educational programs and found a baccalaureate education increased the nurses' contribution to the profession and society. This was demonstrated in the behavior associated with values. This meant they were aware of personal values, value commitments, and realized other persons and other cultures hold contrasting values that must be understood and respected in interaction with them.
Sweeney et al. (1980, 1982) developed a nursing curriculum evaluation model to assure the student nurse becomes the desired graduate nurse. It reported the essential skills needed by baccalaureate graduates from the perspectives of nurse educators, nurse administrators, employees and new graduates. Diverse opinions were identified concerning the importance of psychomotor skills and the larger number of skills deemed essential for practice. Nurse administrators expected the new graduate to enter the hospital with an expansive repertoire of skills and advanced complex skills. Nurse faculty and new nurses did not expect this level of skill development. New graduates indicated disappointment regarding their nursing education programs and student clinical experiences in skill development. This study highlighted the need for nursing educators and nursing service administrators to dialogue and arrive at compatible solutions.

The last report to be presented is an extensive project sponsored by the Midwest Alliance in Nursing. The project’s goals were to achieve consensus between nursing service and nursing education on:

1) competency-based curricula preparing ADN and BSN graduates for entry into nursing practice;
2) competency-based job descriptions for ADN and BSN graduates in the service setting; and
3) competency-based orientation packages to provide for a smooth transition of new ADN (Associate Degree in Nursing) and BSN (Bachelor of Science in Nursing) program graduates to the service setting, and to establish lasting relationships between nursing service and nursing education (Primm, 1987, p.218).

In summary, these reports and studies could dramatically influence the position of nursing in the hospital and the role of the nurse. The gap between education and service is being addressed realizing the
contributions each can make to the nursing profession.

**Nursing Practice.** Nursing practice has been studied extensively and described in a variety of ways: by categorized activities, by physical skills required, by identified "hidden work", by "quality" nursing care characteristics, and by the philosophical and cultural foundations of nursing care.

Yocum (1987) studied the practice patterns of over 4500 newly licensed registered nurse. Subjects responded to questions about nursing activities and client needs. The activity statements were worded in terms of what the nurse does rather than how, how well or why the nurse performs the activity. The study described the practice domain of the nurse based on clinical practice area and the education program attended. Nurses in medical/surgical clinical units scored high in performing routine nursing measures, monitoring clients at risk, preparing clients for procedures, and controlling pain. They scored low in meeting acute emotional/behavioral needs; staff development, management and collaboration; and, quality assurance and safety. They were very low in categories that were specific to a setting such as parenting skills associated with teaching new mothers and fathers how to care for their new infant or the administration and teaching about immunizations to parents of pediatric patients. The middle group of categories for the med/surg nurses was protecting client, planning/managing client care, helping clients to cope with stress, assisting clients with needs related to mobility, assisting clients with self-care, meeting acute physical needs, supporting client’s family, and
ensuing safety during intrusive procedures. The study found work setting (i.e. obstetrical, pediatrics or rehabilitation units) and types of clients (whether young or old) greatly influenced the frequency of the activities.

A time/task study was conducted by The Hay Group about nurses working on med-surg units. Over 850 hospitals were surveyed. They found that 26% of RN's time on average is spent in "professional nursing": physical assessments, care and treatments, monitoring patients' conditions, planning and documenting care. In a typical shift, 22% of the time is spent with support functions: patient education, family contacts, nursing communications and coordination. The largest amount of time, 52% is spent in housekeeping details, answering phones and ordering supplies ("Misuse of RNs...", 1989). The investigators reported the reason these nurses stayed or left an institution was not based on compensation but on reasons directly and indirectly related to the environment, the job, and the perceived opportunity for personal and professional growth.

Nursing practice has been described using words as "knowing", "caring", "intuitive", the "essence of nursing" or "hidden work" in contrast the activities/task approach presented above. Styles (1990) described good nursing care from the patient's perspective and suggested clients should know who is in charge of their personal care and what the plan of care will be. The nurse should be knowledgeable and technically competent, and able to distinguish between what is nice and what is necessary for the client's care. The nurse should not only care about the assigned patients but care for them. The nurse should be organized
and attend to priorities, serve as patient advocate and allow the patient as much control as possible. The nurse should work with doctors and others to ensure the treatment progresses as planned and to minimize complications. The nurse prepares the patient for discharge and recovery.

Wolf (1989) pointed out much of nursing work is hidden and this decreases societal status and perceived value. She conducted a nine month study of a medical unit in a large urban hospital (1988). She investigated four "nursing rituals": postmortem care, medication administration, medical aseptic practices and change of shift report. Wolf observed nurses pass on their subcultural knowledge about nursing and patient care chiefly by word of mouth and by demonstration. Nursing in her opinion has both sacred and profane components. Wolf described nursing in terms of unseen work and dirty work. The unseen tasks are: common sense and caring work; system maintenance and safety work; interpersonal work; comforting work; privacy work (i.e. collection of private information and personal hygienic needs); sacred work (i.e. moral and ethical problems); and, cognitive work. The dirty work is body work and death work. She believed nursing work should be made visible and not taken-for-granted. Strauss et al. (1985) described the social organization of medicine in similar terms: machine work, safety work, comfort work, sentimental work, articulation work, and the work of patients.

The candid and challenging work of Reverby (1987) contributed to this review. In her book, Ordered to Care, she depicted nursing as a form of labor shaped by the obligation to care in a society that does
not value or know how to evaluate caring. This obligation has resulted in it being described as "women's work", a "duty" encumbered with societal and ideological constraints and difficulties. She views nurses, historically, as individuals from different classes, with heterogeneous experiences and beliefs. This creates a unity and a language problem as efforts are made to mobilize the group toward professional goals. Caring is not only a subjective construct but is work. Reverby challenges nursing via political endeavors, educational and practice clarification, and technological advancement to create the conditions under which caring is valued.

The work of Noddings (1984), Gilligan (1982) and Belenky et al. (1986) can assist nurses in understanding the complexity of work relationships and the task nurses, the majority being females, face. In addition, this literature sheds a positive perspective on the capabilities and strengths of women which would be helpful for nurses to understand as they struggle for identity and a stronger image. Noddings explored caring from an ethical, aesthetical and psychological perspective. She suggested one meaning of caring as the charge "to protect, maintain or be concerned about the welfare of something or someone" (1984, p.9). Gilligan (1982) suggested that women are raised and socialized with an ethic of care, of thinking in terms of the concrete other. Belenky et al. (1986) described five ways women view reality and define truth, knowledge and authority. Women "know" by using intuition, personal meanings and self-understanding. They connect with ideas and seek understanding rather than control over ideas or proof that something is so.
In summary, the practice of nursing in the hospital is influenced by the many changes occurring in health care economics and in professional and educational arenas. These influences have more impact because of the increasing need for more skilled nurses and the plea to change working conditions. As nurses find creative ways to evaluate their worth and communicate this to decision-makers, the status and image of nursing should improve. As this literature demonstrates, nursing in the past emphasized the tangible, active aspects of nursing care. Some of the more recent work, explored the hidden and the "female" strengths of nurse work. There has not been much integrative research which could illustrate the important role nurses play and the way they could influence the hospital. The current study, by focusing on nurses' beliefs within a context, can help to identify other possible studies that would demonstrate the strengths nurses have from the perspective not only of task completion but of many ways of "knowing" about the care of patients.

The Staff Nurse

This section highlights the current research on the role of the staff nurse and her/his clinical practice and satisfaction and dissatisfaction. Benner (1984) has made an important contribution to the understanding of nursing practice. Information from over 1,200 nurses was gathered via interviews, questionnaires, and selected participant observations. Later five levels of competency in clinical nursing practice were identified; novice, advanced beginner, competent, proficient and expert. By examining critical incidents explained by
expert practitioners working in acute care settings, 31 competencies were classified into seven domains of nursing practice: the helping role of the nurse, the teaching-coaching function of the nurse, the diagnostic and patient monitoring function of the nurse, effective management of rapidly changing situations, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices, and organizational and work-role competencies. Benner's work is important to nurse educators and nurse administrators as it provided a practice-based model focusing on what nurses are actually doing.

McCloskey (1982) analyzed questionnaire data from 299 staff nurses to describe the effective nurse. This was similar to Benner's "expert clinician". McCloskey used educational preparation as the dependent variable and the clinical evaluation data were the opinion of others in the hospital. Thirty six variables indicative of nurses' formal education, continuing education, and job responsibilities were analyzed for their effects on job performance. Eighteen variables correlated significantly with job performance. In the findings McCloskey described the effective nurse as:

performed all skills well and in particular had strong professional development skills and critical care skills. Her teaching and collaboration skills were better than other nurses but not as good as her other skills. She was likely to have graduated from an accredited program and to have been an associate degree or diploma nurse who returned to college. She subscribed to nursing journals and attended continuing education programs (McCloskey, 1982, p.57).
Nurses claim they have an independent role different from the dependent role associated with the carrying out of physicians' orders. Bradley (1982) investigated nursing attitudes toward specific nursing behaviors, assuming attitudes guide behavior and identified independent functions. She identified five dimensions characteristic of nursing behaviors from the literature: the utilization of a unique body of knowledge and skills; the utilization of the nursing process; research ability; leadership ability; and, teaching, prevention and maintenance. The utilization of a unique body of knowledge and skills accounted for 29% of the total variance when the data were analyzed. The nursing behaviors describing this dimension were: care plans designed with patient, family and health team, appropriate utilization of community resources that provide individual health care, use of the problem-solving approach in nursing practice, demonstration of basic communication skills, evaluation of individual's reaction to therapy, and teaching health measures and providing health counseling to individual families and other groups in the community. Bradley identified these behaviors as representing the independent functions of the nurse because they are actions performed independently and require accountability.

Three studies conducted by Weiss (1982), Prescott et al. (1987) and Katzman (1989) examined aspects of the nurse's role as it related to the physician's role. Weiss's study included 72 nurses, physicians and consumers. Through the use of the Nominal Group Process, aspects of health care where collaboration seemed to be most needed were identified. The groups reached consensus on 13 areas and dialogued about
those in structured monthly group meetings over a 20 month period. The final product was a Collaborative Behavior Inventory made up of 1,497 items and 13 scales, each scale representing one of the original 13 areas. One scale was physician/nurse role differentiation with 22 professional responsibilities. There was not one professional responsibility identified as more appropriate to the nurse’s role than to the physician’s. Seven areas demonstrated more inclination for the physician’s role: pronouncing people dead, diagnosing a broad range of illness including rare disease, informing the consumer of the diagnosis and prognosis, telling the consumer their opinion of the preferred course of action, admitting and discharging consumers to and from the hospital, writing orders to guide the consumer’s plan of care and determining an appropriate plan of care for the consumer. Based on this list it is not surprising consumers are confused and nurses feel underutilized.

Prescott et al. (1987) reported on nurses’ satisfaction with clinical decision making as an indication of professional autonomy from nurse and physician interviews. Seventy three percent of the nurses were satisfied with their role in making clinical decisions described as having input into the decision making process, having physicians listen to their input and consider their suggestions, and the belief they have a certain amount of decision-making freedom. Twenty two percent were dissatisfied. The decisions were discussed based on "want" and "have" in relationship to nurses’ authority in making them and there was a wide discrepancy between nurses. Organizational factors such as type of unit and size of unit were considered and the education, experience and
interpersonal style of the nurse. Even though nurses were generally satisfied, physicians were resistant to greater discretionary freedom for nurses in making decisions. Trust, control and the lack of understanding about the role each plays in decision-making appeared to be the primary issues.

Katzman (1989) found in a similar study of nurses' and physicians' perceptions of nurses' decision-making authority that conflicting perceptions were placing patients and the health care system at risk. The study had 25 descriptive items. The nurses saw themselves less as assistants to the physicians than did the physicians. The nurses also perceived they have more authority to initiate physical assessments, answer questions about patients' medical regimens, change patients' inappropriate diets and deciding the frequency of taking patients' vital signs than the physicians thought they did. The two groups disagreed over nurses having more authority in health policy making, patient care decision making, and deciding standards of nursing care. This study identified areas requiring collaboration between physicians and nurses.

Nurses' work has mainly been studied by looking at what tasks nurses perform or are allowed to perform. Studies related to what the nurse is really like are sparse. Since creative nursing behaviors are an expectation of the nurse as identified in the ANA Social Policy Statement (ANA, 1980), one study of interest was "Self-Perceived Creativity of Practicing Registered Nurses" (Pesut, 1988). A study population of 32 registered nurses, 43% practicing in the medical-surgical area, responded to the What Kind of Person Are You (WKOPAY) test from the Khatena-Torrance Creative Perception Inventory. Five
factors were used to judge a person's disposition to function in creative ways: acceptance of authority, self-confidence, inquisitiveness, awareness of others and disciplined imagination. This sample of nurses perceived themselves as slightly more creative than the male or female norms established. However, in looking at the five factors individually, the nurses were less accepting of authority, less-confident and less inquisitive than the norms for male and female adults. The nurses scored higher on the awareness of others and there was no significant difference with the factor of disciplined imagination. When compared with the female norms, the nurse group was only different on the factor of disciplined imagination and the nurses scored significantly higher than their female counterpart.

The nurse as a patient advocate is frequently mentioned in the literature. Because of role conflicts, advocacy is difficult to define or evaluate without the exact context described. In 1982, Kohnke wrote a comprehensive book on Advocacy, Risk and Reality which is suggested for further investigation. This is an important and controversial topic in most settings.

The studies on the socialization of nurses dealt primarily with student nurses and not with the experienced graduate nurse. Kramer (1977) is considered by Conway (1983) to present the only consistent conceptual view of nurse socialization to guide research. Kramer (1977) defined and operationalized nurse socialization process as a conditioning to the harsh realities of the world of work. Nurses must adjust to reality shock and become "biculural", meaning achieve competence in the new work subculture while retaining values from the
school subculture. Her approach emphasized value clarification, self awareness and conflict resolution techniques. Kramer and Hafner (1989) explored the impact of shared values on staff nurse job satisfaction and perceived productivity. Over 500 nurses in 24 hospitals were surveyed and job satisfaction was not found to be congruent with shared values.

Feldman (1976) studied the hospital employee socialization process which he defined as four stages: anticipatory socialization, accommodation, role management, and outcomes. He found nurses' and engineers' job satisfaction was high and their jobs were suited to their skills and abilities in comparison to the radiology technologists, accounting clerks and nursing technicians. However, nurses had a great deal of difficulty in defining their jobs and consequently experienced role conflict in comparison to the engineers. In this study, the nurses scored higher on a three-question measure of conflicting demands and were less successful in resolving conflicting demands. Medical and administrative duties at work and scheduling problems and patient' problems effect them at home, causing conflicts. This part of his data would be similar to Kramer's findings.

**Nurse Job Satisfaction.** Substantive studies with graduate nurses have focused on job satisfaction as indicated by turnover, retention, role expectations, and stress in the work place. These concerns were identified in 1949 when the Division of Nursing Resources was formed and continue to plague the delivery of health care and especially of nursing care (Hinshaw, 1983).
Price and Mueller (1981), Wiseman, Alexander, and Chase (1981), and Mueller and McCloskey (1990) developed comprehensive evaluation models which include environmental, organizational, and individual characteristics. In the Wiseman et al. study, personal attributes and job-related attributes were correlated with autonomy, job satisfaction, intent to leave and turnover. The findings indicated neither job satisfaction nor autonomy had a significant direct effect on turnover but did predict a variable in the causal chain, intent to leave. Autonomy was the strongest predictor of job satisfaction with the head nurse scale the strongest predictor of autonomy.

In the Price and Mueller study eight factors influenced job satisfaction: opportunity, routinization, participation, instrumental communication, pay, promotional opportunity, general training and kinship responsibility. When the data was analyzed at the individual level, five were significant predictors of turnover: intent to stay, opportunity, general training, job satisfaction, and kinship responsibility. If intent to stay/commitment, job satisfaction and kinship responsibility increased, turnover decreased. Price and Mueller also found availability of other positions in the community to increase job turnover. Availability of other positions was also found to be a deciding factor for nurse turnover in Prestholdt’s et al. (1988) study of over 100 registered nurses.

Prestholdt et al. (1988) identified four categories of beliefs that influenced nurse turnover: nursing practice beliefs, alternative options, work environment, and economics or physical and emotional costs. The most important was nursing practice characteristics where
nurses desired challenging and interesting jobs, a sense of worth and a feeling of accomplishment. They wanted to work with patients they prefer and have a variety of patient care experiences.

Taunton (1989) studied 71 hospital professionals, including nurses, and found their perceptions of the unit manager's sound management and power to control their work, and a participative leadership style influenced turnover.

Three studies view job satisfaction from the perspective of nurse expectations and actual work. Oechsle and Landry (1987) examined 25 job-related characteristics in which pre-employment expectations of nurses were either congruent on incongruent with their perception of the actual work experience. Twenty seven percent or more of the respondents indicated that there were three groups of items in which their expectations were not met: orientation; direction, support and feedback from the supervisor; and, possibilities for advancement. The researchers felt these areas could cause dissonance between the nurse and the environment leading to job dissatisfaction and turnover.

Larson et al. (1984) looked at 35 quality of work life factors from a survey of 60 nurses from 17 clinical units completed after the first 6 months of employment. The most striking result was all 35 satisfaction variables were significantly predicted by respondents' job expectations and the importance they placed on working conditions. High satisfaction scores were given to: chance to learn new things, variety of clinical cases, and all-RN staff, assistance and support of co-workers, independent/expanded function of the nurse and accessibility/availability of resource people. Low satisfaction scores were salary,
weekend coverage, interaction with other departments, promotional opportunities, unit orientation, and adequacy of staff.

Roedel and Nystrom (1988) looked at nursing jobs and satisfaction by defining job satisfaction in terms of pay, promotional opportunities, supervision and co-workers, and comparing this to job complexity and enrichment defined as skill variety, task identity, task significance, autonomy, and feedback from the job itself. Their results showed that enriched jobs are more satisfying to this population of 135 female nurses.

Simpson (1985) reported on a job satisfaction/dissatisfaction study of approximately 500 nurses from five acute care hospitals. She measured nurses' satisfaction with 20 work environment variables. The results showed nurses at all levels were dissatisfied with their work and work environment.

Nurse researchers have been interested in stress as it relates to nurses' performance and job satisfaction (Jacobson and McGrath, 1983, Allanach, 1988). However, it has been difficult to determine if stress is nonspecific, positive or negative in value (Hinshaw, 1983). In a rather complex study, Packard and Motowidlo (1987) explored subjective stress, job satisfaction and job performance in a population of 366 nurses. Each nurse completed a self-report questionnaire and in addition 165 supervisors and 139 co-workers nominated by the nurses responded to a different questionnaire on job performance. The nurses' self-report questionnaire measured demographic variables, clinical assignments, type A behavior pattern, fear of negative evaluation, frequency and intensity of stressful events, subjective stress, anxiety, hostility, depression,
and job satisfaction. The other questionnaire measured job performance. Job satisfaction correlated with frequency of stressful events, intensity of stressful events, subjective stress, anxiety, hostility and depression. Depression has a strong effect on satisfaction and hostility has a weaker direct effect. Fear of negative evaluation has an opposite effect on job satisfaction meaning that high fear of a negative evaluation related to higher levels of job satisfaction, and also reported higher levels of stress. Low job satisfaction appears to be a consequence of depression which is a consequence of stress.

In summarizing job satisfaction studies, it is apparent job satisfaction is very complex and has many personal and contextual variables. It becomes critical for nursing administrators to consider the nurse population they are employing and ascertain their unique characteristics when creating or maintaining a positive work environment. The current study attempts to understand nurses by allowing their opinions of their job to emerge without any prior definitions of what satisfaction is or is not to them. This approach is different from the studies reviewed and offers another way to discover similar information.

The general tone of findings of staff nurse research is not a surprise. However, each study tended to examine slightly different variables, making comparisons difficult. The "average" nurse wants to work in an environment that recognizes her skills and rewards her for them. She desires flexibility in the work schedule and variety in the patient care work assignment. Of interest is the lack of reference to work overload in the literature reviewed. The nurse desires an
environment that is supportive, congenial, and well managed. She is satisfied with her job if it is characterized by independent decision-making and autonomy.

Comments about the Literature and Integration

It is evident in the preceding review that many investigations focused on hospital and unit organization, nurses' beliefs and nursing practice. Studies examining the relationships among the three areas were not found. Prior research is fragmented and isolated. The same variables are operationalized differently in each study. Clear connections between nursing research, policy and practice are not generally discussed. Under these circumstances, it would appear unlikely significant results would be applied at the policy and decision making levels of the hospital, or the work place of the nurse or in nursing education programs. There is a lack of integrative research between the work of the nurse and the work of the hospital.

There have been a few notable contributions which the nursing community might benefit from reexamining and applying. Ashley's (1977) Hospitals, Paternalism, and the Role of the Nurse, was one of the first efforts to study the relationships among forces impacting on the life and work of the nurse. However, many of the problems she identified remain: the economic versus humanistic interests of hospital management, the subordinate role of the nurse as an exchangeable commodity, and the relative lack of political import and legal influence of the nursing community.
Roberts (1983) furthered the understanding of nurses' position in health care by explaining nurses' behavior in terms of oppressed group behavior; destructive behaviors nurses have been socialized into accepting as appropriate. Nurses have internalized the values of physicians and think status and power are the ways to accomplish nursing goals. Roberts (1983) stated that nurses fear success and have developed a submissive-aggressive syndrome. As a result, nurses lack autonomy, accountability and control over the nursing profession and think of themselves as second class citizens.

Strauss et al. (1985) continuing the work of Becker et al. (1961) have taken a fresh look at the social organization of medical work. The focus of their book was:

...the primacy of work for shaping the divisions of labor which form around it, as well as the experiences and careers of the people who do the work, and for influencing the very structure of the organizations in which work takes place (p.ix).

Strauss et al. discussed illness as a trajectory which encompasses the patient's course of illness and the total organization of work done over that course, and the impact on those involved with the work and its organization. This is integrative research and potentially helpful in dealing with the current complexities of the health care system.

Moos and Schaeffer (1987) developed a wholistic conceptual framework focused on the clinical unit. It emphasizes the individual and small group levels of analysis rather than organizational level. It is a systems perspective which identifies six interactive "panels": the environmental system panel composed of physical and architectural...
features, organizational structure and policy, suprapersonal factors and social climate; the personal system panel composed of type of job and work role, and demographic and personal factors; the cognitive appraisal panel; the coping response panel; the work morale and performance panel; and, the quality of care and treatment outcome panel.

Hart and Moore (1989) and Newman (1990) have published innovative and encouraging nursing articles reflective of an integrative approach. Newman proposed an integrative model of professional practice: a trilevel model of practice which delineates specialized nursing roles based on the nurses' educational preparation, establishes the possibility for collegial relationships with physicians and a potentially cost-effective alternative for hospital management. In the practice area, she proposed individualized care integrated with the team approach, transformation of technology into person-centered transformative caring and a collaborative relationship with clients and other health professionals. She did not elaborate on the meaning of the transformation of technology. Hart and Moore studied organizational climate and nurse stability in critical care units. Organizational climate was operationalized as communication, staff utilization, interdisciplinary politics, and reward and support services. The researchers developed their own Organizational Climate Audit tool (OCA). These descriptors are unique in the nursing literature and demonstrate the inclination to think of the organization as a "culture". The results of the study were extensive and demonstrated that nurse stability and climate should be studied at the unit level rather than at the organizational level of analysis.
CHAPTER III
METHODS

Research Design

The purpose of this field study was to describe the relationships among staff nurses' beliefs, nursing practice and hospital ethos. These three were selected because of the important role nurses enact in the hospital and the health care system, the similarity and close interactions that occur among the three and because each has been studied as an individual phenomenon more frequently then as they affect and are affected by each other. This study, although complex, was designed to provide a more realistic understanding of nurse work in the hospital. The data that emerged are illustrative of the richness of nursing practice and descriptive of the bedrock norms and expectations of the nurses in the study and on this hospital unit.

The study design incorporated Spradley's (1980) definition of ethnographic fieldwork.

Ethnography is the work of describing a culture. The central aim of ethnography is to understand another way of life from the native point of view. The goal of ethnography as Malinowski put it, is "to grasp the native's point of view, his relation to life, to realize his vision of his world.".....ethnography means learning from people. (Spradley, 1980, p.3)

In addition, naturalistic inquiry assumptions guided the researcher. This meant realities are multiple, constructed and holistic,
knower and known are interactive and inseparable, only time and context-bound working hypotheses (idiographic statements) are possible, all entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects and inquiry is value-bound (Lincoln and Guba, 1985).

The study examined staff nurses working on a hospital unit, their natural setting. The unit of analysis was the staff nurse, working on the day shift. The day shift was selected because the largest number of staff nurses work on day shift and interactions between the nurses might provide some understanding of group norms and expectations. The day shift typically had more nursing and patient activities: admission and discharges, patients leaving the unit for examinations or for surgery, and more treatments and medications administered by the nurse.

Site Selection

Preliminary Background. The study site was a 38-bed in-patient unit of an acute care hospital with over 1000 in-patient beds and numerous outpatient clinics. The hospital serves as the teaching hospital to support the educational programs of the health center. The patient population comes from a wide geographical base of state and surrounding states. This hospital was chosen because of its prominent place in area health services, its availability to the researcher and the willingness to participate by the Administrator of Nursing. A general medical-surgical in-patient unit was chosen by the Administrator of Nursing and the Nursing Director of Medical-Surgical Nursing based on the researcher’s criteria discussed below. The process of initial entry
with the nursing administrative staff is included in the discussion. The table of organization for Nursing Service is found in appendix A, Figure 6.

Initial System Entry and Unit Selection. A meeting was held with the Nursing Administrator, the Clinical Nursing Director and the researcher to discuss the intent of the study, unit criteria and the study time. The researcher asked that the unit be staffed predominately with hospital employed staff nurses rather than with nurses hired for a shift from outside agencies. This was important because ethos, as defined, required group identity and a reasonable degree of membership stability. The researcher asked that the unit selected have a stable staff and that the unit not be known as either "good" or "bad", but an average unit with a tenured nurse manager who would not be adversely affected by the presence of a researcher on the unit. The nurse manager, although not a direct part of the study was a critical actor on the unit. Her support and cooperation were obtained by being available at her request, sharing the details of the process and allowing her to have input into that process to suit her leadership style.

A general medical-surgical unit was requested rather than a specialty unit like pediatrics or intensive care, because specialty units have more variables unique to the hospital (i.e. different emergency capabilities, burn units, helicopters, mobile emergency vehicles, equipment, unit size, procedures) and staff tend to self-select into specialty units (i.e. nurses either "really like" the environment of critical care or they don't). The medical-surgical unit
does not have the variety or quantity of equipment as intensive care units. Nurses' tasks on the general medical-surgical unit are not as equipment focused and tend to be similar among nurses, units and hospitals. Nurses frequently begin their nursing careers on a general unit to master what are considered basic nursing skills (sterile procedures, treatments, medication administration) and to learn how to organize and prioritize the care of a group of patients in contrast to the low patient/nurse ratio required in intensive care areas. Nurse researchers have tended to study the more dramatic aspects of the profession like intensive care nursing but the "hard work" of caring for an aging, complicated medical or surgical patient has not been studied as extensively. General units tend to have a patient population similar to patient populations in other hospitals and in community health nursing. From that perspective, future studies may be possible to compare the similarities and differences to the findings of this study.

The unit selected was a unanimous decision made independently by the Administrator of Nursing Services and the Director of Medical-Surgical Nursing. It did meet the criteria described above. The Nursing Director approached the Unit Nurse Manager about her willingness to have the unit be the study site. She was most agreeable and met with the researcher in her office on the unit prior to the beginning of the study to plan for the days the researcher would collect data. This was based on the availability of staff, the established work schedule, the customary days for staff meetings and the need to complete the phases of the study in a short sequence to avoid staff discussions that might
influence nurses’ responses. The number of nurses scheduled on a particular day was important to safeguard patient care.

**Site of Interviews.** The researcher was provided a separate office on the nursing unit for conducting the structured interviews of the staff nurses. They did not have to leave the unit during this time and the staff nurse that would "cover" for her (i.e. watch her patients) while she was with the researcher knew where she could be located in case it became necessary for patient care. All staff nurses carry "beepers" or individual pagers which are activated by the phone system. This office was made available, exclusively to the researcher during the study. This allowed the researcher to maintain consistent hours for the participant observation and stay near the study site. It was a familiar environment for the staff nurses, yet private.

**Participant Observation Site.** The unit is diagrammed in appendix A, Figure 7. It is a 38-bed general medical-surgical unit. The unit has "Nurse Servers" outside each patient room. The Nurse Server is a built-in cupboard with two distinct compartments, each with doors that can be locked and are accessible from the hall and the patient room. The Nurse Server contains the nurses' record of patient care, supplies, linens, medications, dietary trays and trash. The lay-out of the unit becomes critical when considering patient assignments, proximity to portable oxygen, the medication room, the sterile supply room, dietary kitchen, the nurses station, the emergency cart and other activity areas.
The patient care delivery system on the unit was called primary nursing and is defined in Chapter I. The unit has a "primary nurse board" across from the unit's main desk area. The board has patients' names, room numbers, and the primary and associate nurses' names written on it.

Subject Selection

The sixteen staff nurses assigned to the 7:00 A.M. to 3:30 P.M. Monday through Friday and 7:00 A.M. to 7:00 P.M. Saturday and Sunday shifts, during the weeks of the study, were asked to participate. The unit's staffing budget was for approximately 22 staff nurses. Four of the 22 are permanent positions assigned to the evening and night shift. The staff are hired for Monday through Friday with an occasional weekend, or weekends only. There were ten Monday-Friday staff nurses and four weekend staff nurses that were a part of all the data collection methods representing 88% of the day staff and 64% of the entire nursing staff. Two of the staff nurses were each observed twice in the final week of the participant observation phase of data collection because these nurses on their first participant observation day expressed concern that the day had been unusual. One had a very "slow day" and the other had meetings off the unit and an emergency on the initial day. The total number of participant observation days was 16, from 14 staff nurses. One staff nurse completed the questionnaires and the structured interview but left the unit for another hospital position prior to the participant observation phase. Her interview and questionnaire data were included. There were 15 responses each to the questionnaires and
interview data. The staff on vacation or on the evening or night shifts at the beginning of the study were not a part of the study. This included two staff nurses that came to days the second and third weeks of the participant observation phase. In addition to the staff nurses, the unit had two licensed practical nurses, one hospital aide, a unit secretary and occasionally a student nurse on the day shift.

The staff nurses in the study were asked to complete a demographic information sheet including age, sex, years as a registered nurse, years working on this unit, years employed as a registered nurse by this hospital, and their educational background including credentials attained (Appendix A, Table 3). This information was considered important because of the impact that these variables may have on the responses to various questions. All the subjects were female with an average age of 32 years. The average number of years on the unit was 4 years and 3 months and the average number of years as a registered nurse was 8 years and 8 months. The nurses reflected a variety of educational backgrounds. Eight staff nurses had earned a bachelor of science degree in nursing (BSN) in generic educational programs and one had received a master degree following the BSN. Two nurses were in the process of acquiring masters degrees; one following a BSN and the other after receiving a diploma (a three year program usually hospital sponsored) and then a BSN. Two nurses had received associate degrees in nursing (AD, a two year program), one a bachelor of arts degree (BA) following a diploma in nursing degree, and one nurse graduated from a diploma program. All three nursing programs, Associate Degree (2 year), Diploma (3 years), or Bachelor of Science in Nursing (4 years), prepare
individuals to take a state licensing examination. If the person passes the examination, she/he is qualified to be called a registered nurse, RN, and to use that title.

Data Collection Strategy

Following approval by the appropriate bodies within the institution and meetings with the various nursing administrators, the study took approximately six weeks. A multiphase data collection strategy was used to collect the data via questionnaires, structured interviews, participant observations and written materials. The written materials included the unit communication book (i.e. a book that all unit nursing personnel write in to communicate unit changes, personal items like weddings, and positive comments from patients or physicians), budget figures, quality of care evaluations, and job descriptions. By using many methods to collect the data, the triangulation of findings was possible. The five data collection phases are discussed following discussion of the researcher's role and study introduction to the unit staff.

Researcher Role. The researcher tried to explore staff nurses' beliefs, nursing practice and unit ethos through the eyes of the staff nurse and from her perspective. To assist with this identity and to quickly become a part of the group, the researcher wore uniforms from the beginning of the study until the fifth phase when written material was collected. The hours of the study conformed with the staff nurses' work hours. The researcher's attitude throughout was one of "learner"
and her facial and body movements and tone of voice attempted to reflect a non-judgmental attitude. The attempt was made to blend in with the environment. At one point in the study, the researcher was known as "my shadow" by the staff nurses. "Shadowing" is common in nursing and is a technique used with new employees and with student nurses. Some of the "off-unit" hospital personnel would ask if the researcher was a new orientee. The act of following a person around is not uncommon in this setting and does allow for unobtrusive observation and recording of behavior. In addition, the structured one-to-one interviews conducted early in the study seemed to facilitate a comfortable relationship between the nurses in the study and the researcher. The researcher purposely did not share a great deal of personal background to avoid being placed in a consultant role. The hospital policies and procedures were unique and it was appropriate to step back and not plunge forward into action. This is very accepted and expected behavior on hospital units. The notion of "finding out" or "getting someone to help that knows " is common. The only involvement with patient care by the researcher was during two emergency situations.

**Introduction of the study to the staff.** The staff nurses on duty were invited by the head nurse to the nurse conference room on the unit the morning of each interview day. There were four interview days scheduled by the nurse manager. Each day the researcher gave the same presentation to the staff nurses on duty concerning the intent of the study and what they would be asked to do and what the researcher would be doing. These introductory meetings were held at 7:00 A.M. and lasted
less than ten minutes. The nurse manager selected this time based on nurse routines and when she usually had such meetings. Having heard the presentation, the staff nurses were then asked to volunteer to be a part of the study. The voluntary aspect of their participation was stressed. The participants were assured that results would be reported without referring to any participant by name.

The nurse manager did introduce the researcher at the first two presentations and the researcher introduced herself at the third and fourth presentations. The nurse manager only stayed in the room for the first presentation following the introduction. The licensed practical nurses and the hospital aide on the day shift were present at the first presentation. Their knowledge and understanding of the study and the researcher's planned activities was important to minimize their behaving differently with the staff nurses due to the study.

If the staff nurse agreed to be a part of the study, she was given a packet containing the consent form (Appendix B) and questionnaires (Appendix C). Each form was labeled with her code number and the nurses identified themselves throughout the study by code number only. In this way the participants' identity was protected and the data could be analyzed by individual or group. A time for her interview was written on the outside of the envelope and was scheduled for that same day. The participants could indicate whether they wished the tapes and questionnaires returned following the study. Two staff nurses out of the 15 requested their tape be returned. The staff nurses were asked to complete independently the questionnaires prior to being interviewed. There appeared to be enough staff present the days of the interviews to
avoid unnecessary interruption in patient care and stress on the staff nurses.

Phase I Data Collection: Questionnaires. In the first phase of data collection, participants completed two questionnaires, a demographic sheet, and a consent form. They were completed after the study presentation and before the scheduled interview. These were brought to the interview by the participant and all 15 participants completed all the information requested. The questionnaires were completed by each participant on the day of their interview. The time between the study presentation, the completion of the questionnaires and the interview was no longer than 6 hours for some and as short as 15 minutes for others depending on their scheduled interview time. The nurses were completing their regular patient assignments as well.

The two questionnaires were based on a competing values framework (Quinn, 1988). This model has two axes and views organizations as focused from an internal to external orientation (horizontal axes) and having characteristics ranging from control to flexibility (vertical axes). The model identifies characteristics within each quadrant and labels them according to polar opposites or means and ends. The four quadrants created as a result of the intersection of the two lines represent the human relations, open systems, rational goal and internal process organization schools. Organizations are assessed using the questionnaires and then the computed score results are displayed on pie charts. The organization is then analyzed based on the scores displayed in each quadrant and the representative characteristics of that
particular organization school. The model views organizations as composed of competing values based on the polar opposites in the model and attempts to understand the assumptions of the organization from a dynamic perspective.

The first questionnaire was adapted from the Competing Values Organizational Effectiveness Instrument (Appendix C). This instrument measures the individual’s perceptions of organizational performance or effectiveness based on the participants’ rating of 16 questions. According to Quinn (1988) and based on his study of standardized scores of 206 managers who described their work units, a wide array of organizational units in all parts of the country, there is discriminant validity, and reliability scores are high. The nurses were requested to respond to the questions based on their work unit rather than the larger hospital. This questionnaire was used to assist in understanding what the nurses thought about their nursing practice in terms of eight different descriptors; commitment and morale, innovation and adaptation, external support and resource acquisition, productivity and accomplishment, direction and goal clarity, stability and control, documentation and information management and participation and openness.

The second questionnaire (Appendix C), developed by Cameron (Quinn, 1985) and also based on the competing values framework, was titled Diagnosing Corporate Culture. When completed, this questionnaire produces six scores corresponding to the six dimensions of organizational culture: dominant characteristics, leadership, glue, climate, success criteria and management style. The scores are plotted on a profile sheet containing the six matrices and can be summed and
averaged to obtain an overall cultural profile for the unit. The staff nurses were asked to respond to the questions based on their work unit. This instrument allowed the researcher to describe the type of culture or the "climate" on the unit as well as the strength and congruence of the culture relative to the six dimensions. This questionnaire has been used in over 500 organizations including health care organizations.

"Past research using the questionnaire suggests that the instrument is internally reliable and is strongly associated with different types of organizational performance." (Quinn, 1988, p.147)

Phase II Data Collection: Interviews. A structured interview adapted from Quinn (1988) was used in the second phase of the study (Appendix C). The interview questions were also based on the competing values model. A few words were changed (i.e. organization to hospital unit) and a question added asking the participants if they had anticipated any other questions or if they wanted to add any information.

The 15 structured interviews were scheduled for ninety minutes each and were accomplished in four days within a ten day period; a Thursday (5 interviews), Tuesday (4), Wednesday (2), and Saturday (4). This specific schedule was determined based on the nurses' work schedule and decided by the nurse manager. The researcher found the staff nurses to be very attentive to the times each were assigned. The majority of the interviews were completed in 80-90 minutes each without feeling rushed. Two interviews took less than 75 minutes and one went 105 minutes. This variance was based on the nurse and no attempt was made to shorten
responses. When the nurse appeared to be finished with one question, the researcher would ask the next one. The researcher would ask if they had any more comments. All questions were asked of all participants.

The interviews were taped in a private office on the unit. The office had three padded swivel desk chairs, two desks and file cabinets. The only "window", which had a closed blind on it, faced the unit waiting room. The researcher placed the tape recorder on the corner of the desk within easy reach of the nurse and explained that she was free to turn it off whenever she felt more comfortable in doing so. The door was closed during the interview. The swivel chairs allowed the researcher to face the nurse so that nothing was between us. The researcher had a clip board placed on her lap or sometimes on the desk depending on the closeness of the nurse. The clipboard had the interview question sheet on it. The nurse could easily see the sheet and was aware the same questions were being asked of all participants. The nurse could move her chair as she desired in relationship to the researcher, the tape recorder and the desk.

At the beginning of the interview the nurse was asked to say a few words into the tape recorder to alleviate any "stage-fright" and for the researcher to check the machine each time. The nurse was also asked, if she had any questions about the study. Then the structured interviews started.

Phase III Data Collection: Observation of Unit. The third phase consisted of nonparticipant observation which took place the next two days immediately following the interviews. For two half days (6:45 A.M.-
12:30 P.M.), the researcher was present on the unit in various locations to observe the activities and for the unit personnel to get used to her presence (i.e., maintenance, dietary aides, physicians, nursing staff). The housecleaning supervisor and the hospital employees that stock the nurse servers were the ones who asked questions of the researcher. Most of the others either ignored my presence or would look and say hello and proceed down the hall. It was the time for seeing where equipment was placed, what the "Primary Nurse Assignment Board" was all about and in general ask questions mainly for staff to get used to my presence and for the researcher to feel comfortable on the unit. The staff nurses did answer any questions and allowed the researcher just to "be" there while they went about their work.

Phase IV Data Collection: Participant Observation. The fourth phase of data collection was participant observations. This began the following day after the non-participant observation phase and continued for 18 days. One day the researcher was absent from the unit and one day the unit clerk was observed for approximately three hours. Twelve study participants were observed for one day each and 2 participants for 2 days each. This schedule was adhered to because of the time constraints of the researcher and also the unit agreement for the study time. This schedule was very intensive and demonstrated researcher commitment to the study which was acknowledged by staffs' comments and cooperation throughout the study.

The observation times were generally from 7:00 A.M. to 10:00 A.M. and 12:30 P.M. to 3:30 P.M. on the 7:00-3:30 P.M. shift Monday through
Friday, and 7:00 A.M. to 10:00 A.M. and 4:00 P.M. to 7:00 P.M. on the weekend 7:00 A.M.-7:00 P.M. shift. The researcher stayed with the study participant until she left for the day. These particular observation times were chosen because they included unit shift reports (i.e. patient care status is communicated between nurses as nurses come on duty and others leave). The activity of "report-time" at 7 A.M. and 3 P.M. was a routine and consistent activity which facilitated the collection of patient care data. Also, the time between 10 A.M. and 12:30 P.M. tended to be the time the nurse was at the bedside giving direct care or doing ordered procedures. This behavior was validated during the researchers' unit observations and by the nurse manager.

The researcher observed the nurse in all unit areas except at the patient's bedside. Bedside nursing activities were not observed due to patient confidentiality issues and the number of potential permissions needed. The focus of the study was not nurse competency. The study was not on patient-nurse interaction, so that time period (10 A.M.-12:30 P.M.) with the usual corresponding activities and direct patient care contact was not considered crucial to the study objectives. The research question assisted in defining the "space" in which the data were to be collected. The researcher's activities as listening to report or following the participants on the unit did not involve any observations in patient rooms.

A staff nurse was chosen by reviewing the assignment sheet at 6:45 A.M. and selecting a nurse who had agreed to be a part of the study and who had not been observed previously. After the staff nurse was
selected, the researcher asked the nurse's permission to observe her for the observation time.

The nurses always came to the nurses' station to pick up their beepers and the keys that unlock the medication drawers in the nurse servers. In addition, they wrote down their assignment listed on the assignment board at the nurses station.

After receiving their approval, the hours of the observation were explained and they were told what the researcher would be observing (i.e. what they are doing: charting, preparing medications, reading charts, looking for supplies, moving from one place to another and receiving or giving patient shift report). The researcher continued to use a clip board to write on as during the structured interviews and on occasion a few nurses would look and see what was written down. The researcher made no attempt to conceal the written information so they did not appear anxious about what was being documented.

If more writing seemed to be occurring, some would ask, "What are you writing?" The information was not concealed and usually the nurses would read it and make no comment. The general type of activities the nurse was doing was recorded. The researcher would record verbatim the comments made by the nurse to her or to others when the nurse went into the patient room. Usually there was not a long time before the researcher would be standing alone outside the patient's room in the hall and could quickly document what was said or done. Frequently the nurse would tell me where she was going or what she was going to do. Others would ask if the researcher was keeping count of how many times
they had to run for supplies that were supposed to be in the nurse server.

The written documentation was tape recorded by the researcher within a reasonable time frame following the participant observations and expanded as possible to reflect all that was occurring on the unit. The written notes were quite complete due to the way they were immediately recorded and every attempt, within the researcher's limitations, was made to accurately describe the situation being observed.

To be as unobtrusive as possible, the researcher did not initiate conversation but would respond if asked a question or if someone spoke to her. The nurse manager supported the researcher's role as a participant observer even when the nurse was having a "bad day" due to supplies not being in the nurse server, or medications not being available and the nurse having to make extra trips. The researcher did follow the nurse and did not assume a more active role with the nurse. The participant observation period was quite structured, defined and intense. This approach did obtain the data needed but a less structured format might have obtained more informal interactions.

Phase V Data Collection: Unit Documentation. The fifth phase was the collection of written data relative to the structure of the unit and included job descriptions, budget, staffing schedules, quality assurance indicators, communication book, overtime reports, relevant policies and procedures, and inservice reports. The researcher made a list of items when tape recording the participant observations that seemed relevant to
the situation being described. The researcher was given permission by
the nurse manager to xerox documents like the communication book and
nurse job descriptions to enrich the study. The researcher was free to
come on the unit as necessary and had access to this information. The
confidentiality of the information has been maintained and the
researcher collected the information in a classroom on the unit not used
frequently.

Data Analysis

The analysis of the data was sequenced to minimize the researcher
being overly influenced by the findings of other sources of data. The
interviews were analyzed first, second the participant observations,
third the questionnaires and last the communication book. The interviews
and the participant observations were tape recorded, and transcribed to
computer disks. The researcher listened to the tapes and read the
transcribed data to correct any errors. The software program Ethnograph
(1988) was used to facilitate the analysis. The Ethnograph program was
used to number the lines of the data, as well as code and sort the data
based on the research questions. All the sorted data were read to
identify themes. The dominant themes that emerged from this process are
discussed supported by actual quotes from individual data.

The emerging themes from each data collection method were analyzed
to identify similarities and differences between and among them. The
similarities and differences allowed the researcher to identify and
analyze the dominant relationships among staff nurses' beliefs, nursing
practice and unit ethos.
Member checks were not included in the study design. This was due to the time between the end of the data collection period and the evolving nature and processing of the step by step analysis of data (approximately 6 months). There was no assurance that the same participants from the beginning of the study would be present on the unit after the data had been analyzed. In addition, participants were assured all material would be treated confidentially and with the small participant number, member checks might have violated that agreement. The variety of data collection methods, the quantity of data collected, the use of actual quotes and the large percentage of subjects from the work site support the credibility of the final study results. The triangulation of the findings which evolved from the analysis supports a reasonable level of credibility. However, the specific results of this study are probably not generalizable.

Due to the complexity and breadth of this study, two expert nurses not acquainted with the unit read the entire study. They are researchers and practitioners versed in nursing practice and hospital organization. Their input was written and verbal and designed to check the researcher’s analysis and conclusions in relationship to the data and the practice and profession of nursing. One nurse, not employed by the hospital, but very familiar with the unit as a clinical instructor, read a representative sample (five) of individual interview summaries based on the research sub-questions discussed below. Being familiar with the unit, she was asked to read the researcher’s interpretation for consistency and accuracy between the researcher’s interpretation of what the nurses said, the nurses’ interview responses and the ethos of the
unit. The clinical instructor provided verbal feedback and did not identify any misinterpretations. To maintain participant confidentiality, the interview summaries did not reveal participants except by their code number and were available to the nurse only during the session with the researcher. A group response was compiled for the rest of the study analysis and results.

**Interview Data Analysis.** The structured interview data provided responses to the research sub-question: What are the staff nurses’ beliefs about nursing practice and unit ethos? The emerging themes were explored based on similarities and differences between beliefs about nursing practice and beliefs about unit ethos.

The process of data analysis was extensive due to the amount of data available from the fifteen interviews. Following tape transcription, the typed and number lined data from the fifteen interviews was read three times. The first time listening to the tapes and reading the written copy to correct any typist error and the next time to get an over-all feeling of the interview before answering and coding for the following questions: 1. What did this nurse believe she was doing? 2. What did this nurse believe was problematic about what she was doing? 3. What forces did this nurse believe were shaping her practice? and 4. What forces were problematic in shaping her practice? The previous questions helped to focus the data coding. Following data coding, the responses of all the participants were read for each question and a group response was written for each question. At this point in the interview data analysis, the clinical instructor reviewed a
representative number of individual responses as described above. The group response was analyzed for emerging themes. The themes were then the basis for coding and sorting the individual interview data again. This extensive interview data, all participants' actual quotes, now sorted by themes, were read and discussed with the researcher's advisor who is not in the health profession. Actual staff nurses' quotes from the interviews, deemed representative by the researcher and advisor were used to present and validate the themes.

The interview questions, based on the competing values framework, assisted in gathering lengthy data for broad organizational analysis and individual and group responses. The process of analyzing the data first using the subquestions, one through four above, and then the themes was necessary to capture the deeper meanings of the data. The main study question required a deeper insight into staff nurses' specific beliefs about their practice and unit ethos which was obtained by analyzing the data using the other questions.

Participant Observation Data Analysis. The participant observation transcribed data were read to identify general activities the nurse did on the unit to respond to the research sub-question: What is the nursing practice on this hospital unit? Thirty four general activities were identified. Next, the researcher listened to the tape of the participant observation data to identify possible transcription errors and to code the nurses' activities. The activities identified were counted for each nurse. Later, the thirty four activities were collapsed into twelve broad and related functions which provided some of the data for
responding to the sub-question above. The twelve activities are listed in Table 1. The data were read a third time and coded for information indicative of unit norms and expectations. This information was lined and coded using the Ethnograph computer program and emerging themes identified. All the coded data were summarized for similarities and differences between nursing beliefs represented by what the nurse was observed doing and the observed unit ethos.

The similarities and differences between nurses' beliefs and nursing practice identified from the two data collection methods (i.e. interviews and participant observations), were summarized next before analyzing the data from the questionnaires.

**Questionnaire Data Analysis.** The data from the two questionnaires were compiled based on Quinn's instructions (Quinn, 1988). The results were described based on the competing values approach and as representative of staff nurses' beliefs and nursing practice as influenced by unit norms and expectations. The similarities and differences identified and described provided insight into the question: What is the unit ethos?

**Analysis of Pertinent Documents.** The unit communication book was read for the period of the study. The communication book entries were classified into broad areas of nursing practice and unit ethos. Other unit documents (i.e. staffing schedules, budget information and nursing quality of care evaluations) were read for general understanding. The
<table>
<thead>
<tr>
<th>Activity</th>
<th>Ave. no. occurrences (+/- s.d.) per observation period&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing documentation</td>
<td>10.3 (4.1)</td>
</tr>
<tr>
<td>Care planning</td>
<td>22.0 (5.1)</td>
</tr>
<tr>
<td>Performing treatments</td>
<td>14.2 (8.3)</td>
</tr>
<tr>
<td>Checking medication orders</td>
<td>7.1 (3.2)</td>
</tr>
<tr>
<td>Administering oral medications</td>
<td>21.1 (7.2)</td>
</tr>
<tr>
<td>Administering intravenous medications</td>
<td>7.1 (3.9)</td>
</tr>
<tr>
<td>Obtaining unit supplies</td>
<td>5.8 (4.5)</td>
</tr>
<tr>
<td>Obtaining supplies from Sterile Processing Department</td>
<td>4.3 (3.2)</td>
</tr>
<tr>
<td>Interacting with family, teaching patient, or providing emotional support</td>
<td>2.6 (2.0)</td>
</tr>
<tr>
<td>Admissions, discharges, continuity of care</td>
<td>1.2 (1.2)</td>
</tr>
<tr>
<td>Interruptions</td>
<td>12.9 (5.5)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>4.7 (3.2)</td>
</tr>
<tr>
<td><strong>Ave. total no. occurrences</strong></td>
<td><strong>113.3</strong></td>
</tr>
</tbody>
</table>

<sup>3</sup>Ave. for 16 observation periods averaging 6 hr. 20 min.

Twelve nurses were observed once; two were observed twice.
information provided some additional triangulation with the results from the three data sources: questionnaires, interviews and participant observations.

The similarities and differences that emerged from the data about nurses' beliefs, nursing practice and unit ethos were analyzed to describe relationships. The findings of the fifteen nurse interviews, the 16 participant observations, and the findings of the 30 questionnaires (2 questionnaires with 15 participant responses each) and the written documentation provided the data. Two data collection methods revealed information about each (Figure 1). Nursing belief themes are based on findings from questionnaires and participant observations. Nursing practice themes are based on findings from interviews and questionnaires. Unit ethos themes are based on findings from participant observations and interviews. These themes about nurses' beliefs, nursing practice and unit ethos from the specific data collection methods were analyzed for similarities and differences. The interviews and participant observations revealed similarities and differences between nurses' beliefs and nursing practice. The questionnaires and interviews revealed similarities and differences between beliefs and unit ethos and the participant observations and questionnaires revealed similarities and differences between unit ethos and nursing practice.

The analysis of the similarities and differences revealed from the analysis process described above, presented the final evolving similarities and differences and described the emerging relationships among nurses' beliefs, nursing practice and unit ethos.
CHAPTER IV
RESULTS

The results and the analysis of interviews, participant observations, questionnaires, and pertinent documents are presented in this chapter. The main research question centers on the relationships among nurses' beliefs, nursing practice and unit ethos. The intent of this descriptive study was to better understand and to relate what nurses believe they are doing on a daily basis to what they actually are doing. In addition, the study explored what organizational norms and expectations appear to be influencing nurses' beliefs and their nursing practice. The work of the nurse is explored from her perspective but within a web of relations. The staff nurses in the study are called nurses in describing and analyzing the data. All the participants were female so the use of "she" is used as descriptive of this particular nursing unit.

The study findings are described in four sections. The first section presents the findings from each of the three data collection methods: interviews, participant observations and questionnaires. The findings of the fifteen nurse interviews are presented first. They concern the subquestion, What are staff nurses' beliefs about nursing practice and unit ethos? The findings of the 16 participant observations are presented next. They concern the subquestion, What is nursing
practice on the hospital unit? The findings of the 15 questionnaires and the written documentation are presented last. They concern the subquestion, What is the unit ethos?

In the second section, similarities and differences between the findings about beliefs, practice and ethos are presented. The similarities and differences are a result of analyzing the data from interviews, participant observations and questionnaires. Two data collection methods revealed information about each (Figure 1). Nursing belief themes are based on findings from questionnaires and participant observations. Nursing practice themes are based on findings from interviews and questionnaires. Unit ethos themes are based on findings from participant observations and interviews. The themes about nurses' beliefs, nursing practice and unit ethos from the specific data collection methods were analyzed for similarities and differences. The interviews and participant observations revealed similarities and differences between nurses' beliefs and nursing practice. The questionnaires and interviews revealed similarities and differences between beliefs and unit ethos and the participant observations and questionnaires revealed similarities and differences between unit ethos and nursing practice.

In the third section, the similarities and differences revealed from the process described above are analyzed and similarities and differences that result are described and the emerging relationships among nurses' beliefs, nursing practice and unit ethos are discussed. The significance of the findings are presented in the final section of this chapter.
Findings from Interviews, Participant Observations, and Questionnaires

Nurses’ Beliefs Explored by Interviews

Nurses’ Beliefs Revealed from Interview Data: Beliefs about Nursing Practice

The first step of the analysis explored nurses’ beliefs about nursing practice and unit ethos expressed in structured interviews. In exploring interview data, the researcher was attempting to discover and identify the dominant underlying and integral beliefs about nursing practice and unit expectations that influence nurses’ beliefs. Quotes from the actual data are presented and are representative of all the data. The data are available in approximately 500 pages of typed transcripts available from the author.

Nursing practice or the work of the nurse is influenced by many factors such as patients’ severity of illness, the number of patients assigned to her on a particular day, the number of support staff, the equipment available, the collaboration with other health care professionals, and the standards and regulations of the institution and the profession. Procedures, policies and standards of practice are well established and well known. Of course, the beliefs held by nurses about their professional responsibilities do not always coincide neatly with established policies and guidelines. However, the legal definition of nursing practice defines her professional position and responsibilities and the nurse is held accountable by legal mandate. The State of Ohio
Nurse Practice Act of 1987 lays out the duties and accepted practices of a registered nurse:

"providing to individuals and groups nursing care requiring specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, social and nursing sciences. Such nursing care includes:
1) identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen;
2) executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions;
3) assessing health status for the purpose of providing nursing care;
4) providing health counseling and health teaching;
5) administering medications, treatments, and executing regimens prescribed by licensed physicians, dentists and podiatrists;
6) teaching, administering, supervising, delegating, and evaluating nursing practice.

'Nursing regimen' may include preventative, restorative and health promotion activities.'

'Assessing Health status' means the collection of data through nursing assessment techniques which may include interviews, observation, and physical evaluations for the purpose of providing nursing care." (The State of Ohio Nurse Practice Act, 1987)

The nurses in this study expressed their beliefs about nursing practice as they described their work as a direct patient care provider, a professional and an employee within a particular work environment.

The Nurse as the Direct and Primary Patient Care Provider. Patient care comprises the focal point of nursing practice and constituted the primary work of the nurses. They believe nursing practice is the completion of tasks and the caring for their patients physical and emotional needs. They voice dislike for performing all the tasks and call the ones they dislike "non-nursing". The list of non-nursing tasks appears to vary from day to day but includes changing beds, giving
baths, getting patients on and off bedpans, housekeeping and maintenance type tasks, passing ice water, and emptying urinals. They emphasize the importance of giving patient medications and checking physician orders, the patient’s vital signs, and patient’s blood sugar tests. Such tasks are accepted as part of their nursing practice.

The nurses believe they are the direct patient care providers and the primary care providers. They are given the title, "primary nurse". They believe they perform all the physical activities associated with the care for their patients and largely work alone. They express the expectation to plan for a patient’s hospital discharge and to consult with other patient support services on their patients’ behalf. The goal of their care is to do everything their patients need in a wholistic way. One nurse stated:

"Basically I’m a primary nurse. I’m a staff nurse. I do bedside nursing care. I’m responsible for planning and implementing total care for my primary patients and then assisting other nurses with being an associate nurse with her patients. Total care means planning from how to take care of them while they’re in the hospital and any teaching they need and any discharge planning. I usually start implementing discharge planning on admission.

Total care means they help patients achieve some quality to their life which includes emotional and spiritual needs. They believe getting their patients healthier will lead to a better quality of life for them. Some nurses define emotional caring by contrasting it with physicians’ ways of practicing and feel nurses are more nurturing.

Nurses believe they are the "hub of the activity" for their patients. They coordinate services and advocate for their patients within the system. As two nurses noted:
Nursing is the one that is more like the hub of the wheel when you deal with respiratory, dietary, housekeeping, doctors, all that stuff. It feels like you're the one that coordinates with Physical Therapy or Occupational Therapy and this room needs cleaned. You're always the one that knows it first, most of the time. I don't know, I feel like we're really the hub of the activity.

We joke around here that we really are a jack of all trades because we have been expected to be the housekeeper, the mechanic, the electrician, the dietician, the dietary person, the respiratory therapist, the doctor sometimes. We just do everything it seems like.

As nurses advocate for their patients and coordinate their needs for other services, they feel responsible for the performance of these other support services. They believe they "oversee" services and evaluate the affect on the patients well-being.

The nurses believe communication presents many problems as they provide and coordinate nursing care. Communication with and from the physician impacts on what they believe they can or can not do. For example, the purpose and scheduling of tests is not always well communicated. One nurse described this:

I: Are there any communication problems that you can identify?  
S: Yeah, with the doctors, yeah. Who don't tell their patients what's going on, what tests they're going for. They don't tell the nurses what a patient's going for. All of a sudden they call up, they're coming for a patient for a test. They hadn't written an order for that, they didn't tell the patient, they didn't tell the nurse, and you don't know whether they have the right patient.

The nurses believe the communication with other departments takes place at regularly scheduled weekly interdisciplinary rounds but physicians do not normally attend. This is seen as a communication problem.
Yes, we have staff meetings, we have interdisciplinary rounds, where we meet with other people from ancillary, the dietary's there, physical therapy, occupational therapy, social services, continuity of care. Sometimes the doctors will participate, but not as often as we wish they would. Because I think that's one thing that we really need to work on, nursing as a whole, not just this unit. We've really made an effort. They (the physicians) just haven't been open, some of them aren't open to it, other times it's because they have other obligations, because we hold them Thursdays at 9:30, so that unfortunately has fallen through with the doctor's part, but it's still a very important and necessary part of what we do, it's basically to get a handle on discharge planning and how we're going to follow through with that. But it's not limited to that, we talk a lot about inpatient planning, what's going to happen to them here, and how are we going to get them ready for discharge. So it really just encompasses just about everything.

In summary, the nurses believe they are the direct and primary nursing care providers on this unit and they have the responsibility for providing, coordinating and overseeing all the activities related to the care of assigned patients. This could be an overwhelming responsibility when the nurse does not have control over the services of other departments or the communication priorities of the physician. To handle this situation, they focus their work on task completion and try to anticipate problems associated with other departments and the scheduling of tests and procedures.

The Nurse as a Professional. Beliefs about the nurse as a professional vary considerably. For these nurses, notions of professionalism and professionalization cover three areas: a sense of mission and professional commitment; the need for educational opportunities and growth; and their professional and organizational status.
The nurses believe they provide a service to all their patients guided by a set of professional standards. The nurses believe they are committed to a professional career which affords them membership in an "established" professional group. They believe the profession should be visible in the health care issues that impact nurses and nursing. These issues are expressed by one nurse:

I think that nursing as a profession has some very hard work to do. They have had some hard work to do in terms of development as a profession, in terms of autonomy, in terms of recognition, a lot of those kinds of things. I think we still have a very hard row to hoe in that regard, but I am not discouraged at all about nursing. I see a good future for myself and I see it as a potentially excellent profession for other people to enter, if we can get some of the other political and power issues resolved.

In accordance with professional standards the nurses believe the patient comes first. The nurses recognize the different ways that many nurses view their professional role and one nurse relayed how this affected the performance of nursing care:

If you take nursing as just another job, that's all you're going to do, (the tasks) but if you remind yourself of what you came into this profession for, and that's to take good care of these patients, then you are going to take initiative to do all of the things possible for that patient, not just the tasks it takes, good emotional care.

New nurse employees complete an orientation program which is a ten week period with the assistant nurse manager as preceptor. The nurses believe orientation sets the stage for future educational growth because new nurses learn the unit's nursing care standards and work expectations. After this period, the nurses believe they increase their knowledge by informal sharing of acquired information from workshops and
journal reading. They share information with each other when someone attends an outside educational program. This is viewed as "trading" information. One nurse observed:

When you come back, within a certain amount of time, we present what we’ve learned and share with the floor and then we trade.

The actual involvement of the nurses with educational opportunities often is expressed hesitantly and with mixed messages. One nurse said the issue rested primarily with herself:

Training and education, that is relatively limited, although I think it’s limited more by my own lack of initiative, than necessarily by what the nurse manager would support.

Another nurse did not feel it necessary to attend continuing education on any regular basis but felt she should do it herself:

I have gone to a few inservices. I just went to one not too long ago, it was the first one in a few years though actually. There are lists of things which you can do yourself independently, I just don’t always think about going.

One factor which appeared to divide the nurses is their beliefs about education. Some nurses believe, "bedside" nurses, do not need further education because education enhances job mobility rather than job performance.

I just know that I’m responsible for the decisions I make, take responsibility for that and take responsibility for my own growth and learning. ... but I think there are some who are content with where they’re at, that they’re not looking to move on, they’re satisfied in this staff nurse role. They don’t really see themselves moving on and so they maybe their energy is just concentrated in a different way. Where since I have other goals in mind for myself, I just try to take advantage of what I can to promote that.
The nurses describe their professional and organizational status in terms of their credibility, reputation for quality service, knowledge, autonomy in decision-making, and communication lines and relationships.

The nurses believe their credibility within the system is partially determined by making sure others understand what it is they do. However, the nurses strongly believe only nurses can understand nursing. This creates a "we-they" attitude between nursing and hospital administration and nursing and physicians. This also promotes a sense of aloneness and isolation. One nurse stated:

the hospital administrators, etc., the people who are not involved directly in patient care, they don't understand it, and that's a huge gap right now in terms of our credibility, .... because we are not viewed as professionals. It infiltrates. It demoralizes us.

Nurses take pride in their work based on their own evaluation, and physicians' comments related to the completion of physicians' orders. They believe a sense of pride stemming from the quality of nursing care they provide contributes to their positive reputation in the hospital. This positive reputation is supported by the physicians because the nurses are attentive to task completion. The nurses believe the physicians are powerful in the system and therefore strive to meet their expectations.

The nurses believe organizational status is largely based on the physicians view of how "good" the unit is. A "good" unit retains its staff, has enough staff to complete ordered procedures timely, and has nurses who are knowledgeable about patients' condition. The nurses
believe educational degrees will put them on a more equal level in terms of respect with physicians and will remove the feeling of being in a "handmaiden" role. One nurse explained:

I think that it's kind of reached the point where for a long time you wanted to be more equal on the level of the doctors and I think nurses are going to have to gain that kind of respect. I mean, I work with a lot of people that have their masters. They're staff nurses, but they have that extra knowledge base and it's reached the point where you don't want to be looked at as a handmaiden. You want to be looked at from the knowledge that you do have. I feel very respected, but not only by my peers, but by the medical staff. ... I think it's (the respect) something unique to our unit, because it is such a close group and there's longevity here and we have good staffing. We don't seem to have a lot of other stressors right now, though a lot of units are hurting because of the nursing shortage, because we're well staffed and I think that can be a bottom line.

The nurses believe their professional and organizational status is enhanced by the amount of autonomy in decision-making they are granted by the organization and by the physicians. They define autonomy as a sense of freedom and being totally responsible for making decisions about their patients' nursing care. Total patient responsibility is considered a benchmark for recognition as a professional nurse. They believe they are autonomous because of the primary nursing organizational model being used as the approach to assign staff to patients. Autonomy is demonstrated by taking the initiative, by being a risk-taker and having those actions based in patient care. The following quotes illustrate:

I think it's just by stepping out and taking the initiative, you see something, you relate, well this isn't quite right and take the initiative to go and saying to the doctor, this is what's going on and maybe even making a suggestion of something that you've known has worked in the past, and I think through that you gain your autonomy because people will look at you and know that
you’re being conscientious and that you’re trying to do the best for that patient.

I pretty much establish for myself what I want to do, how I want to do it, and when I want to do it. Circumstances put limits on me sometimes, so I have to set some priorities. So in terms of establishing priorities, that’s one of the ways I control my work.

Decision-making has meaning and value at the individual patient care level because these nurses are the primary nurses and are responsible for assigned patients. The nurses have status in their nursing group as primary nurses. The critical decisions nurses make center around physical assessment of the patient and communication with the physician. The nurses have the opportunity to collaborate with the physician and frequently they play a teaching role with new physicians. However they still acquiesce to the exclusive decision-making responsibility of the physicians. The nurses would like to have greater control of the decision making related to patient care activities.

You make many critical decisions in terms of evaluating patient status and determining whether this problem is an urgent problem that needs to be dealt with and I need to call the physician and have him come up stat (immediately) or is it something that can wait a little bit longer. Looking at lab values and getting on the phone and calling the physicians saying the patient’s labs are this, even though that technically is the physicians responsibility, or letting it slide. Assessing patient’s lungs, saying this guy’s going into pulmonary edema, he’s getting a little bit too much fluid, his weight’s up. I think there’s a lot of critical decision making process that goes on, especially with the acuity of patients that we get. The patient has multiple body symptoms involved, one impacting on the other and it can become a snowball effect. It may not seem to be as critical at the time, but if left unchecked, it could have led to a code situation. So I think there’s a lot of critical decision making that goes on.

I think a lot of times the decisions the doctors make about these patients that they write these standardized orders to do with that person, but we’re with them 24 hours a day. I think we need maybe a little more leeway of deciding if this needs to be done, if
that's necessary. If this person has to be weighed everyday and things they just routinely write for all people. After we're with the patient so long, we get to know them and we know what their needs are. Maybe a little more decision making of things that we do.

Professional and organizational status is often expressed by the nurses as having their own chart, work space, and the nursing process that is used in caring for patients.

Well, it's always, it's little things, I think it's nice that we have our own charts, for instance, because that's our work area and it's a way for us to express ourselves. It gives us a hold on the patient. Nursing process that we do have, set nursing practices that we go through, nursing process for one thing.

The nurses believe communication with physicians is difficult and they spend much of their time communicating. The nurses are not always in a direct line of communication with the physicians. This promotes a negative attitude and anger because it results in a denial of decision-making authority for their patients. Lack of communication promotes the belief of low organizational status because the physician with status does not even talk with the patient's primary nurse about what is being planned for that patient. The nurses try to maintain positive communications with physicians but the nurses take the situation to the nurse manager whenever problems arise. They see lines of communication as tightly linked with their beliefs about status in the organization.

... the nurses do most everything. And if it's a follow up or, there's so many things that can go wrong and you're communicating, most of your day you spend communicating things that get screwed up. Actually that's a big beef up here.
Peer communications occur when a nurse asks the nurse identified as knowledgeable about a special type of patient, about a particular patient problem. The knowledgeable nurse is called the "clinical expert". Inquiries are based on the nurse recognizing she needs the expert advice of a clinical expert and the availability of the clinical expert. Communication with the clinical nurse expert is expected and encouraged by all. The identification of the nurse clinical experts is modeled after the physicians' approach to specialization which is an important status differentiation approach.

We go a lot by the book... policies. But if that isn't right for a certain patient, we don't stick to that regardless of anything. We adapt a lot. I mean it depends. If it has to do with diabetes, they go to C. If it has to do with renal, they come to K., cause she used to work on dialysis. Cardiac, they go to another one. Everyone has their own major area, where some people are just general. If there's a question about a specific thing, they'll go to that person and we make decisions.

The Unit Work Environment. Nurses identify themselves to others in the hospital and outside the hospital by the unit in which they work. The work environment of the unit has been known to attract or repel prospective new nurses and quickly gains a reputation within the hospital for the "kind" of place it is. The nurses in the study described beliefs about the work environment in terms of work characteristics and work organization.

The nurses believe their work is physical, intense, stressful, and constantly interrupted. The physical demands of caring for patients; moving, lifting, and walking contribute to their beliefs about the job's physical demands. One nurse described the physical conditions in terms of standing:
Because we stand 8 hours with these patients. We stand maybe three hours at a time with one patient in one room because some patients need so much care.

The nurses believe their work is intense and complex because they have to think about multiple things at the same time, decide which one to do first and not forget to do everything else. The nurses believe intensity varies with the numbers of people in the environment and the work pace. Intensity for some nurses is a function of one’s approach to her responsibilities and the attention to getting the job accomplished in the time allowed.

The nurses believe their work is frustrating and they share how they deal with frustration and stress in many ways. Frustration is exhibited by tears, physical exhaustion and by their talk related to their belief that no one really understands what they do.

Oh gosh, sometimes I don’t put up with that at all. Sometimes I go home in tears and think, what did I do today and sometimes I go home and I guess if you know that you’ve done all that you can, if you’re happy with yourself and can feel good about that...that’s the way I’ve got to deal with it, cause I’ve done all I could.

We all go through our little things where, gosh I’m going to quit tomorrow, because you just feel so, you can’t deal with this anymore, or there’s got to be an easier place to work. Because you do a lot of people, you know they say, I work, I get home and I’m so exhausted I can’t do anything else.

The nurses respond to the stress of the position in many ways. Most nurses learn how to prioritize work requests from their patients and do what they can do in the time they have. Others alter their schedules to take vacation, make sure they get their lunch and break times, and just sit down and take a deep breathe. Talks with peers, a sense of humor as
well as the listening and caring of outside mentors and family members are cited as ways they cope with stress. The recognition by others that a day has been difficult and receiving support from others helps as well.

I think probably the biggest thing I do is just verbalize it, which is very easy to do on the floor, to go to other people who can understand the frustration and the conflict you have between the one idea, versus the hospital’s idea of the right way. I think that to me is good enough, to get that consensus of someone else being, yeah you’re right, I see what you’re saying and feeling support that way. And that can be just going to another staff member or even going to the nurse manager.

I think the personality of the nurses up here, I mean it’s just nice people. Outgoing, a lot of us, we like to kid around, have a sense of humor and when things are really stressful, it’s hard. We play practical jokes, that seems to be, even people who will come in, who weren’t like that to begin with and they see how we kind of are, they get into it also, and everybody just kids around.

Work organization is influenced by variances in the quantity of work, adherence to routines and protocols, the need to complete work within a specific time period and the primary/team approach to patient assignments.

The nurses believe the majority of their workload is controlled by factors outside of themselves; patient admission, discharge and transfer patterns and physicians’ orders for medications and treatments. They have to accept these uncontrollable factors and deal with them within their allotted block of work time as best they can. The majority believe they have too much to accomplish in the time allowed and feel overworked. The nurses approach workload in different and unique ways. For example some work overtime or leave selected work for the next day, or ask for assistance from other nursing personnel. If a nurse does not
maintain her share of the workload because of her "performance", the poor performer is told about it and the expectation is she will improve. A poor performer puts more work on others and is considered a performance problem rather than a slower or inexperienced worker.

Constant interruptions are a strong characteristic of their work environment. They can never start something without being called away to do something else. This happens because they carry a pager-type beeper which is a part of the unit phone system. They do not give their beeper to anyone else and they carry it every place they go. They believe because of the interruptions and especially the beeper intrusions, they have no control over their work priorities. They have to interrupt their work to fetch supplies or respond to a patient's call in another room or area on the unit.

The nurses believe work routines and protocols protect them, establish parameters for their practice rather than themselves, and help create security and stability. Nursing work is considered routine and bounded by procedures so all nurses perform the same activities. They believe the routines are justified because they allow nurses to know how and when to help each other when situations change and facilitates communication to others. As one nurse stated:

At least for me, and I think for the most part, we're all pretty organized in our way of getting our care done. We might organize it differently, but we all pretty much have a set way in how we're going to approach the day and then you adapt to any change that comes in. If you got an admission, then you prioritize something a little bit differently to make room for extra activity that you're going to have. Or if there's a crisis situation, then you delegate to someone else what needs to be done with these people while you're handling the crisis or vice versa. You might be the one who's picking up for someone who's involved in a crisis. So there's got to be a sense of flexibility even though you try to be
organized in a routine. It really kind of makes the flow go a little bit easier when you have a routine set, instead of just, well I'll just go with the flow.

The ultimate judge of nurses' efficiency, effectiveness and organizational value is the time required for task completion. Nursing is "shift-work" and "hourly work". The overwhelming notion of time is expressed by the quote below as well as the need to accomplish certain tasks within certain blocks of time which gives a "pace" to their day.

One nurse describes time in her work day as:

Usually you have first thing in the morning, your 8 o'clock insulins, your meds, your breakfasts, your vital signs from like 7, from 7 - 8:30 you're trying to get all that done. And then after that I do all my baths and get people that need to be up and ambulated and all of that done. By the time you've gotten all that done then it's 11:30 and it's time to do chem strips and noon meds and nitro paste and then get them ready, our lunch trays can come anytime from like 11:15 to 12:15 so depending on who's in the kitchen so you kind of have to watch. And lunches are done like 12:30, 1:00 and then I try to finish up any of my beds or IVs that need changed or tubings or any of that stuff I didn't get done so that you're hopefully about done by at 2 or 2:15 but usually will get one transfer or admission anytime during that time and then they take, they take precedence over whatever you were doing there. If I have a transfer out, if you have somebody going out or a discharge.

The nurses consider time when they offer and give support to others. If they are doing "ok" it is because their time and tasks are in line.

I'm real oriented to what time it is and do I have certain things done by certain times. Am I behind or ahead on my assignment. If we need help, we can ask for help, and usually that comes from the charge nurse or one of the assistant head nurses. And generally during the shift, at least once or twice someone says are you alright, do you need any help, can I do something to help you?
The nurses believe efficiency is determined by time and skill level. If they have to seek help from others it wastes time and therefore they view themselves as less efficient. They express the effectiveness of their work in terms of getting better at what they do based on time management. The nurses believe they are efficient if work is not carried over to the next shift.

As far as getting a routine, each shift always completes their assigned duties or whatever and there's never a carryover from shift to shift. Things are pretty much completed in a timely manner, so in that case, I guess it's efficient.

The primary/team approach to nursing care delivery is the basis of independent decision-making and consequently the basis of nurse professionalism and status. The notion of primary nursing appears to stimulate the nurses to be more informed and to seek the support and advice of other nurses in the unit. It also isolates the nurses, thus innovative ways to promote group cohesiveness emerge. One nurse described this phenomenon as follows:

Well I've always been one that's tried to keep up on everything, but with primary nursing I feel I have a decision making role with my patient, I have more autonomy than I did before so I have to be more up on things than I ever was. So I read a lot and read professional journals, things like that. Plus discuss with other nurses that we work with, a lot of times if we've had a difficult patient up here, we'll sit down together and say, now what would you do, what would your approach be to this patient. We don't have formal team conferences anymore, patient care conferences anymore, but other than when we have our discharge planning rounds. We're very supportive at helping each other, but still when it comes down to the final decision of the care plans for the patient, we're independent.
Many nurses believe a stronger team approach is needed because of the types of patients on the unit and the recognition of the nurses' limitations.

Summary of Nurses' Beliefs about Nursing Practice

1. Nurses believe they are the direct and primary patient care providers on this unit. They do it alone. They perform the nursing tasks and provide physical and emotional care to their assigned patients. They advocate for the patient by communicating, coordinating and troubleshooting within the system.

2. Nurses believe they have the authority and responsibility for their patients' nursing care plan because of the primary nursing care delivery model.

3. Nurses believe they are valued for their ability to accomplish work in a specified time frame and they do not leave their shift unless all tasks are accomplished. Negative sanctions are negative verbal comments and then reporting the behavior to the nurse manager.

4. Nurses believe their practice can stand alone from physicians' practice and little communication between the two occurs even though it may enhance patient care.

5. Nurses believe they are professionals but administrative personnel and physicians do not treat them as professionals unless they have clinical knowledge and expertise acquired primarily by experience.

6. Nurses believe by identifying, labeling and using unit nurse clinical experts, they improve the quality of care provided on the unit.
and decrease the need for each of them to master certain specialized knowledge bases.

7. Nurses believe the nurse clinical experts add status to their unit and to themselves as members of the unit. It reflects the medical model of clinical specialization.

8. Nurses believe other nurses are the only people that can understand what nursing is and therefore rely mainly on each other for support and verification of their self-esteem, professionalism and educational growth.

9. Nurses believe their work is intense, physical, and interrupted frequently.

Two broad themes emerge as this set of beliefs is analyzed further. First, the nurses express a complete and absolute dedication to patients and nursing care in an environment that does not seem to value such dedication. This is demonstrated by nurses' recognition of peer support as the only real support for them. Their dedication to their patients tends to perpetuate the handmaiden image. They fear a poorer quality of care for their patients and deterioration of their image to physicians and to others. Second, work in this hospital is still largely considered and treated as "female work" done by dedicated yet isolated women who feel responsible to do all the work associated with caring for patients. They accept interruptions as a given. They view their work as separate and different from physicians' work.

The interview data was also analyzed for nurses' beliefs as influenced by unit norms and expectations. These findings follow next.
Nurses’ Beliefs revealed from Interview Data: Beliefs about Unit Ethos

The unit ethos is defined as the organizational and group norms and expectations that influence how work is really perceived and conducted. This section describes from the staff nurses’ perspectives what they believe to be the dominant and common patterns of organizational life. Beliefs about dominant and common patterns are broken down as follows: the hospital, unit, support services, nurse peers, physicians, patients, and nurse manager.

Hospital. Hospital ethos influences nurses’ beliefs in terms of respect, corporate goals, work standards, organizational communication and decision-making. These five areas appear to represent the continuing dilemma of a professional group practicing within a hierarchial and bureaucratic organization. The nurses believe the hospital controls their nursing practice through roles (work standards, corporate goals), authority (organizational communication and decision-making), and rewards (respect).

The nurses do not believe the hospital ethos is supportive or respectful of their work. They believe the lack of respect is shown in personal "squabbles", higher pay for agency nurses and the influence of "powerful doctors" over the nurses. The nurses say they have to wait years for equipment they need and when administrators make rounds they spend little time on the unit and only look at "surface" problems. The nurses do not believe the hospital administration understands what they do otherwise as administrators they would treat them differently and with more respect.
Hospital's goals are different from nurses' goals. The hospital is mainly a business concerned with being competitive, enhancing community image and lowering costs. Nursing is concerned with individual care and quality care. The nurses describe the hospital ethos in many ways. One viewed the business orientation of the hospital as follows:

I think the hospital overall is more of a business. I mean I'm here to get a paycheck, too, but I'm also out for the patient and I think the hospital is to an extent, but I think they have to look out for other budgets and what they're turning out, what they're putting in. And they look after that much more.... They want to give quality care, they want to be competitive with their care and what they have. And they want to be well-known for that, but they also want to make a profit, they're real competitive with the other hospitals as far as we have an MRI, we have Cat Scan, we have, we have. They want to do as much as they can at the lowest price and I try to be cost effective, but with my patients, I don't look at that near as much.

Another compared institutional and individual survival:

the hospital as a business has it's own survival to think about, but my concern is the survival of my patients.

However, the nurses believe the hospital sets standards for quality patient care. One nurse observed:

I think our main objective is that we just give quality patient care, that we try to meet the optimum of all the standards that are set for us by the hospital and management and nursing in itself as a profession. But I really think that's really stressed, that we are here for the patient and that has to be our primary focus. ... we all really know that we're here to do a job and to do it well.

The nurses consider nursing administration's organizational structure as not supported by hospital administration. The nurses did
not know who the new nursing administrator was going to be and the nursing offices were relocated to vacant patient rooms for an unspecified period of time. The symbolism was clear; nursing holds minimal value in this hospital. Nurses believe nursing does not seem to be able to make an impact when it comes to making important decisions in the hospital hierarchy. Another concern involves the way nurses are informed about major salary and benefit changes (the newspaper). They consider looking elsewhere for employment because of the lack of direct communication with them about issues that affect their economic security.

Unit. There is a distinct difference between the hospital ethos and unit ethos. The nurses believe the unit ethos has two primary expectations. The first and strongest belief relates to expectations about unit objectives and atmosphere and the second to unit resources, change and creativity.

The nurses believe the objectives of the unit are "to provide the best care we can for our patients and to keep a happy staff". The happy staff orientation is part of their belief about the unit as family and the atmosphere which that belief fosters. The nurses believe the unit is like a family or a group of friends. They treat each other like family members, encourage teamwork, allow members to express certain types of opinions, and see themselves as mutually supportive.

...it's just a warm unit, you're very welcome, people are wonderful to help you. You just have the feeling that no matter what comes up in your day someone can help you, or someone will be there to support you, people will look to you for help and know that they can get it. It's a great support system and we all tend to work together, for the good of the unit, for the good of the patients.
Typical of many families or groups of intimates, the unit protects its members from external forces. They do not see themselves as tightly connected with the larger organization. The nurses admit they are "unit identity based" and appear proud of this fact. The nurses only seem to hear good things about the unit and recognize they live "in a glass house". The only criticism they do acknowledge is criticism from the nursing supervisor. The nurses do not allow staff to be pulled by the supervisor from this unit to other hospital units. Since the unit does not have many personnel vacancies, they do not have to rely on other units to help them out at times. The fact they are not helping others did not seem to bother them. They feel they staff their unit by working extra and changing their schedules when necessary and other units can do the same. The supervisor, no doubt, finds it difficult to argue with the unit's low turnover and absenteeism rates.

We tend to be pretty provincial. I don't know if that's the word or not. But we're self-contained and I don't think, so even in terms of the demands. We kind of have our wall. I: Do you think that's realistic?
S: Honestly, to some extent, it is. I don't know whether it's healthy for the institution as a whole, but quite honestly, most places where I've worked in an acute care setting, the view is what is on this unit? And I think, how the unit manager runs that unit is the most important thing.

The nurses express satisfaction with the quantity of equipment they have on the unit and feel they are generally a "rich" unit. The number of personnel hired to work the unit is considered satisfactory. They believe the inservice educational offerings could be increased. They dislike the physical appearance and decor of the unit.
Changes in their practice routine are imposed on them from others in the environment (hospital or nursing administration or the physicians). This does not include changes initiated by support services. The idea of changing how they practice nursing or how their work could be organized differently to be more cost effective for example, does not appear to be a serious consideration for them. They are not interested in change and there are no apparent expectations to do things differently or be prepared to do things differently. Change is slow in coming. The expectation on the unit is to maintain the status quo and be dependable and stable. The nurses believe the way they work is fine and trying to be imaginative or creative is not the solution.

One nurse explained:

Change does not occur rapidly here at all. Sometimes you present a new idea and it has to be presented maybe once or twice before it’s actually grasped. A lot of things we do because others do it, that’s how we were taught to do it. It’s repetition as opposed to a new way to do something. There’s not a lot of creative thinking that way. A lot of things we do because we’ve always been that way, we do it this way. I mean, people don’t like to admit that, but there really isn’t. Once you learn basic nursing process, there isn’t a lot of change to that. Change occurs with new equipment. Maybe a new technique. But that’s usually initiated from the physicians point of view. We always do our dressings the same way, we don’t change that unless that’s ordered, unless they’ve got a new way for us to do it, and then we have to go learn it. That doesn’t happen every week every month, whatever. We didn’t use creative thinking to come up with that new idea.

Nurse Peers. The nurses exert "peer pressure" or high expectations that work gets done. This is a strong norm of the unit. Peer pressure is often in the form of a frown when the nurse reports off to the next shift and work is carried over. Nurses talk to guilty nurses. If neither
strategy works, than the nurse manager comes into the picture. The scenario is portrayed by one nurse as follows:

Oh well, that’s happened a couple times and I’ve talked to them. And I’ve seen other people talk to them, if they kept repeating it, then we’ll let the nurse manager know there’s a little problem here. Because if they’re not doing their job, if they’re letting work go on to the next shift, when you’re really busy that’s understandable, that’s no problem, but if somebody is just like reading charts and not doing their work, and then leaving it for the next person, that doesn’t go over. We’ll let them know, and if that doesn’t work, then we’ll let the nurse manager know and she’ll talk to them. She’ll tell them, this is a concern and most of the time I’ve seen improvement. Because nobody wants to be the little, black sheep, because if they’re making everybody else mad at them, that’s not going to do them any good either.

The goal of nursing care is to provide quality care to all the patients. Quality care is following through with anything they identify and commit themselves to do for their patients as well as for each other, completion of tasks for their shift, doing the tasks “right” and not slacking off on things. If a nurse does not do things “right” or does not complete her daily work repeatedly, a formal evaluation is given by the nurse manager and the nurses eventually exclude the guilty nurse from “family” gatherings. One nurse described how this might happen:

Exclusion from the group is a good way. Missing an inservice. Little things like that. The little things, I’ve noticed, upon the other shifts, mealtimes, that’s interesting. No one makes sure that you’re asked to eat at a certain time. It’s like, if you’re really busy with your patients you’ll just keep working and working and everyone else will go and they’ll have their meal. And then later it’s like, where’s so and so and well, we better go see what happened to her, instead of at the time. It’s very subtle. You’ll notice, mealtimes are a big thing, because it’s always a certain group eats together and one or two.
The nurses identify two main groups on the unit. One is the core group who has been there the longest and then there are the "others". Each member of the core group is characterized as having "knowledge" meaning an indepth experience in a particular clinical field or a "generalist" meaning they have enough experience and perhaps some additional formal classes. Both the specialist and the generalist are identified as the unit's clinical experts. They have skills which are needed by the rest of the group, like the ability to start intravenous fluids. They are willing to share and to learn, and to admit what they do not know everything. They can be trusted to do what they say they will do. The core group is identified as a "click" by the "others". The nurses in the core group believe the group should remain stable and do not accept the exit of one of their members lightly.

Oh it (click) exists. On the unit, I think the longer people have been around and the more experienced group has a tendency to stay together as a click and I think that's what the new grad finds a lot of difficult is breaking into that group and to be recognized. ... the people down at the bottom are always turning over because they have trouble breaking in and fitting in with the rest of what's going on with the group. But I think basically for the majority of the people that are here, they find it a very supportive work environment. It's an open, caring management.... you have to just learn the nature of the group and I guess they're not really strict hard fast rules, they exist, but, it's really hard to say. Either you catch on to it, or you don't.

There is a way for the new nurse to gain entry into the core group. The nurse must be trustworthy and not prone to backbiting. As one nurse stated:

You're expected to do your job and if you don't do your job, very subtle ways, you're let known that you're not completing your work. But once you fit into the mold of it and you can complete everything timely and you communicate
well with patients and you establish a sense of, what's a good word, you have to be reliable in your nursing judgment. Reliable in your work completion. You have to establish some credibility with your peers. Once you get to that point your day seems to go better. People trust you, you can ask them questions, there's more of a good exchange. I think the new grad up here really has a difficult time for really the first nine to 12 months that they're here. They really don't finish orientation for 10 weeks, but I think it takes longer than that to fit into the routine of the unit.

Teamwork and support on the unit is essential. Teamwork involves a willingness to help when requested and to ask when you need help. It is a two-way relationship. A nurse explains the kind of teamwork that exists or is desired.

I think there's a lot of teamwork. I feel like there is. There's times when you feel very singular and isolated and then there's other times where if you've got a problem and you say, look I've got a problem, I need help, you'll get it, right away. No questions.
I: Even if you're not in the in group?
S: See that's, I don't think it's as easily given to some of the people. But it's hard to tell, maybe that cooperation isn't given to them because they need to be more independent and learn to grow on their own rather than fostering dependence and going to make you more independent. It's really hard to tell. Say a patient definitely gets in trouble, I think it doesn't matter who you are, there's going to be people there to help you regardless.

There are a few nurses who recognize the delicate task of asking the right people for support. Some nurses are not team players and prefer to work alone. Some nurses feel each nurse should handle her own work assignment. The nurses do not ask those individuals for assistance but wait until someone else is available. They learn who those people are because their body language is evident.

The nurses believe they support each other through peer recognition. When a nurse has done a good job with a patient or has been
successful in getting through a difficult day they say something to the
nurse or they nominate her for a special hospital-wide award.

The nurses believe individual behavior and values are important.
Nurses on the unit are expected to be motivated, eager to learn, be a
team player, help maintain a cohesive group, be committed to the job
even to the degree that one feels guilty if they call in ill, be able to
interact with patients and physicians positively, be diligent with
completing tasks, learn how to perform skills well, and be conscientious
and follow through with what needs to be accomplished. Nurses on this
unit are expected to be assertive, but it is a delicate balance between
being assertive and being aggressive. If the nurses are making sure
their patients’ tests and procedures are being done promptly by other
support services or are on the phone clarifying orders with the
physician, such behavior is labeled as assertive behavior and
demonstrates initiative and responsibility. However, if a nurse
complains about another nurse or make comments about her patients’ plan
of care, it is labeled aggressive behavior and it is not tolerated. The
nurses on this unit talk more about professional issues than who is
doing what with whom. They believe they talk directly with each other
about any problems and do little back-biting.

Well you have to be assertive to work here, the aggressive person
is generally avoided or they back off from those kinds of things.
Aggressive comments are usually ignored. There’s a difference. You
have to be assertive when it comes to dealing with physicians and
getting certain things for your patients and stuff. And the
totally passive person who does not assert themselves that way,
you’ll have as much trouble as an aggressive person.

Although we are a bunch of characters up here. We’re very
outspoken on this unit.
I: If you weren’t outspoken would you survive?
S: I don’t think so. I really don’t. I think in order to get along with the physicians sometimes we have to be that way. I’m not talking about interns, well interns sometimes but most of the time, the last couple of years, we’ve had interns who are more intune to patient needs and nursing needs and so forth than we used to have. But some of the residents and a lot of the attending are still from the old school, nurses are handmaidens. So if you don’t stand up for yourself you wouldn’t survive.

Physicians. The nurses believe they do not exercise nursing judgement as frequently as they might since physicians are easily accessible. Nurses express a sense of security in knowing something can be done relatively quickly for patients and feel their actions are covered from a legal perspective because they involve the physician. Nurses frequently disagree with physicians’ decisions but admit they must follow the medical orders. Decisions are dominated by the physicians’ wishes.

The nurses believe communication about the patients is primarily one-way, nurse to physician. The physician only seeks out the nurse to give her directions about tasks they want performed. The nurses believe the physicians should gather information about the patient from her and include her in the decisions about the patient. She believes when she approaches the physicians, they brush her off and do not listen because they are in a hurry to go someplace. The nurses feel physicians do not value what they know. Nurses must speak out to let their opinions be known if they are to survive and be the patient advocate. Some physicians are very open and willing to listen and take the nurses’ advice, while others are described as being difficult. The nurses believe they have must challenge the physicians when their orders are inappropriate. Nurses believe there is potential in this environment to
develop teamwork and collaboration with physicians. A nurse described this potential and the reasons why the difficult situation exists.

the role of nursing in relation to medicine probably is heightened here because of our medical teams, that we tend to work with inexperienced and very changing medical staff, so I think the role of nurses in collaborating and helping physicians learn and sharing from our expertise, takes place here. Or has the potential for doing so. I'm not sure that the medical staff is as open, always, we've had some really good interns in this last year. But I think at least the potential and at least to some limited extent, the practice of collegial relations is there. I'm trying to think in terms of this developing a team approach between medicine and nursing. They tend to round separately and we don't get involved very much in their interaction with a patient, so that I don't think our mutual efforts in the patient's behalf are as strong as they could be. Cause they go in and talk to the patient, get information from the patient, go out and decide what they want to do. We get them in the hall, and try to gunshot little problems that we see, in terms of really problem solving together about things...

Support Services. Support services (i.e. housecleaning, dietary, physical therapy) and nursing services have many complex and continual problems which impact nursing practice. They appear to stem from the differing work goals of nursing and support services, the lack of consistent delivery of quality support services, and the need for communication between nursing and support services. The nurses believe nursing and support services need to remember everyone is here to provide services to patients. Nurses believe they provide and focus on individualized service to their patients where as support service personnel come, do their thing and leave the unit when their specific task is completed.

The nurses believe they have no control over when supplies necessary for patient care are delivered to the unit. The same old
problem of inadequate supply keeps happening so the nurses do not have the basic things they need to do their job. For example, wash cloths to give baths to patients. The nurses believe support service personnel do not take their jobs seriously because nurses frequently do not have the supplies they need. Nurses believe they have to fill in for support service personnel when they do not carry their load. A nurse described the situation vividly:

The irritants, support services, is a biggie. We get very inconsistent support from people who supply linen. Getting our supplies is a constant problem. In general, the physical environment in which we work is not well cared for. We've got our nurse servers that are broken and falling apart, they're filthy inside from trays and that doesn't seem to be a priority to get that kind of stuff taken care of. Irritants are in our dietary and in our phlebotomy department, that there are individuals who don't take their work as seriously and if trays come cold or if patients don't get what they ordered, it's no skin off my nose, so we have some amount of that in dietary. Phlebotomy will not always take a second try at getting blood, or they take forever to get them if we have a stat blood to be drawn. So we end up picking up in housekeeping areas, in dietary areas, in blood drawing areas, more work than we would need to do. Running for supplies. So there's a lot of that kind of stuff that is an irritant.

Communication lines with the support services is lacking and nurses spend a great deal of their time taking care of "failed" support services. In addition, the nurses do not believe they receive adequate or timely feedback on problems brought to their attention. The nurses believe the nurse manager tries to deal with the problems of the support services and nursing personnel believe they have cooperated in trying to solve problems.

Patient. The nurses believe they are taking care of patients who are chronically ill with little hope of recovering, who are emotionally
and physically dependent on them and require the latest in medical care and treatment. They believe most of their patients are "nursing home type" patients and that few will be "cured". Patients are a part of the unit for five to eight days. Patients enter the unit from every location in the hospital and from outside the hospital as well. The nurses believe these patients exhaust them emotionally and they do not receive the staffing or the recognition they deserve for taking care of these patients. One nurse described the type of patients the unit received in terms of a "dumping ground":

... it still is a dumping ground for patients when we get something from everybody and we get the worst things from everybody so the acuity and the tough patient care we have to do is very intense and that's hard and it's not fun, most of it's not fun. It's a mess. There's nothing fun about it.

The nurses joke about the amount of energy it requires to care for these patients and the fact that the staffing-acuity system does not reflect the time these patients require. They describe their patient population almost in terms of nurse martyrs which may explain why the nurses stay and continue to provide nursing care.

...sometimes we joke but it's really in all honesty very true that sometimes we're not giving emotional support to these people, we need emotional support because they are just so demanding and so draining and there isn't a way to account for that. You could chart that all day long, that this person called out every ten minutes, wanted you in there to pull up the covers, to pull the blinds to open the blinds, to pour the water, to gripe at me about this and gripe at me about that, but there's no real way on that tool that they use to justify staffing...

Nurses believe they are rewarded by these patients because sometimes they see they make a difference in their lives. Other times
they describe the process as "... it's like beating a dead horse. You just are getting nowhere sometimes and then they come right back in the same boat".

Nurse Manager. The nurse manager is regarded highly by the nurse participants. The nurses believe they are supported by her and in return they support her. She has specific ways of performing her role in regard to team building, support, communication, conflict resolution, performance and quality care on the unit. The nurses realize she is accountable to nursing and hospital administration.

Every morning at 5:30 A.M. the nurse manager calls the unit to ascertain how the night staff is doing and if the day shift staffing is adequate. She protects her staff from being temporarily assigned to other units and jeopardize the care of the patients on this unit. She allows the nurses to be innovative and to participate in decisions being made about equipment for the unit. She is willing to listen confidentially to any issue that one of the nurses has and promptly handles the situation and resolves conflicts between the nurses. There is a trust level between her and the nurses that facilitates the cohesiveness of the group. Her feedback is usually positive and she makes you feel important. She communicates confidence in her staff so that the nurses want to perform well for her and the nurses believe the nurse manager will help them to accomplish the quality of care they want to give. She reminds the nurses about the standards to be attained but is not hyper-critical, pitches in and helps when needed, and strengthens the notion that the unit is a family. As one nurse described:
She does a lot of positive things that I think build family spirit, she went through a day—every Thursday was pizza, we're ordering pizza, she remembers everyone's birthdays, some of those kinds of things might not seem, not a lot of manager's recognize the contributions that makes but she always recognizes people's special days.

The nurse manager is viewed as a problem-solver between the nurses and able to resolve any disagreements.

She really gets us working together, if there's a problem she tries to solve it, we have very few staff problems between each other, and I think the nurses manager has a big thing to do with that, cause she tries to do whatever she can for all of us.

The nurse manager is the person responsible for hiring new staff that "fit in" with the unit. The nurses believe she hires people that are cooperative and flexible. She prefers hiring experienced people but will hire new graduates, especially if they have worked on the unit as students and she knows how they work. In this way, the nurse manager attempts to maintain the team and family atmosphere.

The nurses believe the nurse manager is supportive of their growth and learning. She makes it a point to find out their special interests and goals. The nurses are recognized when they do well both formally in their yearly evaluations and informally at staff meetings with a "chocolate award". The nurse manager encourages the staff to nominate other unit personnel for hospital-wide recognitions.

The nurses believe the nurse manager is very comfortable with promoting continuing education and is not threatened by others' knowledge because she is confident of herself as a manager. They
describe the growth process as one of attaining more confidence and being allowed to do more as confidence grows.

The nurses believe the nurse manager is very open, direct and current in communications with them. This frequently occurs informally in the conference room. The nurses perceive the nurse manager as sharing information with them promptly unless it is confidential information. She is comfortable with group or individual communication situations.

The standards of care for the unit, emphasized in the ten-week unit orientation program, are well known by all the nursing personnel, are applied equally to everyone, and are audited by the nurse manager. The nurse manager informs them, "in a professional way" if performance is not up to expectations. She expects the nurses to operate within the policies of the hospital and she enforces policies equally.

**Summary: Nurses' Beliefs about Unit Ethos.** Ten beliefs dominate interview responses about unit ethos. The beliefs are:

1. Hospital administration does not respect or support the nurses. Nursing does not have sufficient decision-making authority and visibility within the institution.

2. The hospital is a business concerned with costs, profit and institutional survival where as the nurses' main concern is with quality patient care and cost should not be a primary criteria.

3. All nurses on the unit must provide the best care possible or else they leave.
4. The unit is a family and all the nurses do their part to maintain the integrity of the unit. They expect each family member to function in the position for which they have been hired.

The nurses as family members, support, trust, protect, respect and have fun with each other. They are friends and work as a team. They do not criticize each other but take care of each other. They learn from each other. Peer pressure maintains the standards of work quantity and quality and exclusion from the group assures compliance with those expectations. Loyalty is expected and leaving the group is seen as a breach of membership. They believe all types of patients arrive on the unit and they are competent to take care of them all.

The nurse manager is the quasi-head of the family and role model for maintaining unit loyalty and quality of care. She resolves high level conflicts between members, builds members’ strengths, confidence and self-image, protects the members from outside negative influences and promotes activities that support a cohesive unit. The physicians are viewed as inconsistent, intrusive, irresponsible and elitist neighbors. They are not seen completely as outsiders by the nurses because they do respond to the nurses’ calls in a timely manner. The nurses obey their orders and dutifully call them about certain matters deemed beyond the nurses prerogative. They are not ignored because of legal ramifications and the influence they have with the hospital administrators.

5. Creativity is not a vital part of their nursing care and change is slow. Change is initiated from the physicians via new treatments or equipment.
6. Length of time on the unit and clinical knowledge provide the basis for membership in a core group. The core group is a nucleus of nurses who have tenure on the unit and an identified area of clinical expertise. The less tenured nurses are expected to utilize these experts in their care planning and in patient care circumstances that warrant their advice and counsel.

7. Nurses need to be motivated and are expected to continue to learn.

8. Nurses must be assertive to provide the care necessary for their patients.

9. Nurse-physician communication is one-way and is initiated mainly by the nurse relative to a specific patient concern. The physicians are not expected to communicate openly with the nurses. The nurses are expected to call the physicians and remind them about their responsibilities (i.e. a patient's medication that needs to be renewed).

10. The support services are not perceived as adequate which results in time wasted for the nurses.

The hospital and unit ethos as portrayed by the ten beliefs appear to foster two major expectations for nurse behavior. One is the norm of dependency on each other and the physician. The second is conflict and tension between the nurses as a "family" unit and the support services, physicians and hospital administration.

The hospital ethos does not demonstrate to the nurses respect for what they are doing, so why should the nurses respect the hospital's goals? The fact they may be perceived as different is not the issue but the underlying conflict established because of the lack of respect and
trust felt by the nurses. There is an atmosphere of being separate from the hospital ethos and of indifference. At the same time the nurses know their own personal economic security is at the mercy of the hospital as their employer and therefore they voice frustration. They do not acknowledge that they are part of the hospital ethos and partially responsible for the ethos.

The nurses struggle with, independence/dependence. The nurses want to believe they are part of a protective and forgiving family on the unit yet they isolate themselves. The family environment of the unit fosters dependency. At the same time a primary nursing model which is built on the notion of a professional, autonomous nursing staff masks what is really happening because nurses are supposed to believe that they are autonomous and independent. Nurse dependency is supported by the ethos of the hospital and the family model. Tensions are established. The nurse is expected to accept things the way they are, to feel good about the family, not to rock the boat and yet feel as though she is growing and learning as a professional nurse. For some nurses, the family unit approach is more comfortable than the professional model. They remain in this organization. For others, the professional model which fosters intellectual growth, peer monitoring and critical evaluation is the challenge they desire. They tend to leave the organization.

The nurse is expected to make the system responsive to performing the tests and procedures ordered for the patient. She believes this is for her patients when it is more for the efficient operation of the system (i.e. it is financially important for the hospital to decrease
the number of days the patient is hospitalized). Therefore assertive behavior relative to calling other departments or the physicians is encouraged to achieve the services the patient needs to leave the hospital and support the recent financial constraints placed on hospitals by the Federal Government and health care insurance companies.

Nursing Practice Explored by Participant Observations

The second step of the analysis explored actual nursing practice by observing the same nurses who participated in the interviews. The research question was, What is the actual nursing practice on this hospital unit? The nurses' observed behavior represented their beliefs about nursing practice. The norms and expectations of the unit were reflected in the nurses' behavior and interactions with other hospital personnel. The 16 participant observations, (14 different nurses, two were observed twice) took place on the unit where the nurses work on a regularly scheduled basis.

The participant observation method allowed the researcher to observe what the staff nurses on this unit do on the job. The researcher did not approach the participant observations with any predetermined way of classifying the observed behavior. There are many variables in this complex environment and an attempt to quantify every activity of the nurse was not the intent of this part of the study. The nurses are the staff nurses who are the participants throughout the study. The importance of the following data must be carefully considered as they are descriptive.
The physical characteristics and structural plan of the unit are described to provide a sense of the context for the participant observation data.

The layout of the unit was a U shape with the patient rooms on the outside and the inside areas housing the various offices, conference rooms and supply areas (Appendix A, Figure 8). The majority of hospital rooms can have two patients. The halls were carpeted. The lighting was variable and quite dim at some nurse servers where the nurse does all her charting. The nurse server was a built-in cabinet with doors outside each patients' room. The nurse server was accessible from the corridor and from the patients' room. It contained supplies, linen, nurses' charts and medications for the patients in that room. The doors were usually left open all up and down the corridor. The hallway was noisy from the number of people that were coming on and off the unit. The doors to other parts of the hospital at the end of the unit were very noisy whenever they were opened or closed. They were fire doors and could not be left opened. Dirty linen bags hung on the patients' door or were on the floor by the patients' room for periods of time in the morning.

The housekeeping equipment was in the corridor most of the day. Stretchers, the unit scale and specimen carts from the lab were frequently visible. The staff were searching frequently for the unit's large scales to weigh patients. A dietary cart was a frequent site, with SPD (Sterile Processing Department) carts containing bandages, needles, tape, and various solutions, and linen delivery carts making rounds on a regular schedule. In the afternoon the pharmacy cart arrived and blocked
the entire medication room door and half the corridor during the exchange of each of the patients' medication "bins".

The conference room had a round table and several bulletin boards. They were each designated for certain items to be communicated; staffing needs, quality assurance activities or social. The room had two small couches along the wall and a microwave. It was small but did provide a place for some relaxation.

There were few places for nurses to sit or to have quiet time for care planning. Nurses stood almost exclusively during the day. The only time they were sitting was in the chart room when they were checking medication orders, during the time in the nurses' conference room, and at lunch. The nurses did not seem to be aware of their environment. They walked the hall obstacle course and appeared to shut out the voices when they did their work at the nurse server.

Nursing Practice Revealed by Participant Observations: Nurses' Beliefs

The nurses' behavior was observed for approximately three hours in the morning and three hours in the afternoon. The activities they were engaged in were immediately recorded. The behaviors as recorded from sixteen days of observation were categorized into thirty-four tasks and then condensed into twelve work responsibilities. The twelve work responsibilities (Table 1) were:

* Family contacts, emotional support and teaching
* Oral medication administration
* Intravenous medication administration
* Documentation
* Care planning
* Admission, discharge and continuity of care
* Performance of treatments
* Checking medical orders and physician-nurse dialogue
* Interruptions in the nurse's work flow
* Obtaining supplies from the unit
* Obtaining supplies from SPD area (Sterile Processing Department) and
* Miscellaneous.

The average number of occurrences of each of the twelve work responsibilities was based on an average observation period of 6 hours and 20 minutes per nurse. The total average number of work responsibilities was 113. The average number of occurrences of each of the twelve responsibilities is in Table 1. Figure 2 displays the same information but in a pie chart.

The number of occurrences of a nursing responsibility ranged from a high of 22 to a low of 1. Care Planning (22) and Oral Medications (21) were highest. These work responsibilities were observed in all nurse observations. Care planning included discussing, planning and directing patient care, reading the nurses chart and checking the patient kardex (The kardex is a type of chart where the patient's current plans for tests and treatments are recorded and kept current). Oral medications included preparing and charting oral medications.

Treatments (14) included the tasks of taking patients' vital signs, dressings, measuring intake and output and specimen collection and delivery, making beds and baths, obtaining and recording food and
Figure 2. Average Activity Profile. Data are averages for 16 observation periods averaging 6.33 hours in duration.
refurbishing ice water. Interruptions (13) were categorized based on source; either from the nurse's beeper or interruptions from other employees. Patient related interruptions were tabulated separately and originated from the beeper or from other employees. The patient related interruptions accounted for 4.6 average occurrences; 2.4 in the morning and 2.2 in the afternoon. Other beeper interruptions accounted for 2.6 of the occurrences and other people interruptions accounted for 5.8 of the activities. Documentation (11) included the activities of general charting, preparing chart forms and charges and incident reports.

Obtaining supplies (10) included searching the unit for supplies and going to SFD (Sterile Processing Department) to obtain needed supplies. One nurse was not observed as having to obtain supplies during the observation times. Checking medical orders and physician-nurse dialogue had 7 average occurrences. The checking of medical orders tended to occur in the morning and the nurses were required by policy to check all insulin orders daily and prior to administration. Physician-nurse dialogue was the conversations that occurred in the hallway usually outside the patient's room. This dialogue tended to be for clarification of a physician's order. Miscellaneous (5) included ordering special equipment, looking for the narcotic key, delivering the medication bin to the medication room and trying to find a place for the dietary tray. The work responsibility categorized as miscellaneous was not present in two of the nurse-observation times.

Tasks associated with the family and significant others, emotional support and teaching had an average occurrence of 2 and were not observed for two nurses. Admission, discharge and continuity of care
planning (1) had the lowest number of average occurrences per the 6 hour
and 20 minute observation period.

The twelve work responsibilities appeared to vary in the amount of
patient contact and the amount of physical energy required by the nurses
for implementation. The performance of treatments (14) and the
administration of oral medications (21), both required direct patient
contact and accounted for 42 of the 113 (37%) average number of
occurrences. This does not account for the amount of walking that was
done from place to place and room to room to perform these tasks
according to the times they were ordered to be administered. An
interesting, yet quite obvious, observation common to hospital
environments, was that medications and treatments were ordered for
administration to all patients at the same time. It was quite impossible
for one nurse to administer all the medications to say four or five
patients at the exact time ordered. Even though this was not strictly
adhered to, the mental gymnastics on the part of the nurse to figure
this out might become another source of mental expenditure and concern.
It was expected that the administration of medications and the
performance of treatments be completed within a specified time frame.

The work responsibilities of documentation, care planning,
admission and discharge and continuity of care, and family, emotional
support and teaching accounted for 36 of the total 113 (32%) average
number of occurrences. These tasks tended to involve standing at the
nurse server for periods of time reading and writing.

Checking medical orders, miscellaneous, interruptions, and supplies
accounted for the remaining or 35 of the 113 (31%) average number of
occurrences. These activities generally involved walking from the patients' rooms to other locations on the unit. Depending on where the nurses' patients were geographically on the unit, this tended to vary substantially. The above might suggest that the nurses' work does require a substantial expenditure of physical and mental energy and that working conditions, policies and procedures might be considered that would take these observations into consideration.

A consistent work responsibility of all the nurses and a part of the average 6 hour and 20 minute nurse observation was the formal routine of "patient report". Patient report is a legal and professional requirement to communicate patient information from nurses finishing their assigned shift work to nurses coming on duty for their shift work. All patients must have an assigned registered nurse 24 hours a day. Nurses receive their patient assignment for the shift and then listen to report on their patients. The report includes any new orders for the patient, tests and procedures to be done during the next shift, the patient's health status and any significant patient changes that have occurred during the previous eight to twelve hours of hospitalization. It also includes information not normally documented on the patients' chart (i.e. having trouble getting a particular order from a physician, or a patient's complaints about something to do with the hospitalization). The researcher timed the patient care reports as accurately as possible. The average time was approximately 16 minutes in the morning and 9 minutes in the afternoon. The number of people giving reports to one nurse in the morning varied between one to four nurses and in the evening from one to three. The number of people giving and
receiving reports does not appear to impact the amount of time required for the reports. The amount of time required for the reports appeared related to the unit workload index, a number calculated in the central nursing office from patient care information given to them by the staff nurses. The total time for the morning and afternoon reports appeared highest when the workload index was also elevated.

The design of the study did not include observing the nurses at the patient bedside. Patient confidentiality and the number of permissions from physicians and patients required over the study time, necessitated confining the observation site to non-direct patient care observations. In addition, the research question did not concern nurse-patient interactions. The researcher attempted to record the number of times the nurse went into patients' rooms for any purpose. The total average number of times was 39.5 during the six hours of observation. This was split between 19.5 in the morning and 20.0 in the afternoon. Performing treatments and administration of medications accounted for many of these activities.

Summary of Participant Observation Data about Nursing Practice:

Nurses' Beliefs. Many complex variables are present in the work setting. What nurses did was influenced by the nurse herself and the environment in which she was practicing. What she did at any given point in time appeared to be influenced by structural and normative expectations of the system combined with her own values and competence relative to decision making, creativity, energy level and commitment. The delivery
of care to a particular patient was therefore influenced by all these factors.

The nurses were each observed an average of six hours and twenty minutes. The observation time accounted for approximately 75% of the nurses' scheduled eight and a half hour work day, or 53% of a scheduled twelve hour work day. During this time the average number of activity occurrences was 113. Fifty percent (n=57) of the occurrences were activities of care planning (22), administration of oral medications (21), and performance of treatments (14). Interruptions (13), documentation (11), obtaining supplies (10), checking medical orders and physician-nurse dialogue (7), and IV medication administration (7) accounted for 42% (n=48) of the overt work activities. The remaining 8% (n=8) of the activity occurrences are miscellaneous (5), family, emotional support and teaching (2), and admission, discharge and continuity of care planning (1). The morning and afternoon patient shift reports took an average of 25 minutes per day.

Collecting data via participant observation provided the researcher with the opportunity to get a "hunch" about the time the nurses spent in the patients' rooms. During the observation period, the nurses were not in the patients' room very much. This was of interest because of the emphasis placed on primary patient care, individualized patient care and the nurse as primary patient care provider. It was not possible to accurately time the in-room patient contacts. The number of times the nurses entered the patients' rooms was recorded. The nurses in the study entered the patients' rooms an average of 40 times per 6 hour 20 min observation period. If the nurse had an average of five patients, she
entered a patient’s room approximately eight times in the 6 hour 20 minute time frame. The activity occurrence information indicated one third of the tasks required direct patient care contact.

Why the nurse entered the patient’s room was questioned. If the job responsibilities were divided based on whether they were ordered by the physician or if they were initiated by the nurse as part of the nursing care plan, then another point of interest concerned whether the in-room activities were governed by physician orders or by the nurse as a function of her independent nursing practice. Direct patient contact was normally required by the nurses in completing oral medication administration (21), IV medication administration (7), performing treatments (14), and in completing the admission, discharge and continuity of care process (1). These activities were dependent on physician order. They accounted for 38% (n=43) of the average occurrences of the nurses activities. This suggests the times the nurses entered the room (40) she was engaged in ordered activities rather than activities she initiated independently. Activities mainly associated with the independent practice of nursing are, care planning (22), documentation (11), family, emotional support and teaching (2), and patient interruptions (4.6). These accounted for 35% (n=39.6) average activity occurrences. The other activities, miscellaneous (5), obtaining supplies (10) checking medical orders(7), and other interruptions (8.3) accounted for 27% (n=30.3) average activity occurrences. The nurses did not appear to be in the patients room to any great extent. The above information might indicate that they go in to accomplish ordered work
and not to initiate the activities of patient-nurse care planning, emotional support or teaching.

The work of these nurses can be described as the performance of physical tasks or the hands-on activities of patient care in contrast to teaching, emotional and planning activities. Thirty eight percent (n=43) of the average activity occurrences performed by the nurses are physical tasks, ordered by the physician and requiring direct patient contact. Sixty two percent (n=70) of the work responsibilities based on the average occurrences do not require direct patient contact. Thirty five percent (n=39.6) of work responsibilities not requiring direct patient care are closely aligned with the professional role of the nurse. The work was performed by the nurse without assistance and primarily in the nurse's geographical area.

The activities of the nurse provide information about her behavior which indicates her beliefs. The nurse does what she believes is important, required, or possible. The norms and expectations in the work environment influence this behavior and are presented in the next section.

Nurses' Beliefs as Revealed by Activities

In reviewing the findings of the nurses' activities, nursing work was composed of over thirty tasks condensed into twelve work responsibilities representative of nursing practice. For example, the administration of oral medications included the preparing, giving and charting of the ordered medication. The twelve groupings were a result of the researcher's experience in the field and the overall observations
of how the nurses structured their work. The twelve work responsibilities were then counted to determine an average number of occurrences of each. Two routine activities were observed and either counted or timed as they occurred on the unit: the giving and receiving of the morning and afternoon change of shift-patient report, and the average number of times the nurse entered the patients' rooms. These were described separately in the discussion of the findings. The work responsibilities were classified based on whether the nurse by virtue of her job description and legal standards could or could not perform the responsibility independently of a physician's order. Some responsibilities were related primarily to the physical maintenance of the unit.

The findings of nurses' beliefs as revealed by nurses' activities are summarized into seven statements listed below.

1. The nurses' performed tasks, categorized into twelve major work responsibilities, an average of 113 times during the average 6 hour and 20 minute observation period per nurse. Of the 113, 38% required a physician's order, 35% were independent nursing responsibilities initiated by the nurse and 27% were responsibilities associated with unit or system maintenance.

2. The dependent responsibilities included medication administration, performance of treatments and the admission, discharge and continuity of care planning. The independent responsibilities included care planning, documentation, emotional support and teaching and patient interruptions. The maintenance responsibilities included obtaining supplies, checking physician orders and physician-nurse
dialogue, other interruptions and miscellaneous. The responsibilities were interconnected so discussion must consider the lack of absolute distinct and separate work responsibilities.

3. Nursing practice on this unit was primarily oriented to completing tasks within a specified time frame of the nurse’s scheduled work hours rather than providing patient centered nursing care within a twenty-four hour period or even providing some aspects of care throughout the patient’s hospitalization. Nursing care organization was based on time/task parameters.

4. Tasks were to be completed by the nurse as an independent practitioner called the primary nurse. It was physically and mentally challenging. The nurse was held accountable for the responsibilities ordered by the physician, 38%. They were the responsibilities performed the most. Thirty five percent of the responsibilities initiated by the nurse, appeared based on her knowledge, skills, attitudes and patient needs. These responsibilities the nurse had some discretionary power over executing and could influence the quality of the work more directly. The majority of her independent practice was in care planning and documentation (40 average occurrences out of 113). Emotional support and teaching were almost absent (2 average occurrences out of 113). The maintenance responsibilities tended to be the areas of frustration for the nurse; searching for supplies, non-direct patient care interruptions and checking physicians orders.

5. The nurse entered patients’ rooms an average of 40 times during the observation period. This suggested that direct patient contact was primarily for the purpose of executing physician ordered medications and
treatments which accounted for 42 of the average occurrences in her practice. Over 60% of her activities did not appear to require direct patient care contact.

6. The time spent in change of shift reports, approximately 25 minutes per shift, was a part of the average observation time and represents 7% of the observation period.

7. The nurses performed their responsibilities with little interaction with other nurses, physicians, other unit nursing personnel or the nurse manager. They performed responsibilities alone and with little direct feedback from others. The nurses stood at the nurse server or at the patient bedside performing these responsibilities and rarely sat down except in the nurses conference room or the chart area when they were checking physician orders. The nurses were accountable for what they did and their educational growth was dependent on the patients they cared for and what they needed to do for them.

Nursing Practice revealed by Participant Observations: Unit Ethos

The nurses’ behaviors were observed in the unit context which included the actual physical environment and the formal and informal expectations observed in the nurses’ interactions with others. The physical environment was discussed earlier. Nurses’ behaviors appeared to be influenced by the roles and relationships of three groups: 1. nurse peers, physicians and other unit personnel, 2. nurse manager, and 3. services of other hospital department personnel. The unit nursing staff category included unit based hospital employees with the exception of the registered nurses. The nurse peers were the unit based registered
nurses or unit staff nurses. The following sections describe the behaviors of the groups, the nurse manager and the support services as observed by the researcher during the participant observation periods.

**Nurse Manager.** The position the nurse manager holds influenced nursing practice of her staff. The authority and responsibilities of the nurse manager were accepted by the unit staff nurses and they cooperated and accepted the behavior associated with the performance of the role. She had her work to do and she allowed, facilitated and expected the nurses to do their work. She supported the nurses’ role and in turn they supported her role.

The nurse manager was viewed by the nurses to be accountable and responsible for the staffing and scheduling of the unit staff. She changed the staffs’ work schedules to accommodate other unit and patient needs and was not challenged when she decided the level of staff to be allocated to work at any given point in time. She posted the work schedule ahead of the starting date and expected the staff to fill in uncovered shifts which were sometimes uncovered for a number of weeks. Nurses that volunteered to work extra shifts or alter their usual work schedule pattern were rewarded by her approving their requests for special days as their off work days. The staff knew they were expected to cover the uncovered shifts and in return knew the nurse manager would protect them from being reassigned to other units if they were over-staffed and another unit was in need. She called the unit at 5:30 A.M. every morning to check on the staffing and to discuss the staffs’ assignments for that day with the night nurse. She introduced temporary
staff to the rest of the staff with enthusiasm and explained any unique aspects of this unit to them. The nursing staff responded in the same way to other new or temporary staff.

The nurse manager was seen to be accountable for knowing and controlling system and unit variables so the nurses could practice nursing. For example, she questioned the admitting department when an "off-service" patient was admitted to this unit. She would challenge the phlebotomists (people who draw patient's blood for a specimen) when they did not follow through with what the physician had requested. The unit personnel and nursing and hospital administration expected her to know the staff and their level of competence. She was expected to know the patients and what was "going on" in the unit. She enforced her "no transfer policy" to control the work associated with new admissions and transfers. Transferring patients was considered a "waste of time". She believed her staff capable of providing the best care possible to a wide variety of patients and unless there was an unusual reason why a patient needed to be on a specialty unit, she insisted the patient stay on this unit. She assigned quality review checks to the assistant nurse manager which demonstrated her accountability to nursing and hospital administration for the quality of care delivered and conveyed standards for the quality of care to nurses. What she evaluated were the tasks performed by the nurses and they were rewarded with open praise and recognition. She was "in charge" frequently which meant that she would go around the unit and check on how people were progressing with their work and received patient reports at the change of shift from each of the nurses.
The nurse manager was seen as a helper with patient care because she helped with IV’s, special patient care problems or the general work when the pace or the amount of work increased. She demonstrated her skill in responding to patient and staff needs in taking charge of an emergency situation. She was visible on the unit. The staff expected her to be the liaison with the other hospital departments and refer problems to her. They did not feel that they had the authority to deal with these problems but she did. Any problem was dealt with sensitively, timely and with feedback.

She went around the unit and reminded the nurses every Thursday morning of the 9:30 A.M. Interdisciplinary Patient Discharge Rounds. This appeared to be a source of conflict with the nurses. One nurse felt it was an interruption in the morning routine which was not that beneficial and another voiced concern because when she was assigned new patients on Thursday morning she fumbled around at the conference when asked about the new patient. It seemed a source of embarrassment for some, a waste of time for others and an annoyance to many. The nurses did not talk about these discharge rounds on the unit other than on Thursday mornings.

Her communication techniques were strong, dependable and reliable. She informed the staff about everything as soon as she was aware and they were comfortable knowing that they knew as soon as she did of any changes that might influence their work life. She encouraged open dialogue with herself. The norm was a strong sense of mutual trust and support between the nurses and the nurse manager. The nursing staff were proud to be working with and for her.
The nurse manager cared for her staff and demonstrated this. There was recognition and acknowledgement of her loyalty for the unit, and the staff in return were loyal. A negative word about the unit seldom crossed their lips. She openly voiced that she would not permit her staff to be reassigned to the detriment of the unit. She started a fund for a staff member’s recent loss of her parents yet was protective of the nurses’ private lives. She cared because she helped them do their work when they needed help and was concerned about their energy level when certain situations were difficult and emotionally draining like an emergency. She was a worker and a helper. She was seen trying to locate the scales to weigh a new admission. No task was inappropriate for her to perform. This role modeling set the stage for what was perceived by the nurses as a very supportive work environment.

The nurse manager was concerned about the appearance of the physical environment. She was always putting equipment away or in the right place for other services to pick up. She was kidded about always cleaning up the nursing conference room. She asked housekeeping to do special cleaning jobs.

The nurse manager was a team and morale booster. She helped build enthusiasm for organizing a unit baseball team, she "orders-out" (usually pizza) for lunch periodically, she offered encouraging remarks to the staff when she is "around" on the unit and encouraged unit parties. This role was maximized because of her sense of humor and her characteristic laughter. This resonated, as did her voice, throughout the unit. She wore stylish, colorful clothes under a white lab coat. She was a cheerful and happy person. She walked and talked fast and gave everyone
the feeling of competence and efficiency. She did not waste her time or other's time. The resulting effect was a sense of well-being on the part of the staff, respect for their personal and work time and an acceptable way to cope with the ongoing demands of the unit. It was a fun place to work. Everyone knew it was a fun place to work and that was the way it was to be.

Summary of Nursing Practice as Influenced by Nurse Manager. The nurse manager was a key shaper and maintainer of ethos. She expected staff to provide quality care, work congenially with each other, assist each other as necessary, and to report concerns to her. She expected the staff to be dependent on her as the nurse manager and she maintained control of the unit in that way. She controlled by enforcing quality standards, scheduling and staffing the unit, and evaluating staff performance. She was a strong communicator verbally and voiced praise and support for her unit nurses. Her behavior was closely aligned with that of a mother/servant-figure. She supported, protected and guided the nurses. She allowed growth and development based on the individual nurse and expected the nurses to be team players within this family. She was the communication link to the support services, the physicians and the "outside world".

Unit Nursing Personnel. The unit nursing personnel were observed as a part of the environment as the researcher was following a nurse. They were two licensed practical nurses, a nurse aide and a unit clerk. They were present most of the time on the day shift except for alterations
due to weekend scheduling. Nursing practice was influenced by their presence. They relieved the nurses of many of the tasks associated with patient care. These tasks were delegated to them by the nurses and appeared to be congruent with their job descriptions, legal parameters and professional standards.

The position of the Licensed Practical Nurses created tensions for some nurses. A nurse remarked, "I enjoy working with the LPN, our personal styles match." But some nurses had difficulty with the LPN's role as one incident demonstrated in which the nurse reacted to a physician asking the LPN for patient information and the nurse replied, with a finger shaking up and down, "I am the RN, she's the LPN." This could have been interpreted that the nurse was clarifying the responsibilities of each but it was stated in a very degrading way for the LPN. There appeared to be either a degree of jealousy because the physician was talking to the LPN and not the RN, or perhaps a turf "battle" over who was responsible for what or because of the status associated with knowing something and the RN being the official communicator.

The LPNs also received negative reactions from the unit clerk. The unit clerk frequently would not beep the LPN because she said, "It makes double work for me". The nurse was the ultimate decision maker and not the LPN.

The subservient role that the LPN was placed in by the nurse, by the hospital and by the legal definition of the LPNs' practice role, surfaced in verbal remarks made by the LPN's and nurses. Following a code (called by the LPN), the LPN asked if there was something she could
do. The nurse asked her to find a linen bag to clean up the area. The LPN rather sarcastically remarked, "Well, I can handle that." And at another time she commented to the staff nurse she was working with, "May I make a suggestion, I've had this patient for two days." One afternoon the LPN commented, "Quite a morning. You bust your gut to get your work done and then sit in the afternoon and drink a cup of coffee." The LPN's charted for the nurses and then "I (nurse) just check the charting and sign off."

In contrast to this situation, the nurse aide was viewed in very positive ways. She was praised frequently especially on the weekends when she was there to do vital signs for the nurses. This one nurse aide was responsible for changing the beds on a rotating basis; Monday, Wednesday, Friday for one side and Tuesday, Thursday for the other side. She passed ice water when she was there, stocked the nurse servers with admission packs, bed pans and pads, and in general was seen in a very positive and non-threatening light by the staff nurses.

Feedback and comments about the role of the unit clerk were mixed. Her communicating and coordinating role with other departments was essential. Many times the nurses could not understand what she was saying so they had to call her back to find out. The nurses wanted the beeper system, at the same time it was less than perfect which was a source of frustration for both parties.

Summary of Nursing Practice as Influenced by Personnel. The nurses needed other nursing personnel as helpers to complete all the tasks. However, the nurses had a conflict with that need. The nurses appeared to want a primary nursing model because it affords them the perceived
autonomy of professional nursing. At the same time, the nurses needed a team approach to complete all the work. The result was a blend which at times created conflicts for all. The unit personnel in the family metaphor appeared to be treated as "adopted children" or step children. They belonged but their growth and development was not as significant. They were not viewed as on the same level as the nurses. They were included in the parties and the informal activities but not as much in the total unit conversation. Nurses would not ask them to do anything not in their job description. The unit clerk and the nurse aide seemed to impact nursing practice more than the licensed practical nurses. The licensed practical nurses worked under the direction of the registered nurse by law and had little independent practice. They relieved the nurse of the quantity of tasks to be done but were rarely included in the nursing tasks of planning, teaching or patient care collaboration.

Physicians. The medical staff's hierarchy of authority was graphically operationalized on the unit in terms of communications and decision making. "The" physician was a medical student, an intern, a resident or the "attendee", the senior physician-teacher. The interns and residents were called when orders needed to be changed or there was a patient condition change. At times, whoever was on the unit was asked to resolve the problem if it wasn't going to harm the patient. That occurred when the night nursing staff needed to have a "physician" talk with the family of a recently expired patient. The nursing staff told the medical student who was always on the unit early to do the follow up. The medical student just said, "OK, tell me where to sign the
forms." Occasionally the medical student would obtain patient fluid specimens for their own lab work. In one case when a medical student retrieved 80cc's out of a 24 hour urine collection bottle that was completed and on the way to the lab, he spilled the rest of the specimen, the nurses were distraught. They had completed the collection per the physician's order and now this created repeat work for them. This might mean extra hospitalization for the patient as well. The medical students were the ones that personally transported patients to "make sure they get there." The nurses were very aware that the medical students were the ones who read the nursing charts and asked them all the questions every morning before medical rounds. But the nurses did not appear to use this potential line of communication with the rest of the physician group.

When a physician came into the charting area and requested a chart, even if a nurse was using it, the chart was given up. It was considered appropriate for the medical person to receive swiftly whatever was requested.

Physicians discussed and communicated directly with the patient about changes in orders or treatment plans and did not inform the nurse directly. For example, the fact that the patient's intravenous fluid administration was going to be discontinued or that the patient was going to be discharged today. One day a nurse commented, "I believe her (the patient). Why they didn't say something to me I can't figure out. This happens so many times." There was little communication between the nurse and the physicians. The nurse goes into the patient room right
after the physician, "I need to check because sometimes the things they say, you never know."

The physicians come out of the patient room and caucus in a rather tight and exclusive circle and even if the nurse was standing nearby, she was not included in the discussion. However, she rarely attempted to enter the discussion unless she needed to remind them of something; a narcotic order needing to be renewed or a medication that the patient might benefit from. She waited outside the circle until they started to move and break the circle barrier and then she would make her move toward the intern, not the resident. The nurse did not appear to want to risk what the physician's response might be, or the degrading comments that sometimes occur or the extra work and involvement that might result.

The physicians responded to questions but did not seem to feel the need to share what they were planning to do with the patient. They do not seem to feel it necessary to keep track of what had been done for the patient so they reorder tests and procedures unnecessarily. A nurse said, "This doesn't make any sense. These doctors make me so mad. They lack paying attention to what they've already done."

However, if the nurse does happen to be at the bedside during physician-patient interaction it seemed like the dialogue was one of positive and meaningful discussion about the patient's plan of care. This happened on two occasions. Perhaps part of what happens, is the physicians do not know what nurse is the primary nurse for that patient because the physicians do not look at the primary nurse board in the unit station and the nurse frequently does not identify herself as such.
Also the primary nurse tag outside the patient's room was not always accurate either. This suggested to the physician, nurse accountability was not strong.

One day a physician came into the chart room and said loudly, "Who's got Mr. C.? Who's got the nurse server for Mr. C.?" The nurse responded, I do. Is he going home today?" The physician responded "yes" and she responded sarcastically, "That's nice." Then under her breath she said, "After going through all this hassle, he's going out of the hospital today. I'm tired today and not in the mood for this." Discharge planning was not discussed. It required the communication between nurse and physician. It required the physicians making a decision about the patient's plan of therapy as well.

The nurses followed-up with the physicians if the nurses had a really important concern. For example, when one nurse requested a physician come and talk with a very distraught patient and family because the patient was going to lose his last remaining leg. The nurse did not leave this up to chance. She asked the intern first and then a bit later called the resident. Her reason was she thought they wouldn't do it. Nurses did not feel the physicians dealt with code status either (Code status refers to the treatment to be initiated when a patient is considered to be dying and must be a written order by the physician).

One nurse said, "they (physicians) do not look at the wishes of the patient but primarily just what they want to do." One physician won't write code status because, "He doesn't believe in it". This was always a complex issue and very individual. If the code status was not written on
the patient's order sheet, all means to save the patient would be initiated.

The "teaching" of medical students and interns new to the unit was treated in an "underground" fashion. Similar to how a mother might correct the father. The nurses were teaching but it had to be done in such a way that preserved the status of the "learning physician". The nurses really did not dislike this, but there are parameters. "...as long as they admit they don't know it all, it's ok." And, "Well, you can only be accountable for what you know. If you don't ask it becomes a problem". If a new intern seemed really unsure of what he was doing and made comments like, "Well, hopefully he won't die with this dosage", the nurse was anxious. "Boy, he better make sure. I better make sure that he writes that order. This is a lot of backtracking".

The nurse called a physician for clarification of orders or with a concern particularly when a patient was suddenly going for a test. A one-sided phone conversation illustrated, "She'll be going for both? ... OK". Then when the nurse was off the phone, "She's going for a colonoscopy not a bronchoscopy and hasn't had an enema".

The physicians were prompt in returning their pages or phone calls. The physicians knew if they did not respond promptly the nurses would call the next physician on the hierarchy. That may or may not be the physicians' "evaluator" but had the potential of placing the physician in a position of defending what he was doing or not doing with a particular patient to his superiors. The nurses usually stayed right in the unit desk area to receive that call back. The nurses checked orders or lab data while they waited, or talked with the unit clerk. However,
frequently the exchange with the physician was less than satisfactory as evidenced by these nurse's statements. "He doesn't understand my point". A nurse got off the phone and relayed their conversation, "Well, he says to me, "really bleeding huh", I kept asking him more questions and finally said, "I have more questions, you can't get rid of me so fast". The nurses frequently followed up with the physicians to make sure they wrote their verbal orders. "I wish they would write these orders. They don't listen. They treat you like imbeciles. I don't need this today".

The nurses resented the checking of the computerized laboratory test results. "I wonder why I have to do this. What I think it amounts to is we're checking on the docs and I'm not sure of this responsibility".

Occasionally the physician would come by and take the nurse's chart away from the nurse server (The built in wall unit outside each patient's room that stores supplies, patient's medications and the nurse's chart for that patient). That was not seen as acceptable by the nurses.

The nurses didn't always feel confident that the interns were on top of ways to treat certain patients. An alcoholic patient was starting to have tremors and the night nurse during report said, "They (the physicians) wouldn't give him medication. You need to get on top of these kinds of problems." The night staff had to put the patient in locked leather restraints and get a "sitter" as well because the physicians did not treat this patient in the usual way.

The nurses resented the presence of a really "BIG DOC". (A physician with administrative authority within the medical college) "He
comes in here and aggravates the life of all of us, gives us a lot of verbal orders and after he's left there's this discussion going on about it. And if he doesn't have everything he wants, he pitches a fit."

The physicians did not like to spend time trying to start intravenous fluids (IV's) and frequently the patients had very difficult veins. They wanted the IV's in to administer medication quickly if necessary. They told the nurse to try again when she had difficulty even to the point of refusal on her part. Then, when she was successful they act surprised.

One nurse recognized the dual responsibility of nurse and physician in understanding each others roles. She commented, "some of the docs are so nice, then again it depends on how we react. They're here to do some of the same things and they have ideals too."

**Summary of Nursing Practice as Influenced by Physicians.** The physicians, especially in this teaching institution affected nursing practice as a part of the unit ethos. The nurses treated all "physicians" equally on the surface but the nurses were aware of the different levels of experience and education of the physicians. So, the game that was played for the benefit of the physicians learning their role and for patients' sense of security with the level of medical care, created additional baggage that must be dealt with between nurse, physician and patient. And, most patients knew when they came to a teaching hospital they would be treated by many levels of physicians. The game then between nurse and physician appeared quite unnecessary.
The nurses were sensitive and at times fearful of the effect those in the learning situation might have on their patients. The nurses tried to protect the patient and themselves. Nursing time was spent following up and double checking because of potential errors, frequent changes and lack of patient experience the newer physicians seemed to have. It would seem more constructive to address this entire issue in an educational and constructive way and give recognition to nurses and others in a learning environment that a primary task for everyone is helping and facilitating the teaching and learning of everyone in the system.

It seemed as though physicians did not always want to access their own resources and did not want to communicate what they were doing because they didn't always know what that was going to be. This was a factor with this difficult type of patient population as well. The physicians did not seem to understand or want to know how the nurse could facilitate their work and the nurse doesn't understand what the medical education goals are either. The atmosphere of learning together and at the same time providing a benefit to the patient was not evident. The nurse was there to do his/her orders and to inform them before the patient got into any medical problems. The nurse was there to do nursing care and felt that checking up on what the physician didn't do, when he/she knew it was required, was a waste of her time. The nurse seemed to feel it was her responsibility to communicate with the physician and there was no reciprocal understanding on the part of the physician.

Nurses had legal standards and so did the physicians. Nurses had a role to play in the care of patients that was different than the role of the physician. The nurses' role does not appear to be acknowledged by
the physician because the nurse had nothing to do with his educational process except to successfully carry out the physicians orders so that the medical plan of care was a success and his medical future secure.

The nurses were expected to participate in the discharge planning rounds. The physicians can attend or not. The discharge process was very critical to the financial viability of the hospital because the hospital is reimbursed for patient care based on the patient’s diagnosis and accepted length of stay in the hospital. The entire team was needed to be successful and different standards were being applied to this process depending on who you are.

Nurses had their space and patient charts on the unit and the physicians had their space and patient charts. The physicians did their work and the nurses did theirs. But the nurse had to check the physician orders before she was allowed to carry out some of the patient care. The physician did not know about her plan of care and vice versa.

In applying the family metaphor, the physician was perhaps the typical bread winner. He/she came and went and had the power and authority to be independent and access the resources as he needed to. The nurse, like some spouses, felt undervalued. The deeper understanding of each others roles occurred in emergency situations and was where the value of a competent nurse and physician was demonstrated and valued by both.

Nurse Peers. The behavior of nurse peers observed during the participant observation period appeared to influence particular unit
norms in four general areas; nurse communication, decision-making, clinical information support and stress management.

Communication concerning patients was structured formally in morning and afternoon shift reports. The reports started within five minutes of the time the oncoming shift was expected for duty. If there was a problem with a nurse being late for the shift, it was ok to write out the report but that was rare. A nurse arriving on duty routinely picked up her nurse server keys, beeper and assignment at the unit desk and then proceeded with trying to locate the person that would give her report from the preceding shift. Report was received from one to three nurses. So, this was a process of finding the nurse, sometimes waiting for the previous report to be completed and then hoping not to be too distracted or interrupted by others as you were receiving the report. These were conducted in the halls, wherever they can "pick a spot", usually by a nurse server and with the nurses' backs to the hall. The content of the reports was based on the usual question, "Do you know him?" If the answer was yes, then a shorter update of the patient's last 12-16 hours was provided. If the answer was "no", then a more detailed report was usually given. In general the reports appeared complete because the nurses did not say they didn't know what happened the shift before during the observation day. One nurse stated," Report drove me crazy when I first came. I learned to deal with it". Report was the time the nurse received feedback from her peers on acceptable work productivity. Work productivity meant completing the tasks for the patient and making sure needed supplies that could only be obtained on the day shift were there for the evening and night shifts. Expecting the
next shift of nurses to finish your work, "dumping", was frowned upon. Tasks like "chem strips" (tests to determine a diabetic patient's medication), a new admission's assessment and medical order check, equipment needed for the next shift and especially intravenous fluids that had to be obtained from the pharmacy were not tasks to be "dumped".

If the IV count was wrong or if there was a problem with the documentation of a patient with fluid restrictions, the nurse does not leave until it was correct. If the work was not done because of patient requests, that was accepted. Their charting took precedence over new admission orders. Report was also the time when questions were asked about the best way to do certain treatments or handle a difficult patient problem. The "beeper" or the individual paging system provided a way for the unit clerk or other nurses to communicate with other unit nursing personnel. It was a formal means of communication viewed with mixed reactions. The nurses felt it saved them steps and time if they were in one room and one of their patients in the next room needed something. However frequently they could not understand the message coming over the pager which meant they had to stop what they were doing and make a phone call to the desk or go to the desk and find out what the message was. Most felt the pagers made life difficult.

Informal communication occurred rarely in the hall. Nurses passed each other without a word or body motion. They did inquire if help was needed if a person appeared "stressed". The conference room was the place for informal talk which occurred during "Nemus Time" (Nemus is the patient acuity report to be completed by 9:30 A.M. every day) and lunch time. The conversations revolved around social activities being planned,
physician appearance and personality, the new weekend differential for LPN’s and Assistant Nurse Managers, new homes being planned or built, and the cafeteria lunch menu. At times the talk was stimulated by a topic in the communication book found in the conference room. Frequently they discussed a new treatment or medication or raised patient care questions. It was also the place where comments like, "Amazing how one patient can upset the whole floor" could be made without feeling that a patient’s privacy had been compromised. Or another, "The family are reasonably intelligent. I think we should just ask them, What do you want us to do." This was a discussion about a patient’s code status. They discussed a recent code and how it was handled for many days after the event.

Some formal and informal conversations occurred in the chart room early in the morning when the staff nurses were checking their insulin orders. One morning the conversation was about a very heated interchange between two nurses over some work that had been left by the one nurse and the behavior of that nurse when she was "called" on it.

The decision-making that was observed focused mainly on the administration of medications. The nurse decided when patients going for tests or those not allowed to swallow anything would receive their medications and what ones would be given later. The nurses sometimes grouped their 4 P.M. medications and their 6 P.M. medications and gave them at 5 P.M.. They sometimes gave medications that were outdated rather than disturb the physician at night when the narcotic order had just expired. But that was a concern, "I hope those doctors write that order and on the right person". They were very aware of the need for
physicians to update narcotic orders. The nurse decided when to call the physician with changes in a patient’s condition or treatment effects. With one order, the physician wanted to be called with an elevated temperature. The nurse decided not to call even though the temperature was 102.8 because it wasn’t any different than the last time he was told about it. If the symptoms were normal or the test results were within normal ranges, then the nurse would not call the physician. If the patient’s condition changed, like having blood in the sputum, the nurse called the physician. With off-service patients and physicians, the nurse made decisions a bit differently. They questioned the "off-service" physicians more and one said, "I’m going to call him. He knows we don’t know what we’re doing." When an IV stopped running into the patient’s vein and went into the surrounding tissue, the nurse decided how to treat the swollen arm and did so. However, the nurses would never stop an IV without a written physician’s order.

An interesting discussion occurred when a patient arrived from another hospital with a naso-gastric (NG) tube in place. The tube was not labeled which was a requirement in this hospital. The nurse questioned the charge nurse on who should label and decide this was an NG tube and that it was properly positioned in the patient. The nurses decided it was the physician’s responsibility.

The nurses shared their expertise in many ways. This frequently took place during the formal patient shift report. One nurse during report explained how to do a patient’s dressing, the sliding scale insulin routine, how to check on the chem strips for the patient and how to maintain the patency of a particular tube. The nurses consulted with
each other on anything they had not done before or did not know about for example, how to record a special medication given only after lab reports are complete, the action of an unfamiliar medication, how to take a patient’s blood pressure when the arms cannot be used, and how to get pill-form medications down an NG tube. The nurses identified the unit experts in inserting intravenous needles for fluid replacement therapy and even had the top performers rated! They requested assistance and usually received it or verbal instructions. There were other nurse clinical experts identified as well; obstetrics, diabetes, cardiac, and renal. Then there are generalist experts. So, when a patient presented a concern to the "primary" nurse, she consulted with the identified expert on the unit. "I'll show you the tricks of the trade" was the approach and "I've got to go check with NURSE X. She's our resident expert about this". Nurses asked each other what medications had to be reordered on a regular basis, how to fill out the acuity sheet when a patient was very demanding and an emotional drain on them (the nurses do not feel they get appropriate support in staffing for this kind of a patient), different kinds of respiratory equipment for a pulmonary patient, and the kinds of gauze dressing used for a wet-dry treatment. The nurses seemed to have many questions about renal patients, AIDS patients, diabetic teaching protocols, code status and how to deal with some of the ethical issues surrounding prolonging life. These questions were not addressed in any formal way on the unit. This could be because the nurses were expected to find out the answers on their own.

The nurses appeared to exhibit stress in different ways. Some talked louder, or seemed a bit short or irritable with others, some
walked faster or in general looked distraught. In the midst of a crisis one was affected physically and said, "I think I'm going to throw up." Later she said to a difficult patient, "Did you think I ran away from home, believe me I was tempted." And out in the hall, "I want a different assignment." Another day a nurse was most frustrated because the patient was "swelling up in front of me" and the nurse said, "do you ever just want to call it quits?" One said after coming out of a patient's room, "One of these days I'm going to scream. This may be the day." She was trying to find a slot to put the patient's dietary tray. It was not unusual to hear comments as, "I'm lost. I start something and then I forget what I'm going to do". This nurse was going up and down the hall with a strange look on her face and not a purposeful walking stride.

The nurses tried to handle the unit stress. They verbally supported each other. One said to a nurse going home, "Have a good day. Try and block it out". They kidded each other, "You're supposed to fix them up. (comment to the night nurse from the day nurse) They're no different today". Some said they go shopping to have some diversion. They organized unit sport teams, planned baby showers for the staff and ordered out for pizza whenever they were having a "bad day". Home and family were a big source of support and coping. The nurses maintained routines to help cope with stress. "I am paranoid about the med sheet. I always check that last for fear I might forget something".

Their individual approach to organizing their work was a coping mechanism. One nurse said:

Do you want me to tell you how I've organized my system? It's helpful for me to chart and then I go back and make sure all my tasks are done, what I have done the first part of my day. Then the rest of my day, I go back and check my orders and do my
charting. It's easier to put the charting off than the IV's and the dressings. I try to get the skill stuff out of the way. I collect my bins and take those back and then concentrate on the charting.

Sometimes support for each other seemed selective. For example, nurses gave their beepers to certain ones if they had to leave the floor. And they assured the "receiving beeper nurse" the patients are OK. It was not OK to leave problems for another nurse. A comment was heard from a nurse peer after a code situation and the primary nurse was involved and could not take care of the patient's arriving family, "Well, you know, those are NURSE X's patients". Another time when a request was made and not received, the nurse said, "That's ok, she's is supposed to be on the other side". There appeared to be definite informal rules about who helped who and under what circumstances. Although it was done in a joking way, one nurse said to another who was looking in her nurse server, "hey, what are you doing in my server"? Yet this same nurse borrowed a watch all day to measure patients' vital signs. She was the same nurse who commented, "Nursing has its work and physicians have their work and that's the way it is". She had her own way of coping.

Summary of Nursing Practice as Influenced by Nurse Peers. The nurses' expectations about nursing practice on the unit was a significant influence in shaping actual practice. Patient communication was to occur in morning and afternoon scheduled report times and patients' conditions were rarely discussed except in reports. During report, knowledge and information were shared. A nurse's decision on her
patient's plan of care was not a topic for evaluation or discussion. The nurse’s quality of care given was not discussed. It was acceptable and expected that the nurse discuss special patient problems with the unit clinical expert. Informal communication took place in the nurses’ conference room and rarely out in the halls. They shared personal interests with each other. Experience and skill ability were valued by the nurses.

Nurses helped other nurses if their work was completed, when there was an emergency situation or if a nurse looked especially "distraught". The beeper, or the paging system, was considered a necessary irritant so they all made do with the system.

Nurses made decisions within the parameters of unit and hospital policies and procedures. They were not as policy-bound with the times for medication administration.

Nurses acted out their stress verbally on the unit and in the nurses’ conference room or by quietly talking with another nurse peer or the nurse manager. Nurses knew what nurses to ask for assistance and when to ask them. Nurses completed all tasks with few exceptions before the end of the shift and before they went home. It was not acceptable behavior to "dump" on the next shift.

Services of other Hospital Departments. The activities of the personnel employed by other departments in the hospital were observed to influence nursing practice. Due to the limited time in the participation phase, and because the focus of this study was nursing practice, it was not feasible to review and document all the policies
and procedures from the various services. The point was how were such services influencing the work of the nurse. The departments observed to influence the nurses' practice were transportation, pharmacy, laboratory, dietary, supplies and linen, housekeeping, and respiratory therapy.

The transportation department personnel came and went on the unit with rapidity and rarely did the same person appear twice in the same day. They came to the unit desk area and announced that they were here for patient X, and proceeded to the patient room. The unit clerk, who was usually the receiver of this message, beeped the patient's nurse. Nurses were expected to assist in moving the patient on to whatever means of transportation was required. The transporter brings the stretcher with them, but not any other equipment. When portable oxygen was required, the nurse was expected to obtain the portable oxygen equipment located in the walk-ways between the two main hospital buildings. This could be a concern because the supply of portable oxygen equipment might not meet the demand at the time. In that case, the nurse searched other floors or other patients' rooms. The time it took transportation personnel to arrive to take a patient appeared to be an unknown in most cases. If the patient was not ready or if a medication or a treatment was due at the same time, the transportation person was not allowed to wait. He/she told the nurse to call them back when the patient was ready. The nurse was annoyed if the patient left the unit without her knowledge. The nurses stopped their activities and responded to the transportation call. If they could not respond, they asked the
unit clerk to beep someone else, usually the licensed practical nurse or the nurse aide.

The off-unit tests and procedures were scheduled following the appropriate physician order. The time for the test was at the discretion of the testing department. A question of the unit clerk by the nurses was, "When is Mr. X going down?" When the unit clerk called the other department, the answer was frequently anytime between a two hour time range. This required the nurse to make some critical decisions about the patient's diet, medications, physical condition and stamina. Frequently major time changes in medication administration were required and so follow-up phone calls to the physician were made for clarification.

The unit clerk was a prime source of information for any special instructions on preparing the patient prior to the patients leaving the unit for tests. The nurse was accountable for the condition of the patient when the patient left the unit according to nursing standards of practice. This was why the nurses were concerned when the physician changed the tests ordered or did not communicate via the unit order book that a patient was even going for a particular test. The nurse would sometimes find this out when the patient transporter arrived on the unit to transport the patient. The physician called the departments, like radiology, from other hospital areas and then did not communicate these plans to the unit.

Respiratory therapy was a treatment ordered by the physician. The nurses however, felt responsible for verifying that they performed the ordered treatment and frequently said, "We've had problems with them". In essence the nurses did not seem to know when and if the treatments
were done unless they happened to be in the room at the same time. The nurses felt required to follow-up on this for the well-being of their patients. It fostered a feeling of mistrust between nursing and respiratory therapy.

The nursing activities associated with the administration of medications influenced the nurses’ daily routine. The pharmacy department issued procedures indicative of the amount and type of support they would provide. The medications for each patient were stored in a "bin" located in each nurse server. The nurse was expected to transport the bins between the nurse servers and the medication room to be refilled. Routine medications were only dispensed by the pharmacy at certain time intervals. The medication room houses a large cart for storing the bins. This cart was "exchanged" between the central pharmacy department and the nursing unit on a regular schedule. The medications in the bin were in a locked area of the nurse servers and each nurse had a key that opened all the nurse servers and thus access to the "bin" and the patients’ medications. Although the concept of having the medications as close to the patient as possible was in concert with the notion of providing supplies at the patient site, the real efficiency of this practice should be explored. Due to the "individual dose" approach to medication administration, the medications were in separate, different and labeled packages. Some were very difficult to open and required scissors. It was the nurses responsibility to deliver the bins to the unit medication room at the times required by the pharmacy to fit with their pick up and delivery times.
Medication orders from the physicians were "tubed" to the pharmacy by the unit clerk. If there were special orders or orders written on the left-hand side of the order sheet, the nurse was expected to call the pharmacy and alert them to this fact. If she didn’t she wouldn’t receive the medication. A nurse discovered this pharmacy expectation when she did not have the medication she needed and subsequently called the pharmacy. If the nurse was concerned about drug incompatibility, she could call the pharmacist for assistance. This meant she needed a different level of pharmacological knowledge and awareness of this potential problem. This was a critical issue for patient safety and medication therapy and required another step in medication administration. One nurse remarked, "I don’t want to run antibiotics and pitocin and go home and be worried about it". The nurses frequently borrowed medications from other patients if their patient’s medications had not arrived from the pharmacy. This occurred when an order had been changed or with new admissions. This meant the medication was not readily available at the nurse server and the nurse might go from "bin" to "bin" searching for what she needed.

The availability and kind of support for nurses from the pharmacy department appeared minimal. Yet, the nurses accepted this level perhaps because they had recently received the medication administration activity back from a pharm-tech program that was terminated. The pharmacist was supposed to be the "expert" in terms of medications. Medication therapy was a significant part of patient care. It would seem appropriate for that department to be visible and a more active, vital part of the unit. The only time a pharmacist was obviously present on
the nursing unit was one day when she was making rounds with a group of physicians. It suggested the pharmacy department was willing to expend some of its human resources with the physician and not the nurse.

Nurses frequently expressed frustration over the lack of linen. The "laundry supply cart" was seen on the unit every day however what was delivered was not consistent. One day the employee delivering said, "What you get is what you see. It's hot and the employees in the linen don't like to work when it is so hot." There were only single sheets and p-j bottoms available. Nurses were put into the position of having to use cut-up towels for washcloths and putting bed pads over soiled linen. This required more explanation on the part of the nurse to the patient. It embarrassed the nurse who was the one that had to explain it to the patient. The employee delivering the linen said that all floors receive the same quantity and type of linen supply. It did not appear to be based on patient population types or admission/discharge patterns. Patients were charged separately for certain supplies. It was the responsibility of the person delivering the linen to pick up the charge cards filled out by the nurses and left in the nurse servers. They were never in the exact same location. A concern might be the number of lost charges. Also the charge cards were used for notes to physicians and others, so did not appear to be in demand for charge purposes.

Laboratory personnel were responsible for blood drawing on the unit and for starting blood transfusions on patients. They did not touch any fluid lines that had been placed in a patient's veins. If a patient did have a line available for obtaining a specimen rather than puncturing the patient again, they called the nurse. The nurse then became
responsible for obtaining the specimen. This decision however seemed to vary depending on the laboratory person. This variance in service was a source of frustration to the nurses yet at times when the lab person tried to do a "draw" the nurse said, "Hope he didn’t foul up my IV", or when a specimen was not adequate the lab person was quick to say, "Wasn’t my draw".

The lab did not call the unit about a particular problem which resulted in expensive stat lab work needing to be done so the patient could continue with scheduled surgery. This also required the expenditure of more time on the part of a nurse to correct the problem, not created by her. When a nursing error was made in the labeling of a specimen, the nurse had to go to the lab area and clarify the error. She said they are real nice but "I had to sign my life away" on various incident reports. One afternoon a lab person came on the floor to administer blood and proceeded to direct the Nurse Manager and the nurse who were in the midst of giving and receiving a patient update, to obtain equipment for her to do her job. She needed an IV pole and certain tubing and told them so. This created antagonistic looks and no movement on the part of the nursing staff. The staff nurse, following report found the necessary equipment and took it into the patient’s room so the blood transfusion could be given.

The nurses voiced complaints over the lack of available supplies in the nurse server every observation day. Comments were frequent. "There’s not too many times when I look in there (nurse server) that there’s not something missing". "Run, Run, Run, SPD, SPD, SPD" was heard daily. Once the nurse was shocked when gloves were in the nurse server and she said,
"I'm batting 1000". SPD (Sterile Processing Department) was the area that extra supplies and supplies, not routinely stocked in the nurse server, were stored. It was adjacent to the unit. A nurse that had planned for her patients needs and had gotten the supplies she needed from SPD early in the morning, was quite upset, "I got two (solutions) this morning, but obviously somebody's taken it". Staff, and not just nursing staff, had access to the supplies in the nurse servers and took whatever they needed. As the nurses expressed it, "Seek and find". Most regarded the nurse servers as community domain; it just depended on who got there first.

Housecleaning personnel and their equipment were very visible on the unit. Frequently the equipment was in direct patient care access routes, maximizing the potential for serious accidents. Somehow all personnel seemed to walk around and avoid the equipment. The vacuuming of the rugs was loud and the collection of room trash was inconsistent. Nurses complained that the housekeepers "won't touch anything". They always wore gloves. The housekeeping supervisor was seen making rounds frequently and was observed placing filled dirty linen bags into the bottom of the nurse servers rather than having them hang on the patient's doors where nurses tended to put them for easier access. Nurses complained about no place at the nurse server to put their paper trash. They usually carried the medication paper wrappers, empty IV tubing boxes etc. back into the patients' rooms. They were carrying patient items at the same time and this looked like a real balancing act.
Dietary was a frequent source of comment by the nursing staff yet there was little communication between nursing and dietary except by notes attached to the dietary door. "The best we can do is put a note on the kitchen door. They go to other floors now and when they come back they might see it." A patient requested a toasted cheese sandwich. The sandwich was delivered about 90 minutes later to the patient's room. The kitchen was locked except when dietary personnel were there. At meal time, the dietary aide went to the charting area and announced "clear the tray stands". The nurses did not jump up and respond.

Nurses were not allowed near the kitchen door when dietary personnel were getting the trays filled and passed out to the patients. Yet, that was the only time when they were on the unit. They could be reached by paging the dietary supervisor. Dietary usually picked up the trays about an hour following the delivery to the patients' rooms. The nurses on one side of the hall frequently tried to put the dirty trays someplace. The dirty trays were to be placed on the bottom shelves of the nurse servers for dietary personnel to come by and pick up. However, the nurse server shelves were broken, awaiting some "plastic knob, that's been ordered for months" so maintenance can fix them. This meant the nurses hunted for an empty nurse server to return the dirty trays so dietary will pick them up. When the unit had a full patient census, this became more difficult and time consuming. The unit had large numbers of diabetic patients. This meant that their meal times were critical and controlled the time of insulin administration. It also necessitated different dietary considerations around the clock. The nurses had
adapted by having a "secret supply" of crackers locked in the nurses station for patient emergencies.

Summary of nursing practice as influenced by hospital departments. Nurses do not see themselves as just another hospital department or service. Nursing care was the reason patients come to the hospital. These departments were considered by the nurse to be support services for her in providing patient care. The name "support services" immediately places these departments in a subservient role to the nursing role. Yet nurses frequently felt they are supporting them. On the other side, support services probably viewed their work as support to patient care in a global sense. As a result the criteria for successful performance was different.

The message that the routines of these departments sent to the nurses was that the efficiency and the productivity of their departments was more important than the work of the nurse. Nurses did not perceive any "quick" ways to solve the discrepancy between the other departments ways of operating and the needs of their patients and physician orders. At times it seemed that the department that issued the protocol first got to determine their workload allocation and what they would do and not do. The nurses accepted and complied with the routines of these departments and continued to be frustrated by them. The nurses accepted the control over their nursing practice which the routines of these services have required. Everyone was concerned about "patient care", but the staff nurses were most concerned about "individual patient care" and nurses were comfortable adjusting procedures based on individual patient
needs. The support services were staffed for the average needs of all
types of patients.

Many of the required routines for other departments were controlled
by outside regulatory bodies and there was a lack of understanding on
the part of all employees as to what this meant for them and why.

The staff nurses appeared to have to follow up or be the evaluators
of the delivery of services from other departments. Again because their
concern was the quality of service delivered to their patient. Only the
housekeeping supervisor was observed making rounds or checking on the
quality of the services provided at the unit level. So the number of
individuals doing the "same" job on the unit but at different times was
large and a feeling of "support" can not be facilitated or maintained.
"Support" in the patient care environment was frequently determined by
the sense of competence one provider has of the other provider. The
staff, nursing and support services, do not know each other. They do not
know each others' competence. The color of the uniform was the
identification. This made even a superficial attempt at team work and
trust difficult.

As the patient population has changed with patients requiring
concentrated nursing care in a shorter period of time, the changes made
by these departments in their service levels would appear to impact the
work of the nurse even more. To what degree the support services
influenced nursing practice was not within the scope of this observation
period. It does appear to be dependent on other factors as well; nurse-
stated energy level that day, the number of problems in the day, and the
patient's status. However, support service behavior that was time and
task oriented appeared to create significant tensions between nurses and other department personnel. Nursing care appeared to be the service that was required to be the flexible component in the delivery of services to the patient and the one which focused on individualized services.

The practice of nursing was influenced by the quantity, flexibility and the time that support services were received. The availability and accessibility of supplies needed to perform nursing care was a critical factor for the nurses. Nurses were expected to comply with the times the services were delivered by the support services with little consideration being given to how the services might be coordinated to meet patients' needs more efficiently and more productively in regards to the nurses' plan of care. This was evident with the dietary service and the scheduling of off-unit procedures and tests. The supplies that were to be in the "nurse servers" were frequently unavailable for the nurses even though the suppliers thought they were doing their job. The nurses were required not only to reprioritize the care they were able to give to patients but also be the back-up for the provision of the support service and evaluate the effectiveness of that service in the overall evaluation of hospital care. Nurses were the patient contact for the hospital which included defending the support services to the patient.

Summary of Participant Observation Data about Nursing Practice: Unit Ethos

The data from the participant observations were descriptive in nature and important because of the richness they bring to this study.
In the field setting, the meshing of the nurses' beliefs based on what they actually did and the unit ethos was an intriguing and complex puzzle. The two are so interconnected that attempts to pull them apart leave each less than what they truly represented. The findings presented attempt to describe the nursing practice on this hospital unit from the nurses' perspective. The nurses were each observed for approximately three hours in the morning and three hours in the afternoon. The summary of the participant observations are presented below in two sections: a description of the nurses' activities as indicative of nurses' beliefs and a description of the unit ethos.

The nursing practice by the nurses was influenced by the roles and relationships of the nurse manager, three groups (nurse peers, other nursing unit personnel, and physicians) and support services. A summary statement of each is presented as well as a statement on the physical environment.

1. The nurse manager was a mother-figure on the unit. She was visible and accessible and supported the nurses' role as an independent practitioner. She rarely interfered with the nurses' direct patient care but allowed them the freedom to practice within the general parameters of hospital and professional standards. She evaluated the nurses' work in certain select areas which were mainly related to the ordered responsibilities the nurses performed, such as medication administration. The nurse manager controlled the workload based on the patients assigned to the nurse and was available to assist the nurse when the workload was heavy due to unpredictable patient care
situations. Her role and relationships with the nurses was complementary.

She interfaced with the support services and the physicians as needed and at times requested by the nurse. She maintained the cleanliness of the environment and the social climate of the unit in which the nurses worked. Since the nurse manager was not the focus of this study, occurrences of her actual activities were not chronicled.

2. The physicians were present on the unit at certain, rather predictable periods to make patient visits or "rounds". They did not communicate with the nurses except for specific purposes related to directing their orders. They responded when asked and generally presented the attitude of aloofness and not really being connected with the unit. They came and went, wrote patient orders and participated as necessary. They were independent and autonomous in their behavior.

The nurse was expected to notify the physician of changes in the patients condition based on what plan of treatment they had ordered. The nurses would like to believe the physicians cared about the patients and the unit in the same way they did. The nurses viewed the unit as a "home away from home" and many had been employed here for a long time where as the physicians were there primarily for educational purposes and based on their curriculum rotations would be moving on in a short period of time.

3. The nurses interacted with their nurse colleagues for three main reasons. One was to provide clinical expert opinion on a particular nursing problem, another was to seek or offer assistance as a member of a happy and contained family unit that had a defined job to do in a
defined time period and the last was to support each other with the humans needs of understanding, love and sense of value. These three main reasons are supported by the nurses in how they carried out their nursing practice and the behavior that was exhibited.

4. The support services were a large part of the physical environment of the unit. They were always around, doing something. The question the nurses usually had was what.

The nurses tended to ignore the individuals that were employed by the support services. The nurses expressed frustration whenever they had to go hunting for supplies or were interrupted for some other system support reason. However, these expressions were not supported by the actual number of occurrences in comparison to other nursing responsibilities. The nurse might be able to carry out more independent nursing responsibilities in place of having to deal with any support service issues. The nurses complied with the policies set down by the support services even if they tended to control the nurses' potential for individualizing patient care. The nurses felt powerless in exerting any influence over these services at a higher or policy making level in the hospital. They seemed to demonstrate this frustration and perhaps internal anger by the way they treated them as individuals and as professionals at the unit level.

5. The physical environment of the unit impacted the nurses practice, but in general the nurses seemed to ignore it. They walked over and around all equipment, spent time hunting for equipment, and did not seem to pay any attention to the number of people walking through the unit, the poor lighting and the unit noise. They stood and did the
charting and the care planning at the nurse server located in the busy and noisy hall. This would seem to be more physically and mentally taxing then if they could sit in a quiet place and perform these tasks.

Unit Ethos explored by Questionnaires

The analysis of the questionnaires focused on unit ethos which is the norms and expectations characteristic of the individuals within their work context. Two questionnaires adapted from Quinn (1988) were completed by the 15 nurses (Appendix C). The questionnaires were designed around the competing values model. This model, described in Chapter III and below, appeared very meaningful in trying to understand the complex and competing dynamics on a hospital unit. Applying this understanding to discussions about recruitment and retention of nurses in the hospital environment and exploring the possible restructuring of the nurses' work could be a possible outcome. The underlying beliefs and values of nurses are critical to the change process. The assumption was that nurses who are in the environment and are performing the work are the experts in judging the effectiveness of that work and in redesigning their work to meet the changing patient care needs. A deeper awareness about how nurses understand their world of work and the norms and expectations in that world might contribute to a new organizational model for nursing care delivery. An assessment of unit effectiveness and unit ethos completed by the nurses was expected to reveal tensions with aspects of organizational life such as relationships with nursing and hospital administration, physicians, and nurse peers, disillusionment
with the work of the nurse, and inadequate information and communication systems.

Quinn and Rohrbaugh (1988) were concerned about how experts think about effective organizations to try and understand underlying assumptions and what was causing the behavior. In their research about organizations, describing effective organizations led to longer and different lists of criteria based on each organization. The competing values framework looks at organizations as dynamic and confronted with change, ambiguity and contradictions. The framework assumes that organizations are contradictory systems and, "Managers spend much of their time living in fields of perceived tensions" (Quinn, 1988,p.3). The model has a horizontal and a vertical axes which intersect in the middle and create four quadrants. The vertical axis ranges from flexibility to control and the horizontal axis ranges from an internal to an external focus. Each quadrant represents one of the four major schools of organization theory; human relations, open systems, rational goal and the internal process model. Each model has specific characteristics and is in polar contrast to the opposite corner hence the notion of competing values. The model allows the organization to be explored from the perspective that these polar tensions exist in organizations and are not mutually exclusive. The human relations model stresses the internal organization with criteria as cohesion and morale and the value of human resources training and is in contrast to the rational goal model that values output, productivity and efficiency with planning and goal setting and an external orientation. Organizations want and need both ways of functioning and they are not mutually
exclusive. In the same way the open systems model, an external orientation, values expansion and adaptation, readiness, growth, competition and resource acquisition are stressed. Its polar opposite and an internal orientation is the internal process model which values continuity and consolidation with stability and control, information management and communication as characteristics of the organizations functioning. "The model can be used to diagnose and intervene in actual organizations" (Quinn, 1988, p.50). The information can provide a realistic base for progressive change or adaptation in nurses' work. One questionnaire accessed the nurses' perceptions of organizational performance or nursing practice and the second questionnaire provided an assessment of the unit's underlying assumptions and values or beliefs.

Unit Ethos as Revealed by Questionnaires: Nursing Practice

The Organizational Effectiveness Instrument consists of eight criteria, characteristics of organizations, used to gain insights into the unit expectations that influence nurses' beliefs about their practice (Table 2). The eight organizational components are listed on the left hand side. The individual nurse scores and the average of those fifteen nurses are in each of the cells of the table. For example, the score for participation and openness for Nurse 1 is 1.17 and the average nurse score for participation and openness is 1.25.

Figure 3 places the average of the nurses' scores on a circle chart which profiles the group in relationship to the eight components of the competing values model and facilitates a comprehensive look at the results.
Table 2. Organizational Effectiveness.

<table>
<thead>
<tr>
<th>Organizational Components</th>
<th>Individual Nurse Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D1</td>
</tr>
<tr>
<td>Participation, Openness</td>
<td>1.17</td>
</tr>
<tr>
<td>Commitment, Morale</td>
<td>1.62</td>
</tr>
<tr>
<td>Innovation, Adaptation</td>
<td>1.82</td>
</tr>
<tr>
<td>External Support, Growth</td>
<td>1.15</td>
</tr>
<tr>
<td>Productivity, Accomplishment</td>
<td>1.27</td>
</tr>
<tr>
<td>Direction, Goal Clarity</td>
<td>1.45</td>
</tr>
<tr>
<td>Stability, Control</td>
<td>1.90</td>
</tr>
<tr>
<td>Documentation, Information Management</td>
<td>0.83</td>
</tr>
</tbody>
</table>
Figure 3. Organizational Effectiveness. Average scores for 15 nurses are plotted for eight organizational components. Exact scores are in parentheses.
Average Nurse's Profile. From the data, the profile of the average scores of the nurses reveals commitment and morale, direction and goal clarity, and participation and openness received scores over 1. Based on Quinn's descriptions (1988), this means the nurses perceived their nursing practice as taking place in a positive interpersonal climate and they had a real sense of belonging in the unit. They felt goals were clearly understood and unit objectives could be easily explained. Decision making was by consensus, encouraged and participatory.

Productivity and accomplishment, (0.92) and stability and control, (0.90) have scores in the middle range indicating strength but not as strong as the first three mentioned above. The nurses characterized the work effort as intense with constant striving for greater accomplishment. The work process was seen as coordinated and controlled with a stable, predictable work environment.

The criteria of innovation and adaptation received a score of 0.80 indicating less attention on the unit has been given to innovation and creativity in comparison to the other criteria. New ideas and creative insights are not as stressed or not considered as important as other dimensions. Entrepreneurs are perhaps not as valued on this unit.

External support and growth (0.67) and documentation and information management (0.42) criteria received the lowest scores in relationship to the other eight organizational components. This indicated the nurses' belief that outsiders did not perceive the unit as a vibrant, high potential unit nor was the image that of a strong dynamic unit. In exploring the low score relative to external support, it might also indicate nurses do not work effectively with outside
resource controllers and do not value their potential contributions. Rules and procedures and formal methods did not guide the work as much as direction and goals and quantification and measurement are not key parts of the work climate.

Summary of Questionnaire Data about Unit Ethos: Nursing Practice.
The Diagnosing Corporate Culture Instrument results indicated nurses in this study believed the unit to be extended family where all shared a lot of themselves and there was a great deal of loyalty and commitment. Teamwork was stressed and participation, high trust and openness were evident. The success of the nurses was important to the group and there was concern for each other. The group’s teamwork and cohesiveness was accomplished primarily through the unit leader’s or nurse manager’s coordination and organizational expertise. In contrast the leader in a type A organization tends to be stronger in roles as a mentor, a facilitator, or a parent figure.

Unit Ethos as Revealed by Questionnaires: Nurses’ Beliefs
A second questionnaire, Diagnosing Corporate Culture as adapted, was completed by the nurses to explore the unit ethos as influencing nurses’ beliefs (Appendix C). This questionnaire was developed by Cameron and was based on the competing values model (Quinn, 1988). Six dimensions of organizational culture; dominant characteristics, leadership, glue, climate, success criteria and management style were rated by the participants to assess the underlying values on the unit. The scores from the six dimensions were plotted on a profile sheet to
reveal the strength and congruence of the dimensions. The scores are then summed and averaged to obtain the overall cultural profile for the unit. This tool assessed the type of culture as well as the strength of the values and the congruence of the dimensions. The type of culture is labeled as Type A, B, C, or D and corresponds to the four quadrants of the competing values model and to the characteristics of the four organization theory schools; human relations, open systems, rational goal and internal process. It is therefore possible to describe the culture of the unit based on the four types as assessed through the six dimensions. Type A tends to be an organization that emphasizes team work or human relations, type B adhocracy or open systems type C, bureaucracy or internal process model and type D, the firm or the rational goal model.

Unit Culture characterized based on Nurses' Values or Beliefs. The nurses scores on the six dimensions discussed above (i.e. dominant characteristics, unit leader, unit glue, unit climate, success criteria, and management style) are summed and averaged for each type of organization for each nurse and those scores are the average scores which identify the organization type. These fifteen scores are then averaged to give the average scores for the unit from the perspective of the fifteen nurses and are plotted in Figure 4.

Based on the average composite unit score profiled in Figure 4, the unit is strongly a Type A unit (34.67). Based on Quinn’s descriptions (1988), this means that the unit from the nurses’ perspective was a personal place, like an extended family where people
Figure 4. Nursing Unit Overall Culture Plot. Average scores are plotted for 15 nurses.
shared a lot of themselves. Loyalty and commitment, cohesion and teamwork characterized the unit. The leader was a mentor, a facilitator or a parent and the management style was characterized by teamwork, consensus and participation. The climate was one of participation with high trust and openness. The unit success was based on the development of its human resources, teamwork and a concern for people.

The nurses did not value the characteristics of a D type unit (14.00). This is 8.39 points below the next highest, Type B organization (22.39). A type D organization is characterized by competition, concern for production and achievement. The unit leader is a hard driver, a producer and manages the unit based on achievement. The unit is held together by goal accomplishment and marketplace aggressiveness. The climate is confrontational and emphasis is placed on beating the competition. Success is based on being number one. These characteristics do not depict the study unit.

A Type C organization was viewed strongly as characteristic of this unit. The average score was 26.84, or just 7.83 below Type A. There was only a 4.45 spread between a Type C and Type B (22.39) organization type. A Type C organization is characterized as being a formal and structured place where bureaucratic procedures generally govern what people do. The unit would be held together by the formal rules and procedures because maintaining a smooth running unit is important. The climate emphasizes permanence and stability and the expectations regarding procedures are clear and enforced. This unit is efficient and dependable and defines success in that way. The leader is seen as a coordinator, an organizer or an efficiency expert and the management
style emphasizes security of employment, longevity in position and predictability. The nurses felt that the unit reflected many of the characteristics of a type C organization.

A Type B organization is dynamic and entrepreneurial. It focuses on innovation and development, with a readiness to meet new challenges and try new things. It wants to have the newest products and success is defined by its innovation. The leadership is characterized as a risk taker and innovator and the management style emphasizes individual initiative, freedom and uniqueness. The characteristics associated with a type B organization were much stronger than a type D organization.

**Congruency of the Unit's Dimensions.** The dimensions that characterize the unit ethos are, dominant characteristics, leadership, unit, climate, success criteria and management style. The dimensions displayed congruency as portrayed by the average scores for the unit and plotted on the organizational culture plots, Figure 5.

The highest scores, four out of six, are in the quadrant for the type A organization and there is a strong congruency between the dimensions to support identifying the unit as a type A organization. The only outlier was the lower score in the leadership dimension. Here the leader was seen as a coordinator and organizer characteristic of a type C organization, rather than a facilitator, mentor or parent figure of a type A organization. In contrast five out of the six lowest dimension scores are found in the Type D organization. The high score outlier was in the dominant characteristic dimension where the unit was characterized as productive and achievement oriented, emphasis being
Figure 5. Organizational Culture Plots Using Average Nurse Organization Dimension Scores.
placed on getting the job done. The other significant difference occurred in the climate and success criteria dimensions. The climate dimension has a low score (4.8) in the area of competition and confrontation and high scores (35.33) in two areas; participation and stability. The characteristic of trying new things was not as strong. The success criteria dimension has a low score of 9.87 indicating the units' dislike for competition to be a primary approach of the unit ethos. The success criteria was strongest in its support for teamwork and concern for people. Management style was lowest in the competition arena as well as being strongest in teamwork and participation.

Summary of Questionnaire Data about Unit Ethos: Nurses' Beliefs. In summary, the Organizational Effectiveness Questionnaire completed by the nurses in the study provided insights into the norms and unit expectations about nurses' beliefs. The nurses expected commitment and morale to dominate the attitudes and relationships on the unit. They expected nurses to be goal oriented and to clearly understand the objectives of their nursing practice. The norms emphasized participation and openness on the unit. It is important that the unit be productive and that work be accomplished. The nurses expected the work process to be coordinated and under control and the work environment to be stable and predictable. The areas of innovation and adaptation, external support and growth and documentation and information management were not as important to these nurses in the performance of their work or as the behavioral norms of the unit.
Unit Communication Book

The communication book was a written form of communication between all members of the unit nursing staff and was read by them on a daily basis. It is located in the nurses conference room. It is a lined book with page numbers at the top. All members of the nursing staff wrote in it or put patient and staff cards, post cards, letters or educational information in it. Memos and notices from other hospital departments and administration are placed in the book as they were sent to the unit. The nursing staff initialed most of the information, formal or informal in nature. It appeared to be read and initialed by the staff faithfully. It was an accepted form of "official" notification.

The communication book was read for the observation period to explore the possibility of other influences on nurses' beliefs, nursing practice or unit ethos. During this time there were thirty five entrees in the communication book. Ten of them seemed to relate specifically to nursing practice and twenty five to unit ethos. Of the twenty five categorized as unit ethos, eighteen are communications relative to hospital administration organization changes, the unit's budget or staffing and announcements about changes in the services of other departments. These appeared to be the primary linkage to the rest of the hospital. The nurses noted in the interview data that they were aware of the hospital as a business and this was the only data that seemed to overtly support that awareness. It is not obvious during the participant observation period that the hospital organization or goals impacted nurses' work. The communication book included an example of new equipment information and another on changes in diabetic medications.
One nurse shared some information on new rules for taking care of a patient after a particular procedure. The interview and observation data agreed, nurses have little interaction with the support services and little control over changes in their services that frequently impacted on patients' care. The memos coming from these departments supported that observation. There are directives from dietary, respiratory therapy and medical records. Seventeen of the communications related to relationships and the support aspects of the unit. Examples are items like praising the staff for their good work and the team atmosphere on the unit, physician feedback on the quality of care given on the unit, and the sharing of external family crises. This information is supportive of the data from the questionnaires as well as the interview data.

The tone of the communications to the staff and between the staff was one of warmth and positive regard. When the staff wrote a note, the final comment is always, "any questions, please ask," as well as a "thank you" when appropriate. The communication book was very current based on the dates and is informative. The staff initialed it after they read it probably to let the nurse manager know they had read it and to keep themselves informed from day to day.

Similarities and Differences in Findings about Nurses' Beliefs, Nursing Practice and Unit Ethos from Data Collection Methods

The benefit of exploring the similarities and differences between nurses' beliefs, actual nursing practice and unit ethos can be characterized by the phrase, "It isn't always the way we think it is".
The similarities are not one hundred percent pure and the differences have aspects that are similar. However, the rich data provided by using four data collection methods facilitated a more realistic understanding and the opportunity to explore the complex relationships.

Relationships between Nurses' Beliefs and Nursing Practice

The nurses' beliefs (participant observations) and nursing practice (interviews) findings appeared to be similar in three areas and different in three areas.

Similarities

1. The nurse is the primary patient care provider on the nursing unit. This is demonstrated in what she says and what she does. She provides physical care to her assigned patients but not observable teaching or emotional support. Her nursing care is intense but not as physically intense as mentally demanding because of the many system variables which she perceives as not under her control such as the physician and support service activities. The nurse is isolated in the performance of her direct patient care and this is observed in her practice. In exploring the data deeper, the nurses appear to believe being the primary patient care provider equates to being an autonomous professional. This is contradicted in the data by the number of dependent activities and the maintenance functions which she does. The nurse is an employee of an institution that values time and task activities and not the assumed autonomous role of a professional who
appears to have limited legal authority and minimal power to seriously affect the financial resources of the institution.

2. The nurses expressed no real need to be creative or to change anything they were doing. The nurses express the desire for a "new" physical environment. The nurses believe nursing practice doesn't change and neither do the other services. The nurses try to individualize their patients' care, but the overall organization of practice does not change. In individualizing patient care, friction occurs between nursing and the support services but there is little interaction with other. Change is stimulated by new pieces of equipment or a new technique ordered by the physician. The physician is able to individualize care because he/she orders what is to be done for that particular patient. These orders are carried out by the nurse. The nurses carry out the medical plan of care. It is not viewed as important to consider the nursing plan of care. The nurses do not sense that a change of skills, equipment or knowledge, or a change in the technology of nursing may be a way to provide their services differently or more effectively and efficiently.

3. The nurses are ambivalent about educational advancement and in attending internal or external continuing education programs. Informal exchanges and discussions about patients' treatments and conditions occur during the shift reports, but there is not any organized attempt to present ongoing educational activities. The atmosphere of teaching and learning that one might assume would characterize this setting is not evident. The nurses express an "eagerness" to learn, but that is not evident in the practice. Even with the identified unit clinical experts,
there is little actual use of their expertise. Continuing education offerings are not emphasized and although some of the nurses are "in school", it appears to be a threat to the family unit because in the past nurses used education as the opportunity to seek other types of positions.

Differences

1. Nurses believe the hospital does not respect them and felt this was demonstrated by lack of support, little recognition for their work efforts and exclusion of nursing in decision-making. They also believe they are a "rich" unit and have equipment and the number of nurses they need. They believe the hospital is a bureaucratic organization with a "big business" mentality and this interferes with the accomplishment of unit change. The nursing and hospital administrative personnel are rarely present on the unit during the observation periods. Twice nursing administrators were on the unit and during one of those visits the nurses wondered who the person was. One other time the new hospital administrator came on the unit to introduce himself to the staff. An aura of "the" administration did not appear to influence the unit ethos. The issue of the "bottom line" and discharging patients based on their allowed length of stay for insurance purposes is not discussed on the unit. There is little patient teaching or emotional support given to patients. The nurses do not express frustration over not accomplishing their nursing care goals.

2. The nurses describe nursing practice as patient-centered, physical, intense and interrupted frequently. The participant
observation indicated that the nursing practice did not necessarily mean in direct patient contact. Nurses are not with the patient a great deal. Most of the work appears to be accomplished outside of the patients' rooms. The frequency of interruptions due to the beeper or for obtaining supplies is not dominant either. The nursing practice can be described as "family centered" since the support and concern is directed towards the nurse and secondarily to the patient. A nurse asks another nurse if she is "ok". Nurses do not inquire about the status of another nurse’s patients. That seem to indicate that if the nurse is doing ok, then the patient is probably doing ok. Support is contingent on needing physical help with task completion if time is running out. Nursing practice is performed in isolation.

3. The nurses believe they give the best care possible. That is the goal and they achieve this most of the time. In the practice area, good patient care is the goal. The routines and the protocols especially the disfavor with overtime, assume precedence over individualizing patient requests. This is a potential conflict for the nurses especially in the family atmosphere when no one wants to let the family down. The direct patient care contact is largely dependent on physician ordered care.

Relationships between Nursing Practice and Unit Ethos

The findings in the data revealed six similar themes about the relationship between nursing practice (questionnaire) and unit ethos (participant observations). Differences were not significant.
Similarities

1. The participant observations do not indicate a strong time/task orientation which is in agreement with the questionnaire data which places productivity and accomplishment in the middle of the range of scores.

2. It is not obvious their nursing practice is impacted all that much by being in a teaching environment especially when there is minimal conversation with the physicians. There is little interaction with the physicians, few interruptions in relationship to the total average activity occurrences and a slightly larger number of dependent activities, or those ordered by the physician to be carried out by the nurse. The questionnaire data supports the participant observation data because the nurses scored the areas of external support and growth low as well as the criteria of innovation and adaptation which might be characteristic of a teaching-learning environment.

3. From the participant observations, nurses do get off duty on time and their activities appear completed which supports the questionnaire findings. One issue that can be raised is the patient census during the observation period and in general the work load was not considered high by the nurses. The data from the questionnaire revealed that commitment and morale and direction and goal clarity scored very high and would support the work ethic expressed.

4. The impact of the nurse manager on nurses' actual nursing practice is quite subtle. In reality, the nurse manager is around, but during the observation period there is minimal interaction between the nurse manager and the nurses about their nursing practice. They each do
their own thing. The nurse manager influences the unit ethos overtly by taking care of the physical environment and equipment, taking care of problems with the support services, monitoring certain aspects of clinical practice and planning the staffing schedule. The nurse manager is the person responsible for direction, goal clarity, and participative decision making which were rated high in the questionnaire findings.

5. The nurses support each other by their individual clinical expertise, their offers of assistance to each other and the emotional support they give to each other. This is supported by the high rating of morale and participation and openness from the questionnaire results.

6. The nursing practice relationship with ethos is also congruent on two other aspects. The participant observation data did not reveal any interest on the part of the nurses concerning external support, innovation and adaptation, or a concern about documentation and information management. The nurses, in fact, were not even aware of their physical environment and had minimal contact with support service personnel. These same findings were supported by the low scores in the questionnaire data.

There were no outstanding differences in the findings about the relationship between nursing practice and unit ethos.

Relationships between Unit Ethos and Nurses' Beliefs

The interviews and the questionnaire on organizational culture reveal three similarities and three differences which describe the relationship between unit ethos and nurses' beliefs.
Similarities

1. The unit is described as a family and the nurses support and care for each other as friends. Yet, each nurse is encouraged and eventually has to be independent in her work role. They organize their non-work time to include social activities as baby and wedding showers and sports. This is supported by the questionnaire data which describes the unit as a personal place and an extended family.

2. The nurses see the unit as self-contained. The core group or the "elder sisters" are the clinical experts and are consulted for advice when the newer nurses have a concern. The nurses reach maturity after proving they can be trusted, can perform reasonably well and can complete the work assigned. If the nurse "adjusts", she remains in the family otherwise she leaves. Leaving is a relatively quiet affair, unless the nurse is a member of the core group and then it is treated by the family as a loss, complete with anger, denial and fear. This reaction might be a reaction to who and if someone will replace the departing family member. The questionnaire data describes the unit culture as cohesive, and characterized by loyalty and commitment.

3. The unit's clinical experts appear to resemble the physician model of specialization. In this environment, specialized knowledge amplified power and status. The unit culture is one which supports the development of its human resources.

Differences

1. The nurses' beliefs and practice demonstrate a lack of integration between nursing services and physician services and also between nursing services and support services. There is minimal
communication or interaction unless there is a need for something to be done which only that service can provide by virtue of legal standards, hospital policy or mechanical resources. The nurses are assertive when that situation occurs. There is little understanding on the part of nurses, physicians and support services about the goals of the other services and how they function. Each of the services does their assigned duties with an aloofness that permeates the unit. The boundaries are firm and therefore the opportunity to understand, learn and interrelate with a person in the other service arena is not considered. This way of functioning decreases the opportunities the unit may have for adapting to change and being creative with ways of providing service to the patients. This information is not congruent with the questionnaire results which describes the unit as being oriented to teamwork, participation and openness. These are characteristics of the nurse work group, but it does not carry over to other health care providers.

2. The interviews stress that the work is very time/task oriented. There is no "dumping" of work from one shift to the other, overtime is frowned upon and all tasks must be completed before they sign off duty. They speak about being in a teaching environment in relationship to the amount of tasks they have to do. The questionnaire data characterizes the unit as being oriented to teamwork and consensus approach to decision making. The slight difference is in the degree to which there is sharing of the tasks and the work as a team and on all shifts. The way it is expressed in interviews, time is the key factor and not the patient's total needs and the availability of staff to meet those needs when possible no matter what shift.
3. The nurses say they have a "wonderful" nurse manager and describe what she does in terms similar to a mother. In the interviews, the nurses rarely criticized the nurse manager or their peers. The nurse manager was a role model for unit loyalty and for maintaining unit boundaries with the rest of the hospital system. This was not supported by the questionnaire results and the nurse manager was described as a coordinator and an organizer in contrast to a mentor, facilitator and a parent.

Findings Relative to the Relationships among Nurses' Beliefs, Nursing Practice and Unit Ethos

The main research question, What are the relationships between nurses' beliefs, nursing practice and unit ethos is addressed by describing the similarities and differences among the three variables as they emerged from exploring the nurses' interviews, questionnaires and the data from observing the practice environment. There are five similarities and four differences that emerged.

Similarities

1. The study unit and the staff assigned to the unit resemble a strong traditional family unit. There are roles assigned to the members that are very consistent with the traditional family in Western culture. There is the nurse manager representing a type of mother figure, the nurses as siblings and the physician as the father figure. It is a self-contained and reasonably self-sufficient entity. The nurses think they support and protect each other by not criticizing or finding fault. Conflict is avoided and if necessary the arbitrator is the nurse
manager. They are loyal and committed to the unit and to each other. Success is group success, not individual success so there is teamwork, cohesiveness and high group morale. Stability of the membership and predictability of the work support the family unit.

2. There are areas of similarities in all three domains that represented omissions or the lack of important characteristics of an organization. The first is the lack of integration between the nurses and the physicians and the lack of integration between nurses and support services. Second, the nurses practice in isolation most of the time because they do not have ancillary nursing personnel, they are assigned patients as primary nursing care providers and physicians and nurses do not value discussing patient care issues with each other. Third, there is little communication or sharing of knowledge or expertise by the physicians or the support services with nurses and vice versa.

The nurses have developed their own mechanism for integrating socially and by sharing some needed expertise through the unit's clinical experts. It is a situation in which the power and the status of the physician has overshadowed the need for the organization to be integrated in order to maximize the uniqueness and expertise of all. And nursing has not focused its collective strength in integration and collaboration. With the support services, it is the emphasis on task completion to the exclusion of examining their needed contributions in a cost and efficiency oriented service to patient care.

3. All three data sources supported the finding of lack of creativity and propensity to change on the part of the nurses. Change is
initiated on the unit by others. This continued to place the nurses in a dependent position and did not acknowledge the nurses' potential contributions to the delivery of a more efficient and cost-effective service delivery. The resources have not been given to the nurses to even encourage looking at nursing technology; skills, knowledge and equipment, in a wholistic and creative way. Nurses are "satisfied" by the institution when new bed scales are purchased. Communication systems and documentation systems are lagging far behind in providing the information needed to make decisions rapidly and in response to cost and patient needs. The routines and the policies and procedures of the environment hindered natural growth and creative tendencies.

4. There is the tendency to de-emphasize educational growth and development of the nurses in the study and the lack of an inclusive learning environment on the unit. The importance of having a larger work force that is able to make critical decisions independently and accurately is apparently not viewed as an efficient and economically sound approach to the manpower shortage or to the need for flexibility and adaptability in a competitive health care environment. The dominate physicians would probably not view this in their best interests.

5. The role of the nurse manager or the unit leader/mother/mentor is important. The nurses express the nurse manager's important role and the support they feel from her. The questionnaire data revealed a leader that coordinates and organizes the work and the observations supported these views. The nurse manager was very effective in enacting these roles and had an approach to her position that was positive. This
position might provide a more integrative and dynamic dimension to the unit in the future.

Differences

The differences are important. They allow more exploration into the ethos of the unit and the potential for a deeper understanding of the behavior.

1. The nurses view the hospital as big business and feel the bottom line of cost containment is the primary goal. However this influence was not obviously present in all domains. The issue is, nurses organized the assignment of patients or their work load around what they viewed as a professional nursing model, primary nursing. They have not assessed how this approach might benefit the bottom line of the hospital and still meet their notions of how best to deliver their nursing services for the patient's benefit and their own. Primary nursing has given them a sense of autonomy and accountability but it is not truly recognized or supported by the institution. It appears that nursing is off doing its own thing, irrelevant of the rest of the institution. This approach might leave nursing powerless in the long run. The team approach emphasizes support of their family unit, but is not completely compatible with the primary nursing organizational model.

2. The primary nursing model isolates the nurses and in the family unit orientation that is a sign of independence. Considering the rest of the environment and the patient acuity demands this may become a point of stress for the nurses and lead to more turnover and job dissatisfaction. The primary nursing model does not address peer evaluation of nursing care in any definitive way. The primary nurse
receives her rewards and benefits mainly from the provision of her care to her patients. Her actual work is with patients but does not revolve around patients' individual needs but is unit controlled. That work can be physically demanding and intense depending on her assigned patients from the nurse manager and the availability of nurses willing to assist her. The primary nursing model and the family unit orientation have different expectations.

3. There is difference between the expectations of the family unit, which is to provide good care to patients and the nurses' desire to give the best care possible to their patients. Because the nurses are not aware of the other patients on the unit (report is only about the nurses' assigned patients) it is difficult to judge the overall workload and adjust the level of care that could be provided with the manpower available from the individual nurses' perspective. The quality of care and the level of care provided is difficult to judge or to adjust. This could lead to nurse dissatisfaction.

4. The nurses express a time on task urgency to their work in the interviews that is not as pressing in the other domains. In the questionnaire data, there is strong support to indicate that work productivity and goal orientation is emphasized. It appears to relate more to the family work roles. Work productivity and time on task became more of an issue when patient census increases and patient illness is more acute and demanding or when there is not enough staff to maintain the primary nursing model and patient/nurse ratio.
Significance of the Study Results

In most hospital environments, nurses are struggling for a sense of value, recognition, and importance. Most nurses view the hospital as a negative place to work. It is not the work that depresses nurses, it is the environment in which that work takes place. It is like the saying, "I love my work, but I hate my job." Most nurses love nursing. This is evident in this study: the tenure of the nurses on a unit with a very difficult patient population, the willingness to change their work schedules to meet needs and not their own, to be a part of this study and to continue in an environment that does not overtly demonstrate a concern for them as human beings. They care about patients. They give a great deal of themselves to their work and they want to be nurses. They do not leave the hospital because of the patients, no matter how critically ill they come in and how ill they are when they leave. But the hospital environment takes this all away, usually in a few years. The power and money issue can be debated forever. The fact is nursing does have a valuable contribution to make to an organization. Nursings' strength and potential lies in capitalizing on what nurses do best and always have done best, nursing care. Nurses should be making themselves invaluable to the hospital system instead of creating "professional models" that only nurses understand or value. Nurse educators are trying to provide the health care system with graduates capable of meeting changing work place demands, but the environment must also change especially the hospital. Many ways of organizing the nurses' work have been tried through the years. Many programs for easing the shock of "reality" for new nurses have been tried. These programs and
ways of organizing nurses' work have been well intentioned and aimed at solving nursings' various crises; shortage, lack of prestige, lack of compensation, etc. So often, however what nursing has organized or planned has been in isolation. This study points to the fact that nursing and nurses can not achieve what they think they want in that way. Many factors enter into success within a total organization. Nursing is not an isolated entity, it is a part of a system. The significance of this study is it attempted to describe the work of the nurse as it is implemented within a system. The results are very limited to this setting but some comments about them can be made. The comments also suggest some optimistic if not utopian goals for the hospital and for nursing.

The family model has many positive aspects. It is a humane and caring approach to working with people from diverse backgrounds and with diverse personalities. Basically it is a model whose underlying values are familiar to most Americans and are universal. A healthy family or group respects and supports each of its members. A healthy family encourages critical evaluation of members to improve and assist in an individual's growth and contribution to the family. A healthy family wants its members to look and act their best and represent the group well. They take pride in their image. The healthy family accepts the limitations of its members so there is flexibility and creativity which is needed to adapt to change and threats to its survival. Stability is important for unit maintenance functions, the rituals and the learning of required developmental tasks. But a healthy group knows how to let go when that is best for all concerned. The healthy family uses all the
strengths and abilities of its members. No one person is better than another, different, but not better, not more powerful, or more valued. The healthy family recognizes that tasks are not gender specific. The fact that most nurses are females should be valued for its positive aspects in caring for ill patients. Females are noted for their intuition and for their ability, especially in nursing, to "know" when something isn’t right with a patient. In the same way, females in our culture have not been socialized into aggressive behavior. Why make them? The norm does not have to be that if there is enlightened leadership. The healthy family with males and females binds together and takes care of all. All tasks serve a purpose or they should be eliminated. Policies can and should change. The healthy family will learn how to surface and deal with normal conflict in constructive ways. The family model is positive although incomplete for the nurses on this unit but perhaps this is an approach to be considered in restructuring patient care and nurses' work.

The primary nursing model brought a sense of autonomy, independence and professionalism to the nurses. The family orientation supported the model. But, the implementation of the attributes is influenced by the environment. It seemed unethical to allow the nurses to think they are being "professionals" in the classic definition of the word because they are "primary nurses". The less educated health care providers have been eliminated and the nurse is doing more work and is afraid to protest because of the fear of losing her "professionalism". Autonomy and independence are not going to achieve professionalism for nursing in the hospital environment. Integration and honest collaboration with all in
the organization, identification and pronouncement of the decisions that nurses can and do make competently for patients, expert nursing care based on nursing research, consistency in the quality of the nursing care provided to patients at all times, and a sincere concern and understanding of what is financially possible will assure nursing of its status and prestige within the hospital environment.

Nursing and nurses have a legitimate position within the hospital. It can be a position of great influence. But frequently nursing has not capitalized on that position for nursing's benefit, the patients benefit or the hospital's benefit. Nursing needs to work with and for the system instead of trying to fight a system that is changing rapidly. Nursing will lose touch with the environment it has been a part of. Nurses need to explore ways of integrating with the rest of the system and ways to be creative and flexible.

The hospital in full partnership with all hospital stakeholders needs to establish and implement expectations and goals. It needs to protect all parts of the system from pure power and self-interest of its members. The hospital norms did not filter down or surround the unit. The hospital ethos is not identifiable. So, the unit established its own norms and expectations. This hindered integration within the organization. It also hinders the purposes of the organization: patient care, education and research.
CHAPTER V
CONCLUSIONS

Summary of the Study

The relationships among staff nurses' beliefs about nursing practice and unit ethos, their actual accomplishments as indicated by their nursing practice, and the ethos of the nursing unit were explored in this study. Staff nurses allowed a glimpse of their work lives and shared their beliefs and opinions. The study was designed to uncover what nurses believe they do, what they actually do, and what norms and expectations influence what they do or do not do. The main research question was, What are the relationships among nurses' beliefs, nursing practice and unit ethos?

The design of the study was based on Styles' (1982) concept of the nursing universe which includes the individual nurse, the practice and the profession, and the social context in which nursing is practiced. Quinn's (1988) framework for analysis of competing values in organizations also was applied. Fifteen staff nurses working the day shift on a medical/surgical university hospital unit were the source of data. Four data collection methods were employed beginning with questionnaires, then structured interviews, next non-participant and participant observations and last, pertinent documents. The data
collection period was approximately 6 weeks.

The importance of this study lies in the need to reexamine and perhaps redefine the role of the nurse in the hospital system. In recent years, several national committees and task forces on nursing have recommended changes in the nurses' work place to enhance the sense of professionalism and self-image and to increase job satisfaction and the success of nurse recruitment and retention (National Commission on Nursing, 1983; Larson et al., 1984; Yocum, 1987; Hay, 1988; Prestholdt et al., 1988). Nurses have been influenced by the changing status of women in our society and no longer accept the traditional handmaiden role to the doctor (Melosh, 1982). They want to be recognized for their independent decision making role as the consistent and primary professional caretaker of patients (Prescott et al., 1987). To support this new role, administrators and others in positions of control want a clearer definition of the unique and specific contributions nurses provide to the health and well being of patients. The contributions need to be expressed as quantities of a specific outcome that can be "costed-out" to provide information for health care cost management, a significant environmental influence on health care systems (Mowry and Korpman, 1986). The changing health care system and a more educated public also expect nurses to define and defend their unique role.

Hospital care is only one part of patients' "trajectory" of health and illness care needed in a lifetime (Strauss et al., 1985). Most hospital care is nurse intensive and costly. It usually occurs when patients require constant observation and expensive technological intervention. Thus, an understanding of nurse work in the hospital
setting is especially important. There have been descriptive studies of nurse work (Anderson, 1978; Frede, 1985; Heron, 1987), but none examined relationships among beliefs, nursing practice and ethos.

Before presenting major findings, the limitations of the study are revisited to set the stage for final interpretation. First, the study took place in a single location, a nursing unit, and during a single time period that cannot be replicated. Second, the results are not generalizable because the group of nurses was unique and there was no random sampling. Third, the nursing staff and nurse manager on the unit are considered "stable" (i.e. they have worked together for a relatively long period of time) and the unit had a reputation for giving "very good" care. This might have biased the results toward more positive characteristics in contrast to a unit characterized as having turnover or management problems or not considered a "good unit".

Summary of Findings

The major finding is there are relationships among nurses' beliefs, nursing practice, and unit ethos. Three broad themes emerged from the data and provide a framework for organizing findings. They are professionalization through primary nursing, nurse growth and development, and identification of the nurse within the organization.

Professionalization through Primary Nursing. The first major finding emerges from the belief that the primary care method of assigning patients to nurses is the way to achieve professional status,
power, and autonomy. The nurses believe their role and self-image are enhanced by this work assignment model.

Primary nursing as a model of organizing and enhancing professional nursing has both positive and negative effects. The positive effects are presented first. The primary care nurses do believe they are autonomous professionals because they are "primary nurses". They believe primary nursing has given them status within a bureaucratic organization dominated by physicians. They want to prove nursing is a profession and nursing care is different than medical care. Primary nursing has defined the "accepted" patient/nurse ratio which promotes some degree of stability in the nurses' daily work. Primary nursing clearly identifies the primary nurse responsible for writing a care plan for a patient. The negative effects are worth noting too. Nurses work in isolation, do everything themselves and do not have to respond to critical peer analysis of their performance. The fact nurses work in isolation may inhibit their interface with the larger organizational environments and decrease their political awareness of changes they need to consider to alter their position within the system. This behavior may also be a response to the potential conflict between caring for patients' needs and following the rules of the organization.

To practice successfully, every primary nurse needs to be more knowledgeable about the variety of resources in the internal and external environments and the variety of diseases and treatments characteristic of their patient population. This is a major expectation. The primary nurse needs to be competent in performing clinical skills to maintain her/his position within the hospital and to provide quality
care to each patient. With primary nursing, this becomes more dependent on individual motivation and commitment to nursing.

Four observations are presented because of their effect on primary nursing professionalization and the extent to which they are influenced by each other. They are: the extent to which the nurse in primary nursing works alone, the lack of integration and communication between nurses and other people in the system, the responsibility of the primary nurse in decision making and the effect of primary nursing on patients.

First, it was a consistent observation that all the nurses in the study worked in isolation. The majority of their time was spent outside the patients’ rooms and they worked alone at the nurse server stations in the hall. The nurse server only accommodated one person at a time. Patients in close proximity to each other were usually assigned to one nurse so even with a double occupancy patient room, the nurse worked unassisted. The hall area was noisy and poorly lighted. The physical layout of the unit promoted isolation because there were few places for nurses to sit down and talk without interrupting some other activity or being interrupted.

Second, there was little communication and integration between nurses and other people in the system particularly physicians and support service staff. The hospital staff walked around and rarely acknowledged each other. Everyone appeared to be operating in their own world. There were few formal or informal verbal exchanges between the staff. Piaget’s (1932/1965) description of a child’s moral development provides an interesting comparison. Child development is a progression: by playing together, constraint turns into cooperation and cooperation
into generosity. It takes time for the children to play together and agree on the rules of the game, and then to learn to cooperate. However, in recognizing differences between others and themselves, equality is made relative and eventually becomes equity signifying a fusion of justice and love. If Piaget's concepts are applied to the adult nursing work in this study, it would appear unit personnel are at the first stage of constraint perhaps trying to develop into cooperation.

Third, primary nursing, as an assignment model, does not change nurses' decision making responsibilities or status within the system. These primary nurses did have a positive image of themselves and of the unit, but primary nursing has not changed their status within the organizational hierarchy. Nurses have always been held accountable for their actions. The introduction of primary nursing has not changed this responsibility nor has it redefined the areas of nurse accountability or decision making. The policies and procedures, lines of communication and underutilization of nurses' expertise and critical decision making abilities prevail.

Aiken (1983) in describing six fundamental tensions between hospitals and nurses emphasized the need to align the nurses' current decision making roles and responsibilities with his/her status and power in the system. Aiken's work supports the findings of this study from the perspective of the nurses' decision making responsibilities. However, the nurses in the study demonstrated a significant degree of independence with potential detriment to patient outcomes. This was demonstrated by the lack of planning for patient discharge and the lack of patient teaching. The nurses in the study were autonomous in the
sense that they mainly worked alone but they did not have autonomous authority to make decisions. C. Alexander's research (1981) supported the positive relationship between nurses' perceived autonomy and primary nursing. Primary nursing organization on this unit allowed the primary nurse to make nursing decisions about her patients subject to system policies and procedures. This observation is supported by the unit climate profile which characterized the unit as governed by bureaucratic procedures. Their decisions are not challenged by other nurses. This lack of peer review (supported by nurses' isolation) may affect quality and efficiency of nursing care. It also may be counter to a professional model of nursing care.

The model can inhibit communication and decision making with physicians and other professionals partly because a primary nurse has total responsibility only on duty time. Critical patient care decisions must be made regardless of the work schedule of the primary nurse. So the authority and accountability for decisions about nursing care remains with the nurse on duty. In the study the identification of who was the primary nurse for each patient was not consistently posted nor kept current.

Fourth, patients are affected by primary care because they probably think they have one nurse assigned to them for their entire hospital stay. However, this expectation is misguided because one nurse is not in the hospital 24 hours a day, seven days a week. The number of nurses involved with any patient is high and, consequently, the quality of the service varies. Some patients may get upset and concerned when their nurse has a day off. They wonder who is going to care for them? In
primary nursing, the care patients receive is highly dependent on the clinical expertise, motivation and concern of the primary nurse.

The primary nursing literature reviewed did not address nurse variables as motivation and clinical expertise. The primary nurses in the study were assigned usually to the day shift. The patients' families and significant others never seemed to be there at that time. Thus, there was little opportunity for family teaching and assessment of family support systems by the primary nurse. One of the functions of nursing as identified by Benner (1984), emotional care and teaching, was almost non-existent on this unit. In addition, the unit did not demonstrate the wide range of nursing activities as suggested by Benner. Yocom (1987) found medical/surgical nurses scored high in performing routine nursing measures, monitoring clients at risk, preparing clients for procedures, and controlling pain. They scored low in meeting acute behavioral and emotional needs; staff development, management and collaboration; and quality assurance and safety. The current study had similar findings with the exception of monitoring clients at risk. The nurses in the study were not in the patient room to a great extent which might imply they are not performing as much monitoring of clients at risk, or it might imply that the patient population at the time of the study did not need that monitoring.

The Hay Group study of 850 Hospitals discussed in Chapter II presented different findings to this study. Although this is very difficult to equate, their findings showed nurses spend 26% of their time in "professional nursing activities", 22% with support functions and 52% in housekeeping details. This study showed nurses were spending
approximately 72% in professional nursing activities, 15% in support activities and 13% in maintenance activities. The main point of the above comparison, is the critical nature of knowing what is being measured and compared among hospitals. But this study, seemed to indicate a higher level of professional activities being performed by the nurses and less "non-professional" activities being performed.

Nurses could enhance professionalization through primary nursing by identifying their unique contributions and by implementing a different patient care leadership role. Fine (1982) recommended staff nurse participation at the board and administrative levels of the organization and at the controlling and coordinating levels of nursing service. This was not seen in this study except through the nurse manager participation within the clinical division of nursing services.

Nurses and nursing would be valued more highly if they could define their expertise within the context of the entire hospital system and could identify the unique contribution they make toward patient care. The nurses in the study had a difficult time explaining what it is they do. McCloskey (1982) defined the effective nurse as performing all skills well, especially critical care skills, and having better than average teaching and collaborative skills. This study did not find support for encouraging teaching and collaborative skills. Bradley (1982) identified the independent roles of the nurse. These included care planning with patient, family and health team, appropriate utilization of community resources, demonstration of communication skills, teaching and evaluation of clients' reactions to therapies. This study did not fully support the work of Bradley. The nurses in the study
are performing care planning but the other activities are weak and again demonstrate the nurses' dependence on the system for what they do as nurses.

Primary nursing does not define contributions nor the boundaries between nursing and the support services. The boundary issues should be a concern of total hospital administration including nursing administration. In the study it appeared primary nursing was implemented without preparing or educating other departments and without integrating it with the rest of the system. This was supported by the unit's climate profile. This unit is not characterized by innovation, development, risk, production, and competition. Which would indicate their tendency to remain isolated and avoid confrontation and change. Other health care professionals and departments in the system realized the unit operated with primary nursing care but really didn't understand it and continued to ignore it. The studies by Weiss (1982), Prescott et al. (1987), and Katzman (1989) support the general finding of this study in relationship to the lack of understanding by nurses', physicians' and other health care providers about what other health care providers do or should be doing or not doing. The poor utilization of personnel is costly. This issue should be given major consideration by administrators and researchers concerned with cost containment and personnel management.

The success or failure of primary care appears dependent on a nurse's ability to implement leadership roles in the management of her patient's care. The term "leadership" is critical. Leadership involves an attitude which radiates involvement, commitment and caring. It projects a sense of pride and stature. It is reflected in how one
presents oneself in appearance and in conversation. It means promoting, communicating, coordinating, providing and organizing. It is an integrative and collaborative role that is indispensable in the health care system. It generates a positive image of the nurse. The way primary nursing has been institutionalized in the unit studied however, leadership components have not been stressed. Consequently, the value and worth of the primary nurse as a leader has not been fully realized. Instead she is required to do everything for her patients including tasks that do not require her knowledge and expertise. The National Commission on Nursing (1989) has strongly urged the profession to identify and implement differentiated nursing practice to fully utilize the nurses' skills based on the level of education. This study found that all nurses were functioning the same way and the nurses did not have time to be collaborative, or to give emotional and teaching support to patients. The strong climate characteristic of the unit as an extended family, loyal and committed to supporting each other, may tend to inhibit the development of the nurse as a leader.

Nurses must demonstrate leadership in patient care by managing and integrating the resources needed by very ill patient populations. Most nurses are educated to think and act on behalf of the patient. Yet, nurses are being asked to do more with less, thus probably jeopardizing the successful management and quality of patient care. Patient care leadership in terms of decisions about necessary and desired patient care and the patient's course of movement in, through, and out of the system, has declined because the unit and larger organization rewards task completion and compliance.
In summary, primary nursing needs to be evaluated in this acute care setting by nursing and hospital administration and relevant participants. Nurses need to realize primary nursing does not always result in the desired professionalism. The concepts stressed in the past to arrive at nurse professionalism include: autonomy, independence, advocacy, authority and accountability. These words and concepts tend to project a specific picture of the professional nurse and in most hospitals have not endeared nursing to anyone nor achieved the desired degree of "professionalization".

**Nurse Growth and Development.** The "educational" atmosphere was especially interesting due to the location of the study site in a university hospital. It might be expected staff development and growth would be actively promoted. Instead there was no encouragement of continuing education or staff development pertinent to nurses' work. The nurses spoke about their growth as the variety of patients they cared for and the new tests and procedures ordered by physicians. This finding was supported by Larson et al. (1984). Larson found the quality of work life to be influenced by the chance to learn new things, an all-RN staff, assistance and support of co-workers, variety of clinical cases, independent/expanded function of the nurse and the accessibility and availability of resource people. In this study two areas are not as obvious; the independent/expanded functions of the nurse and the all-RN staff.

The nurses did not demonstrate the feeling of mutual development in the form of collaborative interaction or joint learning activities.
Examples of limited attention to professional development included: the lack of attendance at discharge planning conferences by physicians and the way physician and nurse rounds were conducted. There was no atmosphere of inquisitiveness or sharing of exciting new discoveries between medicine and nursing. Rather the notion of nurse work as "women's work", dedicated, passive, silent, dependent and not particularly "intellectual" was fostered repeatedly. This finding is similar to the work of Ashley (1976) and Reverby (1987). The difference being nurses are now trying ways, such as primary nursing, to change some of the old notions of "women's work".

Patients were valued by physicians and nurses for what new procedure or test could be done on them or what could be learned from them. Physicians in the system appeared to have such a forbidding and extensive hierarchy of power and authority that sharing and mutual learning and growing seemed unlikely without a major reorientation in the way physicians understand, appreciate, and function with other health care providers. In this setting, all health care providers need to understand the need for setting and achieving educational goals in addition to research and patient care goals. The nurses are caught in the middle of this passive "learning" environment. To protect themselves and receive some semblance of work satisfaction, the nurses established the same hierarchy of power and authority within their own unit/family domain as they have experienced the way physicians have organized themselves for power and status. (primary nursing or independent practitioner, clinical experts or medical specialization and a core
group of experienced and tenured nurses or the physicians' medical divisions).

Identification of the Nurse within the Organization. The final major theme of the study contains two observations about the organization/nurse interface. The first is the lack of identity with or understanding of the hospital and its goals and the second is the nurses' dependency on the system's rules and procedures for providing care.

Nurses' beliefs, nursing practice and unit ethos did not reflect an acknowledgement of the organization as a whole. It is difficult to identify any norms that encouraged the identification of a nurse with the larger system, except perhaps the paycheck. When queried about their understanding of the hospital, nurses talked in vague terms about "hospital standards", but were not often specific. The organization's goals, expressed like a distant concern by the nurses, were primarily related to cost containment, institutional survival, and the power of physicians in the organization. The nurses did not acknowledge the reciprocal relationship in being a part of the organization; being influenced by it and influencing it. Therefore they did not perceive the total control over their actions and their own thoughts by the organization. This ultimately will result in their being less productive, creative or a significant part of decision making. They failed to realize the power the system has over them. The nurses appeared to think professionalization within the hospital is achieved by
isolation. Professional nursing in the hospital will become extinct if continued in isolation.

The second observation is the extent of the nurses' dependence on the system for directing the care they provide (i.e. policies, rules, rewards, lines of communication and authority). This finding is similar to Feldman's (1976). Feldman found nurses had difficulty in defining their jobs and expressed role conflict meaning they could not resolve conflicting demands. The nurses in this study expressed difficulty in defining their position, but conflicting demands appeared to be resolved based on whether the problem concerned the nurse's primary patients or did not concern "her" patients. The nurses' goal was to accomplish physician ordered tasks within a specific time frame for her primary patients. The reward was positive comments from the physicians. The lack of independence these goals fostered reduced the possibilities of collaborative or integrative behavior with physicians, support service departments and the larger organization. It also hindered independent and creative thinking and decision making relative to nursing services. The nurses observed were system-trained and responded to its demands. The promoted and rewarded goal was not patient centered service, but system desired task completion.

Dependent nurse behavior was informally supported by the family model of nurse group behavior which characterized this unit. It fostered loyalty to the unit and not to the hospital. It rewarded stability and protection of nurse membership. More emphasis was given to family or group achievement than individual achievement. Conflict tended to be avoided. The nurses spoke very highly of their unit and their work. They
were very happy on this unit. They perceived they worked in a supportive environment. This was a strong theme. They defined support as nurses helping them when asked and especially when their shift was about over and tasks were not completed. It was not a complicated "support system".

Norms for status in the family were based on tenure and clinical knowledge. Dependent behavior, encouraged by virtue of being a family member, did not appear to enhance growth, creativity and flexibility of performance. Rather, it fostered stability, resistance to change and the absence of a stimulating educational environment. Change occurred when physicians introduced new procedures and equipment but not as a result of nurses-originated innovations. Nurses did not recognize they were responding to change rather than being agents of change. In continuing with the norm of dependent behavior, nurses were limiting their own control, authority and development in their own area of expertise, nursing care.

Significance of the Themes

Although specific study findings are not generalizable to other settings and nurses, the themes and the issues which arise from the themes can be discussed in relationship to other settings. The three main themes that emerged from the data; professionalism through primary care, nurse growth and development, and identification of the nurse within the organization, suggest two deeper themes that assist in understanding nurse beliefs, nursing practice and unit ethos as an integrated phenomenon. These themes present themselves because they represent an underlying tension between nurse beliefs and work context.
Tension between nurse beliefs and nursing practice is not as apparent. The tension between beliefs and work context may stem from two rather obvious facts about nurses and hospitals: most nurses are females and hospitals have been organized and administered based on typical male values (dominance, aggressiveness, independence) or manpower.

Most nurses are females and have been socialized in the traditional female orientation. This orientation is carried into the nurse work role which reinforces the female role in the hospital's male dominated organization. The female work role is the "good person" described as a hard worker, patient and self-sacrificing (Gilligan, 1982, p.93).

According to Gilligan (1982), women's sense of self is organized around being able to make and maintain affiliations and relationships and that even the threat of a loss of a relationship is seen as a loss of self. Affiliations are so important that they are valued more than self-enhancement. Gilligan (1982, p.170) stated:

In their (women's) portrayal of relationships, women replace the bias of men toward separation with a representation of the interdependence of self and other, both in love and in work. By changing the lens of developmental observation from individual achievement to relationships of care, women depict ongoing attachment as the path that leads to maturity. Thus the parameters of development shift toward marking the progress of affiliative relationship.

...the observation that women's embeddedness in lives of relationship, their orientation to interdependence, their subordination of achievement to care, and their conflicts over competitive success leave them personally at risk...(Gilligan, 1982, p.171)

The nurses in this study reflected many of these characteristics and they are evident throughout the three themes. Nurses protect and
promote the family affiliation and resist change by depending on policies, doctors' orders and procedures. They avoid educational enhancement as one way to achieve autonomy and independence. They have even made primary nursing fit the female orientation, by isolating "their work" (i.e. nurse work and women's work) from men's work (i.e. doctor's work). The female orientation in the hospital context continues as oppressed group behavior: the internalization of the power group's or physician values (i.e. status seeking and isolation from other hospital personnel); the drive to attain the characteristics of the power group (i.e. specialization and "clinical experts"); and the lack of self esteem and thinking of themselves as second-class citizens (i.e. perceived lack of respect and decision making authority) (Roberts, 1983). Nurses' beliefs and behaviors promote lack of progress toward nurses' voice being heard and understood. It hinders nurses' and nursings' true contributions to patient care which is what nurses say they are trying to accomplish.

The second obvious fact is, hospitals have not been organized or operated based on "people power" but on manpower. Hospitals organized and characterized as bureaucracies value the way men view the work world, not women. Therefore, the structure and process of communication and authority follows an aggressive, competitive approach ignoring the strengths of women's ways of knowing (Belenky et al., 1986). Primary nursing might be successful in this hospital if changes in staff development orientation and practices and changes in organizational rules, roles and relations occurred concurrently. However, this mandates that nurses, too, relinquish their female orientation for a relationship
of equity. Nurses continued to maintain a "working class" mentality even with primary nursing by seeing themselves as second-class citizens to physicians and having to do everything for the patient to prove their worth and importance. As Willis (1981, p.3) describes in a study of working class lads:

In the sense, therefore, that I argue it is their own culture which most effectively prepares some working class lads for the manual giving of their labour power we may say that there is an element of self-damnation in the taking on of subordinate roles in Western capitalism. However, this damnation is experienced, paradoxically, as true learning, affirmation, appropriation, and as a form of resistance.

Once again, the nurses in this study appeared to exhibit resistance to change by protecting the subordinate role through the way primary care has been implemented, lack of integration and communication with others and not acknowledging identification with the larger organization and its environment yet dependent on the hospital’s policies and procedures to define their work.

In summary, as the three main themes of the study are explored further, one is struck by how issues of gender and organizational power relate to professional development. The hospital’s total organization must address the entire issue of equity if hospitals are to improve the work context for all health care providers.

Significance of the Study

Study Methods. This study appears to be the first time nurses’ beliefs, actual nursing practice and unit ethos have been explored and analyzed simultaneously and documented in detail. It is a beginning effort to present the nurses’ work world and how they function within it
from their perspective. This study is an example of a new model for integrative research. The collection and analysis of data in integrative research is achieved by combining conceptual and methodological approaches. As in this study, complex phenomena is explored and described from multiple perspectives using qualitative and quantitative methods. The conceptual foundation explored data from three perspectives: the individual, group and organizational context (Styles, 1982). The methodological approach used quantitative tools (i.e. structured interviews and questionnaires) to obtain data from individuals which were aggregated to group (Quinn, 1988). The qualitative method was the participant observations which assisted in individual, group and unit work context data collection.

The various methods used in this study generated a large quantity of data relevant to the study question. The sequence of data collection was positive and did allow the participant observation phase to progress comfortably for the researcher. A phase for follow-up interviews, group consensus discussions, or audio tape reviews would enhance the validity. However, confirmation of the data results from the various methods was surprising. This result does support the credibility of the findings and is a result of the number of methods used, the variety used and the inclusion of a majority of the nurses on the unit. Data integration occurred as findings from each method were analyzed and as similar or different themes emerged. The similarities and differences provided a way to identify the themes which operated across and among the three perspectives of individual, group and work context. Although the study
methodology was complex, all the methods were important to accomplish the intent of the study.

The Quinn tools that were used in the data collection, structured interview questions and the questionnaires, are based on the notion that competing values are the underpinnings of the behavior of most organizations and that to achieve rational management, individuals must learn how to manage competing values and how to balance the strengths of the behaviors which arise from those competing values. The individual and organization are encouraged to have a balance between all four quadrants to be effective. In this study, Quinn's framework demonstrated that nurses did not have an open, external focus which leaves them vulnerable in dealing with the larger organization. It also demonstrated the tendency to overemphasize one quadrant, human relations.

The tools and model did not demonstrate personal interrelationships in action on the nursing unit. The extent of nurse isolation and what that meant, the lack of talk between individuals, and the feeling of nurse subordination can not be discovered by Quinn's methodology. These were observed via the participant observations. The participant observations allowed for an intense and rich source of data on these issues.

The tools and model point the researcher in a particular direction for possible further investigations such as focused interviews, focused participant observations or group discussions. From this perspective, as Quinn suggests, the tools are useful to assess organizations and to provide a backdrop for understanding the assumptions of an organization.
The tools could help to focus participant observations if analyzed prior to participant observations.

The majority of nurse participants did not express any difficulty in filling out the questionnaires or in responding to the interview questions. The structured interview questions emphasize the organizational structure in contrast to questions that might reveal the individual's opinions and feelings about their work. There was not a significant amount of discussion about patients or about the potential future of nurse work. There were few times when words such as nurse autonomy, nurse accountability, or collaboration were mentioned. The questionnaires and the structured interview questions do not deal with future projections. They deal with the present.

The questionnaires were used to collect data on unit ethos. The questionnaires revealed information unique to each tool: unit effectiveness and unit culture. They each contributed information about different aspects of the unit and therefore the results from the two questionnaires are important but not entirely comparable. The questionnaires did permit the triangulation of data and in general supported the findings from participant observations and written documentation. The amount of nurse time for completing the questionnaires (reportedly less than 20 minutes) and completing the structured interviews (an average of 90 minutes) would justify their inclusion for data collection in further studies.

**Nurses' Work Role Redefined.** Nurses' work has mainly been explored by looking at what tasks nurses perform or are allowed to
perform. Studies related to what the nurse is really like are sparse. Therefore, finding that primary nursing organization was not truly accomplishing change in the authority and status of the nurse, lack of communications with physicians and other health care providers, lack of an educational focus and the extent to which nurses appear unaware of the physical environment and the larger organization were unexpected findings.

The position of the hospital staff nurse must be dramatically changed to keep pace with the changes in all aspects of the health care system. In the future, staff nurses, not just the nursing administrators, must learn how to survive in the political environment of the larger hospital system. The nurse must be knowledgeable of the sources of power and change within the hospital and be willing to be a player in that political arena. The nurse needs to be comfortable with power, negotiation and compromise.

The nurse must learn how to integrate her expertise with all hospital health care providers and be able and willing to articulate this every day in words and actions. The nurse must understand, accept and utilize the expertise and position of other health care providers.

The nurse must be an expert in clinical nursing skills, active in the application of nursing research to patients' needs and able to coordinate patients' care in the hospital. This requires an understanding of financial reimbursement, ability to function as a group leader with knowledge of group decision making, and the ability to resolve conflicts using group skills.
The nurse needs to learn information and communication skills augmented by the latest technology. The nurse must be willing to change and willing to be flexible within the entire system, not just one unit. The nurse must be willing to take risks, identify strongly with the patient, and implement cost effective nursing care and maintaining quality care. This new work role would require change in other parts of the hospital system and larger environment as discussed below.

Educational, Professional and Administrative Significance. Dramatic changes in nurse work and hospital organization may be suggested by the study findings. A redefined work role for nurses in the hospital will require changes at many levels and in many systems such as nursing education, nursing professional organizations, and nursing and hospital administration. The study findings are addressed to these institutions in the following paragraphs.

The nursing profession could be instrumental in identifying the positive role of the nurse and in describing the work of the nurse in proactive language. Autonomy, independence, power, authority, advocacy—all words that are common in recent nursing literature could be replaced with patient and system oriented words; coordinator, promoter, processor of cost effective care, provider, communicator and collaborator. The focus of these words should not be on the individual nurse, but on the nurses’ key position within the health care system. Authority and legitimacy will stem from this contribution rather than from nurses trying to manipulate the system with no-win power strategies.
Nurse power and authority could be legitimized by nurses' knowledge about the resources and the wellness trajectory plan for each patient. Effective and efficient patient care requires an identified person responsible for monitoring and coordinating the plan.

The profession could also focus its research efforts on the development of consistent quality nursing service. The profession could sponsor affordable clinical development programs at times staff nurses could attend or develop video cassettes that could be rented and contribute to nurse growth and understanding of complex nursing care problems.

Nursing administrators, collaborating with the rest of the hospital system might consider a new professional practice model of organized nursing service focusing on nurse leadership, collaboration, coordination and consistent delivery of cost-effective care. In current organizational terms it might combine the principles of group work and team/primary care organization. Group and team membership could vary depending on patient needs. Professional nurses would be encouraged and permitted to implement the care patients need and desire and to be independent critical thinkers. They would not depend on the system for their direction, but on the collective judgments and opinions of many different professionals working with them throughout the system. These nurses should be skilled in the leadership of patient management and care and would have the authority to procure the resources to effectively and efficiently care for the patients according to their hospital-based needs. Nursing professionals would be rewarded for recognizing and incorporating the contributions of health care providers.
needed in the care of hospitalized patients. Such efforts would be enhanced by designing and implementing new and different computerized communication and documentation technology.

Nursing administrators must be aware that job satisfaction is very complex and has many personal and contextual variables. Nursing administrators must consider the nurse population they are employing and ascertain their unique characteristics when creating or maintaining a positive work environment. The current study attempted to understand nurses by allowing their opinions of their job to emerge without any prior definitions of what satisfaction is or is not to them. This approach is different from the studies reviewed in Chapter 2.

Nurse educators might consider reexamining the goals of nursing education to graduate staff nurses who can function as leaders/coordinators as well as patient care providers. The large corporate health care systems, fast becoming the dominant model, will require that someone takes the lead in the management of patients' trajectory of health and wellness. Identification of the most economical place for the development of nurse competency should be a research objective. Is it in the university environment or the hospital environment or both? And, what skills are best taught in the field versus in the academic environment? The efforts to have a consistent educational outcome for registered nurses should continue to be a priority of nurse administrators and nurse educators. The outcome should be the criteria, not the length of the program. Some nurses might complete the nursing program in less than four years and some nurses
might need longer to successfully complete the program. The goal should be nurse competency at the beginning graduate nurse level.

The gap between education and service is being addressed realizing the contributions each can make to the nursing profession. This study revealed how some nurses perceive the function of education in everyday experiences and how these nurses selected to increase their competence.

Organizational leaders have the responsibility for designing and implementing the culture of their organization in concert with the organization's mission and the individuals that will be a part of the organization. The goals of the organization should be clear. Hospitals have a difficult situation because of the number of variables that are operating at the same time; the different levels and numbers of professionals, the legal constraints and requirements controlled by agencies outside the hospital, and the constant challenge to balance all the economic issues. Hospitals need to focus on departmental integration, personnel development, reduction of duplication of efforts and the overall collaborative climate needed to facilitate a productive and positive work place and work force. Nurses' increasing ability to be the managers and safe providers of care in a very complex technological environment needs to be acknowledged by the hospital system.

The ultimate significance of this research rests with the clear implication that change must be evaluated in the light of the culture of the organization. The success of the organization and each part is the composite of not only the beliefs, practices, norms, and expectations of nurses, but of all employees and individuals within the organization.
Recommendations for Future Research

This study does suggest future research. Because of the complexity of this study and the limitation to one unit, a comparative study should be attempted using a research team rather than a single investigator. Depending on resources available, multiple units and sites would contribute understanding to the relationships. Interviewing non-nurses in the system would contribute another important perspective to future inquiry.

Studies on the socialization of nurses are extensive. However they deal primarily with student nurses and value and attitudinal differences related to students' educational program and not with the experienced graduate nurse. The process of socialization and professionalization at the unit level needs to be explored to address the issues of retention and continuing education to maintain nurse competency. Additional studies to identify ways nurses achieve power and negotiate among groups within their particular work environment would contribute information on future continuing education programs and assist in the redefinition of nurses' position within the hospital. The ways nurses could be more creative in their clinical practice and in implementing change requires more study.

The literature appears lacking in studies that explore integration, coordination and communication among health care providers and services in the hospital. How can the hospital be restructured to achieve a meaningful and efficient level of integration and collaboration and control the power of one group over another? How can cooperation be achieved and rewarded in a large bureaucratic organization? Although
this study provides an approach to integration at the unit level by exploring and describing nurses' beliefs and actual practice in the hospital context, focused studies among multiple departments would contribute additional insights for potential system change. The study generates hypotheses for future study such as making specific changes in unit expectations and then determining the impact on the entire staff and unit.

The issues of quantity of work, nurse/patient ratio, and cost of nursing care, continue to require study. Patient outcomes do not have a fixed nursing cost because of all the variables. Future research using computerization might achieve needed information. Procedures and policies concerned with nursing practice and nursing education need to be reexamined in light of this study. The restrictive nature of policies should be researched and evaluated in terms of personpower utilization and the variables of cost, quality, and effectiveness of care. How are they prohibiting the delivery of care? What are the outcomes of policies and procedures? How could representative employees be included in the corporate decision-making process?

The hospital environment is being influenced by the open market more than in the past. The hospital system needs to quickly adjust to new market realities.

This study revealed another potential area for research: the perspectives of patients or clients and their significant others. These individuals are a very critical component in the health care business and health care providers should be talking with them and making them apart of the restructuring of the health care system.
APPENDIX A

NURSING UNIT
Figure 6. Nursing Division Organization Chart.
<table>
<thead>
<tr>
<th>Nurse</th>
<th>Age (Yr)</th>
<th>Degree or Certif</th>
<th>YR Rec'd</th>
<th>Credentials</th>
<th>Yrs RN</th>
<th>Yrs on Unit</th>
<th>Yrs RN at Hosp*</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>26.3</td>
<td>BSN</td>
<td>1985</td>
<td>R.N.C. b</td>
<td>4</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C.O.B.c</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>32.8</td>
<td>BSN</td>
<td>1980</td>
<td></td>
<td>8</td>
<td>4.0</td>
<td>8.0</td>
</tr>
<tr>
<td>03</td>
<td>26.8</td>
<td>BSN MS</td>
<td>1985</td>
<td></td>
<td>4</td>
<td>5.5</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ip d</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>24.8</td>
<td>BSN</td>
<td>1987</td>
<td></td>
<td>2</td>
<td>&lt;1.0</td>
<td>&lt;1.0</td>
</tr>
<tr>
<td>05</td>
<td>26.6</td>
<td>BSN</td>
<td>1986</td>
<td>R.N.C</td>
<td>3</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>06</td>
<td>22.0</td>
<td>ADN</td>
<td>1988</td>
<td></td>
<td>1</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>07</td>
<td>37</td>
<td>BA Dipl.</td>
<td>1982</td>
<td></td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>08</td>
<td>44.3</td>
<td>BSN MS</td>
<td>1967</td>
<td></td>
<td>22</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1980</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>28.2</td>
<td>BSN</td>
<td>1984</td>
<td>Medical-Surgical Nursing</td>
<td>5</td>
<td>8.0</td>
<td>5.0</td>
</tr>
<tr>
<td>10</td>
<td>33.0</td>
<td>BSN</td>
<td>1986</td>
<td></td>
<td>3</td>
<td>4.5</td>
<td>3.0</td>
</tr>
<tr>
<td>11</td>
<td>32.0</td>
<td>BSN</td>
<td>1979</td>
<td></td>
<td>10</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>12</td>
<td>51.1</td>
<td>Dipl.</td>
<td>1959</td>
<td>Medical-Surgical Nursing</td>
<td>29.5</td>
<td>11.5</td>
<td>14.5</td>
</tr>
<tr>
<td>13</td>
<td>26.3</td>
<td>BSN</td>
<td>1986</td>
<td></td>
<td>3</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>14</td>
<td>40.2</td>
<td>ADN</td>
<td>1970</td>
<td></td>
<td>19</td>
<td>6.0</td>
<td>9.0</td>
</tr>
<tr>
<td>15</td>
<td>27.9</td>
<td>Dipl. BSN MS</td>
<td>1973</td>
<td></td>
<td>15.8</td>
<td>5.5</td>
<td>15.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1988 ip</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Years as RN at the test site hospital; bR.N.C., Registered Nurse Certified; cC.O.B., Certified Diabetic Educator; dip, in progress
Figure 7. Floor Plan of Hospital Unit Studied.
CONSENT FOR PARTICIPATION IN
SOCIAL AND BEHAVIORAL RESEARCH

I consent to participating in (or my child's participation in) research entitled:

__________ Relationship Among Staff Nurses' Ideas and Beliefs, Nursing Practice and Hospital Ethos

Brad Mitchell
(Principal Investigator)
or his/her authorized representative has explained the purpose of the study, the procedures to be followed, and the expected duration of my (my child's) participation. Possible benefits of the study have been described as have alternative procedures, if such procedures are applicable and available.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. Further, I understand that I am (my child is) free to withdraw consent at any time and to discontinue participation in the study without prejudice to me (my child).

Finally, I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: 6-5-89 Signed: __________________________ (Participant)

Signed: __________________________ (Principal Investigator or his/her Authorized Representative)

Signed: __________________________ (Person Authorized to Consent for Participant - If Required)

Witness: __________________________

Protocol No. 89BO096

THE OHIO STATE UNIVERSITY

31 A

MS-027 (Rev. 3/87) — (To be used only in connection with social and behavioral research.)
APPENDIX C

QUESTIONNAIRES
PLEASE NOTE:

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

These consist of pages:

240–244 Appendix C
LIST OF REFERENCES


Misuse of RNs spurs shortage, says new study: "Only 26% of time is spent in professional care." (1989). *American Journal of Nursing*, 89, 1223, 1231.


Styles, M. M. (1990). Ten ways to know... Nursing and Health Care, 11(6), 283.


