Clinical Nurse Perceptions of Who Governs the Professional Environment Including
Control over Practice in Provincial Hospitals in Saskatchewan

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College of Graduate Studies and Research
In Partial Fulfillment of the Requirements
for the Degree of Master of Nursing
in the College of Nursing
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ABSTRACT

Organizational restructuring and reform in the health care system has impacted the ability of Clinical Nurses (CNs) to participate in and influence decision making that affects the delivery of patient care. Clinical nurses maintain and advocate a professional responsibility to practice according to specific standards, policies and procedures, and to meet the needs of the patient and family members. Clinical nurses’ participation in decision making at the patient, unit and administrative levels recognizes their abilities and skills as professionals; however, CNs continue to experience a limited role in the decision making and control over nursing practice at all of these levels.

The literature overview examines control over nursing practice including how this complex concept is difficult to define and undervalued within the CNs’ professional practice environment. It is evident in the literature that control over nursing practice is important to the CNs’ professional practice environment ultimately affecting job satisfaction, recruitment/retention, and patient outcomes. Control over nursing practice is explored in relation to internal and external factors that affect the professionalism of the CN. Internal factors are those that are more closely related to the CNs’ scope of practice and include professionalism (influence in decision making including policies and procedures, collegial relations, and professional development), CN satisfaction (workload, scheduling, health, safety and security concerns, supportive management, and opportunities for leadership), safe quality patient care (staffing, education, and specialization), empowerment, and autonomy. The external factors are outside the immediate scope of the CN yet directly and indirectly affect the CNs’ control over nursing practice including health care restructuring, organizational influence, work environment models (shared governance and magnet hospital environments), and nursing leadership.
This study provided CNs employed in the provincial hospitals in Saskatchewan an opportunity and a “voice” to share their perceptions of who governs their professional practice environment including control over nursing practice. This mixed method descriptive survey design used Hess’ Index of Professional Nursing Governance ([IPNG], 1998) along with five questions geared to elicit qualitative responses to study the perceptions of who governs CNs’ professional practice environment including control over nursing practice in provincial hospitals in Saskatchewan. Section one of the IPNG contains a demographic section including information on age, gender, nursing education, and employment information. The second section of IPNG consists of 86 questions that are further divided into six subscales asking respondents to indicate who has control over nursing practice in a number of areas within their particular health facility. The six subscales include Subscale I – Professional control relating to who has control over professional practice in the organization, Subscale II – Organizational influence examining who participates in governance activities within the organization, Subscale III – Organizational recognition identifying who controls nursing personnel and related structures, Subscale IV – Facilitating structures indicating who determines and participates in governance decisions within the organization, Subscale V – Liaison exploring who influences the resources that support professional practice, and Subscale VI – Alignment identifying who sets and negotiates conflict within the organization. These questions are rated on a 5 point Likert scale according to the following response possibilities: 5 = staff nurses only; 4 = primarily staff nurses with some nursing management/administration input; 3 = equally shared by staff nurses and nursing management/administration; 2 = primarily nursing management/administration with some staff nurse input; 1 = nursing management/administration only. Section three – the qualitative questions, contained one closed ended and four open ended questions that provided
CNS an opportunity to share a more personal perspective regarding their perceptions of control over nursing practice in their work environment. These questions included: 1. What does control over nursing practice mean to you? 2. How could control over your practice be changed significantly? 3. Do you feel you have enough control over practice in your work environment? 4. What limits your control over practice in an area that interests you? and What enables your control over practice in an area that interests you?

The total population of 1804 CNs in provincial hospitals in Saskatchewan was invited to participate in this study. One hundred and seventy two CNs (9.53%) responded to this study, including 118 from Saskatoon (11.8%) and 54 from Regina (6.7%). The descriptive data provides data on gender and average age of CNs that is similar to Canadian Institute for Health Information ([CIHI], 2006) and Health Canada (2006a). A greater number of CN respondents indicated their basic nursing education was a diploma and more CNs had attained a baccalaureate degree as their highest level of education when compared to the CIHI data. Twice as many CNs indicated having specialty certification and a higher number were working full time in comparison to the CIHI data. The quantitative data obtained from the IPNG subscales indicates CNs perceive limited control over nursing practice and this is by in large held mainly by nursing management/administration (1) and nursing management with some staff nurse input (2). The subscale results include Professional control (M = 1.72), Organizational influence (m = 2.13), Organizational recognition (M = 1.73), Facilitating structures (M = 1.82), Liaison (M = 2.1), and Alignment (M = 2.1). Overall, the results from the IPNG subscales provide scores of less than “3” on the Likert scale indicating CNs perceive limited control over nursing practice in their professional practice environment. There were no significant differences within the provincial hospitals or between the health regions regarding CNs’ perceptions of control over nursing
practice. In their qualitative responses, CNs provided information related to both the internal and external factors as discussed in Chapter Two. Clinical nurses indicate they face many challenges regarding control over practice including lack of influence in decision making in issues related to policy and procedure, quality patient care, staffing ratios, self-scheduling, and educational opportunities. They also identified external factors affecting their control over nursing practice including a lack of support by management in relation to decision making, a lack of provision of and access to an adequacy of resources, and a lack of communication and collaboration. Many CNs indicated their only influence in decision making was related to direct patient care. Clinical nurses described that being valued, supported, and recognized for their experience and education in decision making positively affects control over nursing practice and more specifically, quality patient care.

Study results offer government officials, practitioners, regulatory bodies, researchers, administrators, educators, nurses, the public, professional association, employers, unions, and any other stakeholders information that provides an opportunity to increase their awareness and understanding of the impact that control over nursing practice has for CNs in their practice environment. If stakeholders are serious in their attempts to recognize CNs’ concerns regarding control over nursing practice in their work environment, the results from this study will provide information facilitating change in the CNs’ control over nursing practice. Ultimately, this affects the CNs’ professionalism and ability to provide quality patient care.
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CHAPTER 1
Introduction

1.1 Introduction to the Problem

Organizational restructuring and reform in the health care system have created uncertainty and vulnerability among clinical nurses within the work environment. This has negatively affected the Clinical Nurse’s (CN’s) role, influence in decision making, and delivery of patient care (Alvarado, Boblin-Cummings, & Goddard, 2000; Green & Jordan, 2004; Kennerly, 2000; McGirr & Bakker, 2000; Nevidjon & Ives-Erickson, 2001). CNs are responsible and accountable to practice according to the standards identified by their professional regulatory body, policies and procedures directed by the health care organization, and the expectations and demands of the patient and family members. The CNs’ ability to have influence in decision making has positive outcomes for the organization, the CN, and especially for the patient (Brooks, 2004; Broughton, 2001; Greco, Spence Laschinger, & Wong, 2006; Hess, 2004; Lowe, 2002; Ma, Samuels, & Alexander, 2003; McNeese-Smith & Crook, 2003; Morrison, Jones-Ladon, & Fuller, 1997; Nedd, 2006; Sengin, 2003; Spence Laschinger, Finegan, Shamian & Casier, 2000; Sullivan, Havens & Vasey, 2003; Tourangeau, Coghlan, Shamian, & Evans, 2005).

1.2 Statement of the Problem

As skilled professionals, CNs should be recognized for having control over nursing practice by participating in decision making at all levels including critical decision making at the bedside. However, relevant research (Aiken et al., 2001a; Canadian Health Services Research Foundation [CHSRF, 2006a]; George, Burke, & Rodgers, 1997; Havens & Vasey, 2005; Hess, 1998; Nedd, 2006; Tourangeau et al., 2005) illustrates that CNs experience a limited role in the
decision making and control over nursing practice at the unit, management, and administration levels. As described by many researchers, (Aroskar, Maldow, & Good, 2004; Broughton, 2001; CHSRF, 2006a; Kramer & Schmalenberg, 2003; Scott, Sochalski, & Aiken, 1999) CNs believe control over nursing practice is a fundamental responsibility of professional nursing. Since the perception of one's ability to function independently as a professional is an important aspect of autonomy, it is important to understand CNs’ perceptions of their own control over nursing practice. Spence Laschinger, Almost, and Tuer-Hodes (2003) agree that a practice environment that provides CNs the opportunity to make decisions also promotes their autonomy and control over nursing practice. Contrary to this, centralized authoritarian decision making has a negative and direct impact on the CNs’ perception of their control over nursing practice and their ability to provide patient care (Aiken, Sochalski, & Lake, 1997; Alvarado et al., 2000; Baumann et al., 2001; Green & Jordan, 2004; Kuokkanen & Katajisto, 2003; Larrabee et al., 2003; McGirr & Bakker, 2000; Porter-O’Grady, 1992, 2003a, 2003b; Sengin, 2003). As well, an organizational environment that places limits on the CNs’ control over nursing practice creates challenges in the recruitment and retention of CNs. Recently, the CHSRF (2006a) identified several important strategies directed at implementing and maintaining quality work environments for the CN. Included in this discussion is the integration of CNs into the organizational hierarchy thereby advancing the CN to policy and decision making positions. This is a key strategy in the recruitment and retention of CNs.

1.3 Purpose of the Study

The purpose of this research study was to identify the perceptions that CNs in Saskatchewan provincial hospitals have regarding who governs the professional practice
environment including control over nursing practice. The study results will provide a description of what control over nursing practice means to CNs in the specific institutions in Saskatchewan.

1.4 Relevance and Significance of the Study

Government officials, practitioners, regulatory bodies, researchers, administrators, educators, nurses, the public, professional associations, employers, unions, and other stakeholders from all sections of the health care system recognize the current trends and future predictions of the nursing shortage. Most of these stakeholders are determined that quality patient care in a quality work environment be developed and maintained (Advisory Committee on Health Human Resources [ACHHR], 2000; Broughton, 2001; CHSRF, 2006a, 2006b; Canadian Nurses Association [CNA] 2001a; 2002; Health Quality Council [HQC], 2003; Leatt, 2001; McGirr & Bakker, 2000; McIntyre & McDonald, 2003; Nevidjon & Ives-Erickson, 2001). This study provided CNs in provincial hospitals in Saskatchewan an opportunity to share their perceptions of control over nursing practice within the organization and their profession and when providing patient care. Awareness of these perceptions by stakeholders can lead to strategies that address valuing and strengthening CNs’ control over nursing practice at all levels, which will support retention/recruitment of CNs. Recognizing and adopting a professional practice model that emphasizes CNs having appropriate control over nursing practice, including shared governance, ensures CNs are involved in the decision making process at various organizational levels. Considering Saskatchewan’s ongoing health care restructuring, it is timely to understand CNs’ perceptions about who governs the professional practice environment including who has control over nursing practice. In addition, the study provides CNs in the specific institutions in Saskatchewan an opportunity to identify what might help foster control over nursing practice in their professional practice environment. Figure 1.1 provides an
overview of control over nursing practice illustrating the relationship between control over nursing practice, decision making, the individual, autonomy and the professional with outcomes relevant to a professional practice environment.

Figure 1.1 Control over Nursing Practice - Decision Making and Relevant Outcomes

Control over Nursing Practice

Decision Making

Professional

Individual

Autonomy

Professional practice/Work environments
Quality patient care
CN satisfaction
Recruitment and retention
Organization
1.5 Definition of Terms

The following definitions were used in the study:

**Autonomy**

Autonomy is the freedom of the individual nurse to make independent clinical nursing decisions regarding clinical issues and to implement appropriate nursing care. It relates to the practice and decision making for which nurses are held accountable (Ritter-Teitel, 2002).

**Clinical Nurse**

A registered nurse practicing nursing in a clinical area where client care is provided within the scope of the provincial union, Saskatchewan Union of Nurses (SUN) and guided by the standards of practice inherent within the provincial regulatory body (SRNA). For the purposes of this study, registered psychiatric nurses (RPNs) and licensed practical nurses (LPNs) were not included in the definition of clinical nurse.

**Control Over Nursing Practice**

As defined by Kramer and Schmalenberg (2004).

Control over practice is a participatory process enabled by a visible, organized, viable structure through which nurses have input and engage in decision making about practice policies and issues, as well as personal issues affecting nurses. The effectiveness of structure is apparent in outcomes achieved and recognition of nursing’s control over nursing practice by others (p. 46).

**Organizational Restructuring**

The redesign of hospital care and service processes, which typically includes changes in roles and responsibilities, downsizing, layoffs, and altered staffing levels (Ritter-Teitel, 2002).
**Provincial Hospitals**

Provincial hospitals include hospitals with high enough patient volumes to support and sustain specialized programs. Such services would include specialized surgical and medical services for cancer treatment, heart surgery, specific diagnostic tests and infant intensive care units (Saskatchewan Health, 2001). The five provincial hospitals included in this study are the Regina General and Pasqua Hospitals in Regina and the Royal University, Saskatoon City, and St. Paul’s Hospitals in Saskatoon.

*Shared Governance*

Shared governance is an organizational framework where CNs can utilize strategies that can both facilitate empowerment and manage their practice with much greater authority. Shared governance strategies include those that foster partnership, equity, accountability, promote job satisfaction, and encourage the CN to be involved in the decision making processes from the bedside to an administration level towards establishing control over nursing practice (Anthony, 2004; Hess, 2004; Williamson, 2005).

1.6 *Research Question*

This research study answers the following question:

What are the perceptions of CNs employed in provincial hospitals in Saskatchewan regarding who governs their professional practice environment including control over practice?
CHAPTER 2

Background

2.1 Literature Overview

Control over nursing practice is a concept embedded within the shared governance literature (Anthony, 2004; Kramer & Schmalenberg, 2003). Outcomes of shared governance are examined in one of three domains: Organizational, work environment, and nurse satisfaction (Anthony, 2004). Inherent to each of these domains is the concept of control over nursing practice and includes both internal and external factors. The internal factors relate to CN professionalism, satisfaction, and quality of care, including the effect that control over nursing practice has on autonomy and empowerment. External factors include health care restructuring, organizational influences, and work environment models, such as shared governance and Magnet hospitals, and nursing leadership. The internal and external factors have an integrated relationship and can be synergistic in how they affect control over nursing practice. Although the literature includes research on many aspects of shared governance including organizational, work environment, nurse satisfaction, and patient outcomes, this study has focused primarily on CNs’ control over nursing practice. The following literature review will discuss control over nursing practice and how it relates to the internal and external factors. Control over nursing practice will be explored and emphasized relevant to its importance to the professionalism of the CN and the associated positive results relevant to patient outcomes, nurse retention and recruitment, and the organizational culture (Brooks, 2004; Broughton, 2001; CHSRF, 2006a, 2006b; Hess, 2004; McGillis Hall, 2003; Spence Laschinger et al., 2000; Tourangeau et al., 2006).
There is extensive layering of the literature relevant to control over nursing practice. In several instances this concept is discussed in different contexts revealing the overlap in the literature. Using a concept map, Figure 1.1, an illustration of the literature overview is provided reflecting, to a small extent, the layering of this complex concept. The bridge between the internal and external factors is outlined in red indicating the interrelatedness of these factors between professional practice models (internal) and work environment models (external).

**Figure 2.1 Concept Map of Control Over Nursing Practice.**
2.2 Control Over Nursing Practice

Control over nursing practice, a recurring issue in professional nursing, has been broadly researched and is identified as a complex concept (Kramer & Schmalenberg, 2003). Control over nursing practice is an umbrella term that is described or influenced by various internal and external factors within the work environment. The internal factors consist of subconcepts that include the influence and participation in decision making that affects the ability of the CN to provide patient care. These subconcepts include professionalism (influence in decision making including policies and procedures, collegial relations, and professional development), CN satisfaction (workload, scheduling, health, safety and security concerns, supportive management, and opportunities for leadership), safe quality patient care (staffing, education, and specialization), empowerment, and autonomy. The external factors directly and indirectly affect the CNs’ control over nursing practice and are outside the immediate scope of practice of the CN including health care restructuring, organizational influence, work environment models (shared governance and magnet hospital environments), and nursing leadership. The following section will provide an overview of the concept control over nursing practice. Challenges regarding defining control over nursing practice will be explored. The concept control over nursing practice will be examined using the following themes of professionalism, CN satisfaction, quality of care, empowerment, and autonomy.

Clinical nurses are committed to providing patient care, acting as a patient advocate, and may find themselves in conflict with the health care organization in fulfilling these commitments. Multiple external and internal factors influence this complex situation. Green and Jordan (2004) propose that the establishment of a partnership between the CN and the health care organization enables the CN to effectively advocate for patient care and also “promotes
power bases that afford nurses optimal work environments” (p. 2) including control over nursing practice. These authors suggest that CNs need to have a “voice” and advocate for a role in decision making to strengthen their positions at the administrative and organizational levels. Subsequently, the CN becomes more accountable and responsible within their professional practice through advocating for quality workplace environments affecting job satisfaction along with recruitment and retention.

The significance of control over nursing practice is difficult to define and undervalued within CNs’ professional practice environment. Kramer and Schmalenberg (2003) completed a research critique on control over nursing practice. They reviewed and listed several tools that have been used in nursing research attempting to quantify the amount of control over nursing practice that CNs feel they have. These various tools contain items that measure control over nursing practice including the ability to participate in policy decisions, staff nurse involvement in policy committees, professional autonomy, ability to implement the nursing process, continuity of care, safe staff ratios and mixes, evaluation of policies that affect practice issues, adequate support systems, and supportive management. However, these authors contend that the tools examined do not provide a clear or common definition of control over nursing practice. These authors believe control over nursing practice has many different and puzzling meanings. Definitions included in their literature review include the CNs’ freedom to make decisions and influence the work environment indicating both professional and clinical aspects of autonomy. Their research study summarizes the participants’ qualitative information regarding control over nursing practice as an “important function of the professional nurse role” and “can be operationalized through some kind of visible, empowered, organizational structure for nurse participation and decision making at the hospital, departmental, and unit level” (p. 441).
Kramer and Schmalenberg emphasize the importance of this concept being organized into clinical, managerial, environmental, and cultural domains to provide the CN power to engage in activities that affect quality patient care and CN satisfaction. Their study enabled CNs to be involved in defining what control over nursing practice means to them, which can be seen as an initial step for the CN to influence decisions that affect the professional nurses’ role. When the concept of control over nursing practice is clearly defined, understood and applied to professional practice it is seen as a visible and empowering strategy addressing CN professionalism, job satisfaction, quality care, empowerment, and autonomy.

Kramer and Schmalenberg (2003) conclude that although control over nursing practice has been broadly researched throughout the nursing literature, the lack of a common definition of this concept remains. These authors suggest that since control over nursing practice has become an important entity in the professional nurse role a clear definition could benefit the CN when communicating the professional role of nursing within and outside the nursing community. Control over nursing practice is a significant concept affecting the CN professionally and individually. Control over nursing practice affects the CNs’ professionalism, workload and satisfaction, and education and specialization. Individually the CN might demonstrate an increase in self-confidence, competence, and self-directedness.

2.2.1 Internal Factors

Internal factors related to control over nursing practice are linked to the CNs’ professionalism that influences direct patient care. These factors include the subconcepts of professionalism, professional practice models, CN satisfaction, quality care, empowerment, and autonomy and affect CN recruitment and retention, patient care, and patient outcomes. Information on recruitment and retention is limited; however, an analysis of organizational
change and its impact on delivery of care by The Ottawa hospital led to deliberate strategies to improve nurses’ work life that included the design and implementation of a professional practice model. Evaluation of this professional practice model is ongoing, but since its implementation noticeable improvements in recruitment and retention have been observed including a decrease in nurse turnover from 11% to 3 % over the last five years (personal communication G. Rodger, March 29, 2005).

2.2.1.1 Professionalism.

The fact that CN participation in decision making affects both professional practice and job satisfaction has been extensively reported in the literature. The CNA (2003) identifies that “nursing is first and foremost a practice profession in which clinical practice is supported by education, administration and research” (p. 1). CNA also posits that “safe and competent nursing care is an essential element of health care” and “participation in decision-making, whether related to the care of the individual client or to the planning and determination of nursing goals, priorities and procedures, provides nurses with a sense of control over their work and a stake in the success and well-being of the organization as a whole” (2001, p. 1-2). Empowerment within the organization creates a favorable work environment for CNs. With organizational commitment, individual feelings of autonomy and self-efficacy are enhanced. The lack of representation of CNs in the organizational or political framework negatively impacts the CNs’ role in the decision making processes and communication of needs limiting their ability to influence change (Baumann et al., 2001; Cameron, Armstrong-Stassen, Bergeron, & Out, 2004; CHSRF, 2006a; Kuokkakanen & Katajisto, 2003). The journey to share a common goal, a vision, a purpose, and influence change is not an independent one but rather a group enterprise
According to Aroskar et al. (2004) the effects of the institutional and administrative practice of nurses were not recognized and valued as being critical contributions to patient care. The majority of nurse participants felt they had “little or no control over practice, which leads to feelings of oppression and moral distress or to leaving nursing altogether” (p. 273). These authors suggest that to improve the personal health, health of populations, and health care system, nurses who provide direct patient care should be involved in health policy decisions, including decision making regarding funding, recruiting, and retaining nurses. Results from this study indicate nurses wanted policymakers to view professional nurses as important resources and ask for their input. McFarland, Leonard, and Morris (1984) identified that nurse dissatisfaction and the nursing shortages reflected issues including lack of input and recognition in policy development and decision making as well as poor working environments. These issues are similar to those issues expressed by CNs of today (CHSRF, 2006a; Kramer & Schmalenberg, 2003; Smith, Tallman, & Kelly, 2006). Organizational commitment and supportive work environments are essential elements to facilitate professional practice. Professional practice models are described as a means for nurses to gain control over their practice through input into decision making.

2.2.1.2 Professional Practice Models.

Arford and Zone-Smith (2005) describe professional practice models as approaches that allow nurses control in decision making regarding the activities, responsibilities, and credentials to practice and provide safe patient care. These authors posit that “if direct care nurses are to
have control over their practice, then, fundamentally, they must decide what that practice is” (p. 468).

Albaugh (2003) reiterates previous research and discusses “clearly, nurses want to be” and “should be informed and involved in all decision-making process that affect nursing practice” (p. 196). An Australian study by Takase, Maude, and Manias (2005) reports CNs’ “opportunities to participate in organizational decision making” are not congruent with the nurses’ professional needs. These authors suggest that having the knowledge and skill to be involved in the decision-making process, but not being provided with this opportunity, results in stress for nurses and leads to increased turnover. Duffield, Aiken, O’Brien-Pallas, and Wise (2004) deduce that factors related to nurses seeking alternative employment included “salary and prestige issues such as career development and promotion opportunities, equality with other professional careers, and being treated as a valued health professional” as well as “professional effectiveness, such as having autonomy in decision making, using a full range of skill, and influencing both the quality of care and policy development” (p. 244). Scott et al. (1999) reviewed research that describes and evaluates nurses’ professional practice. Their review equated the concept of autonomy with control over work including “full command of expert knowledge and allows for accountability and authority in decision making” (p. 4).

Kramer and Schmalenburg (2003) describe control over nursing practice as an important function of professional nurses’ roles. They propose that an organizational structure that encourages CNs’ participation in decision making at all levels also recognizes that CNs’ control over nursing practice is associated with a sense of power linked to quality patient care, CN satisfaction, and cultural outcomes that increase “status, recognition, prestige, and pride in nursing as a professional discipline” (p. 441). They conclude that because of health care reform,
sixty percent of CNs at Magnet hospitals describe little or no control over nursing practice. They provide rationale for this includes the lack of a clear definition of control over nursing practice, and hospital mergers, because they are financially strained and unable to sustain an organizational structure that encourages CNs’ control over nursing practice. Their study results indicate that participants clearly differentiate control over nursing practice from autonomy. In their study CNs’ definition of autonomy is limited to the freedom to make clinical practice decisions that directly involve patient care. These CNs might be highly autonomous but lack the ability to contribute to the decision making process at all levels, which has been recognized as central to the participants’ definition of control over nursing practice.

A non-nursing management model provides insight into different perceptions regarding control over nursing practice. Budge, Carryer, and Wood (2003) studied autonomy, control, and professional relationships in nursing work environments in New Zealand in which the management structure consists of management that are non-nurses yet have primary control over nursing practice. They surveyed 225 nurses using a tool that was developed to measure perceptions of work environments in Magnet hospitals. The Nursing Work Index – Revised (NWI-R) (Aiken & Patrician, 2000) yielded unexpected results. The results indicate that nurses reported their autonomy and control over nursing practice was relatively low but had positive nurse-physician relationships. Results from this study indicate that this non-nursing management model has control over primary administrative authority thus diminishing nurses’ autonomy and control over nursing practice. However, physicians also working within this non-nursing management model indicated they were positioned more as nurses’ colleagues rather than as their as superiors. Results of this non-nursing management model revealed a positive nurse-physician relationship.
Lynn and Kelley (1997) discovered that a case management model promoted a stronger perception of control over nursing practice by case managers over staff nurses. This study identified case managers’ responsibilities as providing direct patient care, following the progress of the patient on a daily basis, following progression of the critical path of the patient, facilitating education, and making referrals for their patients from admission to discharge. In this situation, case management is a model that emphasizes interdisciplinary collaboration that facilitates quality care.

Contrary to their expectations, Parsons, Cornett, Sewell, and Wilson (2004) conclude that control over nursing practice was not seen as a significant outcome following implementation of a healthy workplace intervention. These authors defined control over nursing practice based on Gerber’s control over practice scale (COPS) as “the freedom to evaluate and modify one’s work and to influence others” (p. 301). Their results demonstrated that CNs’ felt their control over nursing practice was the same both pre and post implementation of the healthy workplace intervention. However, the results also indicate that post implementation of the healthy workplace intervention, CNs suggested a significant increase in satisfaction with collegial and physician interactions adding to job satisfaction. Due to a small sample size (n = 15), these results can not be generalized.

Ulrich, Buerhaus, Donelan, Norman, and Dittus (2005) provide national results on how a random sample of 3500 licensed American nurses view their work environment. Their survey concluded that RNs indicate they do not have adequate opportunities to influence decisions about the workplace organization or patient care. They also identify structures to assist nurses to have a greater control over nursing practice including shared governance, Magnet environment, and participative management. These structures contribute to the increased job satisfaction of the
CN, ultimately affecting recruitment and retention. Pertinent to the results of this study there continues to be little information to suggest that CNs are involved in decision making at the organizational or patient care level. Tourangeau et al. (2005) compared RNs to Registered Practical Nurses’ (RPNs) evaluation of their nursing practice environments. They conclude that both professional groups showed low participation in hospital affairs and their control at work was the least satisfying feature. Strategies they suggest are encouraging administration to seek out consultation with “front-line” nurses because their participation in decision making at the unit and policy level is fundamental to achieving standards of high-quality care.

CNs’ influence in the decision making process at all levels improves the relationship between the employee and employer and serves as an avenue in which nurses can improve the culture of their work environment, practicing a higher level of professionalism through control over nursing practice (Cameron et al., 2004; CHSRF, 2006a; George et al., 1997; Green & Jordan, 2004; Havens, 1998; Havens & Vasey, 2003; Ingersoll, Schultz, Hoffart, & Ryan, 1996; Krugman & Preheim, 1999; Mrayyan, 2003; Porter-O’Grady, 2001, 2003a, 2003b; Scott et al., 1999; Smith et al., 2006; Tourangeau et al., 2005). Accountability through decision making and control over nursing practice enhances CN professionalism and satisfaction.

2.2.1.3 CN satisfaction.

Job satisfaction is about how individuals feel about their work. McGillis Hall (2003) presents information on nurses’ job satisfaction that can be studied through nursing behaviors such as intent to leave, job stress, organizational commitment, burnout, and turnover. She also identifies different characteristics that affect job satisfaction such as salary, sense of community, communication, participation, control over nursing practice, autonomy, organizational commitment, support from management, and educational opportunities. Other factors affecting
CN job satisfaction include a supportive organizational culture and practice environment, availability and access to resources, adequate staffing to meet patient acuity and demands, and influence in decision making at all levels (Aiken et al., 2001a; CHSRF, 2006a; George et al., 1997; Havens & Vasey, 2005; Hess, 1998; Nedd, 2006; Tourangeau et al., 2005).

Using a qualitative approach, Geiger-Brown et al., (2004) involved nurse participation to identify themes regarding work environment, health, and well-being. A major theme identified in their study was the unfairness in the nurses’ ability to ‘control one’s work conditions’ including excessive work demands. The second theme was that nurses felt others devalued their solutions to these less than favorable working conditions. Their results suggest that the high demands of nursing work and subsequent injuries reduce quality of life during off work hours. These findings regarding lack of control over workload have been identified in the research resulting in CN frustration, absenteeism, decreased productivity, overall poor morale, and subsequently compromising patient care (Aiken et al., 1997; Alvarado et al., 2000; Andreoli, 1992; CHSRF, 2006a; Geiger-Brown et al., 2004; McGillis Hall, 2003; McGirr & Bakker, 2000; Nevidjon & Ives-Erickson, 2001). Reevaluating staffing practices and ensuring appropriate unit needs and demands are met enables CNs to provide or delegate care accordingly (Aiken et al., 1997; Baumann et al., 2001; CHSRF, 2006a, 2006b; Geiger Brown et al., 2004; Nevidjon & Ives-Erickson, 2001; McGillis Hall, 2003; Richards et al., 1999; Tourangeau et al., 2006).

Improved patient outcomes are evident in workplace environments that provide adequate staffing of CNs who are highly educated and experienced and not simply the representation of mere numbers on duty (CHSRF, 2006a, 2006b; McGillis Hall, 2003; Tourangeau et al., 2006). Nursing workload is directly correlated with nurse satisfaction. An international (United States, Canada, England, Scotland, and Germany) study by Aiken et al. (2001a) surveyed nurses
working in adult acute care hospitals for their perspectives on these work environments. They concluded that in comparison to the previous year, Canadian nurses in this study reported an increase in patient numbers in their work assignments. The authors discuss the increase in patient numbers in nurses’ work assignments in combination with the increase in the acuity levels of patients occurring within Canadian hospitals. Increasing numbers and acuity adds to an already taxing workload for the CN. The complexity of the CNs’ work is difficult to measure. Workload measurement scales have been remiss in not measuring fundamentals of nursing including caring, advanced nursing care, knowledge, education, evidenced based practice, scope of practice and clinical expertise; they are more focused on measuring basic nursing tasks (CHSRF, 2006a, 2006b; McGillis Hall, 2003). Baumann et al. (2001) advise that “nursing effort and expertise are not adequately recognized, measured, or compensated” (p. 5). The increasing demand of work affects patient outcomes and the CNs’ physical, emotional, and psychological health.

Scott et al. (1999) describe nurses’ autonomy and control over work relevant to their professional practice. Their results indicate accountability and authority in decision making were found to be the most significant in relation to job satisfaction. Canadian researchers (Cameron et al., 2004; Tourangeau et al., 2005) along with the research by Aiken et al. (2001a) and her Canadian colleagues discuss their research of nurses’ perception of work environment in relation to job satisfaction. They identify that several factors were linked to job dissatisfaction. These nurse participants were most dissatisfied with their overall participation in decision making. The authors propose that organizations focus on allocating decision making to the “front line worker” in attempt to increase job satisfaction.
Tourangeau et al. (2005) researched nurse participants’ perceptions of their practice environment. Participants’ scoring of the practice environment provided low results that include lack of leadership, lack of recognition, and lack of support from management that negatively affects nurses’ practice environment. This lack of recognition and support are directly linked to the CN job satisfaction and intent to stay in the work force. Aiken et al. (2001a) found similar results and draw attention to the changing role of management as a result of health care restructuring. These changes include fewer management positions, less knowledge or leadership skills, and limited management support of nursing staff that is controlled by organizational structures. Regardless, lack of recognition and poor managerial support impede communication between the organizational structure and CNs affecting the ability to provide quality patient care.

VanOyen Force (2004) evaluates the literature identifying themes that have strong parallels between nursing leadership and nursing job retention. She concurs with several authors and lists characteristics to promote nurse job retention including transformational leadership, positive personality traits, Magnet hospital structures, and an atmosphere of autonomy. She also suggests that a key strategy in retention is the empowerment of nurses through leadership, education, and professional accountability enabling nurses to participate in a shared decision making process.

Albaugh (2003) highlights the importance of understanding nurse “dissatisfiers” and also proposing and implementing strategies to improve nurse satisfaction. These strategies require a strong commitment by the organization and are aligned with similar strategies offered by the Magnet environment. His strategies consist of promoting a nurse-friendly work environment, facilitating direct RN patient care, rewarding exemplary nursing performance, and employing participatory management. He describes participatory management as including staff nurses in decisions that affect nursing, expecting nurse management participation and support, and
aligning management with nurses’ value system. These strategies are necessary to CN job satisfaction, and recruitment and retention. He provides further evidence that this dissatisfaction also impacts quality of patient care and suggests organizational structures should consider strategies to align themselves with the CNs’ value system which emphasizes quality patient care.

Several authors (Aiken, Clarke, Sloane, & Sochalski, 2001; Canadian Institute Health Information [CIHI], 2006; Clarke et al., 2001; HQC, 2005; O’Brien-Pallas, Duffield, & Alksnis, 2004; Sajan & Roy, 2006; Tourangeau et al., 2005) provide information on how health care restructuring affected the Canada wide nursing and health human resource shortage. They recognize that within the Canadian health care system nursing is the largest group in the health care workforce and furthermore, nurses participate in frequent, intense, and vast roles with health care recipients. Therefore, understanding nursing issues and nursing work environments assists in addressing strategies and solutions that include CN satisfaction including recruitment and retention. These efforts directly affect CN, patient safety and quality care, and organizational outcomes.

2.2.1.4 Quality of care.

Quality of patient care is a concern of the organization, CN, and patient. Aiken et al. (2001) state nearly 50% of Canadian nurses reported deterioration in quality of patient care within the last year. These authors suggest the rationale for this is the restructuring in the Canadian health care system. Researchers (Agency for Health Care Research and Quality [AHRQ], 2005; Aiken et al., 2001; Cameron et al., 2004; CHSRF 2006a; CIHI, 2006; Institute of Medicine [IOM], 2004; Tourangeau et al., 2005) are committed to exploring research on CNs’ work environment that will identify strategies to improve the quality of patient care and safety.
Education and specialization, necessary to ensure high quality of care, are often equated with areas within acute care settings, such as emergency and critical care. However, the importance of expertise is evident in all areas of nursing. Foley, Kee, Minick, Harvey, and Jennings (2002) recognize nursing expertise as the ability of nurses to recognize and anticipate impending problems, preventing further complications leading to better overall health outcomes. Better patient outcomes are evident in work place environments that follow a formal staffing plan consisting of CNs that are highly educated, experienced, and supported by the workplace (CHSRF, 2006a, 2006b; McGillis Hall, 2003; Tourangeau et al., 2006).

Thomas-Hawkins, Denno, Currier, and Wick (2003) studied staff nurses’ perceptions of their work environment in a freestanding hemodialysis facility. In this specialized area CNs indicated that within their work environment positive attributes were the intra and interdisciplinary relationships but only 50% felt they had control over nursing practice. Highly autonomous specialized areas might reveal differences in perceptions of control over nursing practice due to an unclear definition of autonomy or control over nursing practice. Forbes, Bott, and Lee-Taunton (1997) studied six dimensions related to control over nursing practice “including responsibility and influence of head nurses, staff nurses, and committees; access to ideas; use of personal resources; and research utilization” (p. 179). These six dimensions were then broken down into subscales. Clinical nurses’ control over nursing practice was found to positively correlate with how CNs’ feel regarding increased autonomy, increased commitment to group cohesion, decreased job stress, and increased job satisfaction. In addition these authors found that critical care nurses scored higher on research utilization than medical-surgical or obstetrical nurses, perhaps due to frequent updating of technology in this department. They did not find that degree prepared CNs scored any higher than diploma prepared CNs with regards to
control over nursing practice. As well, their results revealed no differences between full-time and part-time CNs and their perceptions of control over nursing practice.

From an organizational perspective control over nursing practice assists individuals to align themselves with the organizational goals. As Nicklin (2003) identifies, providing quality safe patient care means addressing the “issues that contribute to patient safety” (p. 67). The positive results of an improved nursing environment are associated with better patient outcomes, nurse retention and recruitment, job satisfaction, and a sense of common purpose. This process which facilitates the flow of energy and power is often labeled empowerment.

2.2.1.5 Empowerment.

The concept of empowerment has been extensively researched from a variety of different perspectives including organizational, work environment (shared governance), and CN professional practice (satisfaction) (Alvarado et al., 2000; Erickson, Hamilton, Jones, & Ditomassi, 2003; Finegan & Spence Laschinger, 2001; Green & Jordan, 2004; Klakovich, 1996; Kuokkakanen & Katajisto, 2003; Spence Laschinger et al., 2000; Spence Laschinger et al., 2003; Spence Laschinger & Havens, 1996; Spence Laschinger & Shamian, 1994; Spence Laschinger & Wong, 1999; Spence Laschinger, Wong, McMahon, & Kaufman, 1999; Thompson et al., 2004). Klakovich (1996) found nurse empowerment scores to be between low to moderate. Her findings suggest that “those in positions of greater responsibility with higher levels of education, work experience and life experience would have greater confidence and competence and thus, higher levels of empowerment” (p. 30). She concludes that work environments need to embrace strategies for the staff nurse to be committed and contribute to the experience of a shared vision. She also identifies that empowerment is having a sense of power or authority which enhances self esteem or self confidence and is an outcome of mutual commitment between the individual
and organization through sharing a common vision. Therefore, empowerment affects the CNs’ intent to stay or leave the work environment. Recruitment and retention continues to be a concern for health care organizations. At a time when health care and organizational restructuring are affecting quality care and patient safety outcomes, providing CNs with a sense of power through control over nursing practice and decision making inspires individuals with confidence. Recognition of this confidence through providing CNs with control over nursing practice and decision making has positive outcomes for the health care organization, CN, and patient (Brooks, 2004; Broughton, 2001; Cameron et al, 2004; CHSRF, 2006a, 2006b; Hess, 2004; Spence Laschinger et al., 2000; McGillis Hall, 2003; Tourangeau et al., 2006).

Erickson et al. (2003) found that empowerment, a concept deeply embedded in control over nursing practice, is evident in a collaborative governance organization. Studies by Spence Laschinger et al. (2000) and Spence Laschinger and Wong (1999) suggest a strong association between empowerment and trust that is consistent with Kanter’s theory linking trust to open communication, information sharing, and increased employee involvement in discussion. They propose that health care leaders should encourage professional practice environments which empower nurses and foster trust. Moss Kanter’s (1999) theory of power and elements of empowerment include the 3C’s: “Concepts, (ideas and technologies, driven by innovation), competence (skills and the ability to use them, improved by teaching), and connections (strategic relationships, nurtured by collaboration)” (p.1). Anthony (2004) states Kanter’s theory on structural power has been fundamental in the development of shared governance models. Spence Laschinger and Haven’s (1996) study supports the use of Kanter’s theory of empowerment in an environment that encourages control over nursing practice. These authors support Kanter’s theory that work structures that foster empowerment have a direct positive correlation on
employee effectiveness, control over nursing practice, and work satisfaction. Porter-O’Grady (2001) proposes that a milieu that supports empowerment provides autonomy when power is expressed legitimately.

Cho, Spence Laschinger, and Wong (2006) studied the factors that would promote empowerment of newly graduated nurses. These authors deduce that the positive effects of empowerment have the same positive results for the newly graduated nurse and the experienced general duty nurse related to organizational commitment. They suggest that one of the strategies fostering empowerment for the new graduate nurse is to have access and opportunity for decision–making at entry to practice. This, along with other strategies, ensures positive approaches to high quality patient care, organizational commitment, job satisfaction, and recruitment and retention. Planning for workplace empowerment and organizational commitment for new graduate nurses is critical in addressing the future nursing shortage.

Nedd (2006) indicates a key issue for health care organizations is to facilitate CN empowerment through empowering strategies. She suggests that these strategies are directed at increasing job satisfaction, and recruitment and retention. These strategies include facilitating access to resources, involving CNs in decision making, and providing recognition. Spence Laschinger and Finegan (2005) depict workplace empowerment as engagement between personal expectations and conditions in the work environment. Optimizing engagement in the work environment through supporting employee access to resources and information, addressing heavy work loads, and supporting control over nursing practice and autonomy ensures an overall CN outcome of better physical and mental health. Their findings specify the importance of control over nursing practice and autonomy within the work environment and subsequent retention of CNs.
2.2.1.6 Autonomy.

Tranmer (2005) identifies professional nurse autonomy as being a complex multifaceted concept that occurs within the context of one’s work. She suggests the definition has two parts. Organizational autonomy involves nurses as participants in the decision making process at the unit, administrative, and organizational level. Clinical autonomy refers to the clinical scope of practice. It is well documented that changes within the health care system have affected the CNs’ practice environment including control over nursing practice and autonomy. A loss of organization or clinical autonomy can lead to CN dissatisfaction and affect quality patient care. As Mrayyan (2003) states, through all of the changes nurse autonomy is an essential element in nurse satisfaction. Therefore, administrators need to develop and support a culture of autonomy for CNs.

McParland et al. (2000) criticize the lack of consistency in the nursing literature in defining autonomy and challenge how autonomy is discussed; is it autonomy of the nurse, patient, or interprofessional power imbalances? Kramer and Schmalenberg (2004) agree there are several definitions of autonomy. These authors suggest that the operational differentiation of autonomy differs from control over nursing practice and relates more closely to the scope of clinical practice; clinical autonomy. Kennerly (1996) identifies the effects of shared governance and the perception of work and the work environment are difficult to measure when using autonomy as an outcome. Further to this, she implemented a model of shared governance in an area that already had high worker autonomy. Kennerly (2000) concluded that for successful implementation of shared governance, autonomy was a prerequisite and not an outcome of shared governance.
Although autonomy has been identified by some as a key concept in control over nursing practice and shared governance, Kennerly (2000) and Richards et al. (1999) contradict this research. These two authors suggest that implementation of a shared governance model has positive outcomes (satisfaction) for CNs, patients, and the organizational culture, yet there has been no evidence to support that autonomy is an outcome of shared governance. In addition, Krugman and Preheim (1999) saw a fluctuation in autonomy throughout their longitudinal study. They suggest that initially, there may be a perception of increased autonomy merely because of the language clarification and identification of perceptions, which may change over time. Kluska, Spence Laschinger, and Kerr (2004) found the variables most strongly associated with empowerment are formal power and autonomy. Spence Laschinger and Havens (1996) ascertain that autonomy is an important factor in nurses’ work. McGirr and Baker (2000) studied nurses’ perceptions of their contributions to a positive work environment from all nursing levels. Their results indicated that although staff nurses felt they contributed to the unit operations, they did not feel they were autonomous in their nursing practice. Limitations to this study include the Director of Nursing’s choice of which unit participated in the study and the low response rate of 42%.

According to Mrayyan (2003), autonomy is difficult to define yet it remains a measurable outcome of CNs’ job satisfaction. She identifies that the “theme of decision-making is a central idea in the concept of autonomy” (p. 2). She concludes that CNs’ participation in decision making enhances their power. Some of the successes evident in promoting, implementing, and succeeding in shared decision making are those that have been incorporated in the Magnet hospital environment. Mrayyan contends nurses’ participation in decision-making is part of their autonomy, enhancing power. Therefore, congruency within the organizational structure, work
environment, patient, and individual decision making opportunities can positively affect the autonomy of nurses, leading to an increase in CN job satisfaction and recruitment and retention. Kluska et al. (2004), suggest that nurses value “opportunities to make decisions based on their expertise and clinical judgment” (p. 123-124). When CNs are in an environment that allows them to practice a high degree of autonomy, nurses feel rewarded and respected. Rafferty, Ball, and Aiken (2001) observed CNs who had a strong commitment to teamwork. These CNs were also found to have a higher level of autonomy, control over nursing practice, team relationship, and decision making, which positively correlates with CN satisfaction.

A recent study in Saskatchewan by Williams, Wagner, Buettner, and Coghill (2001) examined changes in home health practitioners’ perceptions of job satisfaction post-restructuring of their Home Health Care Department. Recent restructuring within the Saskatoon Home Care Department provided Williams et al., an opportunity to examine effects of this environmental restructuring on home care practitioner groups. The home care practitioner groups consisted of Registered Nurses (RNs), Licensed Practical Nurses (LPNs) (which were addressed together), and Home Health Aids (HHAs). The results were specific to variables that included “quality of work life, overall quality of life and personal health and well being” (p. 1). Using the International Women’s Survey (IWS) these researchers identified autonomy to be the most important component relative to job satisfaction. However their results indicate that work satisfaction was more poorly rated post restructuring of Saskatoon Department of Home Care. These results were based on the study of participants’ lack of involvement in the decision making regarding the planning and implementation of the restructuring process. The author’s strategies to address the results of restructuring on the home health practitioners included
supporting “the current perception of RNs around the control they have over their work and the freedom to make decisions should continue to be supported” (p. 4).

2.2.2 External Factors

The concept “control over nursing practice” has been directly and indirectly affected by many external factors. Daiski (2004) relates that health care system restructuring affects the organizational climate and work environment, resulting in negative effects on nurse satisfaction and patient outcomes. External factors are identified as those that are currently outside the immediate scope of the CN. These factors include: 1. Health care restructuring. 2. Organizational influences. 3. Work environment models such as shared governance and Magnet hospitals. and 4. Nursing leadership. Health care restructuring affects decision making at all levels within the health care environment potentially resulting in unpredictable outcomes at the bedside.

2.2.2.1 Health care restructuring.

At the beginning of the 21st century, CNs are continuing efforts to attain and maintain a high quality of patient care with appropriate resources (CHSRF, 2001; CNA, 1996, 2001a, 2001b; Finegan & Spence Laschinger, 2001; Green & Jordan, 2004; Johnson, 2000; Kuokkanen & Katajisto, 2003; Leatt, 2001; Mark, Salyer & Wan, 2003; Ritter-Teitel, 2002; Sengin, 2003). Clinical nurses’ work has intensified because of increases in patient acuity, technological advances, complexities of care provided to the patient families and communities, the aging population, and a lack of resources (ACHHR, 2000; Cameron et al., 2004; CHSRF, 2001, 2006a; CIHI, 2001; McGillis Hall, 2003). Several researchers (AHRQ, 2005; Aiken et al., 2001b; Cameron et al., 2004; CHSRF, 2006a; IOM, 2004; Tourangeau et al., 2005) have studied the effects of health care restructuring on the organizational structure, CNs’ work environment,
and quality of patient care. These works have also elicited valuable information on CNs’ job satisfaction and intent to stay in the nursing profession.

Health care restructuring has implications for several stakeholders as efforts are focused on solving immediate problems and the anticipation of future concerns regarding the nursing shortage. By the year 2011, it is predicted that Canada will experience a shortage of 113,000 registered nurses (ACHHR, 2000). Nurse researchers, nurse advocates, and health critics have identified issues and trends that will guide future planning for nurses including a decentralized approach enabling staff more responsibility in decision making, implementing professional practice models that embrace quality work environments, providing evidence based strategies for staff planning, and incorporating education and leadership opportunities on an ongoing basis (Brooks, 2004; Broughton, 2001; Cameron et al., 2004; CHSRF, 2001, 2006a; Green & Jordan, 2004; Johnson, 2000; McGirr & Bakker, 2000; Nevidjon & Ives-Erickson, 2001; O’Brien-Pallas & Baumann, 1992; O’Brien-Pallas, Duffield & Alksnis, 2004; Tourangeau et al., 2005). Fooks (2005) suggests that in Canada we have addressed the perceived individual health profession shortages by responding to an increase or decrease in numbers as they happen. She suggests that a more proactive approach would include addressing the perceived shortages based on the needs of the population. By anticipating the nursing issues affecting recruitment and retention, strategies aimed at improving CN job satisfaction, including control over nursing practice can influence CN intent to stay. Tourangeau et al. (2005) declare how crucial it is to acknowledge the importance of the nursing workforce and its’ role in quality care. These authors indicate that understanding nurses’ work environments and perceptions of their environments is critical in the development of strategies towards improving patient care, nurse, and organizational outcomes. The results of this research indicate that the CNs’ “control and responsibility at work was the
least satisfying aspect” related to job satisfaction (p. 64). These authors acknowledge that organizational structures influence CN job satisfaction and therefore, recruitment and retention.

McGirr and Bakker (2000) discuss the concept of health care restructuring and the impact it has on the downsizing of hospital administration. This includes the change in the roles of nurse managers and the distance they now experience from the practice environment. These authors suggest a decentralized approach enables staff nurses more responsibility regarding their professional practice and coordination of the environment. Although this decentralization theoretically supports CNs’ contributions to the organization, work environment, and unit practice, CNs are not supported with replacement staff to provide clinical bedside nursing. As previously noted by Williams et al. (2001) in the literature review, the home care practitioner groups consisting of RNs, LPNs, and HHAs indicated a lack of involvement and support in the decision making and restructuring process of their home care department resulting in poor work satisfaction.

2.2.2.2 Organizational influences.

Organizational influences are those elements that relate to the environment in which CNs provide patient care. Aiken and Patrician (2000) characterize organizational attributes to include “an environment supportive of professional nursing practice; autonomy, control over the work environment, and relationships with physicians” (p. 151). The nursing shortage, recruitment and retention issues, related working conditions, and health care restructuring have been extensively discussed in the nursing literature. Of particular relevance is the CNs’ job satisfaction within the organizational structure. Compounding this Armstrong-Stassen and Cameron (2003) suggest budget cutbacks in Canada’s health care system have resulted in a reduction in nursing positions,
layoffs, bed closures, and some hospital closures. This uncertainty within the work environment directly affects the CNs’ satisfaction, recruitment and retention, along with patient outcomes.

Control over nursing practice, autonomy, empowerment, participation in decision making, and a sense of value by the organization have a direct impact on CNs’ job satisfaction, retention, commitment, and team functioning (Aiken et al., 1997; Alvarado et al., 2000; Anthony, 2004; Bell, 2000; Brooks, 2004; Buckles Prince, 1997; Burnhope & Edmonstone, 2003; Cassard, Weisman, Gordon, & Wong, 1994; CHSRF, 2006a; Clarke et al., 2001; DeBaca, Jones & Tornabeni, 1993; George et al., 1997; Green & Jordan, 2004; Havens, 1998; Ingersoll et al., 1996; Kennerly, 2000; Spence Laschinger et al., 2000; McGirr & Bakker, 2000; McGoldrick, Menschner & Pollock, 2001; McNeese-Smith, 1999; Nevidjon & Ives-Erickson, 2001; Sengin, 2003; Stumpf, 2001; Thompson et al., 2004; Tourangeau et al., 2005; Westrope, Vaughn, Bott, & Taunton, 1995). Sengin (2003) discusses the ten attributes that contribute to and influence job satisfaction of the registered nurse. Her summary of the literature suggests that understanding the consequences of health care and organizational restructuring has specific implications for the CN and job satisfaction. She concludes that CN job satisfaction is considerably lower than service industry workers within the United States. This directly affects the recruitment and retention efforts of health care organizations as well as the concerns regarding the predicted supply projections. She declares it is essential to recognize, explore, and understand the attributes contributing to CN job satisfaction. These attributes include autonomy, interpersonal communication and collaboration, professional practice, administrative and management practices, status and recognition, job and task requirements, opportunity for advancement, working conditions and physical environment, pay, and fairness. The formation of strategies
directed at addressing these attributes will only enhance CN job satisfaction positively affecting recruitment and retention and patient outcomes.

Stichler (1992) identifies that “any organizational structure that places accountability and authority for practice issues at the level of the professional practitioner rather than with management will also promote professionalism” (p. 11). She suggests that professionalism requires the clarification of accountabilities leading to more collaborative relationships and improved communication. Implementing a shared governance or Magnet hospital work environment is important in developing and enhancing professional practice. Cameron et al. (2004) demonstrate that nurses wanted “more opportunities to participate in decision-making and recognition for their contributions to their organizations” (p. 80). Organizational support including quality workplace environments, self scheduling, improved nurse physician relationships, job challenges, and career satisfaction depend on the health care organizations’ ability to acknowledge, understand, and work towards addressing these concerns creating an attractive work environment for all CNs. Aiken et al. (2001a) reported that Canadian nurses are involved in self scheduling decisions about 30% of the time. This is compared to Germany’s nurses who participate in self scheduling greater than 60% of the time. Nursing continues to be a predominantly female workforce therefore self scheduling continues to be a concern for nurses in maintaining a healthy home life. Green and Jordan (2004) report that strategies need to focus on increasing nursing’s voice and the contribution that they can have in workplace decision making affecting patient care. These authors identify strategies such as shared governance and workplace advocacy as essential in improving nursing practice environments and patient care delivery. Aiken, Clarke, and Sloane (2002) identify different initiatives implemented by organizations in an attempt to respond to government’s mandated cost containment such as
reducing RN personnel, increasing patient/nurse ratios, reducing support services, eliminating nurse management positions, decentralization of allied health services, implementing work blending training, and eliminating the chief nursing officer (the only communication link between administration and clinical staff as well as the only influence of nursing in administrative decision making). These authors conclude that the organizational climate needs to refocus efforts on supporting and valuing nursing as a determinant towards positive patient outcomes.

Aiken et al. (2001a) identify that Canadian nurses were less satisfied with the working conditions in comparison to their wages. They conclude it is imperative that organizational structures look toward their nursing staff for suggestions to improve the working conditions in the work environment. These suggestions addressing work environment issues can prove beneficial, positively contributing to CN satisfaction, patient safety and quality care, and organizational outcomes.

2.2.2.3 Work environment.

Sleutel (2000) differentiates organizational structure from the work environment. He defines practice environment as “a set of concrete or abstract psychological features, such as job characteristics, autonomy, and promotion opportunities perceived by job incumbents who compare these perceptions against a set of standards, values, or needs” (p. 55). Estabrooks et al. (2002) agree that there is a definite difference between the organizational structure (climate and culture) and the practice or work environment. These authors define practice environment as “a set of workplace features that, when present, enable nurses to demonstrate professional practice characterized by decision-making autonomy, clarity of mission, and organizational responsiveness” (p. 265). Therefore, features that align with the standards and values common
to and practiced by a professional body are indicative of a preferred practice environment. Leadership that embraces this management style and the culture of the work environment transcends to the preservation of safety and safe work practices and recruitment and retention issues. Although many organizations are actively recruiting new nurses to solve their particular nursing shortage, retention of nurses in the work environment has been overlooked as a more global problem solving effort (CHSRF, 2006a, 2006b; Fooks, 2005; McGillis Hall, 2003; O’Brien-Pallas et al., 2004; Tourangeau et al., 2006). Positive perceptions of the work environment have a direct influence on retention of CNs. Hayhurst, Saylor, and Stuenkel (2005) describe factors in the work environment influencing CNs’ decisions regarding retention. Job satisfaction positively correlates with factors such as peer cohesion (social and collegial support), supervisory support (nurturing and visible leadership), higher perceptions of autonomy (self sufficient independent decision making), and a lower perception of work pressure (degree of work demands and time pressure). Maintaining a work environment with experienced CNs that is supportive and less stressful is a key concept to ensuring quality care, patient safety and safe work practices (Cameron et al., 2004; CHSRF, 2006a, 2006b; McGillis Hall, 2003; Tourangeau et al., 2006).

According to McGirr and Bakker (2000) contributions made by CNs are not always clear from an administrative, managerial, or RN perspective. These authors examine what impact nurses at all levels have towards a positive work environment. The nurse participants’ described contributions to the work environment as providing quality nursing care, collegial relations, communication, direct nursing care, and ongoing professional development. Although respondents described contributions to the work environment, they also expressed a lack of autonomy in their nursing practice. Unfortunately, a definition of autonomy was not provided in
the study. Another limitation of this study acknowledged by the authors was that the nursing units were specifically selected by the directors of nursing. Recognizing CNs’ contributions to the work environment is essential: CNs having power, control, and influence in the decision making process leads to strengthening of patient, professional, and organizational outcomes (Alvarado et al., 2000; Buckles-Prince, 1997; Green & Jordan, 2004; Hastings & Waltz, 1995; Havens, 1998; Krugman & Preheim, 1999; Leveck & Bland-Jones, 1996; Mrayyan, 2003; Richards et al., 1999; Scott et al., 1999; Sullivan-Havens & Vasey, 2003; Westrope et al., 1995).

Tourangeau et al. (2005) surveyed Ontario RNs and RPNs (registered practical nurses) and their evaluation of the work environment. Cohort differences included the fact that RPNs were an overall older workforce and advancing their educational development through formal university courses. In contrast, twice as many RNs were likely to work 12-hour shifts and receive injury from a patient-contaminated sharp object. Positive results included RNs’ evaluation of the nurse-physician relationship and provision of quality care. The lowest rated aspects of the work environment by both RNs and RPNs were adequate staffing and resources, adequate support, leadership and recognition from nurse management, and overall job satisfaction. Although this study indicates that RNs continue to provide quality patient care, there are many aspects of the work environment that require improvement.

Ulrich et al. (2005) surveyed RNs about how they view their work environment. These authors elicited results indicating how nurses view respect. Of the seven items listed, the highest indicator of respect was managers involving the nurses in decision making affecting the CNs’ ability to provide patient care. Another key issue identified in this research is management's ability to recognize the importance of the CNs’ family life and the ability for the CN to have flexibility in scheduling of work hours. The results from this study indicate that CNs rated
receiving recognition lower than nurse managers, educators, administrators, and researchers. Efforts by organizational structures to recognize and reward nurses for excellence can be seen as a strategy to improve retention amongst nursing staff. An underlying theme of the CNs’ perception of respect within the workplace is the lack of relationship between management and staff.

A work environment that adopts a collaborative management style recognizes that professionalism, autonomy and leadership style are important to the professionalism and role satisfaction of CNs. Work environments that focus on a decentralized organizational structure facilitate control over nursing practice by the CN. Canadians Girard, Linton, and Besner (2005) illustrate that a professional practice environment that ensures nurses can practice according to the performance standards and values of their profession is an important element in job satisfaction and recruitment and retention. Recognizing the effects that hospital restructuring has had on nurses’ professional roles, a few notable efforts as discussed by Girard et al. have been made by Canadian Health care organizations (Calgary Health Region, 2005; London Health sciences Centre 2004; Ottawa Hospital 2004; University Health Network, 2004) to develop professional practice models. These professional practice models embrace the philosophy of nursing to guide nursing care delivery and empower nurses, resulting in improved quality care. Critical to the development of these professional practice models is the participation of and ownership by nurses. Lavoie-Tremblay (2004) ascertains that health institutions recognize the value of a participatory style of management in improving the work environment. Her study focused on using a semi structured interview of participants (n = 9) post implementation of the participatory management. Results indicate three main challenges including lack of trust among participants, collaboration of interprofessional partnerships, and resistance to the implementation
of changes. Most importantly her findings suggest that participatory management needs support and commitment from all aspects of the organization, work environment and health care workers. The health care workers recognize efforts of problem solving, communication, and interprofessional collaboration contribute to the overall health and care of their patients. As indicated by Green and Jordan (2004) and Stichler (1992) research throughout North America has provided results suggesting that health care organizations that utilize a professional practice model (shared governance or Magnet hospital framework) provide a venue for nurses to feel empowered. Professional practice models can provide nurses with an opportunity to manage their work within the organization having a positive effect on CN satisfaction.

2.2.2.4 Shared governance.

The Institute for Health Services Research of Luton (TIHSRL) along with Mitchell, Brooks, and Pugh (1999) introduce shared governance as a form of participative management that provides nurses with a voice in decision making. Westrope et al. (1995) explain shared governance as a structure and environment that provide CNs empowerment. They portray shared governance as an environment where “professional nurses have the legitimate authority to make decisions about practice and the accountability for the outcomes of these decisions” (p. 45). Shared governance is seen as a strategy to build a partnership, create ownership, and facilitate equity and accountability between the CN and the work environment. This is fundamental to the CNs’ job satisfaction, recruitment and retention, and subsequent quality of care and patient safety. Shared governance is a framework that focuses on strategies that empower CNs in an environment that respects and encourages individual professional accountability. This concept aligns itself with workplace empowerment and organizational commitment as Green and Jordan
Hess (1998) describes governance as “a multidimensional concept that provides the structure and outlines the process by which organizational participants direct, control, and regulate many goal-oriented efforts of other members” (p. 36). Hess (2004) suggests that governance is a “complex phenomenon that encompasses power, control, influence, and authority within organizations” (p. 37). Governance addresses questions like who has control over nursing practice, has influence over decision making, is empowered with formal authority, determines and participates in decisions within the organization, and manages conflict within the organization. Hess discusses shared governance as “formal programs that involve professional nurses in governance decisions by legitimizing their control over their professional practice and extending their authority to such areas as budgeting, scheduling, and evaluating personnel, which were previously controlled exclusively by managers” (p. 37). Hess (2004) maintains that shared governance considers the primary resources for practice as the providers themselves, “thus, to control practice, nurses must have influence over themselves as a professional group” (p. 5).

The conceptual basis of shared governance requires recognizing challenges that influence CNs of today including increased acuity of patients, fewer experienced nurses, lack of recognition from the organizational structure, lack of quality practice environment, budget restraints and bed closures, and inappropriate staff mixes (Cameron et al., 2004; CHSRF 2006a, 2006b; Estabrooks et al., 2002; McGillis Hall, 2003; Tourangeau et al., 2006). In response to these challenges the implementation of shared governance can address challenging nursing issues resulting from the ongoing health care restructuring. Shared governance focuses on nursing issues through establishing collaborative leadership styles and advocating for the
professionalism of nursing. The metamorphosis from a traditional bureaucratic organization towards a health care organization that practices shared governance emphasizes and supports quality work environments, quality patient care, and patient safety, through collaboration, professionalism, and leadership. Organizations that have incorporated shared governance have realized the necessity of working within a collaborative partnership with all stakeholders.

Anthony (2004) suggests that one professional nursing practice model positively affecting quality of care is the structure provided by shared governance. He proposes that shared governance results from the emergence of organizational, management, and sociological theories. Organizational theories contend that investing in employee motivation and growth encourages practices of autonomy, empowerment, and shared decision making. Management theories including Kanter’s theory gave way to the understanding of power in the work place and highlighted the importance of access to work empowerment structures (opportunity, resources, support, and information) allowing workers to accomplish their work. Sociology influenced shared governance by identifying that society accepts that professionals have a specialized knowledge and consequently they should have professional autonomy in managing their work environment. He indicates that shared governance environments enable and support the CN in having the right to act autonomously and have control over his/her own nursing practice.

Westrope et al. (1995) identify positive changes attributed to implementation of shared governance including increased control over nursing practice, decreased turnover and a greater commitment to the organization. Stumpf (2001) found that there is a statistically significant difference between a shared governance framework and a bureaucratic model with regards to professional status, interaction/cohesion, and administration but these results are inconclusive with regards to retention issues. Bell (2000) implemented a team model of shared governance
and indicated there were positive implications regarding teamwork, productivity, and environment. The data came from the pre and post staff member satisfaction survey results based on a 3-point Likert scale. No further data analysis was provided. This questions the studies statistical significance along with the small sample size (n = 28). Howell et al. (2001) found implementation of shared governance revealed differences in the perceptions of shared governance between nursing groups. Nurse managers, nurse specialty groups, and nurse educators had higher governance scores than the general duty nursing staff. Perhaps this is because these are more autonomous groups to begin with and understand a different and more conceptualized idea of shared governance.

Researchers suggest that an organizational structure that incorporates shared governance also promotes a professional work environment. This professional work environment supports CN decision making, autonomy, and control over nursing practice lending itself to increased nurse satisfaction. Batcheller and Berkman (1999) discuss their post-implementation survey of shared governance within their regional site of Austin, Texas. Responses indicate that CNs rate a distinct preference for the shared governance model. Patient satisfaction surveys showed slow but steady increases in ratings. Limitations of this study include the lack of discussion of sample size and no mention of the validity and reliability of the instrument; therefore results are difficult to generalize. Buckles-Prince (1997) conducted a pre and post implementation survey of a shared governance model. She found that shared governance is one strategy for professional and organizational improvement. Although teamwork was an outcome, the CNs also experienced increased workload and increased stress due to a higher absenteeism. This was a direct result of nursing staff participation at councilor meetings necessary in a shared governance model. This study had a low return rate (n = 34) due to leadership changes. The ability to generalize the
results is in question with only 4 units in a 900 bed hospital responding to the survey. George et al. (1997) used research as a change strategy to integrate staff prior to hospital amalgamation in the state of Wisconsin. This was a descriptive study that used qualitative and quantitative methods. Open ended questions and the Professional Nursing Governance questionnaire (PNG) (Hess, 1998) determined that CNs preferred a shared governance structure and autonomy levels were strengthened when CNs moved from a bureaucratic organization to a shared governance framework. Limitations of this study include this research being done in only one hospital acquisition and a low response rate (47%). Health care organizations continue their efforts to create a quality work environment that provides quality patient care. Kouzes and Posner (2003a) indicate when power is removed, a common vision can ensue. An organizational framework of shared governance encourages interdisciplinary partnerships, enhanced professionalism, and professional role satisfaction. Research, implementation and evaluation of the shared governance model is a process that develops over time influencing CNs’ autonomy and control over nursing practice (Alvarado et al., 2000; Anthony, 2004; Brooks, 2004; Dunham-Taylor, 2000; Kouzes & Posner, 2003a, 2003b; Poster-O’Grady, 1992; Thompson et al., 2004).

2.2.2.5 Magnet hospital environment.

Thirty years ago, one of the key frameworks for attracting and retaining CNs in the United States, was the American Academy of Nurses (AAN) development and implementation of the Magnet hospital environment. A Magnet environment is a milieu that supports empowerment and provides autonomy and power to be expressed legitimately (Brooks, 2004; DeBaca et al., 1993; Porter-O’Grady, 2001). These Magnet hospital environments supported professional nursing practice models characterized by a high degree of CN autonomy, control over nursing practice, communication and collaboration, and a strong and visible nursing
leadership (Aiken et al., 1997; Bumgarner & Beard, 2003; Havens, 2001; Havens & Aiken, 1999; Miller, Galloway, Coughlin, & Brennan, 2001; Spence Laschinger, Almost, & Tuer-Hodes, 2003; Richards et al., 1999; Scott et al., 1999).

Magnet hospitals are renowned for their ability to promote excellent nursing care and to retain as well as attract exceptionally qualified nurses (Aiken et al., 1997; Bumgarner & Beard, 2003; Havens & Aiken, 1999; Scott et al., 1999). Havens and Vasey (2005) recognize strategic implementation of organizational models that assume professional practice environments for CNs can positively affect the retention of nurses and patient care. VanOyen Force (2004) describes her experience in the development of a shared governance model and integrating the Magnet Standards of Excellence in the hospital that involves the CN in decision making. She links this to the CNs’ feeling of being valued and important and concludes that CNs’ participation combined with integration of new roles, skills, and behaviors fosters control over nursing practice. Today, control over nursing practice continues to be an important and successful element in the Magnet hospital environment. Magnet environments promote quality work environments for their employees leading to a positive experience for CNs, an increase in recruitment and retention, and better patient outcomes (Aiken et al., 1997; Bumgarner & Beard, 2003; Hader & Eisler 2001; Kramer, 1990; Spence Laschinger et al., 2003; SRNA, 2001a; Sullivan et al., 1999).

Clinical nurses’ control over nursing practice, job satisfaction, autonomy, empowerment, and management support are also prevalent in the Magnet hospital environment. Magnet hospital environments are highly renowned work environments implementing strategies directed at the recruitment and retention of CNs. Creating and sustaining a positive work environment is an essential strategy directed at the current and predicted nursing shortage. Magnet hospitals
have had a significant positive effect on the CNs’ professional practice environment. Upenieks (2003) studied different variables in Magnet and non-Magnet hospitals and CNs’ level of empowerment and job satisfaction. She found that CNs in the Magnet environment perceived more autonomy to make decisions and received more support by nursing leadership than those CNs in non-Magnet facilities. Some of the Magnet hospital characteristics include the nurse executive having influence within the executive decision making team, a flat organizational structure, decentralized decision making, and support of nurses by administration. These environmental characteristics enable the CN to have control over nursing practice in the delivery of quality care and patient safety, fundamental in CNs’ job satisfaction and recruitment and retention. Smith et al. (2006) studied Northern Canadian Nurses’ perceptions of Magnet hospital characteristics (supportive management, nurse-physician relationship, and professional autonomy) within their northern and rural western Canadian hospitals. These authors examined the Magnet hospital characteristics in relation to participants’ (n = 123) job satisfaction. This mixed method survey revealed 73% of the respondents being satisfied with their job. Their findings suggest that in the rural area of Northern Canada, nurses feel job satisfaction is relevant to managerial support and professional autonomy. However, the nurse-physician relationship was not seen to be important to nurses’ job satisfaction. Their qualitative information revealed nurses negative view of management and subsequent attitudes towards nurses. Developing leadership skills in management and managers might improve this negative attitude.

2.2.2.6 Nursing leadership.

Kouzes and Posner (2003a) indicate that leaders are ordinary individuals who have the ability to enable people to bring out the best in themselves and others. Mass, Brunke, Thorne, and Parslow (2006) state that nursing leadership is a key factor in maintaining nurses’ workforce
and providing quality patient care. The CNA (2005) identifies that nursing leadership has also been affected by health care restructuring. The CNA’s concern is, with the changing nursing workforce and the impending retirement of the baby boomers, who will aspire to nursing leadership roles? There is great concern regarding who will mentor the younger generations of nurses in leadership roles within all of the domains of nursing, education, administration, research, and clinical practice. Nursing leadership involves participating in decision making in all areas that affect patient care from administration to bedside. Nursing leadership which focuses on visibility and participatory decision making positively affects nurse retention. The culture of the work environment is directly affected by nursing leadership.

The CNA (2002) contends that “strong nursing leadership, from the executive level to the unit level, complimented by maximizing the leadership potential of every nurse, is an essential element to achieve quality care and quality professional practice environments” (p. 2). The CNA also identifies that regardless of position or title, any nurse can lead (2005). VanOyen Force (2004) identifies characteristics of the nursing leader essential in promoting CN retention. She identifies that there is a strong need for a leadership style that fosters individual control over nursing practice through autonomy. She suggests that a strategy for organizations is to incorporate a participatory management style similar to shared governance or Magnet hospitals that supports CNs’ control over nursing practice, autonomy, professional accountability, empowerment, and flexibility to act on their expert judgment. VanOyen Force lists these characteristics as charisma (effective communication), individualized consideration (individual attention to each nurse), and intellectual stimulation (advanced problem-solving skills).

Several authors recognize and support nursing leadership which encompasses characteristics of the transformational leader (Broughton, 2001; Gullo & Gerstle, 2004; Hocker
& Trofino, 2005; Kouzes & Posner, 2003a, 2003b; Porter-O’Grady, 1992, 2003a, 2003b, 2003c; Scobie & Russell, 2003). Scobie and Russell (2003) articulate “leadership is not synonymous with management” and “transformational leadership, vision, perseverance and leadership with a passion for nursing” are characteristics important to CNs (p. 325). A transformational leader has a vital and critical role which includes a vision and passion that motivates all individuals to lead, thus transforming all people involved (Broughton, 2001; Porter-O’Grady, 2003a, 2003b; Scobie & Russell, 2002). Kouzes and Posner (2003a, 2003b) identify five practices of a transformational leader: Model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. Hocker and Trofino (2003) recognize these five practices results in “loyal, satisfied nurses with high morale who stay with the organization and are committed to its success” (p. 212). Thyer (2003) acknowledges that transformational leadership facilitates an environment that is empowering and embraces a team commitment to decision making. She also discusses the importance of autonomy and CNs’ participation in shared decision making. Parson (2004) suggests that a theoretical model that incorporates a Magnet hospital philosophy can ultimately create healthy workplaces increasing control over nursing practice. These are assumed outcomes of shared leadership. Alvarado et al. (2000) indicates that strong leadership skills are required and should involve the CN in decision making.

Manojlovich (2005) studied the effect of unit-level leadership on the relationship of structural empowerment. She identified that many nurses continue to “have a lack of control over the content and context of their work environment” (p. 366). In addition nursing leadership at both the organizational and unit levels influences the CNs’ professional nursing practice environment. Decision making and control over nursing practice are often seen to be in the hands of nursing leaders as they control relevant information regarding nursing practice.
Although there may be a shared vision to see CNs have more control over their practice environments, she suggests “the reality may be that only unit based nurse managers and higher-level nurse executives have the authority and formal power to make it happen” (p. 367). Therefore, CNs’ perception of nursing leadership may greatly influence the professional practice of the CN. She concludes that nursing leadership is fundamental for the CNs having control over his/her work. Redistribution of power, authority, and role clarification can facilitate the CNs’ access to information and control over nursing practice.

Hocker and Trofino (2003) suggest “the ultimate retention tool is a leader’s ability to lead” (p. 212). Gullo and Gerstle (2004) posit that nursing leadership requires a transformation in the leadership styles and strategies that health care restructuring has created. These authors suggest that the transformational leader--one who shares power, vision, and success with members--has benefits for the individual, department, and organization. They suggest that “the more power that is given away, the more power the leader has because of the motivation, inspiration, and stimulation extended to others” (p. 261). Their study revealed that the empowerment of RNs is directly linked and enhanced by transformational leadership behaviors. However, this leadership style did not neutralize the negative effects of the restructuring environment on CNs. It has been demonstrated that leadership style and control over nursing practice have a direct effect on job satisfaction and CNs’ intent to remain in nursing (Brodbeck, 1992; Griffiths, 2003; Ingersoll et al., 1996; Larrabee et al., 2003; Porter-O’Grady, 2001, 2003a, 2003b; Spence Laschinger & Havens, 1996; Westrope et al., 1995).
2.3 Summary of the Literature

Control over nursing practice has been identified as a complex concept to define. Control over nursing practice has been explored using internal and external factors. The literature review highlighted control over nursing practice using the internal factors of professionalism, professional practice environments, CN satisfaction, quality of care, empowerment, and autonomy. The external factors which affect control over nursing practice include health care restructuring, organizational influences, work environments (shared governance and Magnet hospital environments), and nursing leadership. Finally, the common threads and connections between these concepts relevant to control over nursing practice have been identified in relation to CN job satisfaction, recruitment and retention, quality care, and patient safety.

2.4 Conceptual Framework

In an attempt to identify professional autonomy in the CNs’ work environment, Hess (1998) developed and described the Index of Professional Nursing Governance (IPNG) as an instrument to measure “professional nursing governance of hospital-based nurses” (p.35). The IPNG measures the perceptions of governance of health care personnel on a continuum from traditional, to shared, and to self governance. The scores are based on a 5-point Likert response scale. The scale ranges from 1- 5 including “1 = nursing management/administration only, 2 = primarily nursing management /administration with some staff nurse input, 3 = equally shared by staff nurses and nursing management/administration, 4 = primarily staff nurses with some nursing management/administration, and 5 = staff nurses only” (p. 39). Likert scores of 1 and 2 indicate decision making dominated by management/administration. Scores higher than 3 indicate more staff nurse participation in decision making. The IPNG range of total scores reflecting (management) decision making environment is from 86 - 172. An environment which
utilizes shared decision making between CNs and management would have an IPNG range of 173 - 344. If CNs are the decision making group IPNG range would be from 345 – 430. Hess describes professional governance as a “multidimensional concept that encompasses the structure and process through which professionals control their professional practice” (p. 36). The IPNG collects information on CN demographics (gender, education, employment, years practicing, and certifications) and organizational characteristics such as specialty units. It is an instrument that measures six dimensions of governance including control over nursing practice. These six dimensions are directly derived from the professional, organizational, and nursing literature and are identified as subscales of IPNG which include professional control, organizational influence, organizational recognition, facilitating structures, liaison, and alignment.

2.4.1 Subscale I: Professional Control

According to Hess (1998), professional control speaks to the issue of “who has control over professional work in a formal organization” (p.37). The purpose of this subscale is to examine who has control over professional practice. This subscale includes elements of professional practice such as what nurses can do at the bedside, developing standards of care, assessing and providing for professional educational and development, incorporating research into nursing care, and determining methods of nursing care delivery. Clinical nurses are responsible for decision making every day that influences patient and organizational outcomes that reflect nursing accountability, responsibility, and competency. Hoffart and Woods (1996) indicate professional practice “supports registered nurse[s’] control over the delivery of nursing care and the environment in which care is delivered” (p. 354). Professional practice is what CNs practice daily, consisting of professional values, accountability, responsibility, development, quality care, autonomy, and relationships. Having control in the CNs’ work environment is an
important extension of what impacts decisions at the bedside. A professional practice environment is one that includes a governance approach, supports the registered nurse in control in the environment, and recognizes and values professional relationships. As Rietdyk (2005) depicts, nurses are leaders in enhancing professional practice. She explains the professional practice environment improves the quality of the work place. Acknowledging a professional nursing environment increases job satisfaction, CN productivity, quality of care, patient outcomes, and supports nurse recruitment and retention.

Establishing who has control over professional work in a formal organization is important in any environment. In essence, this helps to provide the CN with role identification and role clarification. Arford and Zone-Smith (2005) articulate that a professional practice environment consists of much more than clinical nursing education, experience, and application at the bedside. These authors suggest that professional nursing practice environments have transformed from “structuring professional practice at the clinical level of nurse - patient interactions to the organizational level of ensuring an environment supportive of professional practice” (p. 467). Simply stated, they identify that a professional practice model requires “nursing control of the organizational operational definition of nursing” (p. 468) in order to achieve effective and safe care. Complementing this Hess (2004) suggests, “to control practice, nurses must have influence over themselves as a professional group” (p. 37). He proposes CNs who have the opportunity to be a part of decision making that influences policy facilitate more control over nursing practice, fostering a positive professional practice environment. Once CNs identify themselves as a professional group and take control over the organizational operational definition of nursing (what nurses need) they can reach their full potential of responsibility to maintain standards of practice thus ensuring safe practice with positive patient outcomes. Arford
and Zone-Smith (2005) agree that an organization that ensures an environment supportive of professional practice exemplifies independent professional nursing practice thus promoting nurse patient interaction. Therefore, it is imperative that CNs continue to strive to have influence in decision making regarding resource allocation. This is an essential element in supporting their professional work within the organization.

2.4.2 Subscale II: Organizational Influence

Organizational influence, as described by Hess (1998), addresses the question of “who has influence over the information and resources that support professional work” (p.37). This subscale of the IPNG consists of questions that look at access to information and resources for professional practice including daily patient assignment, consulting of nursing services outside of the unit and outside of nursing, flow of patients, and procuring supplies for nursing care. Each organizational infrastructure embraces a particular culture and climate. Within the culture and climate are deeply rooted values, beliefs, and assumptions that are practiced by organizational members providing a sense of community and commitment. Klakovich (1996) maintains the organizational culture can either facilitate or hinder accomplishment of objectives. Estabrooks et al. (2002) identifies that these organizational practices can influence CNs’ professional practice and quality work environments. However, she articulates that the sustained support of individuals and groups have a significant influence in establishing and maintaining the professional environment. Therefore, the practice (culture and climate) of the organizational structure and support of individuals and groups influences the professional practice environment. Adopting and sustaining a professional practice environment enhances CN job satisfaction.

Supporting professional practice includes having access to resources and information that facilitates skill based and knowledge practices of the CN. Spence Laschinger (2004) reports that
the perceived lack of respect experienced by CNs in the current system was directly linked to the lack of workplace efforts to provide CNs with “access to information, support, resources, opportunities to learn and grow, and strong alliances in the organization for building nurses’ perceptions of respect in the workplace” (p. 360). She suggests that strategies to improve respect in the workplace include basic elements of communication, which show concern for CNs’ issues and providing accurate information about organizational happenings affecting CNs’ work. She suggests resources to support a professional practice environment, professional care and safe nursing care will also help in countering challenges with recruitment and retention. She concludes that by providing CNs’ empowerment structures within the work environment that address access to information, resources, support, and opportunities for professional development will facilitate meaning, value, and respect within the workplace.

Arford and Zone-Smith (2005) propose that legitimizing CNs’ work elicits meaning and challenge to the professional practice of nursing. These authors contend strategic efforts such as self-scheduling, flexible work hours, advocating autonomy, competency advancement programs, and organizational reimbursement are associated with an improved work environment, job satisfaction, and CN nurse retention. Further to this CNs must have educational opportunities to share in decision making at the unit level and within the organizational context. In addition, professional development opportunities as well as engaging in leadership activities should be made available for CNs to experience. A resource in other words, is not merely the presence of a body, but rather the knowledge, skill, and education that allows the CN to evolve. These authors identify that nursing’s position of power within the organization is directly related to control over resources.
The study by Tourangeau et al. (2005), as discussed in the literature review, reported results of RN and RPN (registered practical nurse) participants indicating that adequacy of staffing and other resources were the lowest rated aspects of their practice environment. In developing strategies to address this issue, these authors speculate that administration should actively consult with nursing staff regarding the required nursing resources necessary to meet patient care needs. This can only enhance organization recognition and respect of CNs at the policy level.

2.4.3 Subscale III: Organizational Recognition

Hess (1998) defines organizational recognition as “who is empowered with formal authority by the organization” (p. 37). This subscale examines who in the workplace controls practice and influences resources. Some of the questions in this subscale address daily patient care assignment, controlling the flow of admissions and discharges, a more formal mechanism for consulting support services, and determining staffing levels. The recognition and value received from an organization that is consistent and committed to supporting the professional development of nurses is an important element in the CNs’ job satisfaction. As Hoffart and Woods (1996) propose, a professional nursing environment is facilitated when the organizational structure supports and values the nursing department. These authors summarize that professional recognition occurs within three levels. Level I are temporary short term rewards: Reimbursement for meetings, conferences, and tuition. Level II includes rewards based on recognition of achievements: Sabbatical leaves, clinical ladders, and salary bonuses for education and certification. Level III are rewards more tied to organizational goals: Research, publications, and administrative roles. Therefore, one can predict the importance of organizational recognition as it is linked to nurse satisfaction and recruitment and retention.
As employees of organizations, CNs are challenged when trying to accomplish meeting patient and organizational needs. It is imperative that CNs find a more effective balance of their time. Arford and Zone-Smith (2005) clearly propose that CNs have their organizational authority formalized allowing CNs to design independent clinical decision-making regarding patient assessment, writing orders not requiring prescriptive authority, ensuring credentialing mechanisms in place for performance of competencies, and deciding what defines nursing work. In addition, these authors indicate collaborative efforts between CNs and the organizational authority must be used to ensure decisions specific to unit needs are met. Aligned with this, Hess’ (1998) 11-hospital study validating the IPNG found that one of the most important factors differentiating shared governance from traditional organizations was “the nurse’s ability to exercise control over personnel in such areas as hiring, transferring, promoting, and firing personnel” (p. 40). Clinical nurses having full control over nursing practice extends their responsibilities to staffing, performance appraisals, creation of new positions, and involvement in decision making regarding supplies and budgets. Clinical nurses must continue to advocate participating in the governance decision making within the organization.

2.4.4 Subscale IV: Facilitating Structures

Hess (1998) renders that facilitating structures examines the question of “who determines and participates in structures that provide a vehicle for making governance decisions in the organization” (p.37). The information from this subscale points towards who participates on committees that decide strategic planning and budgets for the organization, nursing department, and unit. Recognition of the facilitating structures such as leadership, ancillary staff, scope of CN work, and interdisciplinary practices assists in identifying the structural dimensions of a professional practice environment. As Hess suggests, power and control need to be distributed in
an effort to reconcile conflict between professional groups. He also identifies the necessity of legitimizing the CNs’ professional practice by extending their authority to include areas otherwise controlled by administration. This formal type of authority provides CNs an equal voice among different facilitating structures, groups, committees, and organizational structures. CNs’ commitment to participate in decision making regarding issues such as practice, management, quality, and education establishes meaning for control of practice, resulting in better patient outcomes.

Lavoie-Tremblay (2004) determines it is essential for all health care workers to realize the complexity, duplication, and any inequality in the distribution of work duties among health care workers and professional groups. She goes on to discuss the purpose of revising the organization of work responsibilities in order to make simple changes that might result in a reduction of work demands. Her qualitative study recognized that health care workers and managers possess differing experience and expertise necessary to create a healthy workplace. Through participation and trust, developing solutions to create a healthy workplace is empowering to the CN affecting optimal patient care. Gullo and Gerstle (2004) communicate that influencing the CNs’ empowerment and job satisfaction in the work environment results in advocating more effectively for patients, asserting for better working conditions, and participating in constructive discussion regarding changes in hospital policies.

Manojlovich’s (2005) study outlined in the literature review, provided results that indicate many CNs continue to have a lack of control regarding the practices in their environment affecting patient care. Clinical nurses having the opportunity to participate in leadership activities and decision making activities encourages the control of relevant information necessary for nursing practice. Therefore, the redistribution of power, authority, and
role clarification can facilitate the CN to have control over nursing practice. In addition this redistribution should include the CN having access to information and contributing to the allocation of organizational resources.

2.4.5 Subscale V: Liaison

Hess (1998) declares the dimension of liaison should not be underestimated as this depicts “who has access to information necessary for controlling practice and influencing the allocation of organizational resources” (p. 37). Data gathered from this subscale focuses on which group has access to the information and resources that support the professional practice environment of the CN. Typically one would identify the manager as the liaison between the organizational and functional structures and the CN. Historically, management approaches have utilized the traditional organizational hierarchy framework, famous for enforcing accountability without power. Middle and upper management have been afforded security in their authority to administer their decision making solutions in addressing many different issues. However, difficulty recruiting and retaining CNs has led organizational structures to reevaluate their organizational and management approach. Having information accessible is only one important component of the CNs’ ability to make decisions relevant to safe patient care. Identifying what CNs perceive as important for their work environment is crucial to job satisfaction and recruitment and retention.

Ulrich et al. (2005) studied RN perceptions of their work environment, as discussed in the literature review, and provided results that indicated RNs received the lowest recognition of the RNs’ family life and flexibility in hours compared to educators, researchers, and administrators in addition to the lack of respect they perceive in the workplace between management and staff. Therefore, recognizing the impact that managers have on both the organization and the CN
affects communication regarding change within the workplace. Acknowledging both perspectives is imperative.

Hoffart (1996) identifies that organizational systems, often highly complex integrated structures, must recognize the importance of effective nurse leadership. Effective nursing leadership fosters empowerment and engages CNs in decision making, encouraging innovation and planning at all levels. This practice lends itself to professional environments grounded in accountability and skills. A management approach that includes offering meaningful opportunities for all CNs to contribute ideas in non-threatening environments with positive support is recommended.

2.4.6 Subscale VI: Alignment

As identified by Hess (1998) alignment represents “who has the ability to promote, negotiate, and manage conflict and goals within the organization” (p.37). Hess depicts that conflict within the organizational structure needs a formalized grievance framework to be followed. This subscale looks at who in the organization has the power to negotiate conflict. There is a plethora of governing bodies that regulate the CNs’ practice environment. Regulatory bodies, labor affiliations, quality assurance committees, and hospital policy and standards guide the CNs’ practice environment. Ultimately, responsibility and accountability are based on the CNs’ knowledge and ability to provide safe patient care. When the ability to provide safe patient care is jeopardized, conflict arises. The ability to manage conflict and goals within the organization has been taken away from the CN and traditionally been left to upper management. Baker (1995) suggests that the traditional hierarchical organizational structure typically managed conflict with a suppressive type of method. With the decentralization of the organizational structure, along with the ever changing role of the CN, Baker identifies that conflict remains a
significant problem in nursing practice. Conflict management requires collaboration from all stakeholders in order to achieve a common goal or resolution. Collaboration towards goal resolution ultimately affects team building. Baker identifies that inherent to a shared governance model is the concept of team building, “improved trust, communication, and group cohesion” (p. 297). Gullo and Gerstle (2004) suggest that strategies need to be embraced that will provide changes and challenges for CNs providing them with a sense of accountability, personal belonging, partnerships, and equity that “best meets the patients’ needs and upholds the standards of professional nursing practice” (p. 265).

Green and Jordan (2004) identify that shared governance promotes power bases to address healthy work place environments including “accountability, empowerment, conflict resolution, and patient advocacy” (p. 4). These authors agree with Porter O’Grady (2003a) and the IOM (2004) suggesting that leadership structures should include nursing staff in nonhierarchical decision making. This would involve supporting decision making and conflict resolution at point of care delivery. Organizational structures are responsible for providing information and skills for CNs to effectively deal with conflict and conflict resolution. These are specialized skills and require transformation from a hierarchical communication model to a model of low level resolution. The collaborative strategies that determine the effective use of conflict resolution facilitate CN empowerment, autonomy, satisfaction, and quality care having a direct positive effect on professional, organizational, and patient outcomes.

Klakovich (1996) proposes that empowerment is an influential process that aligns both individual and organizational goals through synergy, developing a shared vision, and creating a unity in purpose. She suggests that empowerment provides individual ownership within an organization thus aligning the individual’s commitment to the organization. According to Kuhar,
Miller, Spear, Ulreich, and Mion (2004) clear communication between nurses and administration is imperative and enables information sharing that guides practice, steers decision making, and builds a stronger team. This research identified communication and teamwork as significant factors in the multi-component approach to create an environment conducive to job satisfaction and staff retention. Commitment and teamwork are essential elements in creating a professional practice quality work environment. Reid Ponte, Kruger, DeMarco, Hanley, and Conlin (2004) agree that an alignment between the individual, unit, and institutional level that understands, supports, and values professional development enhances quality of care. They determine that involving the CN in planning and decision making will lead to an increase in job satisfaction, safer work environment, and stronger patient care.

2.5 Summary of Conceptual Framework

The Institute of Medicine ([IOM], 2004) along with the Agency for Health Care Research and Quality (AHRQ) conducted a study to analyze the work environment of nurses in relation to patient safety. They clearly articulate 18 recommendations that address patient safety. Several are aligned with current strategies to address the nursing shortage. They suggest management practices that engage in strong nursing leadership, support staff involvement (Professional control) in organizational decision making (Organizational influence), facilitate a management structure of trust to achieve effective communication between nursing and leadership (Facilitating structure), support nursing staff in operational decision making, and the design of work processes and workflow (Organizational recognition), and provide resources to support nursing staff in their knowledge base and clinical decision making (Liaison) is paramount for patient safety and nurse retention. These management practices require communication and collaboration from all stakeholders towards an effective and acceptable resolution (Alignment).
As demonstrated, their recommendations parallel the six dimensions Hess (1998) produced from the professional, organizational, and nursing literature including *Professional control*, *Organizational influence*, *Organizational recognition*, *Facilitating structures*, *Liaison*, and *Alignment*. 
CHAPTER 3

Methodology

This chapter describes the procedure used to study the perceptions that CNs have regarding who governs the professional practice environment including control over nursing practice within the specific institutions in Saskatchewan. The design, setting, sample, ethical considerations, instrument, and procedures are discussed.

3.1 Design

This study used a descriptive survey design to investigate the perceptions of CNs employed in the provincial hospitals in Saskatchewan regarding who governs their professional practice environment including control over practice. Loiselle, Profetto-McGrath, Polit, and Beck (2007) contend that descriptive research creates an opportunity for researchers to provide a description of phenomena. They also suggest that descriptive research can provide information for the purpose of both qualitative and quantitative research. These researchers articulate that “quantitative description focuses on the prevalence, size, and measurable attributes of phenomena, [while] qualitative researchers…. use in-depth methods to describe the dimensions, variations, and importance of phenomena” (p. 21). For the purpose of this study a three part questionnaire containing both quantitative and qualitative questions was used.

3.2 Setting

According to Saskatchewan Health (2001), criteria for a provincial hospital include those hospitals with high enough patient volumes to support and sustain specialized programs. Services rendered include specialized surgical and medical services for cancer treatment, heart surgery, specific diagnostic tests, and infant intensive care units. Government identifies reasons that provincial hospitals are important to the rural and urban populations of Saskatchewan.
“Provincial hospitals in Regina and Saskatoon perform 72 per cent of all surgeries in Saskatchewan” and “many of their patients come from outside the two cities” (p. 39). Therefore, the provincial hospitals face pressures that include accommodating high patient volumes, high acuity and complex patient needs, increasing demand for services and resources, frequent updating of technology and medical equipment, and availability of optimal resources to ensure the best patient outcome. The five provincial hospitals in Saskatchewan include three in Saskatoon, Royal University, St. Paul’s, and Saskatoon City Hospital and the two Regina hospitals, Regina General and Pasqua. Combined, these Provincial hospitals serve an urban population of 396,705. As Saskatchewan Health (2001) indicates, these hospitals are also responsible for providing health care service to individuals from rural areas, a total Saskatchewan population of 1,024,788. Although Statistics Canada (2006) reports a decrease in Saskatchewan’s population from 978,933 in 2001 to 968,157 in 2006, people in Saskatchewan continue to rely on the provincial hospitals for many specialized services including “diagnostic tests such as MRI scans and a wide range of surgeries and specialized medical services” (Saskatchewan Health, 2001, p. 39).

3.3 Sample

3.3.1 Inclusion Criteria

The target population for this study was CNs currently employed in one of the five provincial hospitals in Saskatchewan. The SRNA generated a list of 1804 CNs who identified on their licensure renewal form that their primary place of employment was one of the five provincial hospitals in Saskatchewan, and had agreed, through their yearly registration process, to be involved in research (survey) distribution. The sample consisted of a target group that met the inclusion criteria and were willing to be surveyed through their identification of primary
place of employment as one of the five provincial hospitals in Saskatchewan. This entire accessible population of CNs was included in this sample and invited to participate in the survey regarding their perceptions of who governs the professional practice environment including control over nursing practice. The criteria for inclusion in the sample included being a registered nurse practicing clinical nursing within one of the five provincial hospitals in Saskatchewan. Clinical nurses in other facilities in rural and urban areas of Saskatchewan were not included because this study focused on CNs in the provincial hospitals in Saskatchewan. Clinical nurses from other facilities may have a different experience and interpretation of control over nursing practice relevant to their particular environment. Nurse managers and those in senior nursing administration were excluded from the survey results as they are responsible for a different aspect of nursing services. However, survey results indicate some nurse managers completed the survey, perhaps indicating movement from a CN to a manager position during the registration year.

3.3.2 Sample Size and Response Rate

The selection of sample subjects was done by the SRNA Systems Administrator through the current SRNA database in June, 2005. As of October 20, 2005 the number of active nurses willing to participate in third-party research within the five provincial hospitals was 1804. The SRNA mailed a total of 1804 surveys to CNs including Regina General –582, Pasqua –228, Royal University –602, St. Paul's –213, City Hospital –179.

Of the 1804 CNs contacted by the SRNA, 172 responses were received by the researcher. The overall response rate was 9.53%. Forty surveys were received from the Regina General (9.3% response rate), 14 from Pasqua (6.1% response rate), 71 from Royal University
(11.8% response rate), 27 from St. Paul's (12.6% response rate), and 20 from City hospital (11% response rate). There were no survey responses eliminated from the sample.

3.4 Ethical Considerations

A cover letter (Appendix A) included in the SRNA mail out identified the researcher as a graduate student inviting the participation of CNs in this study. The letter explained that participation was strictly voluntary, and had no foreseeable risks to the participants. The letter clearly indicated the paper survey excluded any identifying data that would compromise the participants’ confidentiality thereby ensuring anonymity. To maintain confidentiality during the research process, data was stored in a secure area in the researcher’s home. Following completion of the research, all data will be securely stored for 5 years by Professor Marlene Smadu, Thesis Chairperson and Associate Dean, College of Nursing, University of Saskatchewan.

Ethical approval for the study was received from the University of Saskatchewan Behavioral Research Ethics Board in August, 2005 (Appendix C).

3.5 Instrument

Vincent (1999) defines descriptive research as “involving or describing current events or conditions” and “the most common tool of descriptive research is the survey” (p. 7). In this study a description of CNs’ perceptions regarding the professional practice environment including control over nursing practice was created by using a written survey questionnaire (Appendix B). The survey questionnaire contained three sections, with the first two sections being composed of the Index of Professional Nursing Governance [IPNG] (Hess, 1998), and the third section containing one closed and four open-ended questions. The first section collected demographic information, including age, gender, nursing education, and employment information. The second
section provided a number of questions regarding various aspects of nursing practice, and asked nurses to rate their perception of who controlled those various aspects. The third section provided participants a non-structured opportunity to answer five questions regarding their perceptions of control over practice within the professional practice environment.

The IPNG has been used by George et al. (1997) to assess nurses’ attitude towards governance and professional practice autonomy following a hospital merger. That study examined the perceptions of nurses in two different facilities post merger. The results from the study indicated nurses’ perceptions of accountability and professional autonomy were different between these two facilities. Being aware of and acknowledging these differences enabled a more effective transition into the merger for staff. Internal consistency reliability for the IPNG subscales (nursing personnel, information, resources, participation, practice, and goals) was 0.97. Loiselle et al. (2007) define internal consistency of an instrument as “reliability to the extent that all its subparts measure the same characteristic” (p. 319). Validity of the research instrument is seen in the study by Howell et al., (2001) where it was “used to measure nurses’ perceptions of governance facility wide” (p. 189). In Howell’s study the IPNG was found to have content validity of 0.95 using Pop ham’s average congruency procedure. Internal consistency was demonstrated (alphas: 0.87 to 0.91) and test retest reliability was 0.77.

Fryar Anderson (2000) used a descriptive comparative correlation study to identify differences between “nurses who practiced in a hospital with a shared governance structure and nurses who practiced in a hospital without shared governance” (p. 112). Her findings suggest that nurses who practice within a shared governance environment are significantly more involved in governance issues and have a greater degree of empowerment leading to increased job satisfaction. One of three instruments used in her study was the IPNG. In her study content
validity of the IPNG was demonstrated using a total average congruency score (0.95). Internal consistency of the instrument was established using Cronbach’s alpha (0.95), test-retest reliability was 0.77.

Chinese researchers Lee, Yang, Lee, and Wu (2000) used a quasi-experimental design to study nurses’ perceptions and the effects of implementing a unit based shared governance (UBSG) structure in a 150 bed Taiwanese community hospital. Their results indicate that nurses involved in UBSG group (n = 29) had higher perceptions of professional control over nursing practice than the control group (n = 24) that were not involved in the implementation of UBSG. These findings conclude a UBSG environment facilitated nurses involvement in governance activities, decision-making and professional practice. The content validity of the IPNG (Chinese version) was 0.89. Cronbach’s alpha was established (0.98) with test-retest reliability at 0.74. Vincent (1999) describes correlation as “a numerical coefficient that indicates the extent to which two variables are related or associated” and “is always between +1.00 and -1.00” (p. 88). He explains that a correlation coefficient of 0.00 indicates no relationship between two variables tested. Although the higher the coefficient the greater the reliability of the instrument, Vincent cautions that “a correlation coefficient indicates the amount of relationship between two variables, it does not indicate the cause of that relationship” (p. 88). He indicates that in general a correlation coefficient above 0.7 is acceptable. A relationship between two variables does not allow the researcher to use correlation as an inferential statistic. However, Loiselle et al. (2007) indicate “the higher the reliability coefficient, the more accurate (internally consistent) the measure” (p. 319).
3.5.1 Methods of Measurement

3.5.1.1 Quantitative.

The first and second sections of the survey questionnaire used for this research study were the “Index of Professional Nursing Governance” (IPNG) (Appendix B), developed by Hess in 1998. Hess (2004) describes the IPNG as “an 86 item survey instrument that measures nurses’ perceptions about who governs the professional environment, including control over practice” (2004). This instrument consists of 11 demographic questions (section one) as well as the 86 questions asking what respondents perceive regarding who has control over nursing practice in their particular health care facility (section two). Development of the IPNG consisted of a four-phase study to establish content validity, feasibility, reliability, and construct validity. Phase three calculated Cronbach’s alpha for the total instrument as 0.95. Phase four derived a Pearson correlation coefficient test-retest correlation for reliability of 0.77. Written permission to utilize the IPNG for this research study was obtained from Dr. Hess in November, 2004. Minor changes were made to the tool pertained to the demographic data; in questions three and four “associate degree in nursing”, not an option in Canada, was removed from the educational degree preparation question.

Section one of the IPNG questionnaire consists of 11 questions that provide demographic information about the respondents. As Loiselle et al. (2007) describe, nominal data “involves using numbers simply to categorize attributes” and provide “examples of variables that are nominally measured include gender and blood type” (p. 342). The nominal variables used for categorization in this included sex, age, basic nursing educational preparation, highest educational degree, employment status, number of years as a practicing nurse, title of present
position, type of nursing unit working on, number of years worked in this institution, and any specialty certifications.

Section two of the IPNG tool contains 86 questions to be rated on a 5 point Likert scale regarding how the CNs perceive control over nursing practice. The Likert scale contains the following response possibilities: 5 = staff nurses only; 4 = primarily staff nurses with some nursing management/administration input; 3 = equally shared by staff nurses and nursing management/administration; 2 = primarily nursing management/administration with some staff nurse input; 1 = nursing management/administration only. Subscale I - Professional control (who has control over professional practice in the organization): Includes 13 questions that ask for perceptions on who has control over activities such as promoting opportunities and discipline. Subscale II – Organizational influence (who participates in governance activities within the organization): Contains 14 questions that ask for perceptions on who has influence on issues such as staffing, equipment, and resources. Subscale III – Organizational recognition (who controls nursing personnel and related structures): Involves 22 questions that addresses who has official authority in developing policies, standards of practice, and evaluations. Subscale IV – Facilitating structures (who determines and participates in governance decisions within the organization): Consists of 10 questions regarding who is likely to participate in committees affecting nursing issues at the unit and administration level. Subscale V – Liaison (who influences the resources that support professional practice): Consists of 15 questions asking for perceptions of who has access to information and resources. Subscale VI – Alignment (who sets and negotiates conflict within the organization): Accounts for 12 questions related to who is involved in issues around conflict and determining unit and hospital wide policies and procedures). Loiselle et al. (2007) ascertain that “descriptive statistics, such as averages and
percentages, are used to synthesize and describe data” (p. 344). Results generated from the survey were directed at synthesizing the data to describe the descriptive phenomena.

3.5.1.2 Qualitative.

Loiselle et al. (2007) contend the purpose of a qualitative data analysis has many considerations and is challenging for the researcher. These authors suggest that supportive narrative from the respondents adds to the richness of the researcher’s quantitative data results. The qualitative analysis provides meaning and explores a deeper understanding from the respondents’ perspectives. Section three of the survey questionnaire contains one closed and four open-ended questions and focuses on a more personal perception of the CNs’ professional practice environment and control over nursing practice. The questions in this section include: 1. What does control over practice mean to you? 2. How could control over your practice be changed significantly? 3. Do you feel you have enough control over practice in your work environment? 4. What limits your control over practice in an area that interests you? 5. What enables your control over practice in an area that interests you? The participants’ comments were transcribed and examined for categories and themes. The themes identified were aligned with the internal and external factors identified in Chapter Two. Themes relevant to the internal factors include CN professionalism, satisfaction, quality of care, empowerment, and autonomy. The external factors are identified as health care restructuring, organizational influences, work environment models (shared governance and magnet hospital environment), and nursing leadership. The themes identified from this section provided information that expanded on the quantitative data.
3.6 Procedure

The following information pertains to the events surrounding the procedure of approval and implementation of the research study. On April 8, 2005 the thesis committee met and signed the Approved Thesis Proposal Form. In June 2005, the Application for Research Approval of Research Protocol was submitted to the University of Saskatchewan Behavioural Research Ethics Board (Beh-REB). In June of 2005, following the Beh-REB application, an Application for Approval of Research Protocol per SRNA policy was forwarded to SRNA with a copy of the University of Saskatchewan’s Beh-REB Application for Approval of Research Protocol. In August 2005, approval (#05-190) was received from the University of Saskatchewan Beh-REB. The approval was subject to two modifications. These modifications included two changes to the information letter. First, it needed to be stated clearly that the data would be stored by the research supervisor and second, a revision of the current contact number for the Research Ethics Office was required. These modifications were then made to the information letter and resubmitted to the Research Ethics Office with the modifications underlined as directed. Upon completing and submitting these modifications the original Beh-REB approval of August 5, 2005 served as the certificate of approval for the study. This modified information letter was then forwarded to the SRNA to be included in the survey package (Appendix A).

Communication and collaboration with the SRNA began in May, 2005. Several email and telephone conversations transpired with the Systems Administrator. Based on the communication with the SRNA staff, they were able to identify 1804 registered nurses from five provincial hospitals that had agreed to be involved in research by indicating this on their previous registration renewal forms. Five different colors of paper were used to differentiate the surveys from the 5 provincial hospitals, Regina General – 582 (tan), Pasqua 213 (blue), Royal
University 602 (yellow), St. Paul’s 228 (pink), and Saskatoon City Hospital 179 (green). The research survey was sent out on November 27, 2005 with a return date of December 20, 2005. A letter from the SRNA included with the survey identified that its role in the research project was only to facilitate communication with regards to third-party research. An introductory letter, from the researcher inviting potential CNs to participate in this study, together with the survey package was included with the SRNA mail out (Appendix A). Unfortunately, the SRNA failed to include a stamped return envelope to the researcher within the research package. Subsequently, the researcher received 3 emails and half a dozen calls from individuals that commented on the fact that there was no self addressed return stamped envelope. Responses given to these individuals included a verbal or email apology regarding the oversight and assurance that a self addressed stamped envelope would be mailed to them within the week. The SRNA Systems Administrator was contacted by email on November 30, 2005 regarding the problem. An apology letter (Appendix E) was drafted along with a return envelope and forwarded to the SRNA for delivery by December 5, 2005. These were mailed out to the survey recipients by December 6, 2005. The reminder postcards were mailed by SRNA on January 10, 2006 with a proposed survey return date of January 15, 2006. The mailing of the reminder postcards (Appendix D) and the return date were extended in order to account for the time lost from having to mail the self-addressed stamped return envelope separately. There were no surveys returned after February 15, 2006.

The completed questionnaires were to be sent to the home of the researcher using the self addressed stamped return envelopes. Due to the fact that the self addressed return stamped envelopes were not sent out with the surveys, some of the respondents mailed their survey to the Office of Research Services Ethics Office (listed on the bottom of the cover letter, Appendix A).
The Office of Research Services Ethics Office then forwarded the completed surveys to the thesis supervisor, Professor Marlene Smadu, who then forwarded them to me. An explanation was then provided to the University of Saskatchewan Office of Research Services, Ethics Office Support regarding the problem with the return envelopes and procedure following. The returned surveys were separated by the researcher according to the color of questionnaire. All three sections of the questionnaire were kept intact to ensure accurate data collection and synthesis of information.

3.7 Data Analysis

The Statistical Package for Social Sciences (SPSS) Version 10.0 was used to analyze the descriptive data including the quantitative data from each question in Section one and two of the IPNG tool. Section one of the IPNG tool, the demographic information, included the overall response rate (9.53%). A chi-square test of the gender differences indicated no statistically significant difference between the regions. These results were displayed in a bar graph with comparisons to CIHI (2006) Saskatchewan and Canadian statistics. A two-tailed t-test compared the average age of CNs between Regina and Saskatoon and revealed no statistically significant difference. The frequency table provided explored the range of age in years of CN respondents. Nursing education was described using basic nursing education, highest level of nursing education, and certification. Chi-square tests revealed no statistically significant differences between the regions with respect to basic nursing education. The highest level of nursing education was documented and frequencies calculated. The overall results were illustrated using a pie chart. Frequencies were explored regarding specialty certification indicating 10.5% of respondents had received specialty certification from the CNA national program and 40% of CNs indicate some type of specialty certification from a professional organization. Title of
present position provided results in three categories, CN, educator, and manager. Number of years in the present position and number of years in this institution were examined by frequencies and demonstrated in a line graph reflecting percentage in years. Chi-square test results expose no statistically significant difference between Saskatoon and Regina participants with respect to employment status. A bar graph exemplifies the distribution of employment status between the regions, Saskatchewan, and Canadian statistics. A two-tailed t-test was used to measure the variance in the average number of years in nursing and revealed similar results between Saskatoon and Regina participants indicating no statistically significant differences. The frequency table displays the overall ranges of the respondents.

For section two of the IPNG tool, the statistical significance was set at 0.05 with a confidence interval of 95%. The mean, standard deviation, and frequencies were calculated for each question in section two of the IPNG tool. The mean, standard deviation, and Cronbach’s alpha of each of the six subscales in section two (professional control, organizational influence, organizational recognition, facilitating structures, liaison, and alignment) were also calculated. Two-tailed t-tests were used to make comparisons of each subscale between the responses of the CNs in Regina and Saskatoon indicating no statistically significant differences. Multivariate analysis of variance was performed to identify between subject effects of each subscale within and between the regions. No statistically significant differences of between subject effects were identified.

Section three of the survey consisted of one closed and four open-ended questions focusing on a more personal perception of the CNs’ professional practice environment including control over practice. The respondents’ comments were transcribed according to question and hospital affiliation. The responses were then categorized into internal and external factors that
were identified in Chapter Two. The responses were then explored for themes according to the internal and external factors.

Loiselle and Profetto-McGrath (2007) posit that the qualitative data reflect the truth of human experience. These authors discuss the four criteria necessary for establishing trustworthiness, “credibility, dependability, confirmability, and transferability” (p. 325). The qualitative responses were interpreted and re-interpreted six times to establish common themes and create credibility of the interpretation. These themes were then categorized and documented for the thesis supervisor to review in consultation with the researcher, which adds to the dependability of the data interpretation. Based on the consultation with the thesis supervisor, changes were made to the fit of the responses according to the internal and external categories in order that the CNs’ responses be given the appropriate justice they deserved, thus adding to the confirmability of the data interpretation.

The internal factors are more closely related to the CNs’ direct ability to provide safe patient care and include professionalism, satisfaction, quality of care, empowerment, and autonomy. The common themes relevant to these internal factors include decision making (influencing policies and procedures) and quality care (staffing ratios, mixes, flow, patient placement, access to resources to facilitate patient care, and educational opportunities) relevant to the CNs’ ability to deliver patient care. The external factors are more distant to the CNs’ control over practice and includes health care restructuring, organizational influences, work environment models (shared governance and magnet hospital environment), and nursing leadership. Themes relevant to the external factors included funding and allocation of resources (government and organizations), organizational influences on the work environment (hospital, SRNA, and SUN) and collaboration (collegial support). The information obtained from the
transcribed responses from each of the provincial hospitals was then combined into one document. The themes provide personal information on CNs’ perceptions of who governs the professional environment including control over practice in provincial hospitals in Saskatchewan supporting and contributing to the results from the quantitative data (Loiselle et al., 2007), providing ‘thick description’ and transferability.

On Sept 1st, 2006 an updated status report form was received and submitted to the Chair of the Research Ethics Board and approved on September 8th, 2006 extending the research status for up to one year. May 11th, 2007 the thesis committee met to review the thesis draft and provide suggestions for improvements, select an external examiner, and a defense date.
CHAPTER 4

Results

The primary purpose of this study was to determine CNs’ perceptions of their work environment including control over practice in provincial hospitals in Saskatchewan. This chapter reports the data analysis and interpretation of the results for this study. The quantitative data analysis includes descriptive statistics related to the demographics of CNs and their perceptions. The statistical methods used to analyze the quantitative data included chi-square tests, two-tailed t-tests, Pearson correlation, Cronbach’s alpha, and multivariate analysis of variance (MANOVA). Qualitative data were transcribed, examined for categories, and organized into themes to describe the narrative responses. The qualitative responses added insight and meaning to the quantitative findings in this mixed method study.

4.1 Response Rate

The overall response rate was 9.53% (n = 172) from a stratified random sample of a possible 1804 CNs. The final sample indicated that a higher response rate was received from CNs in Saskatoon (n = 118, 68.6%) than CNs in Regina (n = 54, 31.4%), Table 4.1.

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<th></th>
<th>Distributed</th>
<th>Returned</th>
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<tr>
<td>Regina</td>
<td>810</td>
<td>54</td>
<td>6.7</td>
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<tr>
<td>Saskatoon</td>
<td>994</td>
<td>118</td>
<td>11.8</td>
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<tr>
<td>Total</td>
<td>1804</td>
<td>172</td>
<td>9.53</td>
</tr>
</tbody>
</table>

4.2 Section I Demographics

Data results and interpretations for this study are provided for the demographic section in relation to gender, age, basic educational preparation, highest level of education, specialty certification, and employment status (full-time, part-time, number of years as a practicing nurse, years in present position, and years in this institution).
4.2.1 Gender

The CIHI (2006) reports that the overall Canadian nursing workforce, including Saskatchewan’s, continues to be predominantly female \((n = 237,668, \, 94.4\% \text{ and } n = 8,255, \, 96\% \text{ respectively}) \). However CIHI also indicates that male nurses are increasing at a slow and steady rate in Canada and Saskatchewan \((n = 14,007, \, 5.6\% \text{ and } n = 294, \, 3.4\% \text{ respectively}) \). In Saskatchewan, male nurses have increased by 0.6\% from 2001 \((n = 232)\) to 2005 \((n = 294)\). Although the statistics from the National Survey of the Work and Health of Nurses (NSWHN) (Health Canada, 2006a) provide information on all nurses (RNs, LPNs and RPNs), they indicate similar percentage results for the number of female nurses in Canada and Saskatchewan \((n = 297,600, \, 94.5\% \text{ and } n = 10,900, \, 95.6\% \text{ respectively}) \) and male nurses in Canada and Saskatchewan \((n = 17,300, \, 5.5\% \text{ and } n = 500, \, 4.3\% \text{ respectively}) \). In this study there were more female than male respondents from both Saskatoon \((n = 108, \, 91.5\%) \) and Regina \((n = 51, \, 94.4\%) \). Eleven males \((6.5\%) \) and 159 \((93.5\%) \) females responded to the question on gender \((n = 170)\). In this study a higher number of males responded from Saskatoon \((n = 9)\) compared to Regina \((n = 2)\). A chi-square test indicates no statistically significant difference in participants’ responses with respect to gender. As illustrated in Figure 4.1 gender make-up of the CNs in this study, similar in Regina and Saskatoon, is also similar to the CIHI and NSWHN statistics.

Figure 4.1 CNs in Saskatchewan: Gender Makeup.
4.2.2 Age

The average age of nurses in Canada has increased from 43.7 years in 2001 to 44.7 years in 2005 (CIHI, 2006). CIHI reports that the average age of Saskatchewan nurses has increased from 44.1 years in 2001 to 45.6 years in 2005. Elliot (2003) reports similar data from the Saskatchewan Health and Saskatchewan Learning (SHSL) document indicating the peak age distribution of RNs is between 45 – 49 years. Health Canada (2006a) provides similar information indicating the average age of the Canadian RN is 44.3 years. CNs participating in this study in Regina (n = 52, M = 44 years, SD = 11.0, and SE = 1.0) were slightly older on average than those in Saskatoon (n = 113, M = 42 years, SD = 8.7, and SE = 1.2). An independent t-test revealed variance in age is not statistically significant between the CNs of Regina and Saskatoon. The participants in this study were similar in average age to Saskatchewan and Canadian nurses according to CIHI and Health Canada data. In comparison to Elliot’s results, the CNs from this study were slightly younger. The reported age in years for CNs ranged from 22 – 70. The largest number of CN respondents (n = 61, 36.9%) were between 40 – 49 years. Three percent recorded their age to be greater than 60 (n = 5). CIHI reports similar Canadian results, indicating thirty one percent of the RN workforce was between 40 – 49 years in age and 7% greater than 60 years in age.

Table 4.2 Range of Age in Years of CN Respondents (N = 165).

<table>
<thead>
<tr>
<th>Age in Years (Range)</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 – 29</td>
<td>26</td>
<td>15.8</td>
</tr>
<tr>
<td>30 – 39</td>
<td>32</td>
<td>19.4</td>
</tr>
<tr>
<td>40 – 49</td>
<td>61</td>
<td>36.9</td>
</tr>
<tr>
<td>50 – 59</td>
<td>41</td>
<td>24.9</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>100</td>
</tr>
</tbody>
</table>
4.2.3 Nursing Education

4.2.3.1 Basic nursing education.

CIHI (2006) reports that in 2005 there was a higher number of nurses indicating a baccalaureate degree (51.8%) as their basic nursing education than a diploma (48.1%). Sixty five percent of the CN respondents \( n = 112 \) in this study indicated their basic nursing education was a nursing diploma and 34% \( n = 60 \) reported they had a baccalaureate degree as their basic nursing education. The Health Canada (2006a) report indicates 33% of RNs in that study had a degree in nursing, a much lower number than CIHI results but much closer to the results of this study. A comparison analysis of basic nursing education and health region cross tabulation, using chi-square tests, revealed no statistically significant difference between Saskatoon and Regina participants with respect to their basic nursing education.

4.2.3.2 Highest level of nursing education.

Forty seven percent of respondents \( n = 80 \) indicated their highest educational degree was a diploma while 45\% \( n = 77 \) recorded having a baccalaureate degree in nursing. Six individuals listed having a master’s degree in nursing and three had a non-nursing master’s degree. Four participants indicated they had a non-nursing baccalaureate degree and one individual recorded a post graduate diploma. CIHI’s (2006) data show that in 2005, 30\% of Saskatchewan nurses had acquired a baccalaureate in nursing as their highest level of education. In comparison to the CIHI results for Saskatchewan nurses, more participants in this study indicated having a baccalaureate degree as their highest level of education. The pie chart, Figure 4.2, provides an overview of the highest educational degree of CNs in this study in Saskatoon and Regina.
4.2.3.3 Certification.

Professionalism in nursing, which includes continued learning, demonstrates a dedication and commitment of nurses to ensure safe and quality patient care. CIHI (2006) reports 5.4% of RNs in Canada are certified with a national program offered by the CNA. In comparison participants in this study reported a 10.5% certification with the CNA national program, a noticeably higher rate of certification. There are several organizations providing a variety of educational opportunities for continued learning in nursing. Forty percent \((n = 70)\) of the CN participants identified receiving specialty certification in continuing education from a professional organization.

4.2.4 Title of Present Position

The sample for this research was CNs in provincial hospitals in Saskatchewan as self-reported on the SRNA annual registration renewal form. However, CN respondents documented their present position in one of the following three categories: CN, educator, or nurse manager. Clinical nurses included staff, general duty, and bedside nurses \((n = 133, 84.71\%)\). Twelve percent \((n = 19)\) of respondents represented educators (clinical educator and coordinator). Five respondents \((3.19\%)\) in the study indicated that they were now in nurse manager positions indicating continuous movement in the nursing profession. CIHI (2006) indicates that the highest percentage distribution
of the RN workforce in Saskatchewan and Canada is that of staff nurses (80.9% and 76.6% respectively).

4.2.4.1 Number of years in present position.

Clinical nurses \((n = 171)\) in this study reported the number of years in their present position as ranging from ten to 36 years. Saskatoon \((n = 118, M = 9.49, SD = 8.97)\) respondents reported having slightly more years in their present position on average than those from Regina \((n = 53, M = 7.85, SD = 8.32)\), Figure 4.3.

4.2.4.2 Number of years in this institution.

The CN respondents \((n = 168)\) reported the number of years in their current institution, which averaged 13 years. Saskatoon and Regina results were alike in average number of years in the current institution \((n = 115, M = 12.23\) and \(n = 53, M = 14.66\) respectively). Figure 4.3 depicts the CNs’ range in years in present position and institution.

Figure 4.3 CNs in Saskatchewan Range in Years in Present Position and Institution.

4.2.5 Employment Status

CIHI (2006) reports that only 58.5% of Saskatchewan nurses are employed in the hospital sector, “one of the lowest rates amongst the provinces” (p. 33). CIHI’s definition of hospital sector
includes “(general, maternal, pediatric, psychiatric), mental-health center and rehabilitation/convalescent center” (p. 34). Statistics reported by CIHI indicate similar trends in employment status between Saskatchewan nurses (54.8% full-time and 34.4% part-time) and overall Canadian statistics (55.4% full-time and 32.7% part-time). In this study, CNs were asked to indicate whether they worked full-time \( n = 120, 70.2\% \) or part-time \( n = 51, 29.8\% \). Fewer of the Saskatoon respondents \( n = 80, 68.3\% \) were in full-time positions than Regina respondents \( n = 40, 74\% \). As expected, then, more Saskatoon respondents \( n = 37, 31.6\% \) were in part-time positions than Regina participants \( n = 14, 25.9\% \). When compared to the CIHI results for Canada and Saskatchewan, a greater number of respondents from this study indicated working full-time rather than part-time. A Chi-Square test exposes no statistically significant difference between Saskatoon and Regina participants with respect to employment status \( p - 0.449 \). Figure 4.4 indicates part-time and full-time employment status of CNs in this study in Saskatoon and Regina in comparison to Saskatchewan and Canada.

Figure 4.4 CNs Employment Status in Saskatoon \( n = 116 \) & Regina \( n = 54 \) Compared to CIHI results Saskatchewan and Canada.

![Figure 4.4](image)

4.2.6 Average Number of Years in Nursing

Analysis of the responses indicates the average number of years nursing in provincial hospitals in Saskatchewan is similar between Saskatoon \( n = 116, M = 17.9 \) years and Regina \( n =
An independent two-tailed t-test measured the variance in number of years in nursing between Saskatoon and Regina participants. Results conclude that the variance in number of years in nursing between the participants has no statistically significant difference \((p = 0.838)\). Table 4.3 displays the ranges for the average number of years in nursing. The highest number of respondents had between 26 – 30 years in nursing \((n = 33, 19.5\%)\) followed closely by those CNs with < 5 years in nursing \((n = 32, 18.9\%)\).

**Table 4.3 CNs in Saskatchewan - Number of Years in Nursing \((N = 169)\).**

<table>
<thead>
<tr>
<th>Number of Years in Nursing (Range)</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5</td>
<td>32</td>
<td>18.9</td>
</tr>
<tr>
<td>6 – 10</td>
<td>17</td>
<td>10.1</td>
</tr>
<tr>
<td>11 – 15</td>
<td>15</td>
<td>8.9</td>
</tr>
<tr>
<td>16 – 20</td>
<td>27</td>
<td>15.9</td>
</tr>
<tr>
<td>21 – 25</td>
<td>23</td>
<td>13.7</td>
</tr>
<tr>
<td>26 – 30</td>
<td>33</td>
<td>19.5</td>
</tr>
<tr>
<td>31 – 34</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>&gt; 36</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>169</td>
<td>100</td>
</tr>
</tbody>
</table>

Analysis and interpretation of the demographic data -- CNs’ gender, age, basic and highest educational preparation, specialty certification, and employment status (full-time, part-time, and number of years as a practicing nurse, number of years in present position and this institution) -- indicates that there were no statistically significant differences between CN participants from Regina and Saskatoon in this study. From the demographic information gleaned, CNs in this study were similar to CIHI (2006) results of nurses in Saskatchewan and Canada. The exception is that more CNs in provincial hospitals in Saskatchewan in this study indicated having baccalaureate education as their highest level of education than the CIHI results. As well, more CN respondents in this study were certified with the CNA national certification program than RNs generally according to CIHI.
statistics, and more CNs in this study reported having full-time employment than RNs generally according to the CIHI data.

4.3 Section II Subscales Regarding Control Over Practice

Section two of the IPNG survey tool consists of 86 statements organized into six subscales regarding control over professional nursing practice. The six subscales address Professional control (who controls professional practice), Organizational influence (who participates in structures related to governance activities in the organization), Organizational recognition (who controls nursing personnel and related structures), Facilitating structures (who determines and participates in structures in governance decisions within the organization), Liaison (who influences the resources that support professional practice), and Alignment (who sets and negotiates conflict within the organization) related to a number of areas of patient care, nursing practice, organizational processes, allocation of resources, relationships, and other aspects of a CNs’ work life (Appendix B).

The Likert scale for each statement had the following response possibilities regarding who has control over nursing practice: 5 = staff nurses only; 4 = primarily staff nurses with some nursing management/administration input; 3 = equally shared by staff nurses and nursing management/administration; 2 = primarily nursing management/administration with some staff nurse input; 1 = nursing management/administration only. Participants in this study were asked to rank each statement using the 5 point Likert scale; however a few respondents chose to mark a spot between the two numbers on the scale. For the purposes of this study those ratings were determined to be scores of 1.5 and 2.5. Mean scores were calculated for each statement and each subscale. An independent two-tailed t-test measured the equality of the means of the subscales between regions. Using a general linear model, a comparison between hospitals and regions was performed. The multivariate analysis of variance (MANOVA) tests revealed no statistically significant differences when comparing between subject effects of each subscale within and between regions. Cronbach’s alpha was determined to indicate the reliability of Hess’ tool relevant to each subscale.
4.3.1 Summary of Results Regarding Control Over Practice

Each of the six subscales of the IPNG builds upon the previous subscale information in a stepwise progression examining similar concepts within a slightly different context described in Hess’ instrument. A description of each subscale, summary of each subscale findings, and a singular table format for each subscale scores has been provided for clarity. The overall mean scores for each of the six subscales, which range between 1.7246 and 2.1381, indicate that CNs generally perceive that their work environments are controlled by nursing management/administration only (1), or primarily nursing management/administration with some staff nurse input (2).

Subscale I, professional control, deals with who has control over activities related to professional work in the organization. As discussed by Hess (1998), the purpose of this subscale is to examine who has control over professional practice. As Table 4.4 illustrates, the results for Subscale I, professional control, indicate CNs in this study do not perceive they have professional control over their work environment negatively affecting their control over practice.

Table 4.4 Subscale I: Professional Control.

<table>
<thead>
<tr>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>161</td>
<td>1.00</td>
<td>5.00</td>
<td>1.7246</td>
<td>.39043</td>
<td>.152</td>
</tr>
</tbody>
</table>

Subscale II, organizational influence, as described by Hess (1998), identifies who influences and has access to information supporting professional work relevant to a number of nursing activities. Table 4.5 provides the results for Subscale II, organizational influence, suggesting CN respondents perceive limited ability to influence and access information in activities within this subscale, limiting their control over practice.

Table 4.5 Subscale II: Organizational Influence.

<table>
<thead>
<tr>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>151</td>
<td>1.00</td>
<td>5.00</td>
<td>2.1381</td>
<td>.52064</td>
<td>.271</td>
</tr>
</tbody>
</table>
Subscale III, *organizational recognition*, as defined by Hess (1998) examines who in the organization has formal *authority*, “influence over the information and resources that support professional work” (p. 37) relevant to nursing personnel, control over practice, and influencing resources. Table 4.6 identifies CNs in provincial hospitals in Saskatchewan perceive limited *formal authority* to control practice in these areas within Subscale III negatively affecting control over practice.

**Table 4.6 Subscale III: Organizational Recognition.**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational</td>
<td>149</td>
<td>1.00</td>
<td>5.00</td>
<td>1.7309</td>
<td>.44199</td>
<td>.195</td>
</tr>
</tbody>
</table>

Subscale IV, *facilitating structures*, is described by Hess (1998) as identifying who participates in committee structures and activities affecting nursing issues from the unit to the administrative level. Although some of the questions in this Subscale indicated that CNs experience some shared participation in certain activities, overall they perceive this area is controlled by primarily nursing management/administration (2). Table 4.7 provides the results to Subscale IV, *facilitating structures*, indicating CNs perceive limited *participation* and control over practice in activities within this Subscale.

**Table 4.7 Subscale IV: Facilitating Structures.**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitating</td>
<td>163</td>
<td>1.00</td>
<td>5.00</td>
<td>1.8261</td>
<td>.49452</td>
<td>.245</td>
</tr>
</tbody>
</table>

Subscale V, *liaison*, as documented by Hess (1998), focuses on which group has *access* to *information* regarding activities that determine allocation of organizational resources that control and support professional practice. Results from Subscale V, as outlined in Table 4.8, indicates CNs perceive they have limited *access to information* in these areas, limiting control over practice.
Table 4.8 Subscale V: *Liaison.*

<table>
<thead>
<tr>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison</td>
<td>154</td>
<td>1.00</td>
<td>5.00</td>
<td>1.9134</td>
<td>.54859</td>
</tr>
</tbody>
</table>

Subscale VI, *alignment,* as identified by Hess (1998), represents who in the organization has the *ability* to promote, negotiate, and manage conflicts. Overall CNs perceived limited *ability* to participate in these activities, negatively affecting their control over practice, Table 4.9.

Table 4.9 Subscale IV: *Alignment.*

<table>
<thead>
<tr>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment</td>
<td>164</td>
<td>1.00</td>
<td>5.00</td>
<td>2.1006</td>
<td>.53415</td>
</tr>
</tbody>
</table>

The overall mean scores for each of the six subscales, which range between 1.7246 and 2.1381, indicate that CNs generally perceive that their work environments are controlled by nursing management/administration only (1), or primarily nursing management/administration with some staff nurse input (2). Table 4.10 provides an overview of the minimum and maximum score, mean, standard deviation and variance for each of the six subscales.

Table 4.10 CNs in Saskatchewan Index of Professional Nursing Governance Subscale Scores.

<table>
<thead>
<tr>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Control</td>
<td>161</td>
<td>1.00</td>
<td>5.00</td>
<td>1.7246</td>
<td>.39043</td>
</tr>
<tr>
<td>Organizational Influence</td>
<td>151</td>
<td>1.00</td>
<td>5.00</td>
<td>2.1381</td>
<td>.52064</td>
</tr>
<tr>
<td>Organizational Recognition</td>
<td>149</td>
<td>1.00</td>
<td>5.00</td>
<td>1.7309</td>
<td>.44199</td>
</tr>
<tr>
<td>Facilitating Structures</td>
<td>163</td>
<td>1.00</td>
<td>5.00</td>
<td>1.8261</td>
<td>.49452</td>
</tr>
<tr>
<td>Liaison</td>
<td>154</td>
<td>1.00</td>
<td>5.00</td>
<td>1.9134</td>
<td>.54859</td>
</tr>
<tr>
<td>Alignment</td>
<td>164</td>
<td>1.00</td>
<td>5.00</td>
<td>2.1006</td>
<td>.53415</td>
</tr>
</tbody>
</table>

*p < .05
A two-tailed t-test measuring equality of means of each subscale indicate no statistically significant differences from each other between regions, as outlined in table 4.11.

Table 4.11 CNs in Saskatchewan Subscale comparison between regions (equal variances assumed, * equal variances not assumed).

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Region</th>
<th>n</th>
<th>M</th>
<th>SD/SE</th>
<th>t</th>
<th>df</th>
<th>p (two-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (Control)</td>
<td>Saskatoon</td>
<td>109</td>
<td>1.75</td>
<td>.41/.04</td>
<td>.989</td>
<td>159</td>
<td>.324</td>
</tr>
<tr>
<td></td>
<td>Regina</td>
<td>52</td>
<td>1.68</td>
<td>.33/.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II (Influence)</td>
<td>Saskatoon</td>
<td>105</td>
<td>2.1</td>
<td>.53/.05</td>
<td>.786</td>
<td>149</td>
<td>.433</td>
</tr>
<tr>
<td></td>
<td>Regina</td>
<td>46</td>
<td>2.1</td>
<td>.47/.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*III (Authority)</td>
<td>Saskatoon</td>
<td>103</td>
<td>1.76</td>
<td>.48/.05</td>
<td>1.34</td>
<td>114</td>
<td>.182</td>
</tr>
<tr>
<td></td>
<td>Regina</td>
<td>46</td>
<td>1.7</td>
<td>.35/.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV (Participation)</td>
<td>Saskatoon</td>
<td>113</td>
<td>1.9</td>
<td>.49/.05</td>
<td>1.41</td>
<td>161</td>
<td>.159</td>
</tr>
<tr>
<td></td>
<td>Regina</td>
<td>50</td>
<td>1.7</td>
<td>.48/.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V (Access)</td>
<td>Saskatoon</td>
<td>108</td>
<td>1.9</td>
<td>.55/.05</td>
<td>.336</td>
<td>152</td>
<td>.737</td>
</tr>
<tr>
<td></td>
<td>Regina</td>
<td>46</td>
<td>1.9</td>
<td>.53/.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI (Ability)</td>
<td>Saskatoon</td>
<td>112</td>
<td>2.1</td>
<td>.54/.05</td>
<td>-.476</td>
<td>162</td>
<td>.635</td>
</tr>
<tr>
<td></td>
<td>Regina</td>
<td>52</td>
<td>2.1</td>
<td>.51/.07</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. n = sub sample size. M = mean. SD = standard deviation, SE = standard error. t = computed value of t-test. df = degrees of freedom.

*p < .05

4.3.2 Subscale I: Professional Control

Subscale I, *professional control*, which deals with the matter of who has *control* over activities related to professional work in the organization, from determining what nurses can do at the bedside to promoting opportunities, and discipline had the lowest mean score of all the subscales (n = 161, M = 1.7). Table 4.12 provides an overview of means from each statement in this subscale, from highest to lowest mean.
Table 4.12 Subscale I Professional Control Highest to Lowest Mean.

<table>
<thead>
<tr>
<th>Question</th>
<th>n</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Developing and evaluating patient care standards and quality assurance/improvement activities</td>
<td>170</td>
<td>2.35</td>
</tr>
<tr>
<td>1 Determining what activities nurses can do at the bedside</td>
<td>171</td>
<td>2.25</td>
</tr>
<tr>
<td>7 Assessing and providing for the professional/educational development of the nursing staff</td>
<td>171</td>
<td>2.24</td>
</tr>
<tr>
<td>11 Selecting products used in nursing areas</td>
<td>171</td>
<td>2.17</td>
</tr>
<tr>
<td>12 Incorporating research ideas into nursing care</td>
<td>171</td>
<td>2.10</td>
</tr>
<tr>
<td>13 Determining methods of nursing care delivery (e.g. primary, team, case management)</td>
<td>171</td>
<td>1.97</td>
</tr>
<tr>
<td>5 Determining activities of ancillary nursing personnel (aids, unit clerks, etc.)</td>
<td>170</td>
<td>1.75</td>
</tr>
<tr>
<td>4 Evaluating (performance appraisals) nursing personnel</td>
<td>168</td>
<td>1.52</td>
</tr>
<tr>
<td>9 Promoting RNs and other nursing staff</td>
<td>165</td>
<td>1.50</td>
</tr>
<tr>
<td>3 Setting levels of qualifications for nursing positions</td>
<td>171</td>
<td>1.27</td>
</tr>
<tr>
<td>10 Appointing nursing personnel to management and leadership positions</td>
<td>169</td>
<td>1.21</td>
</tr>
<tr>
<td>8 Making hiring decisions about RNs and their nursing staff</td>
<td>171</td>
<td>1.20</td>
</tr>
<tr>
<td>6 Conducting disciplinary action of nursing personnel</td>
<td>170</td>
<td>1.20</td>
</tr>
</tbody>
</table>

Results from this subscale indicate CNs in Saskatoon ($n = 98$, $M = 1.3$) and Regina ($n = 43$, $M = 1.2$) perceive that areas such as personnel, nursing activities, standards and protocols,
professional education, nurse performance and disciplinary action, selecting products, incorporating research and determining the model of nursing care delivery are controlled by nursing management/administration only (1) or primarily nursing management/administration with some staff nurse input (2).

The frequencies of this subscale are illustrated in Figure 4.5. Overall the respondents \( n = 161, M = 1.7 \) indicate that within this subscale nursing management/administration only (1) and primarily nursing management/administration with some staff input (2) control many activities including nursing personnel. Question one \( n = 171, M = 2.3 \) pertains to who controls and determines what activities nurses can do at the bedside. Only four nurses (2.3%) of all CN respondents ranked staff nurses only (5) have control over what activities nurses can do at the bedside. The majority of CN respondents (66.1%) listed nursing management/administration only (1) and primarily nursing management/administration with some staff nurse input (2) control what activities nurses can do at the bedside. For question thirteen \( n = 171, M = 1.97 \) 79 CNs chose nursing management/administration with some staff nurse input (2), 56 CNs chose nursing management/administration only (1) and only one CN chose staff nurses only (5) control determining methods of nursing care delivery (primary, team, or case management). For question 12 \( n = 171, M = 2.35 \) 74 CNs responded that primarily nursing management/administration with some staff nurse input (2) control incorporating research ideas into nursing care while only nine CNs chose “4”, primarily staff nurses with some nursing management/administration input, control this activity. Question two \( n = 170, M = 2.35 \) – developing and evaluating patient care standards and quality assurance/improvement activities – records a higher mean however 80 CNs indicated this activity was controlled by primarily nursing management/administration with some staff nurse input where as 51 CNs perceived primarily staff nurses with some nursing management/administration control this area. The overall results of this subscale indicate that CNs perceive a limited role for themselves
in *professional control* relevant to control over professional activities in this area. Cronbach’s alpha was calculated to be 0.780 for this subscale.

**Figure 4.5 CNs in Saskatchewan Frequency Subscale I Professional Control (n = 161).**

| ♦ 1 – nursing management/administration only. |
| ■ 2 – primarily nursing management/administration with some staff nurse input. |
| ▲ 3 – equally shared by staff nurses and nursing management/administration. |
| ■ 4 – primarily staff nurses with some nursing management/administration input. |
| * 5 – staff nurses only. |

### 4.3.3 Subscale II: Organizational Influence

Subscale II (*n* = 151, *M* = 2.1), deals with *organizational influence* and who *influences* and has *access* to *information* supporting professional work relevant to a number of nursing activities including staffing assignments (ratio, acuity and patient), procuring supplies, regulating patient flow, unit budgets, nursing salaries, accessing resources, suggesting new clinical and managerial support systems. Table 4.13 illustrates the mean result from each question from highest to lowest.

<table>
<thead>
<tr>
<th>Table 4.13 Subscale II Organizational Influence Highest to Lowest Mean.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>22 Consulting hospital services outside of nursing (e.g. dietary, social services, pharmacy, human resources, finance)</td>
</tr>
<tr>
<td>16 Making daily patient care assignments for nursing personnel</td>
</tr>
</tbody>
</table>
21 Consulting nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical) 166 2.9

18 Regulating the flow of patient admissions, transfers, and discharges 169 2.6

17 Monitoring and procuring supplies for nursing care and support functions 169 2.6

15 Adjusting staffing level to meet fluctuations in patient census and acuity 170 2.3

24 Determining cost-effective measures such as patient placement and referrals (e.g. placement of ventilator-dependent patients, early discharge of patients to home healthcare) 168 2.1

14 Determining how many and what level of nursing staff is needed for routine patient care 170 2.1

23 Making recommendations concerning other departments’ resources 168 2.0

20 Recommending nursing salaries raises and benefits 158 1.8

25 Recommending new hospital services or specialties (e.g. gerontology, mental health, birthing centers) 168 1.6

26 Creating new clinical positions 169 1.3

27 Creating new administrative or support positions 169 1.2

19 Formulating annual unit budgets for personnel, supplies, equipment, and education 170 1.1

Figure 4.6 presents the frequencies of Subscale II, organizational influence, indicating that CNs (n = 151, M = 2.1) in Saskatchewan perceive slightly more opportunity to influence and have access to some information in certain activities within this subscale. However the overall mean (2.1) of this subscale identifies that CNs perceive nursing management/administration only (1) and primarily nursing management/administration with some staff input (2) influence and have access to information in most dimensions in this subscale. Clinical nurses perceive areas that are closer to being equally shared by staff nurses and nursing management/administration (3) include question 22 (n = 169, M = 3.4) consulting hospital services outside of nursing, question 16 (n = 169, M = 3.3) making daily care assignments for nursing personnel, and question 21 (n = 166, M = 2.9) consulting
nursing services outside of the unit. In contrast, only ten CNs indicated that primarily staff nurses with some nursing management/administration (4) have influence and access to information relevant to question 14 \((n = 170, M = 2.1)\) regarding who determines how many and what level of nursing staff is needed for routine patient care, whereas 87 CNs indicated this area was influenced primarily by nursing management/administration with some staff nurse input (2). Responses to question 15 \((n = 170, M = 2.6)\), adjusting staffing level to meet fluctuations in patient census and acuity, indicated 89 CNs chose this activity was influenced and accessed by primarily nursing management/administration with some staff nurse input (2) while only three CNs chose staff nurses only (5) influence and access this activity. In regards to question 18 \((n = 169, M = 2.6)\), 56 CNs selected primarily nursing management/administration with some staff input (2) influence and access the regulation and flow of patient admission, transfers and discharges; however 34 CNs reported primarily staff nurses with some nursing management/administration input (4) influence and access this activity. The results from question 20 \((n = 158, M = 1.8)\) reveal only 16 CNs selected staff nurses only (5) have influence and access to recommending nurses salaries, raises and benefits whereas 105 CNs chose nursing management/administration only (1) influence and access this activity. By and large, CNs indicated they perceive a limited role in the influence and access to information within the dimensions of subscale II, organizational influence, negatively affecting control over practice. Cronbach’s alpha was calculated at 0.794 for this subscale.
4.3.4 Subscale III: Organizational Recognition

Organizational recognition \((n = 149, M = 1.73)\) addresses who has formal authority in the workplace for nursing personnel, control over practice, and influencing resources. Statements are directed at which group in the CNs’ perspective has formal authority in several activities, as presented in Table 4.14 from highest to lowest mean score. Question 40 \((n = 168, M = 2.9)\) had the highest mean score in this subscale indicating that CNs in provincial hospitals in Saskatchewan who participated in this study perceive on average they have some control regarding formal authority, moving to equally sharing this responsibility with management/administration (3) in determining the procedures required for daily patient care assignments. Clinical nurses indicate little formal authority in many areas within this domain including question 37 \((n = 169, M = 2.1)\) generating schedules, question 39 \((n = 168, M = 2.1)\) staffing levels according to acuity, question 42 \((n = 167, M = 2.2)\) controlling the flow of admissions and discharges, and question 45 \((n = 165, M = 2.1)\)
consulting support services outside the unit, with the means all below “3” (equally shared by staff nurses and nursing management/administration). Several other questions in this subscale revealed mean scores less than 2 and the results were heavily weighted towards nursing management/administration only (1) and primarily nursing management administration with some staff input (2) indicating CNs perceive limited control over practice in these areas.

Table 4.14 Subscale III Organizational Recognition Highest to Lowest Mean.

<table>
<thead>
<tr>
<th>Question</th>
<th>n</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 Procedures for determining daily patient care assignments</td>
<td>168</td>
<td>2.9</td>
</tr>
<tr>
<td>41 Daily methods for monitoring and obtaining supplies for nursing care and support functions</td>
<td>167</td>
<td>2.7</td>
</tr>
<tr>
<td>46 Formal mechanisms for consulting and enlisting the support of hospital services outside of nursing (e.g. dietary, social service, pharmacy, physical therapy)</td>
<td>167</td>
<td>2.5</td>
</tr>
<tr>
<td>42 Procedures for controlling the flow of patient admissions, transfers, and discharges</td>
<td>167</td>
<td>2.2</td>
</tr>
<tr>
<td>45 Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical)</td>
<td>165</td>
<td>2.1</td>
</tr>
<tr>
<td>39 Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity</td>
<td>168</td>
<td>2.1</td>
</tr>
<tr>
<td>37 Procedures for generating schedules for RNs and other nursing staff</td>
<td>169</td>
<td>2.1</td>
</tr>
<tr>
<td>38 Acuity and patient classification system for determining how many and what level of nursing staff is needed for routine patient care</td>
<td>165</td>
<td>2.0</td>
</tr>
<tr>
<td>29 Written patient care standards and quality assurance/improvement programs</td>
<td>170</td>
<td>1.9</td>
</tr>
<tr>
<td>28 Written policies and procedures that state what nurses can do in direct patient care</td>
<td>170</td>
<td>1.7</td>
</tr>
<tr>
<td>49 Access to office equipment (phones, personal computers, copy machines)</td>
<td>167</td>
<td>1.7</td>
</tr>
<tr>
<td>34 Annual requirements for continuing in – services</td>
<td>169</td>
<td>1.6</td>
</tr>
<tr>
<td>44 Procedures for adjusting nursing salaries, raises and benefits</td>
<td>161</td>
<td>1.4</td>
</tr>
<tr>
<td>47 Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass)</td>
<td>166</td>
<td>1.4</td>
</tr>
<tr>
<td>31 Written process for evaluating nursing personnel (performance appraisals)</td>
<td>168</td>
<td>1.4</td>
</tr>
</tbody>
</table>
The data in this subscale has a mean score ($M = 1.73$) indicating that overall, CNs perceived limited *formal authority* in most activities in this subscale. They perceive *formal authority* in the workplace -- *control* over practice and *influencing* resources -- is controlled by primarily nursing management/administration with some staff nurse input (2) and moving to equally shared by staff nurses and nursing management/administration “3”.

As Figure 4.7 illustrates, some of the statements in subscale III had responses across the range of 1-5 indicating some CNs perceive some sharing of *formal authority* in certain areas. Question 42 examines the procedures for controlling the flow of patient admissions, transfers, and discharges. Sixty-one CNs chose primarily nursing management/administration with some staff nurse input (2) while only 14 CNs selected primarily staff nurses with some nursing management/administration input (4) have *formal authority* in this area. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity, question 39 revealed similar results, as 69 CNs chose primarily nursing management/administration with some staff nurse input (2) and 16 CNs selected primarily staff nurses with some nursing management/administration (4) have *formal authority* in this activity. Question 37 addresses who has *formal authority* in generating
schedules for RNs and other nursing staff. Sixty-eight clinical nurses indicated that primarily nursing management/administration with some staff nurse input (2) and only 15 CNs chose primarily staff nurses with some nursing management/administration (4) have formal authority in determining schedules for RNs. Question 28 \((n = 170, M = 1.7)\) revealed no CNs selected staff nurses only (5) have formal authority in writing policies and procedures stating what nurses can do in direct patient care. The results from question 34 \((n = 169, M = 1.6)\) reveal 103 CNs perceived nursing management/administration only (1) and only three CNs chose primarily staff nurses with some nursing management/administration input (4) have formal authority regarding annual requirements for continuing in-services. The overall results from subscale III indicate CNs in provincial hospitals in Saskatchewan who participated in this study perceived limited formal authority in several activities of organizational recognition, which negatively influences CNs control over practice. Cronbach’s alpha was calculated to be 0.872 for this subscale.

**Figure 4.7 CNs in Saskatchewan Frequency Subscale III Organizational Recognition \((n = 149)\).**

<table>
<thead>
<tr>
<th>♦</th>
<th>1 – nursing management/administration only.</th>
</tr>
</thead>
<tbody>
<tr>
<td>■</td>
<td>2 – primarily nursing management/administration with some staff nurse input.</td>
</tr>
<tr>
<td>▲</td>
<td>3 – equally shared by staff nurses and nursing management/administration.</td>
</tr>
<tr>
<td>■</td>
<td>4 – primarily staff nurses with some nursing management/administration input.</td>
</tr>
<tr>
<td>*</td>
<td>5 – staff nurses only.</td>
</tr>
</tbody>
</table>
4.3.5 Subscale IV: Facilitating Structures

Subscale IV, facilitating structures \((n = 163)\) with an overall mean of \(1.8\), includes ten statements about who participates in committee structures and a number of activities affecting nursing issues at the unit and administration level. The results from question 50 \((n = 168, M = 2.8)\), the highest mean in this subscale, point toward CNs perceiving they have some input, moving to equally sharing participation with nursing management/administration \((3)\) in some decision making functions relating to clinical practice. Questions 52 \((n = 166, M = 2.3)\) – nursing departmental committees for clinical practice and 56 \((n = 166, M = 2.1)\) – forming new unit committees indicate that there is a trend towards CNs experiencing some participation in nursing unit and departmental committees for clinical practice; however this is primarily controlled by nursing management/administration \((2)\). Table 4.15 provides an overview of the mean scores for each statement from highest to lowest.

**Table 4.15 Subscale IV Facilitating Structures Highest to Lowest Mean.**

<table>
<thead>
<tr>
<th>Question</th>
<th>( n )</th>
<th>( M )</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 Participation in unit committees for clinical practice</td>
<td>168</td>
<td>2.8</td>
</tr>
<tr>
<td>52 Participation in nursing departmental committees for clinical practices</td>
<td>166</td>
<td>2.3</td>
</tr>
<tr>
<td>56 Forming new unit committees</td>
<td>166</td>
<td>2.1</td>
</tr>
<tr>
<td>54 Participation in the multidisciplinary professional committees</td>
<td>167</td>
<td>1.9</td>
</tr>
<tr>
<td>(physicians, other hospital professions and departments) for collaborative practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57 Forming new nursing departmental committees</td>
<td>167</td>
<td>1.8</td>
</tr>
<tr>
<td>58 Forming new multidisciplinary professional committees</td>
<td>167</td>
<td>1.7</td>
</tr>
<tr>
<td>51 Participation in unit committees for administrative matters</td>
<td>167</td>
<td>1.6</td>
</tr>
<tr>
<td>such as staffing, scheduling and budgeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53 Participation in nursing departmental committees for administrative</td>
<td>167</td>
<td>1.6</td>
</tr>
<tr>
<td>matters such as staffing, scheduling, and budgeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55 Participation in the hospital administration committees for matters</td>
<td>165</td>
<td>1.3</td>
</tr>
<tr>
<td>such as employee benefits and strategic planning</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The seven remaining statements in this subscale address participation in staffing, scheduling, budgeting, multidisciplinary professional committees, employee benefits and strategic planning, and forming new committees whether they relate to the unit, nursing department, multidisciplinary area, or hospital administration. The results from these remaining seven statements – primarily nursing management/administration with some staff nurse input “2”-- indicate that CNs perceive less participation in these areas also.

Figure 4.8 indicates more CNs perceive that greater participation lies with nursing management/administration only (1) and primarily nursing management/administration with some staff input (2) controlling the nursing issues within this subscale, at the unit and administrative level. Clinical nurses indicated limited participation regarding question 51 – unit committees that establish decisions regarding staffing, scheduling, and budgeting – as there were only three CNs that chose “4” primarily staff nurses with some nursing management/administration input and none that chose “5” staff nurses only. Question 52 addresses who participates in departmental committees for clinical practice. Seventy CNs indicated this activity was managed primarily by nursing management/administration with some staff nurse input (2); only 16 CNs chose primarily staff nurses with some nursing management/administration input (4), and no CNs chose staff nurses only (5). Seventy nine CNs indicated that participating in unit committees for clinical practice (question 50) is equally shared by staff nursing and nursing management/administration (3). None of the CNs indicated that staff nurses only (5) participate in this activity. Question 54 looks at the participation in multidisciplinary professional committees (physicians, other hospital professions, and departments) for collaborative practice and reveals that 62 CNs selected nursing management/administration only (1) and 61 CNs chose primarily nursing management/administration with some staff nurse input (2)
participate in this activity. Only 37 CNs chose “3”, equally shared by staff nursing and nursing administration/management. Overall the results displayed in Figure 4.8 reveal that CNs seldom chose staff nurses only (5) on the 5 point Likert scale participated in activities within this domain. Those statements that indicated CNs selected “5” as their choice had frequencies of fewer than 5, suggesting that most CNs perceive little or no control in the facilitating structures including committees that require participation in activities affecting nursing issues at the unit and administration level. Cronbach’s alpha was calculated at 0.837 for this subscale.

**Figure 4.8 CNs in Saskatchewan Frequency Subscale IV Facilitating Structures (n = 163).**

![Graph showing participation levels](image)

- ♦ 1 – nursing management/administration only.
- ■ 2 – primarily nursing management/administration with some staff nurse input.
- ▲ 3 – equally shared by staff nurses and nursing management/administration.
- □ 4 – primarily staff nurses with some nursing management/administration input.
- * 5 – staff nurses only.

**4.3.6 Subscale V: Liaison**

Subscale V, liaison (n = 154, M = 1.91), focuses on which group has access to information regarding activities that determine allocation of organizational resources that control practice such as quality assurance of nursing practice, professional accountability, unit budget and expenses, hospital
finances, unit and departmental goals, strategic planning, results of satisfaction surveys, physician/nurse satisfaction with collaborative practice, nurse satisfaction, statistics of nurse turnover and nurse ratios, management and physician opinion of nursing services, and access to up-to-date nursing resources. The lowest mean scores in this subscale was from questions 61 \((n = 164, M = 1.7)\) – compliance of hospital nursing practice with regulatory agencies, 62 \((n = 167, M = 1.4)\) – annual unit projected budget, 63 \((n = 163, M = 1.3)\) – hospital financial status, and 65 \((n = 168, M = 1.4)\) – hospital strategic planning. The results indicate that CNs perceive on average that nursing management/administration only (1) have access to information in these areas. Table 4.16 provides the mean scores for questions in this subscale indicating that CNs perceive more access to information regarding current resources in nursing practice, various satisfaction surveys, and satisfaction with clinical practice than in other areas.

<table>
<thead>
<tr>
<th>Question</th>
<th>n</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>74 Access to resources concerning recent advances in nursing practice (e.g. journals and books, library)</td>
<td>168</td>
<td>2.7</td>
</tr>
<tr>
<td>73 Nursing peers’ opinion of bedside nursing practice</td>
<td>165</td>
<td>2.6</td>
</tr>
<tr>
<td>70 Nurses’ satisfaction with their salaries and benefits</td>
<td>164</td>
<td>2.6</td>
</tr>
<tr>
<td>69 Nurses’ satisfaction with their general practice</td>
<td>165</td>
<td>2.3</td>
</tr>
<tr>
<td>60 The quality of hospital nursing practice</td>
<td>166</td>
<td>2.1</td>
</tr>
<tr>
<td>64 Unit and nursing department goals and objectives for the year</td>
<td>167</td>
<td>2.0</td>
</tr>
<tr>
<td>67 Physician/nurse satisfaction with their collaborative practice</td>
<td>162</td>
<td>1.9</td>
</tr>
<tr>
<td>66 Results of patient satisfaction surveys</td>
<td>166</td>
<td>1.8</td>
</tr>
<tr>
<td>61 Compliance of hospital nursing practice with requirements of surveying agencies. (Joint commission, state and federal governments, professional groups)</td>
<td>164</td>
<td>1.7</td>
</tr>
<tr>
<td>72 Physician's opinion of bedside nursing practice</td>
<td>162</td>
<td>1.7</td>
</tr>
<tr>
<td>68 Current hospital status of nurse turnover and vacancies</td>
<td>167</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Figure 4.9 demonstrates the frequency results from subscale V. Results from question 74 indicate only 16 CNs chose “5”, staff nurses only have access to information regarding the recent advances in nursing practice. Forty nine CNs selected “3”, equally shared by staff nurses and nursing management/administration regarding question 73, nursing peers’ opinion of bedside nursing practice. Although the mean for question 70, nurses’ satisfaction of their salaries was 2.6, 46 CNs responded that nursing management/administration only (1) and 38 CNs responded primarily nursing management/administration with some staff nurse input (2) controlled access to information in this area. Fifty-nine CNs responded that access to information regarding question 60, the quality of hospital nursing practice, is held primarily by nursing management/administration with some staff input (2) and 48 CNs selected nursing management/administration only (1). Seventy one CNs indicated that nursing management/administration only (1) and 54 CNs chose primarily nursing management/administration with some staff nurse input (2) have access to information relevant to patient satisfaction surveys, question 66. Regarding question 67, there were only three CNs who reported nursing staff only (5) have access to information regarding physician/nurse collaborative practice, whereas 64 CNs listed nursing management/administration only (1) has access to information regarding this. Question 68 – information surrounding the current hospital status of nurse turnover and vacancies – indicated 90 CNs answered that access to information regarding these activities was available to nursing management/administration only (1). Overall results to question 69 that addresses nurses’ satisfaction with their general practice reveal a mean of 2.3,
indicating CNs perceive access to information regarding this activity is primarily held by nursing management/administration with some staff nurse input (2). Only seven CNs responded staff nurses only (5) have access to information regarding RN satisfaction with their general practice. In general CNs perceive a limited access to information relevant to the subscale of liaison concerning the activities that enable control over nursing practice and influence of organizational resources. Cronbach’s alpha for this subscale was calculated at 0.873.

Figure 4.9 CNs in Saskatchewan Frequency Subscale V Liaison (n = 154).

1 – nursing management/administration only.
2 – primarily nursing management/administration with some staff nurse input.
3 – equally shared by staff nurses and nursing management/administration.
4 – primarily staff nurses with some nursing management/administration input.
* 5 – staff nurses only.

4.3.7 Subscale VI: Alignment

Subscale VI, (M = 2.1), addresses the alignment or the abilities of various groups to participate in setting goals and negotiating the resolution of conflict at various levels in the organization. The overall results from subscale VI (n = 164, M = 2.1) reveal that CNs perceive that nursing management/administration only (1) and primarily nursing management administration with some staff nurse (2) input have the foremost ability to be involved in these activities. In this subscale,
CNs perceive they have less ability to be involved regarding activities relevant to questions 85 ($n = 167, M = 2.0$) determining nursing departmental policies and procedures, 83 ($n = 168, M = 1.6$) creating and writing of the hospital philosophy and goals, and 86 ($n = 168, M = 1.5$) determining hospital-wide policies and procedures. Clinical nurses in provincial hospitals in Saskatchewan who participated in this study perceived that within this subscale having the ability to participate in activities is limited to primarily nursing management/administration with some staff nurse input (2) negatively affecting control over practice.

**Table 4.17 Subscale VI Alignment Highest to Lowest Mean.**

<table>
<thead>
<tr>
<th>Question</th>
<th>$n$</th>
<th>$M$</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 Create a formal grievance procedure</td>
<td>166</td>
<td>2.9</td>
</tr>
<tr>
<td>75 Negotiate solutions to conflicts among professional nurses</td>
<td>167</td>
<td>2.4</td>
</tr>
<tr>
<td>81 Write the goals and objectives of the nursing unit</td>
<td>168</td>
<td>2.3</td>
</tr>
<tr>
<td>77 Negotiate solutions to conflicts between nurses and nursing management</td>
<td>167</td>
<td>2.3</td>
</tr>
<tr>
<td>78 Negotiate solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, etc.)</td>
<td>167</td>
<td>2.2</td>
</tr>
<tr>
<td>76 Negotiate solutions to conflicts between professional nurses and physicians</td>
<td>168</td>
<td>2.2</td>
</tr>
<tr>
<td>84 Write unit policies and procedures</td>
<td>168</td>
<td>2.1</td>
</tr>
<tr>
<td>82 Write the philosophy, goals and objectives of the nursing department</td>
<td>168</td>
<td>2.0</td>
</tr>
<tr>
<td>85 Determine nursing departmental policies and procedures</td>
<td>167</td>
<td>2.0</td>
</tr>
<tr>
<td>79 Negotiate solutions to conflicts between professional nurses and hospital administration</td>
<td>166</td>
<td>2.0</td>
</tr>
<tr>
<td>83 Formulate the mission, philosophy, goals, and objectives of the hospital</td>
<td>168</td>
<td>1.6</td>
</tr>
<tr>
<td>86 Determine hospital-wide policies and procedures</td>
<td>168</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Table 4.17 indicates that CNs perceive they have some ability to be involved in areas that require conflict resolution and creating a formal grievance procedure. Question 80 ($n = 166, M = 2.9$) has the highest mean in this subscale, indicating that CNs perceive they have the ability to create
a formal grievance procedure and this activity is moving closer to being equally shared by staff nurses and nursing management/administration (3).

Figure 4.10 reveals the frequency results of this subscale providing information on the CNs’ ability to participate in setting goals and negotiating conflict related to some activities affecting control over practice. Question 84 revealed that 41 CNs responded that nursing management/administration only (1) and 74 selected primarily nursing management/administration with some staff input (2) had the ability to write unit policies and procedures. No CNs chose staff nurses only (5) in response to question 84. The results from question 81 indicated that 30 CNs chose that the ability to participate in writing the goals and objectives of the unit is dominated by nursing management/administration only (1) and 72 chose primarily nursing management/administration with some staff input (2). Only five CNs chose primarily staff nurses with some nursing management/administration input (4) have the ability to participate in writing the goals and objectives of the unit. Negotiating solutions to conflicts between nurses and nursing management, question 77, revealed that 83 CNs selected primarily nursing management/administration with some staff nurse input (2) and 31 CNs chose nursing management/administration only (1) had the ability to negotiate these activities. Overall CN responses indicate they perceive no independent ability to participate in setting goals and resolving conflicts in this domain (alignment), negatively affecting control over practice. Cronbach’s alpha for this subscale was 0.859.
Hess’ (1998) classification of governance distribution is based on the sum of the mean scores ($\sum M$). According to Hess, a traditional governance structure ($\sum M = 86 - 172$) is one where control and decision making in all six subscales is done by management/administration only (1). In this study the sum of the mean scores ($\sum M = 163$) indicates CNs perceive their professional practice environment is mainly dominated by management and administration (1), characteristic of a traditional governance structure.

Multiple analysis of variance (MANOVA), Table 4.18, indicates the test of between subject effects of each subscale reveal no statistically significant differences of subscale results between the five provincial hospitals ($p > .05$).
Table 4.18 Test of Between Subject Effects for the Five Provincial Hospitals.

<table>
<thead>
<tr>
<th>Source Variable</th>
<th>df</th>
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<th>(\lambda^2)</th>
<th>p</th>
</tr>
</thead>
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<td>.847</td>
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<tr>
<td>Influence</td>
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<td>.279</td>
<td>.430</td>
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<td>Authority</td>
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<td>.950</td>
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<td>.438</td>
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<tr>
<td>Participation</td>
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<td>.893</td>
<td>.235</td>
<td>.471</td>
</tr>
<tr>
<td>Access</td>
<td>4</td>
<td>.092</td>
<td>.028</td>
<td>.985</td>
</tr>
<tr>
<td>Ability</td>
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<td>.547</td>
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<td>.702</td>
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</tbody>
</table>

Error 117

Note. df = degrees of freedom. \(\lambda^2 = \text{eta}^2\). F = Fisher’s ratio. *p < .05

The MANOVA comparing the subscale results between Regina and Saskatoon health regions conclude there are no statistically significant differences (\(p > .05\)), Table 4.19.

Table 4.19 Test of Between Subject Effects for the Two Regional Health Authorities.

<table>
<thead>
<tr>
<th>Source Variable</th>
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</thead>
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<td>Ability</td>
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<td>.687</td>
<td>.205</td>
<td>.409</td>
</tr>
</tbody>
</table>

Error 120

Note. df = degrees of freedom. \(\lambda^2 = \text{eta}^2\). F = Fisher’s ratio. *p < .05

4.4 Narrative Responses

Section three of the survey contained one closed and four open-ended questions that focused on a more personal perception of the CNs’ professional practice environment including control over practice. The questions in this section included: 1. What does control over practice mean to you? 2. How could control over your practice be changed significantly? 3. Do you feel you have enough
control over practice in your work environment? 4. What limits your control over practice in an area that interests you? 5. What enables your control over practice in an area that interests you?

Initially the participants’ comments were transcribed according to question and hospital affiliation. The responses were then categorized into internal and external factors that had been identified in Chapter Two. The responses were explored for themes according to the internal and external factors. Internal factors are related to the CNs more direct ability to provide safe quality patient care and are elements of a professional practice model including professionalism, CN satisfaction, quality of care, empowerment, and autonomy. Common elements were identified among these subconcepts that have particular relevance to the CNs’ influence and participation in decision making that affects patient care. The themes established from the subconcepts include decision making (influencing policies and procedures) and quality of care (staffing ratios, mixes, flow, patient placement, access to resources to facilitate patient care, and educational opportunities) relevant to the CNs’ ability to provide patient care. The external factors have been described as more distant to the CNs’ control over nursing practice and include the subconcepts of health care restructuring, organizational influence, work environment models, and nursing leadership. Common themes within the subconcepts include funding and allocation of resources (government and organizations), organizational influences on work environment (hospital, SRNA, and SUN), and collaboration (collegial support). A number of responses had several interrelated themes. The information obtained from the transcribed responses from CNs from each of the provincial hospitals was then combined into one document. This section discusses the themes that were captured from the narrative responses.

4.4.1 - 1. What Does Control Over Nursing Practice Mean to You?

There were 152 nurses who responded to this question. One hundred and eleven nurses commented on what control over nursing practice meant to them in relation to internal factors. Many of their responses included specific suggestions that addressed the importance of CNs having input in
decision making so that it is a collaborative initiative between management and the clinical nursing staff. An overview of their comments indicates that a considerable number of CNs perceived their ability to participate in decision making directly impacted patient safety. Other CNs indicated the need for ongoing support and being valued by management regarding their input and experience in making decisions about unit and departmental issues that affect patient care. Some of their comments were aimed at the CNs’ ability to participate in the development of policies and procedures, practice issues such as patient load and patient assignment, as well as input into scheduling.

Sixty-one CNs described their control over nursing practice as regulated by organizational influences and the work environment that directs CN practice, more closely related to external factors. Included in this section were 30 CN responses that perceived management/administration had control over their practice and 28 CN responses that perceived the SRNA had a direct influence on their control over practice. Some of these respondents indicated that both management and the SRNA had control over their practice. Three CNs felt SUN had an influence on control over practice.

Internal Factors

The themes related to the internal factors that emerged about CN perceptions of control over nursing practice include decision making and quality of care relevant to the CNs’ ability to provide or delegate patient care. The themes are as follows:

Influence in decision making.

Decision making is described by CNs as having input and opportunities to influence patient care and maintain nursing standards of practice. CNs commented (110/152) on the importance of being supported, encouraged, and involved or having influence in decision making affecting their control over nursing practice. Some comments included:
• “Control over practice is very important to me. As a responsible professional whose licensing body, the community we assist, and personal beliefs expect me to provide nursing care to the best practice standard. I need control over that practice environment in order to maintain best practice standards”

• “Meaningful input into decision making that impacts frontline nursing practice. Decision making done in a cooperative environment with senior management as I truly believe that they are in general too removed from the real pressures, and that some practice standards and policies are created in a ‘perfect world’. ”

• “I would say it refers to the ability and opportunity to contribute to setting the direction of practice. It means having some say on the matter without entirely relying on administration to define practice.”

• “Ability to have input into decisions regarding practice i.e. patient load, patient assignment, development of policies and procedures. Input into scheduling. Ability to set practice standards.”

• “It means that I have an opportunity for input regarding my nursing practice including policies, procedures, and environment. It means that my concerns are heard respectfully. It means that my observations, a receipt of years of knowledge and experience, (sic) are taken seriously. Ultimately, it means or translates into safe and effective patient care.”

• “Having input into decisions. Voicing concerns/opinions. Being involved.”

• “It does not mean ‘total’ control, but rather, input into the changing roles of nursing and recognition of the vast education that nurses now have. Ability to practice their nursing skills at our desired level keeping in mind education knowledge and experience.”

• “To be able to meet current professional standards. To have the capacity to change care to accomplish the above.”
“Control over practice means being able to integrate new practices/policies into my work environment. It means being able to advocate for patients and be heard and respected.”

“Setting professional standards. Being treated as a professional by others (professionals). Being updated on policies, techniques, procedures.”

“Determining and upholding standards of care and being involved in both policy and practice.”

“Being able to influence through best practice that which influences my practice, i.e. staffing mix, environment, time to research best practice, being heard and listened to.”

“It is an aspect of clinical governance. To me, it means nurses having control of the management and organization of nursing care and the practice environment (at unit level).”

“Ability to make decisions and give input influencing patient care and nursing standards and the way care is provided.”

“To have input in the decisions that affect practice issues.”

“That nurses should be allowed to make decisions about patient care. That their observations and opinions should be given consideration and respect.”

“Opinions and needs of nurses considered valuable in our care for the patients.”

“It means you have some say over what you do in your work environment.”

“Being able to give patient care.”

“How much control each individual RN has over his or her practice. The amount of autonomy one has, to make decisions regarding care given.”

Quality of care.

Clinical nurses (44/152) indicated that influencing and contributing to decisions regarding staffing levels/mixes, patient placement, and education facilitate the CNs’ ability to ensure quality of care. Some of the responses include:
“Input into…determining appropriate nurse to patient ratios.”

“Having input, in regards to staffing with increased work loads.”

“Being able to influence through best practice that which influences my practice i.e. staffing mix, environment…”

“Being able to provide safe nursing care with proper equipment.”

“Better able to give patient care.”

“That if I want to change the ways something is done in the clinical area related to safety or efficiency, I can.”

“Having the ability to actually put into effect our ability to practice to our full scope of practice and give safe patient care…”

“Good lines of communication between nurses and management. Consistent and regular staff education and meetings…”

“Having control over things like self education (i.e. reading up on things to keep current. You pretty much are responsible for your own education as we don’t have control over things like environment, certification, and (sic) policies.”

“Control to me means having the knowledge ability and authority to create change to nursing practice based on current research.”

“Being able to have access to resources to provide evidenced (researched) based practice.”

“Encouragement and access to up to date info affecting practice (patient care).”

External Factors

Work environment (management/administration, SRNA ,and SUN).

The theme of work environment, directly relevant to the external factors, reflects how outside influences affect the CNs’ control over nursing practice. Clinical nurses described how the influence
by management/administration (30), SRNA (28), and SUN (3) affected control over nursing practice. Their comments include:

- “Nursing management/administration has the control”.
- “It means being able to advocate for patients and be heard and respected. It does not mean inviting staff nurses to sit on committees just to listen to people with ‘real power’ and rubber stamp their agendas/proposals.”
- “…management has the power to direct the workforce so if I cannot complete my workload to even minimum standard, who is really controlling my practice?”
- “Management/administration has the final say as to how a nurse delivers care.”
- “The body that regulates our practice.”
- “Practice standards that are regulated for patient safety and well-being.”
- “You have missed 2 very important factors in your questionnaire – that’s the facts [sic] most hospitals have unionized nurses and 2) we are governed by the SRNA. These 2 institutions assist us in controlling our practice and you’ve not mentioned them at all. I want to have a participatory type of management that’s transparent in what they do. Right now I feel like I’m in a military institution – ‘do as you’re told’ – and get out if you don’t like it.”

4.4.2 - 2. How could control over your practice be changed significantly?

A total of 141 CNs responded to this question. One hundred CNs indicated their control over practice could be changed significantly by addressing what the literature has identified as internal factors. Their responses generally indicated that CNs need to have influence on and be directly involved in participating in decision making that includes policies and procedures, practice issues, staffing concerns, and educational opportunities that affect safe patient care. There were many
detailed responses regarding the need for the CN to be involved in decision making particularly regarding patient care issues.

Forty one CNs provided information that described how changing external factors could significantly alter their control over practice. Several CNs provided criticism regarding the lack of managerial support that severely affected their work environment, limiting their control over nursing practice. Many of these CNs combined responses were directed towards the unreasonable expectations that nurses face. This included detailed information about managements’ failed attempts to provide for the necessary resources. Other CNs pointed directly towards nursing management as being responsible for the lack of adequate staffing. There were also responses by CNs that were specific to the lack of resource funding, collaborative support, and access to ancillary staff that limited their control over nursing practice. The following internal and external themes emerged from this question:

**Internal Factors**

*Influence in decision making.*

Clinical nurses (71/141) indicated that control over their practice could be changed significantly by having the opportunity to influence decision making that affects patient care from the bedside to the administrative level. Their suggestions included:

- “More decision making needs to occur at the patient/nursing level and less at senior nursing level.”
- “By incorporating involvement of myself and the nursing staff I work with in decision making that affects patient care to a greater level. Bedside RN input has become rarer every year. It is very limited currently in practice.”
- “Have front-line nurses involved in the decision making process in all areas of the workplace.”
• “Staff input heard, valued, and acted upon.”
• “For administration to listen to some of our ideas – they hear us but do not follow through.”
• “Allowing general RNs to have a say in the running and policy procedures on the ward.”
• “Participation and visibility of registered nurses on committees or with organizations whose
decisions affect nursing interests and practice.”

Quality of care.

The CNs’ ability to maintain quality of care was described by 27 of the 141 respondents as an
important factor in significantly changing control over practice. Their comments are as follows:
• “It could be changed by allowing the staff RN to have input into appropriate staffing needs
for acuity and types of patient on the ward. The staff allocated for each shift for each CNs
patient needs is determined very largely by manager with minimal staff RN input. Bedside
nursing, patient needs and acuity are best assessed by the staff working on a daily basis.
There needs to be a representative from the ward to management and administration issues
reflecting a ward.”
• “A patient acuity measurement system which would show the types of patients we have on
our unit. Maybe then we could be staffed properly for all shifts – not just the day shifts.”
• “To have safe and manageable patient/nurse ratios to promote a positive work environment.
On-going in-services and education with time to be able to do this.”
• “Increased paid time to participate in committee work and clinical practice studies.”
• “Better education, resources and implementation of evidenced based practice.”
• “More education…”
• “More day to day on-going teaching i.e. in-services…”
• “Education days have been cancelled permanently due to lack of staff.”
• “Time to study and act upon evidence based practice.”
External Factors

Several CNs (41) indicated changing the currently experienced lack of support from management regarding decision making, work environment, and collaborative practice could significantly alter their control over practice. The following themes and responses are provided:

Work environment (management/administration, SRNA, and SUN).

Clinical nurses (20/141) described the lack of support they receive from management/administration and also the power that management/administration possess negatively affects their control over practice. A more supportive work environment could significantly change their control over practice. Their comments included:

- “Sadly I believe that administration holds the reins over our practice so tightly that most likely no matter how much we try (which we have) they will continue to hold 99% of the power of decision making.”
- “By nursing management changing what we do now.”
- “I think admin/nurse management control this and I’m not sure how it can be changed.”
- “#1 Less – MUCH LESS administration. #2 administration by nursing persons only.”
- “Management to listen to staff nurses, allow nurses to have more input into overall policies, etc.”
- “Finding finances to have appropriate equipment relative to direct client care.”
- “For better: - increased staffing so that I can do a more thorough job. – more of or better equipment so that I can spend more time with patient care.”
- “Shortage in staff – nurse to patient ratio (increasing patient numbers). Shortage of supplies – makes nursing procedures difficult.”
- “Better nursing/patient ratios.”
- “Increase RN staffing with increased acuity of patient and numbers.”
• “Increase staffing levels, making sure non-nursing jobs are done by support staff.”

Collaboration.

Twenty one percent of the respondents (30/141) indicated that more collaboration could significantly change their control over practice including being respected and valued by management and their colleagues, as well as interdisciplinary collaboration. Examples of responses included:

• “More collaboration between management and staff nurses.”
• “By sharing ideas. More collaborative approach rather than medical model.”
• “There would need to be more cooperation among various sites in the region to create common and standard practices across the region.”
• “Frequent meetings between nursing and administration to seek input.”
• “I do not think that nurses are consulted or utilized in adequate ways when it comes to practice. Basically told this is the way it is done. Some issues could be best reviewed with a collaborative approach from management and staff nurses.”

4.4.3 - 3. Do you feel you have enough control over practice in your work environment?

The overall response from this closed ended question that elicited a yes/no answer indicated that 50% of CNs who responded did not feel they had enough control over practice in their work environments. The breakdown of the 172 respondents’ answers follows:

• Eighty seven participants (50%) who answered this question felt they had no control over their practice environment.
• Forty three participants (25%) who answered this question felt they did have control over their practice environment.
• Twenty two participants (13%) felt they had control over their practice sometimes.
• One participant was not sure
• Twenty two participants did not answer this question.
4.4.4 - 4. *What limits your control over practice in an area that interests you?*

One hundred forty-four CNs indicated that both the internal and external factors, as previously discussed, limit their control over practice in an area of interest. Many CNs provided information on internal factors such as staffing issues and a lack of up-to-date educational opportunities limits their control over practice. There were also several CNs who indicated that mainly the lack of influence and participation in decision making limited their control over practice in an area that interests them. However the majority of responses by CNs leaned heavily towards the lack of resources (external factor) impacting the ability to provide adequate staff and education for the CN.

Several CNs reported the lack of support within the organizational structure, particularly from management/administration -- an external factor -- is a limiting factor in control over practice. Their responses included management being unapproachable, communicating poorly and not providing adequate resources for safe patient care. Supplies that would be deemed essential are described by CNs as being inadequate, such as blood pressure equipment. The following themes and comments pertain to this question:

*Internal Factors*

Clinical nurses indicate that a lack of influence in decision making and quality care limits their ability to control practice in an area of interest.

*Influence in decision making.*

Clinical nurses indicated a limiting factor in control over practice is lack of influence and participation in decision making (17/144). Some examples include:

- “…No invitation from management and administration to participate.”
- “…Lack of shared decision making.”
- “Feeling as though what bedside nurses say isn’t being heard.”
Quality of care.

Comments by CNs (25/144) identify the lack of effort to address quality of care issues limits their control over practice in an area of interest. The most frequently identified theme in quality care was the lack of education/research available for CNs. Some comments include:

- “Lack of resources to enable staff to participate in meeting.”
- ”There is very limited funding available for education.”
- “…limited education and resistance to change.”
- “No education/staff room.”
- “Lack of empowerment (access to information, resources, support and professional education).”
- “Set up of education on our ward.”
- “Lack of time and management support to encourage further study/teaching in an area.”

External Factors

The lack of resources, collaboration and funding are themes that limit control over practice. The themes and responses include:

Funding and resources.

Clinical nurses (42/144) contend that the lack of resources limits their control over practice.

- “Fiscal restraints and differing organizational priorities.”
- “Closing and restructuring of rural centers forces me to drive over 1 [sic] hour to work and home again.”
- “Finances.”
- “Money. The budget comes up a lot. Everyone is trying to be fiscally responsible.”
- “Employer, manager, health care system that is money oriented now – not patient care oriented.”
“Budgets that limit safe patient care.”

Work environment (management/administration, SRNA, SUN).

Clinical nurses (52/144) indicate that there is a lack of support from management/administration that limits control over practice in an area of interest. Six respondents felt the SRNA and ten indicated SUN limited their control over practice. Their comments include:

- “An authoritarian, dominating administration.”
- “Override by management.”
- “Management has the final say…”
- “Administration doesn’t care.”
- “…Administrative indifference.”
- “Management caring more about their budget than the patients or staff.”
- “The management style is currently not conducive to participation in decision making. Input is rarely ‘invited’.”
- “The SRNA’s degree entry to practice. Discriminatory to Diploma nurses…”
- “SUN, policies, opportunities, work times…”
- “Limitations by union…”

Collaboration.

The lack of collaborative practice is described by CNs (32/144) as an area that limits control over practice and requires ongoing attention in the work environment. Their responses include:

- “The lack of team (multidisciplinary) based approaches.”
- “Nurses versus physicians and other discipline practices.”
- “Medical Staff (i.e. aneth./docs) have control over our area.”
- “Communication (or lack of it) with management and administration.”
- “Lack of management listening and being open to staff nurses for appropriate patient care.”
• “Colleague support or non-support or sabotage.”
• “Collaborative practice has not been integrated into practice – our system appears physician-centered rather than client focused.”

4.4.5 - 5. What enables your control over practice in an area that interests you?

One hundred and twenty four CNs responded to this question providing answers that included both internal and external factors. Several CNs indicated that influence and participation in decision making, specifically staffing issues, and educational opportunities that affect safe patient care enable their control over practice. Many of these responses regarding participation in decision making had an emphasis relevant to the concepts of autonomy in clinical practice, empowerment in the work environment, and current education directed at patient safety issues. Relevant themes to the internal and external factors and specific comments follow:

Internal Factors

Respondents describe having influence in decision making and enabling quality of care are important for control over practice in an area of interest.

Influence in decision making.

Clinical nurses (43/128) report that influence in decision making is an enabling factor for their control over practice. There responses describe more clinical decision making “in practice” that focuses on empowerment and autonomy. Their comments include:

• “To have input into changes that will benefit client care.”
• “Self confidence. Experience.”
• “Experience to say what I want &/or need to [sic] my practice.”
• “Experience.”
• “Professional practice ethics. Professional conduct. Level of autonomy.”
• “My personal initiative in ongoing education, evidence based practice and client advocacy drives my optimal provision of care.”

• “A direct voice that is heard and become part of bring about training, procedural, policy changes.”

Quality of care.

The CN responses to quality of care (23/124) emphasize the CNs’ need for educational opportunities, including research and evidence based practice that influences safe patient care. The following are examples:

• “Keeping current and knowledgeable (best practice, research).”

• “Policy and procedure manuals. Nursing journals. Research.”

• “Resource based practice – changes are not being made according to current trends in research.”

• “Education.”

• “Information.”

• “Increase knowledge…”

• “Increase knowledge (reading, knowledge).”

• “Safe patient care must always prevail.”

External Factors

Several CNs indicated there was a need for support from management and administration as well as a more dedicated effort by all stakeholders regarding collaborative support. Clinical nurses reported the external factors have a significant effect on enabling their control over practice. The following themes and comments were evident:
**Work environment (management/administration, SRNA, and SUN).**

Clinical nurses (40/128) report that a supportive work environment enables their control over practice. Five of the 40 responses indicated CNs did not have supportive management. Their comments include:

- “There is a genuine movement among some areas of nursing management to involve front line nurses in creating practice standards to facilitate improvements in patient care.”
- “Respect and trust from manager to allow me to make decisions and give input into decisions.”
- “Support by administration to go ahead and participate in these issues.”
- “Supportive management and coworkers.”
- “The manager supports use of our full scope of practice.”
- “My manager(s) is/are very supportive.”
- “Nurse manager that fosters participation and staff input.”

**Collaboration.**

Many CNs (40/128) indicate that a collaborative work environment is an enabling factor in control over practice. Their responses included:

- “Support of peers, doctors, nursing manager, and clinical educators to pursue ideas, research, and education.”
- “Excellent communication and collaboration with other nursing staff. Relatively good communication and collaboration with physicians and non-nursing departments.”
- “Support from managers, administration, physicians that fosters and environment for evidence based practices.”
- “Collaboration between physicians and nurses...”
- “Administration and physician support. Increased authority.”
4.5 Summary of Results

This chapter has presented the analysis and interpretation of the results from this study. The quantitative data analysis included descriptive statistics related to the demographics and CNs’ perceptions of the IPNG subscales, as well as appropriate inferential statistical analysis. The descriptive data provides data on gender and average age of CNs that is similar to data presented by CIHI (2006) and Health Canada (2006a). A greater number of CN respondents indicated their basic nursing education was a nursing diploma versus CIHI data that reports a higher number of RNs having a baccalaureate degree as their basic nursing education. However results from this study indicated more CNs had attained a baccalaureate degree in nursing as their highest level of education in comparison to the CIHI data that shows fewer Saskatchewan nurses have recorded a baccalaureate degree in nursing as their highest educational degree. Of interest are the results that twice the percentage of CNs in this study report having specialty certification from the CNA national program compared to data provided by CIHI. Although there is a similar trend in employment status, CNs in this study reported a much higher number are working full-time versus part-time than the overall CIHI results. The quantitative data from the IPNG subscales, Professional control (who controls professional practice, $M = 1.72$); Organizational influence (who participates in structures related to governance activities in the organization, $M = 2.13$); Organizational recognition (who controls nursing personnel and related structures in the organization, $M = 1.73$); Facilitating structures (who participates in structures and decision making within the organization, $M = 1.82$); Liaison (who influences the resources to support professional practice, $M = 1.9$); Alignment (who sets and negotiates conflict within the organization, $M = 2.1$), provided information that indicates CNs perceive limited control over nursing practice in several areas within each subscale. The overall results indicate the control over nursing practice is perceived to be held mainly by nursing
management/administration (1) and nursing management/administration with some staff nurse input (2). The qualitative data were transcribed, examined for categories, and organized into themes. The qualitative responses revealed internal and external factors previously outlined in Chapter Two. The themes representing the internal factors include decision making (influencing policy and procedures) and quality of care (staffing ratios, mixes, flow, patient placement, access to resources to facilitate patient care, and educational opportunities). Themes relevant to the external factors include funding and allocation of resources (government and organizations), organizational influences and work environment (hospital, SRNA, and SUN), and collaboration (collegial support). The lack of influence and support in decision making affecting patient care issues is clearly evident and provides richness to the statistical findings. The next chapter presents a discussion of the methodological issues, the conceptual framework, and the research findings presented within the context of the literature review. The limitations of the study are provided and recommendations are made for stakeholders and additional research.
Chapter 5
Discussion and Conclusions

Organizational restructuring and reform in the healthcare system have challenged the CNs’ ability to have control over nursing practice in a professional practice environment, precariously affecting the quality of patient care. Confounding this sense of uncertainty, stakeholders from all aspects of the healthcare system are determined that quality patient care in a professional practice environment be maintained. The results from this study provide information to stakeholders regarding CNs’ perceptions of control over nursing practice in the five provincial hospitals in Saskatchewan. The six subscales examined were Professional control (who controls professional practice), Organizational influence (who participates in structures related to governance activities in the organization), Organizational recognition (who controls nursing personnel and related structures), Facilitating structures (who determines and participates in structures in governance decisions within the organization), Liaison (who influences the resources that support professional practice), and Alignment (who sets and negotiates conflict within the organization). Separately, the six subscales provide information relevant to particular areas of the CNs’ control over nursing practice; however, when taken together the scores reveal who has more influence over their professional practice environment and decisions within the organization. The professional practice environment and decisions within the organization, according to participants in this study, is primarily under the control of nurse managers/administrators (1) or nurse managers/administrators with some involvement of staff nurses (2) as indicated on the 5 point Likert scale. Each subscale will be discussed later in this chapter in relation to control over nursing practice referencing the literature to emphasize important findings.
The participants indicate that the professional practice environment can be positively influenced by valuing CNs’ participation in decision making, at all levels, in issues that affect control over nursing practice that are relevant to quality patient care. The literature shows that acknowledging CNs’ participation in decision making and control over nursing practice positively influences CNs’ satisfaction and subsequently retention/recruitment. There is limited literature pertinent to Saskatchewan’s CNs that examines CNs’ perceptions of control over nursing practice in the professional practice environment of provincial hospitals, which prompted this study. Results from this study regarding perceptions of CNs’ control over nursing practice will be compared to previously mentioned studies using Hess’ tool (IPNG). In this chapter, a discussion of the methodological issues, the conceptual framework, and the research findings are presented within the context of the literature review. Recommendations are made for stakeholders and additional research.

5.1 Methodological Issues

This study was a descriptive mixed method survey design to investigate the perceptions of CNs employed in the five provincial hospitals in Saskatchewan regarding who governs their professional practice environment including control over nursing practice. The criteria for a provincial hospital, established by Saskatchewan Health (2001), include those hospitals with high enough patient volumes to support and sustain specialized programs. Such services include specialized surgical and medical treatment for cancer, heart surgery, specific diagnostic tests, and infant intensive care units.

5.1.1 Response Rate

A total population sample of 1804 CNs indicating their primary place of employment was one of the five provincial hospitals in Saskatchewan were invited to participate in the study. An
overall response rate of 9.53% was received, a very poor return. In collaboration with the
Systems Administrator of the SRNA, the researcher had intended for each subject to receive a
research package containing a cover letter (Appendix A) identifying the researcher and purpose
of the study, the survey, and a self addressed stamped return envelope. Unfortunately, the self
addressed stamped envelope was not included in the research package. Immediate attempts were
initiated by the researcher to rectify the situation. The researcher immediately drafted an
apology letter that included an SRNA contact phone number in case respondents had discarded
the survey and wanted a replacement mailed to them. The apology letter was enclosed along
with a self addressed stamped envelope into 1804 envelopes for immediate distribution by the
SRNA. The box of envelopes was then couriered to the SRNA for immediate distribution
(within a five day period). The researcher delayed the SRNA distribution of the reminder post
cards to participants to a later date. The data collection period went from November 27th, 2005 to
January 15th, 2006 rather than December 20th, 2005 as initially planned. There were no surveys
returned after February 15th, 2006.

Other reasons for the low response rate might include “survey fatigue” or burnout due to
the increased volume of surveys administered to individuals over the previous year. Health
Canada (2006b) indicates that “survey fatigue” relates to individuals who do not respond to
surveys for various reasons such as lack of time, sense of exhaustion, sense of apathy, lack of
access to a computer, preferred hard copy, and lack of simplicity in obtaining a hard copy of the
survey. Researchers (Coates, 2006; Nair, Adams, Ferraiuolo, & Curtis, 2007; Porter, 2004) also
suggest that response rates are falling due to participant disengagement and disinterest in
surveys, “survey fatigue”. These authors suggest that survey participants are more likely to
participate if the feedback they contribute is considered as valuable and is acted on in some way that demonstrates their voice is heard.

5.2 Conceptual Framework

The conceptual framework used for this study was based on Hess’ understanding of control over nursing practice as articulated in the IPNG survey tool, which in addition to a short demographics section, includes six subscales addressing various aspects of control over nursing practice: Professional control (control of professional practice), Organizational influence (participation related to activities in the organization), Organizational recognition (control of nursing personnel and related structures), Facilitating structures (participation in decisions within the organization), Liaison (influencing of resources supporting professional practice), and Alignment (negotiating conflict within the organization). The conceptual framework provided a structure that was effective in maintaining the continuity between the description of the study tool and subsequent discussion of the results of this study that was supported by the relevant literature. The IPNG survey tool captured pertinent information about the CNs’ perspectives regarding control over nursing practice at the bedside, unit and administrative levels, and their perceptions of their work environment in provincial hospitals in Saskatchewan.

5.3 IPNG Demographics

In this study demographic variables did not reveal any statistically significant differences between CNs in the five provincial hospitals. As well, the results of the subscales indicate no statistically significant differences within or between regions. Approximately 6.5% males and 93.5 % females responded to the study consistent with the CIHI (2006) report regarding the gender composition of Saskatchewan and Canadian RNs that show nursing continues to be a predominantly female workforce. According to study results, 61.8% of CNs were over the age of 40. The average age of CNs ($M = 42.6$ years) is slightly younger than the average age of RNs
in the general nursing population, described by Elliot (2003) as 45 – 49 years, Health Canada (2006a) as 44.3 years, and CIHI as 44.7 years in Canada and 45.6 years in Saskatchewan. As indicated by Tourangeau et al. (2005), ongoing efforts need to be implemented to support the aging RN workforce in having control over nursing practice in a professional practice environment. The Canadian Nursing Advisory Committee ([CNAC], 2002) provided information on strategies to retain older workers. One of the strategies, also discussed in the CHSRF document (2006a), proposed a phased - in retirement program by 2004. The other strategy for retaining older workers proposed by Saskatchewan Health (2005), included work opportunities such as coaching, mentoring and teaching, providing equipment, and human resources that are directed at the needs of older workers to allow them to continue to work for a longer period of time. In comparison to CIHI data of the RN workforce and age distribution there were more CNs who responded to this study that were in the age group of 20 – 29 and 40 – 49. Reasons for this might include the fact that Elliot (2003) indicates that younger RNs are more likely to work in the hospitals and that RNs in the 40 – 49 age group have high retention rates and tend to stay in the profession.

A higher number of CNs reported having a nursing diploma (65%) versus a baccalaureate degree (34%) as their basic nursing education. These results differ from CIHI (2006) that reports a greater number of RNs (51.8%) across Canada have a baccalaureate degree compared to diploma (48.1%) as their basic education. However Health Canada (2006a) reports 33% of nurses have a baccalaureate degree as their basic education suggesting closer results to CNs (34%) in this study. One explanation for this difference might be that CIHI data is obtained from the RN regulatory bodies across Canada while Health Canada was a survey similar to this study in that it relied on RNs participating on a volunteer basis. Elliot (2003) suggests the SRNA’s
move from diploma to baccalaureate entry to practice in 2000 has increased the number of younger nurses in Saskatchewan with a baccalaureate degree; however, as CIHI reports, many Saskatchewan nurses continue to leave the province seeking employment. Additional information by CIHI reports that although 96% of Saskatchewan graduates remain in the province there is, over time, some migration of Saskatchewan graduates. CIHI acknowledges the difficulty in measuring the migration patterns of baccalaureate graduates; however, it also reports 29.2% of Saskatchewan graduates have migrated and are employed in Alberta, British Columbia, or Ontario. Collective agreements can make it difficult for new graduates to attain full time employment affecting the recruitment and retention issues within this province.

Forty-seven per cent of CNs reported their highest educational degree as a baccalaureate degree in comparison to CIHI’s (2006) report of Saskatchewan RNs at 30%. Forty five percent of CNs indicated having a diploma in nursing as their highest educational level compared to the CIHI report of Saskatchewan RNs (68.1%). It is possible that a higher number of degree nurses, who are knowledgeable regarding the importance of research in nursing, were interested in completing this survey. Other explanations might include the implementation of the baccalaureate degree as entry to practice in 2000 that has encouraged diploma nurses to attain their degree, the cessation of the diploma nursing program in Saskatchewan, distance education and teleconferencing that facilitate baccalaureate education for diploma prepared nurses, an increase in retirement of nurses with a diploma, or overall attrition.

A higher percentage, approximately 10.5%, of CNs reported certification with the CNA national program compared to the overall CIHI (2006) results (5.4%). This could point to the dedication of CNs in this study to continued learning. As well, healthcare reform in Saskatchewan has affected many CNs in rural areas requiring them to travel and work in more
populated urban facilities. Clinical nurses in urban facilities are also experiencing an increasing patient acuity, explosion of technology and workplace demands. As a result, many CNs have demonstrated diligence and self-directedness in their efforts to keep current with research and knowledge that will affect patient care. Another explanation might include provincial efforts (Saskatchewan Health, 2005) in accordance with one of the CNAC (2002) recommendations to establish an infrastructure providing support to clinical and other nurses through work-related professional development and other educational opportunities. The Regional Health Authority’s (RHA’s) retention and recruitment strategies to provide support for continuing education and development may have prompted some CNs to further their education and complete certification.

Consideration must be given to selection bias regarding the increased number of CNs reporting certification with the CNA national program. These results might be an under representation of the actual level of CNA certification due to the usage of several different acronyms by the CN respondents that did not clearly identify their national certification as being with the CNA.

Eighty four percent of CNs responding to this study indicated they were a staff, general duty, or bedside nurse. Nineteen respondents indicated they were a nurse educator and five respondents recorded being in a management position. This information might demonstrate the mobility of nurses within the year from CN positions to nurse educator or nurse manager positions. Fifty percent of CN respondents indicated they had less than five years experience in their present position and 35% reported less than five years experience within the current institution.

CIHI (2006) statistics of RNs working full-time in Saskatchewan (54.8 %) and Canada (55.4%) are lower than the results from this study that report 70.8 % of CNs work full-time. In contrast, a lower number, 29.8 % of CNs in this study, work part-time compared to CIHI results.
of nurses working in Saskatchewan (34.4 %) and Canada (32.7 %). The largest number, 19.5 % of CNs responding to this survey, had worked in nursing between 26 to 30 years. It is possible that CNs who have been in nursing for many years and working full-time have more experience within the organization and the hospital work environment and therefore were more interested in participating in this study regarding control over nursing practice.

5.4 Discussion of IPNG Subscales

The dimensions of governance regarding control over nursing practice are examined using the six subscales of Professional control (control of professional practice), Organizational influence (participation related to activities in the organization), Organizational recognition (control of nursing personnel and related structures), Facilitating structures (participation in decisions within the organization), Liaison (influencing of resources supporting professional practice), and Alignment (negotiating conflict within the organization). For the purpose of this discussion, means of less than “3” on a 5 point Likert scale were interpreted to indicate that the CNs in this study perceived that nursing management/administration had more control over their practice than they did. For each subscale Cronbach’s alpha was calculated to be greater than 0.75.

5.4.1 Subscale I: Professional Control

Subscale I, professional control ($M = 1.7$) includes statements regarding who has control over activities relevant to professional practice such as nursing personnel, including promoting opportunities and discipline. Hess (1998) describes this subscale as information pertaining to who has control over professional practice within the organization. It is evident that CNs perceived limited control over their professional practice in their formal organization. This subscale had the lowest mean score of all the subscales indicating primarily nursing management/administration with some staff nurse input (2) have control in this area. In fact this subscale revealed that CNs perceived they have the least amount of control over professional
practice in comparison to all the other dimensions. They perceived little input or control in the following realms that directly affect the bedside care of the patient from bedside nursing: Patient care standards/quality assurance, educational development, products for nursing care, incorporating research ideas in nursing, determining the model of nursing care for their professional work, and delegation of support personnel. When analyzing the IPNG subscale results in their study, Lee et al. (2000) found similar results to this subscale ($M = 1.7$) indicating primarily nursing management/administration with some staff nurse input (2) have control of the activities in this subscale. The study by George et al. (1997) reported results of nurses’ perceptions of their work environment being more closely related to a traditional governance structure; the results specific to subscale I in the IPNG were slightly lower than the current study indicating only nursing management and administration (1) were involved in decisions related to control over professional practice. Howell et al. (2001) provided similar results of subscale I indicating nurse management/administration dominates in activities in this subscale with little or no input from staff nurses. Although the results by George et al. and Howell et al. are describing factor analysis data, comparisons provide similar results to this study. Mathews and Lankshear (2003) report that professional practice structures primarily affect the nurse as clinician, and these authors noted that nurses have little authority to create systems that enhance professional practice issues or development. They suggest the model of nursing care provides an environment, a formal structure, offering RNs the opportunity to participate in decision making that is supportive of incorporating evidence-based practice and promoting professional practice in the workplace.

It is clear that CNs perceive they have limited involvement in decision making that is relevant to direct patient care. This challenges one, if not many, of the retention and recruitment
activities by the RHA’s proposed in the Saskatchewan Health document (2003) that encourages staff participation in decision making. Other strategies by the RHAs include quality workplace initiatives that are described as those that may impact nursing. These initiatives that may impact nursing are categorized as organizational support, employment recognition, human resource policies, the nature of the work, and leadership. There is an obvious discrepancy between the RHA’s understanding that the involvement of front-line staff in committees affecting control over professional practice are initiatives that may impact nursing and the results of CNs in this study that suggest influence and involvement in decision making affecting control over nursing practice does impact nursing.

In addition Saskatchewan Health (2003) mentions the Quality Workplace Program pilot sites implemented by the SRNA (2001a) that focused on shared decision making between front-line staff and management. The HQC (2003) provided a summary report of this project that showed no statistically significant changes in mean subscale scores pre and post implementation. However, HQC reports that, at the pilot sites, there were moderate improvements in staff perceptions about the quality of their work environment. These pilot projects involved rural and long-term care facilities that do not necessarily reflect the opinions or concerns of CNs in the provincial hospitals. It is important that stakeholders such as Saskatchewan Health, SRNA, HQC, SUN, and the public make efforts in recognizing the issues CNs in provincial hospitals in Saskatchewan have regarding quality workplace initiatives in their area of nursing practice. In recognizing the opinions and concerns of CNs in provincial hospitals, concentrated efforts at addressing these concerns can be made to increase the CNs’ control over nursing practice, improve their morale, and overall satisfaction that ultimately leads to improved quality patient care.
Qualitative responses related to Professional Control.

A definition of control over nursing practice was not provided in this study; however one of the open-ended questions in section three of this study asked CNs to describe “what control over nursing practice meant to them?” Their responses indicated that being supported, encouraged, and having influence in decision making positively affects their control over nursing practice. They described how participating in decision making would have a positive impact on their professional practice environment including areas such as best practice, research, integrating new practices/policies, nursing standards, and practice issues. One CN said control over nursing practice meant “it is an aspect of clinical governance. To me it means nurses having control of the management and organization of nursing care and the practice environment (at the unit level).” The narrative responses regarding “what control over nursing practice meant to them?” are very similar to the qualitative study results by Kramer and Schmalenberg (2003). These researchers conclude that nurses define control over nursing as participation and decision making at all levels in the nurses’ professional role. Several CNs in this study commented on the difficulties they faced in attempting to be involved in committees including an inability to be replaced on the ward. Aroskar et al. (2004) and Estabrooks et al. (2002) provide consistent opinions that a lack of support is discouraging and can lead to feelings of oppression among individuals and groups that have a direct impact on their ability to establish and maintain a professional practice environment and could eventually encourage nurses to leave the nursing profession.

The results from subscale I conclude that on average CNs in this study do not perceive they are involved in the decision making related to patient care and do not perceive they have
control over nursing practice in their professional work environment. The subscale results are similar to those found in the previous research (Aiken et al., 2001a; Cameron et al., 2004; Greco et al., 2006; Krairiksh & Anthony, 2001; McFarland et al., 1984; Health Canada, 2006a; Spence Laschinger, Sabiston, Finegan, & Shamian, 2001; Ulrich et al., 2005) that point out RNs have limited opportunities to influence decision making and control over nursing practice at the unit, management, and administrative levels. Arford and Zone-Smith (2005) indicate that professional practice environments must be transformed ensuring the CN has control over the operational definition of nursing, therefore influencing the decision making of the CN from the patient interaction to the organizational level. Of importance is recognizing the value of the CN in the decision making process in all areas affecting patient care. The Canadian efforts discussed by Girard et al. (2005) involving CNs in the development of a professional practice model, emphasizing control over nursing practice, by the Calgary Health Region (2005), London Health Sciences Centre (2004), The Ottawa Hospital (2004), and University Health Network (2004) require consideration, evaluation, and perhaps implementation in Saskatchewan healthcare organizations.

Clearly the results of this subscale indicate CNs perceive some control in some areas of this subscale; however, they generally perceive that management/administration has control in most of the areas of this subscale. Of particular importance is that CNs perceive they have little input and control in decision making that affects direct patient care, specifically determining what activities nurses can do at the bedside, deciding on educational needs, selecting products used in nursing areas, incorporating research ideas into nursing care, determining methods of nursing care delivery, activities of ancillary personnel, and appointing nurses to leadership positions. Therefore, there is value in further research regarding CNs’ perceptions of their
involvement and decision making in these areas emphasizing control over nursing practice specific to areas affecting patient care. Of particular importance would be to include the use of focus groups providing CNs the opportunity to describe their control over nursing practice or a pre and post-implementation study of a professional practice model that would contribute to the CNs’ ability to identify, describe, and compare their experiences regarding control over nursing practice.

5.4.2 Subscale II: Organizational Influence

Subscale II, organizational influence ($M = 2.1$), addresses who in the organization has influence and access to information and resources that facilitates professional practice. Clinical nurses perceived more influence and access in nursing activities in this dimension. The highest mean scores of all 86 survey questions were observed in this subscale. Clinical nurses perceived they have the most influence and access to information that concerns daily patient assignments, consulting nursing and hospital services, monitoring and regulating staffing levels based on patient census and acuity as well as regulating patient flow. Lee et al. (2000) found similar results ($M = 2.7$) after data analysis of the IPNG subscale II pre-implementation of a unit based shared governance model. Much lower results were reported by George et al. (1997) who used the IPNG to collect data on nurses in a traditional governance structure that identified only nursing management and administration (1) were involved in decisions relating to access of information. Fryar Anderson (2000) found no statistically significant differences when comparing results of the analysis relevant to the IPNG subscale II between nurses of shared governance and non-shared governance groups. Howell et al. (2001) reported results from subscale II that indicated management/administration with some staff nurse input (2) controlled
the activities in this subscale. The results provided by George et al. and Howell et al. indicate similar results using a factor analysis.

It is interesting that CNs perceive the greatest *influence* and *access* to information when consulting hospital services outside of the nursing unit. This emphasizes the ability of the CN to advocate for patient care and collaborate with other professionals for the patient’s benefit. Clearly, creating daily patient care assignments is an integral part of the CNs’ responsibility to ensure appropriate nursing personnel to meet patient care needs and should be the primary responsibility of CNs with some nursing/management input, which would have shown as a rating of (4) in this study. However, with a mean of 3.3 the CNs in this study perceived that this activity is more equally shared by staff nurses and nursing management/administration (3). Consulting nursing services outside the unit is also an area that CNs perceive they have more control over; this is not surprising as nurse-to-nurse referrals that elicit nursing expertise do not require a physician order.

Clinical nurses perceived much less *influence* and *access* in activities including determining staffing assignments (ratio and patient acuity), levels for routine patient care, patient placement and referrals, nursing salaries, support systems, and budgets for resources (personnel, supplies, equipment, and education). These results are similar to those of Tourangeau et al. (2005), Cameron et al. (2004), Spence Laschinger et al. (2001), and Greco et al. (2006) who indicate RNs reported one of the lowest ratings of the nursing practice environment was the ability to participate in decision making, and the inadequacy of influencing staffing and other resources necessary for patient care. Obviously in this study information regarding nurses’ salaries should be accessible to CNs; however, this area is bound by the collective-bargaining contract and therefore CNs cannot influence their salaries at the organizational level.
Although CNs perceived that they had influence and access to some information (M = 2.1), they also perceived a limited ability to influence and access information in areas that affect direct patient care. It is evident that CNs should have influence and access in activities that determine the regulation of patient flow, staffing assignments, communicating with the organization to suggest alternate support systems, and accessing resources which would be recorded as “3” or greater on the 5 point Likert scale. These areas are important to the CNs’ professional practice and directly affect patient safety and quality care. Research (Aiken et al., 2002; Health Canada, 2006a; Tourangeau et al., 2006) reported nurses’ explanations for the deterioration in patient care pointed towards the lack of staffing to meet patient care needs. Clearly organizational efforts aimed at recognizing and valuing CN input in areas that directly affect patient care are linked to enhancing CN control over nursing practice, satisfaction, and recruitment and retention. Previous research (Aiken et al., 2001a; Nedd, 2006; Spence Laschinger et al., 2001; Spence Laschinger et al. (2001); Spence Laschinger, 2004; Tourangeau et al., 2005; Ulrich et al., 2005) confirms the lack of ability for nurses to influence and have access to information that concerns resources like adequate staffing to meet patient acuity demands, and decision making at all levels negatively influencing RN satisfaction. Although CN satisfaction was not explored in this study, the results are similar to Tourangeau et al. (2005) and Cameron et al. (2004) indicating nurses reported their practice environment rated poorly in the adequacy of staffing, resources, and the work environment, negatively affecting RN satisfaction. Qualitative responses related to Organizational Influence.

Clinical nurses were asked in the open-ended questions “how control over their practice could be changed significantly?” The narrative themes supported the need for CNs to have more influence in accessing information and resources, as one participant commented “equipment
placement, D/C times, workloads, staffing levels, charts. More staff inputs with management.
Sick time, workload, overtime – budget issues, cost effective. Surveys, meetings. Team
meetings. Goals for unit.” However, CNs indicated yet again having access to decision making
and activities that affect direct patient care and promote a professional practice environment
were the most important factors in significantly changing the CNs’ control over nursing practice.
As one respondent so eloquently stated regarding control over nursing practice “it could be
changed by allowing the staff RN to have input into appropriate staffing needs for acuity types of
patient on the ward. The staff allocated for each shift for each patient’s needs is determined very
largely by the manager with minimal staff RN input. Bedside nursing, patient needs and acuity
are best assessed by the staff working on a daily basis. There needs to be a representative from
the ward on management and administration issues reflecting a ward.” These results are similar
to those reported in the literature (Spence Laschinger et al., 2001; Spence Laschinger 2004;
Tourangeau et al., 2005; Ulrich et al. 2005).

Included in the narrative responses was an overwhelming concern that quality patient
care and patient safety were being compromised. This theme can be summarized by the
statement of one CN: “Management needs to listen and ‘understand’ that nurses are concerned
regarding patient safety and about nursing safety and legal liability, and not force nurses to
practice in less than a safe manner.” These responses were closely aligned with previous
qualitative research (Spence Laschinger et al., 2001). Spence Laschinger (2004) reported similar
results where RNs perceived a lack of respect that negatively influenced their ability to access
information, support, and resources in the workplace. Health Canada (2006a) reported nurses
from hospital settings commented that inadequate staffing (38%) was a common problem. It is
clear that in this study a summary of the narrative responses indicated CNs perceive resources as
not simply personnel, but the knowledge, skills and education that positions CNs with a form of power in the organization to assist in the control of resources. The narrative responses in this study were not a venue for complaining about workload, but rather an opportunity to emphasize concerns regarding staffing practices, ensuring appropriate unit needs are met and enabling CNs to provide or delegate care accordingly.

It is evident that many of these concerns, including the lack of respect and support CNs perceive, negatively affects their ability to access information and resources in the workplace and have been repeatedly discussed and researched in the literature (Aiken et al., 2001a; Baumann et al., 2001; CNAC, 2002; CHSRF, 2006a, 2006b; Geiger Brown et al., 2004; McGillis Hall, 2003; Spence Laschinger et al., 2001; Tourangeau et al., 2006); however, CNs in this study report they continue to experience a lack of influence and access to resources that affect direct patient care. CNAC (2002) and CHSRF (2006) recommendations include having sufficient numbers of support staff to allow nurses to provide optimum direct care to patients and clients. As illustrated in this research, CNs perceive accessing the necessary resources, including adequate support staff, continues to be a challenge for the CN, making it difficult to provide safe quality patient care. Another CNAC recommendation was to consult, solicit and follow suggestions of the RN enabling them “control over their professional practice decisions” (p. 39). As CNs indicate in this research, it is evident that ongoing collaborative efforts are necessary to incorporate CN suggestions into professional practice decisions. Consulting CNs regarding influence and access to resources that are necessary to meet patient care needs enhances the CNs’ control over nursing practice as well as the organizational recognition and respect of the CN at the policy level.
Clinical nurses perceive some control over nursing practice in certain activities in this subscale; however the results also indicate that this control is, at best, equally shared by staff nurses and nursing management/administration, 3 on the 5 point Likert scale. Of particular importance is a commitment by organizations and CNs to work towards recognizing and valuing CN input in areas that directly affect patient care. Administrators should be encouraged to survey CNs regarding input into decision making at all levels - patient, unit and organization. This is a means of communicating and recognizing the value of the CN. Results from these surveys can direct goal setting facilitating CN input in decision making.

5.4.3 Subscale III: Organizational Recognition

Subscale III, Organizational recognition \( (M = 1.73) \), identifies who has formal authority in the workplace to control practice and influence resources. Lee et al. (2000) provides results of the IPNG analysis \( (M = 2.2) \) which are slightly higher than the overall mean subscale results of this study. George et al. (1997) reported RNs perceived nursing management/administration (1) only had formal authority in this subscale. Fryar Anderson (2000) indicates nurses from a non-shared governance setting had lower mean scores, however the actual mean was not provided. Howell et al. (2001) also provide results leaning to nursing management/administration having the most formal authority with some staff nurse input on some areas of this subscale. Results provided George et al. and Howell et al. indicate similar results using factor analysis data. Clinical nurses in this study perceived they have some influence or formal authority in a variety of procedures including daily patient care assignments, monitoring and obtaining supplies, the flow of admissions and discharges, consulting services both outside of nursing and the unit, generating schedules, and suggesting nurse staffing related to acuity levels. Interestingly the narrative responses contradict the subscale results indicating that the CNs perceive they have less
formal authority and influence in resources pertaining to the above areas. Many CNs indicated that having influence and participating in decision making directly impacted patient safety. Some of their comments focused on the need for management to value their input and experience in decision making in unit and departmental issues affecting patient care including their ability to participate in the policies and procedures surrounding practice issues such as patient load, assignment, and scheduling. One CN described control over practice meant “being able to influence through best practice that which influences my practice i.e. staffing mix, environment...”

Although the results for individual statements from this subscale indicate CNs perceive they have some formal authority and influence in certain areas within this subscale, the overall mean for the subscale remains low, indicating CNs perceive the formal authority and influence continues to lean towards nursing management/administration with some staff nurse input (2) with some areas being equally shared by staff nurses and nursing management/administration (3) in areas affecting patient care issues. It is concerning that CNs perceive they lack ability to determine staffing levels based on fluctuations in patient census and acuity and lack a patient classification system (a workload measurement tool) that assists in determining nursing ratios. Workload measurement tools, although not 100% effective, have been referred to in the literature (CHSRF, 2006a; CIHI, 2001; McGillis Hall, 2003) as an asset in providing CNs concrete evidence of basic nursing tasks to support their decisions concerning staffing, acuity, and resources. Workload evidence reports and provides data sets that inform stakeholders of nurses’ workload issues that ultimately affect patient care. As Buerhaus and Needleman (2000) identify, policy makers are accountable, relevant to the public’s interest, to formulate policies that minimize adverse patient outcomes, improve quality patient care, and improve systems to
support quality patient care. Clinical nurses must conscientiously position themselves, as part of their professional responsibility, to advocate for these types of data tools that will provide evidence regarding workload issues. In addition, CNs indicate limited formal authority to control and influence decision making related to the written policies and procedures that state what nurses can do in direct patient care; the formal authority lies with nursing management/administration with some staff nurse input (2). Clinical nurse input into the policies and procedures relevant to direct patient care, the area of expertise of the CN, would prove beneficial for quality patient care.

Qualitative responses related to Organizational Recognition.

A narrative theme identified by CNs was the lack of formal authority and influence they had in staffing for acuity levels, daily patient assignments, and obtaining supplies. When asked “what limits your control over nursing practice?” one CN commented “acuity, increase with workload. Staffing levels; continuous added practice issues that increase our workload even further. In-services falling short. Lack of support from administration when evaluating nursing practices and appropriate needs.” It is unclear why CNs continue to experience inadequate resources to provide adequate staffing when there is overwhelming evidence within the literature (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Sloane, Lake, & Weber, 1999; CHSRF, 2005, 2006a, 2006b; IOM, 2004; Tourangeau et al., 2006) that confirms inappropriate staff ratios significantly increase the mortality rates of patients and are related to negative CN satisfaction within the work environment. Clinical nurses also commented on the need for a “patient acuity measurement system which would show the types of patients we have on the unit. Maybe then we could be staffed properly for all shifts – not just day shifts.” Nursing workload measurement systems have been utilized to provide concrete assessment of the work
environment however are remiss in measuring fundamentals of nursing including caring, knowledge, education and clinical expertise (CHSRF, 2001, 2006a; McGillis Hall, 2003).

It is clear the dimensions in subscale III require collaborative efforts between CNs and the organizational authority to ensure specific unit needs that facilitate standards of nursing practice and quality patient care are met. As mentioned by one respondent, it requires “working collaboratively with admin, management, physicians, nurses, and other health care professionals to deliver safe, quality care to influence positive patient outcomes. Moving away from hierarchical structure of health care organization i.e. Decision made from “top-down”, with an increase of decision making at level of patient care involving nurses, physicians, OT, PT, pharmacy, etc.” CHSRF (2006b) advocates that staffing plans be “developed at the organization and unit levels in consultation with front-line nurses, using a shared governance model” (p. 3). CHSRF defines shared governance as an organizational process enabling nurses’ control over nursing practice and the ability to influence administrative decisions. The recommendations from CNAC (2002) recognize that a workplace committed to the professional practice environment by involving nurses in decision making at the practice and policy level benefits the employer and patient care practices. It is of particular importance that organizational structures continue to work toward a workplace that recognizes and values the CN in decision making at all levels. As evidenced by the qualitative responses the CNs align themselves closely with the arena they are comfortable and familiar with, educated and competent in, and the most concerned about - issues related to direct patient care.

It is also necessary for CNs to involve themselves in efforts to achieve organizational recognition by exhibiting *formal authority* to control practice and *influence* decision making within the organization. According to Mathews and Lankshear (2003) the *formal authority* that
exists regarding RNs (skill mix, ratios, etc.) resides with the management and needs redistribution allowing RNs (clinicians) authority to direct their professional practice environment. Results from this study are similar to the results (Aiken et al., 2001a; Greco et al., 2006; Spence Laschinger et al., 2001; Spence Laschinger, 2004; Ulrich et al., 2005) that indicate RNs are not provided adequate opportunities to influence or have access to formal power in decisions about the workplace, organization, or patient care. As Aiken et al. (2001a) and Spence Laschinger (2004) report, the lack of recognition and managerial support impedes respect and communication between the organizational structure and CNs, affecting their morale and subsequent ability to provide quality patient care. Cronin and Becherer (1999) found similar results that indicate staff nurse performance is significant in affecting high staff morale and motivating nurses to continue to provide quality patient care.

In order to facilitate organizational recognition, CNs must ensure the organizational structure consults ‘front-line’ nurses to participate in decision making from the unit to policy level. Spence Laschinger (2004) reports the lowest scores by nurses in her study related to structural empowerment are those for access to information and resources. She found the lack of access to information and resources to be significantly related to a negative perception of respect. Health Canada (2006a) also reports a large number of hospital nurses describe a lack of respect from their superiors. In addition Spence Laschinger and Sebastian (2000), Spence Laschinger and Finegan (2005), and Spence Laschinger et al. (2001) report CNs who are supported and encouraged to participate in decision making feel empowered, which is linked to positive feelings of autonomy, control over nursing practice, and decision making within the organization. Therefore, it is important to recognize that efforts directed at enabling the CN formal authority to control practice and have influence in decision making positively affects the
CNs’ professional respect, job satisfaction, and organizational commitment. The ability of the CN to have *formal authority* and participate in decision making empowers nurses at all levels within the organization.

Clinical nurses perceive limited control over nursing practice relevant to the domain of *organizational recognition* which emphasizes *formal authority* in the organization. Clinical nurses require recognition and support of their expertise. Efforts by external bodies such as the SRNA and SUN, who are accountable to the public and the CN, can elevate the recognition and support deserving of the CNs’ expertise and professionalism. Therefore, CNs’ expertise, an element of professionalism, might be further acknowledged by organizational structures and the public stakeholder. Recognizing the importance of CNs having decision making opportunities within the organization is critical to the overall job satisfaction and recruitment/retention of CNs. The value of this is their obvious dedication to quality patient care.

5.4.4 Subscale IV: Facilitating Structures

Subscale IV, *facilitating structures* (*M* = 1.8), determines who participates in committee structures that make decisions in the organization including committees that determine strategic planning and projected budgets and expenses for the organization, nursing department, and unit. The overall results from subscale IV indicate CNs perceive greater *participation* lies with management/administration with some staff nurse input (2). Clinical nurses also perceive shared ability (3) with nursing management/administration to *participate* on some committees particularly related to clinical practice within the unit and nursing department. However, the results from individual statements in this subscale indicate that CNs perceive they have limited ability to *participate* on committees that relate to multidisciplinary professionalism, organizational budgets and expenses, staff scheduling, and strategic planning. Lee et al. (2000)
reported similar results when analyzing the IPNG data in subscale IV ($M = 1.9$). Fryar Anderson (2000) and George et al. (1997) reported IPNG results indicating nurses from a non-shared governance setting had less participation in decision making than nurses in a shared governance structure. As recorded by Howell et al. (2001) nurses reported having more influence moving towards equally sharing access to information and resources with nursing management/administration. There are similar results by George et al. and Howell et al. using a factor analysis of the IPNG. Similar results by Lake and Friese (2006) indicate hospitals that had an unfavorable nurse practice environment (nonmagnet status) also provided nurses a limited opportunity to participate in hospital affairs. Tourangeau et al. (2005) offer similar results to this subscale, as RNs rated the lowest aspect of their nursing professional practice environment was related to the lack of participation in hospital affairs. It is essential, as supported by the literature, (CHSRF 2006a; Green & Jordan, 2004; Page, 2004) that CN participation and influence in policies to determine per shift staffing levels, is an important element of the CNs’ control over nursing practice affecting quality patient care.

Qualitative responses related to Facilitating Structures.

The narrative responses echo the results of this subscale. One individual responded with a lengthy commentary to the question “what limits control over nursing practice in an area that interests you?” by providing this example, “the management style is currently not conducive to participation in decision making. Input is rarely ‘invited’. It takes a lot of my individual energy to provide input Ex. A letter organized and signed by all nursing staff on our unit regarding some concern we had regarding patient care and staff education was sent; No reply received and our unit manager was actually reprimanded for not having her staff follow the ‘appropriate’ process. There is no built in process for staff input that I am aware of. There are no longer committees
with staff nurses on them and there used to be. i.e. nursing procedure committee, Code blue committee, Nursing Audit committee, just to name a few that used to exist with staff RN members included.” Interestingly this CN identifies that she/he is aware of no formal structure, committee, or process that enables CNs to participate in, have representation on, or voice concerns about relevant issues. Clearly organizational structures must establish accessible lines of communication for CNs to “at least” access information, working towards the opportunity for CNs to participate in processes that relate to decision making affecting patient care.

Although control over nursing practice was not defined in this study, when CNs were asked the closed ended question “do you feel you have enough control over nursing practice in your work environment?”, 50% responded that they felt they had no control over nursing practice within their work environment. It is not clear whether that applied to the patient, unit, or organizational level. If this data represents the lack of ability of CNs to practice at the bedside, this is a definite concern. In addition to this, 13% felt they had control over their practice sometimes. Fourteen percent of the participants did not even answer this question and only 25% of CNs felt they did have control over their practice environment. Results from Health Canada (2006a) report indicate in Saskatchewan 29% of nurses perceived having low autonomy. The results from this study are comparable to the study by Manojlovich (2005) on structural empowerment indicating that most nurses continue to experience a lack of participation in decision making in the organizational context of their work environment, which affects the CNs’ professional practice and job satisfaction. Canadian research (Aiken et al., 2001a; Cameron et al., 2004; Greco et al., 2006; Spence Laschinger et al., 2001; Tourangeau et al., 2005) also provides comparable results and identifies that CNs perceive an overall lack of participation in decision making which is the most dissatisfying feature of their jobs. Although this study did not
examine CN satisfaction, it is obvious that CNs limited input or opportunity to participate in decision making can have a negative effect on CN satisfaction.

It is imperative that CNs continue to request participation in decision making at all levels within the organizational structure in order to influence and advocate for patient safety and quality patient care. Establishing a professional practice environment that promotes respect, autonomy, leadership, and control over nursing practice is essential in recruiting and retaining nurses (CHSRF, 2005, 2006a, 2006b; CNAC, 2002). Participation in the decision making processes acknowledges the CNs’ professional attributes within the professional practice environment positively influencing control over nursing practice.

Clinical nurses in this study, the largest group of health care providers, perceive limited control over nursing practice when participating in activities in this subscale. Of particular importance is the lack of control CNs perceive to participate in multidisciplinary professionalism and staff scheduling. Further exploration regarding the implementation of professional practice environments which recognizes CN involvement in decision making at all levels and interdisciplinary collaborative practice, can prove positive for the CN and the organization. Communication of these potential implications is necessary to influence changes in the CNs’ professional practice environment.

5.4.5 Subscale V: Liaison

Subscale V, liaison \((M = 1.9)\), focuses on which group has access to the information and resources that control and support the CNs’ professional practice environment. As indicated by the overall mean of this subscale, CNs perceive they have some input, but nursing management/administration has the most access to information and resources in the activities that control and support the professional practice environment \((2)\). The activities that CNs
perceive they have limited access to include compliance of hospital nursing practice with requirements of surveying agencies, physicians’ and managements’ opinion of bedside nursing practice, nurse turnover and vacancies rates, unit projected budget and actual expenses, hospital’s strategic plans for the next few years, and financial status. Clinical nurses perceived a more shared (3) access to information in areas such as access to resources concerning recent advances in nursing practice, nursing peers’ opinion of bedside nursing practice, and nurses’ satisfaction with their salaries and benefits. Clinical nurses perceived they had some input, but primarily management/administration (2), has access to information regarding results of hospital and nurse satisfaction with clinical practice, nursing department goals, and the quality of nursing practice. Lee et al. (2000) describes a similar overall mean (2.0) on the results of this IPNG subscale. Fryar Anderson (2000) and George et al. (1997) indicate that nurses who do not participate in a shared governance structure have limited participation in control over professional practice. In particular George et al. (1997), provides results that point towards nursing administration/management only (1) having the access and information to control professional nursing practice. Results from Howell et al. (2001) indicate a somewhat different response indicating nurses are gaining more participation shared with management/administration in decision making and committee structures. Comparisons can be made to the results by George et al. and Howell et al. with the data obtained from the factor analysis.

It is concerning that CNs perceive they have limited input in accessing information relevant to the quality of nursing practice and nurse satisfaction with clinical practice. The access to this information lies primarily with nursing management/administration with some staff nurse input (2). It would seem reasonable that this information be highly accessible to CNs
because professional practice evolves around the quality of nursing practice and nurses
satisfaction with clinical practice. If these areas are unsatisfactory then CNs need to know in
order to recommend or implement necessary changes. It is clear that CNs perceive they do not
have control over assessing for or determining their educational needs and incorporating research
ideas into nursing care. Clinical nurses do perceive more access to current resources and recent
advances in nursing practice through journals, books, and library. However this question did not
clearly specify whether this information was acquired at home or at work. There was also no
indication of any internet access for learning at work either. The positive levels in this area might
be the result of the CNs’ individual responsibility and accountability for keeping current with
evidence based research guided by standards of practice. This sometimes self-directed
independence is commonly demonstrated in the quality of nursing practice, nurse satisfaction
with clinical practice, and incorporating recent advances in nursing practice. These values are
closely aligned with and supported by the CNA code of ethics and the SRNA’s standards of
nursing practice. The CN is also responsible to the SRNA for ongoing assessment, planning, and
evaluation of educational needs in order to demonstrate competence in nursing practice.
Although access to information that controls and supports the professional practice environment
might be limited in the work place, CNs are consumers of information that provides them with
resources necessary for quality of patient care.

Qualitative responses related to Liaison.

Although CNs indicated a more shared access to information in these areas when asked
“how control over their practice could be changed significantly?” a relevant theme in the
narrative responses focused on the lack of resources necessary to maintain standards of practice.
As one CN indicated, in order for his/her practice to be changed significantly “there would need
to be a commitment by upper level management to dedicate resources necessary to research and form practice standards. Unfortunately, given the ongoing shortage of nurses, this is likely not going to be possible in the future.” These comments by CNs are similar to those reported by Spence Laschinger et al. (2001) where RNs indicated the lack of resources that support the work environment also decrease the quality of patient care.

It is obvious that the appropriate allocation of resources is crucial for the CN to practice according to the standards of practice set out by the regulatory body and the organizational structure directed towards providing quality patient care. Clinical nurses can find themselves in conflict when standards of practice are not met due to lack of resources; doing more with less is often the “rule” rather than the “exception”. Similar results by Greco et al. (2006), Lake and Friese (2006), McCusker et al. (2004), and Tourangeau et al. (2005) indicated one of the lowest rated scores in the nurses’ work environment was ‘resource adequacy’. Albaugh (2003) stresses that organizational structures should consider strategies to align themselves with the CNs’ value system, which emphasizes quality patient care.

It is concerning that CNs perceive their control over nursing practice is limited in this subscale which is specific to accessing information that controls and supports professional practice. Administrators might focus on implementing professional practice environments that support CNs and positively affect CN recruitment/retention. The administration/management structure must be challenged to recognize and be committed to understanding nursing issues and nursing work environments that emphasize quality patient care and therefore positively contribute to the CNs’ control over nursing practice, satisfaction, and recruitment/retention. It is of particular importance that administrators make efforts to increase CNs access to information.
and these efforts might include the use of email, open forums to stimulate discussion, periodic staff surveys and visible nursing leadership.

5.4.6 Subscale VI: Alignment

Subscale VI ($M = 2.1$), alignment, examines who has the ability to set goals and negotiate conflict at various organizational levels. In most of the areas of this subscale CNs perceive they have limited abilities to be involved with negotiating conflicts between nurses, nursing management, members of the health care team, and physicians. It is not surprising that CNs perceive that their strongest abilities lie with creating a formal grievance procedure, which is in accordance with the SUN contract/collective agreement and enforced by SUN executive members. Lee et al. (2000) report similar results in their analysis of the IPNG tool regarding subscale VI ($M = 2.0$). Fryar Anderson (2000) provides results from her study of a non-shared governance group of nurses indicating they have significantly less ability in these activities within the organization. George et al. (1997) also identify nurses indicated nursing management/administration only (1) have the ability to set goals and manage conflicts. Howell et al. (2001) in their study using the IPNG tool report nurses have a more shared ability to set goals and manage conflict with management/administration. Although the results by George et al. and Howell et al. are describing data from a factor analysis, comparisons provide similar results to this study.

Healthcare reform and organizational restructuring have proven challenging for CNs in many ways. Clinical nurses committed to upholding the standards of practice and advocating for quality patient care may find themselves in conflict with the organizational structure, work environment, regulatory body, and union. Budd, Warino, and Patton (2004) surmise CNs may view collective-bargaining strategies as one of the only effective means for nurses to gain control
over their practice. Clark, Clark, Day, and Shea (2000) propose collective-bargaining is a process allowing professionals the opportunity to demand “the standards of their profession be respected and enforced” (p. 95). These comments provide some insight into the rationale for collective-bargaining. It is unclear why CNs in provincial hospitals in Saskatchewan in this study, who are a 100% unionized, perceive limited or no control over nursing practice within their professional practice environment.

Conflict negotiation at various levels of the organization is a challenging venture. Stakeholders from administration and clinical nursing postulate different priorities and perspectives affecting CNs’ professional practice issues that sometimes make compromise difficult. To date, conflict negotiation continues to be a process that requires effort from all disciplines. Green and Jordan (2004) suggest that engaging nurses in decision making, work redesign and conflict resolution enhances nurse empowerment within the work environment. These authors also suggest that although the concept of collaboration is embedded in conflict resolution, typically nurses have limited skills in this area. It is clear that CNs need knowledge and practice regarding conflict negotiation strategies in preparation for ongoing collaboration, which affects their ability to advocate for and provide quality patient care. Multidisciplinary team members also bring differing perspectives to the table, all seeking a place in the decision making process. It is understandable that all team members recognize the potential benefits in utilizing a multidisciplinary collaborative approach as long as all parties in the decision making process are respected.

*Qualitative responses related to Alignment.*

Promoting collaboration, a theme in the narrative responses, is perceived by some CNs as something that requires further effort. Collaboration is supportive leadership that embraces a
vision, shared by all healthcare disciplines, towards a common goal—in this instance the goal is quality patient care. Although some CNs reported good working conditions, they suggested there was need for improvement in communication, clarification in the accountability and responsibility of physicians, and more support by management in these processes. One CN responded “control over my practice may be changed significantly when the physician who heads our department retires. Your survey deals with nursing management/administration. In our unit, I find nursing management receptive to new ideas/concerns, whereas the medical staff is less receptive and has more control over my practice.”

It is evident that more work needs to be done around improving nurse-physician relationships. This work includes efforts at establishing an environment with mutual respect, trust and professional recognition which ultimately affects quality patient care. Manion and Bartholomew (2004) suggest that developing a sense of community in the workplace with trust and collaboration connects individuals and is a proven workforce retention strategy. The recommendations by CNAC (2002) indicate that collaboration between all stakeholders, employers and unions’ works towards meeting staffing needs in the work environment and also offering flexibility to the individual. It is concerning that CNs perceive limited ability and control over nursing practice in relation to collaborative practice. Administrators need to invest in team development strategies that facilitate collaborative practice to address this concern. Ongoing efforts to understand the organizational structure and accommodate the CNs’ control over nursing practice need a sincere, committed, and collaborative approach. These efforts reap positive results for the organization, the CN, and unmistakably, the patient.
5.5 Discussion of Themes from Qualitative Data

Section three of the survey contained one closed and four open-ended questions that elicited a more personal response to control over nursing practice. There were five questions including: 1. What does control over nursing practice mean to you? 2. How could control over your practice be changed significantly? 3. Do you feel you have enough control over nursing practice in your work environment? 4. What limits your control over nursing practice in an area that interests you? 5. What enables your control over nursing practice in an area that interests you? Responses from these questions were identified as internal (more directly related to the CNs’ ability to provide safe quality patient care – professionalism, CNs’ satisfaction, quality of care, empowerment, and autonomy) or external factors (more distant to the CNs’ control over nursing practice – health care restructuring, organizational influence, work environment models, and nursing leadership) as described fully in Chapter Two. These responses were then examined for themes. The following provides a discussion of the themes from the narrative responses.

5.5.1 - 1. What does control over nursing practice mean to you?

In response to this question the most frequently identified theme, relevant to the internal factors, and described by CN respondents was influence in decision making. Almost three quarters of CNs commented on the importance of being involved or having influence in decision making affecting their control over nursing practice. Health Canada (2006a) report high proportions of nurses in hospitals indicated having a low control over practice. Clinical nurses provided a variety of comments regarding “what control over nursing practice meant to them?” including having input into practice, integrating new practice/policies in the work environment, being involved in both policy and practice, influencing decisions regarding staffing issues, and having input into decisions affecting practice issues. The second theme relevant to internal
factors was related to providing quality care. As described by CNs this was having influence and contributing to decisions regarding staffing levels/mixes, patient placement, and education to ensure quality care. Several CNs indicated that having input into staffing levels and mix was important in providing quality care. The Health Canada data is similar to this study, indicating less than half of the respondents felt staffing in their hospital workplace was sufficient to provide quality care. These findings are also similar to that of Aroskar et al. (2004) where nurse participants identified little or no control over practice. Researchers (Aroskar et al., 2004; Duffield et al., 2004; Spence Laschinger et al., 2001; Takase et al., 2005) have provided evidence that links lack of participation in decision making to a lack of control over nursing practice - part of nurses’ professionalism – leading to an increase in turnover.

Clinical nurses also identified themes relevant to external factors particularly in relationship to the work environment. They described how external factors including influence by management/administration and the SRNA negatively affected control over nursing practice. Many respondents were very specific in their commentaries identifying that management/administration has the control of the CNs’ practice. Research on nurses’ perceptions of workplace empowerment, magnet hospital characteristics and job satisfaction by Spence Laschinger et al., (2003) indicates a supportive management is important to the CNs’ control over practice.

5.5.2 - 2. **How could control over nursing practice be changed significantly?**

Three quarters of respondents provided comments on a well documented theme, relevant to the internal factors that included having influence on and being directly involved with decision making concerning policy, procedures, practice issues, staffing, and educational opportunities that positively affect safe patient care. Over one half of their responses were aimed at changing
the current system that does not provide CNs the opportunity to participate in decision making at many levels. Over one fifth of the responses were directed to changes that would affect the ability of the CN to maintain quality of care. Many nurses indicated that education and improved staffing levels would further benefit their control over nursing practice. This echoes the results of Tourangeau et al. (2005) that reported one of the lowest rated aspects of the RNs’ work environment was adequate staffing.

Respondents identified two themes related to the external factors. There were 20 responses by CNs indicating that less control by nursing management of the CNs’ work environment and 30 responses identifying the need for improved efforts towards collaboration would significantly change the CNs’ control over practice. Embracing a supportive leadership style, an essential strategy for organizational success, fosters individual control over nursing practice through autonomy, and collaboration (Alvarado et al., 2000; Gullo & Gerstle, 2004; Hocker & Trofino, 2003; Kouzes & Posner, 2003a; 2003b; Thyer, 2003; VanOyen Force, 2004).

5.5.3 - 3. Do you feel you have enough control over nursing practice in your work environment?

This closed ended question drew out a more concrete answer from CNs. Thirteen respondents indicated having control over practice sometimes, one quarter of the respondents indicated they did have control over their practice environment; however, one half of the CNs’ responses expressed they did not have enough control over practice in their work environment. The results of the current study mimic those of Ulrich et al. (2005) as RNs indicated they do not feel they have adequate opportunities to influence decision making in the organizational workplace or patient level. Although no definition of control over practice was provided, the
responses to this question certainly indicate CNs perceive a lack of control in their work environment.

5.5.4 - 4. What limits your control over nursing practice in an area that interests you?

Recurring themes, relevant to the internal factors, are evident by the CN responses. These themes include the lack of influence and participation in decision making, particularly staffing issues, and a lack of up to date educational opportunities that limits the ability of the CN to have control over practice. However this question provoked more responses that pointed towards the external factors limiting the CNs’ control over practice in an area of interest. A large number of CNs responses related to themes relevant to the external factors. These themes are identified as a lack of resources and funding, collaboration and work environment. Of these three themes, the work environment and the lack of support from management/administration were identified by CNs as limiting their control over nursing practice. Health Canada (2006a) reported low supervisory and co-worker support was more prevalent in hospital settings, experienced by about one third of nurses and contributes to work stress. Previous research (Aiken Clarke, & Sloane 2000, 2002; Spence Laschinger et al., 2001; Spence Laschinger et al., 2003) confirms that a supportive management structure enables the CNs’ control over nursing practice and positively affects the quality of patient care. There was also strong evidence suggesting CNs interest in collaborating with other disciplines to promote a team approach for patient care. Tourangeau et al. (2005) provide similar results identifying the control and responsibility of nurses’ work environments was the least satisfying aspect of their practice.

5.5.5 - 5. What enables your control over nursing practice in an area that interests you?

Clinical nurses provided responses indicating influence and participation in decision making (internal factors) enabled their control over nursing practice. Most of their comments
were related to autonomy and decision making in direct client care. The request for educational opportunities and resources was seen as a factor in enabling their control over nursing practice in an area of interest. There were also two prevalent themes related to the external factors. These include a supportive and collaborative work environment that enables the CNs’ control over practice in an area of interest. As previously reported (Cameron et al., 2004; George et al., 1997; Mrayyan, 2003; Spence Laschinger et al., 2001; Tourangeau et al., 2005) a supportive and collaborative work culture can be evidenced through CNs influence and participation in decision making enhancing CN professionalism, satisfaction, and specifically control over nursing practice.

5.6 Limitations

There are a number of limitations to this study. The fact that a stamped return envelope was not included with the survey likely affected the response rate. As Polit and Hungler (1995) indicate “failure to enclose a return envelope could have a serious effect on the response rate” (p. 348). Caution must be taken when interpreting the quantitative results of the study due to the low response rate which decreases the ability to generalize the quantitative results. However the qualitative results have provided rich narrative themes and transferability of these themes is likely acceptable. The results from this study pertain to CNs in provincial hospitals and cannot be generalized to the rural hospitals in Saskatchewan. Although comparisons of the study sample population with CIHI (2006) statistics indicate similarities in the demographics of the study population with the overall RN population, sampling error must always be considered. Selection bias may have occurred given the high percentage of CNs that indicated they had certification with the CNA national program. The use of a self reported questionnaire increased
the chance of response-set biases. A limitation to the qualitative self report questionnaire results is the researcher’s subjective categorization of the narrative responses into themes.

5.7 Recommendations

In view of the researcher’s experience with this study, the following recommendations are provided.

1. Research Process

• The SRNA develop and use a consistent research mail out protocol to simplify the collaboration process with the researcher. In view of the low response rate and obvious communication glitch, a formal written framework is suggested to ensure the accurate communication of information necessary to provide an accurate mail out of pertinent information, hopefully reducing the chance of error with mail out protocol. This information will be discussed with the SRNA following completion of this study.

2. Professional Practice Model

• That CNs be supported in their efforts to develop and implement a professional practice model that supports the key elements of a professional practice environment including professionalism, scope of practice and standards of practice. This might include providing resources for CNs to research, analyze, develop, and implement a model of nursing care that supports CNs’ professional practice.

• That CNs continue to advocate and request professional development programs and continuing educational programs that provide information on professional practice models. They can also sequester support from their professional organizations and nursing leaders that have knowledge and expertise in professional practice models. Requesting surveys or information through the SRNA or SUN regarding professional practice environments should be considered.
The regulatory agencies have a vested interest in and focus on patient safety; therefore the professional practice environment and maintaining quality patient care are a priority for them. As Gullo and Gerstle (2004) indicate nurses must “act as change agents” to encourage the health care organization to adopt leadership and professional practice environments that maintain standards of practice (p. 265).

3. *Continuing education and professional development*

   - That CNs be diligent in their requests for ongoing education and professional development opportunities. These opportunities should include a needs assessment by management regarding the educational requirements of CNs. Of importance are the CNs’ identified educational needs, paid education days, confirmed replacements for education days, financial support for conference attendance, and access to resources such as monthly journals, evidenced based research articles, and internet usage.

4. **Workload Measurement Tool**

   - That CNs continue to research, select, develop and/or adopt a workload measurement tool which evaluates staffing practices and ensures appropriate demands of the unit are met enabling clinical nurses to provide care as necessary.

5. **Management Support**

   - That employers, nursing management and administration, and CNs collaborate to adopt a model of professional practice that recognizes and supports CN participation in decision making. Implementation of a professional practice environment is closely aligned with the recruitment/retention of the CN and safety of the patient.
6. *Intra-Facility Collaboration*

- Provincial hospitals should explore internal initiatives that foster CN professional practice environments with a focus on communication and collaboration between nursing management/administration and interdisciplinary professionals. Efforts directed at interdisciplinary collaboration have a positive impact on CN satisfaction, recruitment/retention and most importantly, safe patient care.

5.8 *Future Research*

The results of this study have led to the following recommendations for future research in this area.

1. Replication of this study ensuring the inclusion of the return envelope in the survey package would be beneficial in examining survey response rate and perhaps the ability to generalize the results of this study.

2. Replication of this research study using the IPNG tool and applying it to specific units in each of the five provincial hospitals to provide further information regarding CN perceptions of control over practice.

3. Future research to include the use of focus groups to discuss control over nursing practice in their particular area. This would enable identification of challenges that CNs face to be acknowledged, addressed and supported in the literature and perhaps allow for necessary interventions to follow.

4. Increasing CN presence at all levels of decision making and measuring patient, nurse, and systems outcomes.

5. Pre and post implementation study of a professional practice model to determine any significant results related to the CNs’ control over nursing practice.
6. Research regarding the ongoing changes in health care restructuring and the impact on the CN.

5.9 Conclusion

Health care restructuring has created many ongoing challenges within the CNs’ work environment directly affecting the CNs’ participation and influence in decision making particularly relevant to patient care issues. Although clinical decision making was not explored in this study the researcher acknowledges that through nursing judgements, an internal locus of control, CNs are making decisions minute by minute and hour by hour, that significantly affect patient safety, health, and well being. This study looked at CNs involvement in decision making from a broader perspective pertinent to individual patient care. This mixed method descriptive survey design examined CNs’ perceptions of their work environment including control over nursing practice. Control over nursing practice was explored using the internal factors, more closely related to the CNs’ influence regarding (professionalism, satisfaction, quality of care, autonomy, and empowerment) and the external factors which are more distant to the CNs’ influence (health care restructuring, organizational influences, work environment models, and nursing leadership). Clinical nurses described they have limited influence and or participation in decision making from the patient, unit, and administrative levels that has negative results related to CN satisfaction, retention/recruitment, organizational culture, and patient outcomes. Overall, CNs perceive control over their nursing practice is held by management/administration. Study results offer government officials, practitioners, regulatory bodies, researchers, administrators, educators, nurses, the public, professional associations, employers, unions, and any other stakeholder’s information that increases their awareness and understanding of the impact that
control over nursing practice has for CNs in their practice environment. Ultimately, this affects the CNs’ professionalism and ability to provide quality patient care.
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Appendix A

Cover Letter
Dear Colleague,

My name is Cheryl Brunoro. I am a graduate student in the College of Nursing at the University of Saskatchewan. As part of the requirement for completing the Masters in nursing program I am conducting a survey of clinical nurses in Saskatchewan. I am hoping for your participation in the research study that is looking at “Clinical nurses and who governs their practice environments including control over practice”. The supervisor for this study is Dr. Marlene Smadu.

As clinical nurses in the acute care centers, you have a vital role in fostering quality professional practice environments for your professional practice, colleagues and also the care of your patients. In this study I am hoping to identify the perceptions of clinical nurses within the five provincial hospitals in Saskatchewan about who you think governs the practice environment including control over practice.

Your contribution in the study is strictly voluntary, but I encourage you to participate. It is imperative at this time that clinical nurses provide information about who governs their practice environment including the bedside, the unit, administration and political levels. The study will not benefit you individually but rather will offer insight into a perspective that the clinical nurses have in provincial hospitals in Saskatchewan about their control over practice. If you choose not to participate, your decision will have no consequences to you. The questionnaire will take you approximately 20 minutes and does not require your identification at any time. Anonymity is assured. There are no foreseeable risks associated with you participating in this study. Completion of the questionnaire assumes consent to participate. Please complete the questionnaire by December 20th, 2005.

The use of a paper survey excludes any identifying data that would compromise confidentiality. The surveys for each of the five provincial hospitals are different colors in order to facilitate sorting of responses by hospital. However, the surveys are not numbered and individual nurses cannot be tracked. Data collected will be analyzed using ANOVA statistical program. All data will be stored by the research supervisor. The results of the study will be published as a report for a Masters thesis and will be summarized for publication in professional journals and or conference presentations and also available through the University of Saskatchewan Research Services.

Your participation is greatly appreciated. You may contact the Research Ethics Office at 306-966-2084 if you have any questions about your rights as participants. If you have any questions please do not hesitate to contact my supervisor (Marlene Smadu) or myself at the following numbers.

Yours truly,

Cheryl Brunoro
1036 Aird St.
Saskatoon, SK
SRN 0T1
306-384-7645
cherylshome@shaw.ca

Professor Marlene Smadu
College of Nursing
University of Saskatchewan
marlene.smadu@usask.ca

Office of Research Services
University of Saskatchewan
Box 5000 RPO University
Saskatoon, SK
S7N4J8
306-966-2084
http://www.usask.ca/research
Appendix B

Survey Questionnaire
The purpose of this questionnaire is to learn how you, as a clinical nurse, perceive who governs the professional practice environment including control over practice. There are right or wrong answers.

The questionnaire is composed of three sections. Please answer all of the questions as they are all applicable to your clinical practice.

For most of the questions you simply need to check the number on the questionnaire as to who you believe governs the professional practice environment based on the scale that has been provided.

Your confidentiality is maintained during and after the results of the study are posted. There is no way your participation in this study can be identified.

Thank you for your participation.
**PROFESSIONAL NURSING GOVERNANCE**

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

1. Sex: Male ___ Female ___
2. Age: __________

3. Please indicate your BASIC nursing educational preparation:
   - Nursing Diploma ___
   - Baccalaureate Degree in Nursing ___

4. Please indicate the HIGHEST educational degree that you have attained at this point in time:
   - Nursing Diploma ___
   - Master’s degree, Non-nursing ___
   - Baccalaureate Degree in Nursing ___
   - Doctorate, Nursing ___
   - Doctorate, Non-nursing ___
   - Master’s Degree in Nursing, Specialty ___

5. Employment Status:
   - Full-time, 35-40 hours per week ___
   - Part-time, less than 36 hours per week (specify number of hours per week): ___

6. Please specify the number of years that you have been practicing nursing ___

7. Please indicate the title of your present position ___

8. Please indicate the type of nursing unit that you work on:
   - Medical ___
   - Surgical ___
   - Critical Care ___
   - Operating Room ___
   - Recovery Room ___
   - Emergency Room ___
   - Clinic ___
   - Other (Please specify): ___

9. Please specify the number of years you have worked in this institution ___

10. Please specify the number of years you have been at this present position ___

11. Have you received any specialty certifications from professional organizations? ___ YES ___ NO
    If YES, please specify the type of certification and year received ___

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

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

**PART I**

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

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

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

## PART II

<table>
<thead>
<tr>
<th>Activity</th>
<th>Influence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Determining how many and what level of nursing staff is needed for routine patient care</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>15. Adjusting staffing levels to meet fluctuations in patient census and acuity</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>16. Making daily patient care assignments for nursing personnel</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>17. Monitoring and procuring supplies for nursing care and support functions</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>18. Regulating the flow of patient admissions, transfers, and discharges</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>19. Formulating annual unit budgets for personnel, supplies, equipment and education</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>20. Recommending nursing salaries, raises and benefits</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>21. Consisting nursing services outside of the unit (e.g., administration, psychiatric, medical-surgical)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>22. Consisting hospital services outside of nursing (e.g., dietary, social services, pharmacy, human resources, finance)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>23. Making recommendations concerning other departments' resources</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>24. Determining cost-effective measures such as patient placement and referrals (e.g., placement of ventilator-dependent patients, early discharge of patients to home health care)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>25. Recommending new hospital services or specialties (e.g., gerontology, mental health, birthing centers)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>26. Creating new clinical positions</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>27. Creating new administrative or support positions</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

## PART III

<table>
<thead>
<tr>
<th>Activity</th>
<th>Influence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Written policies and procedures that state what nurses can do in direct patient care</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>29. Written patient care standards and quality assurance/improvement programs</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>30. Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>31. Written process for evaluating nursing personnel (performance appraisals)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>32. Organizational charts that show job titles and who reports to whom</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>33. Written guidelines for disciplining nursing personnel</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>34. Annual requirements for continuing in-services</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>35. Procedures for hiring and transferring nursing personnel</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>36. Policies regulating promotion of nursing personnel to management and leadership positions</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>37. Procedures for generating schedules for RNs and other nursing staff</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
### PROFESSIONAL NURSING GOVERNANCE

| 38. Acuity and patient classification system for determining how many and what level of nursing staff is needed for routine patient care | 1 2 3 4 5 |
| 39. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity | 1 2 3 4 5 |
| 40. Procedures for determining daily patient care assignments | 1 2 3 4 5 |
| 41. Daily methods for monitoring and obtaining supplies for nursing care and support functions | 1 2 3 4 5 |
| 42. Procedures for controlling the flow of patient admissions, transfers, and discharges | 1 2 3 4 5 |
| 43. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education | 1 2 3 4 5 |
| 44. Procedures for adjusting nursing salaries, raises and benefits | 1 2 3 4 5 |
| 45. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical) | 1 2 3 4 5 |
| 46. Formal mechanisms for consulting and enlisting the support of hospital services outside of nursing (e.g. dietary, social service, pharmacy, physical therapy) | 1 2 3 4 5 |
| 47. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass) | 1 2 3 4 5 |
| 48. Location of and access to office space | 1 2 3 4 5 |
| 49. Access to office equipment (e.g. phones, personal computers, copy machines) | 1 2 3 4 5 |

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

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

### PART IV

| 50. Participation in unit committees for clinical practice | 1 2 3 4 5 |
| 51. Participation in unit committees for administrative matters such as staffing, scheduling and budgeting | 1 2 3 4 5 |
| 52. Participation in nursing departmental committees for clinical practices | 1 2 3 4 5 |
| 53. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting | 1 2 3 4 5 |
| 54. Participation in multidisciplinary professional committees (physicians, other hospital professionals and departments) for collaborative practice | 1 2 3 4 5 |
| 55. Participation in hospital administration committees for matters such as employee benefits and strategic planning | 1 2 3 4 5 |
| 56. Forming new unit committees | 1 2 3 4 5 |
| 57. Forming new nursing departmental committees | 1 2 3 4 5 |
| 58. Forming new multidisciplinary professional committees | 1 2 3 4 5 |
| 59. Forming new hospital administration committees | 1 2 3 4 5 |
### Professional Nursing Governance

In your hospital, please circle the group that has ACCESS TO INFORMATION about the following activities:
1. Nursing management/administration only
2. Primarily nursing management/administration with some staff nurse input
3. Equally shared by staff nurses and nursing management/administration
4. Primarily staff nurses with some nursing management/administration input
5. Staff nurses only

### Part V

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

### Part VI

75. Negotiate solutions to conflicts among professional nurses
76. Negotiate solutions to conflicts between professional nurses and physicians
77. Negotiate solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, etc.)
78. Negotiate solutions to conflicts between professional nurses and nursing management
79. Negotiate solutions to conflicts between professional nurses and hospital administration
80. Create a formal grievance procedure
81. Write the goals and objectives of a nursing unit
82. Write the philosophy, goals and objectives of the nursing department
83. Formulate the mission, philosophy, goals, and objectives of the hospital
84. Write unit policies and procedures
85. Determine nursing departmental policies and procedures
86. Determine hospital-wide policies and procedures
Section I: Basic Demographic Data

Section II: Clinical Nurses’ Perceptions of who governs the practice environment

Section III: Clinical Nurses’ feelings of control over practice within the practice environment

1. What does control over practice mean to you?

2. How could your control over practice be changed significantly?

3. Do you feel you have enough control over practice in your work environment?

4. What limits your control over practice in an area of interests you?

5. What enables your control over practice in an area that interests you?
Appendix C

University of Saskatchewan Ethics Approval
The University of Saskatchewan Behavioural Research Ethics Board has reviewed the Application for Ethics Approval for your study "Clinical Nurse Perceptions of Who Governs the Professional Environment Including Control over Practice in Provincial Hospitals in Saskatchewan" (05-190).

1. Your study has been APPROVED SUBJECT TO THE FOLLOWING MINOR MODIFICATION(S):
   - Please ensure that all data is stored by the research supervisor. This should be stated in the information letter.
   - Please revise the information letter to include a statement acknowledging that the participants may contact the Research Ethics Office at 306.966.2984, if they have any questions or concerns about their rights as participants. The contact information provided for the Office of Research Services is incorrect.

2. Please send one copy of your revisions to the Ethics Office for our records. Please highlight or underline any changes made when resubmitting.

3. The term of this approval is for 5 years.

4. This letter serves as your certificate of approval, effective as of the time that the requested modifications are received by the Ethics Office. If you require a letter of unconditional approval, please so indicate on your reply, and one will be issued to you.

5. Any significant changes to your proposed study should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

6. This approval is valid for five years on the condition that a status report form is submitted annually to the Chair of the Research Ethics Board. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions: http://www.usask.ca/research/behavsc.shtml

I wish you a successful and informative study.

[Signature]

Valerie Thompson, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Office of Research Services, University of Saskatchewan
Room 1007, 110 Gilmour Hall, Box 6000 RPO University, Saskatoon SK S7N 4J8, CANADA
Telephone: (306) 966-6576 Facsimile: (306) 966-6577
http://www.usask.ca/research
Appendix D

Reminder Postcard
Hello, this is a reminder that you have been invited to participate in a survey about clinical nurses and who has control over your practice environment. Please complete the survey by January 15, 2006.
I encourage you to participate but remind you that your participation is strictly voluntary.
As clinical nurses in the acute care centers, you have a vital role in fostering quality professional practice environments for your professional practice, colleagues and also the care of your patients.
Thank you,

Cheryl Brunoro
Appendix E

Apology Letter
December 3, 2005

Dear Nurses:

This information is forwarded to you in addition to the recent survey sent to you by the Saskatchewan Registered Nurses Association. The title of the survey is “Clinical nurses and who governs their practice environments including control over practice”.

Please find the enclosed self addressed stamped envelop for you to return your questionnaire to the researcher, Cheryl Brunoro.

I would like to apologize for this oversight in neglecting to send the self addressed stamped envelope to you for your perusal. If you have already discarded the survey and would still like to participate please call the SRNA and request another survey be sent to you. As stated in the previous cover letter your contact at the SRNA is Linda Harcourt (Director of Finance and Administration), toll free number 1-800-667-9945 or info@srna.org.

Regards,

Cheryl Brunoro
1036 Aird St.
Saskatoon, SK
S7N 0T1
Appendix F

University of Saskatchewan Ethics Status Report Form
In the field of clinical research, maintaining ethical standards and regulatory compliance is crucial. The University of Saskatchewan Research Ethics Board (Behavioural) elevated the importance of ethical oversight, particularly concerning clinical nurse perceptions of who governs the professional environment, including control over practice in provincial hospitals in Saskatchewan. This status report, submitted on August 8, 2006, was prepared by Dr. Marlene Smidt and supervised by Cheryl Brunoro, a Masters Student. The title of the study was "Clinical Nurse Perceptions of Who Governs the Professional Environment Including Control over Practice in Provincial Hospitals in Saskatchewan." Dr. Smidt and Brunoro undertook this study to assess the perceived governance structures within the workplace, focusing on the professional environment of nurses. The study's brief summary noted the recruitment and data collection period from December 2005 to January 2006, with a target enrollment of 1815 nurses. The actual number of contacts through the Saskatchewan Registered Nurses Association was 1816, and 172 surveys were returned, indicating a high rate of participant engagement. The alignment of the study's completion date was in January 2006 with ongoing data analysis expected to conclude in April 2007. The study also emphasized the importance of ethical considerations in the project's implementation, ensuring the well-being of research participants and the integrity of the study's findings.

Cheryl Brunoro's involvement in this project was further highlighted by the submission of an annual status report, as stipulated by the REB. This report was due within one month of the anniversary date, ensuring continuous ethical oversight. The submission of an annual status report is pivotal in maintaining the validity of the ethics certificate, which could be automatically invalidated if not submitted by the required date. This emphasizes the importance of diligence in adhering to ethical and regulatory guidelines.