

THE RELATIONSHIP OF ORGANIZATIONAL CLIMATE
TO QUALITY OF NURSING CARE IN
THE CRITICAL CARE UNIT

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our supervision by _____ Quie K. Branum, R.N., B.S.N. _____

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_____ in the Critical Care Unit _____

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CHAPTER I

INTRODUCTION

Just as certain atmospheric climates are conducive to the growth of a particular plant or tree, so certain organizational climates are conducive to the exhibition of particular behaviors. This climate is the collective personality of the group and either fosters or inhibits certain behaviors within the group. Organizational climate is affected by leadership style, structure and size of the organization, group goals, sophistication of personnel, procedures and equipment, communication and conflict and has an effect on job satisfaction and job performance.

Nurses within critical care units are a highly specialized group of people working under a great deal of pressure with the latest developments in equipment to care for acutely ill patients. Many nurses are aware of the effects of the atmosphere in which they practice although they may have difficulty identifying what factors make it easier to work in one unit than another. They describe feelings of being accepted or constantly supervised or appreciated although they cannot seem to pinpoint why they felt that way. Nevertheless, they behave in

response to the cues that they get from the atmosphere in which they work.

This study seeks to describe some representative critical care unit organizational climates and correlate them with the quality of nursing care in the unit. By identifying the climates associated with good and bad nursing care, perhaps nursing can begin to foster atmospheres in which high quality nursing care will be promoted and poor quality nursing care will be inhibited.

STATEMENT OF PROBLEM

Does the organizational climate within a critical care unit have an effect on the quality of the nursing care?

PURPOSES

1. To compare three critical care units to determine whether the unit with the most "open" organizational climate has higher quality nursing care than the others
2. To identify an organizational climate(s) that is conducive to high quality nursing care
3. To identify dimensions of the organizational climate that may be manipulated in order to improve or enhance the quality of nursing care

BACKGROUND AND SIGNIFICANCE

People do not operate in a social vacuum; the greater part of their lives is spent within organizations and institutional settings as members of groups. These groups are dynamic with changing memberships, goals, and functions. They are made up of individuals who, for one reason or another, have come together to accomplish something. The group's values and those of the individual members become one as the group progresses. Patterns of behavior and communication develop. Certain members arise as leaders and/or exercisers of authority. Conflicts arise and are resolved, or smoulder and flare from time to time. A type of group identity arises that attracts others of a like mind.

Katz and Kahn (1967) state that system theory is basically concerned with problems of relationships, of structure, and of interdependence rather than with constant attributes of objects. They describe two basic procedures for identifying social systems and determining their function: (1) trace patterns of energy exchange, and (2) ascertain how the output is translated into energy. They continue:

. . . all social systems, including organizations, consist of the patterned activities of a number of individuals. Moreover, these patterned activities are complimentary or interdependent with respect to some common output or outcome (Katz and Kahn 1967, p. 12).

They describe nine characteristics of an open system:

(1) Importation of energy -- raw material to be used; energetic input

(2) Transformation of the energy -- work processes

(3) The output -- patient care

(4) Cycles of events -- routines, accepted approaches of treatment (repetition does not have to involve identical act but may include similar activities directed toward the same goal)

(5) Negative entropy -- a reversal of the natural tendency to dissipate energy without replacement

(6) Information input -- negative feedback, and coding process

(7) The steady state and dynamic homeostasis -- preservation of the character of the organization while allowing for growth and expansion within the system

(8) Differentiation -- multiplication and elaboration of roles and specialization

(9) Equifinality -- more than one means of achieving the same end

Conceptualizing the critical care unit using Katz and Kahn's nine characteristics of an open system provides a method for evaluating the interaction of the group on the output which is patient care. Staff and equipment are both very important in the specialized world of critical care; they, along with patients, are the potential energy of the system (the energetic input/raw material) that must be coordinated and transformed into the output which is patient care; the product, goal, and purpose of the group. This energy must be replenished and restored to maintain the system. The success or quality of the output feeds back to influence the availability of energetic input/raw material or to propagate the system. Therefore, anything that affects the system's energetic input or energy transformation affects the outcome which is patient care, and anything that affects patient care in turn affects energetic input and energy transformation.

The setting in which this open system operates has its own peculiar culture or climate. This climate has been compared analogically to atmospheric climate. Just as the meteorological climate is made up of dimensions such as sunlight, rain, and wind velocity, so organizational climate is made up of dimensions such as autonomy, reward, and warmth (Hellriegel and Slocum 1974). In 1964, Forehand

and Gilmer reviewed the current organizational climate literature and defined organizational climate as:

A set of characteristics that describe an organization and that (a) distinguish the organization from other organizations, (b) are relatively enduring over time, and (c) influence the behavior of people in the organization (p. 362).

In studying the organizational climate of schools, Halpin (1966) reported on his eight-dimensional, sixty-four item Organizational Climate Descriptive Questionnaire (OCDQ) that enabled him to identify six types of organizational climates. The climates were ranked in respect to openness vs. closedness. Margulies (1965) modified the OCDQ to fit any situation and subsequently used it to measure the relationship between organizational climate and job satisfaction.

There are few studies available that have applied any organizational climate research to nursing although Lyon and Ivanavich (1974) used registered nurses in their study. There are tools and studies measuring performance of nursing both on the individual (Wandelt and Stewart 1975) and collective (Wandelt and Ager 1974) levels. Quality of nursing care then is a measurable dimension of patient care. By studying the effect of organizational climate on the quality of nursing care being delivered to patients, nursing can begin to learn why nurses exhibit certain work

habits; and what conditions promote the highest quality nursing care. The atmosphere in which nursing is practiced may be a determinant of what is practiced.

HYPOTHESIS

The quality of nursing care in a critical care unit is directly proportional to the openness of the organizational climate in which it is practiced.

DEFINITIONS

1. Organizational Climate -- "a set of characteristics that describe an organization and that (a) distinguish that organization from other organizations, (b) are relatively enduring over time, and (c) influence the behavior of people" (Forehand and Gilmer 1964)

2. Quality of Nursing Care -- the degree to which accepted standards are met through the delivery of patient care by nurses

3. Nurses -- Registered nurses who have current experience and may also have had special education in the care of critically ill patients

4. Critical Care -- "care of the acutely or critically ill patient who requires constant or almost constant nursing attention with the utilization of multiple nursing skills" (Wandelt and Ager 1974, p. 74).

5. Nursing Care -- the deliberate action taken by nurses to meet the patient's biological, psychological, sociological, cultural, and spiritual needs

6. Critical Care Unit -- a physical space set aside for the care of seriously ill people containing specialized sophisticated equipment and specially trained and educated nurses and physicians

7. First Level Staff Nurse -- "a nurse who, traditionally, is charged with responsibility for providing care that is safe, adequate, therapeutic, and supportive for meeting the nursing care needs of the patients. One who, purportedly, is prepared for her responsibility by one of the programs of nursing education that prepared individuals for state licensure as registered nurses" (Wandelt and Ager 1974, p. 45)

LIMITATIONS

The measurement of the quality of patient care may have been limited by the potential desire of the nursing staff to make their performance meet the projected expectations of the rater. It may have further been limited by unconscious bias of the observer.

DELIMITATIONS

This study was limited to:

1. Registered nurses working full time as staff nurses in the selected critical care units
2. The eight dimensions of measurement and six types of organizational climates described by Halpin (1966)
3. Critical care units of six beds or more

ASSUMPTIONS

It was assumed that:

1. An organizational climate exists within a given critical care unit that can be perceived and described
2. People behave in response to cues they perceive from their environment

OVERVIEW OF CHAPTERS

Chapter I describes the characteristics of an open system and defines organizational climate, and presents the purposes and rationale for the study. Chapter II elaborates on both open system theory and organizational climate. Support is offered for using quality of nursing care as a measure of job performance. Chapter III describes the setting, population, and the two tools, Wandelt and Ager's Quality Patient Care Scale and a modified Organizational

Climate Descriptive Questionnaire. Chapter IV compares the nursing care and climate variables in the three critical care units. Chapter V offers a summary, conclusions, and implications derived from the analysis of Chapter IV and makes recommendations for further studies.

CHAPTER II

REVIEW OF LITERATURE

Open System Theory

Open system theory described by Katz and Kahn (1967) grew out of a need for a framework from which social scientists could systematically study human organizations. A host of psychological, sociological, cultural, and socio-economic theories were proposed to understand and explain events, phenomena, and effects of human organizations. Some theories such as Behaviorism, Field theory, and Freudian theory applied individual characteristics to organizations and fell short of the total picture that included structure and environment. Others such as Marx, Weber, and Durkheim studied structure and made their theories too general or too specific to study systematically a broad group of organizations. Katz and Kahn (1967) point out that prior social scientists tended to describe organizational structure in terms of common goals or physical laws making them closed systems. These closed systems ignored environmental effects and individual differences or regarded them as constants.

Open systems are characterized by cycles of events. The system itself is a cycle made up of self closing cycles.

The overall system is dynamic and propagates itself through an input-transformation-output-feedback-input cycle (Figure 1).

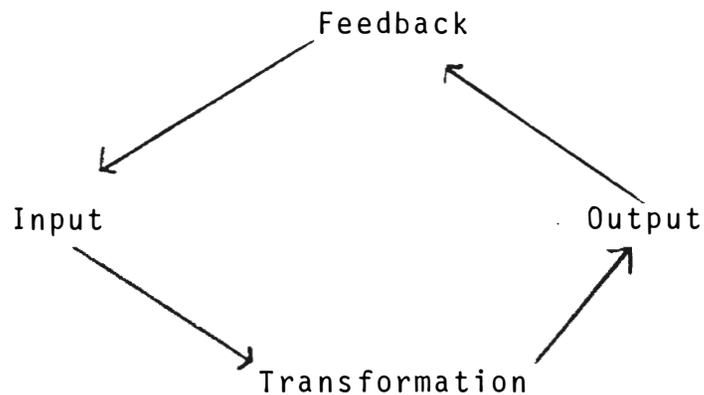


Figure 1. Cycles of events

Cycles of activities act as boundaries for the organization. Many times, difficulty arises in defining the boundaries of an organization, particularly when no physical boundaries exist. Therefore, repeated patterns of activity identify an organization and define the realm in which it operates. These activities do not have to be identical, but represent usual or expected responses to input that achieve expected outcomes. These are the processes of the organization.

The second concept essential to the understanding of open system theory is that of Negative Entropy. "The general law of entropy states that any system will tend to run down, lose its differentiated structure, and become one with its environment" (Katz and Kahn 1967, p. 68). The general law of entropy parallels the second law of thermodynamics that states heat will dissipate until a state of equilibrium is reached. If an object is heated above room temperature and the source of heat is removed, the object will give off heat decreasing its own temperature and raising the temperature of the room until equilibrium is reached. Negative Entropy is the process by which the system continues to function. This process is accomplished through acquisitive and extractive mechanisms. The system is able to acquire or import new energy in the form of raw material/energetic input from the environment. It then extracts the maximum benefit from that raw material in producing the best possible output. The quality of the output then affects the quality and availability of acquirable raw material. Just as entropy leads to dissipation and equilibrium, Negative Entropy leads to polarization, i.e., better and better or worse and worse (Figure 2). In the latter case, negative entropy breaks down and the system dissipates.

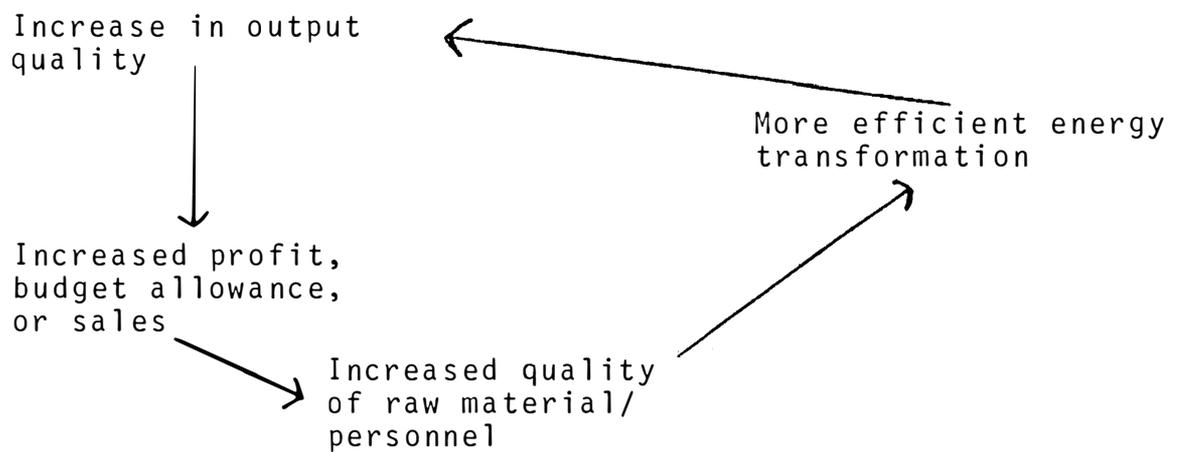
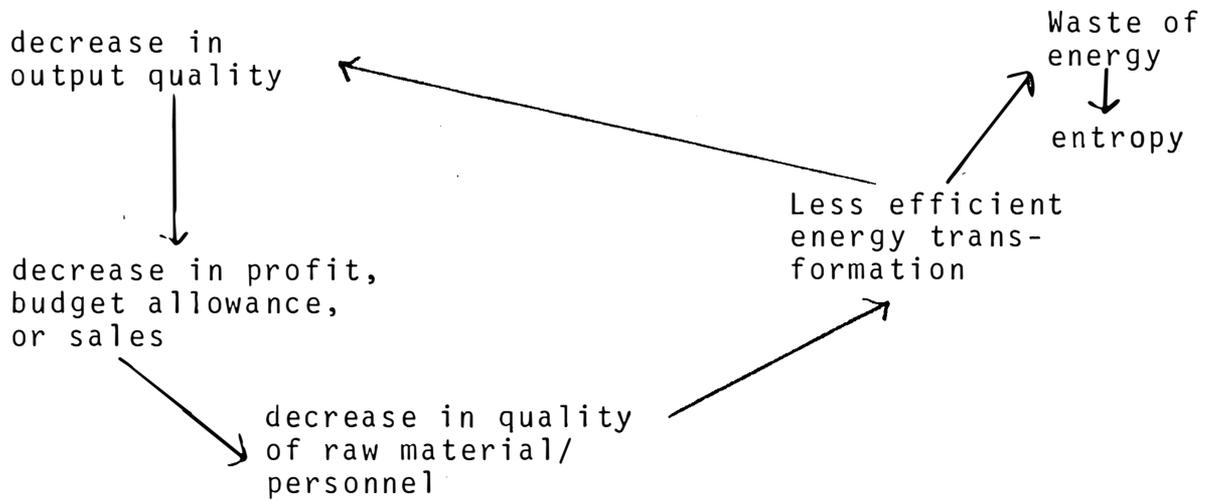


Figure 2. Polarization in negative entropy

Fortunately, the cycles of entropy do not function in a vacuum, but are interrelated with feedback and activity cycles. The processes of information input, negative feedback and coding screen the effect of the environment on the system to some extent. Not all information in the environment is important, essential, or beneficial to the system; therefore, there are coding processes that analyze, store, and use cues from the environment.

Cycles of events, feedback systems, and negative entropy all work together to maintain a "steady state" or "dynamic homeostasis." The basic idea in this steady state is preservation of the character of the system. It is a dynamic process just as the name indicates. The system adapts to its environment by ingesting or acquiring control over external forces. The system tends to grow by multiplication of similar systems rather than enlarging the system, that is, a change in quantity rather than quality.

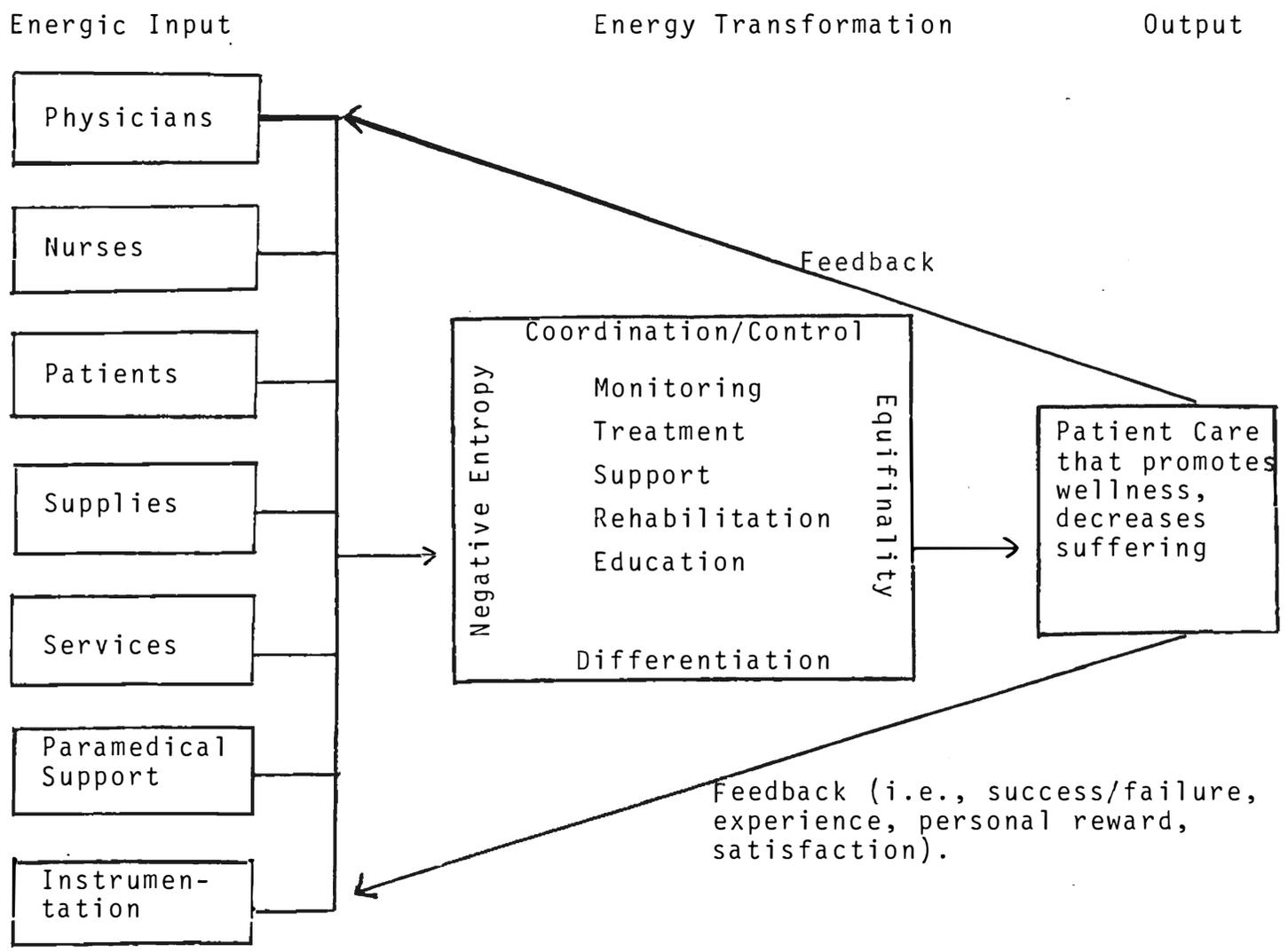
Open systems move in the direction of differentiation and elaboration. "Diffuse global patterns are replaced by more specialized functions" (Katz and Kahn 1965, p. 25). One aspect of differentiation is progressive mechanization. Processes and activities become more specialized and there is increased sophistication and division of labor.

One final characteristic of open systems is that of equifinality. This principle states that systems can reach the same final state from differing initial conditions and varying pathways. Equifinality allows for individuality among groups or organizations who are seeking the same goal.

The Critical Care Unit
as an Open System

Figure 3 represents the critical care unit as an open system. Physicians, nurses, patients, specialized equipment and services are the raw material of the system that is transformed into the patient care output. No two critical care units are precisely the same; they differ in complexity, procedures, and size, yet they all have the common goal of high quality patient care during catastrophic illness or injury (equifinality). Critical care units are characterized by highly trained and educated staff and sophistication of equipment; many are research oriented (differentiation). The system is able to import new raw material from the environment and transform it; feedback, in the form of success or failure of treatment and procedures, experience, and reward affect the availability of raw material. When a shortage of raw material (nurses, physicians, patients, etc.) occurs, the unit is able to continue

Figure 3. Open system conceptualization of critical care unit.



operation until the shortage is relieved (negative entropy).

The Concept of Organizational Climate

Organizations do not function in vacuums, therefore theories proposed to study organizations must also study the environment in which the system functions. Social theories that study organizations in terms of their internal structure without considering their external environment are seeing organizations as closed systems and thereby limit the understanding of organizations (Emery and Trist 1960).

Open system theory . . . would maintain that environmental influences are not sources of error variance but are integrally related to the functioning of a social system, and that we cannot understand a system without a constant study of the forces that impinge upon it (Katz and Kahn 1965, p. 27).

Within the study of environmental effects on organizations and organizational behavior, a great deal of research has been done on organizational climate. Forehand and Gilmer (1964) reviewed the current literature of their time on organizational climate. They identified two approaches to the study of climate: (1) examining behavior in contrasting organizations (comparative studies), and

(2) studying the effects of changing conditions in a single organization (longitudinal studies). Regarding the collection of data, they continue:

Measures based on perception have advantages in research convenience, and may have theoretical meaning in their own right, but in such a measure characteristics of the individual and the organization are confounded (Forehand and Gilmer 1964, p. 365).

Thus arises one of the ongoing conflicts on organizational climate; that is, should organizational climate be measured objectively or subjectively? Are the dimensions best measured by an objective outsider or are they purely the perceptions of the members of the organization? Halpin (1966) stated that whether or not a climate perceived by the faculty to be "open" is really "open" is irrelevant. If they feel it is "open" then it is. Maynard (1974) concluded that the way in which employees view their work environment is more a function of that environment than of the personal frames of reference which they bring to the work situation.

There have been several fairly complete reviews of the research in Organizational Climate (Forehand and Gilmer 1964; Guion 1973; James and Jones 1974; Hellriegel and Slocum 1974; Schneider 1975). All seem to agree that there is very little that anyone can conclude from the available

research except that there is still no agreement as to what organizational climate means, how to measure it, what to measure, or how to classify what has been measured. Some (Johanesson 1973; James and Jones 1974) question whether climate needs to be measured at all; they say perhaps the concept of organizational climate is just another measurement of job satisfaction.

This disagreement as to whether organizational climate and job satisfaction are the same has been proven unfounded (LaFallette 1974) and was never really accepted by some (Schneider 1975). Hellriegel and Slocum (1974) differentiate the two by saying that organizational climate is descriptive and job satisfaction is evaluative.

Halpin and Croft's Taxonomy of Climates

The most defined and replicable approach to the study of organizational climate was originated by Halpin and Croft (Halpin 1966) to describe and classify the climates of different school systems. Their Organizational Climate Description Questionnaire (OCDQ) was later modified for use in settings other than schools (Margulies 1965) and has been used for several studies (Margulies 1965; Newton and Margulies 1969; Lyon and Ivanovich 1974).

Halpin and Croft (1966) were the first to describe a taxonomy of climates and set up dimensional criteria that make up each climate. With this taxonomy of climates, a variety of settings and variables could be compared using a common denominator. They measured eight dimensions:

1. Disengagement -- the teacher's tendency to be "not with it" . . . focuses on the teacher's behavior in task oriented situations.
 2. Hindrance -- routine busy work that hinders rather than facilitates work.
 3. Esprit -- morale.
 4. Intimacy -- the teacher's enjoyment of friendly social relations with each other.
 5. Aloofness -- behavior by the principal characterized as formal or impersonal.
 6. Production emphasis -- highly directive, close supervision.
 7. Thrust -- role modeling by principal.
 8. Consideration -- principal's inclination to treat teachers "humanly."
- (Halpin 1966, pp. 150-151)

Using computerized factor analysis of the items in the OCDQ, the dimensions were arranged to characterize six organizational climates ranging from open to closed. Hall (1972, pp. 586-587) presents them clearly in Table 1.

Halpin (1966) and Margulies (1965) give descriptions of conditions found in each of the six climates.

1. The open climate is characterized by high morale and minimal bickering among staff. The superior

TABLE 1
HALPIN AND CROFT'S SIX ORGANIZATIONAL CLIMATES

<u>Climate</u>	<u>High</u>	<u>Average</u>	<u>Low</u>
Open	Espirit Thrust Consideration	Intimacy	Hindrance Disengagement Aloofness Production Emphasis
Autonomous	Espirit Intimacy Aloofness Thrust	Consideration	Disengagement Hindrance Production Emphasis
Controlled	Hindrance Production Emphasis	Thrust Aloofness Espirit	Disengagement Intimacy Consideration

Familiar	Disengagement Intimacy Consideration	Thrust Espirit	Hindrance Aloofness Production Emphasis
Paternal	Disengagement Production Emphasis	Thrust Consideration	Hindrance Intimacy Espirit Aloofness
Closed	Disengagement Hindrance Aloofness Production Emphasis	Intimacy	Consideration Thrust Espirit

acts as a role model rather than make minute rulings for staff to follow. The superior is friendly and considerate of staff. It is unnecessary for him to push production or closely supervise staff because they produce easily and freely.

2. The autonomous climate is again characterized by high morale and minimal bickering. The superior acts as a role model but has little direct contact with the staff. The staff tends to be very close and socializes with each other away from work. There are few rules and routine busywork.

3. In the controlled climate there is a lot of routine busywork to occupy the staff and at the same time, a push from superiors to produce. Morale is neither good or bad and the staff may not have a lot of contact with the immediate superior. Gripping is at a minimum but so is socialization among staff and consideration of staff by superiors.

4. In the familiar climate there is much gripping and disagreement. The staff is close personally and superiors are considerate of staff. Morale is moderately high and there are few rules and more role modeling by superior. There is minimal busywork, and the superior associates with staff without pushing them to produce.

5. The paternal climate is characterized by a staff that does not work well together. The superior's behavior is non-genuine as he attempts to satisfy the staff's social needs and fails to control them. The superior's behavior is so non-aloof that it is intrusive. His consideration is oversolicitous rather than genuine concern for the staff.

6. The closed climate is marked by poor morale and motivation among staff. The superior is aloof and impersonal sending down a multitude of rules to control the staff rather than setting an example. There is a great deal of busywork and minimal job satisfaction.

These vignettes of the six organizational climates have characterized Halpin and Croft's (1966) findings. Each is defined in terms of the eight measurable dimensions.

Organizational Climate and Job Performance

In studying organizational climate, researchers have attempted to correlate it with organizational structure (Lawler et al. 1974; Hellriegel and Slocum 1974), job satisfaction (Lyon and Ivanovich 1974; Friedlander and Margulies 1969; Tatro 1974; LaFollette 1974), job performance (Dyer 1972; Lawler 1974; LaFollette 1974), and motivation (Litwin and Stringer 1968). In a recent review of current

research on organizational climate, Schneider (1975) discusses the work of M. D. Dunnette and concludes that "performance equals ability and a climate which stresses the display of individual differences" (Schneider 1975, p. 457).

$$\text{Performance} = \begin{array}{c} \text{Personal Ability} \\ + \\ \text{Open Organizational Climate} \end{array}$$

Lawler and Hall (1974) report that the perceived organizational climate is significantly related to measures of organizational performance. Hellriegel and Slocum (1974) report nine studies which show a significant relationship between organizational climate and job performance. They also point out that this relationship is poorly understood. Frederickson (1966) indicates that the consistency of the climate, that is, the more polarized it is (loosely supervised vs. closely supervised) the higher the organizational performance. Inconsistent climates were associated with lower performance. In studying organizational climate and nursing performance, Dyer et al. (1972, p. 294) state:

Sources of variation in performance and, thereby, nursing care of patients can arise from the attributes nurses bring to the work situation or from the characteristics of the working environment.

If quality of nursing care is to be the measure of performance for nursing, then a tool or tools designed to

measure quality must be developed. Lindeman (1976) summarizes some of the current developments in nursing quality measurement. She states that there are currently tools that measure structure, process, and outcome. She cautions against generalizing from one area to another. In other words, against assuming good outcomes mean good process or conversely that good process means good outcomes. Hegyvary and Hausman (1976) studied the relationship between nursing process and patient outcomes and concluded that inconsistent relationships indicated a need for continued assessment of both process and patient outcomes for nursing. Katz and Kahn (1967, p. 4) state:

There are shortcomings, however, in the very limited generalizations which can be derived from dealing with outcomes rather than the dynamic processes responsible for the outcomes. This type of treatment [outcome] approaches a closed system conceptualization in that the human inputs are ignored or regarded as constants.

Hegyvary and Hausman (1976) go on to point out that although structure and outcome are related to nursing process, only nursing process is a measure of the nursing care provided. Measurements of nursing process then can be equated with job performance in nursing.

Nursing Correlates of
Organizational Climate

A few studies have been done relating organizational climate or climate dimensions to nursing and nursing care. Lyon and Ivanovich (1974) reported that nurses had more job satisfaction and performed better as nurses when there was a minimum of routine work (low hindrance) and a high degree of autonomy (high thrust). Funkhouser (1971) reports a significant correlation between high morale (high esprit) and high quality nursing care. He goes on to say that when pettiness, jealousy, and competition as to who is the best nurse (high disengagement) occupy the attention of the nurses, nursing care suffers. Hegyvary (1974) studied organizational climate and patient care outcomes but did not attempt to conclude what aspects of climate were responsible for variations in patient care outcomes.

In these studies, four climate dimensions are associated with high quality nursing care, low hindrance, low disengagement, high esprit, and high thrust. Table 1 (p. 22) shows that these four correlates of high quality nursing care are found only in the two most open climates (open and autonomous). Based on the findings of these studies and the descriptions of the six organizational climates (Halpin 1966), one could predict that the more

open the organizational climate, the higher the quality of nursing care.

In summary, the critical care unit is characterized as an open system demonstrating cycles of activities that represent the processes of the organization. These nursing processes are equated with job performance and measure one dimension of the system output which is patient care. Halpin and Croft's (1966) taxonomy of climates provides a representation of organizational climate that can be coupled with quality of nursing care and compared between units to determine whether or not a more open climate fosters a higher quality care.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Setting

The setting for this study was the critical care units of three private teaching hospitals in a large metropolitan city. All three units were combined medical-surgical units and did not include coronary care. Bed capacity of the units ranged from ten to fifteen beds. An example of the agency permission form is shown in Appendix A.

Population

The population was composed of the full-time staff nurses (RN) who work in each of the units. The sample consisted of at least 30 percent of the total population in each unit. Six patients from each unit were selected by a convenience sampling method in order to evaluate the quality of nursing care in the unit. The staff in Unit C represented the temporary combination of two critical care units. For the purpose of this study, staff nurses from the other unit were considered to be float or temporary nurses working in the host unit.

The organizational climate of the unit ordinarily located in that geographical area was measured. No attempt was made to evaluate patients who specifically had nurses from this unit assigned to them. Each staff nurse was asked to sign a copy of Texas Woman's University's Form A Written Presentation to Subject (Appendix B) to indicate their willingness to participate in the study. These forms were collected separately from the questionnaires to protect the participants' anonymity.

Tools

Measurement of organizational climate was accomplished by use of a modified Organizational Climate Description Questionnaire (Margulies 1965). (See Appendix C). This modified version has already been used successfully in a hospital situation with registered nurses (Lyon 1974).

The original Organizational Climate Description Questionnaire (OCDQ) was developed by Halpin and Croft (Halpin 1966, pp. 145-155). They decided first to determine the dimensions they felt described organizational climate in public schools. They prepared a Likert-type test with a number of simple descriptive statements. Respondents were asked to indicate to what extent the statements described their school. A bank of 1,000 items was

built through testing, primarily with Form III, 71 elementary schools and 1,151 respondents, a final Form IV of 64 items was conceived. Form IV was submitted to factor analysis and eight dimensions of organizational climate were identified. The items were then assigned to a subtest that corresponded to each dimension. Four subtests (Disengagement, Hindrance, Esprit, Intimacy) applied to teacher behavior. The four other subtests (Aloofness, Production Emphasis, Thrust, Consideration) referred to the principal's behavior.

In his study, Newton Margulies (1965, pp. 72-77) desired to use Halpin and Croft's taxonomy of climates, but he felt the wording of many, if not all, of the items in the OCDQ were inappropriate for any setting other than a school. He interviewed employees in a sample industrial firm in the San Fernando Valley area to develop the changes in the original items as well as creating some new items which would be compatible with the framework and dimensions of the original OCDQ.

In order to determine whether or not the 'new' questionnaire was capable of (1) discriminating between several possible climates, and (2) yielding a reasonable consensus within a defined organizational setting, a pilot study was done in four departments of an organization and

profiles were computed. Two judges classified the departments according to Halpin and Croft's six descriptions. The judges' classifications were correlated using the rank correlation method. The correlation coefficient was 0.94 indicating reasonable correlation.

For the purposes of this study, Margulies' OCDQ was modified further by the substitution of the word "nurse" or "staff nurse" for employee; the word "headnurse" for "supervisor" and "department manager"; the word "unit" for "department": and "hospital" for "company" when appropriate.

Another page was added to the OCDQ to collect certain demographic information from each respondent such as age, education, experience, and length of time of employment in this unit, professional memberships, marital status.

The quality of nursing care was measured with the Quality Patient Care Scale (Qualpacs) devised by Wandelt and Ager (1974). A copy of the Qualpacs is shown in Appendix D.

The Quality Patient Care Scale (Wandelt and Ager 1974) is a list of sixty-eight items describing actions taken by nursing personnel as they provide care for an individual patient. Each item is evaluated on a scale from one to five or, "poorest care" to "best care."

The items are grouped into six categories according to scientific and sociocultural bases. The six subsections are:

- I - Psychosocial: Individual -- Actions directed toward meeting psychosocial needs of individual patients.
- II - Psychosocial: Group -- Actions directed toward meeting psychosocial needs of patients as members of a group.
- III - Physical -- Actions directed toward meeting the physical needs of patients.
- IV - General -- Actions that may be directed toward meeting either psychosocial or physical needs of the patient or both at the same time.
- V - Communication -- Communication on behalf of the patient.
- VI - Professional Implication -- Care given to patients reflects initiative and responsibility indicative of professional expectations (Wandelt and Ager 1974, p. xi).

The Quality Patient Care Scale (Qualpacs) measures the quality of patient care received by patients in any setting where nurse-patient interactions occur. It has proven valuable in the collection of data regarding the current status of patient care, in preparation for planning, and in instituting changes in patient care delivery.

Qualpacs was tested for reliability by several means. The first was interrater agreement. Evidence for interrater agreement was drawn from three studies: one at

Harper Hospital, Detroit; one at a midwestern university hospital; and one in connection with a cancer care project conducted in a Detroit hospital. Reliability of internal consistency was measured by an estimate of Kuder-Richardson reliability which computed item, subscale, and total score analysis. Evidence of stability reliability was obtained in the Harper study when one rater observed and evaluated five patients on two consecutive days and produced a correlation of .98 for the two days.

To test validity, eight supervisors and directors at Harper Hospital were asked to rank-order the twenty-one wards at Harper in terms of quality of care given on the wards. Using the Spearman-Brown formula, the reliability of the eight judges was estimated to be .56. Correlation with Qualpacs was .52.

Data Collection

A modified version of the OCDQ (Margulies 1965) was distributed to the full-time staff nurses (RN) in each of the selected critical care units. The questionnaires were self-administered on the nurses' own time and collected by the researcher. A cover letter accompanied the OCDQ explaining briefly the purpose of the questionnaire and instructions for its use.

In administering the Qualpacs, six patients were selected from the census of each unit; Unit B had an average census of six patients; therefore, all patients in the unit were used. Unit A had thirteen patients on its census. Patients in the even numbered rooms were used. In Unit C the average census was also thirteen and the odd numbered rooms were used. Two patients were evaluated on each of the three scheduled shifts. The observer sat in a strategic area of each patient room so that visual and audible observation of each interaction between nurse and patient was possible. Each interaction was then evaluated on a scale from one to five according to the items listed in the Qualpacs. Prior to administration of the Qualpacs, a copy of "A Fact Sheet About Qualpacs" (Wandelt and Ager 1974, pp.80-81) (Appendix E) was distributed to the headnurse of the unit to be shared with the staff nurses on all three shifts. In addition, before and after administration of the Qualpacs, the observer answered any questions from patients and staff.

The three units were designated A, B, and C. The organizational climate dimensions for Unit A were then correlated with the Qualpacs score for Unit A. The procedure was then repeated for Unit B and Unit C. Relationships

between climate dimensions and quality of nursing care were then identified.

Treatment of Data

The modified OCDQ was evaluated to determine item and subtest means. The subtest mean scores grouped the dimensions to indicate the relative closedness or openness of the organizational climate within the individual critical care units. The Qualpacs was evaluated to determine item, subtest, and overall means. The test means for each patient were then averaged to assign a numerical value to the nursing care on each unit.

In summary, the nursing care for eighteen patients, six patients from each of three critical care units was observed using the Qualpacs (Wandelt and Ager 1974). From these observations, a numerical score was derived assigning value to the quality of the nursing care delivered there. This value was then compared to the organizational climate dimensions in the unit as measured by a modified version of the OCDQ (Halpin and Croft 1966).

CHAPTER IV

ANALYSIS OF DATA

Raw scores for each item and dimension as well as overall scores for both tools were subjected to mean evaluation. Means were reported for comparison collectively for all three units and individually for comparison within and between groups. Dimensions of the Qualpacs were compared between groups using the Kruskal-Wallis one-way analysis of variance (Siegel 1956).

In evaluating the data collected by the Qualpacs, the first step was to rank the three units by their overall scores. It was necessary to determine (1) whether or not there was a difference in the quality of the care delivered by each unit; and (2) if that difference was significant. Table 2 shows that there was a difference in the scores that allowed ranking. However, the Kruskal-Wallis analysis indicates a $p < .20$ or no significant difference in the overall quality of the nursing care given in each of the three critical care units. No attempt was made to assign an absolute value reflecting good or bad nursing care. The units were compared relatively, the highest number indicating best care.

TABLE 2
 OVERALL MEANS AND RANK ORDER
 FOR EACH UNIT

Unit	Overall Mean	Rank
A	3.89	2
B	3.82	3
C	4.25	1

Table 3 reports the means for each dimension of the Qualpacs for each unit. In comparing each of the dimensions between units, the only significance was in communication. Unit B was scored very significantly lower in communication than either Units A or C. The item consistently receiving the lowest scores was "#57--Well developed nursing care plans are established and incorporated into nursing assignments." Standard care plans were written and available, but there was little or no evidence that they were being incorporated into nursing care assignments or being consulted on any regular basis. This phenomenon was observed to some extent in the other units as well.

In all three units, two of the lowest scores were for items in the General and Professional Implications dimensions. These two dimensions contain items that

TABLE 3
COMPARISON OF QUALPACS DIMENSION MEANS
BETWEEN UNITS

Variable	Unit A	Unit B	Unit C
Psychosocial	4.07	4.15	4.24
Physical	4.26	4.25	4.54
General	3.48	3.59	3.71
Communication	4.19	3.46	4.34
Professional Implications	3.55	3.63	3.92
Overall	3.89	3.82	4.25

evaluate individualization of nursing care and evaluation and adjustment of planned care in response to changes in patient needs. It was observed that when standard care plans were used, there was no individualization for special patient needs. In many instances, privacy was at a minimum. Although this may be a consequence in some cases of the need for constant direct observation, many times it is unnecessary. Families were not consistently involved or consulted in planning or implementing nursing care. Care plans and cardexes reflected little or no adjustment other than medication changes as patients progressed. Verbal or written evidence of insight into deeper or psychosocial needs of

critical care patients was not readily available. Upon questioning individual nurses, some were able to identify needs or problems for individual patients, but there was no written evidence of nursing care designed to meet those needs.

Due to the high degree of sophistication of equipment and procedures that are routine in critical care and the highly dependent state of most of the patients, one might predict that the physical care dimension might receive the highest score. This prediction holds true in this case; however, care must be exercised in generalizing, as many have done, that critical care units are oriented toward giving physical care and neglecting the person who is receiving the care. There was no significant difference between the scores for the physical and psychosocial dimensions. The observation that there was a lack of evidence of individualization of nursing care spanned both physical and psychosocial aspects of care.

In evaluating the data from the OCDQ, each of the sixty-four items was assigned to the appropriate dimensions from their random arrangement on the tool. A mean score for each dimension was then determined for each of the three critical care units. A mean of 6-7 was considered high; 3-5 as average; and 1-2 as low. The spread of means

was compared with Table 1 (p. 22) in order to determine the organizational climate for each unit.

Table 4 indicates the mean scores for each of the units as well as a cumulative look at all responses without regard to the unit each subject worked in.

TABLE 4
OCDQ DIMENSION MEANS

Dimension	Unit A	Unit B	Unit C	Overall
Disengagement	4.33	3.53	4.93	4.32
Hindrance	3.63	3.12	4.43	3.92
Esprit	4.26	4.4	3.77	4.14
Intimacy	4.27	5.41	5.08	5.24
Aloofness	3.24	3.02	3.14	2.96
Production Emphasis	4.19	4.72	4.58	4.45
Thrust	4.62	4.43	3.96	4.36
Consideration	4.38	3.4	3.48	3.85

Since all the dimension means fell into the center or average designation of the scale, they could not be grouped into climates. Using the χ^2 one variable case or "goodness-of-fit" technique, it was determined that there was no significant difference between the dimension means

for each sample unit and the overall means derived from evaluating all responses without reference to the unit the subjects came from. Bohn (1972) states that "the closer a sample mean is to the population mean, the more reliable (the better estimate) it is" (p. 24). This would indicate that although the data does not support or reject the stated hypothesis, the sample size in each case was adequate for collecting reliable data.

The demographic data (Table 5, Appendix F) indicates similarities among the individuals not only in each unit, but across unit boundaries. Seventy-nine percent of the nurses were thirty years of age or younger; 75 percent had diplomas or a B.S.; 82 percent had attended a critical-care course; 79 percent had attended at least one workshop; 93 percent were female; and working in the unit was the primary source of income for 72 percent of them.

The three critical care units A, B, and C were ranked in order of the relative quality of the nursing care they delivered. This difference in quality was proven to be insignificant using the Kruskal-Wallis analysis of one-way variances. Due to the grouping of the climate dimensions along the middle of the scale, they could not be sorted into the defined organizational climates for comparison. Comparison of the climate dimension means to the

overall means using the "goodness-of-fit" technique indicated that the data was reliable and there was no significant difference between the unit means and the overall means. The demographic data indicates a high degree of homogeneity among the staff nurses in each of the three units.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Nurses have indicated that there was some as yet undefined variable(s) operating within a particular nursing unit that influenced their performance within that unit. This study has sought to define that variable as organizational climate or the "atmosphere" that nursing is practiced in. The purposes of the study were to: (1) compare three critical care units to test the hypothesis that the quality of the nursing care delivered (performance) is directly proportional to the relative openness of the organizational climate; (2) identify an organizational climate(s) that is conducive to high quality nursing care; and (3) identify dimensions of organizational climate that may be manipulated in order to improve or enhance the quality of nursing care.

The Qualpac was used to evaluate the quality of nursing care and a modified version of the OCDQ was used to measure organizational climate. Six patients were selected from each critical care unit; two for each shift. Nurses were asked to voluntarily complete the OCDQ and return it to a central location in the unit. There was no significant difference in the quality of nursing care delivered in each

of the three units or in the mean values for the climate dimensions.

Conclusions

Evaluation of the collected data indicates:

1. There is no significant difference in the organizational climate of the three units
2. No specific organizational climate as defined in this study can be identified in any or all of the three units
3. There is no significant difference in the quality of nursing care delivered in either of the three units
4. Demographic data reflect a very homogeneous population
5. Although the sample size in each unit is small (30%-40% of N), it reliably reflects the whole

In reflecting on the purposes of this study, it would appear that those purposes were not met. It was impossible to compare the units in such a way that could test the hypothesis since climates could not be identified as to relative openness vs. closedness, nor could one unit's nursing care be considered significantly better than another.

Secondly, since none of the overall Qualpac scores even approached the "Best Care" category of 5 on the scale, it would be inaccurate to say that the "climate" identified by this study is conducive to high quality nursing care.

Finally, since all the climate dimensions fell within a narrow mid-range, it was not possible to identify specific dimensions that perhaps could be manipulated to improve or enhance nursing care quality. There was no evidence to support or reject the results of previous studies that associate high esprit, high thrust, low disengagement, and low hindrance with high quality nursing care (p. 27).

Implications

These findings cause several questions to arise:

1. Is nursing different enough from education and business that the climate variables are different

2. Are the climate variables appropriate, but a tool specifically designed for nursing is necessary to accurately measure them

3. Is performance (quality of nursing care) more dependent on the individual attributes the nurse brings with her to the unit than the atmosphere she works in (p. 25)

4. Does climate have the same significance among health professionals as it does in education and business

5. Is there perhaps a "critical care" climate that can be identified in other geographic areas as well as between units which are not so homogeneous

These questions imply that not enough is understood about either nursing or organizational climate and certainly not of the relationship between the two. Nursing in critical care is practiced within an organizational setting and the nurses themselves are a subgroup subject to the same organizational variables as any group with a common goal. It is logical to assume then that they would also respond to the same basic cues as other members of other groups in similar situations. More study needs to be done in nursing using the principles and theories of organizational psychology in order to identify aspects of nursing which can be used to improve nursing and encourage qualified practitioners to remain active in nursing.

Recommendations

It is recommended that the following study be conducted: That this study be repeated using a less similar population varying the type of agency as well as the type of critical care unit; i.e., CCU, Thoracic, Neuro.).

This would be a pivotal study from which other studies could be based depending on the results. If the results are similar to those in this present study, then the idea of a common critical care climate could be pursued. If the new study is significantly dissimilar, then perhaps the purposes of this study might be explored in greater depth.

APPENDIX A

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO _____

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date _____

Signature of Agency Personnel

Signature of student

Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

Appendix B

TEXAS WOMAN'S UNIVERSITY

(Form A -- Written presentation to subject)

Consent to Act as a Subject for Research and Investigation:

(The following information is to be read to or read by the subject):

1. I hereby authorize Kay Branum
 (Name of person(s) who will perform
 procedure(s) or investigation(s))

to perform the following procedure(s) or investigation(s):
 (Describe in detail)

A modified version of the Organizational Climate Description Questionnaire (OCDQ) will be distributed to the full-time staff nurses in each of the three Critical Care Units. This questionnaire makes statements that may or may not describe your Critical Care Unit. Please read each statement carefully and mark your agreement or disagreement at the side. There is no correct answer or best atmosphere. Take the questionnaire home with you and complete it on your own time away from the pressures of the unit. When you have completed it return it to the unit where it will be collected. DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE.

2. The procedure or investigation listed in Paragraph 1 has been explained to me by Kay Branum.
 (Name)
3. I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts:
 (Describe in detail).

There should be no risk for any individual involved since the information to be collected is of a group or collective nature rather than individual. The agency may be distressed at any rating of nursing quality that is less than acceptable but the agencies are not to be identified in the study. With both the organizational climate questionnaire and the Qualpacs, there is no way to retrieve

TEXAS WOMAN'S UNIVERSITY

(Form A -- continuation)

3. I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:

This study offers a chance to look at the atmosphere in which nursing is practiced to determine whether or not the atmosphere affects the nursing process.

4. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

Subject's signature

Date

(If the subject is a minor, or otherwise unable to sign, complete the following):

Subject is a minor (age _____), or is unable to sign because:

Signatures (one required)

Father

Date

Mother

Date

Guardian

Date

APPENDIX C

DEAR STAFF NURSE:

MANY NURSES HAVE COMMENTED THAT THE ATMOSPHERE IN WHICH THEY WORK HAS A GREAT DEAL TO DO WITH HOW WELL THEY WORK AND HOW MUCH THEY FEEL THEY HAVE ACCOMPLISHED BY THE END OF THE SHIFT. ESPECIALLY AS CRITICAL CARE NURSES, WE WORK UNDER SPECIAL DEMANDS AND PRESSURES. THIS STUDY SEEKS TO INVESTIGATE THE PROPOSITION THAT OUR WORK ENVIRONMENT AFFECTS THE QUALITY OF THE NURSING CARE WE GIVE.

THIS QUESTIONNAIRE MAKES STATEMENTS THAT MAY OR MAY NOT DESCRIBE YOUR CRITICAL CARE UNIT. PLEASE READ EACH STATEMENT CAREFULLY AND MARK EACH ONE AS FOLLOWS:

STRONGLY AGREE
AGREE QUITE A LOT
SLIGHTLY AGREE
NEITHER AGREE OR DISAGREE
SLIGHTLY DISAGREE
DISAGREE QUITE A LOT
STRONGLY DISAGREE

THERE IS NO CORRECT ANSWER OR BEST ATMOSPHERE. THIS STUDY ONLY SEEKS TO DETERMINE WHETHER OR NOT A DESCRIBABLE ATMOSPHERE, "ORGANIZATIONAL CLIMATE," EXISTS; AND WHETHER OR NOT THERE IS A RELATIONSHIP BETWEEN THAT ATMOSPHERE AND THE QUALITY OF THE NURSING CARE THAT IS DELIVERED.

PLEASE TAKE THE QUESTIONNAIRE HOME WITH YOU AND COMPLETE IT ON YOUR OWN TIME AWAY FROM THE PRESSURES OF THE UNIT. IT WILL TAKE ABOUT 10-15 MINUTES TO COMPLETE. A BOX WILL BE AVAILABLE IN AN AREA DESIGNATED BY YOUR HEADNURSE FOR YOU TO RETURN THE QUESTIONNAIRE. PLEASE RETURN THE QUESTIONNAIRE AS SOON AS POSSIBLE.

1. The headnurse shares new ideas with her staff nurses.
2. The headnurse explains reasons for criticism.
3. The headnurse goes out of her way to help staff nurses.
4. Nurses interrupt each other in group meetings.
5. The headnurse contacts staff nurses every day.
6. Staff nurses leave the company grounds whenever possible.
7. Nurses in this department keep to themselves.
8. The headnurse runs the group meeting in a formal way.
9. Nurses talk about their personal life to other nurses.
10. There is a minority group of nurses who always oppose the majority.
11. The headnurse uses constructive criticism.
12. Staff nurses go about their work with great vim, vigor, and pleasure.
13. Group meetings are mainly management report meetings.
14. The headnurse helps staff nurses settle any differences.
15. The headnurse tries to get better salaries for her nurses.
16. Nurses seek special favors from the headnurse.
17. Nurses spend time after work with other nurses who have problems.
18. The headnurse talks a great deal.
19. The headnurse makes all work-related decisions.
20. Nurses socialize together in small select groups.
21. The morale of nurses in this unit is high.
22. The headnurse corrects the mistakes of staff nurses.
23. The headnurse sets an example by working hard herself.
24. Group meetings are organized with a strict agenda.
25. Nurses know the family background of other nurses.
26. The headnurse helps staff nurses solve personal problems.
27. The headnurse ensures that staff nurses work to their fullest capacity.
28. Nurses exert group pressure on non-conforming workers.
29. Nurses work together when doing routine duties.
30. Nurses have fun socializing together during working hours.
31. The headnurse encourages staff nurses to improve their weaknesses.
32. The headnurse stays after work to finish any uncompleted work.
33. Routine duties interfere with our primary jobs.
34. Nurses usually eat lunch by themselves.
35. Nurses ask senseless questions in group meetings.
36. The mannerisms of nurses in this department are annoying.

Item Number	Strongly Agree	Agree Quite a Lot	Slightly Agree	Neither Agree or Disagree	Slightly Disagree	Disagree Quite a Lot	Strongly Disagree
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
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34							
35							
36							

37. The headnurse exchanges ideas with staff nurses.
38. Nurses in this department have a good deal of loyalty.
39. Staff nurses are informed of the reasons for a supervisor's visit.
40. The headnurse looks out for the personal welfare of staff nurses.
41. Assistance from other units is readily available when needed.
42. Nurses prefer to work by themselves.
43. Extra materials are available for job use.
44. The headnurse is usually well prepared at group meetings.
45. There is considerable laughter when nurses gather informally.
46. Sufficient instruction is available for the operation of equipment.
47. Too much time is spent in meetings.
48. The headnurse is easy to understand.
49. The headnurse checks on the capability of all staff nurses.
50. Administrative paper work is burdensome in this hospital.
51. The rules set by nursing service are never questioned.
52. Sufficient time is given to prepare administrative reports and nurses' notes.
53. Procedures in this hospital are bothersome.
54. Supplies are quickly available.
55. Nurses in this unit talk about leaving the hospital.
56. The headnurse does personal favors for her staff nurses.
57. In group meetings there is the feeling of "let's get things done."
58. Nurses help select jobs to be worked on and patient assignments.
59. Nurses invite other nurses to visit them at home.
60. Nurses ramble when they talk in group meetings.
61. Most nurses accept the faults of their co-workers.
62. The headnurse is on the job before the other nurses arrive.
63. Staff nurses' closest friends are other nurses of this unit.
64. The headnurse schedules work for all nurses.

Item Number	Strongly Agree	Agree Quite a lot	Slightly Agree	Neither Agree or Disagree	Slightly Disagree	Disagree Quite a lot	Strongly Disagree
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
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55							
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57							
58							
59							
60							
61							
62							
63							
64							

1. Age: _____ 20 - 25 _____ 31 - 35 _____ 41 - 45
 _____ 26 - 30 _____ 36 - 40 _____ 46 or over
2. Education: (check as many as apply)
 _____ A.D. _____ Diploma _____ BSN _____ MS
 _____ Other (specify)
3. Years of nursing experience:
 _____ less than 1 _____ 4 - 6 _____ 10 - 20
 _____ 1 - 3 _____ 7 - 10 _____ more than 20
4. Years of critical care unit experience:
 _____ less than 1 _____ 4 - 6 _____ 10 or more
 _____ 1 - 3 _____ 7 - 10
5. Have you attended a critical care course: _____yes _____no
6. Have you attended any workshops or conferences as
 participant? _____ teacher or leader? _____
7. Do you belong to any professional organizations?
 _____yes _____no
8. If yes, specify: _____
9. Sex: _____ M _____ F
10. Marital Status:
 _____ Single (never married) _____ Divorced
 _____ Widowed _____ Separated _____ Married
11. Is your income a second income for your family?
 _____ yes _____no

APPENDIX D

**QUALITY PATIENT CARE SCALE
INFORMATION FACE SHEET**

Patient	Unit
Name _____	Name _____ Type _____
Record # _____	Number of Rooms _____
Room # _____ Accommodations _____	Number of Beds _____
Admission Date _____	Census _____
<i>Diagnosis:</i>	LEVELS OF CARE (Number of patients in each)
Admission _____	A _____ C _____ E _____
_____	B _____ D _____
_____	_____
Current _____	PERSONNEL CODE AND CENSUS
_____	Registered Nurse R _____
_____	Practical Nurse P _____
_____	Nursing Student SN _____
_____	Practical Nursing Student PN _____
_____	Instructor I _____
Condition of Patient _____	Head Nurse H _____
_____	Candy Striper C _____
_____	Supervisor S _____
_____	Orderly O _____
_____	Ward W _____
_____	Aide A _____
_____	Unknown Initiator U _____

OTHER PERTINENT DATA:

Date _____

Rater _____

Time of Day _____ AM/PM

INTERACTIONS _____

REPORTS: Change of Shift _____

OUTCOMES: Total Item Mean Score _____

Team _____

Total of Items Used _____

Other _____

Score (Mean of Means) _____

Additional notes or questions:

QUALITY PATIENT CARE SCALE

RATER'S NOTES

FOR

ASSESSMENT AND PLANNING CARE

PATIENT _____

ORDERS, NEEDS, NURSING ACTIONS

Diet (meals, fluids, nourishment)

Medications

Treatments (dressings, irrigations)

Special care:

- a. colostomy, trach., etc.
- b. skin-bath, lotion, etc.
- c. traction, cast
- d. decubiti

Observation of condition

- a. Direct
- b. Monitors (V.S., Pacemakers, etc.)

Diagnostic Tests

- a. On ward
- b. Off ward

Activity (bedrest, ambulation, etc.)

Sensory deficit (blind, aphasic, deaf)

Safety

Teaching patient and family

Socialization and diversion

Multiple services (referrals, consultations)

Reporting and recording

Planning for continuity of care

	ITEM NUMBER	BEST CARE BETWEEN	AVERAGE CARE BETWEEN	POOREST CARE BETWEEN	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
10. The rejecting or demanding patient continues to receive acceptance. # D/*I	10						29-30
11. Patient receives care that communicates worth and dignity of man. # D	11						31-32
12. The healthy aspects of the patient's personality are utilized. # D/*I	12						33-34
13. An atmosphere of trust, acceptance, and respect is created rather than one of power, prestige, and authority. # D	13						35-36
14. Appropriate topics for conversation are chosen. # D	14						37-38
15. The unconscious or nonoriented patient is cared for with the same respectful manner as the conscious patient. # D	15						39-40
AREA I MEAN							41-42-43

PSYCHOSOCIAL: GROUP

Actions directed toward meeting psychosocial needs of patients as members of a group.

16. Patient as a member of a group receives warmth, interest, and attention from the staff. # D	16						44-45
17. Patient receives the help necessary to accept limits on his behavior that are essential to group welfare. # D	17						46-47
18. Patient receives encouragement to participate in or to plan for the group's daily activities. # D	18						48-49
19. The member of the group is provided with the opportunity to assume responsibility according to his capability. # D	19						50-51

- 20. Staff proposals for patient activities appropriately reflect interests and needs of the group members. # D
- 21. Patient is helped to vent his emotions in a socially acceptable way within the group. # D
- 22. Praise and recognition are given for achievement according to individual needs and with respect for others in the group. # D
- 23. The rights and integrity of the group member are protected within the group structure. # D

ITEM NUMBER	BEST CARE	BETWEEN AVERAGE CARE	BETWEEN POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
20						52-53
21						54-55
22						56-57
23						58-59
AREA II MEAN						60-61-62

PHYSICAL

Actions directed toward meeting physical needs of patients.

- 24. Nursing procedures are adapted to meet needs of individual patient for treatment. # D
- 25. Patient's daily hygiene needs for cleanliness and acceptable appearance are met. # D
- 26. Nursing procedures are utilized as media for communication and interaction with patient. # D
- 27. Physical symptoms and physical changes are identified and appropriate action taken. # D
- 28. Physical distress evidenced by the patient is responded to quickly and appropriately. # D
- 29. Patient is encouraged to observe appropriate rest and exercise. # D/*I

24						63-64
25						65-66
26						67-68
27						69-70
28						71-72
29						73-74

	ITEM NUMBER	BEST CARE	AVERAGE CARE BETWEEN	POOREST CARE BETWEEN	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
40. Patient and family are involved in planning for care and treatment. # D/*I	40						28-29
41. Patient's sensitivities and right to privacy are protected. # D	41						30-31
42. Patient is helped to accept dependence/independence as appropriate to his condition. # D	42						32-33
43. Resources within the milieu are utilized to provide the patient with opportunities for problem solving. # D	43						34-35
44. Patient is given freedom of choice in activities of daily living whenever possible and within patient's ability to make the choice. # D	44						36-37
45. Patient is encouraged to take part in activities of daily living that will stimulate his potential for positive psychosocial growth and movement toward physical independence. # D/*I	45						38-39
46. Activities are adapted to physical and mental capabilities of patient. # D/*I	46						40-41
47. Nursing care is adapted to patient's level and pace of development. # D	47						42-43
48. Diversional and/or treatment activities are made available to the patient according to his capabilities and needs. # D	48						44-45
49. Patient with slow or unskilled performance is accepted and encouraged. # D	49						46-47
50. Nursing care goals are established and activities performed which recognize and support the therapist's plan of care. # D/*I	50						48-49
51. Interaction with the patient is within framework of the therapeutic plan. # D	51						50-51

	ITEM NUMBER	BEST CARE	AVERAGE CARE BETWEEN	POOREST CARE BETWEEN	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
52. Close observation of the patient is carried out with minimal disturbance. # D	52						52-53
53. Response to the patient is appropriate in emergency situations. # D	53						54-55
							56-57-58
AREA IV MEAN							

COMMUNICATION

Communication on behalf of the patient.

54. Ideas, facts, feelings, and concepts about the patient are communicated clearly in speech to medical and paramedical personnel. # D
55. Family is provided with the opportunity for reciprocal communication with the nursing staff. # D/*I
56. Ideas, facts, and concepts about the patient are clearly communicated in charting. *I
57. Well-developed nursing care plans are established and incorporated into nursing assignments. *I
58. Pertinent incidents of the patient's behavior during interaction with staff are accurately reported. # D/*I
59. Staff participate in conferences concerning patient care. # D
60. Effective communication and good relationships with other disciplines within the hospital are established for the patient's benefit. # D/*I

54							59-60
55							61-62
56							63-64
57							65-66
58							67-68
59							69-70
60							71-72

ITEM NUMBER	BEST CARE	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
52. Close observation of the patient is carried out with minimal disturbance. # D							52-53
53. Response to the patient is appropriate in emergency situations. # D							54-55
AREA IV MEAN							56-57-58

COMMUNICATION

Communication on behalf of the patient.

54. Ideas, facts, feelings, and concepts about the patient are communicated clearly in speech to medical and paramedical personnel. # D
55. Family is provided with the opportunity for reciprocal communication with the nursing staff. # D/*I
56. Ideas, facts, and concepts about the patient are clearly communicated in charting. *I
57. Well-developed nursing care plans are established and incorporated into nursing assignments. *I
58. Pertinent incidents of the patient's behavior during interaction with staff are accurately reported. # D/*I
59. Staff participate in conferences concerning patient care. # D
60. Effective communication and good relationships with other disciplines within the hospital are established for the patient's benefit. # D/*I

54							59-60
55							61-62
56							63-64
57							65-66
58							67-68
59							69-70
60							71-72

61. Patient's needs are met through the use of referrals, both to departments in the hospital and to other community agencies. # D/*I

ITEM NUMBER	BEST CARE	AVERAGE BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
61						73-74
AREA V MEAN						75-76-77

PROFESSIONAL IMPLICATIONS

Care given to patient reflects initiative and responsibility indicative of professional expectations.

62. Decisions that are made by staff reflect knowledge of facts and good judgment. # D/*I

63. Evidence (spoken, behavioral, recorded) is given by staff of insight into deeper problems and needs of the patient. # D/*I

64. Changes in care and care plans reflect continuous evaluation of results of nursing care. # D/*I

65. Staff are reliable; follow through with responsibilities for the patient's care. # D/*I

66. Assigned staff keep informed of the patient's condition and whereabouts. # D

67. Care given the patient reflects flexibility in rules and regulations as indicated by individual patient needs. # D/*I

68. Organization and management of nursing activities reflect due consideration for patient needs. # D/*I

62						78-79
63						11-12
64						13-14
65						15-16
66						17-18
67						19-20
						21-22
AREA VI MEAN						23-24-25
Sum of Item Means Number of Items Rated						
Mean of Item Means						26-27-28

APPENDIX E

QUALITY PATIENT CARE SCALE

A FACT SHEET ABOUT QUALPACS*

For distribution to and discussion with Head Nurses
and Ward Nursing Personnel

What

A Survey to Evaluate the Quality and Conditions of Delivery of Nursing Care to Patients at _____ Hospital

Conducted by the Department of Nursing

When

Date _____ to _____ Date

Why

- I. To examine the quality of care provided to patients at _____ Hospital.
- II. To identify ward activities and conditions which might influence quality of care (e.g., number of personnel, number of treatments, equipment, number of critical patients, etc.).
- III. To provide information to Department of Nursing (supervisory and unit personnel) to serve as a base for planning for personnel assignment, inservice education, etc.

How Will the Study Be Conducted?

The Nurse Observer will spend a *two*-hour period observing the selected patient(s). Five to six patients will be observed on each unit. The observer will observe the care received by the patient(s) and ascribe ratings to pertinent items on the *Quality Patient Care Scale*.

The Nurse Observer will not participate or intervene in any nursing actions unless in her judgment not to do so would be dangerous for the patient.

The Nurse Observer will sit in the patient's unit during the observation period, in an area where it is possible to observe the patient and yet be as unobtrusive as possible.

She will be making recordings of her observations, therefore, she will be "turning pages," etc. Conversation with her by personnel and patients is to be discouraged during the observation periods. After she has finished her observation period discussion is permitted if the patient or personnel desire it.

The study is not an efficiency rating of personnel. Names of personnel are not recorded. The study is concerned with what nursing care the selected patient

*Developed by Kathlene F. Monahan

QUALITY PATIENT CARE SCALE

receives regardless of who does it. From the records the Nurse Observer keeps it would not be possible to retrieve a person's name and give an efficiency rating.

Patient Information

The Nurse Observer will examine the patient's chart or kardex so that she has information concerning the needs of the patient whom she will be observing. In addition, she may need to supplement her information by spending a short time consulting with the head nurse or nurse who is providing care for the selected patient.

What Help is Needed from Head Nurses?

A. *Help in Identification and Selection of Patients*

1. The Nurse Observer will seek the charge nurse's assistance in identification of patients for the study.
2. The charge nurse will be contacted and consulted regarding the identification of patients who may be expected to receive a number of nursing interactions and interventions.
3. The observer has to observe patients for whom something is being done. If patients are scheduled for "off-ward" activities they should not be included in the study.

B. *Introduction to Staff*

Briefly explain that:

1. The study is to look at what activities nursing personnel do for patients.
2. The observer will be sitting in the patients' unit and will be "thumbing" papers.
3. *It is not an efficiency rating.*
4. Personnel are requested to continue their normal activities and disregard the presence of the observer.
5. The observer will wear a lab coat.

C. *Introduction to Patients*

A nurse who knows the patient should:

1. Introduce the observer to all patients in the immediate study area.
2. Explain briefly what the observer will be doing and why she is there.
3. Explain that the observer will be "observing" and writing and will not be talking or working with patients.
4. It is not necessary to state specifically *which* patient is being observed.

APPENDIX F

TABLE 5
DEMOGRAPHIC DATA

Variable		Unit A n = 12	Unit B n = 7	Unit C n = 9	Overall n = 28
1. Age	20-25	7	1	2	10
	26-30	4	4	4	12
	31-35	0	1	2	3
	36-40	1	1	0	2
	41-45	0	0	1	1
2. Sex	Male	1	0	1	2
	Female	11	7	8	26
3. Marital Status	Single	8	2	2	12
	Divorced	1	0	3	4
	Married	3	5	4	12
4. Income	Primary	10	3	7	20
	Secondary	2	4	2	8
5. Education	A.D.	4	0	2	6
	Diploma	5	2	5	12
	B.S.N.	3	4	2	9
	M.S.	0	0	0	0
	Other	0	1 (foreign)	0	1

TABLE 5 (continued)

Variable		Unit A n = 12	Unit B n = 7	Unit C n = 9	Overall n = 28
6. Nursing Experience	1-3 yrs.	0	0	0	0
	4-6 yrs.	6	3	2	8
	7-10 yrs.	4	2	3	10
	10-20 yrs.	2	2	3	7
	20 yrs.	0	0	1	2
7. Critical Care Experience	1 yr.	3	1	0	4
	1-3 yrs.	5	2	1	8
	4-6 yrs.	3	2	7	12
	7-10 yrs.	1	1	1	3
	10 yrs.	0	1	0	1
8. Critical Care Course	Yes	11	3	9	23
	No	1	4	0	5
9. Participated in Workshop	Yes	9	4	9	22
	No	3	3	0	6
10. Lead or taught in a Workshop	Yes	0	0	2	2
	No	12	7	7	26
11. Membership in professional organization	Yes	2	3	4	10
	No	10	4	5	18

APPENDIX G

TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Kay Branum Center: Dallas
Address: 4810 B Bradford Dr. Date: 17 OCT 77
Dallas, Texas 75219

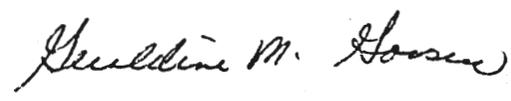
Dear Miss Branum

Your study entitled The Relationship between Organizational Climate
and the Quality of Nursing Care in Critical Care
has been reviewed by a committee of the Human Research Review Committee
and it appears to meet our requirements in regard to protection of the
individual's rights.

Please be reminded that both the University and the Department
of Health, Education and Welfare regulations require that written
consents must be obtained from all human subjects in your studies.
These forms must be kept on file by you.

Furthermore, should your project change, another review by
the Committee is required, according to DHEW regulations.

Sincerely,



Chairman, Human Research
Review Committee
at DALLAS

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