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by

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Work relationships and organisational commitment of nurses: An analysis of policy-practice differences

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Submitted in fulfillment of the requirements of the degree of Doctor of Philosophy

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DEDICATION

This thesis is dedicated to the memory of my Pop

*Thomas John Eagle*

1929 – 2009

for always encouraging me to reach for the stars.
ABSTRACT

For several decades, one of the major issues facing Australia’s health sector has been a shortage of nurses; a trend also evidenced across many other Organisation for Economic Co-operation and Development (OECD) countries. Without a suitably sized nursing workforce, a society’s ability to care for the population is diminished, and will continue so unless this trend is reversed. One of the factors contributing to this shortage is the poor retention of currently employed nurses, which results from, in part, a high proportion of nurses lacking commitment to their organisations. For public sector hospitals, the largest employer of nurses in Australia, this lack of organisational commitment is a continuing concern that impacts upon the ability of health organisations to provide care to patients.

This thesis examines the factors that impact upon nurses’ commitment to their organisations. A theoretical framework, Social Capital Theory (SCT), was used as a lens through which to view the behaviour of nurses. The reason for this choice of theory is that SCT is used to examine the relationships in the workplace by exploring their quality, structure, and the context in which they operate. This research uses the SCT framework to interpret how relationships impact upon nurse outcomes, including their level of role ambiguity, the extent to which they perceive that they are empowered in their work, and most importantly, their organisational commitment. Of particular interest to this study is the difference between these organisational practices and the organisation’s espoused policies, to identify gaps and areas for improvement.

The research used a sequential mixed methods approach. Four methods of data collection were used comprising surveys, focus groups, interviews, and document analyses, so as to examine the relevant issues from a variety of viewpoints and triangulate data. Respondents comprised nurses working in two public sector hospitals located in Australia. The data includes 167 surveys, 12 focus groups and 17 interviews. Analysis of the quantitative data involved using regression analysis and
path analysis, while the qualitative data were analysed using manifest and latent content analysis.

Results of the quantitative and qualitative analyses identified that nurses had low levels of commitment to their organisation. The main factor which impacted upon nurses’ commitment to their organisation was the quality of nurse relationships. This included relationships with their supervisor (also known as Nurse Unit Manager), with the upper levels of organisational management, and with nurse colleagues. The second factor which impacted upon nurses’ commitment to their organisation was the lack of support mechanisms in place. This factor included a lack of organisational resources; a lack of facilities with which to perform their work; a lack of respect and support from others; and a poor organisational culture. These findings identified that the nurses were ambiguous about how to perform their role in the work environment, that they had decreased job performance because of this, and were not well empowered to perform their work. Nurses did, however, perceive that their social networks were effective in assisting them to solve work-related problems. The results of the analyses also identified multiple gaps between organisational policy and practice. In particular, the data suggested that reality did not match organisational policies regarding the value of nurses; the quality of the relationship between nurses and all levels of organisational management; the quality of patient care; and the increased efficiency and effectiveness that organisational policies and procedures are aimed at achieving.

Overall, the research concludes that the quality of relationships at work and the level of support provided to nurses were instrumental in contributing to nurses’ commitment to their organisation. The nurses were operating in a very ambiguous environment characterised by low levels of support from management, and as a consequence, were not better committed to their organisation. The findings of this thesis are significant because they demonstrate the importance of relationships and organisational culture in affecting the success of individual outcomes in the workplace, such as problem-solving effectiveness and organisational commitment. The findings make a significant contribution to, and extend existing knowledge
about, the role of relationships and organisational social contexts in affecting employee outcomes. The findings also contribute knowledge to the field about how to increase nurses’ commitment to their organisations and how to identify areas for improvement in nursing practice. These will inform organisations and government about how to improve nurse retention and minimise future nursing shortages.
STATEMENT OF ORIGINALITY

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

__________________
Natasha Emma Currant
August 2011
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KEY TERMS

Key terms are used throughout this thesis and are defined as follows:

**Affective commitment** refers to an employee’s desire to stay in the organisation based on their emotional attachment to, identification with, and involvement in the organisation (Allen & Meyer, 1990).

An **Enrolled Nurse** is a lower level nurse whose training or education at a certificate or diploma level is satisfactory for registration and a role as a nurse at a lower level than as a Registered Nurse (Australian Nursing Federation, 2005).

A **Nurse Unit Manager (NUM)** is a Registered Nurse who is responsible for leading a nursing team and the provision and coordination of resources at a ward level (College of Emergency Nursing Australasia, 2008).

**Nursing** involves the autonomous and collaborative care of individuals in ill health when they are unable to care for themselves, the promotion of good health, advocacy, research, policy development and education (Australian Nursing Federation, 2010; International Council of Nurses, 2010).

An **organisation** is a social arrangement of people with a clearly defined hierarchy of authority for the controlled performance of collective goals (Buchanan & Huczynski, 2003; Campbell & Craig, 2005).

**Organisational culture** refers to the symbols, values, ideologies and assumptions that unconsciously guide the behaviour of the organisation and its employees and provide a sense of cohesiveness (Cartwright & Cooper, 1993).

A **private hospital** is a privately owned and operated organisation that charges patients fees for services for the patient’s choice of doctor, hospital,
practitioner, and extra service, food and accommodation services (Australian Department of Health and Ageing, 2008b).

A **public hospital** is a hospital that is controlled by an Australian state or territory offering free health care and accommodation to all residents of Australia (Australian Department of Health and Ageing, 2008b).

A **Registered Nurse** is a Bachelor qualified nurse licensed to practice without supervision while undertaking the duties of nursing mentioned in the definition of Enrolled Nurse (Jolly, 2007).

**Retention** is the percentage or number of employees that remain within an organisation (Phillips & Connell, 2003).

For the purposes of this research, **upper level management** refers to all types of managers and associated administrative employees above the level of Nurse Unit Manager within the organisation’s hierarchy of management. These managers are responsible for the daily operations and long-term strategic management of the organisation (Chin, 2004).
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CHAPTER 1 - INTRODUCTION

1.1 Introduction

Like many other developed countries across the world, Australia is currently experiencing a shortage of skilled nurses. Underpinning these shortages lie problems within the professions such as high workloads, decreased quality of patient care, inflexible rosters, and dissatisfaction with pay levels. Due to the widespread prevalence of these issues, the retention of nurses has also become a problem. However, particular focus in recent years has centred upon how to improve nurses’ commitment so as to improve their retention. This research contributes to an understanding of the factors affecting nurses’ commitment to their organisation by exploring how relationships at work, along with the culture of an organisation, impact upon the commitment of nurses. This research views these issues through the lens of Social Capital Theory, which assumes that networks of relationships may be used strategically by employees to gain advantages that would not have been available otherwise. Subsequently, this research extends the literature by examining the quality and type of relationships that are utilised by nurses to assist them in solving problems in the workplace. The research also examines the effectiveness of the relationships. Furthermore, the literature is extended by examining how the quality of relationships impacts upon a number of factors that have been previously identified as predictors of nurses’ commitment to the organisation. Finally, this research also explores any differences that may exist between organisational policy and organisational practice to identify areas for potential improvement, and extend the literature regarding policy/practice differences in a nursing context. Altogether, this research makes a significant contribution to theory and practice by identifying areas that may assist in improving nurses’ commitment to the organisation, thereby assisting in understanding how to better retain nurses.

This first chapter introduces the research and its significance, and sets the context in which it is situated. The background of the research is outlined first, by exploring the Australian health care system and the changes the public health care
system has undergone in recent decades. Following this, the profile of nurses working within Australia and the nature and extent of the nursing shortage is detailed. The reasons for, and outcomes of, this shortage are outlined. Having set the background and context in which nurses are working, the specific research problem examined in this research is stated, namely how do the quality of relationships at work impact upon the organisational commitment of nurses? This is followed by a brief introduction to how relationships at work are explored in this research. The significance of this research and the mixed methods approach undertaken are then detailed, followed by the delimitations and key terms utilised in the research. Finally, the structure of this thesis and remaining chapters is outlined.

1.2    Background to the research

The following section outlines the context of this research by exploring Australia’s health care industry with a particular focus on the public health care system in which the study is undertaken. It also explores the literature on the nursing shortage seen across Australia and most of the world, including the reasons for it and proposed solutions to alleviate the problem.

1.2.1    Australia’s health care system

Australia’s health care system is based upon the principle that all citizens have the right to access safe and effective health care regardless of their financial capacity (Hilless & Healy, 2001). The health care system is structured into private and public sectors. The private sector is a fee-based system that allows individuals choice in the location and provider of their health care. However, this research focuses on the public health care system, in particular hospitals, which plays a dominant role in the overall health care system. The Australian states and territories run public sector hospitals, and most of the complex health care such as major surgery, organ transplants and intensive care is provided by these hospitals (Australian Bureau of Statistics [ABS], 2008a). Collectively, public hospitals in
Australia provide more than 54,000 beds representing 68% of all beds in the hospital sector, and are the primary method of health care for most Australians (ABS, 2008a). The public health care system is funded and administered by the national, state, territory and local governments, with some additional funding support provided by private health care (ABS, 2008a; Hilless & Healy, 2001). The system is covered by Medicare which is the federally tax-funded, public health insurance scheme that covers the major costs of medical services, prescription pharmaceuticals, and public patient treatment in hospitals in Australia (ABS, 2008a).

For at least the last two decades, funding from the Commonwealth Government has failed to keep pace with an increased demand for the services of the public health care system, thus resulting in significant financial problems within the sector (Biggs, 2003). This increased demand has resulted from a growth in Australia’s population averaging 1.5% annually with more than 22 million residents at the end of 2009 (ABS, 2010). Complicating this demand is the increased life expectancy of residents as Australians are now living longer than ever before and using more health services. In 2007, the average life expectancy was 80.5 years, compared to 77 years in 1998 (ABS, 1999, 2009). The strain on the health system is increasingly evident in the shortage of beds and long waiting lists for elective surgery in Australian hospitals (Bradfield, 2008; Senate Community Affairs Reference Committee, 2002).

One factor that has caused considerable strain on the public health care system and the public sector overall, is the constant pressure to reduce costs while increasing efficiency (Lee, 2008). This challenge resulted from government reforms arising from the introduction of New Public Management (NPM). NPM began to emerge after the release of the 1975 Report of the Royal Commission on Australian Government Administration, and increased noticeably with the appointment of the most recent Liberal federal government, elected in 1996 (Anderson, Griffin & Teicher, 2002), and deposed in 2007. The NPM approach, which was prevalent in the private sector but lacking in the history of the public sector, was argued to be
efficient and effective (Dixon, Kouzmin & Korac-Kakabadse, 1998) and created significant changes to the way the public sector was managed.

The overall aim of the NPM was to transform the culture of the public service from a strict bureaucracy to a more flexible, performance-based service that would enable greater efficiency, accountability, equity, responsiveness to change, and quality of service to customers while also reducing costs and increasing income (Anderson et al., 2002; Hood, 1995; Maor, 1999). Accountability increased with the introduction of codes of conduct, changes in organisational values, and stricter supervision (Anderson et al., 2002; Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996). The public were now viewed as “customers” and subsequently, customer service was designed to be enhanced through increased accountability tools as mentioned above, as well as outsourcing to improve competition and hopefully lead to more competitive and lower costs (Dixon et al., 1998; Hood, 1995; Morley & Vilkinas, 1997). In addition, performance was enhanced by restructuring public sector departments based on products, productivity-based pay and resources, merit-based appointments and promotions rather than seniority, and a focus on measures of outputs and outcomes (Anderson et al., 2002; Dixon et al., 1998; Hood, 1995; Morley & Vilkinas, 1997). However, the success of managerial reforms and of the achievement of performance enhancements is debatable (Lee, 2008; Simms, 2009) with great potential for inconsistencies between objectives and reality for organisations. Accordingly, recent reforms in Australia have focused on more sustainable funding, centralised decision making, patient centred care that is timely, accessible and of a higher quality, and greater transparency of information regarding services, among others (Council of Australian Governments, 2011).

In terms of public sector hospitals, the NPM made many significant changes, most notably in that hospitals that were once run and managed by physicians and medical professionals were now run by professional managers and administrative professionals with vital hospital space being allocated to accommodate all of these administrative functions (Winthrop & Vane, 2002). Significantly, the introduction of business practices which emphasised efficiency and effectiveness frequently
conflicted with health practices which emphasised high quality patient care and procedures that could be time consuming and costly (Winthrop & Vane, 2002). One example includes decreased lengths of stay in hospitals to reduce costs and deal with increased demand for beds (Australian Institute of Health & Welfare [AIHW], 2006). Additionally, nurse and hospital cultures changed when the training of nurses in Australia moved from in-hospital training to a four-year university degree with associated university fees (Winthrop & Vane, 2002). Nurses are required to meet cost targets while caring for patients and expected to quickly adapt to increased technology in the workplace that has quite often been time consuming and which has required high levels of skills from experienced staff (Winthrop & Vane, 2002). Similar requirements from the United States health system suggested that some of the learning about new technologies has had to occur outside the scheduled work hours of nurses (Krichbaum, Diemer, Jacox et al., 2007), which has increased the potential for, and indeed the frequency of, ambiguity in the workplace. This has largely been because of the increasing complexity of the new technologies and new work procedures (Hofmann, Lei & Grant, 2009) and the paucity of time available to learn them adequately. One of the many negative outcomes believed to result from health care reforms is the shortage of nursing staff.

1.2.2 Australia’s nursing shortage

Prior to examining the background surrounding nurse shortage and retention issues in the Australian context, it is important to explore the role of nurses. The role of a nurse is to assist sick individuals in activities that will contribute to their recovery through duties including “the promotion of good health, prevention of illness, and care for the ill, and disabled and dying” (Australian Nursing Federation, 2010, p. 1). These roles mean that nurses are front line staff members who are essential for delivering safe and effective healthcare (Buchan & Calman, 2004; Tucker, Edmondson & Spear, 2002). Nurses may work in a variety of settings including hospitals, aged care facilities, home care, birth centres, allied health facilities and other health-related organisations.
This research is conducted on nurses working in public sector hospitals. They comprise the largest proportion of a hospital’s staff, and are the most frequently allocated care providers for patients during stays in hospital. Nearly 63% of the nursing workforce in Australia is employed in a hospital setting (ABS, 2008b; AIHW, 2010). The female domination of the nursing profession is highlighted by recent figures indicating that females occupy 91% of the nursing workforce and 88% of the Nurse Manager roles (ABS, 2008b; AIHW, 2010). Furthermore, nursing is highly represented in part-time work arrangements at 49%, which is slightly higher than the part-time rate for all employed women at 47%, but substantially higher than for all employed persons in Australia which has an average part-time rate of 31% (ABS, 2008b). This suggests that women are highly represented in part-time work roles regardless of the occupation and it is widely speculated that this is because many females prefer to work part-time and in casual arrangements. The latter, often necessitating the use of flexible working arrangements (Preston, 2002). This speculation is reflected in figures, which show that of the 49% of nurses working part-time, the largest group was aged between 30 and 44 years (58%), which is the age group when many females leave the workforce or reduce their working hours to raise children (ABS, 2008b).

In Australia, there is a serious shortage of nursing staff with shortages being identified for Registered Nurses, Enrolled Nurses and in particular, Midwives (Australian Government Department of Education, Employment and Workplace Relations [DEEWR], 2010; Garnett, Coe, Golebiowska, Walsh & Zander, 2008). Estimates made prior to 2010 suggested that Australia would be 40,000 short of required nurse numbers by the year 2010 (Karmel & Li, 2002). However, projections beyond this time have been difficult to conclude. Numbers are no longer being estimated as focus is now placed on undertaking those actions that are thought will alleviate the shortages such as increasing use of nurses from overseas and providing additional nurse training places (Australian Government Department of Health and Ageing [DHA], 2008a). These efforts appear to be mitigating the problem with recent research suggesting that the number of nurses employed in Australia has been slowly increasing (AIHW, 2010).
Internationally, similar shortages are being seen with the largest in North America and Europe (Buchan & Calman, 2004; Buerhaus et al., 2000; Doiron & Jones, 2006; Keenan & Kennedy, 2003; United States Department of Health and Human Services, 2002). Estimates from the United States predict up to a 36% shortage of nurses by 2020 if current trends continue with similar shortages expected across many other developed countries (Biviano, Fritz, Spencer & Dall, 2004; Buerhaus, Staiger & Auerbach, 2000).

However, regardless of the additional efforts made to increase the number of recruits and training places for nurses in Australia, problems will still occur if high levels of turnover are not reversed, with nurses continuing to leave the industry and their organisations. High levels of turnover have significant financial implications for an already strained health care system. Research from the United States suggests that the cost of replacing a registered nurse is estimated to be up to US$42,000 (Contino, 2002; O’Brien-Pallas, Duffield & Hayes, 2006) and up to US$145,000 for specialty or surgical nurses (Curran, 2006; Hatcher et al., 2006). This cost can result from advertising for and interviewing new nurses, lost productivity for new employees while they are learning and training for the job, increased use of part-time employees, overtime, decreased productivity of temporary staff replacing nurses who have left, leave payouts to employees, and burnout and lost productivity of remaining nurses from additional workloads (Colosi, 2001; Duffield, 2005). In addition, some believe that the cost of turnover is between four to five times higher than that for which hospitals account because of decreased productivity and morale, settling-in, and orientation programs to name a few, non-measurable costs (Johnson & Buelow, 2003; O’Brien-Pallas, 2003).

A number of practical difficulties for nurses that have affected the workplace culture and daily work duties of nurses have resulted from the nurse shortage and NPM reforms. One such major difficulty is the change in work hours due to insufficient staff and less flexible rostering policies as well as to increased requirements to work shifts. For instance, nurses may be required to work over any period within a 24-hour a day, 7-day a week roster. Statistics from Australia in 2008...
show that long hours are sometimes required from nurses, with 20% of full-time nurses working more than 45 hours per week (including 8% working more than 55 hours and 4% working more than 65 hours per week) (ABS, 2008b). Whether these additional hours were paid as overtime or worked as unpaid additional hours within full-time positions was not specified. In Queensland, nurses are reporting that they experience a lack of flexibility in work hours and scheduling (Webster, Flint & Courtney, 2009). Research from outside Australia suggests similar problems with overseas nurses being dissatisfied with their hours of work (Flinkman, Laine, Leino-Kilpi, Hasselhorn & Salantera, 2008 [Finland]), working long hours on a regular basis (Rogers, Hwang, Scott, Aiken & Dinges, 2004 [United States]), and not being given rest breaks. All these factors lead to mandatory overtime and difficulties in balancing work commitments with personal commitments (Pellico et al., 2009 [United States]).

Another outcome of the nursing shortage and NPM reforms is an increase in workloads for the nurses (Buchanan & Considine, 2002; Neuman & Lawler, 2009). The workloads of nurses have increased and are becoming more difficult to maintain due to fewer staff with more and broader tasks, increased responsibilities and accountability, and the continual need to adapt to improving medical and technological advances, which become time consuming to learn and master within an already high workload (Buchanan & Considine, 2002). Part of the cause of this is that nurse staffing levels have not been maintained. There has been failure to replace nurses when they leave their position (Allan, 1998) resulting in an increase in the ratio of patients to nurses. The high workloads forced upon nurses have been identified as significant sources of stress for nurses (Lim, Bogossian & Ahern, 2010) and most importantly of all, have been associated with nurses leaving the profession entirely (Considine & Buchanan, 1999).

Research from other OECD countries such as the United States and Canada show a number of negative outcomes that have resulted from similar cost-driven reforms. Nurses are reporting that the quality of patient care is decreasing (Carayon & Gurses, 2005; Dickerson, Brewer, Kovner & Way, 2007; Zeytinoglu et al., 2007a).
In addition, research has suggested that high workloads may lead to negative patient outcomes including infections, bleeding and shock, due to a lack of time for nurses to care for their patients (Atencio, Cohen & Gorenberg, 2003; Needleman, Buerhaus, Mattke, Steward & Zelevinsky, 2002; Page, 2004; Stanton, 2004). This is illustrated in research which suggests that up to 40% of the work of nurses is not related to the direct care of patients (Aiken, Clarke, Sloane, Sochalski & Silber, 2002; Laschinger & Havens, 1997; McNeese-Smith, 1999). One reason for this is the substantial increase in the amount of paperwork nurses must complete for accountability purposes, which reduces the time available for patient care (Cherry, Ashcraft & Owen, 2007; Pellico et al., 2009; Tuckett, Parker, Eley & Hegney, 2009 [Australia]).

A significant amount of research conducted in Australia has demonstrated that nurses are dissatisfied with their pay and desire more (Buchanan & Considine, 2002; Dockery, 2004; Hegney, Plank & Parker, 2006; Preston, 2005). Similar findings have been found internationally as well (Dickerson et al., 2007 [United States]; Flinkman et al., 2008 [Finland]; Khani, Jaafarpour & Dyrekvandmogadam, 2008 [Iran]; Pellico et al., 2009 [United States]; Pillay, 2009 [South Africa]). Even though international studies are conducted in a different health care context, the nature of the nursing role remains largely unchanged, and therefore, dissatisfaction with pay for the demands of the nursing role is relevant to the Australian context. However, reviews of existing research suggest that pay alone is not the entire problem. For instance, recent research in Australia has suggested that satisfaction with pay was not significantly related to retention (Cowin, Johnson, Craven & Marsh, 2008). Furthermore, when pay was examined alongside other factors such as satisfaction with colleagues or management, or the need to improve the behaviour of management, satisfaction with pay did not rate as significant, as was found in Japan (Ishida, 2000; Tsai & Huang, 2008). From these Australian and international studies, it could be suggested that factors other than pay are impacting upon nurses’ commitment to the organisation.

Many solutions to the current and projected nursing shortage in Australia have been proposed with some arguing that attraction/recruitment is not the
problem, but rather that the retention of graduates and experienced nurses should be a priority, so as to retain existing knowledge and skills, and because it is a more cost effective option than recruitment (Cowin & Jacobsson, 2003; Jones, Bonner & Pratt, 2005). Therefore, it is not how to attract, but how to best retain nurses, that is a major issue in the health sector (Cowin & Jacobsson, 2003; Jones et al., 2005; O’Brien-Pallas et al., 2006).

To retain nurses, it is important to understand and address the reasons why they are leaving the industry. Several studies on nurse retention and the working conditions of nurses have been undertaken within Australia over the last decade (see Buchanan & Considine, 2002; Hegney, Plank, Buikstra, Parker & Eley, 2005; Preston, 2002). In line with much of the research on the impact of NPM reforms, the findings suggest that the culture of the health care organisations in which nurses are working has changed. Many of the causes of this are the strains, mentioned previously, that are placed upon nurses as a result of the reforms and the nursing shortage including shift work and increased workloads. These factors have also contributed to a number of other poor outcomes for nurses both within and outside of the work environment.

One of the main outcomes that has resulted, and that is further fuelling nursing shortages, is the poor level of organisational commitment of nurses. In this thesis, commitment, organisational commitment, and affective commitment are used interchangeably. A review of the commitment literature suggests that commitment is a primary predictor of retention and when commitment is high, employees are less likely to leave an organisation/industry/profession (Flinkman et al., 2008; Mathieu & Zajac, 1990; Meyer & Allen, 1997; Pitt, Foreman & Bromfield, 1995; Vandenberghe & Bentein, 2009). The high workloads and nurses’ dissatisfaction with policies and practices that have resulted from NPM reforms have been shown to impact upon the commitment of nurses both in Australia (Garnett et al., 2008) as well as internationally (Gray & Phillips, 1994 [United Kingdom]; Secombe & Smith, 1997 [United Kingdom]; Zeytinoglu, 2007a, b [Canada]). Therefore, further
exploration of the factors affecting commitment of nurses is likely to contribute to knowledge about retention.

Another effect of the NPM reforms in Australia was a change in the quality of relationships due to competing priorities in the workplace. A decreased quality of exchanges and relationships between nurses and their Nurse Manager became evident (Bartram, Joiner & Stanton, 2004; Cheung, Bessell & Ellis, 2004; Victorian Government Department of Health Services, 2001). For instance, the role of the Nurse Manager changed dramatically from clinical leadership to largely financial and performance management of human and material resources (Brunetto & Farr-Wharton, 2006; Buchanan & Considine 2002; Neuman & Lawler, 2009). It is reported that the Nurse Manager’s ability and influence in nursing matters has decreased and resulted in a decrease in morale, empowerment and commitment among nurses (Neuman & Lawler, 2009). In line with those of nurses, the workloads of Nurse Managers have also increased, while they report a lack of support and increased micro-management by their own superiors (Neuman & Lawler, 2009). Other levels of management have not been immune to the effects of NPM reforms, with studies suggesting that nurses are dissatisfied with the perceived lack of support from upper management as a result of the changes (Bartram et al., 2004; Cheung et al., 2004; Victorian Government Department of Health Services, 2001). This suggests that upper levels of management have been affected by the changes, and the results of this are filtering down to lower levels of the organisation including nurses working on wards.

The culture of health care organisations changed to meet the new priorities of NPM reforms, but had unintended significant consequences for the way that nurses perceived they were treated. For instance, research as early as the mid 1990’s reported that nurses no longer felt that they were valued or recognised for their work (New South Wales Health, 1996). Although organisational culture is about more than simply feeling valued, this is just one of many studies that has suggested negative changes to the culture of health care organisations. This is important as organisational culture is a significant contributor to nurses’ commitment to the
organisation (Chen, 2004 [Japan]; Liao, Wei & Lin, 2008 [Japan]) with research suggesting that nurses are more likely to stay when they perceive greater levels of empowerment in their work (Laschinger, Finegan, Shamian & Wilk, 2001 [Canada]).

The importance of culture, and perceptions of empowerment, and of the quality of relationships, is demonstrated in the success of “magnet-designated hospitals”, which embody a focus on each of these aspects. Magnet-designated hospitals are hospitals that are approved by the American Nurses Credentialing Centre (ANCC) as meeting benchmarks for quality patient care, nursing excellence, and innovative and professional nursing practice (American Nurses Credentialing Centre [ANCC], 2011). These types of hospitals are regarded as valuing nurses. They actively work to improve the work environment of nurses, and they subsequently experience decreased nurse turnover as a result. The concept of magnet hospitals originated in 1983 with a study conducted by the American Academy of Nursing’s (AAN) Taskforce on Nursing Practice in Hospitals during a then national nursing shortage (Nursing & Midwifery Office of South Australia, 2009). The study found that hospitals which displayed a number of characteristics called Forces of Magnetism made the working environment and culture of these hospitals more attractive to nurses and therefore increased recruitment and retention levels (ANCC, 2011). The culture of magnet hospitals is considered to be supportive and pro-nurses, with a greater emphasis on patient care than non-magnet hospitals have. Within these hospitals, the structure of the organisation is decentralised and flexible with shared decision-making processes, open-door management policies, and two-way communication and feedback (Buchan, 1999). Furthermore, management strives for visionary leadership with an increase in their participation and support, and aims for a greater commitment to advancing the qualities of their clinical nurses by improving their levels of patient care and their professional development (McClure, Poulin, Sovie & Wandelt, 1983). In addition, sufficient staffing levels are maintained and nurses’ autonomy and accountability are encouraged (ANCC, 2010).

Numerous studies since initial research in 1983 have confirmed that magnet-designated hospitals achieve greater levels of nurse retention, satisfaction, and
increased respect for nurses by other staff and management, along with improved patient outcomes than other hospitals do (Aiken, Havens & Sloane, 2000). They also lead to increased empowerment through supportive decision-making, interdependent relationships, and autonomy (Upenieks, 2003). As of mid-2010, there were 372 magnet-designated hospitals across the world with one in each of Singapore, Lebanon, and New Zealand; two in Australia; with the remainder in the United States (ANCC, 2010). In Brisbane, Australia, Queensland’s Princess Alexandra Hospital became the first magnet-designated facility in the southern hemisphere in 2004, with the Sir Charles Gairdner Hospital in Perth, Western Australia being the second (Queensland Health, 2010). Although the rates of magnet accreditation are increasing every year, it is not fast enough to decrease nursing shortages in the short term. Furthermore, although the hospitals investigated in this research project were not magnet-designated, the practices encompassed under magnet designation are of interest to this research due to the potential benefits to be gained.

There are many lessons to be learned regarding why and how magnet-designated hospitals are more successful at retaining and satisfying their nursing staff. One lesson is that the quality of nurses’ relationships with others at work appears to be valued, particularly with supervisors and other levels of management. The second lesson is that supportive cultures lead to increased empowerment and retention of nurses within hospitals. This leads to the conclusion that the retention of nurses is likely to increase when changes are made to improve both the support available to nurses within the organisational culture of hospitals and the work relationships of nurses with others.

1.3 The research problem

Numerous studies across the world have identified the importance of retaining nurses who are currently working (Jones et al., 2005) because this is a more cost effective method of keeping nurse numbers constant while also retaining the knowledge base that exists. Subsequently, the aim of the current research is to gain
a greater understanding of the factors affecting nurses’ commitment to the organisation in order to contribute to understanding the factors affecting nurse retention. However, one area of research into the factors affecting nurses’ commitment to the organisation that is not well understood is the quality of relationships. This research posits that one of the keys to improving the commitment of nurses is to improve the quality of the relationships that surround nurses. Therefore, the research problem examined in this research is:

*How does the quality of relationships at work impact upon the organisational commitment of nurses?*

The following section explores relationships at work and how Social Capital Theory is used to illustrate the importance of these.

### 1.3.1 Relationships at work

When working within an organisation, employees develop different types of relationships with a number of different individuals. The quality of relationships is likely to influence the outcomes of both the organisation and individuals within it. To determine how relationships impact upon the organisational commitment of nurses, it is important to determine what makes up these relationships and how they are formed and used in the work environment. One way to do this is to explore Social Capital Theory, which views relationships as a tool for obtaining benefits within the organisational environment.

Social Capital Theory is used in this research to provide a lens for examining nurses’ commitment to their hospital. Social Capital Theory argues that people benefit from the quality of relationships that they possess. These relationships become capital or assets in a social form and can be very valuable. The theory assumes that individuals belong to a number of social groups, termed social networks, and the relationships between the members of the network create a potential and valuable source of information (Adler & Kwon, 2002; Coleman, 1990;
Lin, 2000; Walker & Christenson, 2005). In the nursing context, nurses’ social networks may include nurses in their own or other wards; their Nurse Unit Manager (NUM); medical professionals with whom they may or may not work; members of nursing unions or professional associations; as well as family and friends. Research has shown social capital to be useful in gaining access to information and that information can then be used to solve problems in the workplace (Cohen & Prusak, 2001). The theory may be applied within three distinct areas of relational, cognitive and structural capital.

The relational dimension focuses on the actual relationships that exist in the workforce. It is believed that relationships with other organisational members exist to serve a purpose. This purpose may be for approval, prestige or sociability among other reasons (Nahapiet & Ghoshal, 1998). The quality of the relationship is based upon trust obtained from previous interactions which inform the individual about whether the contact can be trusted and whether any benefit will be obtained from the exchange (Moran, 2005). Therefore, the quality of relationships is directly related to the ability to access and gain information. Examples of common and frequent relationships held by nurses include relationships with their supervisor, colleagues and medical professionals, who may provide assistance with patient care as well as help provide a collaborative working environment.

One of the most important relationships in which employees are involved is the supervisor-employee relationship. One way this relationship can be measured is through Leader-Member Exchange, which argues that the quality of a relationship between a supervisor and employee is a result of the exchanges that occur between them (Graen & Scandura, 1987). High quality relationships are typically more satisfying for both parties and lead to greater exchanges of information and resources. Low quality relationships do not possess these benefits and may be a source of dissatisfaction for either party. As a result, the quality of the supervisor-employee relationship plays a large role in the employment relationship and impacts upon employees’ commitment to the organisation (Gerstner & Day, 1997).
Exchanges between supervisors and employees and any other individuals require effective communication processes. Communication refers to the exchange of information (Daft, 1997). An example in the nursing profession would be communicating patient requirements between nurses and doctors, and also conveying information during change of nurse shifts. Communication is important to the relational dimension of social capital because successful relationships depend on exchanges that are based upon mutual benefit from valuable resources.

The second dimension of social capital is the cognitive dimension. This dimension focuses on the contextual framework such as the beliefs and behaviours that support social capital (Llewellyn & Armistead, 2000). These beliefs and behaviours are largely examined through the culture of the organisation, which is the values, symbols and assumptions within an organisation that create conscious or unconscious actions and behaviours to create a sense of cohesiveness among its members (Cartwright & Cooper, 1993). A strong culture is considered to be pivotal in understanding all organisation-related phenomena and is beneficial because it decreases ambiguity surrounding the expected behaviours of employees (Beyer, 1981). Each organisation is likely to have multiple subcultures, which are cultures within cultures, and which differ between different departments, wards, locations or types of employees. Organisational culture is important to this and any other research involving social capital because the patterns within organisational culture dictate the appropriateness or inappropriateness of engaging in exchanges with other individuals. For instance, if the culture values independence, employees may persist with trying to solve a work-related problem on their own rather than approaching a colleague or supervisor. Subsequently, opportunities for exchanges of information or resources with others have been missed, plus the opportunity is also missed to improve relationships with these people as well as improve morale and communication processes.

The third dimension of social capital is the structural dimension. This dimension refers to the structure of the relationships such as who you reach and how you reach them (Burt, 1992; Mannion & Davies, 2005). Relationships are
important sources of support for employees because they enable information to be communicated amongst individuals (Evans & Carson, 2005; Nahapiet & Ghoshal, 1998). The relationship or connection with each person is referred to as a tie and the strength of each of these ties is very important. For example, weak ties (such as with a visiting doctor from overseas) are more likely to possess new, interesting or innovative information than strong ties (such as with a doctor who has worked in the same ward or hospital for the last ten years). Therefore, this research is concerned with who nurses approach when they experience a problem, what the nature of their relationship is and how well they know that person. That is, in order to identify the strength of their ties and the benefits that they are likely to receive from them. This research is also concerned with who the organisation formally wants employees to approach and whether this is occurring which will provide clues as to the presence of gaps between policy and practice, and identify areas for organisational management to focus their efforts. By understanding the characteristics of these relationships, it is possible to improve them, thereby enhancing the availability of support and information to employees, which may positively increase nurses’ levels of commitment.

1.4 Significance of the research

Much of the research on the nursing shortage points to the need for positive changes in the work environment of nurses. This was very clearly identified in the early 1980s and is still evident today, as demonstrated by the success of, and increase in, magnet-designated hospitals. The success of magnet hospitals has been credited to their supportive and participative organisational cultures (Aiken et al., 2000). However, the foundation for supportive organisational cultures and many other individual and organisational outcomes is undoubtedly the quality of the relationships between the individuals within the organisation (Cohen & Prusak, 2001; Coleman, 1990; Seibert, Kraimer & Liden, 2001). As mentioned in the previous section, Social Capital Theory (SCT) provides a useful framework for examining the structure of the relationships within an organisation and the cultural framework in
which they reside. Subsequently, this research adopts SCT as a framework to examine the quality of relationships shared by nurses at their work in order to identity how this impacts upon nurses’ commitment to their hospitals.

However, a review of the literature (see Chapters 2 and 3) suggests that there are significant gaps evident in existing research. The first gap relates to the literature on social capital, in which several areas regarding further research have been identified. First, further research is needed to explore the social capital of different organisations and different types of employees, particularly due to the lack of research on the social capital of nurses working within Australia. This research therefore seeks to address these gaps in the literature by examining the social capital of one type of employee working within one type of environment, that being nurses working within public hospitals located within one Australian state. A second gap is that, although preliminary research into singular dimensions of social capital has surfaced, much more is needed about how the three dimensions of relational, cognitive, and structural social capital collectively impact upon nurses’ role ambiguity and perceptions of empowerment, and the resultant impact on commitment. This research addresses these gaps by examining variables that are representative of all three dimensions of SCT, simultaneously.

To explore the impact of attributes of social capital on nurse outcomes including organisational commitment, issues identified in the literature as being relevant to nurses and considered to display attributes of each of the dimensions of SCT, are examined. Relational social capital is interpreted by examining the quality of the exchanges that occur between nurses and their immediate supervisor, the Nurse Unit Manager (NUM). In addition, the tools of this relationship, the quality of communication processes, are also examined. Cognitive social capital is then interpreted by examining the quality of the organisation’s culture. Finally, structural social capital is interpreted by examining nurses’ problem-solving social networks. The main aim of these variables is to determine their impact upon outcomes such as role ambiguity, perceptions of empowerment, and nurses’ commitment to the
organisation, which is an important contribution to the minimal literature in this area. This leads to the first research question to be examined:

RQ₁ What is the impact of variables that display qualities of relational, cognitive and structural social capital on the role ambiguity, perceived empowerment, and affective commitment of nurses?

One important part of social capital is social networks and how employees use these relationships to gain benefits in the workplace. A review of the literature shows minimal research has been undertaken on how nurses solve work-related problems. Even less research has been undertaken on the role of social networks in assisting employees to solve problems, and the resulting impact that this has on their commitment to the organisation and retention within the nursing industry. The current research addresses this gap by examining who nurses approach within their network when they need assistance in solving a work-related problem, and their relationship to these individuals. This leads to the second and third research questions:

RQ₂ Who are the members of nurses’ problem-solving social networks and what is the strength of the ties between contacts?

RQ₃ How effective are nurses’ problem-solving social networks and what is the role of supervisors in this network?

Finally, in order for organisational management to improve outcomes, they need to understand where discrepancies exist between what occurs in practice and what is supposed to occur, which is determined by organisational policy, by identifying any gaps present. This research contributes to the literature relating to policy-practice differences in a nursing context. This leads to the fourth and final research question:

RQ₄ What differences exist between organisational policy and organisational practice regarding variables that display qualities of relational, cognitive and structural social capital, and work outcomes such as role ambiguity, perceived empowerment, and affective commitment of nurses?
It is important to note here that this research was one part of a large-scale project examining evidence-based ways to improve the retention of nurses and was undertaken by this researcher and two chief investigators. The larger project examined a number of antecedents of nurses’ commitment including social capital factors, well-being, stress and work-life balance, and individual and organisational-related outcomes. The research presented in this thesis was one part of the original large-scale project and focuses on the impact of social capital and other outcomes on nurses’ commitment, but does not explore individual outcomes such as stress, well-being, and work-life balance. Further details regarding the larger research project and how this research study fits into that, as well as information on the specific duties undertaken by each researcher can be viewed in Appendix 1.

Overall, this research contributes to the literature by providing greater insight into the relationship between social capital and employee outcomes, particularly organisational commitment. This thesis will make both theoretical and practical contributions to the literature on nurses, nurse commitment, employee outcomes and social capital. Specifically, this is achieved through the following:

- An examination of hospital-based nurses’ social capital from a holistic perspective using all three dimensions of social capital simultaneously;
- A greater understanding of how hospital-based nurses use social networks and social capital to enable them to solve work-related problems;
- Further insight into the role of social capital and the importance of relationships in reducing negative outcomes such as role ambiguity and in improving perceptions of empowerment; and
- Increased knowledge regarding the impact of social capital and relationships upon hospital-based nurses’ commitment to the organisation and therefore, retention in the nursing profession.
- Clarification and understanding of some factors impacting upon nurses working in hospitals located within Australia.
1.5 Research methods

The main aim of this research is to identify how the quality of nurses’ relationships affects their commitment to the organisation, to further understanding of some of the factors affecting commitment, and thereby improving the retention of nurses. Accordingly, the positivist paradigm suits the research design because it emphasises the need for valid and reliable results that may be generalised to a larger population (Easterby-Smith, Thorpe & Lowe, 2002; Guba, 1990). Due to the large number of factors under investigation and the need for deeper understanding of the factors affecting nurses’ organisational commitment, this research employs a mixed methods approach by gathering both quantitative and qualitative data.

The research site is two public sector hospitals located within Australia. Participants include nurses who were working within the hospitals at the time of the research on wards identified by hospital management as experiencing high levels of turnover. Nurses within these wards were randomly asked by the researchers to participate in the research.

A sequential mixed methods approach consisting of four methods of data collection were used in this research. A survey containing quantitative questions (using validated instruments) was used to examine each of the factors, as well as four qualitative questions, which were designed to understand the working environment of nurses, factors affecting their commitment to the organisation, the role of their supervisor in helping them to solve work-related problems and their problem-solving social networks in general. Focus groups and interviews were then conducted to examine the factors affecting nurses’ perceptions of empowerment. Finally, document analyses were undertaken to identify organisational policies regarding the variables examined, and any differences between these policies and organisational practices as identified through other data collection methods.

The quantitative data were analysed using multiple regressions and path analysis using SPSS software. The qualitative data were analysed using manifest and
latent content analysis to identify the frequencies and meanings behind the data. Pattern-matching of the data was then conducted and led to the development of emerging themes.

1.6 Delimitations

A delimitation of this research is that it is confined to affective commitment, which is an employee’s desire to stay with the organisation (Allen & Meyer, 1990). This research is not concerned with other forms of commitment such as continuance commitment, which is the need to stay in the organisation, or normative commitment, which is the obligation to stay in the organisation. Nor is this research concerned with the degree of actual turnover experienced by the people being researched. The results of this research may therefore be generalised only to nurses’ affective commitment to their hospital and does not measure a variety of other predictors of the commitment or retention of nurses.

A second delimitation of this research is that the target sample was limited to nurses working within a public sector hospital environment. Nurses working within hospitals located within the public health care system were chosen for this research as the public health care system is a major employer of nurses working within Australia (ABS, 2008b). Subsequently, these results may not be generalisable to nurses working outside of a hospital environment or the public health care system, both within Australia and overseas.

1.7 Structure of the thesis

This thesis is organised into eight chapters. Chapter 1 has explored the context of the public health care system in Australia and the reforms undertaken that resulted in significant workplace changes. The shortage of nurses in Australia and the associated arising problems were then explored. Finally, the significance of
this research in exploring the impact of work relationships on the organisational commitment of nurses was then detailed as a way to gain a better understanding of why nurses are leaving, and therefore provide evidence of how to improve their retention.

Chapter 2 discusses Social Capital Theory as a framework for exploring the relationships that nurses have and the context in which these are situated. The chapter reviews the literature regarding the relational, cognitive, and structural dimensions of Social Capital Theory and the relevance of this to nurses. A figure is then provided demonstrating the areas that are proposed and examined in this research to provide insight into the quality of social capital present.

Chapter 3 reviews the literature relating to the areas under examination in this research. These areas include measures to explore the social capital of nurses including the relational dimension through the supervisor-employee relationship and communication processes; the cognitive dimension through the organisation’s culture; and structural dimension through problem-solving social networks. Two work outcomes - role ambiguity and perceptions of empowerment - are then discussed as individual factors that impact upon the areas under examination. The organisational commitment literature is then reviewed, followed by an examination of differences that may occur between organisational policy and organisational practice and the implications that potential differences may have for this research. The gaps in relevant research are identified, and research questions and hypotheses for this research are proposed.

Chapter 4 details the methodology utilised in the research. A positivist epistemology is employed in this research to emphasise research that is valid and reliable. A justification is provided for the use of a mixed methods approach, which examines the issues being studied using quantitative and qualitative tools including surveys, focus groups, interviews, and document analyses. The research sample used, as well as the reliability and validity of the research undertaken are analysed. The ethical implications are considered.
Chapter 5 outlines the results of the quantitative analyses of the data, which were gathered from validated survey instruments to measure a number of predictor and outcome variables in this research. This chapter details the results of the regression analyses and the calculation of the strength of the ties and the characteristics regarding nurses’ problem-solving social networks in response to the research questions and in relation to the hypotheses being investigated.

Chapter 6 outlines the results of the qualitative data, which were obtained through open-ended survey questions, focus groups, interviews, and document analyses. The findings are presented as dominant themes which arose from the combined data from the above listed methods. These findings build upon the quantitative results to explain in greater depth nurses’ perceptions of empowerment in their work and the positive and negative aspects affecting their commitment to the organisation. Furthermore, analysis of organisational documents confirmed differences between organisational policy and organisational practice, as identified through both the quantitative and qualitative data.

Chapter 7 combines and discusses the results and findings from the quantitative and qualitative analyses and the implications of these for the organisational commitment of nurses and other individual outcomes.

Finally, Chapter 8 summarises the major conclusions of this research and discusses the implications of these for organisational management theory and practice. The contributions made to the organisational behaviour, social capital and nursing literature are stated, along with the limitations of this research and areas for further investigation.
CHAPTER 2 – SOCIAL CAPITAL THEORY

2.1 Introduction

This chapter explores the conceptual framework of Social Capital Theory (SCT), which was used in this research as a lens to view how the quality of relationships affects employee outcomes such as organisational commitment. SCT assumes that individuals gain benefits from relationships and ties held with other members of social networks (McElroy, Jorna & van Engelen, 2006). This chapter outlines the theoretical framework of SCT which underpins this research. SCT is introduced with a discussion of its applications across different types of groups. An in-depth review of social capital within organisations and the benefits of this, as well as the factors affecting social capital are then outlined. The chapter then explores the relational, cognitive, and structural dimensions of SCT and the status of existing research into SCT on nurse employees. Included here is a discussion of the first research question which examines the relationship between the three dimensions of SCT, and the individual outcomes and organisational commitment of nurses working within Australia. Finally, the chapter finishes with an exploration of why the study of SCT is useful for organisations. The following section now introduces the assumptions that underpin the theory.

2.2 Social Capital Theory

SCT argues that individuals belong to numerous social groups or networks across multiple facets of their life where membership to these groups is based on their level of trust. The trust developed within these network relationships develops into a goodwill bank account which is used selectively to gain benefits for the individual and others (Adler & Kwon, 2002; Walker & Christenson, 2005). When maintained over time, the contacts or individuals within these networks become trusted sources of knowledge and resources and serve to further strengthen the quality of the relationship (Burt, Hogarth & Michaud, 2000). Therefore, the higher
the quality of relationships, the more effective the network is likely to be to its members (Kessels & Poell, 2004; Nahapiet & Ghoshal, 1998).

Recognition of the potential gain that may be derived from relationships is one of the reasons why SCT has generated much interest in recent years (Sobel, 2002). These benefits usually result in access to a range of resources or information that is considered to be of value to each party within the network (Coleman, 1990; Lin, 2000). There is potential for an increased flow of information which is facilitated by providing information about opportunities and choices that otherwise may not be available, as well as the exchange of resources, favours and exchanges (Coleman, 1988; Lin, 2001; Tsai & Ghoshal, 1998). For example, social networks can be used to assist employees in seeking jobs and gaining promotions. Employers and prospective employees prefer to learn about job opportunities and job seekers through sources that they trust (Lin, 2001). Seeking information about jobs through networks is also more cost effective than formal job search strategies and can provide the individual with an advantage over others who do not possess access to this information (Granovetter, 1995, 2005). This is because the individuals have access to information such as errors to avoid and more efficient and effective processes to use (Granovetter, 2005) thereby increasing their chance of being successful. Furthermore, employees who gained their position through personal contacts frequently exhibit lower turnover rates than those who did not (Fernandez, Castilla & Moore, 2000).

Benefits of social networks may also be experienced in the form of improved social interactions with others. For instance, being a member of a group creates a sense of belonging for members and makes an individual feel worthy of being in a social group and provides recognition and a sense of identity because of it (Lin, 2001). Furthermore, social networks provide credibility and validity of information and individuals because the network backs up the individual and their resource, and provides a greater source of influence (Lin, 2001). All together, these provide emotional support and public acknowledgement to the individual.
Individuals may belong to multiple groups across a wide variety of contexts. However, a simple classification of these areas or levels includes societal, organisational and individual levels of social capital (Kessels & Poell, 2004). These levels are illustrated in Figure 2.1. Social capital at the societal level is evident by examining communities and large networks and refers to the stock of relationships that combine to create human networks and communities for cooperative action (Cohen & Prusak, 2001). Social capital at the organisational level is evident by examining organisations and any groups or networks affiliated with it. Specifically, it refers to the collection of relationships and connections with others that facilitate collective action and give an organisation or individual access to new knowledge (Leana & Van Buren, 1999; Mannion & Davies, 2005; Nahapiet & Ghoshal, 1998). Finally, social capital at the individual level is evident by examining individuals and small groups and refers to the collection of relationships that produce resources accrued from relationships of mutual acquaintance and recognition (Burt, 1992). Regardless of which level social capital exists at, the common theme amongst them is the desire to facilitate beneficial collective action through trust.

This research is concerned with social capital at the organisational and individuals level in order to gain a greater understanding of the factors affecting employees and their environment by exploring the quality of the relationships and social networks surrounding them. Social capital at the organisational level refers to the network of trusting relationships within an organisation that facilitate collective action and provide access to new knowledge (Leana & Van Buren, 1999; Mannion & Davies, 2005; Nahapiet & Ghoshal, 1998). The focus of social capital at this level is the quality and structure of these relationships and how they are used to gain advantages for both the members and the organisation itself. Organisations are a great place in which to develop social capital because every organisation possesses a number of employees that are each members of multiple social networks from within and outside of the organisation, thereby improving the potential and capacity for social capital to develop. Each member of the organisation is either a full-time, part-time, or temporary employee (Leana & Van Buren, 1999), and members can include buyers, suppliers, contacts from professional associations and more.
Moreover, several outcomes of social capital such as commitment, learning, knowledge, and responsibility (Cohen & Prusak, 2001) are already present within the employment relationship because of the nature of the organisation itself. Due to the potential of the number of organisational members, and the many benefits that can be derived from social capital and its networks, SCT has emerged as an important area of interest for human resource professionals and organisational management.

![Figure 2.1 Three levels of social capital (adapted from Kessels & Poell, 2004).](image)

A review of the organisational behaviour literature suggested that the link between organisational effectiveness and employee outcomes is well established. Considerable research has been undertaken at the organisational level regarding the relationship between social capital, access to information, and greater innovation (Cohen & Prusak, 2001; Kessels, 2001; Nahapiet & Ghoshal, 1998). Previous research suggests significant relationships between social capital and problem-solving, trust, and carrying out daily work duties more effectively and efficiently (Cohen & Prusak, 2001; Moran, 2005). This was supported by Granovetter (2005) who argued that productivity can be enhanced by an individual’s social position. This is because many
tasks require cooperation from others; and because tacit knowledge can only be acquired through others when conforming to the “book” or rules is not appropriate. For example, newcomers to the organisation who fail to fit in with a group can be disadvantaged in terms of productivity as they are not privy to vital work practice information that is normally gained through interaction with others (Dalton, 1959; Granovetter, 2005). Social capital may enhance organisational effectiveness due to the exchange of strategic resources, which can lead to performance differences and competitive advantages among organisations (De Wever, Martens & Vanderbempt, 2005; Gulati, Nohria & Zaheer, 2000; Tsai & Ghoshal, 1998).

Overall, the literature pertaining to social capital at the organisational level suggests that this is a very important area of investigation that is only in its infancy. A number of studies have suggested that social capital is advantageous to the overall productivity and effectiveness of the organisation as well as to its employees. The importance of this concept is detailed in the following section.

2.3 Why study social capital?

Social Capital Theory assumes that the higher the quality of relationships held by an individual, the more beneficial that these will be for its members. This research uses SCT as a lens to explore the factors impacting upon the organisational commitment of nurses. By focusing on variables that show evidence of the relational, cognitive and structural dimensions of SCT, such as the quality and structure of relationships, and the context in which they are situated, the researcher is able to gain a greater understanding of the factors affecting nurses’ commitment to the organisation. The literature has already established that the quality of relationships impact upon the effectiveness of a variety of organisational processes (see Cohen & Prusak, 2001; Coleman, 1990; Haskins, 1996; Lin, 2001; Seibert et al., 2001). This research therefore uses SCT as a framework to examine the quality of
the relationships, the context in which they reside, and the effectiveness of a variety of organisational processes that lead to organisational commitment.

This research builds upon and adds insight into the relationship between attributes of social capital and organisational commitment and is conducted on nurses within a hospital environment. It will address several gaps in the literature including aiding understanding of the role of social capital in improving organisational processes such as commitment to the organisation which may improve an organisation’s overall effectiveness (Dess & Shaw, 2001; Nahapiet & Ghoshal, 1998). This research applies Nahapiet and Ghoshal’s (1998) model of relational, cognitive and social capital and the impact of the dimensions at the one time and explores the cognitive dimension of social capital, which is frequently neglected in favour of the relational and structural dimensions (De Wever et al., 2005). There is also an identified need to more clearly understand the context surrounding the measurement of social capital (Cavaye, 2004).

The next section explores the intricacies of organisational social capital in more depth by reviewing literature regarding its three main dimensions and what these mean to the quality of relationships at work.

### 2.4 Dimensions of social capital

According to Nahapiet and Ghoshal (1998) SCT at the organisational level is evident through three dimensions of relational, cognitive and structural social capital (see Figure 2.2). Subsequent literature has supported this framework as being an effective way to explore the area of social capital (De Carolis & Saparito, 2006; Haines & Bedard, 2001). Nahapiet and Ghoshal’s (1998) framework guides this research by acting as a lens to examine how the quality of organisational relationships impacts upon outcomes. Each of these dimensions is explored next.
2.4.1 **Relational social capital**

The relational dimension of SCT assumes that it is the quality of past interactions that determine the quality of relationships held by an individual and which motivates them to collaborate with others and exchange vital resources (Kessels & Poell, 2004; Moran, 2005; Nahapiet & Ghoshal, 1998). Past interactions occur through the process of exchanges including creating and disseminating knowledge, ideas and opinions; sharing and assisting in problem-solving; and giving or receiving feedback (Kessels & Poell, 2004; Moran, 2005). These past interactions result in the presence or absence of trust and trustworthiness, which is one of the ways that the relational dimension of SCT is evident within organisations.

Trust has been identified in many research studies to be a prerequisite to any successful relationship and refers to the willingness of an individual to be vulnerable to the actions of another individual based upon their belief in that person's trustworthiness or ability to follow through with promises made (De Wever et al.,
As with any type of relationship, the level of trust present will determine the future exchanges and outcome of the relationship. Due to the multidimensional and reciprocal nature of trust, a situation is created in which the presence of trust encourages exchanges, and exchanges then encourage further trust (Fukuyama, 1995; Jeffries & Reed, 2000; McKnight, Cummings & Chervany, 1998; Putnam, 1993; Tyler & Kramer, 1996). With respect to social capital and social networks, the level of trust possessed will determine an individual’s choice of which person to access for assistance or support (Adler & Kwon, 2002; Mannion & Davies, 2005; Moran, 2005; Tsai and Ghoshal, 1998).

A number of factors are taken into account when determining the trust and trustworthiness of an individual. Some of these include the perceived integrity of the individual, the competence of the exchanges that occur between the parties, and the predictability of the usefulness of the exchange based upon the alignment of common goals (Butler, 1991; Hosmer, 1995). For example, Gefen, Rose, Warkentin and Pavlou (2005) argued that sharing common values and goals makes individuals more likely to be trusting of other network members. This trust enables both individuals within the exchange to predict the success of future exchanges and accompanying levels of trust (BarNir & Smith, 2002; Das & Teng, 1998). Another factor that affects the trustworthiness of a contact is the initiating individual’s predisposition to trust, or willingness to depend on others (Brunetto & Farr-Wharton, 2007; McKnight et al., 1998). This is important because the decision to engage in an exchange is a result of an analysis of the costs and benefits of doing so, and vulnerabilities and risks involved. When an individual initiates an exchange, they are in a vulnerable position because they are displaying a weakness or gap in their knowledge (Jensen, 2000). In addition, the other individual is also vulnerable because they are allowing access to their knowledge and experience, and taking a risk that their actions will be reciprocated at a later time (De Wever et al., 2005; Szulanski, 1995). The result of this is that both parties are in a vulnerable position as are the organisations involved with either party (De Wever et al., 2005). Consequently, trust and trustworthiness are not only the most important factor in
creating exchanges, but also the most fragile (Mannion & Davies, 2005; Nahapiet & Ghoshal, 1998).

The fragility of trust and trustworthiness is demonstrated in how quickly and easily it may be broken, resulting in diminished motivation to engage in further exchanges. One example in which this may be demonstrated is through short-term initiatives used by organisational management such as downsizing and the consistent use of temporary staff, which inhibit an employee’s ability to form meaningful relationships with others (Campbell, Campbell & Chia, 1998; Leana & Van Buren, 1999). Alternatively, long-term initiatives such as permanent positions with leave benefits, and investment in training and development, as well as other rewards by organisational management encourage the development of trust (Brunetto & Farr-Wharton, 2006; Leana & Van Buren, 1999).

Rewards encourage the development of norms, which are the specific actions regarded by a population as proper and correct, or alternatively, improper and incorrect (Coleman, 1990). Together, these form the context in which individuals know what is expected of them, to better enable them to perform functions appropriately (Adler & Kwon, 2002; Thieme, 2007). Additionally, they also create obligations and expectations, which refer to a duty or commitment to undertake an activity at a future time (Nahapiet & Ghoshal, 1998). As a member of a social network, there is an obligation to other members to participate and share resources such as knowledge and information in exchange for membership within the group (Adler & Kwon, 2002). This form of obliged motivation influences an individual’s motivation to engage in an exchange because they believe that positive outcomes will be achieved by that action (Nahapiet & Ghoshal, 1998; Whittaker, Burns & van Beveren, 2003).

Norms also acts as a framework for the development of relationships within the workplace. Norms and sanctions are the motivational component of social capital because they influence the behaviour of others and allow the group to exert some level of control over behaviours that may affect them (Coleman, 1990;
Goddard, 2003; Smedlund, 2008). Norms facilitate this and other collective actions through general understandings, implicit norms, and generalised, resilient trust as opposed to strict hierarchical control mechanisms that may be imposed by management (Fukuyama, 1995). Consequently, norms are one of the many sources of social capital and are considered very important in both creating and maintaining social capital (Adler & Kwon, 2002; Coleman, 1990; Coleman & Hoffer, 1987).

Within an organisation, norms are dependent on regular and effective communication so that individuals may internalise them accordingly (Coleman, 1990; McElroy et al., 2006). Perceiving attributes of the organisation and the people within it as similar to the individual’s attributes, such as a desire for high quality output and strong relationships with clients for example, increases motivation to engage in collective behaviours and improve relationships with others (Ashforth & Mael, 1989). Subsequently, communication processes are another variable that may be measured to provide insight into the quality of relationships at work. Norms are communicated to employees informally in a variety of ways to ensure their adherence (Coleman, 1990). However, they do not come with sanctions or reinforcements as rules do (Ostrom, 2005), which highlights the importance of rules such as organisational policies and procedures reflecting the norms in place. One way in which organisational policies and procedures may support norms is through promotion and selection practices such as selecting and rewarding employees that they trust to share in the organisation’s goals and values (Bigley & Pearce, 1998; McKnight et al., 1998). Promotion practices can also support the development of social capital by reinforcing acceptable behaviours and practices, and using the promoted employee’s display of accepted behaviour to influence other employees’ behaviours (Leana & Van Buren, 1999).

Another way in which organisational policy can reinforce acceptable behaviours is through newcomer socialisation programs. Organisational socialisation refers to the process of learning the norms, values and approved behaviours that new employees undertake in order to become a member of an organisation (Van Maanen, 1976). Through programs such as these, newcomers are exposed to the
norms and preferred behaviours of the organisations and recognise and understand the importance of undertaking these. Subsequently, accommodation of these behaviours and expectations would ideally be higher and lead to greater undertaking and implementation in the future. Examples of newcomer socialisation programs that have been shown to successfully contribute to these aims include mentoring programs (Ostroff & Kozlowski, 1993; Seibert, 1999), training programs (Klein & Weaver, 2000; Nelson & Campbell Quick, 1991), and numerous alternative socialisation tactics (Allen & Meyer, 1990; Ashforth & Saks, 1996; Jones, 1986). Furthermore, it is expected that the role of the newcomers, and existing employees’ social networks would assist in these programs and processes (Morrison, 2002a) by providing the motivation and access for these to be both undertaken and successfully applied. Therefore, relationships facilitate the adherence to, and communication of, norms in which relationships are built, thereby influencing the future effectiveness of the norms and the relationships.

In addition to communication processes, the organisation itself plays a role in the development of relationships and social capital. For instance, the organisation and its management may encourage the development of trust and reciprocity by embedding the relationships within the social structure of the organisation, thereby improving the flow of information and decreasing the loss of tacit knowledge from voluntary turnover (Droege & Hoobler, 2003; Leana & Van Buren, 1999; Nahapiet & Ghoshal, 1998). The organisation may embed relationships within the social structure of the organisation by reinforcing the obligations and expectations present, and reward or punish these accordingly (Brunetto & Farr-Wharton, 2006; Smedlund, 2008). These same behaviours also affect the content of exchanges by affecting the quality and flow of information (Koka & Prescott, 2002; Granovetter, 2005). Subsequently, communication processes are also a key component of the effectiveness of social capital within the workplace, although some propose that a greater understanding is needed of how communication processes either facilitate or thwart the development of social capital (Fussell, Harrison-Rexrode, Kennan & Hazleton, 2006).
The main outcome of high trust relationships is that individuals are more willing to engage in exchanges (Nahapiet, Gratton & Rocha, 2005). High levels of trust are evident in effective problem-solving and decision-making (Fussell, Harrison-Rexrode, Kennan & Hazleton, 2006; Hunt, Tourish & Hargie, 2000) as well as increased flows of information, resources and social support received (Cohen & Prusak, 2001; Kessels & Poell, 2004; Nahapiet & Ghoshal, 1998). It has even been suggested that an effective social network is really just a high trust social network (Casson & Guista, 2007). However, high trust relationships do not always lead to positive outcomes. For instance, high trust relationships can lead to individuals being closed off to outside ideas, and a reduced volume and meaning of information available (Mannion & Davies, 2005). Moreover, when trust is low or not present at all, the risk is higher for the individual and they may not pursue other members irrespective of any obligations and expectations that may be in place (Schoorman, Mayer & Davis, 2007; Thieme, 2007). Therefore, there is evidence to suggest that a high, (but not too high) level of trust is necessary for the successful engagement of exchanges between individuals.

Overall, a review of the literature relating to the relational dimension of SCT as proposed by Nahapiet and Ghoshal (1998) demonstrated that a significant amount of research has examined these areas, and that it can be concluded that the relational dimension is perhaps the most researched dimension of all due to its focus on relationships within the workplace. However, several gaps were identified as being important. First, the relationship between employees and their supervisor was identified as being significant to social capital. Several studies suggested that greater understanding was needed about the supervisor-employee relationship and the role that trust plays in this, but from a social capital perspective (Bolino, Turnley & Bloodgood, 2002; Hodson, 2005; Molm, Takahashi & Peterson, 2000; Pastoriza, Arino & Ricart, 2008). This is particularly important in light of research which has suggested that the quality of relationships held between employees and management impact on the effectiveness of organisational processes, and therefore the organisation’s overall effectiveness (Cohen & Prusak, 2001; Coleman, 1990; Haskins, 1996; Lin, 2001; Seibert et al., 2001). Second, there is a need to further
identify and understand what factors influence employees’ motives to create social capital within an organisation, and third, of the benefits and risks of social capital (Adler & Kwon, 2002). Together, these gaps in the literature propose that greater examination of the quality of the supervisor-employee relationship, and potentially other workplace relationships, and the associated processes and factors affecting these, are necessary and beneficial to the understanding of social capital at the organisational level.

2.4.2 Cognitive social capital

The cognitive dimension of SCT argues that the social context of an organisation, which is the quality of the atmosphere surrounding an organisation and its members, is essential in supporting the relationships in place. More specifically, this dimension refers to how behaviours and beliefs support the development of social capital by providing interpretations and systems of meaning (Cicourel, 1973; Llewellyn & Armistead, 2000). The social context works to support relationships by providing a framework of behaviour that is common amongst members, thereby resulting in a collective understanding and approach to the achievement of tasks and outcomes (Klimosky & Mohammed, 1994; Nahapiet & Ghoshal, 1998; Pastoriza, 2008; Thieme, 2007). Subsequently, employees develop a shared vision and goal for their actions (Smedlund, 2008). Together, these work to encourage the development of relationships and social networks.

One of the many reasons why it is so important for the social context of the organisation to be unified is because when individuals believe that their efforts are integral to the organisation’s actions, such as through understanding how their work fits into the overall goals of the organisation (Gist & Mitchell, 1992), they are more likely to voluntarily engage in activities for the collective good and spend less time on individual-interest activities (Leana & Van Buren, 1999). Whereas normally, formal procedures force employees to cooperate with the organisation’s goals (Fukayama, 1995), high quality relationships encourage cooperation while emphasising the benefits to be obtained. This increases perceptions of the level of control and
ownership possessed by all parties involved and creates a greater sense of responsibility for its growth, success and continuation (Koka & Prescott, 2002). For example, many propose that social capital is a jointly owned asset between the organisation and its employees, or the network itself, and must be viewed accordingly for it to be used to its maximum potential (Burt, 1992; Edelman, Bresnen, Newell, Scarbrough & Swan, 2004; Mannion & Davies, 2005). The organisation does this through the development of organisational policies to support relationships at work (Kessels, 2001) and employees do this by engaging in exchanges throughout their daily activities (Orr, 1990). However, the wide range of ownership also poses problems because relationships, and therefore social capital, are an intangible asset that cannot be fully protected from the loss of key members (Miller & Shamsie, 1996). For example, some suggest that the loss of even a few key network members encourages the loss of further members and erodes social capital, sometimes completely (Dess & Shaw, 2001; Leana & Van Buren, 1999). Furthermore, it is argued that social capital cannot be traded amongst people (Nahapiet & Ghoshal, 1998), which, together means that social capital can be fragile (Mannion & Davies, 2005; Nahapiet & Ghoshal, 1998).

Another reason why it is important for the social context of the organisation to be unified is because it makes an organisation and its staff more flexible and able to cope with change. High quality relationships enhance the willingness of employees to engage in necessary behaviours thereby making the organisation more flexible (Leana & Van Buren, 1999). One example would be during times of organisational change whereby high quality relationships would support and unite employees together at times of upheaval and stress, thereby making employees more adaptive to change. The existence of trust is essential here as employees need to trust in the organisation and fellow colleagues that adapting their behaviour would result in a benefit to the individual as well as the organisation. Together, these previous findings suggested that a unified, positive and supportive organisational context is necessary for the successful exchange of information, knowledge and resources.
The social context of an organisation is evident by examining the culture of an organisation which refers to the symbols, values, ideologies and assumptions that unconsciously guide the behaviour of an organisation and its employees (Cartwright & Cooper, 1993). A number of studies have suggested that employees’ perceptions of the culture and climate of the organisation are significantly associated with many organisational outcomes (Gollan, 2005; Ostroff & Bowen, 2000; Ostroff, Kinicki & Clark, 2002; Simons & Roberson, 2003). Some even argue that social capital is an asset that cannot be evaluated or fully understood without knowledge of the context with which it is situated (Sobel, 2002). Therefore, examining the culture of an organisation as well as the organisational processes is viewed as an effective way to interpret the cognitive social capital within an organisation.

The role of management is very important when seeking to understand the role that the social context plays in the development of relationships. The reason why management is so integral to an organisation’s social capital is largely due to the power and control that they possess over organisational practices. For instance, it is organisational management who are ultimately responsible for the success and effectiveness of an organisation, regardless of how that effectiveness may be measured. In terms of the successful contribution of social capital to this effectiveness, summarily, management are responsible for the initiatives, rules and processes that contribute to the social context of the organisation (Leana & Van Buren, 1999; Nahapiet & Ghoshal, 1998; Pastoriza, 2008). Furthermore, management determines the extent to which employees share vital information and resources required and therefore improve organisational effectiveness. One outcome of this is that management possess a large amount of control over the level of trust present within the organisation (Curtin, 1994). Subsequently, management is also a source of support for employees and a major contributor to the relationships within an organisation. For instance, Leana and Van Buren (1999) argue that organisational practices must support the development of relationships through providing both stability and flexibility. These can be achieved by offering job security to employees, investment in further training and education, and clear promotion and selection procedures. Therefore, the effectiveness of the
organisational processes and practices prescribed by management are important in setting the context for the organisational relationships, and social capital.

There are multiple ways in which the social context of the organisation supports the development of relationships, and therefore social capital. The first way is through the creation of a shared language and shared narratives. The social context within an organisation frequently possesses its own shared language which guide the way in which individuals communicate with each other in ways such as asking questions, sharing information, and conducting business in general (Nahapiet & Ghoshal, 1998). This shared language allows members to anticipate the behaviour of others so as to increase the efficiency and effectiveness of actions and outcomes (Klimosky & Mohammed, 1994). Shared narratives are similar to a shared language but use metaphors, good stories, myths and legends, and fairy tales to cross contexts and enhance the quantity and quality of information exchanged, thereby aiding interpretation (Bateson, 1972; Nahapiet & Ghoshal, 1998). These increase the meaning of information to other members as they understand these due to their overlap in knowledge and experience (Cohen & Prusak, 2001; Klimosky & Mohammed, 1994; Nahapiet & Ghoshal, 1998). Together, a shared language and shared narratives increase the expectations and meaning of information that is shared between organisational members. These result in shared understandings, which when high, provide motivation to engage in more activities, which can result in greater value and perhaps greater innovation (Cohen & Prusak, 2001; Klimosky & Mohammed, 1994; Nahapiet & Ghoshal, 1998).

The second way that the social context supports the development of relationships is by promoting a good flow of information through producing an environment that is conducive to exchanges of knowledge and information (Leana & Van Buren, 1999; Nahapiet & Ghoshal, 1998). Because organisations possess a high quantity of partnerships, collaboration, interaction, learning and knowledge sharing (Cohen & Prusak, 2001; Kessels & Poell, 2004), there is a broad source of information in terms of volume, diversity and richness that are available within a small physical proximity to the individual (Koka & Prescott, 2002). The social context of an
organisation encourages the dissemination of information through dialogue and exchanges with others, which facilitates access to others and information that they may be able to provide (Klimosky & Mohammed, 1994; Nahapiet & Ghoshal, 1998). The organisation’s systems of reward and punishment then reinforce these (Granovetter, 2005; Koka & Prescott, 2002). The outcome of this is an increased potential for information to be obtained about opportunities and choices that otherwise may not be available (Lin, 2001), greater creativity and innovation amongst employees (Kessels & Poell, 2004; Moran, 2005; Nahapiet & Ghoshal, 1998), and additional opportunities to build upon the quality of relationships and level of trust within these.

The third way that the social context supports the development of relationships is through the increased social support available to employees (Klimosky & Mohammed, 1994; Nahapiet & Ghoshal, 1998). Social support refers to the provision of actual or perceived resources from others that satisfy an individual’s basic social needs or desire for interaction in order to increase well-being (McIntosh, 1991; Thoits, 1982). Typically, support is provided by sources such as supervisors, work colleagues, family and friends who provide assistance in a time of need (House, 1981; Meyer, 1994). This support may be emotional such as listening to problems and taking a personal interest in the receiver (House, 1981; Nelson, Brice & Gunby Jnr, 2010). Alternatively, support may be instrumental or informational such as assistance with a task or the provision of data, facts, knowledge or other information (House, 1981; Nelson et al., 2010). Recent research has suggested that high levels of social support decrease burnout and emotional exhaustion amongst employees (Kilfedder, Power & Wells, 2001; Sullivan, 1993) and are positively associated with greater involvement in more innovative problem-solving (Nelson & Brice, 2008). Interestingly, early research suggested that the presence of ambiguity surrounding an employee’s role was instrumental in generating social support because individuals who experienced role ambiguity sought out more information and therefore increased communications with others and the social relations resulting from this (Kahn, Wolfe, Quinn, Snoek & Rosenthal, 1964). Regardless of how the support is
provided and who it is provided by, social support is a necessary part of belonging within any group environment.

Overall, a review of the literature pertaining to the cognitive dimension of social capital identified that the area has been moderately researched. However, the researcher argues that more research is necessary regarding the interrelationship between the cognitive dimension with both the relational and structural dimensions. A greater understanding of the collective relationship between all three dimensions would optimise the ability of organisational management to enhance cognitive aspects such as organisational culture by understanding the larger picture and its positive benefits.

### 2.4.3 Structural social capital

The structural dimension of SCT assumes that the structure and characteristics of the relationships within a network play a large role in the success of that network. The structure and characteristics of relationships refers to the overall pattern of connections related to who an individual reaches, how the individual reaches them, how well the individual knows them, and the nature of the relationships (Burt, 1992; Mannion & Davies, 2005). These are evident by examining the ties connecting the contacts and the configuration of the network itself.

Network ties refer to the relationships and connections that are made with other members of a network (Granovetter, 1973). Ties held by individuals may include family, friends, partners, colleagues, acquaintances, and members of professional associations to name a few, while examples of ties held by organisations may include customers, clients, professional associations, government, buyers, and suppliers to name a few (Granovetter, 1973). Ties may be either absent, strong or weak based on the closeness and frequency of interactions in the relationship, as well as the emotional intensity and reciprocal commitments of those involved (Granovetter, 1973, 1982; Hansen, 2002; Marsden & Campbell, 1984).
Absent ties are those that lack significance such as a relationship with a store shop assistant from where a newspaper is brought (Granovetter, 1973). This tie is rarely used for gathering benefits such as information and resources as there is minimal to no relationship present or information to gain. This type of tie is therefore considered to be of little relevance in understanding the social networks of employees.

Strong ties are relationships that are close and commonly refer to close family, friends, and colleagues. Due to the close nature of these ties, the relationship with the tie is usually considered to be more long-term, intense and secure, while also being more accessible and helpful (Elfring & Hulsink, 2003; Krackhardt, 1992). Therefore, strong ties are considered a strong source of support for individuals.

Weak ties are commonly relationships with acquaintances that are characterised by lower amounts of interaction, emotional intensity, intimacy, and reciprocal services (Granovetter, 1973; Hansen, 2002; Levin & Cross, 2004). This type of tie is usually the greatest in number, and the most frequently discussed. Yet, weak ties are considered more valuable and are referred to as “the strength of weak ties” because acquaintances mix with a broader range of people than strong ties do, and are exposed to more novel and innovative information from these sources (Granovetter, 1973, 2005). In contrast, strong ties such as close friends associate with similar people to us and an overlapping of information occurs. Subsequently, individuals are likely to gain the most benefit from weak ties. Although there are a greater number of weak ties as opposed to strong ties, it is these weak ties that hold a greater chance for exchanges of important information across a network (Granovetter, 2005). Because of this, weak ties have been shown to be advantageous in job seeking (Granovetter, 1973; Lin, 1982); promotion (Burt, 1992; 1997; 2000); and the diffusion of ideas (Granovetter, 1982; Rogers, 1995), particularly weak ties that are developed over the span of an entire career (Granovetter, 1995, 2005).
In addition to the strength of the tie, some ties in a network may be joined by a bridge. A bridge refers to a line in a network that is the only path between those points (Granovetter, 1973). Burt (1992) argues that the ways in which ties are bridged are more important than the quality. He argues that an individual receives greater advantage when they possess ties between different parts of different networks because the tie is the only route in which information can flow between these networks. In addition, these ties frequently provide new information in a more timely fashion through bridges to socially distant regions of a network that may not have been reached alternatively, while also increasing the opportunity for further valuable exchanges with the bridged contact (Burt, 1992; Granovetter, 1973; 1982; Nahapiet & Ghoshal, 1998).

Collectively, the strength of ties amongst members has been shown to affect the potential benefits obtained from the social network (Levin & Cross, 2004). Hoang and Antoncic (2003) posit that for a network to be effective there must be both strong and weak ties linking individual actors. This is believed to be because different ties are argued to have different benefits in different ways (Elfring & Hulsink, 2003). Therefore, although weak ties are considered to be the most advantageous (Granovetter, 1973), a network that consists of weak ties alone would not be as affective, in part due to the lack of close and supportive relationships (Elfring & Hulsink, 2003; Krackhardt, 1992).

In addition to the strength of the network ties, the configuration of the network is also important and refers to the pattern of linkages in the network including their density, connectivity, and hierarchy (Nahapiet & Ghoshal, 1998). The reason why the configuration of networks is important is because aspects such as these can influence the flexibility and ease of information exchanges and therefore the development of intellectual capital (Ibarra, 1992; Krackhardt, 1989; Nahapiet & Ghoshal, 1998). This is achieved through developing high quality relationships across a wide variety of organisational members which increases the opportunity for higher quality sources of information from further distances (Burt, 1992; Mannion & Davies, 2005). For example, Morrison (2002a) found that employees with more dense and
stronger informational networks possessed greater role mastery and clarity as a result of employees participating in newcomer socialisation initiatives who possessed greater organisational knowledge from network contacts across different departments, including supervisors as well as just colleagues. In addition, Granovetter (2005) argues that the greater density a network has, the greater the chance that norms will be clearer, strongly held and enforced and therefore, adhered. This is because dense networks provide more opportunities for information and ideas to be exchanged, thereby increasing the amount, and prevalence of, desired behaviour. In turn, this makes deviance from desired behaviour harder to hide and more likely to be punished. In contrast, dense networks may be perceived to be less beneficial and efficient because everyone knows each other and shares the same information, and any new information is spread quickly and diffused (Burt, 1992). It is for these reasons that some suggest that the structure of networks is more important than the size of a network alone (Burt, 1992).

A review of the literature pertaining to the structural dimension of social capital theory suggested that it has been extensively researched due to the popularity of Social Network Theory. However, a need has been identified for more research on the characteristics and ties of the social networks used by various different types of employees (Mehra, Kilduff & Brass, 2001). The current research is valuable in addressing this gap in examining the ties accessed by nurses within social networks for the purpose of solving problems in the workplace. The findings will add insight into how the quality of relationships impact upon work outcomes.

2.5 Social capital in the nursing profession

This research uses SCT as one way in which to explore the relationships and organisational culture that comprises nurses’ work environment. This is important because improving the work environment of nurses is believed to be one of the main ways in which to increase the commitment of nurse employees. A review of the
literature identified that a significant gap exists in relation to nurse employees and social capital with minimal research studies identified. Of those that exist, there appeared to be a consensus that social capital has tremendous potential in supporting health care in general, and particularly for nursing staff (Chang, Gotcher & Chan, 2006; Lauder, Reel, Farmer, & Griggs, 2006; Pesut, 2002). However, all identified studies did not explore social capital from a big picture perspective by addressing all dimensions, but rather, explored singular topic areas such as relationships, and failed to more fully explore the implications of these for social capital. Subsequently, the review of the literature in the following paragraphs focuses on areas used to illustrate social capital, rather than Social Capital Theory itself. This fragmented approach to exploring social capital in the nursing sector provides many opportunities for further research from a more holistic perspective such as this current study, but allows minimal background from which to build upon.

Regarding nurse relationships, trust is incredibly important to health care organisations and occupations such as nursing due to the professional risk involved with caring for patients (Gilson, 2003). This highlights the importance of relationships as nurses frequently work independently based on the advice and instruction of others, and therefore need to be able to trust others and possess a high quality relationship (Curtin, 1994). Examination of literature suggested that the quality of the relationship between nurses and their immediate supervisor is highly important. Research by Hegney, McCarthy, Rogers-Clark and Gorman (2002) on nurses working within rural Australia identified that the relationships with immediate supervisors was one of the most important factors that influenced nurses’ commitment to stay in rural nursing. Some even argue that a mentoring relationship between nurses and their supervisor is a very effective form of social capital because they provide the support that nurses are seeking, and because mentoring relationships have a long history of being a successful tool (Block, Caffey, Korow & McCaffrey, 2005; Hofmeyer & Marck, 2008; Hofmeyer & Scott, 2006). Research by West et al. (1999) suggests that relationships with supervisors and other senior nurses is important because they are able to send information across long social distances in a social network, thereby giving them greater control and making
them more persuasive. However, research by Brunetto, Farr-Wharton and Shacklock (2011) on 1064 public and private sector hospitals located across multiple Australian states, suggested that less-than-optimal supervisor-employee relationships existed in the sample due to a lack of accessibility and availability of their NUM, and the lack of ward-based promotion and by NUMs personally, of the importance of possessing social networks in a work context.

The quality of relationships with nurse colleagues was also important and positive. Social support through colleagues was suggested to be an invaluable source of social support for nurses, in part because they were more accessible and offered greater practical assistance (Dallender, Nolan, Soares, Thomsen & Arnetz, 1999; Jenkins & Elliot, 2004).

As mentioned in Chapter 1, the culture of the organisation that nurses work in has undergone significant changes that have impacted upon the daily work activities of nurses. However, research by Hofmeyer and colleagues (see Hofmeyer, 2003; Hofmeyer & Marck, 2008; Hofmeyer & Scott, 2006) suggested that social capital has tremendous potential for improving the working conditions and quality of work-life for nurses. They argue that improving the social relationships in place will encourage nurses to participate more within the organisation, feel more able to provide input, and feel an increased sense of belonging (Hofmeyer, 2003; Hofmeyer & Scott, 2006) which will improve the organisation’s culture and morale.

Some research was identified that suggested that social capital is beneficial in fostering a learning environment for nurses (Gopee, 2002) as it increases the flow and exchange of knowledge and information. For instance, Field (1999) argues that a lot of learning is social and occurs informally around corridors and other common areas in an organisation. However, it is acknowledged that it is the responsibility of Nurse Managers, and nurses themselves, to create an environment that supports further learning (Hepner & Hopkins, 2000). However, the lack of a supportive management culture is said to inhibit further learning for nurse employees (Alderman & Lipley, 2001). Therefore, the behaviour of organisational management
through the provision of support has the potential to affect the quality of both the organisation’s culture and the relationships within it.

Regarding the structure of relationships and social capital, Mannion and Davies (2005) argue that social capital and social networks are useful tools in the functioning of health care systems. Nurses and other health care employees are required to provide a high quality of coordinated care to patients, which require the communication and exchange of vital information and resources, as well as constant problem-solving in the face of ambiguity (Mannion & Davies, 2005). They argue that social networks are a beneficial way in which these processes may be optimised. This assertion is supported by Chang et al. (2006) who found that increased levels of social interaction between nurses facilitated greater opportunities for access to information and resources. The outcomes of Chang et al.’s. (2006) research was that high social capital reduced the degree of ambiguity experienced by nurses while also reducing levels of emotional exhaustion and job tension.

The role of networks and access to information is relevant when considering who nurses may approach in the workplace. For instance, Edmondson’s (1996) research identified that some nurses were reluctant to consult physicians who may have caused a problem, or hold beneficial information regarding a problem they were experiencing, due to the low status of nurses. The existence of social networks and high quality relationships (such as trusted colleagues or nurses in an advanced role with access to more information) is one approach that may reduce this occurrence (Hofmeyer & Marck, 2008).

Overall, the review of this literature suggested a significant gap in understanding the relationship between social capital and organisational commitment of nurses, although the literature does identify a number of areas for further investigation as a result of this. There is a need for greater understanding of social capital in general with regards to nurses (Chang et al., 2006; Lauder et al., 2006). Mannion and Davies (2005) specify that focus should be placed on the role of
trust in particular. Lastly, more research is needed on how social ties differ between different types of employees including nurses (Mehra et al., 2001).

### 2.6 Proposed theoretical framework

This research examines the factors impacting upon the organisational commitment of nurses working within Australia using a SCT framework. This leads to the first of the research questions which explore the impact of factors that represent the three types of social capital on work-related outcomes, including organisational commitment, and is as follows:

RQ$_1$ What is the impact of variables that display qualities of relational, cognitive and structural social capital on the role ambiguity, perceived empowerment, and affective commitment of nurses?

The ways in which each of the three dimensions is explored in this research are represented in Figure 2.3. The relationship that these factors have with the work-related outcomes being investigated, and a diagrammatic representation of these, is provided in the following chapter. The order of the hypotheses examined in this research are based on the model at the end of Chapter 3 and are not in sequential order based on the topic areas discussed in the following chapter.
The relational dimension of SCT refers to the quality of relationships and their associated processes. Accordingly, these are evident through examining the quality of the relationship between supervisors and employees, termed leader-member exchange, and the communication processes between them. This is because the relationship between a supervisor and their employee is an important relationship for all employees, and is also a significant source of information regarding their organisation, their employment relationship, and other expectations. Therefore, the quality of exchanges within the supervisor-employee relationship and the
organisational communication processes amongst it are affective ways in which to add insight into the relational component of social capital and the degree of trust present in the relationship. The three hypotheses used to examine these two variables are outlined in the following chapter.

The cognitive dimension of social capital is concerned with the social context in which relationships are situated. Examining the culture of the organisation is a commonly used method to determine the quality of social capital, and is based on a foundation of evidence which suggests that many organisational outcomes (such as job satisfaction for instance) are a result of the quality of the organisational culture (Gollan, 2005; Ostroff & Bowen, 2000; Ostroff et al., 2002; Simons & Roberson, 2003). Therefore, examining the organisation’s culture is an effective way to measure the social context of an organisation in which social capital is developed. Three hypotheses used to examine organisational culture are detailed in the following chapter.

The structural dimension of social capital is concerned with the structure of relationships and is evident by examining the relationships within social networks. In this research, the social network used by nurses to assist them in solving work-related problems is examined. Previous research suggests that social networks are a beneficial tool for solving problems (Boyte, 1995; Sirianni & Friedland, 1997) because high quality relationships facilitate access to contacts with helpful knowledge and skills. The problem-solving social networks of nurses is a very under-researched area and examination into this will contribute to the literature by enabling greater understanding of the role of social network relationships in the problem-solving processes of nurses. Two research questions are proposed in order to examine this variable. No hypotheses are used as this variable is examined using frequencies only and did not require the development of any hypotheses.

The research is then concerned with the impact that the predicting factors have on nurse outcomes including role ambiguity, perceived empowerment, and ultimately nurses’ organisational commitment. Research suggests that the presence
of role ambiguity decreases an employee’s levels of commitment, performance, and satisfaction in their role (Foote, Seipel, Johnson & Duffy, 2005; Jolke et al., 2000; Rhoads, Singh & Goodell, 1994). In addition, ambiguity then decreases employees’ perceptions of empowerment and autonomy (Conger & Kanungo, 1988; Kalbers & Cenker, 2008; Siegall & Gardener, 2000). Each of these factors then has the potential to negatively affect nurses’ commitment to their organisation. Four hypotheses were examined for role ambiguity, one hypothesis for perceived empowerment, and two hypotheses for organisational commitment.

2.7 Conclusion

This chapter has explored SCT as one way in which to view the quality of the relationships and social context that are impacting upon nurses’ commitment to their organisation. An overview of SCT was provided and an in-depth look at social capital at the organisational level followed. This review provided valuable insights into the impact that social capital can have on an organisation and its members and the outcomes resulting from such. The relational dimension identified the importance of relationships to employees and the components of trust, norms and obligations that reside within those relationships. The cognitive dimension was then explored to demonstrate the importance of a high-quality and supportive organisational culture in facilitating the development of organisational relationships. Following these, the structural dimension outlined how these relationships can be structured through the type, strength and configuration of ties within the social network that the relationships constitute. A significant gap in the literature regarding social capital and nurse employees was then detailed, and a rationale given for why SCT is important and worthy of further investigation. The final part of this chapter presented the proposed theoretical framework for this research, and the proposed research question that arise from the framework. The following chapter reviews the literature on each of the variables used in this research.
CHAPTER 3 – LITERATURE REVIEW

3.1 Introduction

This chapter provides a detailed review of the literature in relation to the concepts introduced in Chapter 2 which are being investigated in order to provide insight into the quality of social capital present. The aim of examining these concepts is to assist in determining the role that SCT plays in the organisational commitment of nurses. This chapter begins with an exploration of the measures used in this research to add insight into the relational, cognitive and structural dimensions of SCT. A review of the quality of exchanges (leader-member exchange) and communication processes within the supervisor-employee relationship is provided to assist in interpreting the quality of relational social capital. The culture of the organisation, representing the cognitive dimension of social capital, is then explored. Problem-solving social networks, which reflect the structural dimension of social capital, is also undertaken. Following this, a review of the literature pertaining to the outcomes of role ambiguity, perceptions of empowerment and the organisational commitment of nurse employees is explored. Finally, differences between policy and practice are briefly detailed.

The first section within this chapter explores the quality of the exchanges that occur between supervisors and employees as one of the ways in which to interpret relational social capital. These exchanges refer to the term lead-member exchange and a review of the literature and research pertaining to this concept is now outlined.

3.2 Leader-member exchange

Leader-member exchange (LMX) refers to the social exchanges that occur between an immediate supervisor and their employee, and the resulting quality of the relationship over a period of time (Graen & Scandura, 1987). LMX theory argues
that supervisors manage employees differently which, over time, leads to a diverse quality of relationships between supervisors and employees and results in different outcomes from different groups of employees (Graen & Uhl-Bien, 1995). Therefore, examining the quality of exchanges between supervisors and employees is one measure that can be used to determine the overall quality and status of this relationship. Furthermore, the importance of possessing a high quality relationship and high quality exchanges between supervisors and employees is heightened because the supervisor-employee relationship is one of the most significant relationships that an employee possesses within the workplace.

The quality of social exchanges and the resulting relationship is classified as either a high quality social exchange relationship or low quality economic exchange relationship.

### 3.2.1 High quality social exchange relationships

The first classification, employees who have high quality social exchange relationships, also referred to as the “in-group”, exhibit social characteristics that extend beyond the minimum required for an employment relationship (Sparrowe & Liden, 1997). The emphasis in this type of relationship is on the social nature of the exchanges, which means that supervisors and their employees are more motivated and willing to put in a greater effort to improve the quality of their relationship. This group receives a large amount of benefits from the relationship because of its nature, which increases the propensity of both supervisors and employees to make more effort to maintain the quality of the relationship.

Employees within the in-group typically possess a relationship with their supervisor that is also characterised by higher levels of mutual support, trust and respect (Gerstner & Day 1997; Mueller & Lee 2002). Such employees are more empowered in their work and willing to support the decisions of their supervisor (Keller & Dansereau, 1995; Laschinger, Purdy & Almost, 2007; Wayne, Shore & Liden, 1997). Furthermore, when employees perceive high levels of support from their
supervisor, they are also likely to experience high morale and commitment (Podsakoff, Mackenzie, Lee & Podsakoff, 2000). Another benefit of being in the in-group is that these employees are liked more by the supervisor, regardless of the employee’s work performance (Graen & Uhl-Bien, 1995). Both the supervisor and employee enjoy a high degree and quality of emotional support, loyalty, trust, professional respect, and contribution to future exchanges (Graen & Uhl-Bien, 1995; Liden & Maslyn, 1998). The characteristics of this relationship are important because it has many implications for the employee, supervisor, and organisation. For instance, supervisors are willing to allocate more time and resources to members within this group. Some of the major benefits of this are the increased flow of information and feedback for employees and their subsequent increased level of involvement and participation (Brandes, Dharwadkar & Wheatley, 2004; Mueller & Lee, 2002; Yrle, Hartman & Galle, 2003). These then lead to reduced ambiguity because employees know what is expected of them (Dunegan, Uhl-Bien & Duchon, 2002; Graen, 2004). It also increases employees’ potential to solve problems within the workplace due to greater knowledge, information and control over their work (Mumford, 1986).

3.2.2 Low quality economic exchange relationships

Alternatively, the second classification, employees who have low quality economic exchanges, also referred to as the “out-group”, exhibit social characteristics that are limited to the minimum requirements specified of an employment relationship (Sparrowe & Liden, 1997). The emphasis in this type of relationship is the economic nature of the exchanges, as opposed to the social nature of high quality social exchange relationships. This classification means that supervisors and their employees are not motivated or willing to engage in any actions that may improve the quality of their relationship beyond expectations. The economic nature of the exchanges means that the relationship is focused around being paid to undertake work, as opposed to working for reasons such as the enjoyment, challenge or potential to improve the employee’s career. Subsequently, employees in the out-group do not receive the benefits enjoyed by the in-group.
Instead, employees are supervised more, while receiving less support and attention from their supervisor and less access to organisational resources (Liden & Maslyn, 1998). This results in less satisfaction, empowerment and commitment by the employee (Gerstner & Day, 1997; Liden & Maslyn, 1998).

### 3.2.3 Factors affecting the quality of exchange relationships

There are a number of factors that can contribute to whether a supervisor-employee relationship exhibits high or low quality exchanges. For example, each exchange that occurs between a supervisor and employee is different, based upon the amount of time and effort required for that exchange (Graen & Uhl-Bien, 1995). Some argue that supervisors are largely responsible for the quality of the exchanges because they are frequently the ones in control of resources of time and effort (Graen, 1976) due to their position of authority over the employee. A result of the varying exchanges that occur, and the resulting in and out-groups that arise from these, is the creation of a wide range of different quality relationships that end up affecting other areas within the organisation.

Another factor that can affect the quality of supervisor-employee exchanges is the conditions that affect the time and energy available to provide the exchanges. Significant research on supervisors such as NUMs has documented the pressures faced by them because of healthcare reforms and the environment in which they work (Schmalenberg & Kramer, 2009). Many of these studies have been negative and emphasised the decreased professional leadership, empowerment, and participation of Nurse Managers in nurse-related decisions (Bolton, 2003; Liang, Short & Lawrence, 2005; Neuman & Lawler, 2009). This has resulted in NUMs who are performing a larger number of economic management duties as opposed to nurse management duties (Buchanan & Considine, 2002; Neuman et al., 2002). Subsequently, Nurse Managers have become overworked, micro-managed, and sometimes, not supported by their own management (Neuman & Lawler, 2009). Some argue that many Nurse Managers do not possess the relevant management,
communication, problem-solving and negotiating skills that are required in their role (Shaffer, 2003) due to the large shift away from nursing management and towards economic management. The pressures placed on Nurse Managers decrease the time and energy they have available to commit to their nursing staff.

There is a strong relationship between the quality of exchanges and employees’ turnover intentions (Gerstner & Day, 1997; Morrow, Suzuki & Crum, 2005). This means that employees in the out-group are more likely to leave their organisation than employees from the in-group. Some research even argues that an effective supervisor–employee relationship is the factor most likely to improve commitment and retention because those in the in-group are more likely to share resources (Cohen, 2006; Taunton, Boyle, Woods, Hanson & Bolt, 1997). However, there is an identified need for more research on the supervisor-employee relationship and employees’ affective commitment to the organisation (O’Driscoll & Beehr, 1994). One potential reason for the relationship between LMX and turnover is that a high quality supervisor-employee relationship increases the satisfaction of employees in their work (Graen, 2004; Jansen & van Yperen, 2004; Laschinger et al., 2007). This was supported by research that suggested the more satisfied employees are with the style of leadership used by authority figures, the lower their intention to quit (Liao et al., 2008).

Another important factor to consider is the role of turnover in future relationships. Specifically, turnover facilitates a reduced quality of exchanges because relationships typically cease when employees receive promotions, transfers, move to other equivalent positions, or retire (Graen, 2004). Therefore, poor quality exchanges and relationships lead to increased turnover, which then forces supervisors to establish new relationships with replacement employees, thereby decreasing the potential social capital possessed by the supervisor. This situation means that poor quality exchanges actively work to decrease social capital within the organisation both directly and indirectly. Alternatively, high quality relationships serve to increase the social capital in place (Llewellyn & Armistead, 2000).
Communication resulting from the quality of the supervisor-employee relationship also affects peers working within the associated team. This is because peers are the most frequent source of interaction within organisations (Louis, Posner, & Powell, 1983). Therefore, it is important to explore the impact of supervisor-employee relationships on the effectiveness of teamwork. If team members believe the preferential treatment of one team member is deserved, the entire team may benefit as they use their peers to gain greater access to, and information from, their supervisor. In contrast, if peers within a team resent the preferential treatment that someone receives because it appears undeserved; the workgroup may suffer collectively as they distance themselves from the high quality LMX peer and their supervisor. Consequently, there are situations in which a middle quality LMX relationship may be preferable to a high quality LMX relationship. Those with medium quality LMX relationships may experience more of the positive benefits of a high quality LMX relationship such as additional access to the supervisor without experiencing any negative consequences or resentment from other team members (Graen, 2004).

A review of the literature suggests that minimal research has been conducted on the supervisor-employee relationship for nurses and the resulting outcomes of this relationship (Klieman, Quinn & Harris, 2000; Yrle et al., 2003). Existing research in Australia has suggested that nurses are experiencing a lack of support from management and colleagues (Victorian Government Department of Health Services, 2001). Furthermore, the importance of receiving support from supervisors is demonstrated in research by Bartram et al. (2004), which found higher job satisfaction in areas where nurses had high levels of support and empowerment. However, a significant research gap does still exist in the relationship between supervisor-employee relationships, and nurse behaviour.

A review of the literature suggests that the supervisor-employee relationship is one of the most important relationships within an organisation. The literature has demonstrated that this relationship is associated with many individual and organisational outcomes and is a valuable context through which to examine the
relational social capital of employees. As part of this review, several knowledge gaps and areas for further research were identified. The main areas were the need for further research into the outcomes of the supervisor-employee relationship within a nursing context, and the need for greater understanding through multiple forms of data collection, such as through the use of a mixed methods approach (Graen & Scandura, 1987). This research extends the literature by examining the role of the supervisor-employee relationship and its impact on the organisational commitment of nurses. Furthermore, the role of other social capital factors and other employee outcomes is also explored and most importantly, the role of NUMs in assisting employees with problem-solving processes is also examined. No hypotheses are listed here as LMX was combined with the following variable, communication processes, during the analysis stage. The hypotheses for these combined concepts are therefore provided at the end of the following section.

The second variable for examination that assists in interpreting the role that relational social capital plays in the relationships being investigated are the communication processes present between supervisors and employees. A review of this literature follows.

### 3.3 Communication processes

Communication refers to the exchange of information between two or more parties (Daft, 1997). One major source of communication for employees is from their supervisor (Griffin, 1983), and communications are argued to be one of the most influential actions within the supervisor-employee relationship (Gilmore & Carson, 1996; Johlke & Duhan, 2000). This was reflected in the use of communication processes being examined within social capital research (Hazleton & Kennan, 2000). Communication is regarded as the way in which social capital is developed, maintained and utilised because it affects the general atmosphere of the organisation, which is referred to as the organisational culture (Smidts, Pruyn & Van Riel, 2001). When effective communication processes are in place, they facilitate a
culture that supports more effective organisational processes and relationships (Rothwell & Scedl, 1992). For instance, effective supervisor-employee communication processes have the potential to decrease employees’ ambiguity with respect to tasks and situations (Johlke & Duhan, 2000; Sutcliffe, Lewton & Rosenthal, 2004). This then improves their ability to solve work-related problems (Ibarra & Andrews, 1993; Kim, 2002) which may result in greater feelings of empowerment and improved job satisfaction (Johlke & Duhan, 2000; Quinn & Spreitzer, 1997). A study examining nurses working throughout rural Australia suggested that good communications were a factor that influenced nurses to remain in their role, and poor communications influenced their decision to leave (Hegney, McCarthy, Rogers-Clark & Gorman, 2002).

A review of the nursing literature suggested that poor communication is an issue for nurse employees (Dallender et al., 1999), particularly for nurses working within a hospital environment (Ishida, 2000). One example given was of the poor communications during the nurse handover, which occurs between the end of one nurse’s shift and the start of another’s. Recent research suggested that nurses perceived that they did not receive critical information, while they did receive unnecessary information, and they were unable to ask questions regarding the information required (Kalisch, Weaver & Salas, 2009). Further analysis revealed that these poor communications had negatively affected the quality of teamwork processes within the wards (Kalisch et al., 2009). Alternative research by Faulkner and Laschinger (2008) and Laschinger (2004) identified that supervisors and other types of managers played a large role in communication processes. Specifically, giving effective feedback was perceived by nurses to be an act of respect by some nurses (Faulkner & Laschinger, 2008), which is even more important when additional research identified that nurses felt that their supervisor and other managers had not shared information about workplace changes or demonstrated compassion for the nurses’ responses to these (Laschinger, 2004). Each of these studies highlights the fact that supervisors and other levels of management are important providers of information and communication, and subsequently, the quality of these are considered important by nursing staff.
A more detailed exploration of communication processes follows by examining the four main characteristics of communication including its frequency, mode, content, and direction (Krone, Jablin & Putnam, 1987).

### 3.3.1 Communication frequency

The first characteristic, communication frequency, refers to the quantity and duration of communications between individuals (Mohr & Nevin, 1990). One of the assumptions of communication frequency is that a higher quantity and duration of communication is likely to produce more favourable outcomes than a smaller frequency and duration (Johlke & Duhan, 2000). Additional research supports this assumption by suggesting that problem-solving (Fussell et al., 2006) levels of job satisfaction (Johlke et al., 2000) and commitment were enhanced with increased communication (van Vuuren, de Jong & Seydel, 2007). Therefore, in order for effective communication to take place, it makes sense that a greater amount of communication be exchanged between supervisors and their employees, and on a more frequent basis. This ensures that information and requirements are being communicated so as to reduce any ambiguity in the workplace (Brunetto & Farr-Wharton, 2008). However, the frequency and duration of communications were not found to impact upon the job productivity of employees (Johlke & Duhan, 2000). This is likely to be because high quantities of communication are not as important as the quality of the communication content in determining supervisors’ instructions for employees’ work outcomes. Subsequently, the literature has suggested that further research be undertaken into the relationship between communication frequency and various job outcomes (Becerra & Gupta, 2003; Johlke & Duhan, 2000). Together, the literature relating to frequency of communications suggested that there is much more to making communications effective.

The frequency of communication also plays a large role in the development and maintenance of social capital. For example, increased communication makes the motives of the sender more transparent, which encourages trust and trustworthiness and improves the quality of relationships (Becerra & Gupta, 2003;
Whitener, Brodt, Korsgaard & Werner, 1998). Due to the importance of trust in all organisational relationships (Moran, 2005), this is a continued concern for organisations. Alternatively, previous research has suggested that when there is a low frequency of communication, employees rely more on their colleagues (Becerra & Gupta, 2003). This researcher posits that perhaps it is because colleagues work together to pool their knowledge and information when it is not being communicated sufficiently from supervisors and other managers. Effectively, employees seek support from fellow colleagues in order to obtain the required information for them to complete their task, which enhances their non-supervisory support network.

### 3.3.2 Communication mode

The second characteristic, communication mode, refers to the degree of formality of the channel or method used to communicate (Johlke & Duhan, 2000; Stohl & Redding, 1987). The degree of formality may be either formal or informal and the mode of communication used is dependent upon the nature of the work and the communication outcomes desired. The first mode, formal communications, are characterised as impersonal communications such as group meetings and written communication such as letters and reports (Johlke & Duhan, 2000). Formal communications are frequently used in workplaces due to the convenience, professionalism, and ability to communicate with larger numbers of staff that they offer. However, formal methods may also inhibit creativity and innovation amongst employees (Alavi & Leidner, 2001) due to the strict and professional format and structure that characterises these methods as formal.

Alternatively, informal communications are characterised as more personalised and impromptu than formal communications and include most verbal and face-to-face communications (Johlke & Duhan, 2000). This mode of communication is more conducive to building good workplace relationships as it encourages interpersonal communications that enhance the quality of workplace relationships. For instance, supervisors are better able to provide feedback to their
employees or quickly pass on new information that may be relevant (Kraut, Fish, Root & Chalfonte, 1990). This makes this type of communication best suited for environments characterised by a need for quick responses and actions (Burns & Stalker, 1961; Johlke et al., 2000) such as nurses working within a hospital environment. High incidences of informal methods of communication are also positively associated with increased job satisfaction amongst employees (Muchinsky, 1977). However, although informal modes do offer many advantages, they may also be criticised for being a waste of valuable knowledge due to a lack of formal recording of the exchange (Liyanage, Elhag, Ballal & Li, 2009) and this may later influence other organisational processes and outcomes such as performance evaluations.

3.3.3 Communication content

The third characteristic, communication content, refers to the “directness” of the communication and its intended effects (Johlke & Duhan, 2000). On the one hand, communication may be direct with a strong intent to influence and desire for prompt compliance using methods such as coercion, threats or promises for reward (Frazier & Summers, 1984). Direct communications are more likely to be used by NUMs in instances of emergency care. On the other hand, the communication may be indirect with the purpose being to spread information or encourage responsibility (Mohr, Fisher & Nevin, 1996). The indirect communication method is more conducive to developing organisational relationships because the communications encourage the attainment of organisational goals, and therefore entail motivation, which improves the quality of the relationship between the sender and receiver (Frazier & Summers, 1984). Under these circumstances, supervisors may not be required to supervise employees as intensely because employees would have a greater understanding of the purpose of the task to be achieved, which may lead to improved perceptions of empowerment. Indirect communications are one of the main reasons why mentoring programs within the workplace are so effective. Mentoring programs entail a more experienced employee assisting a less experienced employee in developing their personal and professional growth by
sharing expertise, values, and skills in the workplace (Cahill & Payne, 2006; Hale, 2004). However, a review of the literature suggested that more research is needed on the content and strategy of communication used between supervisors and employees (Fussell et al., 2006) which may facilitate a greater understanding of the role of communication content in the development of organisational relationships.

### 3.3.4 Communication direction

The fourth and last characteristic is the direction of communication, which can flow using any vertical or horizontal combination (Farace, Monge & Russell, 1977). Uni-directional communication, which flows one way only, such as being passed downwards from a supervisor to an employee, was historically prevalent (Dansereau & Markham, 1987; Johlke et al., 2000). However, bi-directional communication, which is the two-way flow of communications, such as from supervisors to employees and from employees to supervisors, is now viewed as a preferred approach. Two-way communication enables the employee to provide more input than previously while giving supervisors the opportunity to respond to feedback (Johlke & Duhan, 2000). Subsequently, two-way communication increases employees’ job satisfaction and performance and is the strongest of the four areas of communication in decreasing employees’ ambiguity surrounding what is expected of them in their work role (Jablin, 1979; Johlke et al., 2000). However, more research is needed on the relationship between two-way communication and role ambiguity (Johlke et al., 2000). Two-way communication is also beneficial in strengthening the quality of the supervisor-employee relationship by encouraging exchanges. Consequently, the level at which two-way or bi-directional communication occurs between supervisors and their employees is an important area of interest for this research.

A review of the communication literature and nurse communication literature specifically suggested that these were heavily researched areas. Furthermore, the quality of communication processes, particularly between supervisors and employees, is clearly associated with a number of individual and
organisational outcomes. However, this review did identify that more research is required on supervisory communication processes and the collective effect of all four characteristics of communication on work-related outcomes in general and their role in social capital (Becerra & Gupta, 2003; Fussell et al., 2006; Johlke & Duhan, 2000; Johlke et al., 2000). This current research extends the literature by examining the role of supervisor-employee communication processes and the impact of this on employees’ commitment to the organisation within a nursing context. Therefore, this research proposes the following hypotheses to test the impact of the quality of the supervisor-nurse relationship and its associated communication processes on a variety of the work-related factors discussed:

**H1** There is an inverse relationship between the quality of the **supervisor-employee relationship and its communication processes** (LMX and communication processes) and **role ambiguity towards customers** (customer ambiguity) for nurses.

**H2** There is a positive relationship between the quality of the **supervisor-employee relationship and its communication processes** (LMX and communication processes) and **perceived empowerment** (meaning and competence, self-determination, and impact) for nurses.

**H3** There is a positive relationship between the quality of the **supervisor-employee relationship and its communication processes** (LMX and communication processes) and **affective commitment** for nurses.

The following section reviews the literature and research conducted on organisational culture, which is used in this research to interpret the cognitive dimension of SCT by determining how this creates an environment that either supports or thwarts the development of relationships and employees’ levels of commitment to the organisation.

### 3.4 Organisational culture

Broadly speaking, organisational culture is the overall unique character or atmosphere of an organisation that distinguishes it from other organisations.
Specifically, organisational culture refers to the symbols, values, ideologies and assumptions that unconsciously guide the behaviour of the organisation and its employees and provide a sense of cohesiveness (Cartwright & Cooper, 1993). This means that a unique environment exists within every organisation which provides a framework for employees to follow and reduces any uncertainty about what is expected of them (Beyer, 1981). Employees learn these unconscious behaviours because they have developed slowly over time as a response to internal processes and external influences (Schein, 1984, 1990; Wilson, 2001).

Schein (1984) argued that organisational culture consists of three levels of artefacts, values, and basic assumptions. The first level is artefacts, which are the visual and tangible items that can be seen, heard and touched. These artefacts are deliberately constructed aspects of organisational culture and include the physical environment such as architecture and technology, and public documents such as mission statements and employee orientation manuals (Schein, 1984). The second layer of organisational culture is values which refer to norms, ideologies and philosophies, which determine and justify employees’ actions and are a direct reflection of the artefacts (Schein, 1984). For example, nurses may comment that they value input from patients’ family members and this may be expressed in the organisation’s code of conduct. This example demonstrates another important role of the NUM or other authoritative roles within wards. Specifically, it is the role of the NUM to ensure that policies and values set by upper management are communicated to, and understood by, lower level employees (Kowalczyk, 2002; Viitanen, Wiili-Peltola, Tampsi-Jarvala & Lehto, 2007). The third layer of organisational culture is basic assumptions, which are the deep, underlying and unconscious assumptions that dictate the employees’ thoughts, perceptions, behaviour and feelings (Schein, 1984). The assumptions originate from values and lead to a behaviour. When this behaviour is successful, it becomes an unconscious response and underlying assumption about how to do things in the organisation (Schein, 1984). These behaviours subsequently become so ingrained within employees’ that they are difficult to change and frequently hard to identify.
Therefore, discovering the basic assumptions held by employees is the key to fully understanding the organisational culture and employees’ behaviour (Schein, 1984) and is the area of greatest interest in this research.

**3.4.1 Professional values**

In the nursing context, one of the basic assumptions held by nurses is their professional values, which are different from the espoused values that reflect organisational artefacts. The nursing profession sets specific professional values as the preferred standard and as a framework for evaluating nurse behaviour (Weis & Schank, 2000). For example, values set by the Australian Nursing and Midwifery Council (2008) include: quality care; respect and kindness; diversity; access to quality care; informed decision-making; safety; ethical information management; and the promotion of health and well-being through sustained practices. Other nurse values identified by previous research include: honesty and integrity; quality and excellence in work; teaching and mentoring; hard work; understanding and helping others; and faith (Miller, 2006). These values are very important to nurses due to their moral responsibility to look after their patients’ health and because they are constantly faced with situations requiring value utilisation such as advocacy and rationing of sparse medical supplies (Glen, 1999). It is subsequently important that these values be integrated into clinical practices to give further meaning to nursing work and encourage increased cohesiveness among staff (Shaw & Degazon, 2008). Furthermore, it is important that these values are identified when examining organisational contexts so as to understand the foundation for employee’s behaviours.

However, one downside to the existence of professional values is the potential conflict that may arise with organisational values (Raelin, 1989). This means that nurse employees are constantly being forced to decide and choose between often-conflicting values and priorities in their daily work and within the culture of the organisation. One of the main reasons for this is because the integration of values has become increasingly difficult in recent years in the Western
world due to the number of changes experienced within health organisations that have profoundly affected nurse and hospital culture. Many argue that the managerialist reforms occurring within Australian healthcare are largely based upon cultural changes (Anderson et al., 2002; Hood, 1995; Maor, 1999). However, recent research has suggested that nurses perceived their organisational culture negatively (Webster et al., 2009). This is an alarming finding due to other research on nurses which suggested that the culture of an organisation plays a large role in their commitment to the organisation and intention to quit (Chen, 2004; Liao et al., 2008).

Another cultural change experienced by nurses was in respect to requirements for training and further education. In Australia between 1985 and 1993, the training of nurses moved from in-hospital training to a four-year university degree with associated university fees (ABS, 2005; Winthrop & Vane, 2002). This move has lessened the number of nurses previously available to work during training as now trainees attend studies at a training institution elsewhere and typically working part-time in a non-nursing related role to pay their bills. In addition, the need for further education to improve pay prospects, professional growth, and work conditions such as greater autonomy has also increased (Ishida, 2000). The positive outcomes of further education for nurses include increased perceptions of empowerment (Christiaens, Abegglen & Gardner, 2010; Kuokkanen, Leino-Kilpi & Katajisto, 2003) and a lower intention to quit (Liao et al., 2008). However, some nurses have indicated that gaining further skills and education has resulted in little or no financial benefits (Dickerson et al., 2007) or other benefits. One study suggested that the lack of a supportive management culture inhibited further learning for nurses (Alderman & Lipley, 2001). Similar studies suggested that the culture of health care in general, and the culture within individual organisations, may not be supportive of further education despite the goals of reforms being to empower nurses and improve workplace culture (Anderson et al., 2002; Hood, 1995; Maor, 1999).
Glaser, Zamanou and Hacker (1987) argued that organisational culture can be best determined by examining the following aspects: teamwork; morale; information flow; involvement; and meetings.

### 3.4.2 Teamwork

The first aspect, teamwork, refers to the extent that employees feel they work together as part of a successful team (Glaser et al., 1987). A high quality of teamwork has been shown to be very advantageous with health professionals experiencing increased job satisfaction, recognition of individual contribution and motivation, commitment (Xyrichis & Ream, 2008) and increased morale (Day, Minichiello & Madison, 2007). Patients also benefit from high nurse teamwork with subsequent increases in the quality of patient care and satisfaction (Meterko, Mohr & Young, 2004; Xyrichis & Ream, 2008). One study even found that poor teamwork which resulted in incomplete patient paperwork, led to a decreased quality of patient care, which led the authors to argue that teamwork is critical for safe and effective nursing patient care (Kalisch & Lee, 2010).

In order for a team to work together successfully, the literature states that a number of processes must occur. For instance, open communication and the sharing of information from each of the team members, supervisors and the organisation, has been shown to influence the ability of nurses to work together more successfully (Kalisch et al., 2009; Walker & Avant, 2005; Wheelan & Burchill, 1999; Xyrichis & Ream, 2008). Trust is also essential for effective teamwork if employees are to work cooperatively (Collette, 2004; Kalisch et al., 2009; Pyoria, 2007). Other antecedents of successful teamwork include understanding and a supportive culture that values teams through actions such as the provision of support, resources and education (Collette, 2004; Pyoria, 2007; Walker & Avant, 2005; Xyrichis & Ream, 2008). The NUM plays a large role in this by fostering positive teamwork and relationships at the ward level (Day et al., 2007) and encouraging team goals and performance, discussing these during meetings, and communicating the feedback amongst staff, as was found in research on nurses (Wheelan & Burchill, 1999).
3.4.3 Morale

The second aspect of organisational culture, morale, refers to employees’ feelings about the general atmosphere, character, and motivation within their workplace that may encourage them to undertake their work (Glaser et al., 1987). Morale is an area that is extensively researched and viewed as being strongly related to a number of individual and organisational outcomes. Previous research suggested that poor levels of morale are a frequent concern for nurses, particularly in the United Kingdom, the United States, Sweden and Australia (see Callaghan, 2003; Hegney et al., 2006; Nolan, Brown, Naughton & Nolan, 1998). Some of the reasons that are believed to account for this are the constant restructuring and challenges faced within health systems worldwide (Blythe, Baumann & Giovannetti, 2001; Brunetto, Farr-Wharton & Shacklock, 2010; Callaghan, 2003). For example, one of the many managerialist reforms implemented was a greater frequency of strict controls through policies and procedures, which were shown to decrease morale (McKnight, Ahmad & Schroeder, 2001). Further research suggested that dissatisfaction with organisational policies and practices increases the chances of employees leaving the organisation (Gray & Phillips, 1994; Secombe & Smith, 1997).

The relationship between employees and their supervisor is also strongly associated with employee morale (Gerstner & Day, 1997) with increased managerial support offered to employees suggested to increase morale as well as commitment (Podsakoff et al., 2003). Similarly, the relationship between nurses and their colleagues, and the quality of teamwork, were also significantly associated with levels of morale, as was the quality of patient care (Day et al., 2007). Improved morale also results in an increase in employees’ levels of job satisfaction (Judge & Watanabe, 1993) and commitment (Chen, 2004; Liao et al., 2008). Despite the wealth of research conducted on nurse morale, there is still an identified need for further research on Australian nurses with regards to the relationship between morale and absenteeism, commitment, turnover and productivity (Day et al., 2007).
3.4.4 Information flow

The third aspect of organisational culture, information flow, refers to the links and channels of flow of information to the individual and others within the organisation, in order to help them complete their job more effectively (Glaser et al., 1987). Effective information flows rely upon a supportive social context or culture (Dess & Shaw, 2001: Kessels & Poell, 2004), in part because supervisors and colleagues are the most common sources of information flow, and therefore knowledge, within an organisation (Meyer, 1994). Supervisors are particularly important in this process as traditionally, they are responsible for ensuring that organisational policies and communications get relayed between lower level employees and upper management (Bloor & Dawson, 1994; Jermier, Slocum, Fry & Gaines, 1991), even though research shows that this is not always effective (Viitanen et al., 2007). The flow of information and the quality of relationships that the information flows through are vital components of an effective organisation. Together, positive flows of information and strong relationships contribute to a culture of trust and unity (Fairholm & Card, 2009) as they make the sender more transparent and trustworthy, and communicate to employees what is acceptable behaviour and what the organisation values (Fell-Carlson, 2004). Furthermore, possessing strong relationships increases the chances of receiving information about opportunities that may not have been available otherwise (Lin, 2001). Subsequently, health organisations with good flows of information are considered by nurses to be attractive places to work (Kramer & Schmalenberg, 2004). Other benefits of effective information flow are the increased capacity for problem-solving and innovation that results from the increased information and knowledge that is shared (Brooks, 1994; Kessels, 2001).

3.4.5 Involvement

The fourth aspect of organisational culture, involvement, refers to whether employees have input and are involved in decision-making processes, thereby making them and their opinions feel valued (Glaser et al., 1987). Greater
involvement offers employees more responsibility and ownership over their role, which contributes to their level of teamwork, empowerment, problem-solving, and performance (Johnson, 2009; Nelson et al., 2010). In addition, increased involvement enhances the amount and quality of information received by employees, and their level of satisfaction with their work (Frone & Major, 1988). This is why organisational change efforts are more effective when employees are actively involved in the change, as opposed to simply being informed of what is occurring (Moore, 2001). Furthermore, research suggests that increased involvement facilitates a culture based upon respect due to increased accountability, as seen in nursing research conducted at magnet hospitals (Barney, 2002; Dickerson et al., 2007; Faulkner & Laschinger, 2008). However, many studies suggested that nurses perceived that they lacked the ability to participate in decision-making or provide input regarding their work and the organisation, and subsequently, felt that they were not being listened to (Khani et al., 2008; Krichbaum et al., 2007; Pellico et al., 2009). Additional research identified that not being listened to resulted in poor perceptions of empowerment (Webster et al., 2009) and that the need to be listened to by their manager was, alongside feedback, were the most important components of communication (van Vuuren et al., 2007). These studies suggested that the culture of some health care organisations did not support or value the contribution of their nursing staff.

### 3.4.6 Meetings

The fifth aspect of organisational culture, meetings, refers to how efficient and effective meetings are within the organisation (Glaser et al., 1987). Meetings are rituals that reflect the culture of the organisation by facilitating social and organisational identities as well as social cohesion amongst its members (Weick, 1995). However, the effectiveness of meetings is frequently disputed as focusing more on social processes rather than decision-making processes and meetings are therefore argued as being a poor use of time (Peck, Six, Gulliver & Towell, 2004). In the nursing context, the changeover of shift is an important type of meeting that occurs amongst all nurses on a regular basis (Bomba & Prakash, 2005). Recent
research on the effectiveness of nurse handovers suggested that communication in this area was a large issue with unnecessary information provided instead of critical information, and was marked by an inability to ask questions, which resulted in a decreased quality of teamwork (Kalisch et al., 2009). Although the research on nurses’ handover meetings is limited, this study did suggest that the culture of the studied organisation did not support open communication, knowledge or participation for nurses. One solution to this problem is an additional five to ten minutes for nurses to informally discuss patients’ needs to reduce any ambiguity or conflict and improve the quality of patient care (Joiner & Bartram, 2004). This would ultimately increase the opportunities available to nurses to communicate and both give and receive support to their colleagues.

Another way in which support is enacted is through a culture that values its nurses and recognises the contribution of their work to the overall function of the organisation. A review of the nursing literature suggested that a lack of value, recognition and respect from the organisation and its management was a major issue for nurses and the review has generated significant interest because of this (see Barron, West & Reeves, 2007; Dickerson et al., 2007; Faulkner & Laschinger, 2008; Laschinger & Finegan, 2005; O’Shea & Kelly, 2007; Southwick, 2005; Webster et al., 2009). Targeted research suggested that a lack of respect for nurses was identified to be greater from upper levels of management (Day, 2005; Khani et al., 2008) and supervisors, as opposed to colleagues (Laschinger, 2004). Furthermore, many studies have reported that nurses perceive there to be a lack of understanding of nurses’ work from upper management (Ishida, 2000; Krichbaum et al., 2007) and a lack of compassion towards nurses and Nurse Managers when organisational changes impact negatively upon the nurses’ work (Laschinger, 2004; Neuman & Lawler, 2009). Overall, research has shown that when employees are provided with greater respect and appreciation, a number of improvements occur, including increased job satisfaction and perceptions of empowerment, and a decreased intention to leave (DeCicco, Laschinger & Kerr, 2006; Faulkner & Laschinger, 2008; Kuokkanen et al., 2003; Laschinger, 2004; Milton, 2005).
A review of the organisational culture literature suggests that there is growing evidence that organisational outcomes are the product of employees’ perceptions of the organisational culture (Gollan, 2005; Ostroff & Bowen, 2000; Ostroff et al., 2002; Simons & Roberson, 2003). One example of this is evidence that has suggested that nurse empowerment is impacted by employees’ understanding of the organisational vision and goals, and the emphasis placed on teamwork and openness (Quinn & Spreitzer, 1997; Spreitzer, 1995a, b; 1996). Overall, this review of the organisational culture literature suggested that the area has been extensively researched. Hence, the inclusion of organisational culture as a measure of the cognitive dimension of social capital is widely agreed upon as appropriate.

However, it was identified that minimal research has been conducted on the role that organisational culture plays in social capital, together with the relational and structural dimensions. The literature identifies that more research on the organisational culture of nurses working within Australia is necessary, particularly with regards to morale (Day et al., 2007). In addition, more research is needed on the role of culture in knowledge sharing (Al-Alawi, Al-Marzooqi & Mohammed, 2007) and how culture supports participative behaviours such as team rewards and decision-making (Morrow, 1997). Furthermore, more research is needed in contexts with more specialised areas of knowledge (Al-Alawi et al., 2007) such as physicians and nurses. More research is also needed into the relationship between culture and empowerment and the variables affecting this relationship (Johnson, 2009). Therefore, this research extends the literature by examining the relationship between organisational culture as identified through basic assumptions, and outcomes including role ambiguity, perceptions of empowerment, and affective commitment within a nursing context. As mentioned in Chapter 2, the hypotheses examined in this research are based upon their order in the model at the end of this chapter and are not ordered sequentially in each of the topic areas discussed in the beginning of this chapter. Accordingly, the following hypotheses are provided:

$$H_8$$ There is an inverse relationship between organisational culture (teamwork, morale, information flow and involvement, and meetings)
and role ambiguity (customer ambiguity and supervisor ambiguity) for nurses.

$H_9$ There is a positive relationship between organisational culture (teamwork, morale, information flow, and involvement, and meetings) and perceived empowerment (meaning and competence, self-determination, and impact) for nurses.

$H_{10}$ There is a positive relationship between organisational culture (teamwork, morale, information flow, and involvement, and meetings) and affective commitment for nurses.

The following section reviews the literature on the social networks used by employees to assist them in problem-solving. This assists in interpreting the structural dimension of SCT and how the structure of relationships impacts upon outcomes.

### 3.5 Problem-solving social networks

The ability to effectively solve problems throughout daily work activities is a key skill required by employees and organisations alike. A problem refers to a non-routine event where an undesirable gap between the expected and the actual state arises and results in the presence of ambiguity (Brightman, 1988; Kepner & Tregoe, 1976; Tallman & Gray, 1990). This ambiguity occurs because of a lack of knowledge, clear direction, or solution to a problem and it is considered a problem because it prevents employees from completing their tasks, achieving their goals and moving onto the next task, thereby impacting upon the effectiveness of problem-solving (Tallman & Gray, 1990; Tucker et al., 2002).

The process of problem-solving refers to identifying, resolving, and removing a problem, including identifying what the problem is, and developing and choosing from a variety of potentially effective solutions (D’Zurilla & Goldfried, 1971; Tallman, Leik, Gray & Stafford, 1993). When a solution is effective, the problem-solving has been successful, the problem is resolved, and the desired goal is achieved (Nelson et
al., 2010). However, this is not always the case, and many problems may remain unsolved if not dealt with appropriately.

A review of the literature shows very minimal research on the problem-solving processes used by nurses. However, one significant study by Tucker et al., (2002) examined the depth of problem-solving undertaken by hospital nurses who are considered to be front line employees and found that they are more likely to encounter problems, particularly in relation to patient care. Examples of problems that the nurses encountered included missing or incorrect information and medication, missing or broken equipment, and waiting for resources (Tucker et al., 2002). The observations from Tucker et al’s., (2002) study suggested that two types of problem-solving took place. The first type was ‘first order solutions’ which are purely reactive, short-term, and involve fixing the immediate problem at hand so that work can continue. The second type was ‘second order solutions’ which are proactive and long-term as they involve identifying and changing the causes of the problem to prevent another recurrence. However, only 10% of problems engaged second order solutions and these were considered a low priority for nurses who were time-poor and considered that waiting for resources or relying on others for assistance was a poor use of their limited time. Earlier research confirms similar outcomes and suggested that employees may sometimes resist recognising that a problem exists in the first place due to the need to invest time, effort and resources in addressing and rectifying the problem (Tallman et al., 1993). This suggests that a lack of resources for staff is affecting the ability of nurses to solve problems effectively. Morrison and Phelps (1999) supported this and argued that employees will only undertake deeper problem-solving if they think it will improve work systems, and if it is worth the lost time, effort, and interpersonal risk of communicating failure. Altogether this means that the dominance of first order solutions keeps organisational systems the same or even worsens existing problems, and minimises learning opportunities for nurses (Tucker et al., 2002).

Communication processes play a major role in effective problem-solving. For instance, research suggests that problem-solving is more effective when information
is available in a timely fashion (Fussell et al., 2006, p. 158) and when there is good quality communication with management, which impacts upon employees’ perceived empowerment (Quinn & Spreitzer, 1997). Furthermore, when solutions are identified, they frequently have to be communicated to another person, such as a nurse and physician or nurse and supervisor. This extra step of communication is an opportunity for errors to occur as well as providing barriers to inhibit the successful undertaking of a solution to the problem (Maier, 1967). However, group-based problem-solving is seen to be advantageous as it reduces the potential for communication problems and encourages responsibility when others are involved in the decision and the reasons for it (Maier, 1967).

One of the main keys to effective problem-solving is accessing the relevant information from which to develop a solution. The necessary information must be available in a timely fashion in order for it to be of assistance (Fussell et al., 2006). One of the ways in which information may be accessed is through informal networks (Chang & Harrington, 2007; Cross & Parker, 2004). Of particular importance to this research is the network of contacts that is approached when employees proceed to attempt to solve a problem. This is referred to as a problem-solving social network. Social networks have been covered previously in the structural dimension of Social Capital Theory (Chapter 2) and are extended here and applied to problem-solving.

A review of the literature identified the lack of a definition for problem-solving social networks and it is posited in this research to refer to the social network or group of contacts utilised in the process of solving a work related problem. Social networks are advantageous for many work-related activities including solving problems (Boyte, 1995; Sirianni & Friedland, 1997). This is because high levels of social capital provide access to other individuals and the knowledge they possess (Kirton, 2003). One of the factors affecting the choice of source is trust, which has been shown to improve the effectiveness of problem-solving processes (Fussell et al., 2006). However, irrespective of which contact is pursued, each of these studies demonstrated that support from others through social capital and social networks is vitally important to effective problem-solving (Maier, 1967).
A review of the literature found minimal research on the specific details and processes surrounding the social network that individuals used to assist in problem-solving. Research examining whom individuals contact for help in solving problems suggested a variety of contacts. For example, the quality of the relationship between supervisors and their employees and the quality of their communication enhances the ability to solve problems (Ibarra & Andrews, 1993; Kim, 2002). One reason for this is likely to be that supervisors help employees access the necessary information for them to solve problems (Cohen & Prusak, 2001; Haskins, 1996) which leads to decreased ambiguity (O’Driscoll & Beehr, 1994). In addition, Larson and Luthans (2006) argued that individuals were more likely to turn to colleagues, friends, family and others rather than supervisors in a bid to develop the most effective way to solve the problem at hand. Therefore, the choice of which contact to use depends on many factors, and yet previous research exploring these factors is minimal.

A review of the literature has also identified a significant gap regarding the problem-solving social networks used by employees, and even less research examining the social networks used to assist in problem-solving by nurses. The minimal research that does exist suggested that 85% of nurses sought assistance with work-related problems from their immediate colleagues and 75% from their manager and that half of the nurses were satisfied with their level of support for solving problems (Dallender et al., 1999). In addition, the literature suggested that problem-solving is enhanced through collaboration with others (Kirton, 2003) thereby suggesting that problem-solving is more effective when working with others. Some research has suggested that informal networks are essential to effective problem-solving due to the heavy reliance upon knowledge and information that is best retrieved from a network of others (Chang & Harrington, 2007; Cross & Parker, 2004). Furthermore, information obtained from social networks has been shown to positively impact upon innovative problem-solving (Nelson & Brice, 2008), which may be interpreted as second order problem-solving in accordance with Tucker et al’s. (2002) classifications.
One area of literature that did appear to be closely associated with problem-solving social networks was research regarding help-seeking.

### 3.5.1 Help-seeking and network contacts

When seeking advice or assistance with a problem, the process of help-seeking may become necessary where an individual makes a choice to approach a person for assistance. The important component of help-seeking is the cost-benefit analysis that becomes involved in order to achieve the stated goal of reducing uncertainty, while also maintaining face (Lee, 2002; Morrison, 2002b). This means that an individual evaluates whether they will gain a benefit from asking a specific person, and if doing so will be achieved without embarrassment or feeling incompetent (Hofmann et al., 2009). Subsequently, a risk that enters the individual’s evaluation of whether to engage in help-seeking is the potential for revealing a lack of competence (Lee, 2002) or other costs such as time and effort (Tyre & Orlikowski, 1994) that need to be reduced (Grant & Ashford, 2008). These costs may be reduced through trust (Schoorman et al., 2007) which was discussed in Chapter 2, and accessibility (Borgatti & Cross, 2003).

Accessibility refers to the ease of accessing an individual in a time of need. Accessibility encourages help-seeking by making it easier to ask the helper and because it reduces the perceived costs of asking for help (Hofmann et al., 2009). One of the recommended ways in which accessibility is increased is through organisations possessing formal help roles. These roles are formally designed and communicated to employees as a source to approach for help. In addition to assistance with problem-solving, employees may also require help with general work-related issues such as policies and procedures; or new employees may require additional assistance with orientation to the organisation or work area. The benefit of formalised helping roles are that those individuals designated as helpers would most likely be more accessible to relevant employees than they would be otherwise, as has been found in existing research (Hofmann et al., 2009). Further research also identified that individuals were likely to engage in help-seeking if formal roles were
in place, and if the organisation promoted these roles (Morrison, 1994) such as through policy documentation and an organisational culture that supported these roles, thereby highlighting policy/practice congruence.

The shortage of nurses and accompanying high workloads experienced by nurses creates a problem regarding the accessibility of help providers. Hoffman et al., (2009) argue that when accessibility is not available, it is the quality of the relationship in place that puts seekers into the in-group and legitimises their approach behaviour (Hofmann et al., 2009). However, help seekers who are not regularly on the ward (such as agency, temporary or new nurses) may not be aware of whom to approach for assistance and may be unaware of the accessibility and trustworthiness of other parties (Hofmann et al., 2009). Subsequently, organisational policies dictating sources of assistance are emphasised here as a solution to the above.

Regarding the provider of help-seeking assistance, consistent themes throughout the research suggested that expertise was a necessary requirement in most cases. For instance, help-seekers are more likely to seek help from individuals whom they perceive to be experts through job-relevant experience, provided that they are also perceived as accessible and/or trustworthy (Hofmann et al., 2009). However, the same study also identified contrasting findings in that a number of people perceived as having less expertise were approached regularly because they were perceived as accessible and trustworthy (Hofmann et al., 2009). However, the concept of centrality, which is the degree of connectedness of an individual, suggests that the most valuable network contacts may not be those in a position of formal authority, but rather, a multitude of other network contacts who may possess more power as they possess higher quality relationships with other members (Sparrowe, Liden, Wayne & Kraimer, 2001). Therefore, accessibility and trustworthiness are the common denominators in these results, regardless of expertise or formal role, although these are advantageous.
Regarding the contacts within problem-solving social networks and the relationships within these, research by Creswick and Westbrook (2006) found that when experiencing problems, nurses sought assistance from other nurses within their own ward. However, they did not prefer to seek assistance from other kinds of professionals or individuals from the same ward such as doctors, clinicians, allied health professionals, or administrative staff (Creswick & Westbrook, 2006; West, Barron, Dowsett & Newton, 1999). This was supported in another study which suggested that nurses were sometimes reluctant to consult physicians who held relevant information on a problem, due to the perceived low status of nurses (Edmondson, 1996). Although the exact reasons for this are unclear, one study did suggest that experience and knowledge are the best predictors of good problem-solving performance (Jacobs & Jones, 1995). Therefore, nurses seek out other individuals who are familiar with their problems and their work duties and who may be more likely to have a greater understanding of the situation than other professionals.

Overall, a review of the literature on problem-solving social networks suggested that this is an area in need of extensive research and validation. This was even more so the case with gaps identified within the nursing literature. Significant gaps were identified concerning who comprised nurses’ problem-solving social networks, what the nature of the relationships was between all the contacts, and how effective these networks were for nurses. This research adds to the literature by addressing these gaps through testing the following research questions:

RQ$_2$ Who are the members of nurses’ problem-solving social networks and what is the strength of the ties between contacts?

RQ$_3$ How effective are nurses’ problem-solving social networks and what is the role of supervisors in this network?

The next section explores the literature and research regarding one outcome, role ambiguity, how this is impacted upon by the other measures in this research, and the effect that role ambiguity has on nurses’ commitment to the organisation.
3.6 Role ambiguity

Role ambiguity refers to the lack of specific and necessary information that is required by an employee in order for them to undertake their work role effectively (Rizzo, House & Lirtzman, 1970; Van Sell, Brief & Schuler, 1981). This makes role ambiguity the opposite of role clarity, which occurs when an employee understands their fit and function within an organisation or context (Foote et al., 2005). Therefore, the lower an employee’s level of ambiguity, the greater ability they have to perform their duties competently. This has been demonstrated in previous research with high role ambiguity contributing to decreased job performance (Hartenian, Hadaway & Badovich, 1994; Singh, 1993). However, ambiguity often arises from the context in which the employee operates which means that the culture of the organisation may dictate behaviours and practices that generate or prevent the alleviation of ambiguity. Alternatively, the organisation’s culture may provide a supportive framework for employees that informs them of what is expected of them, thereby reducing ambiguity (Beyer, 1981). For example, employees may not understand what is required of them in undertaking a work task and the range of permitted flexibility in executing that task (Singh & Rhoads, 1991). This is particularly relevant in the health care sector as individuals are likely to become more ambiguous about what is required as work and technologies become more complex (Hofmann et al., 2009). This ambiguity inhibits their degree of autonomy (Kalbers & Cenker, 2008) as they cannot undertake work independently if they do not know what is required. In addition, an employee may not fully understand what support mechanisms are available to assist them, or the role and type of relationships that may be established with various levels of management and colleagues within the workplace (Singh & Rhoads, 1991). These are just some of the many ambiguous circumstances that employees may experience and together, they decrease employees’ motivation and perceived empowerment to perform their work well and inversely affects their ability to respond to work-related problems (Joiner & Bartram, 2004; Siegall & Gardener, 2000).
Considerable other research has previously been conducted on role ambiguity. For instance, research has suggested that role ambiguity contributes to decreased commitment (Allen, Freeman, Russell, Reizenstein & Rentz, 2001; Foote et al., 2005). One of the reasons for this is likely to be because working in an environment where an employee does not know what is expected of them, can lead to decreased satisfaction in their work (see Kemery, Mossholder & Bedeian, 1987; Rhoads et al., 1994). Therefore, due to the complexity within work roles and organisations themselves, employees may experience multiple types of ambiguity at the same time (Rhoads et al., 1994). Accordingly, more research is needed on different types of role ambiguity and their effect on different job outcomes (Rhoads et al., 1994). This research is interested in the ambiguity surrounding two important parts of all employees’ job roles: customers and supervisors.

3.6.1 Customer ambiguity

Customer ambiguity occurs when an individual is uncertain about how to interact with or respond to, customers’ actions (Johlke & Duhan, 2000). This may include being unsure as to how to rectify customer dissatisfaction with a product or service, or the extent to which an employee is expected to meet customers’ requests with regards to time, effort or expense. When applied to the nursing context, patients become the customers because they are the consumer of the health services being provided. Typically, customer ambiguity is considered the most important of all types of ambiguity because it represents the majority of an employee’s work efforts (Johlke & Duhan, 2000). A review of previous general literature into customer ambiguity has suggested that experiencing customer ambiguity may lead to decreased job performance while also decreasing employees’ job satisfaction and commitment to the organisation (Johlke et al., 2000; Rhoads et al., 1994). Therefore, identifying any customer ambiguity, and subsequently rectifying this, is important for both individual and organisational outcomes.
3.6.2 Supervisor ambiguity

The second type of ambiguity that is central to this research is ambiguity surrounding supervisors. This type of ambiguity occurs when employees are uncertain about their supervisor’s demands, expectations and requirements of them (Johlke & Duhan, 2000). Supervisor ambiguity is especially important due to the significance of the relationship between employees and their supervisor, and the impact of this on multiple outcomes as mentioned previously. Similar to customer ambiguity, the literature clearly identifies that when employees experience ambiguity surrounding their supervisor, their job performance, satisfaction and commitment to the organisation decreases, and their intention to leave the organisation is increased (Johlke et al., 2000; Rhoads et al., 1994). This supports other research which found reduced ambiguity when supervisors provided feedback, assistance with problem-solving, and both social and material support (O’Driscoll & Beehr, 1994). This is not surprising considering the nature of the supervisor-employee relationship. For instance, employees receive a large number of instructions and requests from their supervisor about how to undertake work tasks. The supervisor is, however, also a primary source of information and resources, which has the potential to decrease other types of ambiguity for the nurse. Therefore, supervisors have the ability to increase and clarify information, and provide feedback to reduce both ambiguities surrounding their expectations of their employees and other types of ambiguity being experienced (Howell, Dorfman & Kerr, 1986).

A key problem that results from the existence of higher than desired levels of supervisor ambiguity is the detrimental impact that it has on the supervisor-employee relationship and the resulting impact on an employee’s stock of relational social capital. For instance, employees experiencing high levels of supervisor ambiguity may perceive a lower quality relationship with their supervisor. This is then likely to decrease the frequency and quality of exchanges and communication processes, which then creates a cyclic process and exacerbates the ambiguity that is occurring. This supports previous research, which found associations between role
ambiguity and the quality of supervisor-employee exchanges and communication processes (Dunegan et al., 2002; Johlke et al., 2000; Nelson, Brunetto, Farr-Wharton & Ramsay, 2007; Sutcliffe et al., 2004). However, although this experience may decrease the relational social capital with supervisors, it may also serve to increase the quality of other relationships. For instance, employees may turn to colleagues for assistance and information (Chiaburu & Harrison, 2008), thereby increasing their social support, communication processes, and stock of relational social capital with non-supervisor sources.

Although role ambiguity has been shown to affect many individual and organisational outcomes, a review of the literature suggests that minimal research has been conducted on the role ambiguity experienced by nurses and the factors affecting this. The research that does exist mirrors the general role ambiguity findings and suggests that when role ambiguity increases, there is a corresponding decrease in job satisfaction (Gormley, 2003). Furthermore, it identifies that role ambiguity is dependent upon clearly defined roles and procedures (Dodd-McCue, Tartaglia, Meyer, Kuthy & Faulkner, 2004), and control and feedback (Elovainio & Kivimaki, 2001). All of these results suggest that the role ambiguity experienced by nurses is an important area for further investigation.

A review of the literature regarding role ambiguity has demonstrated that this concept is an important issue in understanding a variety of individual and organisational outcomes. Role ambiguity has been identified as being closely associated with, and dependent upon, both the relational and cognitive dimensions of social capital through each of the supervisor-employee relationship, communication processes, and organisational culture. The review also demonstrated the relationship between levels of ambiguity experienced by nurses and their performance, satisfaction, and commitment to the organisation. However, this review also demonstrated the significant gap in the research regarding the relationship between role ambiguity and outcomes for nurse employees. Furthermore, this research contributes to our understanding of other general factors and their relationship with role ambiguity and the outcomes from these (Johlke &
Therefore, this research extends the literature by examining these relationships and outcomes. The following hypotheses are therefore presented:

\[ H_4 \] There is an inverse relationship between role ambiguity surrounding customers (customer ambiguity) and perceived empowerment (meaning and competence, self-determination, and impact) for nurses.

\[ H_5 \] There is an inverse relationship between role ambiguity surrounding customers (customer ambiguity) and affective commitment for nurses.

\[ H_{11} \] There is an inverse relationship between role ambiguity surrounding supervisors (supervisor ambiguity) and perceived empowerment (meaning and competence, self-determination, and impact) for nurses.

\[ H_{12} \] There is an inverse relationship between role ambiguity surrounding supervisors (supervisor ambiguity) and affective commitment for nurses.

The following section explores the literature and research regarding perceptions of empowerment as the second outcome used in this research to understand how relationships impact upon the organizational commitment of nurses.

### 3.7 Perceived empowerment

Psychological empowerment refers to an individual’s desire and perceived ability to control their work role and context through authority, skill and freedom (Spreitzer, 1995a; b). Employees’ perceived empowerment functions as a motivation to encourage them to perform up to or beyond the basic requirements of the work role. For instance, employees with low levels of empowerment will perform only what is required of them and in an unenthusiastic manner because they feel compelled to work for no perceived benefit. Alternatively, highly empowered employees will enthusiastically perform all required duties and believe in their own ability to perform well.
How employees develop perceptions of empowerment, typically result from the environment of an organisation and its work practices. The culture of an organisation plays a significant role in fostering perceptions of empowerment through supportive and empowering means (Bartram et al., 2004; Joiner & Bartram, 2004; Spreitzer, 1995a, b; 1996; Thomas & Velthouse, 1990). Workplaces that encourage involvement and input by employees (Menon, 1999) and teamwork result in more empowered employees (Quinn & Spreitzer, 1997; Siegall & Gardener, 2000). Similarly, improved communication processes and the free flow of, and access to, information supports employees in undertaking their work more efficiently, thereby resulting in increased perceptions of empowerment (Quinn & Spreitzer, 1997; Randolph, 1995). One way that this may be achieved is through high quality relationships with supervisors, which, research has suggested, results in greater empowerment (Laschinger et al., 2007). The outcomes of empowered employees have been found to be increased performance (Fulford & Enz, 1995) and satisfaction (Bartram et al., 2004; Upenieks, 2003). Ultimately, empowered employees contribute to the organisation’s overall effectiveness (Bowen & Lawler, 1992; Hartline & Ferrell, 1996).

The concept of empowerment is multifaceted and widely agreed to consist of four components including meaning, competence, self-determination, and impact (Spreitzer, Kizilos & Nason, 1997; Thomas & Velthouse, 1990). These components were explored by Spreitzer (1995) and argued to be an appropriate and validated measure of psychological empowerment in a work context.

### 3.7.1 Meaning

The first component of empowerment, meaning, refers to the perceived value of a task or role and its purpose (Thomas & Velthouse, 1990). Therefore, employees with high levels of meaning feel confident that their work is beneficial to the organisation or its clients for instance, and the employee is more willing to undertake their tasks and gain more enjoyment from doing so (Deci & Ryan, 1985). One of the ways in which employees derive meaning from their work is through an
organisation’s culture which values the importance of employees and the work that they do (Siegall & Gardener, 2000) and how that contributes to the overall goals and performance of the organisation (Quinn & Spreitzer, 1997; Randolph, 1995). This is supported by research suggesting that respect for employees has resulted in increased perceptions of empowerment (Faulkner & Laschinger, 2008). Furthermore, respect was also found to mediate and predict the relationship between psychological empowerment and organisational commitment (DeCicco et al., 2006). The quality of communications between supervisors and employees helps to reinforce employees’ perceived meaning, as does increased levels of teamwork (Dodds, Lawrence & Wearing, 1991; Siegall & Gardener, 2000), which provides support and collaboration amongst colleagues, and potentially increases job performance and outcomes. Employees with high levels of meaning in their work are also more satisfied with their job (Dodds et al., 1991; Siegall & Gardener, 2000). Another benefit of high levels of meaning is that the employee’s values are most likely to be congruent with their work and perhaps the organisation (Spreitzer & Mishra, 2002). Therefore, encouraging meaning in employees’ work is based on the cultural practices of an organisation and may be enhanced through methods aimed at improving cultural values and practices.

### 3.7.2 Competence

The second component of empowerment is competence, which refers to an individual’s ability to perform a task with skill (Thomas & Velthouse, 1990). This component is important because high levels of competence enable employees to feel that they have sufficient resources to deal with any organisational changes (Spreitzer & Mishra, 2002; Thomas & Velthouse, 1990). Particularly within the healthcare sector that is constantly changing, competence offers employees a coping mechanism to assist them with the constantly changing environment. A review of the literature regarding competence as a part of empowerment suggested that the role of this aspect has not been extensively researched. Competence has been negatively associated with the job stress of nurses working within Australia (Joiner & Bartram, 2004), however, some surprising research has suggested that competence
is not associated with teamwork or with communication with a supervisor (Siegall & Gardener, 2000) and only moderately related to perceived respect (Faulkner & Laschinger, 2008). However, exploring competence achieved via education and lifelong learning suggests that nurses are more empowered according to the greater levels of education they have (Christiaens et al., 2010; Kuokkanen et al., 2003).

**3.7.3 Self-determination**

The third component, self-determination, refers to an individual’s perception of choice in undertaking actions (Spreitzer, 1995a, b) and is frequently referred to, and confused with, autonomy, which is the actual degree of choice and ability to make their own decisions in their work. Self-determination means that an employee’s sense of control increases if they perceive they have greater choice over the type of work and how it is undertaken, and the time in which it is completed (Spector, 1986; Spreitzer & Mishra, 2002). As with increased employee involvement, an employee becomes more determined and independent when they feel that they have greater choice in their work, rather than simply being told what to do. Subsequently, self-determination is found to be significantly related to communication with supervisors, as this is a main form of receiving communications and directions for their work (Siegall & Gardener, 2000), and is the highest of all four components of empowerment to be associated with higher levels of respect (Faulkner & Laschinger, 2008). Furthermore, despite any negative outcomes from challenges to authority or permitted autonomy, increased self-determination results in reduced ambiguity in nursing staff (Joiner & Bartram, 2004).

**3.7.4 Impact**

The fourth and final component, impact, refers to an individual’s perception that their actions will make a difference to the task or environment (Spreitzer & Mishra, 2002; Thomas & Velthouse, 1990). In order for an employee to feel empowered in their work, they need to feel that their work has an important purpose for the client, colleagues, supervisors, the organisation, or the field of work.
Employees who do understand the purpose and impact of their work are frequently more satisfied in their work (Dodds et al., 1991) and less stressed (Joiner & Bartram, 2004). One way in which employees may identify and perceive that their work has an impact is by ensuring that employees understand how their work contributes to the goals of the organisation (Gist & Mitchell, 1992). This would largely be a responsibility of organisational management, in part by sharing information about the organisation’s performance with employees and rewarding them for that performance (Bowen & Lawler, 1992). Another way in which employees may identify and perceive that their work has an impact is through recognition of good work by organisational management or colleagues (Dodds et al., 1991). Accordingly, an employee’s understanding of the impact of their work is related to supervisory communication processes and the quality of teamwork present within the organisation (Siegall & Gardener, 2000).

Empowering employees is quite a complex task and it is not surprising that many employees lack a feeling of empowerment in their work, and that organisational management do not know how to foster those feelings. As alluded to in the discussion of the four components of empowerment, access to relevant information is a key requirement for empowered employees (Chiles & Zorn, 1995; Randolph, 1995) through feedback (Drake, Wong & Salter, 2007) and effective communication processes (Joiner & Bartram, 2004; Siegall & Gardener, 2000; Spreitzer, 1995a, b; 1996). This is because access to knowledge and information enables employees to better contribute to the organisation’s performance because they understand their role and the impact of it within that performance, thereby reducing any ambiguity experienced (Joiner & Bartram, 2004; Siegall & Gardener, 2000; Spreitzer, 1995a, b; 1996). Furthermore, access to information increases employee’s self-determination because it provides them with the perceived power to make decisions that influence organisational direction and performance. Being able to access information and the sense of empowerment that results from this also leads to more effective problem-solving (Quinn & Spreitzer, 1997) because employees believe that they possess the ability to do so.
The empowerment of nurses is examined in this research because a significant amount of research has linked empowerment to an employee’s level of commitment (Koberg, Boss, Senjem, & Goodman, 1999; Kraimer, Siebert & Liden, 1999). Furthermore, similarly to other nurse outcomes, levels of empowerment have been found to be lower in hospital nurses than in nurses working in alternative health care settings (DeCicco et al., 2006). By understanding the factors that impact upon nurses’ perceptions of empowerment, a greater understanding of how to improve nurses’ commitment is obtained. Furthermore, many of the factors identified here as contributing to perceived empowerment are conducive to measures of social capital. For instance, the quality of the relationship between nurses and their supervisor and colleagues, as well as the quality of the communication processes present, form part of the relational dimension of social capital. In addition, literature relating to the culture of the organisation has clearly demonstrated the importance of examining the context in which the above listed relationships are situated.

A review of the literature suggests that empowerment is an emerging field in which significantly more research is needed in order to fully understand the relationships that may exist (Thorlakson & Murray, 1996). Furthermore, although earlier research on empowerment has suggested that employees must experience all four dimensions of empowerment at the same time in order for organisations to benefit from the employees’ high levels of empowerment (Spreitzer et al., 1997), further confirmation and elaboration of this argument would be beneficial. In addition, more research to identify the factors likely to have the greatest effect on the widest set of empowerment dimensions would be advantageous (Siegall & Gardener, 2000). Moreover, further research is necessary to examine the impact of nurses’ social support and empowerment on commitment and retention, particularly for nurses in a hospital setting, to discover support mechanisms and their impact on job stressors (Joiner & Bartram, 2004). Therefore, this research contributes to the literature by examining the empowerment of nurses working within a hospital setting and the factors affecting this, including the impact of social capital variables.
such as social networks. The following hypothesis is developed to examine the effect of empowerment on commitment:

**H₆** There is a positive relationship between **perceived empowerment** (meaning and competence, self-determination, and impact) and **affective commitment** for nurses.

The following section explores the most important variable examined in this research, organisational commitment, and its relationship with the other factors examined as well as relevance to the research problem.

### 3.8 Organisational Commitment

Organisational commitment refers to an employee’s perceived relationship with an organisation that leads to the decision as to whether to continue or to terminate their employment (Meyer & Allen, 1991, p.67). Because organisational commitment is the determining factor in whether an employee stays or leaves the organisation, as demonstrated through an employee’s intention to leave, it has become a very popular area of research. One of the most significant and clearly identifiable outcomes to emerge from this significant body of literature is the conclusion that organisational commitment is a predictor of an organisation’s overall effectiveness (Meyer, Allen & Smith, 1993; Meyer & Herscovitch, 2001), in part due to the negative effect played by increased turnover due to a lack of organisational commitment (Liao et al., 2008; Vandenberghe & Bentein, 2009).

#### 3.8.1 Dimensions of organisational commitment

The literature identifies that organisational commitment is a complex and multidimensional concept that is commonly accepted by researchers to consist of three dimensions (Allen & Meyer, 1990). The first dimension is normative commitment, which is an employee’s perceived obligation to stay with the organisation (Allen & Meyer, 1990) due to circumstances such as reciprocation for
employer-sponsored training and education programs (Stallworth, 2003), or from socialisation experiences such as organisational induction and training programs, which emphasise the appropriateness of remaining loyal to the employer (Wiener, 1982). The second dimension is continuance commitment, which is an employee’s need to stay because of the perceived costs associated with leaving the organisation such as time and energy “learning the ropes”, or because they have accumulated skills, education, or pension benefits (Allen & Meyer, 1990; Whitener & Walz, 1993). The third and final dimension is affective commitment, which is an employee’s desire to stay based on their emotional attachment to, identification with, and involvement in the organisation (Allen & Meyer, 1990). Of all three dimensions of commitment, affective commitment is the most widely studied and validated (Aven, Parker & McEvory, 1993; Meyer & Herscovitch, 2001). Furthermore, it is considered to be the most beneficial, in part perhaps because research identifies that those with high levels of affective commitment are more likely to be loyal and attached to the organisation, thereby reducing their likelihood of leaving (Flinkman et al., 2008; Vandenberghhe & Bentein, 2009). The factors that impact upon employees’ affective commitment is the only dimension of interest to the current research.

3.8.1.1 Affective commitment

A significant amount of research has been undertaken regarding the factors that increase the affective commitment of employees. Experiences at work were found to be a very significant antecedent (Meyer & Allen, 1991) because when employees’ experiences are consistent with their expectations and satisfy their basic needs, they develop a stronger affective attachment to the organisation compared to those with less satisfying experiences. Therefore, a positive work environment where employees are satisfied in their work (Flinkman et al., 2008; Ingersoll, Olsan, Drew-Cates, DeVinney & Davies, 2002) is likely to lead to a higher affective commitment to the organisation. A review of the literature by Tsai and Huang (2008) suggested that affective commitment was most strongly associated with job satisfaction. It was followed by normative commitment, while continuance commitment was negatively associated with job satisfaction. This means that
methods aimed at increasing employees’ satisfaction in the workplace are an effective tool to improve employees’ affective commitment, and therefore improve the retention of staff.

A review of the literature on the commitment of nurses suggested that many nurses did intend or had thought about leaving their organisation (Flinkman et al., 2008; Ishida, 2000) with one study identifying that up to 60% of nurses had done so (Kuokkanen et al., 2003). The literature also identified that due to cultural changes that resulted from Australian health care reforms, the culture of the organisation has become of particular importance when examining issues surrounding nurse employees’ levels of commitment to the organisation. For instance, the culture of the organisation has been suggested to be a significant contributor to nurses’ commitment to the organisation (Chen, 2004; Liao et al., 2008). In addition, the high workloads that are now common in the nursing profession have also been shown to lead to decreased commitment (Garnett et al., 2008; Zeytinoglu, 2007a). Therefore, when nurses are overworked and dissatisfied with the demands placed upon them in their daily work, they are more likely to look for alternative employment. Accompanying high workloads are the extensive organisational policies that have been introduced as part of the reforms. Nurse dissatisfaction with the policies and the resulting practices have been identified as causes of nurses leaving their organisation (Gray & Phillips, 1994; Secombe & Smith, 1997). Similar findings have identified that high levels of nurse satisfaction with policies considered to be nurse-friendly, result in improved retention rates (Cowin et al., 2008).

The quality of relationships within the workplace is also likely to impact upon an employee’s commitment to an organisation. Previous research has suggested that when employees experience high-quality exchanges with their supervisor and the associated communication processes, they are more likely to want to stay in the organisation (Brunetto & Farr-Wharton 2004; 2006; Garnett, Marlowe & Pandey, 2008; Lacey, 2003; Naude & McCabe, 2005; van Vuuren et al., 2007). Similar results were also found for colleagues and upper levels of management (Dess & Shaw, 2001; Hegney et al., 2002). For instance, when nurses perceive that organisational
management respects and appreciates nurses, their commitment to the organisation, in turn, increases (DeCicco et al., 2006; Kuokkanen et al., 2003; Laschinger, 2004). There are a number of studies that suggested the relationship between nurses and upper levels of management plays a key role in nurses’ commitment to their organisation. This was most clearly demonstrated in the consistent identification of the need for management to improve their behaviour in general, as implied through a lack of trust, micromanaging, and tolerance of bullying behaviour for example (Ishida, 2000; Laschinger, 2004; Laschinger & Finegan, 2005; Pellico et al., 2009). Subsequently, the quality of relationships experienced by nurses within the organisation is a contributing factor to their commitment levels.

A review of the literature surrounding commitment has demonstrated that it in general is well understood. However, more research is needed on the affective commitment of nurses and the factors affecting this. Specifically, the relationship that social capital plays in this is far from understood (Dess & Shaw, 2001), particularly regarding nursing staff. Therefore, this research contributes to the literature by examining the collective impact of social capital outcomes on the affective commitment of nurses working within Australia. Previously stated hypotheses have highlighted relationships between affective commitment and leader-member exchange, communication processes, organisational culture, role ambiguity, and empowerment. The following hypotheses are proposed to test the first research question about the overall impact of the variables on nurses’ affective commitment:

\[ H_7 \] There is a significant relationship between the independent variable and work-related outcomes (LMX and communication processes, customer ambiguity, meaning and competence, self-determination and impact) and affective commitment for nurses.

\[ H_{13} \] There is a significant relationship between the independent variables and work-related outcomes (teamwork, morale, info flow and involvement, customer role ambiguity, supervisor role ambiguity, meaning and competence, self-determination, and impact) and affective commitment for nurses.
The final section in this chapter briefly explores the literature regarding gaps and differences between organisational policy and organisational practice, and the implications of these.

### 3.9 Differences between policy and practice

A problem that is common to many organisations is the gap or difference between organisational policy (what the organisation says they do) and organisational practice (what the organisation really does) (Hofmeyer & Marck, 2008). For instance, organisational policy applies to a number of organisational-espoused values and goals. These may include policies, procedures, goals, mission statements, values, and strategic directions. Each of these sources of organisational policy sets in place a direction for which organisational management at all levels is expected to comply and enforce. The ultimate aim of these policies is that they be implemented and carried out at the operational level, thereby resulting in organisational practice. However, this frequently is not the case.

Organisational practice is the actual reality of the work environment that employees create and participate in on a daily basis. This outcome is a result of not only the organisational policy, but also other competing individual and organisational factors. For instance, the culture of an organisation affects all practices and behaviours and plays a strong role in change initiatives (Clement, 1994; Johnson, 1992). The social context and relationships surrounding the employees and managers directly responsible for implementing organisational policy also affect the success of policy implementation (Nahapiet & Ghoshal, 1998). The literature explored previously in this chapter has already established the myriad of factors such as the managerialist changes within the Australian health care environment (already alluded to) that may impact upon the success of policy implementation. This is reiterated in other research that suggested clear gaps were evident between corporate measures of efficiency and nurse workforce measures of efficiency, of which nurse measures of efficiency are measured from the complexities of nursing
work (Hofmeyer, 2003; Liaschenko, 1997; Varcoe, 1998). When policy is affected by any of the above or other intervening factors mentioned, a gap or difference is created between organisational policy and organisational practice.

It is vitally important for organisations to be able to identify and understand any gaps or differences between policy and practice. This is because gaps will typically exist to some extent and this is to be expected. However, when significant gaps occur, which frequently is the case in many organisations, this is likely to cause many problems and decrease the effectiveness of the organisation. Most importantly, gaps between policy and practice lead to role ambiguity as employees do not fully understand what is expected of them and how they are to behave. An identified problem is the need to identify those factors that are affecting the commitment of nurses in order to increase their levels of commitment to the organisation and increase the retention of nursing staff. However, understanding the gaps and differences that exist between various aspects of policy and practice within the studied organisation is a key step within this process. Therefore, the following research question is explored:

RQ₄ What differences exist between organisational policy and organisational practice regarding variables that display qualities of relational, cognitive and structural social capital, and work outcomes such as role ambiguity, perceived empowerment, and affective commitment of nurses?

Research Question 4 is measured qualitatively and results in the development of key findings and therefore no hypotheses are proposed within this research question.

3.10 Proposed model for examination

In order to test the impact of the factors affecting nurses’ commitment to the organisation, a model is proposed and depicted in Figure 3.1. The first column of independent variables includes the four factors identified in Chapter 2 as showing
evidence of social capital. This research is then concerned with the resulting impact of these factors. The second column, work-related outcomes, contains two factors of role ambiguity and perceived empowerment that are empirically proven to be affected by the independent variables. Lastly, the third column contains the final and most important variable in this research, affective commitment. The overall impact of the independent variables and work-related outcomes on organisational commitment are explored, and the way in which this is achieved is outlined in the following chapter. Following this, an analysis of organisational documents will enable comparisons to be made between organisational policy and organisational practice.

Figure 3.1 Proposed Model for examination exploring the impact of the independent variables on work-related outcomes and organisational commitment.
3.11 Conclusion

This chapter has explored the various concepts examined in this research in accordance with the theoretical framework proposed in Chapter 2. These included the variables used to assist in identifying the quality of the relational, cognitive and structural social capital present. Furthermore, three outcomes of role ambiguity, perceptions of empowerment, and organisational commitment were detailed. The major theoretical developments within each of these areas were outlined and gaps in the literature were identified, which subsequently highlighted the need for the research. As a result, hypotheses were proposed to examine each of the research questions being investigated. A summary of each of the research questions and hypotheses in this research can be viewed in Appendix 2.

The next chapter outlines the methods employed in this research, including methodological justification for the research, the context of the research and specific methods used to conduct the research.
CHAPTER 4 – METHODOLOGY

4.1 Introduction

This chapter provides an outline of the methodological approach underpinning this research, the methods utilised, and the theoretical issues associated with these. The chapter begins by exploring the various research paradigms utilised by researchers and discusses in detail the rationale for the positivist approach used in this research. Following this, the specific research procedures undertaken are detailed including diagrams representing this process and the relationships amongst the variables examined. This precedes a discussion of the sequential mixed methods approach used, and a justification of why it is the most appropriate method for this research. The sampling method undertaken is explored, followed by an overview of the structure for conducting the survey, focus groups, interviews and document analyses. How the data were analysed and ethical issues surrounding this research are then discussed.

4.2 Research framework

A research framework refers to the philosophy or paradigm that guides research. Specifically, it refers to the framework for how a researcher observes and understands phenomena by guiding what is seen and how it is understood (Babbie, 2004). This means that when conducting research, the researchers are guided by their own basic belief systems and this influences the assumptions that arise from what they experience and the data that they collect (Guba & Lincoln, 1994). There are three major research paradigms including positivism, constructivism and pragmatism, which are described below.
4.2.1 Positivism

Positivism is one of the earliest and most dominant paradigms and is sometimes referred to as the scientific, quantitative, empiricist and deductive method (Crotty, 1998; Veal, 2005). Positivism assumes that social phenomena are external and not confined to contexts or time, and because of this they have to be judged scientifically and objectively using strict measures (Easterby-Smith et al., 2002; Veal, 2005). This means that all social phenomena exist simply because they do and are just waiting to be identified and explained. The positivist paradigm believes that maintaining an objective point of view and conducting the research in a scientific manner heightens the ability to predict and control the phenomena under investigation, which increases their generalisability to a larger population (Guba, 1990). Generalisability refers to the ability to generalise the data to larger populations or contexts that are similar to the ones being examined (Maxwell, 1992). Phenomena are most accurately measured and applied to greater populations when they are examined using strict and proven methods that cannot be altered by researcher bias or any other bias. The high need for generalisability and strict controls mean that positivist studies frequently use hypotheses to direct the research (Crotty, 1998; Easterby-Smith et al., 2002). This ensures that statistically probable results are obtained from simple, accurate and appropriate methods (Easterby-Smith et al., 2002). Therefore, positivism uses strict protocols to achieve the most statistically accurate and generalisable results from phenomena that have been analysed from an objective point of view.

In order to address the research questions under investigation, the current research requires the use of both quantitative and qualitative methods, which necessitates the use of a mixed methods approach. The positivist paradigm is the most appropriate paradigm for this research because it dictates stricter protocols that lead to the development of more valid, reliable and generalisable data. This is advantageous when using a mixed methods approach as it increases the quality of the different methods used, and the collection, analysis and interpretation of the
data that arise. The mixed methods approach is detailed more in the next section including a justification for its use in this research.

4.2.2 Constructivism

Constructivism is sometimes referred to as interpretive, phenomenological, qualitative, or inductive research is the research of social phenomena from the perspective of human interactions and social context where people ‘construct’ reality, as opposed to objective factors ‘discovering’ it (Crotty, 1998; Easterby-Smith et al., 2002; Veal, 2005). Because of these beliefs, the researcher is considered a part of the research and may affect the outcomes achieved. Furthermore, constructivism judges social phenomenon through the language and meanings that people attach to experiences (Easterby-Smith et al., 2002). Theoretical abstractions result from the rich data of a small number of cases, and generalisability is based upon the quality of the data rather than a large sample (Easterby-Smith et al., 2002).

4.2.3 Pragmatism

Pragmatism is an action-oriented paradigm that is primarily concerned with successful and realistic solutions to problems (Patton, 1990). Unlike positivism and constructivism, which focus on methods and using these to produce research outcomes, pragmatism uses the problem and research questions under investigation to guide the techniques used because these are considered more important (Rossman & Wilson, 1985; Tashakkori & Teddlie, 2003). Focusing on the research problem improves the quality of the findings because the most appropriate methodological path is chosen for the context and problem being investigated (Patton, 1990). Pragmatism is increasingly being regarded as the paradigm on which mixed methods research is founded (Tashakkori & Teddlie, 2003), which requires the integration of both quantitative and qualitative methods, and allows more freedom when choosing the research design (Creswell, 2003). However, for this research, pragmatism was not considered as appropriate as positivism for the reasons mentioned previously.
4.3 Research design

A research design is a plan outlining the strategy and approach undertaken to address research questions or hypotheses under investigation (Holsti, 1969; Jupp, 2006). The purpose of outlining a research design is to first, ensure that the methods utilised are appropriate for exploring the research questions (Yin, 2003), second, outline to the reader how the research was undertaken to aid replication (Kumar, 2005), and third, to help the researcher carry out the research with a well thought out plan from the early stages of the research (Jupp, 2006). The methodological literature identifies three major approaches to conducting research including quantitative, qualitative and mixed methods approaches (Creswell, 2003; Tashakkori & Teddlie, 2003; 2008). Quantitative research is embedded in the positivist paradigm and holds that social phenomena are external and objective and need to be tested using scientific means in the form of numbers (Bryman, 2004). In contrast, qualitative research is embedded in the constructivist paradigm and holds that social phenomena are continually changing and subject to individuals’ interpretations and need to be tested using words (Bryman, 2004). The mixed methods approach is a combination of both quantitative and qualitative approaches and is described in more detail below.

4.3.1 Mixed methods

Mixed methods research refers to the combination of quantitative and qualitative methods, techniques, approaches, concepts or language into one single research project (Johnson & Onwuegbuzie, 2004). The method is increasingly being seen as an acceptable alternative to solely quantitative or qualitative studies. This is because the use of multiple methods conducted either simultaneously or sequentially allows for greater understanding of the research problem and greater choice in how to achieve that understanding (Creswell, 2003; Johnson & Onwuegbuzie, 2004). In addition, the use of multiple methods compliments weaknesses found in mono-method studies and strengthens validity and reliability (Brewer & Hunter, 1989; Creswell, 2003; Johnson & Turner, 2003). Furthermore, it
also allows for greater exploration of problems that are considered complex or under-researched, and greater examination of problems from multiple angles and perspectives.

Several different approaches have been proposed as part of a mixed methods design. The literature identifies three approaches to mixed methods designs as explained by Creswell (2003). The first is sequential procedures in which researchers seek to expand their understanding of phenomena by undertaking one method (such as collecting qualitative data), and following this up with another method (such as quantitative data gathering) and vice versa. The second approach is concurrent procedures whereby two methods are undertaken at the same time and are used together to interpret the results. This approach allows for one smaller method to be nested within a larger method in order to analyse different research questions or areas within a study. The third approach is transformative procedures where theoretical lenses are used to guide the choice of methods undertaken, topics pursued, and the outcomes reached.

A sequential mixed methods approach was chosen as the most appropriate design for the current research. This is because the method enabled a quantitative and qualitative survey to be followed by qualitative focus groups, interviews and document analyses to gain a greater in-depth understanding of the quantitative results and allow comparisons to be made amongst the data. Sequential mixed methods allow the data to be converged following each collection and for comparisons to be made at the time of interpretation (Creswell, Plano-Clark, Gutmann & Hanson, 2003). This is advantageous because it allows alterations to be made to the data collection methods if an unexpected issue arises in the data. The disadvantage of this approach is that when examining the same problem using different methods, it can be difficult to merge or analyse the different forms of data and resolve any discrepancies that arise between these (Creswell, 2003).
4.3.2 Validity and reliability

When designing research it is important to take into consideration the quality of the methods used, and the resulting interpretations and conclusions from the data. This is determined through the validity and reliability of the research. Validity acts as a check of the quality of the data and results (Babbie, 2004; Creswell & Plano-Clark, 2007; Hair, Bush & Ortinau, 2003) and reliability refers to the ability to replicate the same results in repeated studies of the same phenomena (Babbie, 2004). However, validity and reliability differ between the quantitative and qualitative domains. Mixed methods researchers have sought to combine different quantitative and qualitative terminology relating to validity and reliability or propose new terms altogether with limited success (Dellinger & Leech, 2007). For example, Tashakkori and Teddlie (2003) propose the use of the term ‘inference quality’ to replace validity. Similarly, Johnson and Onwuegbuzie (2004) propose the term ‘legitimation’. The conclusion drawn from these proposed terms is the need for further research and discussion into the use of validity and reliability in mixed methods research (Creswell & Plano-Clark, 2007). Because of the disparity in terminology and until the mixed methods community reaches a consensus, this research uses the traditional terms of validity and reliability.

Validity is specifically concerned with the extent to which the instruments used accurately describe the phenomena under investigation (Babbie, 2004; Hair et al., 2003). Validity is frequently classified into several types including construct validity, internal validity, and external validity.

4.3.2.1 Construct validity

Construct validity refers to the quality of the instruments used and their ability to measure what they intend to measure (Hair et al., 2003), and their relationship with the theoretical framework and other variables in the research (Zikmund, 2003). To increase the construct validity in this research, validated instruments from previous research and the process of data triangulation were used.
Details of these validated instruments are in Section 4.5 Survey and data triangulation is outlined in Section 4.3.2.5 Triangulation.

### 4.3.2.2 Internal validity

Internal validity refers to the accuracy of the causal relationships established (Bryman & Bell, 2007; Ghauri & Gronhaug, 2005) as determined by a thorough investigation of the literature. A high internal validity means that there is no doubt that the independent variable is the cause of the status of the dependent variable (Zikmund, 2003). Internal validity is considered stronger in qualitative research because of the increased time of data collection enabling greater congruence between concepts and observations (Bryman & Bell, 2007). This research used the process of pattern matching, which compares data from this research with predicted patterns from extant literature to identify themes and areas of consistency that emerge. Further explanation of this process is in Section 4.9 Data analysis.

### 4.3.2.3 External validity

External validity refers to the sampling undertaken and the ability of the findings to be generalised to and across the wider population, different times and contexts (Bush, 2002; Ghauri & Gronhaug, 2005). This requires that the research be conducted in settings consistent with the real world in which others may replicate the research using different participants and other settings (Zikmund, 2003). It also highlights the importance of having a representative sample as small numbers of cases decrease the external validity of the research (Bryman & Bell, 2007). This research used a research site that is typical of large organisations and a representative sample for the sample size. These are explained in more detail in Section 4.4 Sampling and access.
4.3.2.4 Reliability

Reliability refers to the dependability of the instruments to produce the same data from repeated collections of the same phenomena (Babbie, 2004). Quantitative research is considered to possess higher reliability than qualitative research because it uses specific measurable survey instruments that can be used to replicate a study, and the response choices are clearly defined, compared with qualitative research in which contexts, questions, and interpretation may vary (Babbie, 2004; Creswell, 2003; Tashakkorie & Teddlie, 1998). In qualitative research, reliability plays only a minor role in terms of consistency of theme development (Creswell, 2003). Reliability in this research was increased by following a research process that may be easily replicated. This process is explained in more detail in Section 4.3.3 The research process.

When addressing validity and reliability concerns in research, there are a number of threats which need to be taken into consideration. These include inadequate definitions and measures of variables, procedures such as instrument changes throughout the research, and significant changes to participant characteristics such as beliefs and perceptions (Creswell, 2003). The reliability of research instruments can also be affected by the wording of questions, the physical setting, the nature of interactions, and the mood of the respondent as well as their perceptions and resulting changes towards their responses (Kumar, 2005). Subsequently, due to the strengths within both the quantitative and qualitative domains, a mixed methods framework was undertaken to compliment strengths and minimise any weaknesses (Hunter & Brewer, 2003; Tashakkorie & Teddlie, 1998; 2003), and potentially increase both the validity and reliability of the study. Using a mixed methods approach also entails triangulation, which is now outlined in the following section.
4.3.2.5 Triangulation

Triangulation refers to a research approach that employs more than one method of data collection and analysis (Sarantakos, 2005). The primary purpose of triangulation is to ensure a more accurate explanation and analysis of the phenomena under investigation, and to counterbalance weaknesses in one area by using strengths in another (Brewer & Hunter, 1989; Cox & Hassard, 2005; Jack & Raturi, 2006). This contributes to the validity and reliability of the findings, and increases their generalisability. The principal advantages of using triangulation are the increased understanding, amount, and variety of data, and confidence in the interpretations and findings from that data (Jick, 1979). However, the disadvantages also result from the advantages in that there is an increased amount of time and difficulty in examining the data, and the potential for conflicts to arise between investigators due to various differences (Thurmond, 2001).

The type of triangulation used in this research, data triangulation, is the collection of data from different or multiple times, contexts or individuals (Denzin, 1978; Mitchell, 1986). These included data from surveys, focus groups, interviews, and document analyses within two research sites over a period of six months, across all levels and classifications of nurse employees, including nurses with a variety of qualifications and specialisations and Nurse Unit Managers. That is, the data on nurses was collected from the nurses’ own perspectives, and also from the perspective of their supervisors. The advantage of data triangulation is the greater amount, depth and variety of information that can be obtained as opposed to using one type of data collection (Banik, 1993) and the reduced risk of reaching false conclusions (Hammersley, 2008). However, this can also be a disadvantage as the amount of data obtained can be difficult and time consuming to analyse and incorrect interpretations can be made because of this (Hammersley, 2008; Porter, 1989).
4.3.3 The research process

The mixed methods research process followed in this research is based upon the suggested approach of Creswell (2003) and is presented in Figure 4.1. This process is based upon the sequential design of mixed methods and was conducted over the six months from April 2007. Stages one and two consisted of surveys, focus groups and interviews to determine nurses’ perceptions of the issues being investigated. Quantitative data from the surveys were analysed using SPSS software and qualitative data from the open-ended survey questions were analysed using content analysis. Focus groups and interviews were also conducted at this time to examine the nurses’ perception of empowerment and the qualitative data from both of these were analysed together. The reason why the same area of empowerment was examined using two methods is because some respondents did not want to participate in focus groups and preferred to participate in an interview. Furthermore, the respondents and participants in the surveys, focus groups and interviews were not necessarily the same people.

Stage three consisted of a document analysis which began with interviews with two senior administrative staff within the hospital sites to identify the most appropriate documents for nurses that discuss the issues under investigation. Once these documents were identified and confirmed, they were then analysed using content analysis techniques. Finally, the findings from the document analyses were compared and contrasted against the findings from each of the surveys, focus groups and interviews to identify any differences between organisational policy and organisational practice.

The mixed methods technique was useful in examining the impact of variables that provide insight into the level of social capital present, on employee outcomes such as commitment to the organisation. A combination of quantitative and qualitative data examined all variables within this study and enabled nurses to elaborate on important topics. Furthermore, it enabled the researcher to compare differences between organisational practices as identified in the surveys, focus
groups and interviews, with organisational policy as espoused in the organisational documents.

**Figure 4.1** Research process map outlining sequential mixed methods design (Adapted from Creswell, 2003)

Quantitatively, three models were examined in this study. These variables were tested separately across three models due to the similarity amongst some of the independent variables and work-related outcomes as is explained in the principal components analysis in the following chapter. Figure 4.2 depicts the relationships between the variables that represent relational social capital, and outcomes. The quality of exchanges between nurses and their NUMs and the quality of the communication processes that accompany these provide some insight into the relational social capital within the organisation. The impact that these variables, together, have on the degree of role ambiguity experienced, how empowered nurses subsequently feel, and the resulting impact on nurses’ affective commitment to their organisations, is examined.

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Figure 4.2  Proposed model no. 1: Insight into the quality of relational social capital present and its impact upon outcomes.

Figure 4.3 then depicts the relationships between variables used to provide clues into the quality of the cognitive social capital present in the organisation, and outcomes. Here, the impact that organisational culture has on the outcomes of role ambiguity, perceived empowerment, and affective commitment to the organisation, are examined.

Figure 4.3  Proposed model no. 2: Insight into the quality of cognitive social capital present and its impact upon outcomes.
Figure 4.4 depicts the relationships between variables used to provide insight into the quality of structural social capital present, and outcomes. The quality of the problem-solving social networks used by nurses in this study is examined to explore its relationship with the same work-related outcomes and level of affective commitment examined in the previous models.

![Diagram](attachment:figure_4_4.png)

**Figure 4.4** Proposed model no. 3: Insight into the quality of structural social capital present and its impact upon outcomes.

Qualitatively, the impact of all variables examined in this research have on each other, are examined. The first survey item asking if nurses do not approach their NUMs for assistance, and if not, why not, provides insight into the quality of the exchanges and communication processes between nurses and their NUMs, and may go further to shed light on other factors such as any role ambiguity present or how empowered nurses feel as a result of the relationships with their supervisor. The second, third and fourth survey items may also provide valuable insight into all factors examined, and in particular, regarding nurses’ commitment to the organisation. The focus groups and interviews explore the factors affecting nurses’ perceptions of empowerment to identify potential relationships. The document analysis examines any mention of all the variables being explored to identify the organisation’s policies and position on these. Together, this sequential mixed
methods approach enables a comprehensive analysis, both quantitatively and qualitatively, of the variables being investigated.

4.4 Sampling and access

When designing a research sample it is important to clearly distinguish where the sample should be obtained from and whom it should include. The unit of analysis refers to the specific case or group of cases being investigated (Teddlie & Tashakkori, 2009). In this research, the unit of analysis is employees working within public sector hospitals located in Australia. Within this unit of analysis, a target population is identified which is a specific group of a population that is of interest and relevance to the research (Zikmund, 2003). In this research the target population is “nurses”. Within the target population, a sample frame is also identified which are the units of a population from which the sample is selected (Babbie, 2004). This research was undertaken in conjunction with a health district located in Australia and two hospitals were identified by management of the health district as being important to this research and representative of the nurse population. The two hospitals investigated did not possess Magnet-designated accreditation. The sample frame in this research became wards identified as possessing high numbers of nurses with a moderate to high level of staff turnover and a high density of patients. Due to this desired sample frame, management of the health district specifically chose these wards, and there was limited research access to the other wards.

Having identified where the research sample is being obtained from, it is then possible to use a sampling procedure to select the specific sample to be targeted. The two main types of sampling procedures include probability sampling and non-probability sampling. This research used a form of non-probability sampling called purposive or judgmental sampling. Purposive sampling occurs when samples are selected based upon an expert’s judgment and knowledge of which will be the most
useful or representative for the research being undertaken (Babbie, 2004; Neuman, 2003). As mentioned previously, the most appropriate and representative wards for this research were identified by management of the organisation. This method of sampling was appropriate for this research because it provided access to samples from a specialised population that are more informative than others, which enabled the researcher to gain a deeper understanding, to be able to generalise to a larger population, as is recommended by Newman (2003).

When deciding what the appropriate sample size is for particular research, a number of factors must be taken into consideration. These include the degree of accuracy required, the degree of variability or diversity in the population, and the number of different variables that will be examined simultaneously (Neuman, 2003). Larger samples are necessary if the researcher requires higher levels of accuracy, if there is a large degree of variability in the population, or if a number of variables are to be examined simultaneously (Neuman, 2003). This research had a small sample due to the restrictions placed on it by management of the organisation. However, a large sample was not deemed necessary as this sample is considered representative (as confirmed by the organisation) due to nursing being a female-dominated profession and because they are working in typical hospitals across two sites.

4.5 Survey

The first method of data collection used in this research was a survey containing closed and open-ended questions. Surveys are one of the most widely used and appropriate methods for collecting data to answer questions relating to behaviour, attitudes, beliefs and opinions, characteristics, expectations, self-classifications, and knowledge (Neuman, 2003). Common types of surveys can include mail, self-administered, telephone, face-to-face or web-based surveys (Babbie, 2004). The advantages of using this method included the ability to access large samples and gather refined responses from that sample; the ability to maintain consistency of questions across respondents; and surveys are typically cheaper and
more convenient to both researchers and respondents (Babbie, 2004; Mangione, 1995; Neuman, 2003). However, disadvantages of using surveys can include a lack of depth and understanding in responses and the context surrounding these, and a poor response rate or unanswered items (Babbie, 2004; Mangione, 1995).

A self-administered survey was used in this research. This type of survey is commonly used to gather data about respondents’ behaviour, beliefs, attitudes, and opinions (Neuman, 2003). The objective of these surveys was to obtain specific responses to test the variables in this research. This method was advantageous because it was possible to leave the survey in each of the wards for nurses that work alternative shifts to access and complete when convenient. Providing return envelopes also encouraged participants to return the survey in their own time rather than completing it during their shift while the researcher was present. These envelopes were addressed to the researchers, not hospital management, thereby ensuring no interference with the data and increased confidence of anonymity by the respondents.

### 4.5.1 Pre-test

A pre-test or pilot utilises a small number of representative respondents to complete the research instrument to act as a guide and ensure it is appropriate for a larger population (Zikmund, 2003). Conducting a pre-test also enables the researcher to ensure that the respondents will understand the questions being asked and to remove any ambiguous or biased questions (Zikmund, 2003). A pre-test of the survey used in this research was conducted on the Hospital Reference Group who is located at one of the hospitals studied. This group consisted of 10 individuals comprising Nurse Unit Managers (NUMs) and senior hospital management. The items within the survey were scrutinised for their relevance to the research as well as for correct terminology and response fields. A number of individual items from different instruments were removed due to close similarities in wording and the terminology of Nurse Unit Manager was changed to Line Manager which reflected the hospitals preferred terminology. Following this, changes were made and the
final survey received approval from the Hospital Reference Group, hospital ethics committee, and the university research ethics committee.

4.5.2 Survey design and measures

The survey included variables examined in both this research and variables examined by the senior researchers as part of the larger project. Due to this, the following instruments and other information relate only to this research. The relevant survey elements consisted of 97 items across five parts: (Part A) demographics, (Part B) leader-member exchange, communication processes and role ambiguity, (Part C) problem-solving social networks, (Part D) organisational culture, and (Part E) perceptions of empowerment and affective commitment. The survey is included as Appendix 3. The quantitative items used a Likert scale of 1 = ‘strongly disagree’ to 6 = ‘strongly agree’. These were used because Likert scales are commonly used and accepted in surveys due to their simplicity and convenience (Neuman, 2003). The open-ended questions provided at least two lines for responses. In order to address each of the research questions and hypotheses, the following instruments were used in this research. These instruments are presented in order of their examination in the model depicting the relationships between variables (Figure 4.2).

4.5.2.1 Demographic variables

Demographic variables were contained in ‘Part A – Characteristics about you and your career’. These items asked for each respondent’s gender, age, position and length of time in their role, employment status, and type of ward. In addition, the items asked how long the respondent had worked within the district, their previous positions within the district and at other hospitals, the length of time in nursing, highest level of education, and if they were presently studying.
4.5.2.2 Leader-member exchange

Graen and Uhl-Bien’s (1995) validated instrument was used to determine the quality of exchanges between nurses and their superior. The instrument consisted of six items on a Likert scale ranging from “Strongly disagree” to “Strongly agree”.

4.5.2.3 Communication processes

Johlke and Duhan’s (2000) validated instrument was used to determine respondents’ perceptions of the communication occurring in their workplace. The instrument consisted of nine items within the following variables: “Informal communication mode” (2 items), “Indirect communication content” (4 items), and “Bi-directional communication flow” (3). These variables were measured using a six-point Likert scale ranging from “Strongly disagree” to “Strongly agree”.

4.5.2.4 Organisational culture

Glaser et al’s. (1987) validated instrument, the Organisational Culture Survey, was used to determine the culture and context of the nurses’ work environment. The instrument consisted of 28 items within the following variables: “Teamwork” (8 items), “Morale” (7 items), “Information flow” (4 items), “Involvement” (4 items), and “Meetings” (5 items). These variables were measured using a six-point Likert scale ranging from “Strongly disagree” to “Strongly agree”.

4.5.2.5 Problem-solving social networks

A validated instrument by Chakuthip, Brunetto, Farr-Wharton and Ramsay (2008) was used to determine the characteristics of nurses’ problem-solving social networks. The instrument consisted of five items. The first item asked the number of work-related problems the nurses encounter with six responses ranging from “0” to “11+”. The second item asked who they approached to help them solve a work-related problem using a ranking system of (1) “position / person you approach the most”, (2) “next position / person you approach the most”, and (N) (representing
Never) “positions / persons you never approach”. Thirteen categories of responses were provided ranging from (a) “Nurse Unit Manager” to (m) “Other”. The third item used a table of “a” through to “e” requesting that respondents write in the relationship with five people and why they choose that person to regularly assist them in problem-solving or gaining information. Item four asked how well respondents knew the persons listed using a table of “a” through to “e” on a Likert scale of “not at all” through to “closely”. Item five asked how useful their network was using a Likert scale of “Not at all” through to “Extremely useful”.

4.5.2.6 Role ambiguity

Johlke and Duhan’s (2000) validated instrument was used to determine respondents’ level of ambiguity surrounding their work role. The instrument consisted of two variables including “customer ambiguity” (3 items), and “supervisor ambiguity” (3 items). These variables were measured using a six-point Likert scale ranging from “Strongly disagree” to “Strongly agree”.

4.5.2.7 Perceived empowerment

Spreitzer’s (1995a) validated instrument was used to determine respondents’ feelings of empowerment. The instrument consisted of 12 items including the following variables: “Meaning” (3 items), “Competence” (3 items), “Self-determination” (3 items), and “Impact” (3 items). These variables were measured using a six-point Likert scale ranging from “Strongly disagree” to “Strongly agree”.

4.5.2.8 Affective commitment

Meyer et al.’s. (1993) validated instrument was used to determine respondents’ degree of affective commitment to the organisation. The instrument consisted of eight items within the variable “Affective commitment”. The variable was measured using a six-point Likert scale ranging from “Strongly disagree” to “Strongly agree”.

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4.5.2.9 Intention to leave

Three questions asked nurses about their intentions to leave. The first item asked nurses if they planned to leave their present position within the next year, requesting a yes or no response. The second and third items asked nurses if they planned to work part-time in nursing within the next year or the next five years using a six-point Likert scale ranging from “Strongly disagree” to “Strongly agree”.

4.5.2.10 Open-ended questions

The survey contained four open-ended questions to obtain a greater understanding of respondents’ experiences beyond the quantitative responses. The first open-ended question asked nurses if they did not approach their NUMs when they experienced a work-related problem in the workplace, and if not, then why not. This question was asked because the relationship between nurses and their supervisor, the NUM, is one of the key organisational relationships that employees possess, and a primary way in which employees access information and resources to help them perform their work. Consequently, whether nurses are or are not approaching their NUMs to help them solve work-related problems, and the reasons for this, are important to understand. The second question asked nurses about the best aspects of working for the organisation and the third asked about the worst aspects, to identify issues of concern that were not addressed in the quantitative questions. Finally, the fourth question asked nurses about the one thing that management would need to change in order for the nurses to remain committed to the organisation. For full details of these items, see Appendix 3.

4.5.3 Procedures to increase the response rate

Several approaches were employed in order to increase the response rate for the survey. Coleman and Briggs (2002) argue that surveys and their accompanying instructions need to be clear, simple and easy to read, and spark interest in the respondents. The layout of the survey, and terminology used throughout was
discussed and agreed upon with the Hospital Reference Group to ensure consistency and understanding of key concepts used within the hospital site. Each survey included an information sheet (Appendix 4) with the university logo demonstrating the importance of the research and the collaboration between the university and the hospital. This information sheet also outlined the confidentiality and anonymity conditions that respondents are protected under and that the research was approved by both the university and hospital research ethics committees. Between one to four sessions with nurses within each ward were held to explain the research, assist respondents in completing the survey, and to encourage their participation. Nurse Unit Managers within each ward were enlisted to remind, and encourage participation by, their nursing staff. Completed anonymous surveys were asked to be returned to the researchers, not the hospital management, in a further attempt to increase the response rate.

4.6 Focus groups

The second method of data collection used in this research was focus groups. A focus groups is defined as a group of individuals interacting together to discuss and comment upon a topic of interest (Gibbs, 1997; Keown, 1983). The purpose of conducting a focus group is to explore a topic in more detail, and the nature of gathering a group of people together quite often produces results that would not have normally been discovered in non-group methods (Babbie, 2004). For example, the group setting allows the participants to compare the ideas and issues amongst themselves to indicate significance, rather than the researcher determining what is more important (Carson, Gilmore, Perry & Gronhaug, 2001). This means that focus groups are very appropriate in preliminary or exploratory studies and particularly in areas regarding complex behaviour or perceptions (Krueger, 1994) such as this research.

The principal advantage of using the focus groups is the synergy that is created, and the higher quality and wider range of data that results from the
interactions of the participants in the group (Keown, 1983; Krueger, 1994; Stokes & Bergin, 2006). The responses provided by respondents are also of greater depth as they are in the respondents’ own words as opposed to having pre-determined responses (Babbie, 2004). Other advantages include greater flexibility, speed and cost effectiveness (Alreck & Settle, 2004; Krueger, 1998; Zikmund, 2003). There are multiple reasons why focus groups may be more time and cost effective, such as that the data is being collected from multiple respondents at the same time, which results in less transcribing and less time for which the researcher may need to be compensated (Carson et al., 2001). However, the primary disadvantage of focus groups is the lack of generalisability due to the small sample sizes, even when multiple groups are conducted (Alreck & Settle, 2004; Keown, 1983). Disadvantages are due to the group nature of the method such as the potential for groupthink (Bloom, 1989; Minichiello, Aroni & Hays, 2008), individuals feeling inhibited in groups (Greenbaum, 1998; Hedges, 1985), and discrepancies between public agreement and private disagreement (Robson, 1990). Other disadvantages include: difficulties in assembling participants; the need for moderators to have specialised skills and possess less control than in interviews; and the data can be difficult to analyse (Babbie, 2004; Hall & Rist, 1999; Krueger, 1994).

Nonetheless, focus groups are a valuable research tool for gaining a greater or more in-depth understanding of data previously collected from research methods such as surveys (Johnson & Turner, 2003). The focus groups in this research were designed to add insight into the factors affecting nurses’ perceptions of empowerment, in order to determine how this may affect their ability to undertake their jobs effectively. Furthermore, focus groups were central to understanding the issues surrounding relationships that quantitative methods could not examine in depth.

4.6.1 Procedure for focus group research

Undertaking focus group methodologies requires extensive planning and for that reason, this research used the framework of Carson et al. (2001) who states that
focus group methodology involves addressing the following areas: defining the problem; establishing the number of focus groups; size of groups and length of sessions; wording of questions; timing and site selection; recruitment of participants; selecting the facilitator; pre-testing the focus group question; and the conduct and conclusion of the discussions. The first area of planning mentioned, defining the problem, has previously been covered in the literature review (Chapter 3). Each of the other areas is now discussed.

The number of focus groups that need to be undertaken depends largely upon the topic being investigated (Carson et al., 2001). However, the homogeneity of the group and the number of new ideas from each new group will also determine the number of groups that will be necessary (Carson et al., 2001). For example, traditionally a minimum of six focus groups are held in order to identify trends and patterns across groups (Krueger, 1994). A large number of groups, 12, was used in this research because only one variable, perceived empowerment, was being tested and therefore a large number of groups was necessary to identify patterns and increase the validity and reliability of the responses. The focus groups tested this variable because even though a number of related factors were identified in the surveys as being important, many of those factors were included in the larger project, and perceptions of empowerment were of most contribution to this study.

The number of participants in focus groups can vary widely, however, between four and 12 participants is common (Krueger, 1994). It is important that focus groups are small enough to encourage participation by all respondents and greater interaction, but also large enough to generate sufficient information and different opinions (Carson et al., 2001; Krueger, 1994). However, groups must also not be so large that participants are not able to speak due to the lack of pauses (Carson et al., 2001; Krueger, 1994). Depending on the number of participants in the group and the number and complexity of questions, focus groups will typically last for between one to two hours’ duration (Krueger, 1998).
When asking questions, it is important that the questions be worded so that they are direct, simple and comfortable, and so that participants are able to understand the meaning of the question as it is being conveyed (Krueger, 1998). The individual questions asked in this research focus group were clear and direct while also being very broad, to enable participants to answer with the response they felt was most relevant and important. The questions used were “What are the factors that most affect your perception of empowerment at your hospital?” and “Can you tell me why you think this?” The questions were not pre-tested as it was not deemed necessary because the questions were used in previous validated studies. The topic of empowerment had also previously been tested in the quantitative survey and no confusion about its meaning was encountered.

When selecting a site to conduct the focus groups, it is important to ensure that the site is neutral and relaxed to encourage informal discussions, while also being convenient and easily accessible (Carson et al., 2001). The site chosen for this research was a meeting room located within one of the research sites, which contained round meeting tables to encourage participation. This site was convenient, easily accessible and familiar to the participants across both hospital sites. Meetings with the participating organisation were held to discuss participation for the focus groups and the organisation arranged for several Nurse Unit Managers and senior management to be available at different times. All participants volunteered to be present and no coercion occurred from either the participating hospital or their management, nor the researcher. Proceedings were tape recorded for transcribing later, with the permission of the participants. The information sheet and consent form for the focus groups is included in Appendices 5 and 6 and the focus group protocol is at Appendix 7.

The facilitator of a focus group (also referred to as a moderator) plays a vital role in conducting a successful focus group. They need to develop rapport with the participants and encourage interaction amongst them, ensuring that every participant gets a chance to speak (Zikmund, 2003). They also need to be able to listen carefully and be friendly enough to establish rapport and make participants
feel comfortable (Zikmund, 2003). Most importantly, the facilitator needs to keep the participants focused and on track with the relevant topics to ensure that valuable insights are gained regarding the research questions, and so that consistent and sufficient coverage of the research agenda is achieved (Carson et al., 2001; Johnson & Turner, 2003). The facilitator used for these focus groups was chief investigator 1 from the larger project in which this research project is situated, and who has extensive experience in conducting focus groups. Hospital management specifically required that the focus groups be conducted by chief investigator 1 only and not by this author. However, the author did transcribe the relevant data and conduct their own analysis. For more specific details regarding the author’s role see Appendix 1. The senior researcher welcomed the participants to the focus group and provided a brief outline of her experience and skill in conducting such sessions. The researcher outlined the objectives of the focus group, followed by some ground rules for the session including ensuring that all comments made would be kept confidential and that all participants would have time to make comments. Refreshments were available during this time. The topics for discussion were introduced and the participants provided significant insights. The sessions were closed with appreciation for the participants’ time and thoughts.

4.7 In-depth interviews

The third method of data collection used in this research was in-depth interviews. Researchers frequently use interviews as a basic method to gather in-depth information about phenomena (Fontana & Frey, 2005) because interviews focus on interpreting individuals’ perceptions, views and meanings (Punch, 2005). The main aim of an interview is to gather an in-depth understanding of people’s experiences and the meanings attached to those experiences (Seidman, 1998) that cannot be observed or discovered in other ways (Carson et al., 2001). Interviews may be structured or semi-structured. Structured interviews consist of fixed response categories and analysis procedures to ensure uniformity of responses (Ghauri & Gronhaug, 2005, p.132). Semi-structured interviews typically have only a
few questions designed to identify opinions from a broad point of view (Creswell, 2003). Interviews can be face-to-face, self-administered, or via telephone or mail and may typically last between 45 minutes and 2 hours (Fontana & Frey, 2005). The number of interviews to conduct depends on a variety of factors including the complexity of the topic, the sampling situation, time and costs (McGivern, 2003). Another major contributing factor is reaching the saturation point in the data whereby the number of interviews concludes when each subsequent interview provides similar responses and no new information (Glaser & Strauss, 1967).

The advantages of using the interview method include: greater depth in responses as participants can use their own words to explain their own feelings and attitudes on the topic (Minichiello et al., 2008); greater accuracy and clarity in respondents’ responses and attitudes due to open-ended questions (Ghauri & Gronhaug, 2005); greater flexibility (Punch, 2005); and as a useful alternative to observation and allow more control over the questioning by the researcher (Creswell, 2003). The disadvantages of using the interview method mainly relate to the quality of the responses from the interviewee. The quality of the information is highly dependent on the skills of the interviewer in interviewing subjects (Ghauri & Gronhaug, 2005; Patton, 2002). Furthermore, responses can be dependent on the emotional state of the participant at the time of the interview (Patton, 2002). Other disadvantages to conducting interviews are that they are time consuming (Minichiello et al., 2008), more difficult to analyse, and researchers may be less objective (Ghauri & Gronhaug, 2005).

Interviews were conducted with employees who were unable or unwilling to attend focus group sessions. Similar to the focus groups, the aim of the interviews was to gather detailed information and valuable insights into the factors affecting nurses’ feelings of empowerment. The information obtained from these interviews was joined with the information obtained from the surveys and focus groups, which provided the researcher with a more comprehensive picture of the issues being experienced. In addition, two in-depth interviews were conducted with senior administrative staff of the hospital. These interviews identified the most relevant
organisational documents to examine in this research and are explained in further detail in the following section.

### 4.7.1 Procedure for in-depth interviews

It is recommended that in-depth interviews take into account the planning, commencement, and managing components of the interview (Carson et al., 2001). According to Carson et al. (2001), when planning to conduct interviews, it is important to consider a number of factors. First, the objectives for the interviews need to be clearly established so that the interviews are meeting the need for which they are being conducted. The objectives of the interviews conducted in this research were to discuss empowerment with nurses and identify with senior management which were the most appropriate organisational documents in which the researcher could determine the organisation’s policies regarding the variables under investigation. Second, the number of interviews to conduct depends on a variety of factors including the complexity of the topic, the sampling situation, time and costs (McGivern, 2003). The number of interviews examining empowerment was based on the number of employees preferring to participate in individual interviews. In addition, two interviews were conducted with senior administrative staff who were identified as being knowledgeable about which documents were appropriate for this research. The first interviewee recommended the second interviewee as being the most appropriate person to next approach. Each of the interviews with senior administrative staff lasted for approximately 45 minutes. These interviewees provided considerable information regarding the most appropriate documents to examine in order to determine the organisation’s position on the variables being examined.

Following the usual greetings and pleasantries, all interviews began with an outline of the purpose of the interview and its relevance to the research as suggested by Carson et al. (2001). Verbal informed consent was granted at all interviews, as was permission to tape record the interview for transcribing later. The
information sheet and consent form for the interviews is included in Appendices 8 and 9 and the interview protocol in Appendix 10.

4.8 Document analysis

The fourth method of data collection used in this research was document analysis. Document analysis refers to the analysis of written material into meaningful units of analysis, using applied rules (Aaker, Kumar & Day, 1995). Written material refers to any documents including public documents such as census statistics, mass media such as newspapers, personal documents such as letters and diaries, administrative documents such as minutes of meetings and annual reports, and formal studies and reports (Mason, 2002; Sarantakos, 2005). Due to the large amount of material that may be contained within any type of document, the aim of document analysis is to simplify the material into a form that is more easily analysed. Furthermore, the material contained within documents may be written text, pictures, tables, or figures, and even an absence of material is important when analysing documents. Documents are very valuable for analysis in research because they are a formal method of recording phenomena and the way in which this is recorded provides a lot of insight into questions regarding the what, why, and how. Insight can be provided into the context in which an event occurred such as the underlying social patterns and values which guide behaviour (Cicourel, 1964; Hodson, 1999; May, 2001). For example, in organisational documents, contextual aspects such as underlying social patterns and values provide a glimpse into the culture of the organisation or department it is referring to that may not have been adequately explained or explored in alternative methods of data collection.

One of the most important advantages of using document analysis is its lack of intrusion upon both the subjects and the context in which they are situated (Marshall & Rossman, 1999; Weber, 1990). This means that the analysis is more objective as the researcher is not participating in or affecting anything being analysed. Subsequently, using documents is frequently more time and cost
Another advantage of conducting document analyses that is very important to this research is the ability to compare, verify or contextualise data obtained through other methods such as interviews or surveys, against the contents of the documents, and if need be, on which to base further investigations (Mason, 2002; May, 2001). Hence, in this research, data obtained from surveys, focus groups and interviews regarding nurses’ perceptions of their work environment can be compared and contrasted against what the organisation espouses is currently occurring or trying to achieve, and differences may be identified between these. This is because documents frequently describe the reasons behind why phenomena occur (May, 2001) and in this research, some reasons behind the culture of the organisation. For example, an organisational document may specify that the organisation values efficiency and other methods of data collection may demonstrate that this has resulted in practices to reduce costs. However, documents are frequently criticised as being biased or not representative, and problems may be encountered with incomplete data, comparability, and accessibility (Sarantakos, 2005). Therefore, documents are best used as a supporting method for other forms of data collection, such as in this research.

This research uses document analysis as one of four methods of data collection in order to compare the findings of the previous methods with organisational policy to determine any inconsistencies. This is an appropriate method for this purpose as documents are the best source through which to gather rich, contextual data that will explain the foundation behind the responses obtained in the previous methods and enable comparisons to be made (Marshall & Rossman, 1999; Weber, 1990).

### 4.8.1 Framework for document analysis

Examination of the literature identifies that when conducting a document analysis, it is important to identify the relevant documents and the quality of these before proceeding to analyse them (see May, 2001; Sarantakos, 2005; Scott, 1990). In order to identify the relevant documents for use in this research, the researcher
explored the organisation’s official website to identify publicly available documents which may include information relevant to the research questions and hypotheses. Because the two hospitals were within the one organisation, the policies and practices were the same, as confirmed by both interviews with senior administrative staff. Several documents were identified as being of interest. To confirm the top three to five most relevant documents, an interview was conducted with two senior administrative staff within the research site as suggested by Holsti (1969). These individuals were familiar with all documentation provided to nurses and were able to confirm the most appropriate documents for this research. Following the choice and confirmation of the relevant documents and continuing with step one, Scott’s (1990) four steps of determining authenticity, credibility, representativeness, and meaning were undertaken to determine the quality of the chosen documents. The first step, authenticity, refers to whether the documents are genuine and of known origin (Scott, 1990). The documents analysed in this research were obtained from the organisations official website and confirmed by senior administrative staff from the hospitals in both interviews as being authentic. The second step, credibility, means that the document is free from error or distortion (Scott, 1990). The official company documentation used in this research was approved as accurate by hospital staff and permission granted for its use. The third step, representativeness, means that the documents are typical or representative of that kind of document (Scott, 1990). Each of the documents examined is typical of official company documents of this kind. Last, meaning refers to the document being clear and comprehensive (Scott, 1990). Each of the chosen documents is clearly written and presented, and very comprehensive. Therefore, each of the three organisational documents chosen for analysis is considered to be of high quality. Following the successful identification and determination of quality of the chosen documents, it is then possible to proceed on to the document analysis. The documents in this research were analysed using content analysis which is explained in detail in the following section.
Data analysis

Data from this research were analysed using multiple tools and approaches. The quantitative data were analysed statistically through SPSS software. This analysis included the calculation of alpha coefficients, mean scores, anovas, factor analyses, multiple regression analyses, and path analysis using an ordinary least square (OLS) regression approach. Path analysis is an extension of regression analysis (Garson, 2004) which allows the simultaneous analysis of multiple independent and dependent variables (Stage, Carter & Nora, 2004) to identify the relationships among these. One of the advantages of this approach is that it manages and reduces the incidence of multicollinearity which occurs when independent variables are closely correlated and cause problems in the accurate calculation of regression analyses (Grapentine, 1997, 2000). Factor analyses were conducted to confirm the factor structure of the scales used and decrease the variables where necessary based on areas of similarity (Hair, Anderson & Tatham, 1995). This enabled the removal of any potential instances of multicollinearity.

The qualitative data were analysed using content analysis which is a form of analysis that enables interpretations to be made from written communications. It is defined as “a systematic reduction of a piece of text into a set of statistically manipulable symbols representing the presence, intensity, or frequency of some characteristics” (Shapiro & Markoff, 1997, p. 14). The main purpose of content analysis is to manipulate the text into a form that is easily understood and categorised by researchers in order to make replicable and valid inferences (Krippendorff, 1980). This method was used to analyse the qualitative data for this research as opposed to alternative methods of analysis as it was deemed to be the most appropriate due to the small sample size available.

Content analysis can be undertaken by using either the manifest or latent method, or both. Manifest content analysis is the visible, surface content of written communication and the frequencies of these words (Babbie, 2004; Sarantakos, 2005). It is believed that measuring text by the frequency of words is an indication
of their significance and reliability (May, 2001; Sarantakos, 2005). In contrast, latent content analysis focuses on the underlying meaning of the written communication by interpreting messages, meanings and symbols (Babbie, 2004; Sarantakos, 2005). In this method, researchers are interested in obtaining the hidden meaning behind the words and gathering insight into aspects such as cultural norms, attitudes and standards (Sarantakos, 2005, p.300). There is a divide in the literature regarding whether content analysis is a quantitative method, qualitative, or both. Manifest content analysis is frequently viewed as quantitative (Berelson, 1952; Silverman, 1993) and latent analysis as qualitative (Creswell & Plano-Clark, 2007). However, conducting content analysis using both quantitative and qualitative methods is considered best (Tashakkori & Teddlie, 2003), hence the growth of the mixed methods paradigm. This research views manifest content analysis as quantitative and latent analysis as qualitative, as is supported in the literature (Abrahamson, 1983; Berg, 2001), and the use of both methods in this research results in a mixed methods approach.

The advantages of using content analysis as a method of data analysis are very similar to the advantages of conducting a document analysis. They can include the fact that it is an unobtrusive method of gathering data (Berg, 2001), it is cost effective (Babbie, 2004) and does not require respondents; is commonly more accessible; and can reduce researcher bias as the text is already complete, or has been completed by another person (Sarantakos, 2005). However, some disadvantages include the fact that it may be applicable to only a small population and may omit certain details, some texts may be inaccessible (Sarantakos, 2005), and there is the possibility of bias and selectivity of content (May, 2001).

Once the quantitative analyses and content analysis of qualitative data were completed, the combined data were analysed and interpreted using pattern-matching and through the identification of emerging themes. Pattern-matching is the process of comparing empirical data obtained from this research with predicted and expected patterns, which allows for the identification of emerging themes, which is the consistency between the different forms of data obtained (Yin, 2003).
Together, these techniques enabled the researcher to identify consistencies amongst the data and improve its reliability.

4.10 Ethical considerations

Ethics refer to the moral or legitimate procedure to be followed when conducting social research (Neuman, 2003). The literature identifies several areas of importance when conducting research on human participants including informed consent, privacy, anonymity, confidentiality, deception, harm to participants, and voluntary participation (see Babbie, 2004; Bryman, 2004; Neuman, 2003). The following procedures were undertaken to ensure the ethical conduct of this research. This research and all items and questions contained within the surveys, focus group sessions and interviews, were approved by both Griffith University Research Ethics Committee and the Hospital Research Ethics Committee. An information sheet was attached to the front of the survey (see Appendix 4), and an information sheet and consent form was supplied during focus groups and interviews (see Appendices 5, 6, 8 and 9). Each of these forms detailed the purpose of the research, privacy and confidentiality assurances, and contact details for researchers and authorised persons regarding the conduct of the research. Participants in the focus groups sessions and interviews were consulted regarding permission for proceedings to be taped. Participation was voluntary and participants were advised that they could withdraw without any retribution from their organisation.

4.11 Conclusion

This chapter has outlined the methodology and methods used in this research using the lens of the positivist philosophy which emphasises reliable and valid research. A sequential mixed methods design was used to comprehensively measure the variables under investigation. The specific methods employed included a survey
with both quantitative and qualitative items, focus groups, interviews and document analyses. These methods were undertaken through a purposive sample of nurses working within hospitals located within Australia who were identified by hospital management as working on wards experiencing high levels of turnover. The quantitative data were analysed using SPSS statistical analysis consisting largely of multiple regressions and path analysis. The qualitative data were analysed using manifest and latent content analysis, and pattern-matching and emerging themes were sought following this to identify patterns and themes amongst the data and previous research conducted in the area. The issues surrounding the use of the methods and how they strengthen the quality of this research have also been explored. The next chapter provides the results of the analysis of the quantitative data.
CHAPTER 5 – QUANTITATIVE RESULTS

5.1 Introduction

This chapter outlines the analysis of the quantitative survey data gathered in this research. The chapter begins by detailing the demographics and descriptive statistics of the sample, followed by the reliability statistics of the measures used. The data analysis procedures are then described, including the reliability issues surrounding these. The analysis of the data relating to Research Questions 1, 2, and 3 are provided, along with a summary of the overall quantitative results of this research.

5.2 Demographics of survey respondents

A total of 504 surveys were distributed to nurses working within two hospitals located within one Australian state. Of these, 167 useable surveys were returned, representing a response rate of 30%. Females accounted for 88% (N = 147) of respondents, and 12% were male (N = 20). Regarding age, 22% of respondents were up to 30 years of age; 44% were between the ages of 31 and 45 years; and 34% were above the age of 45 years. Of these respondents, 2% (N = 3) were “Line Managers” (Nurse Unit Managers); 28% (N = 46) were “Clinical Nurses”; 56% (N = 93) were “Registered Nurses”; 8% (N = 14) were “Enrolled Nurses”; and 2% (N = 4) were “Assistants in Nursing”. Nurse Unit Managers were referred to as “Line Managers” in the survey at the request of hospital management as this is the terminology used within the hospital. Interestingly, during the data collection stage the researcher did need to clarify the meaning of “Line Manager” to participants. Regarding length of employment in this role, 28% (N = 47) of nurses had worked in this role for less than 1 year; 34% (N = 57) had worked for between 1 and 5 years; 26% (N = 43) had worked for between 5 to 15 years; and 12% (N = 20) for more than 15 years. Regarding status of employment, 53% (N = 88) were full-time employees; 40% (N = 67) were part-time employees and 7% (N = 11) were pool nurses.
Data gathered from the 2006 Australian Census (ABS, 2008b) show similar demographics of nurses across Australia including a domination of females (91%) compared to males (9%), and similar proportions of nursing qualifications (78% Registered Nurses, 9% Enrolled Nurses). The census data therefore suggested that the population used in this research study is representative and potentially generalisable to the nursing population within Australia. More detailed demographic characteristics of the respondents are provided in Table 5.1.
The demographic data of the survey respondents were explored to determine potential significant relationships between the demographic data and the variables examined. Table 5.2 outlines the demographic attributes exhibiting significant relationships with variables being examined. An independent t-test found that there were no significant differences between gender and all variables.
examined in this research. That is, gender did not affect the results. Similarly, a one-way analysis of variance found no significant associations between the age of respondents, Length of nursing career, and Highest levels of education achieved, with all variables examined. However, a one-way analysis of variance did identify significant relationships between the Position occupied by nurses (Line Manager [Nurse Unit Manager], Clinical Nurse, Registered Nurse, Enrolled Nurse, Assistant in Nursing, Other [Midwife etc.]) and the variables of Supervisor ambiguity ($F[5, 160] = 2.723, p < .05$), Meaning and competence ($F[5, 160] = 3.588, p < .05$), and Impact ($F[5, 160] = 7.065, p < .05$). In relation to Supervisor ambiguity, significant associations were found with both Registered Nurses and Other nurse positions. In relation to Meaning and competence, significant relationships were found between Clinical Nurses, Registered Nurses, and Enrolled Nurses. In relation to the Impact variable, significant relationships were identified between all classifications of nurses with the exception of Assistants in Nursing. Levine’s test was not significant for each of the variables of Supervisor ambiguity ($F[5, 160] = 1.541, p < .05$), Meaning and competence ($F[5, 160] = .938, p < .05$), and Impact ($F[5, 160] = 968, p < .05$) and therefore, the homogeneity of variance assumption was not violated.

### Table 5.2 Demographic attributes with significant relationships to the examined variables

<table>
<thead>
<tr>
<th>Demographic attributes</th>
<th>Variables</th>
<th>ANOVA F</th>
<th>ANOVA P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Supervisor ambiguity</td>
<td>2.723</td>
<td>.022</td>
</tr>
<tr>
<td></td>
<td>Meaning and competence</td>
<td>3.588</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>Impact</td>
<td>7.065</td>
<td>.000</td>
</tr>
</tbody>
</table>

* $p < .05$

Finally, an Independent t-test identified that significant relationships did exist between whether nurses were studying at the time, and LMX and communication processes ($t[164] = -1.412, p < .05$), Supervisor ambiguity ($t[164] = -1.412, p < .05$) and Meaning and competence ($t[164] = -1.421, p < .05$). The Levine’s test for equality of variances was not significant for each of the variables of LMX and communication processes ($F[165] = .019, p < .05$), Supervisor ambiguity ($F[164] =
.013, p < .05) and Meaning and competence (F [164] = .002, p < .05), thus, the homogeneity of variance assumption was not violated.

5.3 Principal components analysis

When examining a large number of items and variables, it is useful to conduct a factor analysis, which decreases the number of variables being examined by exploring and grouping together their underlying dimensions (Hair et al., 1995). When using variables obtained from previous research, a confirmatory principal components analysis may be applied to confirm the underlying factor structure of those variables. Each of the instruments used in this research was validated in previous research and therefore a confirmatory principal components analysis was undertaken to confirm the factor structure for this research. This principal components analysis found three models were suited to partially explain the relationships between the variables. These three models are described next.

5.3.1 Model 1

Model 1 comprised 45 items within the variables. The Kaiser-Meyer-Olkin Measures of Sampling Adequacy (KMO = .892) was greater than 0.6, and Bartlett’s Test of Sphericity was significant ($\chi^2$ = 6139.878, p < .05). Seven factors had Eigenvalues above 1 (Factor 1 = 16.041, Factor 2 = 4.463, Factor 3 = 3.048, Factor 4 = 2.482, Factor 5 = 1.927, Factor 6 = 1.551, and Factor 7 = 1.290) and accounted for 70.834% of the total variance. Table 5.3 outlines the principal components analysis scores for these factors and Appendix 11 contains the Rotated factor matrix and Scree plots for Model 1.
Table 5.3: Principal components analysis for model 1

<table>
<thead>
<tr>
<th>Factor No.</th>
<th>Eigenvalue</th>
<th>% of variance</th>
<th>Cumulative %</th>
<th>Kaiser-Meyer-Olkin</th>
<th>Bartlett x^2</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>16.041</td>
<td>35.646</td>
<td>35.646</td>
<td>.892</td>
<td>6139.878</td>
<td>.000</td>
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<tr>
<td>Factor 2</td>
<td>4.463</td>
<td>9.917</td>
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<td></td>
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<tr>
<td>Factor 3</td>
<td>3.048</td>
<td>6.774</td>
<td>52.337</td>
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<td>Factor 4</td>
<td>2.482</td>
<td>5.516</td>
<td>57.853</td>
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<td></td>
</tr>
<tr>
<td>Factor 5</td>
<td>1.927</td>
<td>4.282</td>
<td>62.135</td>
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<tr>
<td>Factor 6</td>
<td>1.551</td>
<td>3.447</td>
<td>65.582</td>
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</tr>
<tr>
<td>Factor 7</td>
<td>1.290</td>
<td>2.868</td>
<td>68.450</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Factor 1 consisted of the following significantly loaded variables and items including LMX (items 34, 35, 36, 37, 38 and 39), Communication Frequency (items 13, 14 and 15), Indirect Communication (items 19, 20, 21 and 22), Bi-directional Communication (items 23, 24 and 25), and Supervisor Ambiguity (items 29, 30 and 31). These items explained 35.65% of the variance in the data. The above Communication variables comprise 3 of the 4 variables that make up the instrument for Communication Processes. The remaining Communication variable, Communication Mode, loaded significantly on factor 6 with items 16, 17 and 18. However, due to the closeness and similarities between the singular LMX variable and three out of the four Communication Processes variables, which indicates the presence of multicollinearity, all 4 of the Communication variables, including Communication Mode, were joined together and transformed into the variable named LMX and Communication Processes. Due to the closeness of the Supervisor Ambiguity variable with the LMX and Communication Processes variable, Supervisor Ambiguity is not being tested in Model 1.

Items 132, 134, 135, 136, 137, 138 and 139 loaded significantly onto factor 2 and consisted of the items comprising the variable named Affective Commitment. These items explained 9.92% of the variation in the data. Item 133 from the Affective Commitment scale did not load significantly on any factor and was therefore excluded from the analysis.
Items 129, 130 and 131 from the Meaning variable and items 126, 127 and 128 from the Competence variable of the Perceived Empowerment scale loaded significantly onto factor 3. The loading of these items on the same factor indicated that multicollinearity was present. Subsequently, these two variables of Perceived Empowerment were combined and named Meaning and competence. These items explained 6.78% of the variation in the data.

Items 120, 121 and 122 from the Self-determination variable of Perceived Empowerment loaded significantly onto factor 4. These items explained 5.52% of the variation in the data.

Items 26, 27 and 28 loaded significantly onto factor 5 and comprised the Customer Ambiguity variable of Role Ambiguity. These items explained 4.28% of the variation in the data.

As mentioned in factor one, items 16, 17 and 18 from the sub-scale Communication Mode loaded significantly onto factor 6, and for reasons mentioned earlier, these items were included with the combined LMX and Communication Processes variable.

Items 123, 124 and 125 from the Impact variable of Perceived Empowerment loaded significantly onto factor 7. These items explained 2.87% of the variation in the data.

Together, all 7 factors in Model 1 accounted for 68.45% of the variance in the data.

5.3.2 Model 2

A principal components analysis was conducted on the 54 items within the variables comprising Model 2. The Kaiser-Meyer-Olkin Measures of Sampling Adequacy (KMO = .904) was greater than 0.6, and Bartlett’s Test of Sphericity was
significant ($\chi^2 = 7545.924, p < .05$). Nine factors had Eigenvalues above 1 (Factor 1 = 19.489, Factor 2 = 4.543, Factor 3 = 3.315, Factor 4 = 2.400, Factor 5 = 2.351, Factor 6 = 2.187, Factor 7 = 1.739, Factor 8 = 1.401, Factor 9 = 1.168) and accounted for 71.472% of the total variance. Table 5.4 outlines the principal components analysis scores for these factors and Appendix 12 contains the Rotated factor matrix and Scree plots for Model 2.

Table 5.4: Principal components analysis for model 2

<table>
<thead>
<tr>
<th>Factor No.</th>
<th>Eigenvalue</th>
<th>% of variance</th>
<th>Cumulative %</th>
<th>Kaiser-Meyer-Olkin</th>
<th>Bartlett $\chi^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>19.489</td>
<td>36.091</td>
<td>36.091</td>
<td>.904</td>
<td>7545.924</td>
<td>.000</td>
</tr>
<tr>
<td>Factor 2</td>
<td>4.543</td>
<td>8.413</td>
<td>44.504</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 3</td>
<td>3.315</td>
<td>6.140</td>
<td>50.644</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 4</td>
<td>2.400</td>
<td>4.445</td>
<td>55.089</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 5</td>
<td>2.351</td>
<td>4.354</td>
<td>59.443</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 6</td>
<td>2.187</td>
<td>4.050</td>
<td>63.493</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 7</td>
<td>1.739</td>
<td>3.221</td>
<td>66.714</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 8</td>
<td>1.401</td>
<td>2.594</td>
<td>69.308</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 9</td>
<td>1.168</td>
<td>2.163</td>
<td>71.472</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Factor 1 consisted of the following significantly loaded variables and items including Morale (items 64, 65, 66, 67, 68, 69 and 70), Information Flow (items 71, 72, 73 and 74), and Involvement (items 75, 76, 77 and 78) which are 3 of the 5 variables within Organisational Culture. These items explained 36.091% of the variance in the data and due to the closeness of these 3 variables, and presence of multicollinearity, they were combined and named Morale, Info Flow and Involvement.

Factor 2 consisted of the followed significantly loaded items of 56, 57, 59, 60, 61, 62 and 63 which comprise the Teamwork variable of Organisational Culture. These items explained 8.41% of the variance in the data. Item 58 loaded negatively in Factor 8 and was excluded from the analysis.
Factor 3 consisted of the following significantly loaded items including 132, 134, 135, 136, 137, 138 and 139 which comprise the Affective Commitment variable. These items explained 6.14% of the variance in the data.

Items 79, 80, 81, 82 and 83 loaded significantly onto Factor 4 and comprised the Meetings variable of Organisational Culture. These items explained 4.45% of the variance in the data.

Items 128, 129 and 130 of the Meaning variable and items 126, 127 and 128 of the Competence variable, both part of the Perceived Empowerment scale, loaded significantly onto Factor 5. These items explained 4.35% of the variance in the data. Similarly to Model 1, these two variables were combined into the variable named Meaning and competence.

Items 120, 121, and 122 of the Self-determination variable of Perceived Empowerment loaded significantly onto Factor 6. These items explained 4.05% of the variance in the data.

Items 26, 27 and 28 of the Customer Ambiguity variable of Perceived Empowerment loaded significantly onto Factor 7. These items explained 3.22% of the variance in the data.

Items 29, 30 and 31 of the Supervisor Ambiguity variable of Perceived Empowerment loaded significantly onto Factor 8. These items explained 2.59% of the variance in the data.

Items 123, 124 and 125 of the Impact variable of Perceived Empowerment loaded significantly onto Factor 9. These items explained 2.16% of the variance in the data.

When combined, these 9 factors accounted for 71.48% of the variance in the data.
5.4 Descriptive statistics

The means, standard deviations, correlations, and alpha coefficients for all variables included in this research are presented in Table 5.5.
Table 5.5  Means, standard deviations, correlations and Cronbach’s alphas

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td><strong>INDEPENDENT VARIABLES</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1 LMX and communication processes</td>
<td>4.31</td>
<td>.96</td>
<td></td>
<td>(.93)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Teamwork</td>
<td>4.14</td>
<td>.94</td>
<td></td>
<td>.35**</td>
<td>(.92)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Morale, info flow and involvement</td>
<td>3.30</td>
<td>1.07</td>
<td>.54**</td>
<td>.56**</td>
<td>(.95)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4 Meetings</td>
<td>3.57</td>
<td>1.17</td>
<td>.54**</td>
<td>.43**</td>
<td>.72**</td>
<td>(.93)</td>
<td></td>
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<tr>
<td><strong>WORK-RELATED OUTCOMES</strong></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5 Customer ambiguity</td>
<td>1.95</td>
<td>.86</td>
<td>-.38**</td>
<td>-.18*</td>
<td>-.29**</td>
<td>-.22**</td>
<td>(.85)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6 Supervisor ambiguity</td>
<td>2.68</td>
<td>1.33</td>
<td>-.81**</td>
<td>-.44**</td>
<td>-.54**</td>
<td>-.57**</td>
<td>-.42**</td>
<td>(.92)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7 Meaning and competence</td>
<td>4.94</td>
<td>.76</td>
<td>.29**</td>
<td>.21**</td>
<td>.25**</td>
<td>.23**</td>
<td>-.23**</td>
<td>-.30**</td>
<td>(.87)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8 Self-determination</td>
<td>3.93</td>
<td>1.21</td>
<td>.17*</td>
<td>.28**</td>
<td>.34**</td>
<td>.28**</td>
<td>-.25**</td>
<td>-.33**</td>
<td>.31**</td>
<td>(.91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Impact</td>
<td>3.25</td>
<td>1.23</td>
<td>.36**</td>
<td>.31**</td>
<td>.44**</td>
<td>.36**</td>
<td>-.28**</td>
<td>-.45**</td>
<td>.37**</td>
<td>.56**</td>
<td>(.90)</td>
<td></td>
</tr>
<tr>
<td><strong>DEPENDENT VARIABLE</strong></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Affective commitment</td>
<td>3.44</td>
<td>1.18</td>
<td>.51**</td>
<td>.40**</td>
<td>.73**</td>
<td>.55**</td>
<td>-.35**</td>
<td>-.53**</td>
<td>.35**</td>
<td>.34**</td>
<td>.55**</td>
<td>(.93)</td>
</tr>
<tr>
<td><strong>CONTROL VARIABLE</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Employment status</td>
<td>1.54</td>
<td>.62</td>
<td>-.01</td>
<td>.13</td>
<td>-.05</td>
<td>-.04</td>
<td>.12</td>
<td>.07</td>
<td>-.09</td>
<td>-.12</td>
<td>-.11</td>
<td>-.14</td>
</tr>
</tbody>
</table>

* Numbers in parentheses on the diagonal are the Cronbach’s alpha coefficients of the scales.
** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
5.5 Reliability analysis issues

Each of the scales used in this study was obtained from validated instruments. Following the factor analysis, the alpha coefficients for each scale and variable under investigation were computed to ensure consistency. Scale retention was based on a minimum coefficient alpha of .70 and the greatest number of items, which was required to improve the coefficient alpha (Nunnally & Bernstein, 1994). A summary of the reliability estimates used in this study is presented in Table 5.6. Full details of the reliability estimates for each variable used in this study are presented in Appendix 13.

Table 5.6 Summary of reliability analysis

<table>
<thead>
<tr>
<th>Measure</th>
<th>Cronbach’s Coefficient Alpha: This study</th>
<th>Cronbach’s Coefficient Alpha: Validated study</th>
</tr>
</thead>
<tbody>
<tr>
<td>LMX and communication processes</td>
<td>.93</td>
<td>.80 to .90 range for LMX</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Graen &amp; Uhl-Bien, 1995)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.80 to .86 for communication processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Johlke &amp; Duhan, 2000)</td>
</tr>
<tr>
<td>Organisational culture Teamwork</td>
<td>.92</td>
<td>.87</td>
</tr>
<tr>
<td></td>
<td>.95</td>
<td>.84, .82 and .86</td>
</tr>
<tr>
<td></td>
<td>.93</td>
<td>.89 (Glaser, Zamanou &amp; Hacker, 1987)</td>
</tr>
<tr>
<td>Teamwork Morale, info flow and involvement Meetings</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>Morale, info flow and involvement Meetings</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>Role ambiguity Customer ambiguity</td>
<td>.85</td>
<td>.83</td>
</tr>
<tr>
<td>Supervisor ambiguity</td>
<td>.92</td>
<td>.80 (Johlke &amp; Duhan, 2000)</td>
</tr>
<tr>
<td>Empowerment Meaning and competence</td>
<td>.87</td>
<td>.87 and .81</td>
</tr>
<tr>
<td>Self-determination Impact</td>
<td>.91</td>
<td>.81</td>
</tr>
<tr>
<td>Affective commitment</td>
<td>.93</td>
<td>.88 (Spreitzer, 1995)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Meyer, Allen &amp; Smith, 1993)</td>
</tr>
</tbody>
</table>
5.5.1 *LMX and communication processes*

The single variable LMX and communication processes was measured using a combined 19-item set consisting of 6 items from the LMX scale and 13 items from the Communication processes scale. The coefficient alpha value of .93 was greater than the .80 to .90 range of scores reported by Graen and Uhl-Bien (1995) in their study of LMX, and the .80 to .86 range of scores reported by Johlke and Duhan (2000) in their study of Communication processes. Each item met the item-to-item correlation criteria and was included in the analysis. Appendix 13 reports the reliability and item-to-total correlation estimates for the LMX and communication processes variable.

5.5.2 *Organisational culture*

Culture was measured using a 27-item set consisting of 3 subscales including *teamwork* (7 items), *morale, info flow and involvement* (15 items), and *meetings* (5 items). An examination of the 3 subscales produced alpha coefficients of: *teamwork* = .92, *morale, info flow and involvement* = .95, and *meetings* = .93. Each item met the item-to-item correlation criteria. The Cronbach’s alphas reported by Glaser et al. (1987) were .87 for *teamwork*, .84, .82, .86 for *morale, information flow and involvement*, and .89 for *meetings*. Appendix 13 reports the reliability and item-to-total correlation estimates for each of the culture variables.

5.5.3 *Problem-solving social networks*

Problem-solving social networks was measured using 5 items by Chakuthip et al. (2008). This variable uses descriptive measures and therefore is not tested for reliability. Respondents are asked to provide information about who they contact and why. Frequencies and percentages are calculated from this data.
5.5.4 Role ambiguity

Role ambiguity was measured using a 6-item set, consisting of 2 subscales including customer ambiguity (3 items) and supervisor ambiguity (3 items). An examination of the internal consistency of the 2 subscales produced alpha coefficients of: customer ambiguity = .85 and supervisor ambiguity = .92. These alpha coefficients were similar to the Cronbach’s alpha reported by Johlke and Duhan (2000) of .83 and .80. Appendix 13 reports the reliability and item-to-total correlation estimates for each of the role ambiguity variables.

5.5.5 Perceived empowerment

Empowerment was measured using a 12-item set consisting of 3 subscales including meaning and competence (6 items), self-determination (3 items), and impact (3 items). The alpha coefficients for each of these subscales were: meaning and competence = .87; self-determination = .91; and impact = .90. The Cronbach’s alpha scores reported by Spreitzer (1995a) were: .87 and .81 for meaning and competence, .81 for self-determination, and .88 for impact. Appendix 13 reports the reliability and item-to-total correlation estimates for each of the empowerment variables.

5.5.6 Affective commitment

Affective commitment was measured using a 7-item set and all items met the item-to-total correlation criteria. The coefficient alpha of .93 is greater than the Cronbach’s alpha of .82 reported by Meyer et al. (1993). Appendix 13 reports the reliability and item-to-total correlation estimates for the affective commitment variable.
5.6 Quantitative data analysis

The quantitative data collected in this research were analysed through SPSS statistical software. All survey data responses were entered and the necessary items from validated scales were reverse scored in accordance with the scale’s instructions. Alpha coefficients and mean scores were calculated. To identify possible multicollinearity, variables were examined using principal components analysis and similar variables were combined. To answer Research Question 1, multiple regression analyses were used to test Hypotheses 1 through to 6, and 8 to 12, as well as a path analysis using multiple regression analysis to test Hypotheses 7 and 13. The control variable used in this test was employment status. Research Questions 2 and 3 related to nurses’ problem-solving social networks. Each of the items that are part of this research question were analysed by calculating frequencies and percentages of the responses.

5.7 Research Question 1

RQ1 What is the impact of variables that display qualities of relational, cognitive and structural social capital on the role ambiguity, perceived empowerment, and affective commitment of nurses?

The aim of Research Question 1 was to examine the impact of attributes of social capital on affective commitment for nurses. To gain an understanding of the social capital present, a number of variables was examined and resulted in the development of 13 hypotheses. The findings of each of these hypotheses are detailed below.

5.7.1 Hypotheses
Hypothesis 1

H_1: There is an inverse relationship between the quality of the supervisor-employee relationship and its communication processes (LMX and communication processes) and role ambiguity towards customers (customer ambiguity) for nurses.

Hypothesis 1 was supported.

Findings from the regression analysis suggested that the supervisor-employee relationship and its associated communication processes were significantly and inversely associated with the customer ambiguity experienced by nurses ($\beta = -.38$, $p < .000$). Overall, the $R^2$ value suggested that the supervisor-employee relationship and communication processes contributed to 14% of the variance in customer ambiguity experienced by nurses. This means that the higher the quality of the supervisor-employee relationship and communication within it, the less role ambiguity is experienced by nurses. The results are shown in Table 5.7.

**Table 5.7:** Regression analysis detailing the relationship between the supervisor-employee relationship and its communication processes, and role ambiguity towards customers

<table>
<thead>
<tr>
<th>Customer ambiguity</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>LMX and communication processes</td>
<td>-.38*</td>
</tr>
<tr>
<td>$F$</td>
<td>27.67*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.14</td>
</tr>
</tbody>
</table>

* $p < .000$
Hypothesis 2

H2 There is a positive relationship between the quality of the supervisor-employee relationship and its communication processes (LMX and communication processes) and perceived empowerment (meaning and competence, self-determination, and impact) for nurses.

Hypothesis 2 was supported.

Findings from the regression analysis suggested that the supervisor-employee relationship and its communication processes were significantly and positively associated with nurses’ perceived empowerment. Specifically, this relationship contributed to 9% of the variance in nurses’ perceptions of the meaning of their work and their competence in undertaking it (β = .29, p < .000). This variable had the most significant effect on the impact variable (β = .36, p < .000) with approximately 13% of the variance in nurses’ perceived impact of their work explained by the quality of the exchanges and communication with their supervisor. However, self-determination (β = .17, p < .000) had the least significant relationship of all variables tested with only 3%, which suggested that the quality of the supervisor-employee relationship and the quality of its communication processes had the least impact upon nurses’ determination in their work. The results are shown in Table 5.8.

Table 5.8: Regression analysis detailing the relationship between the supervisor-employee relationship and its communication processes, and perceived empowerment

<table>
<thead>
<tr>
<th></th>
<th>Meaning and competence</th>
<th>Self-determination</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>LMX and communication</td>
<td>β</td>
<td>β</td>
<td>β</td>
</tr>
<tr>
<td>processes</td>
<td>.29*</td>
<td>.17*</td>
<td>.36*</td>
</tr>
<tr>
<td>F</td>
<td>15.23*</td>
<td>4.75*</td>
<td>24.81*</td>
</tr>
<tr>
<td>R²</td>
<td>.09</td>
<td>.03</td>
<td>.13</td>
</tr>
</tbody>
</table>

* p < .000
Hypothesis 3

$H_3$ There is a positive relationship between the quality of the supervisor-employee relationship and its communication processes (LMX and communication processes) and affective commitment for nurses.

Hypothesis 3 was supported.

The findings from the regression analysis suggested that the supervisor-employee relationship and the quality of the communication within it was significantly and positively associated with the affective commitment of nurses ($\beta = .51$, $p < .000$). The $R^2$ value suggested that the quality of this relationship contributed to 26% of the variance in the affective commitment of nurses. This means that the better quality relationship held between nurses and their supervisor, the more likely nurses are to commit to the organisation. The results are shown in Table 5.9.

Table 5.9: Regression analysis detailing the relationship between the supervisor-employee relationship and its communication processes, and affective commitment

<table>
<thead>
<tr>
<th>Affective commitment</th>
<th>$\beta$</th>
<th>$F$</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>LMX and communication processes</td>
<td>.51*</td>
<td>58.82*</td>
<td>.26</td>
</tr>
</tbody>
</table>

* $p < .000$
Hypothesis 4

$H_4$ There is an inverse relationship between role ambiguity surrounding customers (customer ambiguity) and perceived empowerment (meaning and competence, self-determination, and impact) for nurses.

Hypothesis 4 was supported.

The multiple regression analysis suggested that customer role ambiguity was significantly and inversely associated with the perceived empowerment of nurses. These results suggested that customer ambiguity accounted for 8% of the variance in nurses’ perception of the impact of their work ($\beta = -.28, p < .000$), 6% of the variance in nurses’ determination in their work ($\beta = -.25, p < .000$), and closely following is a 5% variance in nurses’ perceived meaning in their work and competence to undertake it. Therefore, these results suggest that high ambiguity regarding patients did impact upon and decrease perceived empowerment for nurses. The results are shown in Table 5.10.

**Table 5.10: Regression analysis detailing the relationship between customer role ambiguity and perceived empowerment**

<table>
<thead>
<tr>
<th></th>
<th>Meaning and competence</th>
<th>Self-determination</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer ambiguity</td>
<td>$-.23^*$</td>
<td>$-.25^*$</td>
<td>$-.28^*$</td>
</tr>
<tr>
<td>$F$</td>
<td>9.08*</td>
<td>10.70*</td>
<td>14.04*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.05</td>
<td>.06</td>
<td>.08</td>
</tr>
</tbody>
</table>

* $p < .000$
Hypothesis 5

H₅ There is an inverse relationship between role ambiguity surrounding customers (customer ambiguity) and affective commitment for nurses.

Hypothesis 5 was supported.

The multiple regression analysis suggested that customer role ambiguity was significantly and inversely associated with the affective commitment of nurses (β = -.35, p < .000). These results suggested that customer ambiguity accounted for 13% of the variance in affective commitment. This means that high role ambiguity towards customers did impact upon nurses’ affective commitment to the organisation. The results are shown in Table 5.11.

Table 5.11: Regression analysis detailing the relationship between customer role ambiguity and affective commitment

<table>
<thead>
<tr>
<th></th>
<th>Affective commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer ambiguity</td>
<td>.35*</td>
</tr>
<tr>
<td>F</td>
<td>23.31*</td>
</tr>
<tr>
<td>R²</td>
<td>.13</td>
</tr>
</tbody>
</table>

* p < .000

Hypothesis 6

H₆ There is a positive relationship between perceived empowerment (meaning and competence, self-determination, and impact) and affective commitment for nurses.

Hypothesis 6 was supported.

Findings from the regression analysis suggested that perceptions of empowerment were significantly and positively associated with the affective
commitment of nurses. The most significant result was obtained in the variable impact (β = -.55, p < .000) of which nurses’ perception of the impact of their work contributed to 31% of the variance in their commitment to the organisation. The remaining empowerment variables were not as significant with nurses’ perception of the meaning of their work and their competence in undertaking it (β = -.35, p < .000) and their level of determination (β = -.34, p < .000) explaining 12% and 11% respectively of nurses’ affective commitment to the organisation.

Overall, these results suggested that perceptions of empowerment, particularly the impact dimension of empowerment, were significantly related to affective commitment for nurses. This means that the greater nurses’ perceive the impact that their work has, the greater their affective commitment to the organisation. Results are shown in Table 5.12.

Table 5.12: Regression analysis detailing the relationship between perceived empowerment and affective commitment

<table>
<thead>
<tr>
<th>Affective commitment</th>
<th>β</th>
<th>F</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning and competence</td>
<td>.35*</td>
<td>22.26*</td>
<td>.12</td>
</tr>
<tr>
<td>Self-determination</td>
<td>.34*</td>
<td>20.71*</td>
<td>.11</td>
</tr>
<tr>
<td>Impact</td>
<td>.55*</td>
<td>72.35*</td>
<td>.31</td>
</tr>
</tbody>
</table>

* p < .000
**Hypothesis 7**

$H_7$  There is a significant relationship between the **independent variable and work-related outcomes** (LMX and communication processes, customer ambiguity, meaning and competence, self-determination and impact) and **affective commitment** for nurses.

Hypothesis 7 was supported.

Findings from the path analysis suggested a significant relationship between all independent variables and work-related outcomes, with the affective commitment of nurses. Overall, the $R^2$ value suggested that the independent variable and work-related outcomes accounted for 43% of the variance in nurses’ affective commitment. Results are shown in Table 5.13 and a figure demonstrating these relationships is shown in Figure 5.1.

**Table 5.13:**  Path analysis detailing the relationship between the independent variables and work-related outcomes, and affective commitment

<table>
<thead>
<tr>
<th></th>
<th>Affective commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\beta$</td>
</tr>
<tr>
<td><strong>Independent variable</strong></td>
<td></td>
</tr>
<tr>
<td>LMX and communication processes</td>
<td>.30*</td>
</tr>
<tr>
<td><strong>Work-related outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Customer role ambiguity</td>
<td>-.11</td>
</tr>
<tr>
<td>Meaning and competence</td>
<td>.10</td>
</tr>
<tr>
<td>Self-determination</td>
<td>.02</td>
</tr>
<tr>
<td>Impact</td>
<td>.37*</td>
</tr>
<tr>
<td>$F$</td>
<td>24.33*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.43</td>
</tr>
<tr>
<td>*</td>
<td>$p &lt; .000$</td>
</tr>
</tbody>
</table>
Figure 5.1 Results of path analysis of model 1: The impact of the independent variable and work-related outcomes, on affective commitment.
Hypothesis 8

H₈: There is an inverse relationship between organisational culture (teamwork, morale, information flow and involvement, and meetings) and role ambiguity (customer ambiguity and supervisor ambiguity) for nurses.

Hypothesis 8 was supported.

The results suggested that the organisation’s culture was significantly and inversely associated with both customer role ambiguity and supervisor role ambiguity. This means that when the quality of the organisational culture increases, the role ambiguity experienced by nurses decreases. Supervisor ambiguity was the most significant type of ambiguity impacted upon by organisational culture across all variables. The quality of meetings (β = -.57, p < .000) and the level of morale, flow of information, and level of nurses involvement (β = -.54, p < .000) explained 33% and 30% of the variance in ambiguity towards supervisors. However, the teamwork dimension (β = -.44, p < .000) had the least significant impact, but still represented 19% of the variance in supervisor ambiguity.

In contrast, ambiguity towards customers or patients was less impacted upon by the culture of the organisation. The level of morale, flow of information and level of involvement (β = -.22, p < .000) had the most significant effect, representing 9% of the variance in ambiguity towards customers. Meetings (β = -.22, p < .000) followed, explaining 5% of the variance in customer ambiguity. The least significant dimension was teamwork, representing only 3% of the variance in customer ambiguity (β = -.18, p < .000).

Overall, the results suggested that organisational culture did significantly impact upon the role ambiguity experienced by nurses. Specifically, the greatest type of ambiguity experienced was ambiguity surrounding supervisors. Furthermore, the degree of morale present, flow of information, and level of
involvement permitted were the most significant in this and teamwork was the least significant. The results are shown in Table 5.14.

Table 5.14: Regression analysis detailing the relationship between organisational culture and role ambiguity

<table>
<thead>
<tr>
<th></th>
<th>Customer ambiguity</th>
<th>Supervisor ambiguity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>β</td>
</tr>
<tr>
<td>Teamwork</td>
<td>-.18*</td>
<td>-.44*</td>
</tr>
<tr>
<td>F</td>
<td>5.48*</td>
<td>38.65*</td>
</tr>
<tr>
<td>R²</td>
<td>.03</td>
<td>.19</td>
</tr>
<tr>
<td>Morale, info flow and involvement</td>
<td>-.29*</td>
<td>-.54*</td>
</tr>
<tr>
<td>F</td>
<td>15.22*</td>
<td>68.10*</td>
</tr>
<tr>
<td>R²</td>
<td>.09</td>
<td>.30</td>
</tr>
<tr>
<td>Meetings</td>
<td>-.22*</td>
<td>-.57*</td>
</tr>
<tr>
<td>F</td>
<td>7.93*</td>
<td>80.16*</td>
</tr>
<tr>
<td>R²</td>
<td>.05</td>
<td>.33</td>
</tr>
</tbody>
</table>

* p < .000

**Hypothesis 9**

H₉ There is a positive relationship between organisational culture (teamwork, morale, information flow, and involvement, and meetings) and perceived empowerment (meaning and competence, self-determination, and impact) for nurses.

Hypothesis 9 was supported.

The results suggested that organisational culture was significantly and positively associated with the perceived empowerment of nurses. The most significant dimension affected by the organisational culture was nurses’ perception of the impact of their work. The level of morale present, flow of information, and degree of involvement (β = .44, p < .000) was the greatest significance with 20% of nurses perceptions of their impact explained by this dimension. The quality of
meetings ($\beta = .36, p < .000$) and level of teamwork present ($\beta = .31, p < .000$) followed, explaining 13% and 10% of the variance in perceived impact.

The morale, info flow and involvement dimension also scored consistently higher with self-determination ($\beta = .34, p < .000$) and meaning and competence ($\beta = .25, p < .000$) explaining 12% and 6% respectively. This means that those aspects of organisational culture, namely the presence of morale amongst employees, the flow of information amongst them, and their level of involvement in the organisation, most significantly impact upon nurses’ perceptions of empowerment.

Overall, the results of this analysis suggested that organisational culture is significantly and positively related to nurses’ perceptions of empowerment. In particular, levels of morale, information flow and involvement account for a large proportion of the perceived impact of nurses’ work and their feelings of empowerment. These results are shown in Table 5.15.

<table>
<thead>
<tr>
<th></th>
<th>Meaning and competence</th>
<th>Self-determination</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\beta$</td>
<td>$\beta$</td>
<td>$\beta$</td>
</tr>
<tr>
<td>Teamwork</td>
<td>.21*</td>
<td>.28*</td>
<td>.31*</td>
</tr>
<tr>
<td>F</td>
<td>7.84*</td>
<td>14.13*</td>
<td>17.63*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.05</td>
<td>.08</td>
<td>.10</td>
</tr>
<tr>
<td>Morale, info flow and involvement</td>
<td>.25*</td>
<td>.34*</td>
<td>.44*</td>
</tr>
<tr>
<td>F</td>
<td>11.17*</td>
<td>21.74*</td>
<td>40.17*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.06</td>
<td>.12</td>
<td>.20</td>
</tr>
<tr>
<td>Meetings</td>
<td>.23*</td>
<td>.28*</td>
<td>.36*</td>
</tr>
<tr>
<td>F</td>
<td>9.25*</td>
<td>13.77*</td>
<td>23.91*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.05</td>
<td>.08</td>
<td>.13</td>
</tr>
</tbody>
</table>

* $p < .000$
**Hypothesis 10**

H$_{10}$ There is a positive relationship between organisational culture (teamwork, morale, information flow, and involvement, and meetings) and affective commitment for nurses.

Hypothesis 10 was supported.

The results of the multiple regression analysis suggested that the organisation’s culture was significantly and positively associated with the affective commitment of nurses. The morale, flow of information, and degree of employee involvement ($\beta = .73$, $p < .000$) was the most significant dimension impacting upon nurses’ commitment, contributing to 53% of the variance. The quality of meetings ($\beta = .55$, $p < .000$) was also significant and explained 30% of the variance in nurses’ commitment to the organisation. Lastly, the least significant dimension was the level of teamwork present ($\beta = .40$, $p < .000$) which accounted for 16% of the variance. These results suggested that organisational culture was positively associated with the affective commitment of nurses, and is most strongly affected by the morale, flow of information and degree of employee involvement within the organisation. These results are shown in Table 5.16.

### Table 5.16: Regression analysis detailing the relationship between organisational culture and affective commitment

<table>
<thead>
<tr>
<th></th>
<th>Affective commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\beta$</td>
</tr>
<tr>
<td>Teamwork</td>
<td>.40*</td>
</tr>
<tr>
<td>$F$</td>
<td>30.58*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.16</td>
</tr>
<tr>
<td>Morale, info flow and involvement</td>
<td>.73*</td>
</tr>
<tr>
<td>$F$</td>
<td>182.50*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.53</td>
</tr>
<tr>
<td>Meetings</td>
<td>.55*</td>
</tr>
<tr>
<td>$F$</td>
<td>70.57*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.30</td>
</tr>
</tbody>
</table>

* $p < .000$
Hypothesis 11

H₁₁ There is an inverse relationship between role ambiguity surrounding supervisors (supervisor ambiguity) and perceived empowerment (meaning and competence, self-determination, and impact) for nurses.

Hypothesis 11 was supported.

The results of the multiple regression analysis suggested that supervisor role ambiguity was significantly and inversely associated with the perceived empowerment of nurses. Impact ($\beta = -.45$, $p < .000$) was the most significant dimension identified with supervisor ambiguity explaining 20% of nurses’ perceived impact of their work. The least significant was meaning and competence ($\beta = -.30$, $p < .000$) which accounted for 9% of the variation in nurses’ perceptions of the meaning of their work and how competent they are to undertake it.

The results of this regression analysis have suggested an inverse relationship between role ambiguity and perceptions of empowerment. This means that when role ambiguity increases, perceptions of empowerment decrease. Therefore, the less ambiguous an employee is regarding their supervisor’s expectations, the greater nurses perceive the impact of their work. The results are shown in Table 5.17.

Table 5.17: Regression analysis detailing the relationship between supervisor ambiguity and perceived empowerment

<table>
<thead>
<tr>
<th></th>
<th>Meaning and competence</th>
<th>Self-determination</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor ambiguity</td>
<td>$\beta = -.30^*$</td>
<td>$\beta = -.33^*$</td>
<td>$\beta = -.45^*$</td>
</tr>
<tr>
<td>$F$</td>
<td>15.58*</td>
<td>19.42*</td>
<td>40.31*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.09</td>
<td>.11</td>
<td>.20</td>
</tr>
</tbody>
</table>

* $p <.000$
Hypothesis 12

There is an inverse relationship between role ambiguity surrounding supervisors (supervisor ambiguity) and affective commitment for nurses.

Hypothesis 12 was supported.

The multiple regression analysis suggested that role ambiguity was significantly and inversely associated with the affective commitment of nurses ($\beta = -.53, p < .000$). These results suggested that role ambiguity accounted for 28% of the variance in affective commitment. This means that when nurses experience high levels of ambiguity towards their supervisor, they are less committed to the organisation. The results are shown in Table 5.18.

Table 5.18: Regression analysis detailing the relationship between supervisor ambiguity and affective commitment

<table>
<thead>
<tr>
<th></th>
<th>Affective commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor ambiguity</td>
<td>- .53*</td>
</tr>
<tr>
<td>F</td>
<td>63.09*</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.28</td>
</tr>
</tbody>
</table>

* $p < .000$
**Hypothesis 13**

H$_{13}$: There is a significant relationship between the independent variables and work-related outcomes (teamwork, morale, info flow and involvement, customer role ambiguity, supervisor role ambiguity, meaning and competence, self-determination, and impact) and affective commitment for nurses.

Hypothesis 13 was supported.

Findings from the path analysis suggested a significant relationship between all independent variables and work-related outcomes, with the affective commitment of nurses. Overall, the R$^2$ value suggested that the independent variables and work-related outcomes accounted for 62% of the variance in nurses’ affective commitment. Results are shown in Table 5.19 and a figure demonstrating these relationships is shown in Figure 5.2.

**Table 5.19: Path analysis detailing the relationship between the independent variables and work-related outcomes, and affective commitment**

<table>
<thead>
<tr>
<th>Affective commitment</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent variables</strong></td>
<td></td>
</tr>
<tr>
<td>Teamwork</td>
<td>-.06</td>
</tr>
<tr>
<td>Morale, info flow and involvement</td>
<td>.56*</td>
</tr>
<tr>
<td>Meetings</td>
<td>.01</td>
</tr>
<tr>
<td><strong>Work-related outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Customer role ambiguity</td>
<td>-.08</td>
</tr>
<tr>
<td>Supervisor role ambiguity</td>
<td>-.08</td>
</tr>
<tr>
<td>Meaning and competence</td>
<td>.10</td>
</tr>
<tr>
<td>Self-determination</td>
<td>-.07</td>
</tr>
<tr>
<td>Impact</td>
<td>.27*</td>
</tr>
<tr>
<td>F</td>
<td>31.83*</td>
</tr>
<tr>
<td>R$^2$</td>
<td>.62</td>
</tr>
</tbody>
</table>

* p < .000
Figure 5.2  Results of path analysis of model 2: The impact of the independent variables and work-related outcomes, on affective commitment.
5.7.2 Intention to continue working

In order to determine nurses’ future plans regarding their current role, three questions were asked to determine whether nurses planned to leave their present position within the next year, and whether nurses planned to work part-time within the next one year or five year period.

Regarding the first question about nurses’ plans to leave their present position over the next year, which was measure on a yes/no scale, 84% of nurses indicated that they did not have plans to leave and 16% did plan to leave in the next year.

Regarding the second and third questions about whether nurses plan to work part-time within the next year or next five years, measured on a 1-6 Likert scale, on average, nurses “slightly agreed” that they planned to work part-time in the next year (M = 3.55) and almost “agreed” that they planned to work part-time during the next five years (M = 3.90). Together, these results suggested that a portion of the nursing workforce within the researched hospitals may plan to reduce their working hours in coming years.

5.7.3 Summary of Research Question 1

Overall, the quantitative results from this research were both interesting and significant with all hypotheses examined being supported by the data. Of the 13 hypotheses examined, there were a number of R² scores that were large and had clearly played a significant role in explaining the impact of the independent variables and work-related outcomes upon the dependent variable of affective commitment. A diagram depicting the R² values from the 13 hypotheses can be seen in Figure 5.3.
Note: Problem-solving social networks could not be tested for causality using SPSS software and were therefore not depicted in this diagram.

Figure 5.3  Summary of quantitative outcomes for Research Question 1
5.8 Research Question 2

RQ$_2$ Who are the members of nurses’ problem-solving social networks and what is the strength of the ties between contacts?

Determining who belongs to nurses’ problem-solving social networks was ascertained by examining (a) the number of contacts in the network, (b) what the nurse’s relationship is to each contact and the sequence of approaching contacts, as well as (c) determining how well they know their contacts.

Regarding the first element of Research Question 2, the number of contacts in the network, analysis of the data suggested that the majority (62.87%) of nurses had a social network consisting of between 2 to 5 contacts. There were 17.97% of nurses with greater than 6 contacts, and 13.78% who possessed only 1 contact. However, 4.80% of nurses indicated that they had no social network contacts at all to help them solve work-related problems. These findings suggested that while the majority of nurses possessed a network of multiple contacts, a proportion of nurses relied upon only 1 contact, and a small minority of nurses did not have any contacts to turn to for assistance. The resulting implications of this lack of social networking contacts are discussed in Chapter 7. Detailed results are included in Table 5.20.

Table 5.20 Number of contacts within a network

<table>
<thead>
<tr>
<th>Number of people in network</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8</td>
<td>4.80%</td>
</tr>
<tr>
<td>1</td>
<td>23</td>
<td>13.78%</td>
</tr>
<tr>
<td>2</td>
<td>50</td>
<td>29.94%</td>
</tr>
<tr>
<td>3 - 5</td>
<td>55</td>
<td>32.93%</td>
</tr>
<tr>
<td>6 - 10</td>
<td>18</td>
<td>10.78%</td>
</tr>
<tr>
<td>11 +</td>
<td>12</td>
<td>7.19%</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>0.60%</td>
</tr>
<tr>
<td>Total</td>
<td>167</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Regarding the second element of Research Question 2, the relationships with network contacts and the sequence of approaching these, frequencies were
established about nurses’ contacts and the sequencing of those contacts. When nurses experienced a work-related problem, the first contact they approached was most frequently reported as their Nurse Unit Manager (34.12%), the second most frequently reported was their Clinical Nurse (32.92%), and the third most frequently reported contact was nurses from the same ward (17.96%). Similarly, the second person they approached was most frequently reported to be their Clinical Nurse (32.34%), second most frequently reported to be their Nurse Unit Manager (19.16%), and the third most frequently reported to be nurses from the same ward (10.18%). These results suggested that the Nurse Unit Manager and Clinical Nurse are considered the two most useful contacts to approach when needing to solve a problem, followed by nurses from the same ward. The data analysis suggested that nurses from the same ward are consistently approached for assistance throughout the first to fourth persons, which also suggested that support from colleagues is an important factor in these relationships.

Beginning with the third person approached and beyond, the most frequent responses were more varied, although there were some similarities. For instance, other nurses on the same ward, Nurse Educators, and Clinical Educators and Facilitators were frequent responses. Another important response was the high prevalence of approaching Nurse Educators and Clinical Educators and Facilitators, if the first and second mentioned persons, commonly reported to be the Nurse Unit Manager and Clinical Nurse, were not available or of assistance. This was particularly highlighted in responses to the fifth person approached with nearly 8.38% of respondents indicating that they approach the Nurse Educator at that time. Analysis of responses to the fifth person approached suggested that, following the Nurse Educator, a nurse friend not at this hospital (5.39%), and family members (4.79%) were commonly reported contacts. Finally, the contact approached the least was reported to be friends that are not nurses with responses ranging between 0 and 1.20%. This highlights a theme throughout the responses which suggested the importance of nurses approaching contacts that possessed knowledge in the field of nursing in order to assist them in solving problems, as opposed to an individual outside of the nursing field.
Overall, the results regarding the sequence of approaching network contacts for assistance with solving problems showed a consistent theme of using contacts with clinical experience and authority instead of contacts outside of the nursing field and place of employment. NUMs, Clinical Nurses, and other nurses within the same ward were the most frequently reported contacts for assistance with solving problems. Furthermore, when these contacts were not available or not of assistance, nurses approached other nursing professionals such as Clinical Educators and Facilitators, and Nurse Educators for assistance. Even so, the results also suggested that NUMs were approached only 63.5% of the time. One possible explanation is, as previously mentioned, inadequate access of nurses to NUMs. There are implications of this for nursing outcomes, performance and quality, which are discussed later in this thesis. By contrast, nurses approached Clinical Nurses 73% of the time and the consequences of this are also discussed later in this thesis. Together, these results highlighted the importance of the role of NUMs and Clinical Nurses in solving work-related problems, and the importance of professional assistance for work-related problems. The results are shown in Table 5.21.
Table 5.21  Sequence of approaching network contacts

<table>
<thead>
<tr>
<th>Contact</th>
<th>First person</th>
<th>Second person</th>
<th>Third person</th>
<th>Fourth person</th>
<th>Fifth person</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUM</td>
<td>34.12%</td>
<td>19.16%</td>
<td>6.59%</td>
<td>1.20%</td>
<td>2.40%</td>
</tr>
<tr>
<td>Clinical nurse</td>
<td>32.92%</td>
<td>32.34%</td>
<td>5.39%</td>
<td>1.80%</td>
<td>0.60%</td>
</tr>
<tr>
<td>Other nurse on same ward</td>
<td>17.96%</td>
<td>10.18%</td>
<td>8.98%</td>
<td>8.98%</td>
<td>4.18%</td>
</tr>
<tr>
<td>Nurse Educator</td>
<td>3.00%</td>
<td>3.59%</td>
<td>8.98%</td>
<td>7.78%</td>
<td>8.38%</td>
</tr>
<tr>
<td>Clinical Educator / Facilitator</td>
<td>1.80%</td>
<td>9.58%</td>
<td>10.18%</td>
<td>8.38%</td>
<td>0.60%</td>
</tr>
<tr>
<td>Nurse preceptor</td>
<td>1.80%</td>
<td>1.18%</td>
<td>0.00%</td>
<td>4.19%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Other medical professional</td>
<td>1.20%</td>
<td>2.40%</td>
<td>4.79%</td>
<td>8.38%</td>
<td>4.18%</td>
</tr>
<tr>
<td>Nurse friend not at this hospital</td>
<td>1.20%</td>
<td>2.40%</td>
<td>2.40%</td>
<td>3.00%</td>
<td>5.39%</td>
</tr>
<tr>
<td>Family</td>
<td>1.20%</td>
<td>1.20%</td>
<td>1.80%</td>
<td>1.80%</td>
<td>4.79%</td>
</tr>
<tr>
<td>After - hours coordinator</td>
<td>0.60%</td>
<td>7.78%</td>
<td>8.98%</td>
<td>0.60%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Other nurse on different ward</td>
<td>0.60%</td>
<td>1.80%</td>
<td>2.40%</td>
<td>4.19%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Other</td>
<td>0.60%</td>
<td>1.20%</td>
<td>1.20%</td>
<td>1.20%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Non-nurse friend</td>
<td>0.00%</td>
<td>0.60%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.20%</td>
</tr>
<tr>
<td>No response</td>
<td>3.00%</td>
<td>6.59%</td>
<td>38.33%</td>
<td>48.50%</td>
<td>59.88%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

*a  This table is in descending order based upon the column labeled “First person”.

Regarding the third element of Research Question 2, how well nurses know their network contacts and the strength of these ties, nurses indicated that their first choice of contact was known to them between “fairly well” (29.94%) to “very well” (29.34%), and their second choice was also known to them “fairly well” (37.71%). In addition of those who responded knowing network contacts “fairly well” was also the most frequently listed strength of tie amongst the third, fourth and fifth persons approached. These results suggested that nurses’ social networks comprised largely of moderate strength ties. Detailed results of the strength of ties with network contacts are included in Table 5.22.
Table 5.22  
Strength of ties with network contacts

<table>
<thead>
<tr>
<th>Contact</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Fairly well</th>
<th>Very well</th>
<th>Closely</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>First person</td>
<td>1.79%</td>
<td>15.57%</td>
<td>29.94%</td>
<td>29.34%</td>
<td>16.17%</td>
<td>7.19%</td>
</tr>
<tr>
<td>Second person</td>
<td>1.79%</td>
<td>14.97%</td>
<td>37.71%</td>
<td>26.34%</td>
<td>8.38%</td>
<td>10.77%</td>
</tr>
<tr>
<td>Third person</td>
<td>1.19%</td>
<td>15.57%</td>
<td>35.33%</td>
<td>19.76%</td>
<td>9.58%</td>
<td>18.57%</td>
</tr>
<tr>
<td>Fourth person</td>
<td>2.40%</td>
<td>13.77%</td>
<td>22.75%</td>
<td>12.57%</td>
<td>11.98%</td>
<td>36.53%</td>
</tr>
<tr>
<td>Fifth person</td>
<td>3.59%</td>
<td>7.79%</td>
<td>14.97%</td>
<td>1.79%</td>
<td>12.58%</td>
<td>59.28%</td>
</tr>
</tbody>
</table>

Overall, the results regarding Research Question 2 suggested that of those that responded 95.20% of nurses possessed a social network of some kind. However, there is a minority of nurses (4.80%) with no social networks to rely upon, which needs to be addressed in the future by organisational management. Results also suggested that NUMs, Clinical Nurses and nurses working on the same ward were the most commonly reported contacts to approach when trying to solve a work-related problem. Furthermore, the strength of relationships with the most commonly reported contacts were moderate.

5.9 Research Question 3

RQ₃ How effective are nurses’ problem-solving social networks and what is the role of supervisors in this network?

Research Question 3 referred to the usefulness of problem-solving social networks and the role of supervisors in this. Regarding the usefulness of problem-solving social networks, data suggested that nurses found their network to be “fairly useful” to “very useful” in helping them to solve work-related problems (M = 3.77, SD = .85) on a scale of 1 = not at all useful, to 5 = extremely useful. When determining the usefulness of networks, it is important to take into consideration
the reason why contacts were approached. Consequently, nurses were asked about the reasons for approaching contacts and how this related to their choice of first and subsequent contacts. Data suggested that 23.35% of respondents sought out a first contact that possessed the necessary knowledge and experience regarding the problem, followed by 14.97% who sought contacts that were approachable. Results for subsequent contacts were similar with knowledge and experience of the contact considered most important for the remainder of the sequence of contacts. However, data showed that formal help providing roles, who would be considered the most “appropriate person to see” regarding a problem, were the least commonly cited reason for choosing the first contact. This suggested that nurses may not be receiving appropriate assistance from the staff allocated to certain duties and that nurses may prefer to seek a contact that can provide alternative assistance in the form of support. Detailed results are in Table 5.23.

**Table 5.23  Reasons for using network contacts**

<table>
<thead>
<tr>
<th>Contact</th>
<th>First person</th>
<th>Second person</th>
<th>Third person</th>
<th>Fourth person</th>
<th>Fifth person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and experience</td>
<td>23.35%</td>
<td>28.74%</td>
<td>27.54%</td>
<td>14.37%</td>
<td>8.38%</td>
</tr>
<tr>
<td>Approachable</td>
<td>14.97%</td>
<td>10.18%</td>
<td>8.99%</td>
<td>4.19%</td>
<td>0.60%</td>
</tr>
<tr>
<td>Supportive</td>
<td>11.98%</td>
<td>8.38%</td>
<td>7.78%</td>
<td>9.58%</td>
<td>8.38%</td>
</tr>
<tr>
<td>Other</td>
<td>11.38%</td>
<td>11.98%</td>
<td>6.58%</td>
<td>7.18%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Appropriate person to see</td>
<td>8.38%</td>
<td>5.39%</td>
<td>5.40%</td>
<td>3.59%</td>
<td>2.99%</td>
</tr>
<tr>
<td>No response</td>
<td>29.94%</td>
<td>35.33%</td>
<td>43.71%</td>
<td>60.49%</td>
<td>76.05%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

a This table is in descending order based upon the column labeled “First person”.

When nurses were asked via an open-ended question in the survey if they did not approach their Nurse Unit Manager for assistance with solving problems, then why, 52.09% of nurses did not respond to this question, therefore decreasing the representativeness of the responses. Possible reasons for why this occurred are explained in Chapter 7. Of the 47.91% who did respond, the most frequently reported reason was because Nurse Unit Managers were too busy or not available (22.75%) to help at the time. In addition, many (10.18%) commented that they also
did not approach their NUMs because they had a poor working relationship. This was supported by the suggestion that NUMs were not approachable as they did not seem interested in helping with problems. Together, these results suggested that the quality of exchanges between supervisors and employees may not be optimal. Other interesting responses were the 4.19% of nurses who preferred to solve problems on their own, and the 4.19% of nurses who responded that they did approach their NUMs, which suggested that these nurses may not have understood the question being asked. Detailed results regarding this item are in Table 5.24.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Busy or not available</td>
<td>38</td>
<td>22.75%</td>
</tr>
<tr>
<td>Poor working relationship</td>
<td>17</td>
<td>10.18%</td>
</tr>
<tr>
<td>Not approachable</td>
<td>11</td>
<td>6.58%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>5.39%</td>
</tr>
<tr>
<td>Prefer to see someone else first</td>
<td>8</td>
<td>4.79%</td>
</tr>
<tr>
<td>Prefer to solve it themselves</td>
<td>7</td>
<td>4.19%</td>
</tr>
<tr>
<td>They do approach their NUM</td>
<td>7</td>
<td>4.19%</td>
</tr>
<tr>
<td>No response</td>
<td>87</td>
<td>52.09%</td>
</tr>
<tr>
<td>Total</td>
<td>167</td>
<td>a</td>
</tr>
</tbody>
</table>

Overall, regarding Research Question 3, nurses suggested that their social network was very useful. Respondents indicated that their highest priority was to find a contact that had knowledge and experience in the specific area of the problem. Following this, nurses sought out approachable contacts for assistance. Finally, the main reason preventing nurses from seeking assistance from their NUMs was the lack of availability and business of that person, and the poor relationship that existed between nurses and their supervisor. However, the small response rate to this final question decreases the representativeness of the data.
5.10 Conclusion

This chapter presented and summarised the quantitative data from this study. The demographics of the survey sample were provided to give a description of the demographic background of the respondents as well as the results of analyses of variance to determine significant differences amongst demographics and all other variables. The result of a principal components analysis was provided. Following this, the descriptive statistics of the variables being examined were detailed, as were the reliability issues surrounding these issues. The results of Hypotheses 1 through to 13 were outlined in order to address Research Question 1. This was followed by the results of Research Questions 2 and 3 relating to problem-solving social networks. Finally, a summary of the total quantitative outcomes for RQ1 was outlined and presented diagrammatically for the reader.

The next chapter (Chapter 6) outlines the qualitative findings from this research.
CHAPTER 6 – QUALITATIVE RESULTS

6.1 Introduction

This chapter details the analysis of the qualitative data which supplements the quantitative data analysis provided in the previous chapter. The aim of the qualitative analysis was to provide a deeper understanding of individual nurses’ perceptions of their overall work environment and how this impacts upon their levels of commitment. The qualitative data were aimed at identifying differences between organisational policy, as demonstrated through organisational documents, and organisational practices, as identified through the open-ended survey questions, focus groups and interviews.

This chapter discusses how the qualitative data were collected, the demographics of each sample, and the process used to analyse the data. The findings of the data are then outlined according to the dominant themes identified. Research Question 4 is then addressed. This research question is addressed after the dominant themes because the themes need to be outlined before comparisons between organisational policy and organisational practice can be identified. The chapter then summarises the key findings identified from the analysis.

6.2 Qualitative data collection

This section details the qualitative data collection undertaken in this research and the demographics of the sample groups. As mentioned previously in Chapter 4 (Methodology), qualitative data were gathered in four methods including open-ended questions in the survey, focus groups, interviews, and document analyses. Each of these methods and the sample demographic characteristics of each group of respondents is detailed below.
6.2.1 Open-ended survey questions

The qualitative component of the survey undertaken in this research included four open-ended questions exploring the reasons why nurses did not approach their NUM for assistance, if they did not; the best and worst aspects of working for the organisation; and the one thing that management would need to change in order for nurses to remain committed to the organisation. A total of 167 nurses completed the open-ended survey questions. A summary of the survey demographics was presented in Table 5.1 and described in the previous chapter.

6.2.2 Focus groups

Focus groups were conducted to gain a greater understanding of the factors that affected nurses’ perceptions of empowerment. A total of 12 focus groups were conducted with 61 nurses. However, these nurses did not necessarily include the same nurses as the survey sample as participation in either form of data collection was at the discretion of the participant. Each focus group consisted of between 4 and 8 participants and the section of the focus group in which empowerment was examined (the focus groups were conducted as part of a larger study), lasted for an average of 7 to 15 minutes duration. Most (90%) of the participants were female with more than half of nurses in the 31 to 45 year age group (52%). Registered Nurses comprised 39% of participants and 36% of the sample had been employed in their role for between 1 and 5 years. In addition, 54% worked on a full-time basis and 25% on a part-time basis. Based on the statistics mentioned in the survey sample (ABS, 2008b; AIHW, 2010), this focus group sample was also considered representative of nurses working within Australia, although this sample contained a slightly smaller percentage of part-time nurses. A summary of the focus group participants is presented in Table 6.1.
Table 6.1 Summary of sample demographics for focus group participants

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>55</td>
<td>90%</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30 years</td>
<td>9</td>
<td>15%</td>
</tr>
<tr>
<td>31 – 45 years</td>
<td>32</td>
<td>52%</td>
</tr>
<tr>
<td>&gt;45 years</td>
<td>19</td>
<td>31%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Line Manager (Nurse Unit Manager)</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical Nurse</td>
<td>14</td>
<td>23%</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>24</td>
<td>39%</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Assistant in Nursing</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Other (Midwife etc.)</td>
<td>10</td>
<td>16%</td>
</tr>
<tr>
<td>Length of employment in current role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>14</td>
<td>23%</td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>22</td>
<td>36%</td>
</tr>
<tr>
<td>5 – 15 years</td>
<td>19</td>
<td>31%</td>
</tr>
<tr>
<td>&gt;15 years</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>33</td>
<td>54%</td>
</tr>
<tr>
<td>Part-time</td>
<td>15</td>
<td>25%</td>
</tr>
<tr>
<td>Pool nurse</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>11</td>
<td>18%</td>
</tr>
</tbody>
</table>

\(^a\) N = 61

6.2.3 Interviews

Interviews were also conducted to gain a greater understanding of the factors that affected nurses’ perceptions of empowerment. These interviews were conducted in addition to the focus groups as a number of nurses did not wish to participate in focus groups due to confidentiality fears, but rather preferred to express their views in a private discussion with the researcher. A total of 17 interviews were conducted to the point of saturation where no new data emerged. These nurses did not necessarily include the same nurses as the survey or focus group sample. The sample consisted of 76% females with most nurses aged 31 to 45 years (41%). Most participants worked as Clinical Nurses (35%) or Registered Nurses (29%) with some NUMs present (12%). Equal numbers of nurses had worked in this role for between 1 and 5 years (41%), and between 5 to 15 years (41%) and most of the participants were employed on a full-time basis (88%). This sample comprised more males and full-time nurses than the other samples and could be argued as not
representative of Australian nurse demographics (ABS, 2008b; AIHW, 2010). A summary of the interview participants is presented in Table 6.2.

Table 6.2 Summary of sample demographics for interviewees

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>76%</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>24%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30 years</td>
<td>6</td>
<td>35%</td>
</tr>
<tr>
<td>31 – 45 years</td>
<td>7</td>
<td>41%</td>
</tr>
<tr>
<td>&gt;45 years</td>
<td>4</td>
<td>24%</td>
</tr>
<tr>
<td>Position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Line Manager (Nurse Unit Manager)</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>Clinical Nurse</td>
<td>6</td>
<td>35%</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>5</td>
<td>29%</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>Assistant in Nursing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other (Midwife etc.)</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>Length of employment in current role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>7</td>
<td>41%</td>
</tr>
<tr>
<td>5 – 15 years</td>
<td>7</td>
<td>41%</td>
</tr>
<tr>
<td>&gt;15 years</td>
<td>1</td>
<td>6%</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>15</td>
<td>88%</td>
</tr>
<tr>
<td>Part-time</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>Pool nurse</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

It is important to point out that some of the participants from the first focus groups and first interviews commented that they did not want their personal demographic data to be matched to their responses for fear of identification, due to the small number of participants. Consequently, in further focus groups and interviews the researcher did not record these details. It was therefore not possible to match the respondents’ gender or position in relation to direct quotes gathered from focus groups or interviews.

6.2.4 Document analysis

An analysis of organisational documents was undertaken in order to determine what organisational policies existed surrounding the issues under investigation, and to identify whether there are any differences from the nurses’ perspective, between organisational policy and organisational practice. The
researcher obtained advice regarding the number and type of organisational
documents necessary for examination by interviewing two senior administrative
employees within the organisation who had knowledge of the full range of policies
within the organisation. A total of three documents were chosen. Document one,
the code of conduct, detailed the values and ethos of the organisation and their role
as a health service provider. Document two, the mission and values document,
outlined the mission of the organisation as a health service, which provided a wide
variety of important services to the population of their jurisdiction. The third
document, a print-out of a recruiting website for nurses within this organisation,
outlined the expected benefits of working as a nurse within this organisation. Details
of these documents are included in Table 6.3.

<table>
<thead>
<tr>
<th>Document number</th>
<th>Document type</th>
<th>Summary of contents of document</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Code of conduct</td>
<td>• The code of conduct &lt;br&gt; • Application and breaches of the code &lt;br&gt; • Ethical decision-making processes &lt;br&gt; • Ethical obligations</td>
</tr>
<tr>
<td>2</td>
<td>Mission and values statement</td>
<td>• Mission &lt;br&gt; • Summarised values &lt;br&gt; • Detailed strategic directions of the organisation.</td>
</tr>
<tr>
<td>3</td>
<td>Organisation-specific nurse recruitment website</td>
<td>• Career structures and profiles &lt;br&gt; • Work search facility &lt;br&gt; • Career benefits &lt;br&gt; • Support tools offered &lt;br&gt; • General organisational information and profiles</td>
</tr>
</tbody>
</table>

The chosen documents were representative of this type of document and of
this organisation, as documents such as these are frequently used by similar
organisations and hospitals. The documents are also a representative sample as
they were selected by senior administrative employees within the organisation as
being the most relevant documents for this research and are publicly available on
the organisation’s website for viewing by all nurses. Due to the documents being publicly available, no problems were encountered in gaining access to them, and they were downloaded from the organisation’s website.

The researcher was only permitted to access publicly available documents rather than confidential documents available to organisational staff only. This was due to management concerns over confidentiality of the organisational documentation. This was a limitation in that confidential documents that are only available to employees of the organisation are more likely to contain other specific and relevant information to this research. Furthermore, such confidential communications are likely to be greater in number and specifically directed towards the nurse employees. Therefore, a limitation of using publicly available documents is that more relevant and information-rich data may not be available in these documents.

### 6.3 Qualitative data analysis

The qualitative data gathered for this research were examined using three methods of content analysis, emerging themes, and pattern matching. The first method of data analysis used, content analysis, involves analysis of text into manifest or latent data. Regarding the manifest content analysis, the researcher browsed and read the data to identify the most frequently mentioned topics. On a subsequent reading of the data, the researcher categorised the most frequently listed words and themes, and the number of times that these occurred. These numbers were then calculated into totals and percentages. Following this, a latent content analysis of the documents was then conducted. The researcher first read each of the open-ended survey responses, focus group and interview transcripts, and organisational documents, to identify significant topic areas. On a second read of the data, the researcher classified each response and piece of text into significant categories. Together, manifest and latent content analysis enabled the researcher to identify
important and frequent categories of responses amongst the surveys and interview and focus group transcripts, and the organisational documents.

The second method of data analysis used, emerging themes, enabled the researcher to identify consistencies and themes across the four different sets of data. This method complemented the content analysis by providing a technique to identify and compare the results of the four methods of data collection (Yin, 2003). The research compared the manifest and latent content analysis categories and frequencies amongst the four data sets. These results were then compared against the results of the manifest and latent analysis categories of the organisational documents. Together, a number of dominant themes emerged from the data, and these are outlined in this chapter and discussed in greater detail in Chapter 7 (Discussion).

The third method of data analysis, pattern matching, involved comparing the overall results of the data from this research against findings from the literature in order to identify consistencies and inconsistencies (Yin, 2003). These findings are discussed in Chapter 7 (Discussion).

The purpose of collecting and analysing the qualitative data was to build upon, and gain a deeper understanding of, the quantitative data. It has been suggested that the use of manifest and latent content analysis gives more depth to closed survey questions and provides reasoning behind employees’ responses (Sarantakos, 2005). Direct quotes are a good example of this and the quotes used in this chapter were chosen for their representativeness of similar responses and because they add more descriptive value to the analysis. Furthermore, pattern matching and identifying emerging themes combines the prevailing themes and areas of importance between the quantitative and qualitative data and checks for consistency (Yin, 2003).
6.4 Dominant themes

During the qualitative data analysis, eleven dominant themes emerged. These themes were: (1) a lack of respect and support for the nursing role; (2) nurses possess poor relationships with their NUMs and upper levels of management; (3) a shortage of resources; (4) a shortage of nurses; (5) hospital policies and procedures inhibit efficiency; (6) this is a good organisation for which to work; (7) nurses possessed strong relationships and teamwork with their colleagues; (8) poor communication processes; (9) remuneration is important; (10) autonomy is necessary to feel empowered; and (11) nursing is fulfilling work. A summary of these themes is provided in Table 6.4 showing the dominant theme and the average frequency, from greatest to least, these themes were mentioned during the four methods of data collection.

Discussion of each of the dominant themes is outlined following the summary table. This includes an overview of the combined manifest and latent content analysis findings for each of the four methods of open-ended survey questions, focus groups, interviews, and document analyses. Rather than present the findings separately, by data collection method, they are all presented as part of the overall thematic analysis findings, but with justification from the various data sets. These analyses were supported by direct quotes that are representative of similar responses. However, biographical data was only available for quotes from the open-ended survey questions as focus group participants and interviewees did not want their responses to be matched to their personal details. The key findings resulting from the dominant themes are then presented. Emerging themes and pattern matching of the data in general are discussed in Chapter 7.
<table>
<thead>
<tr>
<th>No</th>
<th>Theme</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Average total for each theme</th>
<th>No. of times mentioned in document analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>A lack of respect and support for the nursing role</td>
<td>50.29%</td>
<td>32.79%</td>
<td>76.47%</td>
<td>53.19%</td>
<td>135</td>
</tr>
<tr>
<td>2</td>
<td>Nurses possess poor relationships with their NUMs and upper levels of management</td>
<td>57.49%</td>
<td>04.92%</td>
<td>52.94%</td>
<td>38.45%</td>
<td>190</td>
</tr>
<tr>
<td>3</td>
<td>A shortage of resources</td>
<td>75.45%</td>
<td>03.28%</td>
<td>17.64%</td>
<td>32.13%</td>
<td>116</td>
</tr>
<tr>
<td>4</td>
<td>A shortage of nurses</td>
<td>79.04%</td>
<td>16.40%</td>
<td>N/A</td>
<td>31.82%</td>
<td>472</td>
</tr>
<tr>
<td>5</td>
<td>Hospital policies and procedures inhibit efficiency</td>
<td>51.49%</td>
<td>19.67%</td>
<td>23.53%</td>
<td>31.57%</td>
<td>129</td>
</tr>
<tr>
<td>6</td>
<td>This is a good organisation for which to work</td>
<td>41.91%</td>
<td>16.40%</td>
<td>11.76%</td>
<td>23.36%</td>
<td>527</td>
</tr>
<tr>
<td>7</td>
<td>Nurses possess strong relationships and teamwork with their colleagues</td>
<td>41.92%</td>
<td>26.23%</td>
<td>N/A</td>
<td>22.72%</td>
<td>105</td>
</tr>
<tr>
<td>8</td>
<td>Poor communication processes</td>
<td>14.37%</td>
<td>16.39%</td>
<td>29.41%</td>
<td>20.06%</td>
<td>246</td>
</tr>
<tr>
<td>9</td>
<td>Remuneration is important</td>
<td>44.90%</td>
<td>03.28%</td>
<td>N/A</td>
<td>16.06%</td>
<td>161</td>
</tr>
<tr>
<td>10</td>
<td>Autonomy is necessary to feel empowered</td>
<td>00.60%</td>
<td>11.48%</td>
<td>05.88%</td>
<td>5.99%</td>
<td>17</td>
</tr>
<tr>
<td>11</td>
<td>Nursing is fulfilling work</td>
<td>16.77%</td>
<td>N/A</td>
<td>N/A</td>
<td>5.59%</td>
<td>40</td>
</tr>
</tbody>
</table>

a Responses do not add up to 100% as multiple responses were provided by participants.
b N/A is used when not mentioned in data.
6.4.1 Dominant theme 1: A lack of respect and support for the nursing role

The most dominant theme to emerge from the qualitative data was the lack of support for, and recognition of, nurses, mostly from upper management, but also from some other health professionals. This theme was strongly evident in responses to each of the open-ended survey questions and in responses from the focus groups and interviews. Details regarding this theme are shown in Table 6.5.

Table 6.5 Frequency of sub-themes within Dominant theme 1: A lack of respect and support for the nursing role

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of respect and support</td>
<td>37.72%</td>
<td>32.79%</td>
<td>76.47%</td>
<td>N/A</td>
</tr>
<tr>
<td>Improve the behaviour of management</td>
<td>12.57%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Respect and support is provided</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>135</td>
</tr>
</tbody>
</table>

* N/A is used when the specified sub-theme was not mentioned in the data.

Analysis of the open-ended survey questions showed that a lack of support and respect was the fifth most frequently listed response regarding the worst aspects of working for this organisation. Nurses believed that they did not receive enough respect or support in general, particularly from upper management. In addition, they also felt that they were treated like a number instead of a valued employee, and that they were treated with disrespect or as if they were expendable. For example, one nurse commented that the worst aspect was:

*Nurses are treated like they were expendable and there is no recognition for work done (Clinical Nurse, female).*
Furthermore, nurses said that upper management needed to improve their behaviour towards nurses by offering more recognition and support. For example, one nurse responded:

*I feel that management do not have first-hand knowledge of me and how I work and it all comes down to others’ opinions rather than direct observation and evaluation (Assistant in Nursing, male).*

Subsequently, increased support and recognition from upper management was the most frequently listed response regarding the one thing that management needed to change in order for the nurses to remain committed. For instance, one nurse said that management needed to:

*Take notice of what is happening at the coal face and LISTEN TO THE NURSES. There is not enough support for the facilitator role from higher management and I would not know how I would feel if I continued in this role for another year (Clinical Nurse, female).*

Overall, analysis of the open-ended survey questions suggested that nurses’ perception of the behaviour of, and their treatment by, upper levels of management was a common concern amongst the survey respondents. Furthermore, the need for upper management to increase and improve the support provided to, and recognition of, nurses was identified as an issue that management needed to change in order for nurses to remain committed to the organisation.

The focus group transcripts showed a similar theme to the open-ended survey questions. Nurses responded that their perceptions of empowerment were also affected by a lack of support and recognition. Many nurses commented that their skills and expertise were not recognised and their contribution not valued. Furthermore, some nurses said that there was a general lack of respect towards nurses and that their views were not considered or taken seriously. Finally, the most common response was the lack of support provided to nurses by management and
doctors, and aspects such as the lack of availability or use of resources. In addition, the interview data overwhelmingly (76.47%) indicated that nurses’ perceptions of empowerment were affected by the level of support and recognition they received. Nurses commented that there was a lack of acknowledgement for aspects such as advanced skills or situations such as dissatisfaction with pay which sometimes led to union involvement. Furthermore, some nurses indicated that management did not listen to them, and several comments were also made about nurses being undervalued. Overall, data from the focus groups and interviews suggested that support and recognition from management was an important issue for nurses and affected nurses’ perceptions of empowerment.

Analysis of organisational documents suggested that the organisation aimed to support its nurses. Manifest analysis of the mission statement and code of conduct documents suggested that respect was a core value of the organisation. Respect was also the most frequently mentioned term in the code of conduct and referred to respect towards fellow staff, all people in general that were affiliated with the organisation. Additionally, some references were made to respect for the law with regards to confidentiality. However, it is important to note that respect for patients and respect towards diversity of backgrounds, cultures and opinions, were least frequently mentioned. Latent analysis of these documents supported the manifest findings and suggested that the organisation did indeed view respect as a primary value of the organisation. This was evidenced in one document where the organisation viewed their employees as an important asset and stated:

    People are an organisation’s most valuable resource...where staff feel respected and valued for their contributions (Document 1: Code of Conduct).

Alternatively, support was not as frequently mentioned as respect although some references were made to the value of support provided to employees and the role of managers in providing support. Latent analysis suggested that although support was mentioned, ways in which this was achieved were not within the scope
of these documents. Manifest and latent analysis of the organisational website suggested a high level of support for nurses and their role. Support was consistently mentioned with regards to support for educational and training opportunities, support to, and from, colleagues, and support in general. Examples of support mechanisms mentioned for nurses were: financial benefits; professional and career opportunities; positive and flexible workplaces; and assistance with returning to work or working in rural areas. Importantly, the high quantity of manifest outcomes from this website is likely to be related to the nature of the website which is dedicated to recruiting nurses and promoting the tangible and intangible benefits of working for the organisation. Overall, manifest and latent content analysis of the organisational documents suggested that the organisation valued its staff and was willing to provide support for these roles. Furthermore, the documents showed consistent and underlying themes about the high value of nurses to the organisation and that this organisation was a good place to build a career as a nurse. The documents also suggested that the organisation was consistent in its espoused attitude of encouragement towards nurses and that it was a nurse-friendly environment.

Overall, the qualitative data suggested a dominant theme of a lack of respect and support from upper management which had affected nurses’ perceptions of empowerment and commitment to the organisation. Therefore, key findings from this dominant theme were:

*Key Finding 1:*  A lack of respect and support decreased nurses’ perceptions of empowerment.

*Key Finding 2:*  A lack of respect and support decreased nurses’ commitment to the organisation.
6.4.2 Dominant theme 2: Nurses possess poor relationships with their NUMs and upper levels of management

The second most dominant theme in the qualitative data was the poor relationships between nurses and their NUMs and upper levels of management. The poor relationship with NUMs was frequently a result of the NUMs being busy and therefore unavailable to assist the nurses when necessary. In addition, the poor relationship with upper levels of management was frequently a result of a lack of support, recognition, and value for nurses by upper management as mentioned previously in Dominant theme 1. Details regarding this theme are shown in Table 6.6.

Table 6.6 Frequency of sub-themes within Dominant theme 2: Nurses possess poor relationships with their NUMs and upper levels of management

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship with all management in general</td>
<td>N/A</td>
<td>03.28%</td>
<td>41.18%</td>
<td>190</td>
</tr>
<tr>
<td>Poor behaviour of, and relationship with, all management</td>
<td>23.95%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Poor relationship with NUM</td>
<td>16.77%</td>
<td>01.64%</td>
<td>11.76%</td>
<td>N/A</td>
</tr>
<tr>
<td>NUM not available</td>
<td>16.77%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

a N/A is used when the specified sub-theme was not mentioned in the data.

The open-ended survey responses suggested that nurses possessed a poor relationship with their NUMs, in part because their NUM was frequently unavailable. This was evidenced through responses as to why nurses did not approach their NUMs for help with solving work-related problems. Several respondents suggested
that their NUM was not available due to being busy or away at meetings and this was demonstrated through one nurse’s comment that:

*There is a lack of access because even though they have an open door policy, their office is often not occupied (Assistant in Nursing, male).*

Nurses also suggested that the relationship with their NUMs was poor due to issues such as a lack of trust, nurses’ perceptions that they will be viewed as incompetent if they ask for assistance, and just a poor relationship in general. For example, one nurse responded that he/she did not approach his/her NUM for help with solving work-related problems because:

*The Nurse Unit Manager is intimidating and busy, and I think they may think less of me for not knowing the answer (Registered Nurse, female).*

In addition, nurses also indicated that their NUM was not approachable because of the NUM’s attitude and lack of interest. Some nurses responded that they preferred to see someone else apart from the NUM due to the nature of the problem for which they were seeking assistance. Alternatively, some nurses preferred to be independent and solve the problem themselves. However, only 4.19% of respondents indicated that they always approach their NUMs regardless of how busy they are or who else is available, as detailed previously in Chapter 5.

It is important to note here that the data comprising the subthemes of a poor relationship with NUMs and NUM not available were in response to the question of when nurses did not approach their NUM for assistance with problem-solving, then why not. Only 52.09% of nurses responded to this question and therefore this has a small sample size and representativeness.

Another sub-theme evident in the responses was the poor relationship with upper levels of management beyond the NUMs. Many nurses indicated that upper management were unapproachable and disinterested in nurses. Furthermore, some
respondents felt that they received no back-up support from management and many felt that they were treated impersonally and as just a number. Several respondents made suggestions that management needed to change their behaviour in order for those respondents to remain committed to the organisation. For instance, many of the participants referred to the need for increased collaboration between management and nurses, and support and recognition, as mentioned previously in Dominant theme 1. However, even though some of these issues have been discussed in Dominant theme 1, it is important that these be mentioned here also because of the impact upon the quality of the relationship between nurses and upper levels of management.

Overall, open-ended survey responses from nurses indicated that NUMs may not have assisted nurses to solve problems in the workplace due to a lack of availability because of time pressures and alternative requirements. Because of these and other problems mentioned here, the relationship between nurses and NUMs was not as optimal as it could be. Furthermore, the surveys suggested that there was also room for improvement in the relationships between nurses and upper levels of management.

Focus group responses did not indicate that the relationships between nurses and their NUMs, and upper levels of management were a major factor affecting their perceptions of empowerment in this organisation. Only a small percentage (4.92%) of focus group participants indicated that a lack of support from their NUMs and upper management negatively affected their perceptions of empowerment. Analysis of interview transcripts showed that half of the participants felt that this issue did affect their perceptions of empowerment. For instance, some nurses felt they had a poor relationship with upper levels of management due to management’s inability to recognise the importance of issues affecting nurses, and failing to recognise nurses at all. In addition, some nurses suggested that a lack of positive feedback and support from their NUMs was important to their perceptions of empowerment. Overall, the interview responses suggested that nurses’ relationships with upper levels of management and their NUMs impacted upon their perceptions of
empowerment. Altogether, the responses from the focus groups and interviews suggested that a poor relationship with NUMs and upper management did negatively affect their perceptions of empowerment.

Manifest and latent content analysis of documents suggested that leadership was a core value of the organisation and that managers of all types played a key role in the implementation of positive behaviours. For instance, the code of conduct document clearly highlighted the importance of nurses approaching managers when experiencing problems or seeking requests for information or assistance. Several references were made to the role of managers in promoting positive relationships. An example of this was a quote regarding the responsibility of managers in creating positive workplace cultures:

*Managers are expected to... promote a culture of openness and direct face-to-face communication; lead by example; and encourage teamwork (Document 1: Code of Conduct).*

The above-mentioned quote was somewhat supported by the recruitment website, however, more emphasis was placed on the website about the duties of management as opposed to managers themselves. Therefore, the organisational documents have highlighted the importance of management and leadership and the role that this should have played in the organisation. Furthermore, although the quality of relationships between employees and management was not directly addressed, it was implied as being important and therefore good relationships were stated as being valued by the organisation.

Overall, analysis of the qualitative data suggested that nurses perceived that the supervisor-employee relationship was vital to effective problem-solving processes and affected perceptions of empowerment. However, it was also suggested by nurses that the relationship between supervisors and employees, and the resulting exchanges were not at an optimal level. Furthermore, the data suggested that the relationship between nurses and upper levels of management
was not optimal either. Consequently, this theme was an important factor that negatively affected the relational and structural social capital of nurses. Therefore, the following key findings are given:

Key Finding 3: *The relationships that nurses possessed with their NUMs and upper levels of management were not optimal and may have adversely affected exchanges between supervisors and employees.*

Key Finding 4: *Poor relationships between supervisors and employees adversely affected employees’ ability to solve work-related problems.*

Key Finding 5: *Poor relationships between supervisors, employees and upper levels of management adversely affected nurses’ perceptions of empowerment.*

Key Finding 6: *Poor relationships between supervisors, employees and upper levels of management may have adversely affected nurses’ commitment to the organisation.*

### 6.4.3 Dominant theme 3: A shortage of resources

Another dominant theme to emerge from the qualitative data, particularly in response to the open-ended survey questions, was the lack of resources available within the organisation and the negative impact that this had on how nurses work. Further details regarding this theme are shown in Table 6.7. The single most significant resource mentioned was the lack of parking for staff due to the locations of the hospitals.
In the open-ended survey questions, parking was the most frequently listed worst aspect of working for this organisation in addition to being the third most frequently listed aspect that management would need to change in order for nurses to remain committed to the organisation. Most nurses indicated that parking in general was a problem. However, some nurses also indicated that they were concerned about safety due to a lack of close proximity of parking for night shifts. These safety issues were of particular focus for afternoon and night shift nurses who were required to walk long distances in the dark. For example, one nurse responded that the one thing that management needs to change was to:

*Provide parking for staff that work late shifts and night shifts and do not give parking for Monday to Friday 9am to 5pm workers please* (Registered Nurse, female).

Another nurse agreed and added that management needed to provide:

*Better parking for medical staff and security after evening shifts. It is difficult to get good parking close to the hospital and there is always the fear of being attacked in the dark* (Enrolled Nurse, female).

Respondents further suggested that resources in general, such as the lack of beds or bed blocks, and facilities for staff such as canteen availability times, were a
constant issue for nurses. Furthermore, a lack of facilities and resources was the third most frequently listed response about the worst aspect of working for the organisation. When asked about the one thing that management needed to change in order to retain the nurses, the fifth most frequently listed response was improving the lack of facilities and resources. For example, one nurse said that management needed to:

*Provide adequate resources so that procedures are not cancelled, wasting even more resources (Clinical Nurse, female).*

This was supported by another nurse who commented:

*Fix the bed block. There are too many patients and not enough beds (Clinical Nurse, female).*

Overall, analysis of the open-ended survey questions suggested that a lack of resources, in particular, parking facilities, had affected nurses’ daily work environment and ability to perform their work. Furthermore, the continued shortage of resources and facilities was viewed negatively by nurses and was suggested to have affected nurses’ commitment to the organisation.

Analysis of focus group comments identified a small proportion of nurses who felt that the lack of parking and bed shortages affected their perceptions of empowerment. In addition, analysis of interview transcripts identified another small proportion of nurses who indicated that the general lack of resources affected their ability to care for their patients more effectively, and increased their level of stress. Overall, the focus group and interview transcripts suggested that a shortage of resources may have affected nurses’ perceptions of empowerment.

Manifest and latent content analysis of the mission statement and code of conduct documents suggested that resources were viewed as important by the organisation in respect to the efficient management of resources while working for
the organisation. Only a small number of references to resources within these documents was related to the number, availability or quality of appropriate resources within the organisation that were needed for staff to undertake their work appropriately. Safety was also stated as being important to the organisation. The manifest analysis identified a number of references made to the safety of the work environment in which employees worked, and how staff can undertake their work in a safe manner. Latent analysis suggested that most of the references to safety were regarding employees’ adherence to safe practices, plus procedures for when this did not occur. Manifest content analysis of the website showed that facilities were mentioned several times, but safety was not. However, latent analysis of the website suggested that both of these areas were mentioned to describe features of the organisation, but were not indicative of a priority or important concern of the organisation. Therefore, in relation to the analysis of documents, facilities and resources were used to promote the attractiveness of working for the organisation but were not a central focus of the documents. Furthermore, it is important to note that parking was not addressed in these documents, which was likely to be due to the large number of hospitals covered by this organisation, and the inability to contextualise the text to specific hospital attributes. However, safety was observed to be a value of this organisation in relation to providing a safe working environment.

Overall, the qualitative data from nurses showed a consistent theme of a lack of perceived resources and facilities, particularly in relation to staff parking and availability of beds for patients. Therefore, key findings from this theme include:

**Key Finding 7:** A lack of resources and facilities adversely affected the ability of nurses to competently perform their work.

**Key Finding 8:** A lack of resources and facilities may have affected nurses’ commitment to the organisation.
6.4.4 Dominant theme 4: A shortage of nurses

The fourth most dominant theme arising from the qualitative data was the shortage of nurses and the impact that this had on workloads, hours of work, and stress levels. Details regarding this theme are shown in Table 6.8.

Table 6.8 Frequency of sub-themes within Dominant theme 4: A shortage of nurses

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>High workloads</td>
<td>29.94%</td>
<td>06.56%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Hours of work</td>
<td>29.34%</td>
<td>06.56%</td>
<td>N/A</td>
<td>13</td>
</tr>
<tr>
<td>More staff needed</td>
<td>08.98%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Stress</td>
<td>05.99%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Decreased quality of patient care</td>
<td>04.79%</td>
<td>03.28%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>459</td>
</tr>
</tbody>
</table>

N/A is used when the specified sub-theme was not mentioned in the data.

In the open-ended survey questions many nurses commented that their workloads were too high and that they were too busy because of this. Furthermore, some nurses said that their workload had decreased the quality of care provided to their patients. However, the quality of patient care represented here did not include aspects outlined in subsequent dominant themes such as the shortage of beds and poor procedures. Therefore, the decreased quality of patient care was likely to have been much higher when these factors were taken into consideration. For example, one nurse responded that the worst aspect of working for the organisation was:

*The workload of particular patients and dealing with not one but several patients at the one time who have more than one complicated illness or condition, and not always being able to address everyone’s needs as much as I would like due to the heavy workload of care (Registered Nurse, female).*
The decreased quality of patient care was echoed by another nurse who noted that the worst aspect was:

*Workloads....I sometimes feel unable to give the care to patients that I would like to due to the lack of staff and the amount of patients presenting (Registered Nurse, female).*

These, and similar, comments suggested that the shortage of nurses had resulted in more than just increased workloads; it had also affected the primary customer being served by the health system, the patient. Nurses also responded that the shortage of nurses and high workloads had forced them to work longer or more inconvenient hours of work as evidenced in responses to the worst aspects of working for the organisation and the one thing that management needed to change to retain nurses’ commitment. Some nurses indicated a constant pressure to work overtime while others expressed dissatisfaction with the lack of choice or flexibility in rostered hours. This was reflected in one nurse’s comment, who stated that the worst thing was that:

*There is only 1 day a month when you get to choose your work days because there are not many positions available and there are only 4 AINs per shift (Assistant in Nursing, female).*

Responses also suggested that the nursing shortage had placed increased stress on nurses because of the increased tasks, hours, or problems that resulted from high workloads. Furthermore, this was perceived by nurses as an important issue that they believed should be acknowledged more by organisational management. For example, another nurse said that management needed to:

*Carry out your promises to reduce stress and strain, and be recognised when problems become too much (Clinical Nurse, female).*
It was clear from many of the responses that staffing levels had not increased at the same rate that the population in the area had, and this was reflected in the shortage of nurses, the pressure for overtime work, and lack of resources (which was described in Dominant theme 3). An example of the increased population was given in the following comment about the worst aspect of working for this organisation:

_ I signed up to work nights with 2 staff in a 10-bed wing and over time it turned into a 32-bed acute medical unit (Registered Nurse, male). _

This latter comment was representative of other responses which referred to the increased population being serviced by these hospitals and the lack of nurses appointed to care for them. The need for more staff and the importance of this was highlighted by nurses’ responses to the question about the one thing that management needed to change in order for them to remain committed. Nurses indicated that better staffing levels were necessary with one nurse responding:

_ We need more staff now and not in 5 years, to deal with the increase in patient population (Registered Nurse, female). _

Overall, the responses to the open-ended survey questions indicated that the nursing shortage contributed to overworked nurses who were not performing at their best, particularly in relation to the quality of patient care. It also suggested that nurses’ quality of work life may have affected their personal life because of a lack of work-life balance due to increased stress, and longer and more inconvenient work hours. Because of this, nurses continued to request the allocation of more nurses both through direct requests, and implicit requests by complaining about the aforementioned problems.

Analysis of focus group comments suggested that a minority of nurses felt that they were too busy to provide better care to their patients. In addition, a few more nurses indicated that their dissatisfaction with working hours affected their
perceptions of empowerment. In contrast, the interviews identified no references to a shortage of nurses or any of the associated sub-themes. Overall, the focus group data suggested that a shortage of nurses may have affected nurses’ perceptions of empowerment.

Analysis of organisational documents suggested that the shortage of nursing staff and the problems resulting from this were not mentioned. Specifically, manifest analysis of organisational documents identified minimal references to most of these sub-themes with the exception of patient care. Regarding the quality of patient care, manifest analysis identified that the care of patients was mentioned many times throughout the code of conduct document and website examined. This implied that the quality of patient care was a high priority for the organisation. Similarly, the latent content analysis supported the manifest findings by suggesting that the care of patients was a consistent focus, in particular the continued desire to provide high quality health services to patients in a timely and efficient manner. For example, the code of conduct document specified that one of the organisation’s values was to provide “timely access to the right health service at the right time in the right setting”. This value implied that the necessary staff, including nurses, and resources would be available when necessary. Regarding the other sub-theme of inflexible hours of work, the documents stated that a variety of working hours were available to nurses, and that expectations regarding these needed to be discussed with supervisors. However, further information regarding working hours was not contained within the documents examined. Overall, the organisational documents placed a high importance on the quality of the patient care, but neglected to mention anything relating to the nurse workforce, workloads, and resulting hours or levels of stress.

Overall, analysis of the qualitative data suggested that there was a shortage of nurses which resulted in increased workloads and strain on existing nurses. Each of these themes was recognised by nurses to be some of the worst aspects of working for this organisation, which were indicators of the importance of these issues to nurses. This was further supported by the focus group data which
suggested that this issue may have affected nurses’ perceptions of empowerment. A number of nurses indicated that the lack of allocation of more nurses did affect their commitment to the organisation. Therefore, the following key findings are given:

**Key Finding 9:** A shortage of nurses and the resulting high workloads adversely affected the ability of nurses to competently perform their work.

**Key Finding 10:** A shortage of nurses and the resulting high workloads may have adversely affected nurses’ perceptions of empowerment.

**Key Finding 11:** A shortage of nurses and the resulting high workloads may have adversely affected nurses’ commitment to the organisation.

### 6.4.5 Dominant theme 5: Hospital policies and procedures inhibit efficiency

A dominant theme emerging from the qualitative data analyses was the negative impact that hospital policies and procedures had for various processes and outcomes, resulting in reduced efficiency. The data suggested that poor policies and procedures were contributing to wastage, including unnecessary bed moving, meetings, or excessive practices such as too much paperwork. The data also indicated that these procedures had affected the quality of patient care that the nurses provided. Details regarding this theme are provided in Table 6.9.
Table 6.9  Frequency of sub-themes within Dominant theme 5: Hospital policies and procedures inhibit efficiency \(^a\)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor policies and procedures prevent efficiency</td>
<td>22.15%</td>
<td>19.67%</td>
<td>23.53%</td>
<td>N/A</td>
</tr>
<tr>
<td>Need to improve policies and procedures to improve efficiency</td>
<td>29.34%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Policies and procedures in general</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>85</td>
</tr>
<tr>
<td>Organisational managements’ need for efficiency and effectiveness</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>44</td>
</tr>
</tbody>
</table>

\(^a\) N/A is used when the specified sub-theme was not mentioned in the data.

Analysis of the open-ended survey responses showed that policies and procedures were a commonly listed response regarding the worst aspects of working for the organisation. Many comments referred to inefficient practices such as excessive paperwork or constant and unnecessary moving of patients. For example, one nurse responded:

> There is too much useless moving of patients, too many bosses, not organised, overuse of imaging...it’s all wasting time (Registered Nurse, male).

In addition, some nurses commented that policies and procedures had prevented effective problem-solving from taking place at the point it occurred, or implementation of procedures to prevent problems in the future. For example, one nurse noted that the worst thing was:
At times a feeling that proactive solutions to continuing problems are not effectively explored (Registered Nurse, female).

These perceptions were supported by another nurse, who said that one of the problems arising from the policies and procedures was:

Management making decisions about nursing with no nursing knowledge (Unspecified type of nurse, male).

Furthermore, several responses referred to the general lack of organisation relating to procedures and resources leading to unnecessary wastage, and that the hierarchy of management was too complex. In addition to policies and procedures being one of the worst aspects of this organisation, they were also the ninth most frequently listed response regarding the one thing that management needed to change for nurses to remain committed to the organisation. Therefore, the open-ended survey responses suggested that a variety of hospital policies and procedures negatively impacted upon nurse practices and affected their ability to perform their work effectively and efficiently.

Analysis of focus group responses identified that policies and procedures were the third most frequently listed aspect that affected nurses’ perceptions of empowerment. Nearly half of the responses suggested that there was a lack of fairness in regards to promotions or instances of bullying and harassment because policies and procedures were either not sufficient or not being followed. Other responses suggested that excessive administrative practices and trying to keep up with changes to policies and procedures had affected nurses’ perceptions of empowerment. For example, one nurse commented that procedures had inhibited her/him from improving her/his own practices. This nurse stated:

We’re not allowed to follow best practice because we’re keeping up with the changes in organisational policies so it’s a bit confusing (Biographical details not available).
Overall, analysis of the focus group responses suggested that hospital policies and procedures were the third most frequently reported factor that negatively affected nurses’ perceptions of empowerment. Analysis of interview transcripts suggested that more than a quarter of participants felt that their perceptions of empowerment were negatively affected by poor policies and procedures. For instance, half of these participants commented that policies and procedures were too slow and had affected responses to patients and surgery waiting times on the ward. The other half of the participants felt that unnecessary contract agreements and being required to check all of their actions with someone else negatively affected their perceptions of empowerment. Together, these focus group and interview responses suggested that policies and procedures had a negative effect on perceptions of empowerment.

Manifest and latent content analysis of organisational documents such as the code of conduct showed that a large number of policies and procedures existed in relation to nurses’ employment with the organisation. These policies referred to a variety of situations such as confidentiality, harassment, offences, patient care, private use of work resources and time management. Manifest analysis of the mission statement indicated that the provision of efficient and effective health services was a value of the organisation. However, due to the short nature of the document, the latent analysis provided no more information regarding this. Manifest analysis of the code of conduct and website suggested that policies and procedures, and the efficiency and effectiveness of working within this organisation were highly valued aspects for the organisation. Latent analysis revealed the large extent to which employees were required to adhere to the policies and procedures with the majority of these terms referring to the strict adherence required by employees. In addition, several instances referred to the efficient management of time and resources while undertaking work, with many general statements regarding the efficient and effective delivery of health services as one of the main goals of working for this organisation. Therefore, analysis of organisational documents suggested that policies and procedures were valued by the organisation for achieving efficient and effective health services. Also, the documents suggested that
nurses were, indeed, expected to follow procedures as instructed, irrespective of whether they were current best practice. Furthermore, the documents stated that strict adherence to policies and procedures was necessary.

Overall, analysis of the qualitative data suggested that some hospital policies and procedures were viewed negatively by nurses and had a large and negative impact on nurses’ work practices and perceptions of empowerment. It is likely that this may have also impacted upon nurses’ levels of role ambiguity due to the constant feelings of ambiguity surrounding scheduled procedures and gaps where policies and procedures made work duties more complex. However, there is insufficient support for a causal relationship between policies and procedures, and commitment to the organisation. Therefore, the following key findings emerged:

**Key Finding 12:** Organisational policies and procedures adversely affected nurses’ ability to perform their work efficiently.

**Key Finding 13:** Organisational policies and procedures may have increased nurses’ levels of role ambiguity.

**Key Finding 14:** Organisational policies and procedures adversely affected nurses’ perceptions of empowerment.

### 6.4.6 Dominant theme 6: This is a good organisation for which to work

Another dominant theme to arise from the qualitative data was that the organisation was a good place to work, irrespective of the problems identified in other themes. The reasons why this organisation was a good place for which to work included the physical location of the hospitals, the educational and career opportunities available to the nurses, and the culture and environment of the hospitals. Specific details regarding this theme can be seen in Table 6.10.
Table 6.10  Frequency of sub-themes within Dominant theme 6: This is a good organisation for which to work a

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical location is good</td>
<td>16.77%</td>
<td>N/A</td>
<td>N/A</td>
<td>21</td>
</tr>
<tr>
<td>Good education and career opportunities</td>
<td>13.17%</td>
<td>09.84%</td>
<td>N/A</td>
<td>416</td>
</tr>
<tr>
<td>Poor culture and hospital environment</td>
<td>11.97%</td>
<td>06.56%</td>
<td>11.76%</td>
<td>90</td>
</tr>
</tbody>
</table>

N/A is used when the specified sub-theme was not mentioned in the data.

Analysis of the open-ended survey responses indicated that there were a number of positive attributes about working for this organisation as evidenced through responses to the question regarding the best aspects of working for the organisation. Many nurses were satisfied with the convenience of the physical location of the hospitals due to close proximity to public transport, the central location of the hospitals in a major city, and being close to nurses’ residences thereby reducing travelling time. Nurses also indicated that another one of the best aspects of this organisation was the educational and career opportunities available to them. Some nurses liked the educational opportunities such as on-going and further education and workshops. In addition, nurses also liked the career opportunities in the organisation such as the diversity of training and working in different areas and specialties. For example, one nurse commented that she was impressed by the:

*Career structure for Registered Nurses and the opportunity to move within this organisation (Clinical Nurse, female).*

Nurses also viewed the individual hospitals themselves and their wards as one of the best aspects. Some nurses stated that they enjoyed working in the public sector as opposed to the private sector, for reasons that were unspecified.
Furthermore, they enjoyed working in their particular ward which was described as friendly. For example, one nurse responded:

*I think that the surgical ward at this hospital is the most pleasant ward I have been on* (Registered Nurse, female).

Overall, the responses to the open-ended survey questions suggested that certain features of the organisation made working there attractive to nurses. These included the central location of the hospitals, the educational and career opportunities available to nurses, and the culture and environment of the hospitals and individual wards.

Analysis of focus group responses identified only one nurse who felt that his/her perception of empowerment was affected by positive cultural aspects such as the levels of teamwork and relationships with colleagues. Interestingly, several nurses felt that negative practices relating to this theme negatively affected their perceptions of empowerment. For instance, several participants stated that the self-promotion of people in power or unfair promotion practices, and lack of development opportunities negatively affected their perception of empowerment. In addition, the data suggested that the majority of nurses’ perceptions of empowerment were affected by the culture of medical dominance by doctors in the hospitals, and the nurses felt pushed aside, ignored, or not adequately informed by doctors because of this. Alternatively, some interviewees suggested that the culture of poor morale, being resistant to change, or not listening to nurses’ suggestions negatively affected their perceptions of empowerment. Therefore, overall the focus group and interview responses suggested that the largely negative atmosphere and culture of where nurses work did negatively affect their perceptions of empowerment.

Manifest analysis of the organisational documents proved quite interesting. This is because the mission statement and code of conduct documents provided little support for this theme with the exception of a few references to creating a safe,
healthy and harmonious working environment. However, manifest analysis of the organisational website documents suggested that this organisation makes thorough use of the benefits available to nurses in order to attract and recruit them to the organisation. For instance, educational and career opportunities were the most frequently mentioned sub-theme with more than four hundred frequencies. The data suggested that the organisation provided a number of educational and career opportunities to nurses, and promoted this fact accordingly. Furthermore, the culture and environment of the organisation, as well as the lifestyle afforded by its location, were moderately promoted. This suggested that positive workplace cultures were important to the organisation. It was also evident through numerous policies and procedures relating to how to manage and reduce negative cultural aspects such as bullying and breaches of conduct. Therefore, analysis of organisational documents suggested that the organisation highly valued lifelong learning and promoted the organisation as a good place to work.

Overall, analysis of the qualitative data suggested that there were several positive aspects about working for the organisation and subsequently, some nurses considered the organisation to be a good place in which to work. However, negative cultural aspects were shown to adversely affect perceptions of empowerment. This theme led to the following key findings:

**Key Finding 15:** The organisation was viewed by nurses as an attractive place to work.

**Key Finding 16:** Negative cultural attributes adversely affected nurses’ perceptions of empowerment.
6.4.7 Dominant theme 7: Nurses possess strong relationships and teamwork with their colleagues

Another consistent theme that emerged from the qualitative data was the importance placed on the quality of relationships with colleagues and the teamwork that resulted from this. Although most of the responses referred to the quality of the relationships with nurses within their own ward, some did also refer to other staff in general from within the hospitals. Details regarding this theme can be seen in Table 6.11.

Table 6.11 Frequency of sub-themes within Dominant theme 7: Nurses possess strong relationships and levels of teamwork with their colleagues

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong relationship and levels of teamwork with colleagues</td>
<td>41.92%</td>
<td>26.23%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Relationship and levels of teamwork with colleagues</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>105</td>
</tr>
</tbody>
</table>

a N/A is used when the specified sub-theme was not mentioned in the data.

In the open-ended survey questions, colleagues, and the relationships amongst them, were the most frequently listed best aspect of working for the organisation. Many nurses indicated that their colleagues were wonderful people and great friendships had developed because of this. For example, one nurse commented that:

_The staff I work with – most of them are excellent nurses and friends_

_(Registered Nurse, female)_

Many nurses indicated that it was beneficial to work with their colleagues because they always had someone from which they could obtain support or
assistance. Several respondents commented on the quality of teamwork present, particularly in emergency or other specialty wards. This was evidenced by another nurse who stated the best thing was:

_The staff are just beautiful ladies to work with. They are cooperative, informative, and professional team workers (Assistant in Nursing, female)._ 

However, several nurses did point out that not all of their colleagues were beneficial to work with by capitalising the word “SOME” in their responses. Furthermore, some respondents made it clear that these positive relationships did not extend to their NUMs and in particular, to upper levels of management, although some did praise their relationship with their NUMs. Overall, the open-ended survey responses suggested that most nurses possessed positive relationships with their colleagues and high levels of teamwork due to this, and regarded it as the best aspect of working for the organisation.

Analysis of focus group transcripts suggested that a minority of participants felt that negative practices related to colleagues had negatively affected their perceptions of empowerment. These included incidents of bullying and a lack of respect from other medical professionals. However, the majority of participants indicated that relationships with colleagues positively affected their perceptions of empowerment. For instance, several nurses indicated that they experienced high levels of teamwork with their colleagues. Other nurses enjoyed the level of support they received and the relationships among them which described colleagues as “part of a family”. In contrast, analysis of interviews showed no references to colleagues or the quality of teamwork present, which was most likely due to the small interview sample. Overall, the focus group responses suggested that the relationships with colleagues and the teamwork that resulted from these, positively affected nurses’ perceptions of empowerment.
Manifest content analysis of organisational documents suggested that relationships and teamwork were important to the organisation. Teamwork was the most frequently mentioned sub-theme and highlighted the importance of teamwork and a team environment in serving the community. However, many of these issues emerged from a reading of the website and only some from the code of conduct. The mission statement indicated that staff were important but did not expand upon this. Latent analysis suggested that many of the references to this theme were general and referred to the need for relationships to exist, but no specific details were made. Therefore, the document analyses suggested that staff were somewhat important to the organisation, and relationships with colleagues and the teamwork that arose from these were also somewhat important to the organisation.

Overall, analysis of the qualitative data showed that nurses placed a high value on the quality of the relationship with fellow colleagues and the teamwork that resulted from these relationships. Furthermore, the data suggested that relationships and teamwork positively affected perceptions of empowerment. These findings are relevant to both the relational and structural dimensions of social capital because they highlighted the quality of the relationships amongst colleagues as important factors for nurses, and suggested that colleagues were an important network tie. Therefore, the following key findings emerged:

*Key Finding 17:* Strong relationships amongst colleagues, and resulting teamwork, was important to nurses.

*Key Finding 18:* Strong relationships amongst colleagues, and resulting teamwork, positively affected perceptions of empowerment amongst nurses.
6.4.8 Dominant theme 8: Poor communication processes

Another theme throughout the qualitative data was the poor communication occurring between nurses, and with management at all levels as well as other medical professionals. Details regarding this theme can be seen in Table 6.12.

Table 6.12 Frequency of sub-themes within Dominant theme 8: Poor communication processes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor communication</td>
<td>14.37%</td>
<td>16.39%</td>
<td>29.41%</td>
<td>N/A</td>
</tr>
<tr>
<td>Communication and information in general</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>246</td>
</tr>
</tbody>
</table>

N/A is used when the specified sub-theme was not mentioned in the data.

Open-ended survey question responses indicated that poor communication processes were the thirteenth most frequently listed worst aspect of working for the organisation. In addition, improving communication was the tenth most frequently listed action that management needed to undertake for nurses to remain committed to the organisation. Several respondents indicated that they were not listened to by management which suggested limited bi-directional communication. Furthermore, other responses suggested that there was a lack of feedback and consultation with nurses. For example, one nurse commented that the worst aspect of working for this organisation was that:

*I feel like I am getting lied to about their intentions and they only tell us what they want us to know (Registered Nurse, female).*

The lack of communication extended to patients. Another nurse recorded a similar response by indicating that there was:
A lack of communication, for example, patients need to be informed about what is happening to them when being transferred from one hospital to another (Enrolled Nurse, female).

Overall, the open-ended survey responses suggested that nurses perceived that communication processes could be improved. Furthermore, the lack of feedback, consultation and poor communication processes were suggested to have impacted upon other areas of their work role such as patient care.

Responses from the focus groups suggested a similar theme with poor bi-directional communication, lack of feedback, and consultation being the fifth most frequently listed response to the factors that affected nurses’ perceptions of empowerment. For example, one participant said that:

*We need more positive feedback for work well done (Biographical details not available).*

The interview responses identified several participants who echoed the same lack of feedback. In addition to this, some participants indicated that they were not being listened to and another participant said that crisis management was poor, which suggested that, again, the flow of bi-directional communication was not optimal. Overall, the responses to the focus groups and interviews suggested a consistent theme of a lack of feedback with two-way communication being less than optimal.

Manifest content analysis of organisational documents suggested that communication, information, feedback and consultation were important to the organisation. The ability to better manage information, and stated aims for open and transparent, face-to-face communication were listed within the mission statement for the organisation. Furthermore, the code of conduct specified that feedback between employees and management, and communication in general were important. However, latent content analysis suggested that several of these
terms, particularly information, were merely used to refer employees to alternative sources of information and were not intended to specify organisational requirements or were an indication of their importance. Therefore, analysis of the organisational documents suggested that communication and information are important to the organisation and valued accordingly.

Overall, analysis of the qualitative data suggested that nurses believed additional feedback, communication, and information were necessary for them to perform their work efficiently. Furthermore, the data also suggested that nurses may have been experiencing some ambiguity surrounding their role due to the poor communication processes in place. Therefore, this theme has implications regarding the relational dimension of social capital. However, only minimal data was identified regarding the relationship between poor communication processes and commitment to the organisation which suggested that this relationship may be worth investigating further. This led to the following key findings:

**Key Finding 19:** Poor communication processes adversely affected nurses’ ability to perform their work effectively.

**Key Finding 20:** Poor communication processes may have adversely affected nurses’ levels of role ambiguity due to insufficient or incomplete information about how to perform their role.

**Key Finding 21:** Poor communication processes may have adversely affected nurses’ commitment to the organisation.
6.4.9 Dominant theme 9: Remuneration is important

Another dominant theme from the qualitative data was the importance that nurses placed on remuneration. The data suggested that nurses were not satisfied with the rates of pay provided, but that they were satisfied with the additional benefits that were offered such as superannuation. This theme was important to nurses because it was clearly identified and consistently mentioned throughout the surveys, focus groups and interviews, as being important to their commitment to the organisation. Details regarding this theme are shown in Table 6.13.

Table 6.13  Frequency of sub-themes within Dominant theme 9: Remuneration is important

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied with remuneration</td>
<td>19.76%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Need to increase remuneration</td>
<td>13.17%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dissatisfied with remuneration</td>
<td>11.97%</td>
<td>03.28%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Remuneration in all forms</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>161</td>
</tr>
</tbody>
</table>

\(^a\) N/A is used when the specified sub-theme was not mentioned in the data.

The importance of all forms of remuneration was a consistent theme throughout the open-ended survey questions. For example, the second most listed response regarding the best aspect of working for this organisation was being paid a wage and the availability of other good financial benefits. Financial benefits included superannuation, leave allowances, salary sacrifice, and the security of these benefits. For example, one nurse commented that the best aspect of working for the organisation was:

The security of benefits such as salary sacrifice and superannuation
(Registered Nurse, female).
However, many nurses also suggested that they were dissatisfied with the remuneration provided and felt that their pay rate was too low. When asked about the worst aspect of working for the organisation, many nurses responded simply with the words “pay” or “poor pay”. Due to the dissatisfaction with pay rates, several nurses indicated that the organisation would need to increase rates of pay in order for nurses to remain committed to the organisation.

Overall, the open-ended survey responses suggested that some nurses were satisfied with the remuneration available to them. However, a number of nurses were also dissatisfied with their remuneration and required pay increases in order for them to remain committed to the organisation.

Analysis of focus group comments identified a minority of participants who indicated that being paid less than they desired did affect their perceptions of empowerment. Alternatively, analysis of interview comments showed no references to the relationship between remuneration and nurses’ perceptions of empowerment. Together, the focus group and interview results suggested that remuneration was not likely to affect nurses’ perceptions of empowerment.

Manifest and latent content analysis of documents suggested that remuneration was not mentioned at all in the mission statement and mentioned very little in the code of conduct document. Most of the references to remuneration in the code of conduct referred to the inappropriate behaviour of accepting gifts of money. However, it was mentioned a number of times on the organisation’s website and was most likely due to the nature of the website for recruiting new nurses and the need to specify the financial benefits that working for the organisation would encompass. Instead, the documents merely proceeded to outline the various forms of remuneration that nurses would be entitled to including salary and wages, benefits such as superannuation, and incentives for study and relocation. These analyses suggested that remuneration was used as a tool to encourage recruitment to the organisation and as an incentive for particular behaviours, but was not considered a value of the organisation in any way.
Overall, analysis of the qualitative data relating to this theme suggested that remuneration was important to nurses and their commitment to the organisation. Therefore, the following key finding emerged:

**Key Finding 22:** Nurses required increased remuneration in order for them to remain committed to the organisation.

### 6.4.10 Dominant theme 10: Autonomy is necessary to feel empowered

Another theme to arise from the data was the importance nurses placed on levels of autonomy in affecting perceptions of empowerment. Although the open-ended survey responses did not provide any data regarding this theme, the focus groups and interviews were more valuable sources of data. Details regarding this theme can be seen in Table 6.14.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>00.60%</td>
<td>11.48%</td>
<td>05.88%</td>
<td>17</td>
</tr>
</tbody>
</table>

Open-ended survey question responses showed almost negligible data regarding perceptions of empowerment or levels of autonomy experienced by nurses. Only one respondent indicated that the desire for nursing to be officially recognised as a profession affected their level of commitment. It could, however, be argued that a number of the previous themes mentioned in this chapter such as the shortage of nurses and resources, and a lack of respect and support for the nursing role, may also have affected levels of autonomy and perceptions of empowerment even though they were not explicitly described as affecting these outcomes. Altogether though, this lack of data from the open-ended survey questions
suggested that autonomy and perceptions of empowerment did not impact upon nurses’ commitment to the organisation.

The focus groups and interviews were specifically used to examine the factors that affected nurses’ perceptions of empowerment and contained richer data than the open-ended survey questions. Analysis of the focus group transcripts suggested that levels of autonomy did impact upon nurses’ perceptions of empowerment. Most of these participants stated that the ability to work autonomously was necessary for them to feel empowered. These comments referred to the ability to work independently, and for the organisation or supervisors to trust that the employees made the appropriate decisions and completed their work. Furthermore, a minority of participants clearly stated that they did not receive much autonomy and that the organisation had decreased the employees’ belief in their ability to undertake their work well. Alternatively, analysis of the interview responses identified only one participant who felt that the constant need to check their work with someone else affected their perception of autonomy. Therefore, the responses to the focus groups and interviews which directly examined perceptions of empowerment, suggested that levels of autonomy did impact upon nurses’ perceptions of empowerment.

Manifest content analysis of organisational documents identified no text in relation to autonomy or empowerment in the mission statement or code of conduct documents. Autonomy was mentioned a small number of times on the organisational website, but these merely stated the increased autonomy that accompanied select nursing job roles and did not elaborate further. In addition, the latent content analysis provided no additional insights into the instances of autonomy mentioned on the organisational website. However, the mission statement did refer to a desire to “improve workforce capacity” which was rather ambiguous, but may encompass greater autonomy of staff. Although this may be implied, it cannot be relied upon and is therefore not considered as a credible interpretation of the data. Therefore, analysis of the organisational documents suggested that autonomy may be granted to a few select nursing job roles, but not
across the board. Furthermore, autonomy and empowerment are not identified as a value of the organisation or considered an important factor.

Overall, analysis of the qualitative data suggested that it was important to consider levels of autonomy when seeking to understand perceptions of empowerment. However, no relationships were identified between autonomy and perceptions of empowerment, and commitment to the organisation. Therefore, the following key finding is provided:

*Key Finding 23:* Levels of autonomy experienced by nurses adversely affected their perceptions of empowerment.

### 6.4.11 Dominant theme 11: Nursing is fulfilling work

The final theme that emerged from the qualitative data was how fulfilling nursing work was for nurses. Nurses suggested that they gained significant enjoyment, stimulation and meaning from caring for patients and using their nursing skills to improve patients’ quality of life. Details regarding this theme are shown in Table 6.15.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Open-ended survey questions</th>
<th>Focus groups</th>
<th>Interviews</th>
<th>Document analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoy working as a nurse</td>
<td>16.77%</td>
<td>N/A</td>
<td>N/A</td>
<td>40</td>
</tr>
</tbody>
</table>

*a N/A is used when the specified sub-theme was not mentioned in the data.

In the open-ended survey questions, working as a nurse and the duties that this involved, was the third most frequently listed best aspect of working for the organisation. Many nurses indicated that they enjoyed using their nursing skills and
making a difference to their patients’ health. For example, one nurse suggested that she enjoyed:

*Using my skills to make a difference to a patient’s journey* (Clinical Nurse, female).

Other respondents indicated that their work provided them with variety, stimulation, experience with complex cases, and general satisfaction and enjoyment such as the following nurse who stated that she valued:

*The vast amount of experience to be gained from very diverse cases, both physically, socially and emotionally. To be able to care for people in a time of need who do not always have a great amount of money to get private health care* (Registered Nurse, female).

Overall, the survey responses suggested that respondents gained a high amount of fulfillment from their work as a nurse due to the caring involved, and variety and challenge of the diverse duties required.

Analysis of focus group and interview responses showed no references to the fulfillment of nursing work. This suggested that nurses’ enjoyment and fulfillment in their role does not affect their perception of empowerment, in large part because this theme relates to the “meaning” dimension of empowerment, and these two methods were seeking data regarding the factors that affected this.

Manifest content analysis of organisational documents showed minimal frequencies regarding this theme with most referring to the variety in duties, roles, and locations offered by the organisation. However, the latent content analysis suggested that the career of nursing was a strong driver of recruitment for this organisation. For example, the recruitment website featured several nursing profiles describing what it was like to work within the area of nursing by depicting a “real nurse” working within the organisation. These were all positive and highlighted the
challenging and fulfilling career of nursing. Therefore, the organisational documents suggested that the organisation has a good understanding of the duties required of a nurse and the importance that this has to both nurse employees and society in general. It also suggested that nurses working within the organisation found their work to be very fulfilling.

Overall, the qualitative data suggested that nurses gained a lot of value from working as a nurse due to the activities involved and the opportunity to improve their patient’s experience. However, there was insufficient data to support a causal relationship between fulfillment and commitment to the organisation. Therefore, this theme led to the following key finding:

*Key Finding 24: Nurses gained high levels of fulfillment from their work.*

### 6.5 Research Question 4

This research question sought to examine the differences between organisational policy and organisational practice so as to identify gaps and therefore areas for improvement. Organisational policy was determined by examining organisational documents and organisational practices were determined by examining nurses’ perceptions of what occurred in their work environment by examining the data from the surveys, focus groups and interviews. Differences between organisational policy and organisational practice were examined across each of the variables examined in this research per RQ₄.

RQ₄  What differences exist between organisational policy and organisational practice regarding variables that display qualities of relational, cognitive and structural social capital, and work outcomes such as role ambiguity, perceived empowerment, and affective commitment of nurses?

Comparative analysis of organisational documents with hypothesis results, dominant themes and key findings suggested several differences between stated
organisational policy and organisational practice. These included (1) NUMs were too busy to provide support to their nursing staff, (2) decreased patient care from inadequate resources, facilities and nursing staff, (3) policies and procedures had a negative effect on work duties, and (4) there was a lack of value, respect, and support towards nurses as compared to the organisation’s espoused values.

The first major difference identified was the impact of nursing shortages on the relationship between nurses and their NUMs that was evidenced by data which suggested that NUMs within this organisation were too busy to provide the support to their nurses that organisational policy suggested they provide. For instance, organisational policy from the code of conduct document stated that managers such as NUMs were to be readily available to nurses to provide information, resources and assistance when necessary. Furthermore, the same document stated that the organisation aimed to achieve a culture of open and transparent communication and that part of this culture included an open door policy. However, Key Findings 1, 3 and 7 suggested that NUMs were not always readily available to nurses because they were too busy attending to their own duties, which was a result of the high workload that NUMs also experienced. Therefore, nurses were not able to approach their NUMs to obtain the necessary information, resources, or assistance that may be required in their role. Therefore, the frequency and quality of exchanges between supervisors and employees was not as optimal as it could have been. Subsequently, nurses frequently and equally (see Table 5.21 in Chapter 5) turned to Clinical Nurses for assistance. A disadvantage of this outcome was that Clinical Nurses may not have possessed the required information or authority to effectively assist the nurse. In addition, the NUMs may never have become aware of the problem occurring in the first place and the opportunity to put an action in place to reduce further recurrences of the problem was reduced. Furthermore, this was likely to have increased nurses’ levels of role ambiguity and affected the ability of nurses to effectively solve work-related problems. Subsequently, it may have also affected nurses’ perceptions of empowerment by impacting upon their belief in their own ability to successfully undertake their work.
This first major difference is an example of how variables that represent relational and cognitive social capital such as supervisor-employee exchanges (LMX), communication processes and organisational culture adversely affected the structural dimension of social capital as measured through problem-solving social networks. Furthermore, these social capital variables were likely to have adversely affected nurses’ level of ambiguity and perceptions of empowerment. Therefore, the first major difference between policy and practice was the fact that nurses may not have been receiving the information and assistance required for them to competently perform their work because of high workloads preventing NUMs from being more available to their nursing staff. Based on this, the following key findings emerged:

**Key Finding 25:** There is a gap between the supervisor-employee relationship espoused by organisational policy, and the actual relationship that nurses reported.

**Key Finding 26:** NUMs were too busy with high workloads to be able to effectively support their nursing staff.

**Key Finding 27:** The high workloads of NUMs adversely affected communication processes and problem-solving from taking place effectively.

The second major difference identified between organisational policy and organisational practice was the reduced ability of nurses to provide quality care to patients and competently perform their work due to inadequate resources, facilities and nursing staff levels. For example, organisational policy dictated that the organisation, including its nursing staff, aimed to provide a quality health service to the members of its district including delivering appropriate services within an appropriate time. Furthermore, the documents stated that the organisation valued caring for people and finding innovative, effective and efficient ways in which to achieve this. However, consistent themes throughout the qualitative data
(Dominant theme 3 and Key Findings 7 and 8) indicated that nurses did not receive adequate resources or have access to appropriate facilities to perform their work or provide quality care to patients. Furthermore, nurses indicated that their ability to provide this level of care was greatly reduced by their high workloads as a result of inadequate staffing levels to accommodate the increased population covered by the hospital district (Dominant theme 4). Also, nurses were obligated to follow all procedures thereby reducing opportunities for innovation, effectiveness or efficiency. Therefore, nurses were unable to provide the required level of health service as defined by policy, because they were not provided with the appropriate tools to do so which led to the following key finding:

**Key Finding 28:** There is a gap between the value of providing quality patient care as espoused by organisational policy, and the reality of decreased patient care due to resource, facility and staffing shortages.

The third difference between organisational policy and organisational practice was the negative impact that hospital policies had on nursing practices despite the aim of policies and procedures being to positively improve practices and outcomes. It is widely acknowledged that the goal of organisational policies and procedures for any organisation is to improve processes and one consequence of this is expected to be reduced ambiguity surrounding tasks and situations. For instance, multiple times throughout the documents, employees were instructed to seek further information from their manager if they were unsure of something or simply required further information. Therefore, policies and procedures are designed to be a positive tool to help staff in their daily work. However, Dominant theme 5 and Key Findings 12, 13 and 14 suggested that policies and procedures had actually decreased the efficiency of processes, and were viewed by nurses as one of the worst aspects of working for this organisation. These findings suggested that policy had negatively impacted upon the nurses’ work environment and processes, and were creating outcomes that were contrary to the purpose of the policies’ existence. Therefore, there is a gap between the intended positive outcomes of policies and
procedures being put into place, and the negative attitudes towards these by nurses due to the negative impact upon the work environment, the duties undertaken by nurses, and the outcomes from these. Consequently, the following key finding emerged from this data:

**Key Finding 29:** There is a gap between the intended positive benefits to be obtained from the existence of policies and procedures, and the actual benefits obtained by nurses in their daily work.

The fourth difference between organisational policy and organisational practice was the discrepancy between the high value placed on nurses as espoused by policy and the lack of value, respect and support experienced by nurses. Organisational documentation indicated that nurses were highly valued employees and were provided with a variety of support mechanisms as part of their employment with the organisation. For example, the mission statement outlined that staff were an organisation’s most important asset. This implied that nurses and the work that they do are supported and valued. However, Dominant theme 1 and Key Findings 1 and 2 explicitly outlined that nurses did not feel that they were valued, appreciated, listened to, or even acknowledged. Furthermore, this was shown to have affected nurses’ perceptions of empowerment. These feelings may also be supported and reinforced by other key findings (see 2 and 4) which further suggested that nurses were not being provided with the necessary tools in order to undertake their work. Therefore, there was a difference between organisational policy regarding the value and importance of nurses, and organisational practice which identified that nurses did not feel valued by the organisation. This leads to the following key finding:

**Key Finding 30:** There is a gap between the espoused values about nursing staff, and the practice of a lack of respect and support towards nurses.
Overall, a number of differences were identified between organisational policy and organisational practice. This section has detailed differences in the form of a lack of resources and staffing, and therefore support, which have led to decreased supervisor-employee relationships and the quality of care for patients. Furthermore, gaps have been identified in the delivery of positive attitudes towards nurses espoused in the documents such as respect, and the nurses’ reported reality of lack of respect. Also, there was another gap between policy and practice with respect to some negative implications perceived by nurses of stringent policies and procedures.

6.6 Summary of key findings

The key findings from the qualitative data suggested that a number of positive and negative factors influenced nurses on a daily basis, some of which may have impacted upon nurses’ commitment to the organisation. A summary of the key findings of the analysis of all the qualitative data is provided in Table 6.16. Overall, the qualitative data identified a larger number of negative factors than positive factors affecting commitment. For instance, the data suggested that a number of factors had adversely affected the ability of nurses to competently and efficiently perform their work including a lack of resources and facilities (KF7), a shortage of nursing staff (KF9), strict organisational policies and procedures (KF12), and poor communication processes (KF19).

Commitment to the organisation was shown to have been adversely affected by a lack of respect and support for the nursing role (KF2), a lack of resources and facilities (KF8) and poor levels of nursing staff (KF11). In addition, commitment was also adversely affected by the poor relationship that some nurses possessed with their NUMs and upper levels of management (KF6), poor communication processes (KF21), and the desire for increased remuneration (KF22). However, no data was found which suggested a positive relationship between the examined factors and commitment to the organisation.
Perceptions of empowerment were also adversely affected by similar factors. For instance, empowerment was adversely affected by a lack of respect and support for the nursing role (KF1), a shortage of nursing staff (KF10), and poor relationships that some nurses possessed with their NUMs and upper levels of management (KF5). In addition, perceptions of empowerment were also adversely affected by organisational policies and procedures (KF14), levels of autonomy (KF23), and negative cultural attributes (KF16). However, strong relationships with colleagues and the resulting teamwork were shown to have positively affected nurses’ perceptions of empowerment (KF18).

Table 6.16  Summary of key findings

<table>
<thead>
<tr>
<th>No.</th>
<th>Key Findings</th>
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<tbody>
<tr>
<td>KF1</td>
<td>A lack of respect and support decreased nurses’ perceptions of empowerment.</td>
</tr>
<tr>
<td>KF2</td>
<td>A lack of respect and support decreased nurses’ commitment to the organisation.</td>
</tr>
<tr>
<td>KF3</td>
<td>The relationships that nurses possessed with their NUMs and upper levels of management were not optimal and may have adversely affected exchanges between supervisors and employees.</td>
</tr>
<tr>
<td>KF4</td>
<td>Poor relationships between supervisors and employees adversely affected employees’ ability to solve work-related problems.</td>
</tr>
<tr>
<td>KF5</td>
<td>Poor relationships between supervisors, employees and upper levels of management adversely affected nurses’ perceptions of empowerment.</td>
</tr>
<tr>
<td>KF6</td>
<td>Poor relationships between supervisors, employees and upper levels of management may have adversely affected nurses’ commitment to the organisation.</td>
</tr>
<tr>
<td>KF7</td>
<td>A lack of resources and facilities adversely affected the ability of nurses to competently perform their work.</td>
</tr>
<tr>
<td>KF8</td>
<td>A lack of resources and facilities may have affected nurses’ commitment to the organisation.</td>
</tr>
<tr>
<td>KF9</td>
<td>A shortage of nurses and the resulting high workloads adversely affected the ability of nurses to competently perform their work.</td>
</tr>
<tr>
<td>KF10</td>
<td>A shortage of nurses and the resulting high workloads may have adversely affected nurses’ perceptions of empowerment.</td>
</tr>
<tr>
<td>KF11</td>
<td>A shortage of nurses and the resulting high workloads may have adversely affected nurses’ commitment to the organisation.</td>
</tr>
<tr>
<td>KF12</td>
<td>Organisational policies and procedures adversely affected nurses’ ability to perform their work efficiently.</td>
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<tr>
<td>No.</td>
<td>Key Findings</td>
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<tr>
<td>KF13</td>
<td>Organisational policies and procedures may have increased nurses’ levels of role ambiguity.</td>
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<tr>
<td>KF14</td>
<td>Organisational policies and procedures adversely affected nurses’ perceptions of empowerment.</td>
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<tr>
<td>KF15</td>
<td>The organisation was viewed by nurses as an attractive place to work.</td>
</tr>
<tr>
<td>KF16</td>
<td>Negative cultural attributes adversely affected nurses’ perceptions of empowerment.</td>
</tr>
<tr>
<td>KF17</td>
<td>Strong relationships amongst colleagues, and resulting teamwork, was important to nurses.</td>
</tr>
<tr>
<td>KF18</td>
<td>Strong relationships amongst colleagues, and resulting teamwork, positively affected perceptions of empowerment amongst nurses.</td>
</tr>
<tr>
<td>KF19</td>
<td>Poor communication processes adversely affected nurses’ ability to perform their work effectively.</td>
</tr>
<tr>
<td>KF20</td>
<td>Poor communication processes may have adversely affected nurses’ levels of role ambiguity due to insufficient or incomplete information by which to perform their role.</td>
</tr>
<tr>
<td>KF21</td>
<td>Poor communication processes may have adversely affected nurses’ commitment to the organisation.</td>
</tr>
<tr>
<td>KF22</td>
<td>Nurses required increased remuneration in order for them to remain committed to the organisation.</td>
</tr>
<tr>
<td>KF23</td>
<td>Levels of autonomy experienced by nurses adversely affected their perceptions of empowerment.</td>
</tr>
<tr>
<td>KF24</td>
<td>Nurses gained high levels of fulfillment from their work.</td>
</tr>
<tr>
<td>KF25</td>
<td>There is a gap between the supervisor-employee relationship espoused by organisational policy, and the actual relationship that nurses reported.</td>
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<tr>
<td>KF26</td>
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</tr>
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</tr>
<tr>
<td>KF30</td>
<td>There is a gap between the espoused values about nursing staff, and the practice of a lack of respect and support towards nurses.</td>
</tr>
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6.7 Conclusion

This chapter presented and summarised the qualitative data obtained from the open-ended survey questions, focus groups, interviews, and document analyses. A total of 11 dominant themes and 30 key findings were developed from the analysis, including the results from Research Question 4. The data identified a number of key issues that nurses experienced, in particular, poor relationships between nurses and their NUMs, and upper levels of management. In addition, a number of issues were identified as having adversely affected the work processes of nurses, which led to adverse effects upon a variety of individual outcomes including role ambiguity, perceptions of empowerment, and affective commitment to the organisation.

The next chapter summarises and discusses the combined findings from the quantitative and qualitative data of this research. The findings are then compared and contrasted with previous research identified in the literature in order to add insight into the role that social capital factors play in nurses’ commitment to the organisation.
CHAPTER 7 – DISCUSSION

7.1 Introduction

This research has explored the relationships of nurses within a hospital environment and how these impacted upon nurses’ commitment to their organisation. The quantitative and qualitative data gathered in this research identified a number of significant findings that were both expected and unexpected. This chapter interprets the data presented in Chapters 5 and 6 and discusses the significance of these findings and how they add insight into the role that workplace relationships play in nurses’ organisational commitment.

This chapter begins by providing a diagrammatic representation of the major themes identified from the combined quantitative and qualitative findings. The remainder of the chapter is then structured in accordance with the sections from this figure. The relationships that nurses held with their supervisor, upper levels of management and colleagues, and the how these were structured are discussed first. Following this, the surrounding environment in which these relationships are situated is then explored through the support provided by the organisation itself, the respect and support provided by others within the organisation, and the culture or context of the organisation. Next, the role that relationships and support play in individual outcomes such as the effectiveness of problem-solving processes, the degree of role ambiguity present, the extent to which nurses feel empowered in their work, and the resulting effect that these have on the job performance of nurses is then explored. Then, the role that each of these issues has on the commitment of nurses to their organisation is examined. Finally, the four major areas of difference between organisational policy and organisational practice are discussed.

7.2 Major themes identified
Figure 7.1 illustrates the major themes that emerged from both the quantitative and qualitative data. The quantitative and qualitative data were classified into four major themes of relationships (MT1), support (MT2), work-related outcomes (MT3) and organisational commitment (MT4). Organisational relationships and support mechanisms are mutually dependent and work together to create outcomes. Of interest in this research are individual nurse outcomes, and ultimately, the impact of these on the commitment of nurses to their organisation. Each of these themes and the associated sub-themes is now discussed.

7.3 **Major theme 1: Relationships**

The results of this research identified that the relationships between nurses and other individuals were strongly associated with several individual outcomes. These results were expected as the importance of organisational relationships had previously been consistently established in the literature. Subsequently, the quality of relationships held by nurses and the resulting benefits and impact of these reflect Social Capital Theory. What was unexpected in this research though, was the parties that nurses identified as being of importance. For instance, this research identified and directly examined indicators such as the quality of exchanges and quality of communication processes between nurses and their supervisors, as an indicator of the quality of the relationship held between nurses and their NUMs. This was the first major finding with regards to relationships held by nurses and it both supports existing literature and is an expected result. However, findings that were not directly examined or expected in this research were the importance of relationships with upper levels of management and with colleagues. Subsequently, Major Theme 1 consists of relationships with supervisors (MT1.1), relationships with upper management (MT1.2) and relationships with colleagues (MT1.3). Overall, this research has extended the framework proposed by Nahapiet and Ghoshal (1998) by examining all three dimensions of social capital using multiple variables. The significance of these results is discussed in the following sections.
**Figure 7.1** Major themes identified from quantitative and qualitative findings
7.3.1 Major theme 1.1: Relationships with supervisors

The first relationship sub-theme identified in the data was the quality of the relationships between nurses and their supervisor or NUMs. The hypotheses and key findings associated with this theme are shown in Figure 7.2. A significant body of literature exists regarding the importance of a high quality relationship between employees and their supervisor and it is considered to be one of the most influential organisational relationships that an employee possesses. Subsequently, measuring and further understanding of the quality of the relationship between nurses and their NUMs was of interest to this research. This was achieved by examining the quality of exchanges and the quality of communication processes between these two parties, and is discussed here.

![Relationships](image)

**Figure 7.2** Major theme 1.1: Relationships with supervisors

The quantitative data identified that nurses perceived the quality of exchanges taking place between them and their NUMs to be satisfactory and that most possessed a good working relationship with their NUMs. However, the fact that nurses considered their exchanges to be satisfactory as opposed to good or excellent, suggested that some problems may be present that are worthy of further investigation.
One finding that may assist in understanding why the quality of exchanges was not higher was the dominant theme identified in the qualitative results of the poor working relationship between nurses and their NUMs, which contrasted with the quantitative findings. That qualitative theme largely referred to poor exchanges with NUMs during problem-solving processes, although these findings may be indicative of a larger problem within the supervisor-employee relationship. For instance, nurses indicated that their NUM was not available to assist them in problem-solving for a portion of the time and those nurses subsequently turned to other sources for assistance. However, the literature states that high quality supervisor-employee exchanges and the accompanying communication processes are beneficial to effective problem-solving (Ibarra & Andrews, 1993; Kim, 2002). Only a small percentage of the sample approached their NUMs regardless of how busy they were or who else was available. Furthermore, the low response rate to the question that is represented in this qualitative sub-theme means that a poor relationship with NUMs may not be representative of the whole nursing population that responded to the surveys. Perhaps the 52.09% of nurses who did not respond to that question did in fact approach their NUMs for assistance, and may have a positive relationship with their NUM. Maybe some nurses possessed such a good relationship with their NUMs that the NUMs made time to assist these nurses regardless of other competing priorities. Furthermore, it could be argued that those nurses were members of the in-group and received greater assistance with problem-solving due to their membership. If this was the case, further investigation is warranted to explore if this is so and examine why NUMs were more available to this group. Alternatively, perhaps this small percentage of nurses followed organisational policy and procedures strictly, which referred to the NUMs as the first point of contact for assistance in many workplace situations. If this was the case, it would imply that organisational policy was being successfully implemented and organisational practice was representative of that. However, the reasons why some nurses always approached their NUMs for assistance in problem-solving was unclear from the data obtained in this research.
Alternatively, some nurses indicated that they simply possessed a poor working relationship with their NUMs for a variety of reasons; further analysis of which was beyond the scope of this research. Perhaps these responses to the role of NUMs in nurses’ problem-solving may also apply to a number of other workplace practices and may be an indicator of why the quality of exchanges was reported by nurses to be satisfactory as opposed to good or excellent. This implied that more attention to improving the quality of the supervisor-employee relationship may also flow on to benefit the efficiency and effectiveness of problem-solving processes as well as other practices within the organisation. One example is the documented increases in perceived empowerment and job satisfaction that result from a high quality supervisor-employee relationship (Laschinger et al., 2007).

The most important implication of the poor quality of the supervisor-employee relationship is the impact that this has on nurses’ commitment to the organisation. A significant amount of research has identified that the quality of supervisor-employee exchanges is strongly associated with intentions to leave (Gerstner & Day, 1997; Graen, Liden & Hoel, 1982; Morrow et al., 2005) and is considered to be one of the factors most likely to improve commitment and retention levels (Cohen, 2006; Taunton et al., 1997). Therefore, the poor quality relationships that nurses have with their NUMs are not likely to be positively influencing their affective commitment to the organisation (Brunetto et al., 2010), and greater attention needs to be placed on these relationships if nurses are to remain with the organisation.

Another finding that may also help to explain the less than optimal quality of supervisor-employee exchanges was the perceived poor communication processes between nurses and their NUMs. Ultimately, managers or NUMs hold a lot of responsibility in ensuring that staff on his/her ward are fully informed in order for nursing staff to be able to carry out their work appropriately. However, many organisational directives are communicated to NUMs by upper management. Therefore, poor communication processes are the responsibility of both NUMs and upper management. This theme identified that nurses believed that they received
inadequate feedback and consultation within the organisation and did not feel that they were being listened to, which suggested that the frequency of exchanges needs to be increased, as well as attention given to the content of the exchanges. However, the shortage of nurses available and the increased workload for both nurses and their NUMs, also evidenced in the qualitative data, were likely to have hindered the frequency and quality of exchanges. Furthermore, these complications were likely to increase the use of more time efficient modes of communication and exchanges such as written memos or passing information from one nurse to another. Although the use of methods such as these is still helpful, they may not be as effective in improving the quantity and quality of exchanges and communication processes.

The mode of communication between nurses and their NUMs was suggested to be largely informal. This meant that communications were predominantly face-to-face as opposed to written communications. One positive conclusion of the high incidence of informal communications is the opportunities available for improving the quality of exchanges, and therefore the relationship between nurses and their NUMs. This is because informal methods of communication increase the interpersonal interactions that are taking place, and contribute to the social atmosphere of the workplace. A high use of informal communications also suggested that nurses were more likely to be satisfied with their communication processes because, according to the literature (Burns & Stalker, 1961; Johlke et al., 2000), informal methods are the preferred method. The prevalence of this method of communication is likely to be a result of the nursing role within the hospital environment in which quick responses and actions are central (Burns & Stalker, 1961; Johlke et al., 2000).

The literature states that another positive outcome from a high incidence of informal communications is that employees were more likely to receive adequate levels of feedback and consultation (Kraut et al., 1990; Tushman & Nadler, 1978). However, this was not supported by the qualitative data which identified that nurses were unhappy with their current levels of feedback and consultation. The
quantitative data similarly indicated that the flow of information within the organisation was poor and that nurses felt that they did not receive adequate information regarding their work environment and their work role. Subsequently, nurses may have been missing out on a variety of information including instructions, opportunities and choices that may have enabled them to perform their work more effectively, as suggested by Lin (2004). Importantly, it is the responsibility of the NUM to ensure that the staff within their ward are fully informed and updated on matters affecting their work role and this research suggests that this may not have been occurring within the wards examined in this research. Therefore, it can be concluded that communication across the organisation may not have been flowing freely and nurses were frequently working in ambiguous contexts.

The importance of effective communication is reflected in the literature which stated that the need for the free flow of information and knowledge is critical in facilitating intellectual capital (Leana & Van Buren, 1999; Nahapiet & Ghoshal, 1998) and the ability to solve problems effectively. A poor flow of communication also inhibits a culture of unity and trust amongst members (Fairholm & Card, 2009) which is essential in developing and improving upon professional relationships. Therefore, some of the reasons why nurses indicated that their working relationship with the NUM was poor, and why the quality of exchanges was not as optimal as it could have been, may have been because nurses did not trust their NUMs. Perhaps some of the nurses felt that their NUMs hides or neglects to pass on information. This certainly was a theme that arose from the qualitative data with regards to the poor working relationship and communication processes with upper levels of management. The busy and chaotic environment that hospitals typically entail, and the reduced time available for lengthy and frequent communications may be another reason for the perceived poor flow of communication and subsequent lack of feedback and consultation by both their NUMs and upper levels of management. In addition, the suggested shortage of nurses and resources, and high workloads may also account for why nurses did not feel adequately informed by their NUMs.
Alternatively, another factor which might explain why nurses did not feel adequately informed and consulted may have been the lack of frequency of communications taking place. The frequency of communications was stated by nurses as satisfactory, but neither good nor excellent, and the respondents suggested that more frequent communication was needed in the organisation. This finding supports existing research (Brunetto & Farr-Wharton, 2008). Consequently, the NUMs within this organisation were losing valuable opportunities to influence their nurses by not communicating more often with them, as found in Johlke and Duhan (2000). Previously mentioned factors imposed on NUMs, such as high workloads and frequent meeting attendance, are the most likely explanation for this. Furthermore, nurses are missing out on valuable information and opportunities to build a better relationship with their supervisor. The literature states that trust is moderated by decreased frequencies of communication (Becerra & Gupta, 2003; Whitener et al., 1998). Therefore, why NUMs and upper levels of management have not taken greater advantage of increasing the frequency of communications is unclear, particularly due to the previously documented link between the frequency of communication with job satisfaction, job performance and problem-solving (Fussell et al., 2006; Johlke et al., 2000). Having said that, organisational policy did espouse and encourage the value of frequent communications between supervisors and employees. However, the demands placed upon both NUMs and nurses, through workloads and such, reportedly reduced the opportunities to increase communications. It is through these contradictory actions that gaps emerge between organisational policy and practice.

Findings regarding the direction of supervisor-employee communications were slightly contrary to the findings regarding the poor flow of information, which were examined as part of organisational culture. For instance, the two-way flow of communication between nurses and their NUMs was identified to be satisfactory whereas the flow of information was unsatisfactory. This leads to the conclusion that perhaps the poor flow of information was related more to information that is communicated by non-supervisory sources, such as upper levels of management. Although the two-way flow was satisfactory, there is substantial room for
improvement and some communications were clearly still flowing from only one direction, which is most likely to be downwards from supervisors to employees, with little input from nursing staff. This suggested that out-dated hierarchical methods of governance and communication were perhaps still prevalent in the hospital environment. This suggestion may contribute to the reason why nurses did not feel that they were consulted and listened to within the organisation. Furthermore, if nurses were only receiving the minimum of two-way communications, and felt that they were not being heard by their NUMs or upper levels of management, their role ambiguity was also likely to have increased (Johlke et al., 2000).

These findings were reiterated in response to the content of communications which suggested that NUMs engaged in discussion with their nurses and sought their opinions and feedback on topics only some of the time. This implied that the remainder of communications consisted of NUMs instructing nurses on how to undertake a procedure. Nurses clearly were not able to provide input and have a say in what occurred in the ward if the majority of supervisor-employee communications were instructive and discouraged dialogue with their staff. Therefore, nurses may have been receiving too many instructions and not enough information from which to make their own decisions (Frazier & Summers, 1984; Mohr et al., 1996). As a result of this, nurses indicated that they did not always understand how their work fitted within the larger scheme of things. These types of top-down communications may not have supported nurses to become empowered in their work or encourage nurse autonomy. Furthermore, the lack of dialogue with nurses may very likely have been increasing the amount of ambiguity they experienced around their role.

Overall, the communication processes between nurses and their NUMs were largely satisfactory, but could benefit greatly from increased attention. Improving the quality of communications is likely to improve the quality of exchanges between these parties, and to increase nurses’ commitment to the organisation as evidenced in research on nurses working within rural Australia (Hegney et al., 2002). Together, these create a stronger and more positive working relationship and increase the
social capital, and therefore support, that nurses possess within the workplace (Evans & Carson, 2005; Nahapiet & Ghoshal, 1998).

7.3.2 Major theme 1.2: Relationships with upper management

The second relationship sub-theme identified in the data was the quality of the relationships between nurses and the upper levels of organisational management. The key findings associated with this theme are shown in Figure 7.3. The qualitative data identified that nurses were very dissatisfied with upper management of the organisation, which was unexpected as it was not directly examined within this research, and hence quantitative data was not collected on this topic. Furthermore, it was also surprising to see the frequency with which upper management appeared in a negative way in relation to several variables that were examined within this research. However, despite this finding being unexpected, previous research has suggested that it is common for nurses to be dissatisfied with organisational upper management (Ishida, 2000; Jaafarpour & Dyrekvandmogadam, 2008; Pellico et al., 2009).

Figure 7.3 Major theme 1.2: Relationships with upper management

Nurses indicated that the relationship between them and upper management was less than optimal largely because of the lack of a relationship between them. The consequences of this lack of a relationship meant that nurses perceived that upper management had little understanding of what nurses were going through on a
daily basis and the issues affecting them, supporting earlier research by Krichbaum et al. (2007). One reason for this may have been because upper management did not frequently visit the wards and nursing staff. Typically, communications flow through NUMs due to the large number of staff working within each ward, which can tend to lead to a lack of consultation with nursing staff. Alternatively, organisational events such as hospital-wide gatherings at which upper management are present, may not be attended by nursing staff due to conflicting times, which are compounded by the high workloads of nurses and shift work and part-time work, which prohibits many from participating in activities outside of their primary role to care for patients.

Due to the above mentioned reasons and situations, nurses also indicated that they felt that upper management did not treat them appropriately as characterised by a lack of respect, support, recognition, and value. In addition, nurses felt that they were treated impersonally and as “just a number”, and that they were not recognised at all. This is not surprising considering the large number of nursing staff that work within each hospital, thereby making it difficult for nurses to be individually recognised. Furthermore, upper management were perceived as unapproachable and disinterested in nursing staff, which compounded nurses’ perceptions even more. Nurses did not feel that upper management supported them, which ultimately affected their perceptions of empowerment in their work. These responses were similar to previous research which found that nurses felt as if management did not respect, value or listen to them (Jaafarpour & Dyrekvandmogadam, 2008).

The importance of the relationship between nurses and upper management was evidenced when nurses indicated that changes in behaviour by upper management were necessary for them to remain committed to the organisation. For instance, many nurses referred to the need for increased collaboration between management and nurses, and support and recognition. This supported previous research by Ishida (2000), which found that the need for management to improve their behaviour was more important to nurses than an increase in pay levels.
A further consequence of these nurses’ perceptions is that upper management may become an elusive group to which nurses feel that they are not privy. Subsequently, upper management were most likely not a source of support for nurses in their daily work. Analysis of the relationship between nurses and their NUMs suggested that nurses may not have been receiving sufficient support from their NUMs. Therefore, nurses were left with minimal authoritative figures from whom to seek support or assistance and must seek support elsewhere. One of the ways in which nurses did seek support, namely through colleagues, is discussed next.

7.3.3 Major theme 1.3: Relationships with colleagues

The third relationship sub-theme identified in the data was the quality of the relationships between nurses and their colleagues and the high levels of importance and value which nurses placed on colleagues. The key findings associated with this theme are shown in Figure 7.4. Both the quantitative and qualitative data suggested that nurses held positive and strong relationships with their colleagues, which supports previous literature (Tsai & Huang, 2008). The first way that this was evidenced was through the positive level of teamwork present in the data. This was not surprising in itself except that the level of teamwork present was the highest scoring section within the measure of organisational culture. From this, it can be assumed that the ability to work more effectively with fellow colleagues played a large role in the social atmosphere or context within the organisation or ward. Subsequently, nurses receive additional social support during their work (Joiner & Bartram, 2004). In the qualitative data, the terms “teamwork” and “strong relationships with colleagues” were used interchangeably by the nurse respondents, which indicated that nurses viewed these two terms similarly. Both the quantitative and qualitative data suggested that relationships with colleagues and levels of teamwork were important with teamwork scoring “satisfactory” in the quantitative data.
The unexpected part of this finding was its constant appearance across the data. For instance, many nurses identified that relationships with colleagues was one of the best aspects of working for the organisation. This finding suggested that these relationships may have positively impacted upon nurses’ commitment to the organisation, although further research is needed to examine this potential relationship. However, the literature does suggest that collegial support encourages nurses to remain at their work (Dickerson et al., 2007). Altogether, it appears that nurses valued and enjoyed the relationships that they possessed with their colleagues and this may have been an additional source of support for them. However, it was not surprising that nurses did value their relationships with colleagues considering the environment in which they were working. For example, nursing includes the direct involvement of nurses in emotionally complex situations and previous research suggests that support from colleagues can lead to a reduction in the emotional exhaustion of nurses (Jenkins & Elliott, 2004). In addition, support from colleagues would be advantageous when dealing with a constantly changing healthcare environment. Nurses would naturally seek support and assistance from those closest to them, who also understand what the nurse was experiencing. Furthermore, nurses would have a greater reliance on their colleagues when their NUM was busy with other duties or not available. This finding supported previous research, which argued that nurses may turn to their peers for support when they lack support from the organisation (Cronqvist, Lutzen & Nyström, 2006). In addition, collegiality is a feature of professional occupations (Finn, 2001) and strong collegial relationships are congruent with this. Therefore, the nurses in this research sought
support from their colleagues and would likely have increased their social capital and social support from non-supervisory sources. Furthermore, these relationships and the support that arose from these, improved nurses’ feelings of empowerment in their work. This confirms previous research, which suggested that employees develop greater meaning from high quality teamwork (Dodds, Lawrence & Wearing, 1991; Siegall & Gardener, 2000). Together, these findings suggested that possessing good relationships with work colleagues provided multiple benefits to nurses, including motivation to perform their work better. This also suggested that the quality of exchanges between nurses and their colleagues were positive.

Despite the strong relationships between nurse colleagues and the positive degree of teamwork within the organisation or ward, morale was poor across all items measured. Nurses reported that they were not motivated to undertake their work or put in their best effort. The data specifically identified organisational management as a source of the poor morale being experienced. Nurses indicated in their responses to the survey that management did not respect them, which was consistent with the qualitative data, identifying that management demonstrated a lack of respect and support towards nurses. One of the factors that may have contributed to the poor levels of morale in the organisation examined was the constantly changing nature of the health system within Australia. Previous research has already documented decreased morale amongst nursing staff due to the workplace changes that resulted from NPM reforms (Callaghan, 2003; Day et al., 2007). Alternatively, the nature of nursing work with high levels of part-time, casual and agency nurses meant that there was likely to have been extensive use of temporary staff. This may have inhibited the ability to develop trusting and meaningful relationships, thereby decreasing the level of morale within a ward and the ability to optimise social networks. Alternatively, the satisfactory, as opposed to good quality of, communication processes may have contributed to this, particularly with existing research on nurse teamwork suggesting that communication is an antecedent to high quality teamwork (Kalisch et al., 2009; Xyrichis & Ream, 2008).
7.4 Major theme 2: Lack of support

A major finding from this research was the crucial role of support mechanisms in workplace relationships. Specifically, support provided by organisational management through resources and facilities to better enable nurses to undertake their work and make them feel like a valued member of the organisation was highlighted as important. The level of respect and support provided to nurses by a multitude of other employees within the organisation affected a number of outcomes examined in this research. Furthermore, these two types of support actively contributed to the quality of the culture in place within the organisation, which either supports or thwarts the quality of the relationships present. Each of the findings within this section were expected and parallel existing research in the area. Subsequently, Major Theme 2 consists of organisational inputs (MT2.1), respect and support from others (MT2.3), and organisational culture (MT2.3). These sections are now discussed.

7.4.1 Major theme 2.1: Organisational inputs

The first support sub-theme identified in the data was the lack of organisational inputs and support provided to nurses. The key findings associated with this theme are shown in Figure 7.5. It was not surprising that this research identified significant issues regarding the lack of resources and facilities available to nurses working within the organisation. Health literature within Australia has previously documented the demands placed upon the health system and the lack of adequate funding, which has led to a lack of resources, facilities, and staffing (Blenden et al., 2003; Bradfield, 2008). This research confirms and supports those previous findings, and adds a more multifaceted understanding of these issues and how they have affected professional relationships within the workplace and nurses’ commitment to the organisation.
Figure 7.5  Major theme 2.1: Organisational inputs

Nurses very clearly communicated that they were undertaking their work in an environment characterised by insufficient resources and facilities. First was a perceived lack of resources and facilities with regards to patient care such as beds for patients, medical equipment and time in which to care for patients, which corresponded with existing literature (Blendon et al., 2002; Bradfield, 2008). These situations were very likely to have contributed to the customer and patient ambiguity said to be experienced by nurses as they were unsure as to how to care for their patients. Furthermore, it could be assumed that nurses would not have felt as empowered in their work due to these obstacles, as it would be difficult to feel a sense of power and control and motivation in situations where there is little control. Furthermore, although patient care was identified as a top priority for the organisation, it was not demonstrated through the real availability of resources, as perceived by nurses, which suggested differences between organisational policy and practice.

The second area identified by nurses was a lack of resources and facilities with regards to nurses working for the hospital, such as the lack of secure parking, canteen and lunch break facilities, and staffing levels leading to high workloads, stress and potential dissatisfaction. The perceived lack of sufficient staff to meet patient demand was a very important finding which had the potential to impact upon a number of other outcomes. This research supported existing literature by
identifying that hospitals were understaffed with nurses, similar to many other healthcare organisations (Garnett et al., 2008), and were dissatisfied with workloads and insufficient resources (Pillay, 2009). The reason for this and most other shortages was most likely to be due to insufficient funding which had led to larger-than-desired ratios of nurses to patients, due to an increased population and financial pressures (Keenan & Kennedy, 2003).

One outcome of the nursing shortage is that nurses are reporting to be caring for a greater number of patients and the increased workload that resulted from that. This situation was commonly identified in previous literature with higher ratios resulting in greater burnout and dissatisfaction (Aiken et al., 2002). Additionally, the literature also outlines the numerous negative outcomes for both nurses and the organisation that result from higher than desired workloads. For instance, both this research and previous literature has suggested that high workloads decrease nurses’ commitment (Zeytinoglu, 2007). This means that forcing nurses to care for a greater number of patients is positively influencing their commitment to the organisation.

Nurses within this organisation were also clearly becoming stressed by the additional demands placed upon them by the lack of staff. Nurses felt they were being pressured into working overtime or more inconvenient hours of work, which also reduced their choice and flexibility. Existing research confirms that this is not uncommon (Rogers et al., 2004). Nurses were also experiencing stress from the additional tasks, roles and problems that resulted from the higher workloads, which again supported existing research (Lim et al., 2010; Zeytinoglu et al., 2007a, b). The resulting outcome of these factors is that nurses’ quality of work life may have been affected, which was also likely to have impacted upon the quality of their work-life balance.
Another outcome of the nursing shortage and its negative impact on the quality of patient care is the impact that these have on nurses’ sense of empowerment. This research identified that nurses did enjoy working as a nurse and the duties that it involved. However, nurses identified that the lack of resources and staff were direct threats to the quality of care provided to patients, which is the primary role of being a nurse. Furthermore, nurses also suggested that their decreased quality of patient care had decreased their perceived empowerment in their work, which supports existing research in this area (Joiner & Bartram, 2004). Considering the enjoyment that nurses in this research stated that they receive from caring for their patients, this is likely to be affecting nurses’ empowerment in their work. Adding weight to this assumption is existing research which suggested that decreased empowerment has resulted from the many health care reforms in Australia (Newman & Lawler, 2009) which have resulted in a lack of staff and resources.

Another insufficient resource listed by nurses was the lack of parking available to nurses and other staff members. The significance of this issue to nurses was demonstrated through the frequency with which it was mentioned in the data. For example, the lack of parking was the first most frequently listed response for the worst aspect of working for the organisation. This finding suggested that parking was a serious and widespread issue across nursing staff that was a largely unanimous aspect of discontent, which supported existing research (Pather et al., 2010; Webster et al., 2009). One of the reasons why parking may have been such a significant issue for nurses could have been due to the impact that this issue placed on the work life of nurses. For instance, nurses would be reminded of this inconvenience every time that they arrived at and departed from their place of work. Furthermore, finding adequate parking for each shift would have required leaving home earlier in order to make time to find a parking spot or perhaps walk the extra distance if parked further away. Together, these conditions may have likely exacerbated the existing stress for nurses in their work role.
Another reason why parking was so important to nurses was discussed in responses regarding nurse safety. Concerns regarding the safety of nurses walking long distances to their car in the dark and late at night were identified as some of the worst aspects of working for the organisation. Although these concerns were not frequent enough to be identified as a dominant theme, they may have touched upon a larger issue worthy of further investigation, which is nurse safety and security in respect to parking, as was identified in previous literature (McNeese-Smith, 1999). Perhaps the perceived failure of management to protect the safety of its nursing staff was viewed negatively by nurses as a lack of respect and value towards staff. Interestingly, the safety of staff members was identified through the organisational documentation as an important consideration for the organisation. However, nurses’ perceptions demonstrate that there was a clear discrepancy between organisational policy and practice.

Another indication of the importance of the lack of parking to nursing staff was the fact that improving the parking availability was the third most frequently listed response to what management needed to change in order for nurses to remain committed to the organisation. This finding suggested that a lack of staff parking was not only an issue of dissatisfaction with the organisation, but also such a significant issue that it may have affected nurses’ commitment to the organisation.

One of the major outcomes highlighting the importance placed on the lack of the various resources and facilities for nurses within this organisation is the perceived lack of respect and empowerment that nurses may have experienced. When nurses perceive that they are not being provided enough resources with which to perform their work, this situation may be viewed by some as a lack of respect where nurses are not viewed as important enough to receive resources that are vital to the effective and efficient undertaking of their work. Consequently, nurses may have felt that they were not seen as important or valued by the organisation and their desire and motivation to perform their work well, or their perceived empowerment, may have been negatively affected by this. This was partly supported by a minority of nurses who suggested that the lack of resources
negatively affected their perceptions of empowerment, as well as their ability to provide care to their patients, thereby increasing their levels of stress. However, the relationship between resource availability and perceptions of empowerment were not directly examined in this research and the issue would benefit from further research.

7.4.2 Major theme 2.2: Respect and support from others

The second support sub-theme identified in the data was the lack of respect and support provided to nurses from others. The key findings associated with this theme are shown in Figure 7.6. Nurses in this research reported that being provided with respect and support from others within the organisation was of high importance to them. Specifically, the lack of respect and support provided to them was a factor that negatively impacted upon a number of outcomes for these staff. In accordance with previous research in this area, nurses wanted to feel valued and respected both as individuals and for the contribution that their work made to the organisation (Laschinger & Finegan, 2005).

Support

MT2.2: Respect & support from others
KF1, KF2, KF30.

Figure 7.6 Major theme 2.2: Respect and support from others

Although some nurses suggested that doctors were particularly lacking in respect towards nurses, most of the comments referred to the lack of respect by upper management. The results of this research have consistently identified upper management as a major player in many nurse outcomes, such as role ambiguity and
job performance, which supports assertions in previous research (Krichbaum et al., 2007; Viitanen et al., 2007). Furthermore, the lack of respect and support provided by upper management was likely to be contributing to the poor relationship, or reported lack of relationship, between nurses and upper management. These behaviours work together to further deteriorate both of these relationships and the working environment for nurses. Compounding these negative perceptions was upper management’s reported unwillingness to consult with, or inform nursing staff of what was occurring within the organisation. The lack of reported involvement was a reflection of nurses’ reported perceptions that their ideas, and therefore, they themselves, were not valued by upper management. Ultimately, these perceptions led to nurses not feeling empowered in their work. It also contributed to the perceived separation between management and nurses by enhancing the effects of nurses belonging to the out-group with regards to upper management.

The importance that nurses place on receiving respect and support in their work was implied through the high frequency with which nurses indicated that improving the behaviour of management was tied to their commitment to the organisation. This supported existing research which found that providing respect and appreciation to employees decreased their intention to leave (Kuokkanen et al., 2003; Laschinger, 2004). Perhaps one of the reasons for nurses’ need for management to change their behaviour was nurses’ desires to work within an organisation that values its employees in practice. Interestingly, organisational policy consistently highlighted the value of its employees to the organisation, and analysis identified that respect was very highly valued by the organisation as a core value. However, nurses’ responses indicated that these were areas of difference between organisational policy and practice.

Support was also a key concern for nurses with many suggesting that they needed additional support in the form of both resources as well as other people. It is not surprising that nurses reported that they did not receive sufficient support. One reason for this is that although organisational policy stated that the organisation supported its nurses through mechanisms such as financial benefits,
and positive and flexible workplaces to name a few, the nurses reported dissatisfaction with these mechanisms. The data suggested that many nurses were not satisfied with their pay. Nurses also indicated that the workplace was not flexible as demonstrated through the lack of flexibility in working hours due to the nursing shortage. Furthermore, as is discussed in more detail in the following section, the culture of the organisation was perceived to be less than desirable. Together, multiple areas within this research have been identified as factors which might explain why nurses did not feel as supported as they would have liked.

As mentioned previously in this chapter, the relationships between nurses and their colleagues were strong and highly valued. Perhaps nurses are receiving support from their colleagues when they should also have been receiving support from the organisation and its management. This is a positive finding for the development of professional relationships and social capital for nurses. However, this is a negative finding for the quality of the relationship that nurses possess with various levels of organisational management.

The lack of respect and support also affected nurses’ perceptions of empowerment in their work. This finding meant that nurses needed to feel valued and encouraged and supported in their work in order for them to want to work better. The need to be recognised as important and valuable, as well as receiving recognition for their skills and listening to their needs within the organisation were identified as being important. These findings support existing research (Faulkner & Laschinger, 2008; Laschinger & Finegan, 2005; Webster et al., 2009) and clarify the importance of the relationships within an organisation.

7.4.3 Major theme 2.3: Organisational culture

The third support sub-theme identified in the data was the poor organisational culture that nurses were working within. The hypotheses and key findings associated with this theme are shown in Figure 7.7. The culture of an organisation provides the foundation from which support is derived. The literature
acknowledges the importance of culture in almost all individual and organisational outcomes, hence its constant inclusion in Social Capital Theory as a contextual basis for the development of relationships. Within the studied organisation, culture was determined to be poor in all measured areas, with the exception of satisfactory levels of teamwork. These results were alarming because it suggested that desired changes to the culture of this healthcare organisation, which is a key indicator of managerialist health reforms (Anderson et al., 2002; Hood, 1995; Maor, 1999), may not have been achieved yet. This finding supports existing research which suggested that the culture of healthcare organisations is not congruent with managerialist goals, and that organisations have some way to go in improving organisational culture (Anderson et al., 2002).

Another alarming effect of a poor culture within the examined organisation is that a poor culture would not effectively facilitate the development or sustainability of organisational relationships, and therefore nurses’ social capital. A supportive and unified organisational context is vital for employees to develop ties and relationships with one another (Cohen & Prusak, 2001; Klimosky & Mohammed, 1994; Nahapiet & Ghoshal, 1998). However, as mentioned previously, the reported lack of organisational inputs, and respect and support from others has led to a negative culture and poor levels of morale. Clearly, nurses did not feel supported or motivated within the organisation. A likely result of these perceptions and feelings is a cohort of nurses who do not feel empowered in their work, and findings of this

Figure 7.7 Major theme 2.3: Organisational culture

Support

MT2.3: Organisational culture

H8, H9, H10, H13.
KF15, KF16,
KF17, KF18, KF28.
research did suggest that culture and empowerment were significantly related to one another, which supports previous research in this area (Koerner, 1993; Spreitzer, 1995a, b; 1996).

Contrary to the quantitative results which suggested that the organisation possessed a poor culture, one qualitative finding suggested that the examined organisation was a good place to work, in part, due to the culture of the organisation. However, although this appears to be the case at first glance, further comparison found that many of those responses were based upon the positive features and attributes available to nurses working within the organisation. These included the availability of educational and career opportunities and the geographic location of the hospitals, as opposed to behavioural and outcome-based activities such as those measured within the survey. Subsequently, analysis revealed that the organisation was viewed as an attractive place to work because of the opportunities available, but that these did not translate into a positive organisational culture.

The reason why nurses viewed the organisational culture as poor may be explained by some of the organisation’s practices and values. For instance, as previously mentioned, nurses indicated that they felt the flow of information within the organisation was poor. The implications of a poor flow of information have been discussed earlier, but what that means to organisational culture overall has not. When employees do not receive enough information, they are also not receiving information about what the organisation values and sees as acceptable behaviour (Fell-Carlson, 2004). Aside from increasing nurses’ ambiguity surrounding their environment and what is expected of them, this also creates an inconsistent and uncertain culture. Consequently, this may have contributed to the poor culture in place, and decreased the potential support offered to nurses.

In addition to nurses feeling that they were not informed about what occurs within the organisation, nurses also suggested that they did not feel involved or able to provide input. Specifically, nurses’ ability to participate in decisions affecting their work and the ability to provide suggestions and opinions on how their work may be
undertaken better were limited. This finding was not surprising considering the minimal amount of dialogue that was occurring between nurses and their NUMs, as it is not possible for nurses to provide their input if they are directly told what to do in their work, rather than become engaged in a discussion about how it could be done. Furthermore, if nurses are not provided the opportunity to be more involved with the organisation and how work is undertaken, they are less likely to view the organisation and others within it positively. For instance, a lack of involvement decreases nurses’ perceived ownership and responsibility over their work which may lead to decreased perceptions of empowerment and further reduce nurses’ ability to solve problems (Bowen & Lawler, 1992; Menon, 1999).

As mentioned in the previous section, positive organisational culture arises from the provision of respect towards others (Barney, 2002), which was reported to be lacking within the studied organisation. The literature suggested that increasing employees’ involvement and accountability within the organisation is one way in which to build a culture based upon respect (Barney, 2002). Moreover, increased accountability is one of the aims of new managerialist goals in order to achieve increased efficiency and effectiveness (Anderson et al., 2002; Ferlie et al., 1996). However, healthcare and organisational management was clearly expecting nurses to be more accountable for their work, while at the same time, reportedly not permitting them to be more involved within the organisation through activities such as decision-making or keeping them informed. Nurses were very likely to be understandably ambiguous about their role, considering this conundrum.

One of the consequences of low involvement by nurses combined with a lack of respect and support, and a poor organisational culture, is the cyclic process that is created. For instance, nurses may not have felt respected because they were not given the opportunity to become more involved, and the culture then did not respect nurses because they were not more involved. However, ultimately it is the responsibility of management to put procedures in place to support behaviours and actions that demonstrate respect and increased involvement on behalf of nurses. Analysis of organisational policy and documentation suggested that these
procedures were in place. However, the implementation of these procedures had clearly not been achieved sufficiently, which identifies a gap between organisational policy and practice.

The reported ineffectiveness of organisational meetings also provided a clue as to why the culture of the organisation was viewed poorly by nurses. Meetings were reported negatively by nurses and were identified as not being efficient or effective. Furthermore, discussions frequently went off-track and wasted time, failed to take into account decisions by all individuals present, and decisions failed to get implemented following the meetings. This supported previous findings which suggested that meetings are sometimes an inefficient use of time and fail to create decisions and actions that end up being effectively translated outside of meetings (Peck et al., 2004). One of the first reasons why meetings were viewed negatively by nurses was likely to be due to the lack of involvement and input that nurses were allowed, as reported previously. Furthermore, meetings are one way in which to disseminate information to employees, and nurses previously reported that they were not adequately informed within the workplace. This supported existing research which suggested that meetings such as nurse handovers between shifts were potential sources of communication problems, and affected the quality of teamwork (Kalisch et al., 2009). These two reasons alone provide some insight into why nurses perceive organisational meetings negatively.

According to Schwartzman (1989) and Weick (1995), meetings are a reflection of the culture of the organisation. That argument does appear to apply to the examined organisation as the potential reasons for why meetings may be viewed so negatively are a result of previously mentioned findings such as a perceived lack of respect, involvement, input and flow of information. This argument is relevant here because many organisational meetings would be led by NUMs. Combined with the reported lack of dialogue and frequency of communications and exchanges that were mentioned earlier, and the lack of information and involvement mentioned here, it is not surprising that meetings were not viewed more positively. Furthermore, it is the responsibility of NUMs to ensure that meetings are more
effective, and therefore NUMs need to play a much larger role and take more responsibility, and greater accountability for the state of the culture that exists. Subsequently, the perceived poor effectiveness of meetings in this instance was a direct reflection of the perceived poor organisational culture within the organisation.

Perhaps another factor which may explain the perceived poor effectiveness of meetings, as well as many other cultural aspects, is the policies and procedures in place. As mentioned previously, nurses reported that policies and procedures frequently inhibited efficiency and effectiveness and disrupted work practices in general. This finding suggested that nurses might have been dissatisfied with organisational policies and procedures, which has been shown to be significantly related to nurse retention (Cowin et al., 2008). Although the rules governing the undertaking of organisational meetings was not within the scope of this research, perhaps it was these rules that prevented nurses from being more involved and informed within meetings. Perhaps it was the organisation’s own policies and procedures which have prevented meetings from becoming more effective, and therefore more supportive of the organisation’s culture.

In summary, both sets of data identified that the culture of the organisation examined was reported to be largely poor with negative morale, a poor flow of communication, inefficient use of meetings and a lack of input and involvement available for nursing staff. Furthermore, the only positive attribute of the organisational culture was the level and quality of teamwork present amongst the nursing staff, which suggested that nurses may have been relying upon their relationships with colleagues in order to continue working within such a negative culture. This was a positive contributor for the development of relationships within the organisation and a negative contributor to nurses’ commitment to the organisation. Although the poor status of the organisation’s culture has likely increased nurses’ relationships with colleagues and improved their social capital, this has been achieved at a significant cost. The poor culture has facilitated the development of collegial relationships through mutual dissatisfaction with the organisation where nurses seek support from one another in order to better handle
the negative pressures placed on them by the organisation (Cronqvist et al., 2006). With a poor culture as the contextual foundation for the development of collegial relationships, it discourages relationships with supervisors, upper management, and other members of staff.

Another consequence that arises from a context which supports collegial relationships as opposed to relationships with other organisational members is the impact upon nurses’ relationship with their supervisor. For instance, if an organisation’s culture encourages or supports relationships with colleagues, less support may be provided to developing relationships between nurses and their NUMs. This decreases the potential for nurses to be included within the in-group and enjoy the benefits of high quality exchanges with their supervisor. Instead, nurses may develop their own group to the exclusion of supervisors and other organisational members. Ultimately, the consequences of a poor culture are conducive to the development of collegial relationships but may be counterproductive to the development of supervisor-employee relationships.

7.5 Major theme 3: Individual outcomes

Another major theme from this research was the impact that relationships and a lack of support had placed on individual nurse outcomes, which then flowed on to impact upon the commitment of nurses. This section discusses the findings of this research regarding how nurses use their social networks to assist them in solving work-related problems. This is followed by a discussion of the degree of ambiguity experienced by nurses in their work and the resulting sense of empowerment felt by these nurses. Finally, the impact of all of these variables on the ability of nurses to perform their work effectively is then discussed. Subsequently, Major Theme 3 consists of problem solving social networks (MT3.1), role ambiguity (MT3.2), perceived empowerment (MT3.3), and job performance (MT3.4). Each of these is now discussed.
7.5.1 Major theme 3.1: Problem-solving social networks

The first individual outcome sub-theme identified in the data was the existence of useful and effective social networks to assist nurses in solving problems. The research questions and key findings associated with this theme are shown in Figure 7.8. This research examined the problem-solving social networks used by nurses as one way to identify the structure of relationships possessed by nurses. A review of the literature identified that there was minimal understanding of the role of social networks in problem-solving processes, particularly for nurses. Therefore, this research extends the literature by identifying the type and strength of relationships within these networks and their effectiveness. Furthermore, this research aids in understanding the role of supervisors or NUMs within these processes.

The data identified several prominent relationships in assisting nurses within the workplace. The first relationship was with the NUMs of the nurse’s ward who was the first most frequently approached contact by nurses when experiencing a problem. On the one hand, this result was surprising because nurses frequently mentioned that their NUM was busy and unavailable. In addition, many nurses also believed that they possessed a poor relationship with their NUM. On the other hand, approaching their NUM first was also the most logical sequence of approach.
This is partly because previous research suggested that supervisors were useful sources for problem-solving as they enabled access to the necessary information for which to solve the problem (Cohen & Prusak, 2001; Haskins, 1996). Furthermore, this is also partly because organisational policy dictated that managers, or NUMs in this instance, be approached when needing information or assistance related to work on the ward. Subsequently, NUMs were placed in a formal help providing role by organisational policy and were perceived accordingly by the nurses. The literature states that individuals with formal helping roles were found to be perceived as more accessible (Hofmann et al., 2009). However, that finding is both supported and not supported by this research because nurses indicated that their NUM was not accessible while at the same time approaching that individual first for assistance. Overall, approaching NUMs first for a work-related problem suggested that organisational policy and organisational practice were congruent with one another, at least for the majority of the nurses.

Nurses indicated that they approached their NUMs and other contacts in the order in which they did, based upon that person’s level of knowledge and expertise in the area. This supported research by Hofmann et al. (2009), which identified that help providers both possessed, and were perceived as possessing, job-relevant experience, and therefore expertise for effective problem-solving. The nurses’ reasons for approaching the contacts suggested that knowledge and experience were key requirements for problem-solving, which is to be expected as nurses would logically seek someone with the appropriate information and knowledge to help them solve the problem. Alternatively, they sought assistance from contacts that were considered approachable which again highlighted the importance of possessing high quality relationships. These findings suggested the importance of possessing contacts with knowledge and experience and therefore, nurses were actively seeking knowledge while undertaking their daily duties and their problem-solving social networks assisted them in doing so.

The above findings demonstrate the importance of improving and supporting supervisor-employee relationships. This supports previous research which found
that the ability to effectively solve problems was enhanced by the quality of the relationship between supervisors and their employees, and the quality of the communication processes that occur within that relationship (Ibarra & Andrews, 1993; Kim, 2002). Adding to this is the reduced instance of role ambiguity that can arise when the supervisor-employee relationship and its accompanying communications are strengthened (Johlke & Duhan, 2000; O’Driscoll & Beehr, 1994). For instance, this research found that the quality of supervisor-employee exchanges accounted for 70% of the variance in nurses’ role ambiguity. This finding is alarming due to the frequency with which nurses reported that their NUM was too busy to assist them. Reducing role ambiguity is relevant here because role ambiguity causes additional problems for employees to solve (Conger & Kanungo, 1988; Joiner & Bartram, 2004; Siegall & Gardener, 2000) and by reducing role ambiguity, the frequency and complexity of problems may also be reduced, thereby improving the work life and efficiency of nurses.

The second prominent relationship was with the Clinical Nurse within the ward who was listed as the second most frequently approached contact for assistance with problem-solving. Interestingly, NUMs and the Clinical Nurse were the top two contacts approached and, when not available or appropriate, the alternate contact was approached next. This was not surprising considering previous research which argued that Clinical Nurses do undertake leadership responsibilities of the Nurse Manager (Kalisch et al., 2009). Perhaps nurses sought out the next suitable contact when the NUM was not available to assist, and the desire for assistance from someone with knowledge and experience, led to the choice of the Clinical Nurse. However, further investigation of this relationship, beyond the scope of this research, is warranted.

The third prominent relationship was with the nurses from within the same ward who were listed as the third most frequently approached contact for assistance with solving problems. This finding provided further support to the assertion that nurses possess high quality relationships with their colleagues, and supported previous research by Larson and Luthans (2006). In addition, other data within this
research identified that nurses agreed that they constructively confronted problems together at a satisfactory level and worked satisfactorily as part of a team. This led to the assumption that nurses derived high levels of support from their nurse colleagues and valued them as a part of their problem-solving social network.

It appeared that the social networks used by nurses to assist them with solving work-related problems were useful and effective. Therefore, the more useful a problem-solving social network is, the greater the potential of the nurse to solve the problem being experienced. Although nurses’ satisfaction with their social network was not examined in this research, it may be assumed that they were satisfied because the network was reported to be useful. If this assumption was accurate, it would provide support for existing research which found that half of the nurses examined were satisfied with their level of support for work-related problems (Dallender et al., 1999).

Examination of the contacts that comprised nurses’ problem-solving social networks identified that most nurses possessed a network of between two and five people. Therefore, the majority of nurses did appear to have a network in place to assist them when experiencing work-related problems. Subsequently, the effectiveness of a social network may not be due to the quantity of contacts, as was suggested by Burt (1992). Perhaps, the success of a problem-solving social network lies in the quality of the relationships. However, it is worth noting that nearly one in five nurses reported only one or no contact to approach when needing assistance with problems on the ward. This finding was alarming because it meant that one in five nurses were experiencing ambiguity surrounding a situation on a continuous basis and were receiving very little or no assistance. One of the reasons for this finding may have been because that population of nurses might have been temporary or new nurses and did not have the time or resources to identify those individuals in formal or non-formal help-seeking roles, or to simply generate relationships with others within the ward or organisation (Hofmann et al., 2009). Subsequently, further research may be necessary to identify if those nurses with one or less contacts are in this group or if their lack of contacts are due to other reasons.
The situation with those nurses may have had ongoing repercussions for other outcomes such as nurse commitment through to the quality of patient care. It also meant that these nurses most likely did not possess rich or even satisfactory levels of social capital in the workplace (Field, 2003). Furthermore, these nurses may not have been receiving access to new knowledge on an on-going basis, which decreases the potential to effectively solve problems and engage in lifelong learning (Kessels & Poell, 2004; Nahapiet & Ghoshal, 1998). Subsequently, an important portion of the nursing population within the examined organisation may benefit from assistance with developing additional professional relationships within the workplace in order to assist in multiple organisational processes, including developing problem-solving social networks.

In summary, the majority of nurses studied possessed effective social networks that assisted them in solving problems in the workplace. However, a small minority of nurses had one to nil contacts, thereby suggesting a lack of support in the workplace. The most frequently used contacts for assistance were their NUMs, followed by the Clinical Nurse and nurses from within the same ward. The main reasons cited for approaching the network contacts used was the experience and knowledge possessed by the contact.

### 7.5.2 Major theme 3.2: Role ambiguity

The second individual outcome sub-theme identified in the data was the presence of role ambiguity for nurses in regards to how to undertake their work. The hypotheses and key findings associated with this theme are shown in Figure 7.9. The nurses working within the organisation were reported to be operating in a very ambiguous environment. This constant state of uncertainty was experienced firstly towards the patients, which was very likely to have been affecting the level of care provided by nurses. Taking into consideration the fact that nursing is a caring profession for which many nurses feel they have a calling (Bloom, O’Reilly & Parlette, 1979; Kim-Godwin et al., 2010), being uncertain about how to effectively care for
patients is an obstacle to the very central functioning of nurses’ work. Although this research did not examine role ambiguity in greater depth beyond the quantitative measure, the qualitative responses did allude to some reasons why nurses may be experiencing ambiguity surrounding their patients.

One clue is the consistent reporting of a lack of organisational inputs such as resources and facilities, inadequate staffing and the resulting high workloads. A lack of any one of these inputs was likely to have affected the nurses’ ability to give the appropriate level of care and assistance to patients. Such an example might be the inability to carry out a specified test on a patient if the required machine was being used elsewhere. The nurse would then be required to problem solve and find an alternative way to conduct the necessary test or locate and negotiate the use of the needed equipment. Due to these problems, nurses may not have always been able to follow organisational policy and procedures appropriately. This improvisation and problem-solving may have also contributed to nurses’ ambiguity. The qualitative data identifies that nurses feel there are too many complex policies and procedures in place, which was widely recognised as a negative attribute of working for the organisation.

Other clues that may explain why nurses were experiencing ambiguity surrounding how to care for patients were the negative communication processes

Figure 7.9  Major theme 3.2: Role ambiguity

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Other clues that may explain why nurses were experiencing ambiguity surrounding how to care for patients were the negative communication processes
and organisational cultural aspects mentioned previously. Frequent communication between employees and supervisors is essential for the employee to understand what is expected of them. The data suggested that improvements could be made in each of these areas. Furthermore, the reported lack of information flow across the organisation, and a culture that did not value participation or involvement by its nursing staff very likely contributed to the lack of information and knowledge possessed by nurses, which resulted in ambiguity.

The strong relationship that role ambiguity had with both two-way communication and the directness of communications was very significant and suggested that reducing the amount of role ambiguity experienced in the workplace could be largely attributed to improving communication processes. This finding supported existing research in this area (Dunegan et al., 2002; Johlke et al., 2002; O’Driscoll & Beehr, 1994; Nelson et al., 2007).

Another reason why nurses may have reported role ambiguity might have been due to their relationship with their supervisor. Results of this research suggested that nurses also experienced ambiguity surrounding their NUMs expectations of, and satisfaction with, their work. Perhaps the ambiguity surrounding patient care was partly due to the low quality of the relationships between the nurses and their NUMs. Notably, ambiguity surrounding supervisors was much more significant than ambiguity surrounding patients. This is not a surprising finding considering supervisors are a major organisational source of information and communication.

The relationship between supervisor-employee communication processes and the quantity of both ambiguity in general and ambiguity surrounding supervisors was very significant with communication processes explaining between 33-60% of ambiguity experienced. The most significant relationship was with two-way communication processes and indirect communications. These results implied that ambiguity decreases when nurses and NUMs are able to communicate freely back and forth with one another with the intent to discuss and dialogue instead of
disseminating instructions. These findings support previous research which suggested that two-way communication was the strongest of the four areas of communication to decrease role ambiguity (Jablin, 1979; Johlke et al., 2000). This finding also begins to address the gap in the literature in regards to the need for greater understanding of the relationship between role ambiguity and supervisory communication processes (Johlke & Duhan, 2000; Johlke et al., 2000). Specifically, this research adds that nurses need to be able to discuss an aspect of their work in greater depth with their NUMs, thereby reducing the potential for ambiguity, as opposed to receiving and acting upon direct instructions.

The perceived less-than-optimal quality of exchanges between nurses and their NUMs was likely to be another one of the reasons why nurses were ambiguous surrounding their supervisors. This is because nurses possess low quality economic exchanges with their NUMs and many/some are members of the out-group, and therefore those nurses are privy to less information and assistance than those nurses within the in-group. Without sufficient information, assistance and support from their NUMs, it is not surprising that some nurses were ambiguous. Supporting this assertion is the finding that the quality of exchanges between nurses and their NUMs accounted for 70% of the variance in the role ambiguity experienced by nurses. Similarly, this finding supports previous research (Dunegan et al., 2002) and asserts that supervisors possess a large amount of power in reducing their nurses’ levels of ambiguity. Perhaps the large percentage of variance is because nurses rely upon their supervisor for direction in their work and assistance when problems arise, although it has been stated previously that NUMs were not available to nurses for assistance with problem-solving, and is another potential reason why nurses were ambiguous. Furthermore, the poor relationship between some nurses and their NUMs, which was identified through the qualitative data, is likely to increase the amount of ambiguity experienced because some nurses would not seek out assistance from their NUMs for fear of being seen as incompetent or because the relationship had deteriorated too much, as was mentioned by some respondents.
Although the relationship between problem-solving social networks and role ambiguity was not examined quantitatively, insight into this relationship was gathered through qualitative data. Role ambiguity occurs when the necessary information is not made available to employees in order to undertake their work effectively (Rizzo et al., 1970; Van Sell et al., 1981). This research has already established that nurses perceive the supervisor-employee communication processes and the flow of information within the organisation to be poor. Furthermore, each of these factors has been significantly associated with role ambiguity in this research as well as in previous research (Johlke & Duhan, 2000; Sutcliffe et al., 2004). From these findings it would seem logical that problem-solving would require a good flow of information and communication processes in order to be effective, and without these, problem-solving is unlikely to be achieved, thereby leading to increased ambiguity. The consequences of this are nurses who are uninformed while trying to solve problems on the ward, which result in decreased perceptions of empowerment in their work, and ultimately, decreased commitment, as was supported in previous research (Allen et al., 2001).

The culture of the organisation played a large role in determining levels of ambiguity amongst nurses. Nurse involvement within the organisation was again the most significant. This led to the conclusion that a culture of greater involvement by nurses assisted in reducing levels of role ambiguity experienced. This relationship highlights the beneficial nature of including nurses more in activities and decisions within the organisation. However, as greater involvement was not reported by nurses within the examined organisation, management were clearly not taking advantage of this opportunity to alleviate uncertainty amongst nurses. The reason why organisational management were not more willing to include nurses further is unclear. However, due to the existing pressures being faced by healthcare organisations such as a shortage of staff and insufficient funding, increasing nurse involvement may be viewed by organisational management as an inefficient use of precious time and resources. Furthermore, the consistency of the significant relationships throughout this research did imply that the organisation possessed a culture that was not supportive of nurses in a variety of ways.
Another interesting finding from this research was identifying that teamwork did not decrease the level of role ambiguity experienced by nurses. This finding was significant because, although nurses were turning to colleagues for support within the workplace, this finding suggested that working as part of a team may not have helped to alleviate ambiguity. Therefore, although working as part of a team increases the potential to share information and knowledge, and ability to handle pressures and obtain support, it may not have alleviated nurses’ ambiguity. It would be safe and logical to assume that social networks are advantageous and would decrease any role ambiguity experienced. This is because social networks provide access to new and broader sources of information that may not be obtained outside of those networks (Koka & Prescott, 2002). Most nurses did possess social networks with multiple members and nurses would therefore have been privy to increased information. Subsequently, problem-solving social networks are likely to have decreased nurses’ role ambiguity. Perhaps it can be surmised that colleagues did not possess the relevant information to alleviate nurses’ ambiguity. Further research into this potentially important area, concerning the role of teamwork in role ambiguity, is therefore warranted.

Based on previous findings from this study, it would appear that the major source for reducing role ambiguity was NUMs and this had two major implications. First, the importance of the relationship between nurses and their NUMs was exemplified again. This is reiterated in findings which suggested that organisational meetings, which are a major source of supervisor-employee communication, were the most significant cultural attribute impacting upon ambiguity surrounding supervisors. Second, network contacts with colleagues may not be as beneficial in reducing role ambiguity as once thought. Considering the high quantity of collegial contacts within nurses’ problem-solving social network, this raises the question about whether nurses were indeed accessing the relevant information that they required.
Another implication of the role ambiguity experienced by nurses is the reported decreased efficiency and effectiveness of their work, which is contrary to managerial goals. Clearly, nurses cannot perform their work to the best of their ability if they are unsure about what is expected of them. Although job performance was outside the aims of this research, it did emerge within the qualitative data as a consistent theme, and previous research has suggested that increased ambiguity leads to decreased performance (Singh, 1993). Therefore, nurses were most likely not performing to the best of their ability within this organisation. Furthermore, as the nurses would be aware of this, their perception of empowerment in their work would also most likely be reduced, which is supported in the literature (Conger & Kanungo, 1988; Siegall & Gardener, 2000).

The most important implication from this research in regards to nurses experiencing role ambiguity is the impact that this had on their commitment to the organisation. This research supports previous literature which identified that the presence of role ambiguity decreases commitment (Allen et al., 2001; Foote et al., 2005; Mathieu & Zajac, 1990; O’Driscoll & Beehr, 1994) and suggests that reducing role ambiguity might be an effective solution to improve nurses’ commitment to the organisation.

In summary, the nurses examined reported experiencing ambiguity surrounding their roles, and particularly towards their supervisors. This is important when considering the status of the relationship between supervisors and employees and indicated that actions aimed at improving the relationship as well as the communication processes that constitute it, and the culture that provides the framework in which these occur, are necessary. For without a supportive context, relationships cannot be built, and outcomes such as role ambiguity and organisational commitment may thus not be improved upon.
7.5.3 Major theme 3.3: Perceived empowerment

The third individual outcome sub-theme identified in the data was the lack of perceived empowerment in nurses regarding their work. The hypotheses and key findings associated with this theme are shown in Figure 7.10. This research suggested that nurses within this organisation were marginally empowered in their work with significant room for improvement. This meant that nurses may not have felt motivated to perform their work more effectively beyond the minimum requirements of the role and may not have felt that they had much desire or ability to control their work, which supports Spreitzer (1996). The reason why this result was obtained is visible through the responses to perceived empowerment.

The quantitative data suggested that nurses derived a significant amount of meaning through working as a nurse and indicated that their work was very important to them. This finding was supported by the qualitative data which identified that working as a nurse was very fulfilling to nursing staff. Together, this meant that nurses may have perceived their work role to be valuable and took great pleasure in performing the work (Bartram et al., 2004; Deci & Ryan 1985; Upenieks, 2003). However, this research did not support previous research by Siegall and
Gardener (2000), who argued that greater meaning may be derived from a supportive organisational culture. To the contrary, this research suggested that nurses’ levels of meaning are high considering the poor and unsupportive organisational culture within the organisation examined. Fortunately, one of the benefits of high levels of meaning is the increased ability of employees to better cope with changes in the work environment (Spreitzer & Mishra, 2002). This is particularly congruent with the nursing role, which has experienced significant workplace changes in recent years (Allan, 1998; Gifford et al., 2002; Winthrop & Vane, 2002) and may account for some positive nurse-related outcomes that are beyond the scope of this research. One contributing reason to why nurses take great meaning in their work is nurses’ reported high levels of competence in their work which suggested that they felt confident in their ability to perform their work. Similar to high levels of meaning, perceiving oneself to be competent in one’s work would also increase the ability of the employee to cope with organisational changes (Spreitzer & Mishra, 2002).

However, the reported less than desired levels of perceptions of empowerment may have been due to nurses’ perceived lack of choice in how their work was undertaken and the impact that their work had upon the organisation. This quantitative finding was similar to the qualitative findings, which suggested that nurses felt as if they were not appreciated, respected, valued or had their views taken into account. This indicated that nurses felt that their role was not of value to the organisation. This is relevant because an overwhelmingly large sample of nurses from the qualitative data identified these behaviours as contributing to their low perceptions of empowerment, which confirms previous research in this area (Bartram et al., 2004; Joiner & Bartram, 2004; Spreitzer, 1996). Furthermore, these low perceptions were likely to have been exacerbated by the reported culture of medical dominance by doctors through the perceived notion of superior knowledge, which led to greater negative behaviours such as being ignored or not adequately informed. Subsequently, more research may be necessary to further identify aspects of cultures and sub-cultures within nursing environments such as medical dominance for example. Specifically, it may be necessary to further identify how nurses are, and
are not, being supported within the workplace. Therefore, it was not surprising that the quantitative data suggested that nurses did not feel as if their work made an impact on the organisation.

Some of the ways in which nurses may have developed their low perceived value was from the reportedly high workloads placed upon nurses and the accompanying decreased levels of patient care, as a result of the perceived shortage of nursing staff, resources and facilities. Previous research suggested that high workloads and a shortage of nurses prohibited nurses from providing the level of care to their patients that they would have liked (Allan, 1998; Heinz, 2004). This may lead to the conclusion that they were not performing their job to the best of their ability. Previous research has already established that perceptions of empowerment are associated with increased organisational effectiveness (Bowen & Lawler, 1992; Hartline & Ferrell, 1996). However, this contradicts existing research by Joiner and Bartram (2004), which found that perceptions of empowerment were not significantly associated with the stress of nurses caused by high workloads. Furthermore, this was likely to have affected their perception of the impact of their work, particularly if nurses felt that organisational management was not willing to provide the necessary resources. This would have been compounded by the perceived cultural norm within the organisation of viewing nurses as lower level employees, and not listening to them and giving them the recognition that they desire. Each of these aspects would have undoubtedly contributed to their perceptions of the impact of their work, and therefore, their commitment to the organisation. This means that a relationship has been established between affective commitment to the organisation, and the qualitative themes of reportedly high workloads, and shortages of nursing staff and other resources. This confirms previous assertions that the new ways of managing the public health system such as increased efficiency of services, which have decreased available funding, have produced a number of negative outcomes (Buchan & Calman, 2004; Buchanan & Considine, 2002; Hegney et al., 2005; Senate Community Affairs Reference Committee, 2002).
The impact of the issues discussed thus far is interesting in light of the high scores obtained for the meaning sub-variable. This suggested that nurses understood the importance of their work, but that this is not reinforced and reflected throughout the organisation. Hence, it is understandable that nurses would possess high levels of meaning and low levels of perceived impact. Furthermore, in order for nurses to feel that they are making a difference to their organisation, they also need to understand how their work contributes to the organisation (Gist & Mitchell, 1992). However, understanding their contribution is also partly the responsibility of supervisors and other levels of management (Dodds et al., 1991) and the quality of supervisory communication processes in place (Siegall & Gardener, 2000). Unfortunately, nurses in this research identified that the relationships between nurses and their supervisor as well as upper levels of management were not optimal, and neither were the poor communication processes and quality of the organisation’s culture. Therefore, it was not surprising that nurses may not have possessed high levels of perceived impact when their contribution to the organisation was not communicated, supported, or reinforced through the actions of management.

This research identified that the quality of exchanges between supervisors and employees was significantly related to nurses’ perceptions of empowerment which supported previous research by Quinn and Spreitzer (1997). Furthermore, the greatest significance in the data was found to be nurses’ perceived impact of their work. However, in the qualitative data this relationship was only supported by a small percentage of participants who instead suggested that relationships with upper levels of management beyond the supervisors, had a greater impact on perceptions of empowerment. This meant that the nurses’ perceived empowerment and belief that their work is important and has an impact on the organisation, might have been determined, in part, by the quality of the exchanges with their supervisor. The importance of NUMs providing adequate support for the nursing role, which was suggested to not be the case in the qualitative data, is vital for nurses to feel that their work is important within the organisation.
Similarly to the quality of supervisor-employee exchanges, the supervisor-employee communication processes and perceptions of empowerment were significant in both the quantitative and qualitative data. Of particular importance here was the quality of two-way communications and indirect communications which encouraged open dialogue between supervisors and employees. This meant that an employee’s belief as to the impact of their work and contribution within an organisation was dependent upon open, and back and forth communication between an employee and their supervisor. In addition, effective supervisor-employee communications are vital for effective problem-solving processes to take place. Previous research asserts that effective problem-solving enhances an employee’s perception of empowerment (Quinn & Spreitzer, 1997). It is argued that empowerment encourages creative and effective problem-solving (Bowen & Lawler, 1992) because empowered employees have a high self-efficacy and belief in their ability to make positive changes and innovations (Bushe, Havlovic & Coetzer, 1996; Conger & Kanungo, 1988; Ford & Fottler, 1995; Quinn & Spreitzer, 1997). However, employees are not able to feel empowered as a result of effective problem-solving processes that result from optimal supervisor-employee communications, if supervisors are not available to assist them and therefore engage in exchanges, as was reported to be the case in this research. Furthermore, it is likely that nurses were engaging in a greater quantity of first order problem-solving that is quick and rectifies the immediate problem at hand (Tucker et al., 2002) if their access to their NUMs and relevant information is limited. This is because second order problem-solving, which entails developing a longer-term solution to avoid recurrence of the problem, entails further information, communication to others, and the ability to make decisions, which may be reduced if NUMs are not available. Ultimately, increased first order solutions may not enhance perceptions of empowerment in this event.

The literature identifies that one of the ways in which employees may develop a perception of their impact upon an organisation is through an understanding of the goals of the organisation (Quinn & Spreitzer, 1997; Randolph, 1995) and how their role contributes to that, which may be obtained through
recognition for their good work by management or colleagues (Dodds et al., 1991; Gist & Mitchell, 1992). However, the qualitative data identified that most nurses did not feel adequately valued or recognised for the work that they did in the organisation. This finding suggested that nurses may not have had high levels of the impact dimension of empowerment, as was the case in the quantitative data. Furthermore, the qualitative data echoed findings of the quantitative data with many nurses suggesting that poor two-way communications and a lack of feedback and consultation did negatively impact upon their perceptions of empowerment. Subsequently, the data suggested that nurses’ perceived impact of their work is partly obtained from communication processes, more so than other dimensions of empowerment. This finding is therefore important when taking into consideration initiatives regarding empowerment of nurses.

Another way in which employees may gain a better understanding of how their work fits within the goals of the organisation (Quinn & Spreitzer, 1997; Randolph, 1995), and therefore increase their perception of their impact on the organisation is through actions aimed at reducing employees’ ambiguity surrounding their role. This research identified that role ambiguity was significantly related to perceptions of empowerment, particularly ambiguity regarding supervisors, which parallels previous findings in this research. Therefore, nurses’ perceptions of empowerment might depend upon the quality of relationships with their supervisor. Furthermore, nurses reported that a large part of ambiguity experienced is a result of inadequate communication processes within this relationship, which supports previous research (Trombetta & Rogers, 1988). The perceived impact of nurses’ work for the organisation was most closely associated with ambiguity, which suggested that perhaps nurses need to understand what is expected of them in order to feel as if they have some form of control over their work, and therefore, feel empowered to undertake their work.

Another reason why nurses may not have felt empowered in their work may have been due to the culture of the organisation. Both this research and previous research in the area (Koerner, 1993; Spreitzer, 1995; 1996) suggested that the
culture or atmosphere of the organisation does affect how empowered employees feel. The level of nurse involvement was clearly significant here and implied that when nurses are more involved in the organisation, they are more likely to feel empowered by their work. This finding confirms previous research (Menon, 1999). One reason for this may have been because nurses feel a sense of ownership over their work and that they are contributing to the organisation when they are offered greater involvement in organisational activities. However, one interesting finding was that the culture of the organisation did not significantly impact upon nurses’ perceptions of their competence in their work and their ability to master their role or perform it well. One conclusion to arise from this finding is that educational and career opportunities are likely to generate positive outcomes that are not affected by the quality of the organisation’s culture, and should therefore be further encouraged.

The quantitative data identified that nurses enjoyed the educational and career opportunities available to them with nearly one fifth of nurses undertaking further study at the time of the data collection. This is an optimistic result for the existence of lifelong learning within the organisation but could be enhanced even further, particularly in light of the high incidence of educational and career opportunities presented in the organisational documents. It is not surprising that four fifths of nurses within this study were not engaged in educational and training opportunities. Some of the reasons that might explain why this is the case may be the reported high workloads and accompanying stress levels and greater amount and more inconvenient hours of work being experienced by nurses. Alternatively, the culture of the organisation may not be supportive of lifelong education, because a culture of lifelong-learning has been shown to play a key role in providing the necessary context for the transfer of knowledge to occur, and therefore, for social capital to be developed (Cohen & Prusak, 2001; Dess & Shaw, 2001; Leana & Van Buren, 1999). The practice of lifelong learning is relevant to this research because increased levels of education and the potential for, or availability of, career opportunities is likely to increase the competence of nurses, thereby improving their perceptions of empowerment in their work. Previous research supports the
relationship between a culture of life-long learning and perceptions of empowerment (Christiaens et al., 2010). Furthermore, educational and career opportunities are attractive to potential and current nursing staff (Aiken, Smith & Lake, 1994; Romano, 2002) thereby increasing the potential of nurses to remain committed to the organisation if they perceive that it will be advantageous for them to remain.

Another very interesting finding in this research was that teamwork amongst colleagues accounted for 84% of nurses’ perceptions of self-determination. This was a significant finding and suggested that the benefits obtained from working within a team, such as closer relationships and increased support, might have improved nurses’ perception that they had control over how their work was undertaken. The qualitative data supported the quantitative findings and found that perceptions of empowerment were enhanced by levels of teamwork and relationships with colleagues. This confirms previous research which suggested that employees develop greater meaning from high quality teamwork such as increased perceptions of empowerment (Dodds et al., 1991; Quinn & Spreitzer, 1997; Siegall & Gardener, 2000). Perhaps teamwork contributed so greatly to nurses’ perceived self-determination because teamwork allows the allocation of duties in accordance with each individual’s strengths. Furthermore, teamwork entails the exchange of information and knowledge that would be beneficial to nurses in undertaking their work. This was an important finding in light of the focus of this research on relationships within the organisation. Furthermore, it identifies the large role that non-supervisor relationships play in making up the relational dimension of social capital.

Another factor that may have contributed to nurses’ less than desired perceptions of empowerment may have been restrictive practices such as extensive policies and procedures. The extensive reforms that occurred to the health sector in Australia in recent years did alter the culture of health organisations as reported in previous research (Buchanan & Considine, 2002; Hegney et al., 2005). An increase in the quantity of policies and procedures was one outcome of this (Senate Community
The qualitative data identified that increased policies and procedures that resulted from these changes were reported in this research to have negatively impacted upon nurses’ perceptions of empowerment. Specifically, policies and procedures were reported to have the single greatest negative impact on nurses’ perceptions of empowerment. The reasons for these are numerous, but many nurses pointed to unnecessary wastage of time, resources, or nursing skills. One prevalent theme that emerged from the data was the negative impact that policies and procedures, among other factors, were placing on nurses’ ability to care for their patients. Nurses consistently stated that they were unable to provide the level of care to patients that they desired. This is not surprising considering previous research which has suggested constant pressure to meet financial and other targets, which is another feature of new public health initiatives aimed at increased efficiency (Buchan & Calman, 2004; Buchanan & Considine, 2002; Winthrop & Vane, 2002). The qualitative data also suggested that the increase in policies and procedures has also been detrimental to nurses’ perceived levels of autonomy. First, the data suggested that nurses’ levels of autonomy might have decreased which supported previous research (Friedson, 1994; Harrison, 2003). Second, nurses identified that possessing autonomy is necessary for nurses’ perceptions of empowerment, which also supported previous research (Upenieks, 2003).

Previous research into perceptions of empowerment has discovered that employees must experience all four dimensions of empowerment at the same time in order for organisations to benefit from the employees’ high levels of empowerment (Spreitzer et al., 1997). However, this was not the case with the organisations examined within this research with only two of the four dimensions scoring positively. This result meant that the benefits that may be derived from increased perceptions of empowerment such as increased levels of commitment among others (Fulford & Enz, 1995; Kraimer et al., 1999; Laschinger et al., 2001) were not being received. Therefore, organisations need to focus on improving all dimensions of empowerment to receive the full benefit of more empowered employees.
The research from this sub-theme contributes to the literature by confirming a number of assertions previously made in the literature. The nurses within this research were identified as being marginally empowered in their work by believing in the work that they undertake and their ability to do that. However, they did not perceive that their work was valued by their organisation, or that they possessed much control over how that work was undertaken. This research supported existing research which has demonstrated a relationship between all variables examined in this research, particularly two-way supervisor-employee communications and the extent of ambiguity surrounding nurses’ work roles. In addition, this research adds to the literature by identifying that nurses positively experienced only two of the four dimensions of empowerment that is necessary for benefits to be received. Therefore, the examined organisation has several avenues for improvement if they are to enjoy the benefits of empowered nurses which can include increased motivation and satisfaction among others.

### 7.5.4 Major theme 3.4: Job performance

The fourth individual outcome sub-theme identified in the data was that nurses’ job performance was being affected by the issues under investigation. The key findings associated with this theme are shown in Figure 7.11. Although the job performance of nurses was not directly examined in this research, it did emerge throughout the qualitative data as a consistent issue that was impacted upon by the other variables examined. The nurses’ ability to perform their work efficiently and effectively was reportedly affected by the lack of resources and facilities available, as well as the lack of nursing staff. One likely reason for this inability to perform their work optimally is the increased ambiguity that would arise when insufficient materials, machines or adequate nursing staff were available in the course of caring for patients. Subsequently, additional time would be spent trying to solve the problem at hand resulting in a loss of time, decreased quality of patient care, and increased stress for nurses.
In addition, nurses within this research reported that the policies and procedures in place were very restrictive and quite often made their work more difficult. This was reported to prevent second order problem-solving, which adopts a longer term solution to prevent problems from recurring, and also decreased nurses’ sense of empowerment in undertaking their work. This finding supports the literature by suggesting that excessive paperwork affected the quality of patient care given (Cherry et al., 2007; Tuckett et al., 2009). Therefore, it was not surprising to find that nurses within this research were not feeling empowered in their work. Interestingly, the existence of policies and procedures is aimed at reducing ambiguity in the work environment and ensuring quality processes. However, this research clearly does not support the use of policies and procedures as assisting these goals but instead, is suggested to further erode quality processes as well as the efficiency and effectiveness of work outcomes.

Finally, the performance of nurses was reported to be negatively affected by the poor communication processes in place. This qualitative finding was largely directed towards upper levels of management, but also applied to the NUMs. Previous research has repeatedly demonstrated the importance of effective communication processes in a number of outcomes such as effective problem-solving (Kim, 2002; Rothwell & Scedl, 1992), reducing role ambiguity (Johlke & Duhan, 2000; Johnson, 1993), and a more positive organisational culture (Rothwell & Scedl, 1992). Therefore, a number of organisational processes, including those listed above, were likely to suffer as a result of poor communication processes.

**Figure 7.11** Major theme 3.4: Job performance
Therefore, this research has identified preliminary results pertaining to the reportedly reduced efficiency and effectiveness of nurses as a result of the resource and nurse staffing shortages, as well as the high incidence of policies and procedures, and communication processes. This research has identified possible relationships amongst these processes and highlights the need for further research into this area to both confirm and further understand these relationships.

7.6 Major theme 4: Organisational commitment

The fourth major theme identified in the data was that nurses’ reported that they were not highly committed to the organisation. The research questions, hypotheses and key findings associated with this theme are shown in Figure 7.12. The overall aim of this research was to identify the impact of a number of factors on nurses’ commitment to the organisation, termed affective commitment. Previous research assumes that when employees want to stay with an organisation, a number of other outcomes are also improved (see Alpander, 1990; Morrison & Chan, 2000). Furthermore, because affective commitment focuses on the employees’ desire to remain with the organisation as opposed to their perceived duty to remain, or focuses on what may be lost if they were to leave, affective commitment seems the most likely form of commitment with advantages to both the employee and the organisation. RQ₁ is discussed last in this chapter because in order to understand the factors that impact upon nurses’ affective commitment, it was necessary to first examine and understand those factors.
This research identified that, on average, the nurses within the organisation reported possessing low levels of affective commitment. Added to this was the 16% of nurses who planned to leave their position in the next year. These are very poor outcomes for the organisation and explain, in part, why the wards that were examined experienced high levels of turnover. The main assumption that can be made from the poor levels of affective commitment was that the nurses might have been remaining with the organisation because they felt that they should remain, or because the cost of them leaving the organisation would be greater than if they were to stay. Perhaps the positive cultural aspects of the organisation mentioned previously such as the availability of educational and career opportunities, physical location of the hospital, and the high quality of relationships with colleagues, may have been what was constituting nurses’ levels of normative and continuance commitment. These attributes were therefore probably working in the organisation’s favour when affective commitment was low.

The quality of the relationship between nurses and their NUMs was significantly related to nurses’ commitment to the organisation, which supported previous research in this area (Brunetto & Farr-Wharton, 2004; 2006; 2007; Gerstner & Day, 1997; Naude & McCabe, 2005). The qualitative data supported this when nurses suggested that management needed to change particular behaviours in order
for nurses to remain committed. Therefore, the NUM or supervisor played an important role in encouraging and improving nurses’ commitment to the organisation. Similarly, communication processes were also significantly related to affective commitment to the organisation, although less significantly than the quality of exchanges between supervisors and employees. The two-way flow of communication and indirect communication that encourages discussion rather than instructions for compliance, were equally significantly related. The qualitative data was more descriptive and reported that improving communication processes was indeed a prerequisite for nurses to remain with the organisation. Nurses clearly stated that they desired greater information, feedback and levels of collaboration between themselves and management. This was likely to be due to the desire to be listened to by management and for the needs of nurses to be heard and taken into account. Therefore, both the quantitative and qualitative results suggested that communication processes were significantly related to the affective commitment of nurses to their organisation. Furthermore, it also identified that improving the amount of communication through methods such as feedback and collaboration, might have been necessary for nurses to remain with the organisation, which, again supported previous research (van Vuuren et al., 2007). This meant that nurses felt that at least part of their desire to stay was dependent upon open two-way communication between the supervisor and employee.

Role ambiguity experienced by nurses was significantly related to affective commitment to the organisation, particularly in relation to ambiguity surrounding supervisors. This parallels previous findings in this research and in previous research conducted by others (Allen et al., 2001; Foote et al., 2005; Mathieu & Zajac, 1990). The quality of the relationship held between supervisors and employees was undoubtedly a contributing factor to this result and highlighted the importance of improving the quality of the relationship and its accompanying communication processes in order to reduce levels of ambiguity, and potentially improve nurses’ commitment to the organisation.
The culture of the organisation played a large role in nurses’ commitment to the organisation, which supported previous research in this area (Chen, 2004; Liao et al., 2008). All dimensions within culture were significant predictors of affective commitment with morale playing the largest role. Each of these findings is important and suggested that the “way that things are done around here” and the level of motivation and positive feelings possessed by nurses across the organisation, might have played a large role in nurses’ commitment to the organisation. The qualitative data supported the quantitative findings and suggested that a culture existed within the organisation where nurses felt that they were not respected and supported, which would have decreased morale. These would have clearly contributed to nurses’ lack of commitment to the organisation. This lack of respect and support was also likely a contributing factor to the morale within the organisation.

Perceptions of empowerment and affective commitment to the organisation were also strongly related, particularly regarding nurses’ perceived impact of their work towards the overall goals of the organisation. This meant that nurses might have needed to feel as if they and their work were contributing and valuable to the purpose of the organisation, which is to provide quality care to its patients. This is supported by the qualitative findings which identified that nurses reported great fulfilment in their work and the knowledge that they are helping people. Furthermore, these findings supported previous research in this area (Fulford & Enz, 1995; Menon, 1999).

The qualitative findings suggested that pay was an important contributing factor to nurses’ commitment to the organisation. Although nurses reported being satisfied with the financial benefits being received, such as salary sacrifice and superannuation, they were not satisfied with their pay rates. This finding supported previous research by Pillay (2009) and Hegney et al., (2005), which suggested that nurses desired more money for their work. However, this finding contradicts research which suggested that satisfaction with pay was not significantly related to retention (Cowin et al., 2008). This is important because affective commitment is a
predictor of turnover (Liao et al., 2008; Vandenberghe & Bentein, 2009) and therefore, nurses’ dissatisfaction with their pay suggests that improving pay levels may reduce turnover while increasing commitment and retention.

The demographics of the sample in this research also likely influenced the levels of affective commitment and degree of turnover. Even though this survey sample is representative of the nursing population in Australia, with figures obtained from the Australian Bureau of Statistics, the largely female-dominated profession does involve many challenges. The nursing profession within Australia consists of 91% females and due to females’ role as the bearer of children and frequently the one who primarily cares for children, females do commonly take career breaks for these reasons or work in a part-time capacity (ABS, 2008b). This may be one of the first reasons for the high level of turnover. In addition, nurses may be rostered to work at any time across 24-hour days, seven days a week, on a shift work basis or work overtime as 20% of the nurse population is reported to do so (ABS, 2008b). These circumstances were identified in the data to be an issue for nurses with increased overtime and less flexible roster hours. This supported previous findings by Buchanan and Considine (2002) which found that the high incidence of shift work combined with other problems such as the exhausting and demanding nature of nursing work were negative issues for nurses.

To summarise this sub-theme, this research has examined the impact of multiple variables on the commitment of nurses to their organisation. This research adds to the literature by confirming existing research that nurses report to not be highly committed to their organisation and most likely are remaining due to a perceived obligation or because the risks of leaving outweigh those of remaining. In addition, this research also confirms that the affective commitment of nurses is impacted upon by all of the variables examined within this research, together accounting for 43% of nurses’ affective commitment. Of these, the most significant variable was the culture of the organisation which highlighted the continuing difficulties of changing the culture of healthcare organisations in order to improve efficiency and effectiveness.
7.7 Differences between policy and practice

Analysis of the differences between organisational policy and organisational practice identified four main differences in investigation of Research Question 4. The first major difference was a reported lack of support from NUMs. Organisational policy dictated that nurses approach their manager or NUM for any type of assistance or information that may be required as part of their employment within the organisation. However, the nurses reported that NUMs were frequently too busy with their own high workloads to be able to assist their nursing staff efficiently. This led to nurses approaching other contacts such as the Clinical Nurse or nurse colleagues for assistance to meet their needs. The main outcome of this situation is that nurses may not have been receiving adequate support from their NUMs, while both organisational documents dictated that they should receive support and that nurses would typically need support from a supervisor within the workplace. Subsequently, the quality of the supervisor-employee relationship may not have been optimal and nurses might not have been effectively supported by their supervisor. This demonstrated an important gap between the quality of the relationship espoused by organisational policy and the reality of the quality of the relationship for nurses. In addition, the reported lack of availability of NUMs may have contributed to the poor cultural attributes that nurses reported. The continued occurrence of NUMs reportedly not being available may also have been contributing to a culture that is characterised as “us and them”, where employees and other levels of management are viewed as different and separate groups. Evidence from this research has suggested that this might have already been the case between nurses and upper levels of management, and the same situation may have been occurring between nurses and their NUMs. Each of these situations has negative implications for high quality supervisor-employee exchanges and communication processes.

The second major difference between policy and practice was the reported lack of resources, facilities and nursing staff which, according to the nurses, led to decreased quality of patient care. For example, organisational policy dictated that
the organisation aimed to provide quality health services to its patients. However, nurses within this research identified that they were providing a lower quality of care to their patients than they desired, due to the restraints placed on them. Therefore, a gap is evident between the degree of patient care espoused by policy, and the reality of decreased patient care provided by nurses. The reason why a lack of relevant materials to perform their work effectively might have led nurses to feel that they were not being supported is because these materials are essential for the successful undertaking of their work. When nurses feel that these are not provided, nurses receive the message that their work is not important enough to warrant being allocated sufficient funding/resources for the necessary materials. Therefore, in addition to not receiving adequate support from the supervisor, nurses were also reportedly undertaking their work without the necessary physical support from resources, facilities and other nursing staff.

The third major difference between policy and practice was the negative effect that organisational policies and procedures had on nurses’ work duties. The data from this research showed that nurses perceived that the high quantity and restrictive nature of the policies and procedures within the organisation frequently prevented them from effectively performing their work. In addition, these policies and procedures reportedly had a very clear and negative impact on the ability of nurses to feel empowered in their work. This was most likely due to the perceived inability to make their own decisions or take greater control over how their work was undertaken. Subsequently, nurses may have felt that organisational policy and practice served to force them to undertake their work in a specified manner as opposed to supporting them to undertake their work in a more efficient, effective and enjoyable manner. With time, this problem is likely to grow, as organisational policies and procedures will potentially become greater in number and more specific, leading to more restrictions on nurses and even less perceived empowerment.

The fourth major difference between organisational policy and organisational practice was the gap between the value placed on nursing staff as espoused by
organisational policy, and nurses’ perceived reality of a lack of value, respect and support. For instance, organisational policy consistently communicated the value of its staff through valuing and supporting the work that they do and that their staff are their most important asset. However, nurses reported that they did not feel valued, respected, recognised, supported or listened to, which supported existing research (Faulkner & Laschinger, 2008; Laschinger & Finegan, 2005; Webster et al., 2009). This suggested that a clear gap existed between the espoused value placed on nurses and the perceived reality of a lack of valuing of nurses, supporting the conclusion that nurses were also failing to be adequately supported in their work.

The overarching conclusion to be derived from the differences identified between organisational policy and organisational practice is that nurses perceived themselves to be operating in an environment with insufficient support from their supervisor, upper levels of management, and from organisational inputs such as resources and facilities, that are essential to undertake their work effectively. The gaps between organisational policy and organisational practice identified here are important because positive improvements in general, and particularly in outcomes such as nurse commitment, will not be achieved if organisational practice does not reflect organisational policy. These gaps demonstrate exactly why nurses might not be committed to the organisation, and where organisational management need to direct their attention if nurses’ commitment is to be increased.

### 7.8 Conclusion

This chapter has interpreted and discussed the quantitative and qualitative findings of this research and identified a number of significant findings. Many of the findings support previous literature and several contribute new knowledge to the literature. Specifically, this research has identified that the quality of professional relationships and the lack of support provided to nurses within the organisation had an important and significant impact on a number of individual outcomes, and ultimately, nurses’ low levels of commitment to the organisation. Specifically, it was
the quality of the relationships with nurses’ supervisors, upper levels of management, and colleagues that were most influential. Furthermore, a lack of support with regards to low reported levels of respect towards nurses, a poor organisational culture in general, and a lack of appropriate resources and facilities with which to conduct their work, were also significant contributors towards the low levels of commitment exhibited by nurses. Finally, the data suggested that nurses were ambiguous towards both their supervisor and how to care for their patients, which contributed to low levels of perceived empowerment and decreased job performance.

The next chapter discusses the overall conclusions of this research and the contribution that these make to the literature.
CHAPTER 8 – CONCLUSION

8.1 Introduction

This final chapter begins by summarising the major themes identified from the quantitative and qualitative data and the theoretical contributions of the research. The implications of these findings for organisational management and policy are then discussed, and finally, the limitations of this research and areas for further research are provided.

8.2 Summary of major themes

As detailed in Chapter 1, the research problem investigated in this thesis was “How does the quality of relationships at work impact upon the organisational commitment of nurses?” This research problem was addressed through four research questions and 13 hypotheses. RQ₁ examined what is the impact of variables that display qualities of relational, cognitive and structural social capital on the role ambiguity, perceived empowerment, and affective commitment of nurses? The factors that impacted upon nurses’ commitment to the organisation fell into three categories of (1) the quality of relationships with the NUMs, upper levels of management, and nurse colleagues, (2) a reported lack of support from others within a poor quality organisational culture, and (3) the quality of individual outcomes that resulted from these.

The first factor affecting nurses’ commitment to the organisation identified that the quality of the relationship between nurses and their supervisor, the NUM, was likely to have been poor. On average, the quality of exchanges was considered satisfactory, but a poor working relationship in general was identified. The reasons reported by the nurses included that NUMs were frequently too busy to be able to assist nurses with problems or other daily activities, and communication processes were also poor. Significant issues were the perceived lack of feedback and
consultation opportunities provided with nurses which concurred with the extant literature. This finding was significant for this research as the relationship between an employee and their supervisor is considered to be one of the most important relationships held by an employee. Furthermore, both this and existing research suggested that this relationship was strongly associated with organisational commitment and a number of other outcomes. Similarly, the relationship between nurses and upper management was reported to be very poor and nurses indicated that an improvement in the behaviour of management through increased consultation and respect towards nurses was a significant issue that influenced their commitment to the organisation. This was a significant finding and is an important area for further investigation due to the identified gap in the literature. In contrast, nurses highly valued the quality of relationships with their colleagues and found this to be a strong source of support, which was an unexpected finding and was not examined in any depth in this research. However, the finding did parallel existing research and confirmed the importance of collegial relationships and social support in strengthening employees’ commitment to the organisation.

The second factor affecting nurses’ commitment to the organisation was a perceived lack of support. This included material support such as adequate funding to provide resources such as beds, equipment and improved staff-patient ratios. It also included a reportedly poor organisational culture that was characterised by a general lack of respect and recognition for nurses as well as a lack of involvement and input into organisational decisions, thereby resulting in poor levels of morale. The reported lack of inputs in the form of material support is significant as it demonstrates the impact that health sector reforms have had at the ward level, and the resulting impact upon nursing staff. Furthermore, despite the fact that many of the health sector reforms are considered to be cultural changes, the fact that nurses perceive their organisational culture negatively suggested that the reforms had not had the desired and intended affects. This was confirmed through the identification of multiple areas of difference between organisational policy and organisational practice, which has extended the literature in this area. Moreover, a significant body
of research exists which suggests that the culture of an organisation is a significant contributor to levels of commitment, which was confirmed in this research.

The third factor affecting nurses’ commitment to the organisation was the quality of the outcomes that resulted from the first two factors. Nurses reported that they experienced significant amounts of ambiguity in their role, particularly regarding their supervisor, and did not feel empowered in their work due to a lack of choice in how to undertake their duties and a poor understanding of the impact of their work upon the overall goals of the organisation. They did, however, take great meaning from their work and believed in the competency of their skills. Ultimately the combination of all the aforementioned factors, together with perceptions of an excessively high level of unnecessary paperwork and restrictive policies and procedures, led to reported decreases in nurse performance and the quality of patient care.

Regarding nurses’ organisational commitment, this thesis identified that nurses most likely had low levels of commitment to their organisation, despite feelings of fulfillment in their work. Sixteen percent of nurses considered leaving their present position within the next year. This figure is likely to impact upon the organisation, its employees and nurses, and the daily work activities and processes. These findings confirm that nurses may still not be committed to their organisation and are leaving. Furthermore, the amount of nurses planning to change from a full-time to part-time capacity suggests that the needs of nurses are changing and will continue to do so, and that it is necessary to keep up with these changes if organisations are to retain their nurses.

Regarding SCT, the three factors mentioned in the previous paragraphs suggested that there were several areas to be addressed to improve the social capital present in the organisation. To interpret the relational social capital present, an analysis was undertaken on the quality of exchanges and communication processes between nurses and the NUMs, and was extended by unexpected results regarding the reportedly poor relationship with upper levels of management and
highly valued collegial relationships with nurses. These findings suggested that the quality of relationships, and therefore, nurses’ relational social capital in general, might have been poor. Importantly, these were identified as being significantly associated with their organisational commitment. To interpret the cognitive social capital present, an analysis of the organisation’s culture was undertaken, and was supplemented by qualitative data which identified that nurses perceived that they were operating in an environment with insufficient resources with which to do their work. The culture of the organisation was reported to be poor and suggested that it did not support the relationships in place. Finally, the structural dimension of social capital was interpreted through examining the social networks used by nurses to help them solve problems and found that the majority of nurses possessed effective problem-solving social networks, although a minority possessed a very small or no network at all to support them.

Problem-solving social networks were explored through RQ$_2$ which examined who are the members of nurses’ problem-solving social networks and what is the strength of the ties between contacts and RQ$_3$ examined how effective are nurses’ problem-solving social networks and what is the role of supervisors in this network. The data identified that most nurses possessed a network consisting of between two and five contacts, and that most nurses knew their contacts fairly to very well, with only a small percentage of nurses possessing no social network contacts at all. NUMs and Clinical Nurses were the first contacts approached for assistance and when NUMs were not approached, it was because they were perceived to be too busy and unavailable to assist. Overall, nurses reported that their social network was from fairly to very effective in helping them to solve problems on the ward. Other than the nearly 5% of nurses who possessed no social network contacts at all, the data suggested that nurses’ social networks were effective in helping them to solve problems. These findings are significant because problem-solving is a key skill required by all employees in a work environment, and because they make a significant contribution to the gap in the literature regarding who nurses approach for assistance with work related problems. The other interesting finding was that nurses first approach those they believe have the knowledge and experience, but
second, they go to those who they believe are approachable, before they go to those who are supportive or in a formal help role.

The final research question examined in this research was RQ\textsubscript{4} which examined the differences that exist between organisational policy and organisational practice regarding variables that display qualities of relational, cognitive and structural social capital, and work outcomes such as role ambiguity, perceived empowerment, and affective commitment of nurses. The data identified a gap between the degree of support that was required to be provided by NUMs towards nurses in accordance with organisational policy, and the perceived lack of support being received from their NUM in practice. This may be as a result of reportedly high NUM workloads. In addition, there was a gap between organisational policy, where the quality of patient care is paramount, and the reality of practice where nurses feel that they are providing a decreased quality of care due to a perceived lack of resources and time due to high workloads. Similarly, a gap was identified between the espoused high value placed on nurses, and the reality of a lack of respect and support perceived by nurses. Finally, the large amount of policies and procedures were reported to frequently inhibit nurses from performing their work to the best of their ability, and from feeling empowered to do so. These findings are significant because they identify areas in which organisational practice may not meet organisational policy. Furthermore, these differences provide clues as to why nurses may not be committed to their organisation. Importantly, these findings make a significant contribution to the knowledge surrounding policy-practice differences, particularly in a nursing context.

Overall, this thesis has addressed the research problem investigated which was “How does the quality of relationships at work impact upon the organisational commitment of nurses?” A number of findings were identified and significant contributions and extensions were made to a number of literatures as described next.
8.3 Contributions to theory

This study makes a number of major contributions to the social capital, organisational behaviour, and nursing literature in the management, organisational behaviour and health disciplines. This research has extended the literature on organisational commitment by using Nahapiet and Ghoshal’s (1998) model of relational, cognitive and structural social capital simultaneously to aid in understanding the factors impacting upon nurses’ commitment to the organisation. Testing all three dimensions of the theory simultaneously was useful because it allowed this research to explore organisational commitment using a broader approach, which enabled the researcher to focus on the context surrounding the variables under investigation and identify relevant variables that may have impacted upon that. Furthermore, the collective combination of the three dimensions provided a better understanding of how workplace relationships affect nurses’ outcomes as opposed to examining only one or two dimensions from the model. The SCT framework was therefore useful in exploring more complex relationships amongst constructs. The broader approach undertaken through the use of a mixed methods approach identified that the quality of relationships with a multitude of other individuals did have a significant impact upon the organisational commitment of nurses. This research contributes to the literature by increasing our understanding of the breadth of social support needed by employees in helping them to remain committed to the organisation. Specifically, this research identifies that although social support from a variety of people is needed, support is especially required from the nurse employee’s supervisor, upper levels of management, and from their colleagues. This research in particular has identified that nurses perceive that they are indeed lacking a number of support mechanisms from their organisation, which have the potential to affect their commitment to the organisation.

This research also adds to the literature by identifying that the quality of the relationship between nurses and their NUMs directly impacts upon their levels of role ambiguity within the workplace. Furthermore, this ambiguity is then directly
related to nurses’ perceptions of empowerment in their work and subsequently their commitment to the organisation. These findings contribute towards knowledge on the importance of the role of supervisors in affecting employee outcomes. Therefore, this research adds to the literature by identifying that the quality of the relationships with each of a nurse’s supervisor, upper levels of management, and colleagues, impact upon her/his commitment to the organisation. Moreover, these findings suggest that the stock of relational social capital held by an individual is valuable for each of the outcomes measured here, and ultimately nurses’ organisational commitment.

An examination of organisational culture to identify cognitive components of SCT identified and confirmed existing research in this area. It does however, contribute to our understanding of how cultural attributes such as teamwork and morale, among others, impact upon the organisational commitment of nurses. However, identification of the extent to which differences existed between organisational policy and organisational practice has contributed to knowledge regarding the importance of integrating organisational policy in daily work activities. Furthermore, the data has identified that differences between policy and practice lead to greater role ambiguity and therefore decreased perceptions of empowerment, as well as decreased job performance and commitment to the organisation. Added to these differences was the impact that a perceived lack of organisational inputs such as resources and facilities, had on nurses’ ability to perform their work. This contributed towards knowledge of how the challenges being faced in the health sector are impacting upon nurses’ ambiguity in their role and empowerment to do their job well. The reason this is important is that we know that these factors directly impact nurse retention, which is a major challenge for hospitals in Australia.

Exploration of the structural components of SCT through examination of the social networks used by nurses to help them solve work related problems has extended the scant literature available in this area. The data identified that nurses prefer to approach individuals with the greatest level of expertise and experience in
the related problem, which was typically the NUMs and Clinical Nurses on the ward. Coincidentally, these individuals also hold more formal authority on the ward, suggesting that authority may play a role regarding which contact to approach. A greater understanding of the contacts that are approached for assistance in problem-solving has been achieved by identifying three important professional relationships that nurses held with the supervisor, a Clinical Nurse with relevant knowledge and experience, and nurse colleagues. This research has demonstrated that the social network used by nurses was effective and therefore, actions aimed at improving the quality of workplace relationships are warranted. Importantly, this research identified that the size of problem-solving social networks can vary greatly, and that the effectiveness of the social network is more likely to be due to the quality of the relationships present, as opposed to the quantity of contacts. Finally, this research identified that knowledge and experience are vital requirements for choice of help providing contacts in problem-solving social networks. Furthermore, it was identified that NUMs were not able to play a larger role in these processes due to nurses perceiving that their NUM was not frequently available, mostly because of their own workload responsibilities. These findings contribute to knowledge regarding the potential impact that health sector reforms have had on the Nurse Manager role and the critical added support being provided to nurses as a result of having support roles, such as Clinical Nurses, in the ward.

This research further contributes to the literature regarding management practice and policy/practice differences, by identifying a number of remaining gaps. The data suggested important gaps between the actual practices and espoused values about the quality of employee relationships with all levels of management, the quality of patient care, respect towards, and value of, nurses, and finally, the outcomes of organisational policies and procedures. These findings have extended the scant literature on policy/practice differences, particularly with regards to nurses, and confirms previous findings relating to the reasons for these gaps such as a lack of resources and funding, and high workloads.
8.4 Implications for management

The findings of this research suggest a number of implications for organisational management. One major implication is with regards to the culture of organisations which produces a context that either positively or negatively influences the behaviour of employees within the organisation. Interestingly, the recent reforms being experienced by the healthcare industry have been specifically targeted towards changing and improving the culture of health organisations. However, this research has demonstrated that there is still some way to go. The studied organisation’s culture still did not provide the level of respect and recognition that nurse employees were seeking and the morale amongst nurses was reported to be poor. Adopting and increasing the quality of initiatives such as those used in the Magnet program into the studied organisation may lead to more positive outcomes as documented by Magnet-designated hospitals (Aiken et al., 2000; Upenieks, 2003). For instance, management should consider increasing nurses’ levels of input and involvement in decisions that affect their work, such as during meetings and by increasing the amount of consultations with nurses more than occurred at the time of the research. This would help to move towards an organisational culture in which nurses feel that they are more valued.

Organisational management and NUMs are advised to reconsider the conduct of ward meetings and shift handovers. These meetings are ideal instances for nurses to be given the opportunity to be heard and provide input and suggestions into the daily operations of the ward and the quality of patient care provided. By enabling this, nurses would perceive that they are recognised for their contribution to the organisation, which is likely to improve their perceived empowerment. NUMs play an incredibly important role in this as they are usually in charge of meetings and will set the tone for what occurs during that time. It would also undoubtedly reduce nurses’ ambiguity surrounding both their supervisor and patients, and potentially other forms of ambiguity. Together, these techniques would serve to increase the amount of perceived autonomy experienced by nurses and their perceptions of empowerment. The implications of these increases include improved commitment.
and therefore, better retention, both of which are critical to the effective achievement of organisational goals and increased patient care.

Management needs to consider the use of tools that will strengthen and improve the quality of professional relationships and provide greater sources of social support for nurses. One such tool is mentoring, which encourages relationships and networks between more experienced and less experienced nurses and provides nurses with more feedback and emotional support, and a wider range of access to other contacts (Joiner & Bartram, 2004; Schroeder & Worrall-Carter, 2002; West et al., 1999). Mentoring would enable nurses to develop relationships with colleagues and improve the quantity and quality of exchanges, communications, flow of information, and ultimately improve nurses’ levels of involvement within the organisation (Duffy, Docherty, Cardnuff, White, Winters & Greig, 2000; Heartfield, Gilson & Nasal, 2005). Mentoring may be arranged through incorporating a buddy system that pairs newcomers and graduates with more experienced nurses within the ward. Alternatively, mentoring may be used to accompany formal education that a nurse is undertaking and reinforce the learning with applied learning under the supervision of an appropriately qualified higher level nurse. There are multiple instances where mentoring may be applied to improve both the quality of the relationships between the two parties in the mentoring relationship, but also to enhance the socialisation of new nurse staff and enhance and reinforce learning conducted outside the ward environment.

The flow of information and communication between nurses and their NUMs and also upper levels of management, reportedly needs to improve so that nurses perceive that they are kept informed of what is occurring, so that they feel more involved, and so as to reduce levels of role ambiguity being experienced. For example, the current use of techniques such as flyers and memos on ward noticeboards could be increased. In addition, these tools provide an opportunity for supervisors to build upon the quality of exchanges, two-way communication processes, and therefore their relationship with nursing staff. Nurses also need to feel that their NUMs are more available to their nurses on a more frequent basis.
Although an open door policy was briefly mentioned in the data, greater effort needs to be made by NUMs to ensure that this behaviour occurs in practice and is understood by nurses. One way may be to make nursing staff a higher priority than they currently are, so when nurses need assistance with a problem, the NUMs will make the necessary time available to them. These behaviours are all likely to result in more empowered and committed nurses, thereby reducing turnover and improving retention as previously established in the extant research (DeCicco et al., 2006; Faulkner & Laschinger, 2008; Joiner & Bartram, 2004; Spreitzer, 1996).

Nurses may assist in improving the flow of information and communication by actively seeking information from noticeboards and through other organisational documentation. Furthermore, nurses can more frequently utilise the NUMs’ open door policy for information and assistance with work-related problems. Nurses can also ensure that when the open door policy is not effective or being supported, or when NUMs are not making themselves available to their staff, that the nurse takes the responsibility to ensure that this is communicated to the NUMs so that it may be rectified.

Upper levels of management should consider making their decisions more transparent and open to input from their nurses in an effort to improve the quality of nurses’ relationships with them and to improve the quality of the organisation’s culture. This includes increasing communications to and from nurses and seeking nurse input through increased consultation. Furthermore, this would increase the presence of upper management to nurses thereby reducing the “us and them” mentality. NUMs would also benefit from the increased support provided to them and their nurses as a result of these actions. As mentioned earlier, such changes to the ways that upper management make decisions, including greater transparency, will likely increase commitment to the organisation, with consequential decreases in turnover.
8.5 Implications for policy

As identified in both the extant literature and the results of this research, many of the factors affecting the organisational commitment of nurses may be attributed to the role of public policy. The Australian Government controls hospital funding which impacts on nurses at the end of the line by reducing the amount of beds and other resources available, as well as the quantity of nursing staff available. These controls have resulted in a perceived lack of beds, resources, nursing staff, and higher workloads. This research suggests that these occurrences have resulted in poorer nurse outcomes including increased role ambiguity and decreased perceptions of empowerment and organisational commitment. Therefore, government should consider increasing funding for additional resources and nurses, as well as increasing pay entitlements to both increase the commitment of nurses currently employed, and to increase the attractiveness of the profession to encourage existing nurses to return to work, and to encourage uptake of additional training places that have been provided in recent years.

Previous research has identified that nurses seek greater autonomy in their work and government could consider increasing the range of roles with higher levels of autonomy such as Nurse Practitioners. Alternatively, policy to increase the autonomy of existing nurses, such as has been done with Certified Midwives, which could also be operationalised elsewhere, would help to increase nurses’ satisfaction with their levels of autonomy. This is important because increased autonomy leads to increased perceptions of empowerment and enables nurses to feel more empowered and satisfied in their work.

Additional changes to public policy could entail increased incentives, particularly financial incentives, for additional education and training. This would increase the competency and breadth of skills of nurses, while also increasing their level of autonomy and perceived empowerment in their work, plus the overall attractiveness of nursing as an occupation.
8.6 Limitations

Even though this research has made a number of significant contributions to the literature, there were some inherent limitations. The first of these limitations related to the context in which the research was undertaken. This research was conducted on nurses working within a hospital environment in only two public sector hospitals located within one state of Australia. Therefore, the findings from this research may not be generalised to all nurses working within hospitals in Australia, but rather, may be limited to nurses working within public sector hospitals.

The second limitation was the restricted access to nurses, which decreased the sample size available for this research. That is, hospital management were only interested in knowledge about wards with higher turnover of nursing staff and therefore they restricted the researcher’s access to these wards only, denying access to wards with lower levels of nurse turnover. This resulted in smaller sample sizes for surveys, focus groups and interviews, and access to only two research sites. Accordingly, comparisons were not able to be made between low and high turnover wards of nursing staff to determine differences in outcomes. Furthermore, the restricted sample size may have biased the overall findings in terms of representativeness. For example, the interview sample group had more males and was predominantly full-time nurses, which was different to the focus groups and survey respondents, but also not representative of Australian nurse demographics. Moreover, access to organisational documents was restricted due to confidentiality concerns and resulted in the analysis of publicly available documentation only, which also may have biased the representativeness of the documents. Confidential documents that are only available to employees of the organisation are more likely to contain other specific and relevant information to this research. Furthermore, such confidential communications are likely to be greater in number and specifically directed towards the nurse employees. The lack of permitted access to confidential documents also limited the quantity of information regarding organisational policy that was available to the researcher for comparison with organisational practice.
Therefore, a limitation of using publicly available documents is that more relevant and information-rich data may not be available in these documents.

The third limitation of this research was the incidence of multicollinearity due to the similar nature of some of the concepts examined within this research, such as leader-member exchange and communication processes. This may have reduced the ability of the instruments to measure what they intended to. However, the researcher conducted a principal components analysis to identify similar constructs and combine them appropriately, based on their underlying dimensions. The transformed variables that arose from this were then used in all quantitative analyses.

8.7 Issues for further research

This research has identified a number of areas that would benefit from further investigation. A review of the literature by the researcher has firstly identified that empirical research into SCT surrounding nurses is extremely limited. The findings of this research have come some way in contributing to that knowledge. However, a greater understanding of nurses’ relationships at work and how these are used by nurses in their daily work environment will contribute to knowledge regarding how to optimise nurse and other employees’ outcomes and potentially, organisational outcomes. By increasing understanding of these, it may be possible to build upon this knowledge and increase nurses’ commitment to the organisation, which then has the potential to improve retention levels.

Further, a review of the social capital literature identified that a more holistic and wide approach to understanding social capital held by employees at the organisational level is necessary. Although relational, cognitive and structural social capital, as per Nahapiet and Ghoshal’s (1998) framework, was commonly used and referred to in previous research, the simultaneous study of all three dimensions has not been a focus of recent research. It is proposed that a collective understanding of
all dimensions of social capital is necessary for a comprehensive understanding of these phenomena.

Examination of variables representing the social capital of nurse employees suggested that nurse employees felt that they possessed poor quality relationships in the workplace, particularly with their immediate supervisor and upper levels of management. Further research into the reasons why nurses might possess poor quality relationships with their NUMs would be advantageous in understanding how to improve these relationships and reduce the role ambiguity that surrounded their supervisors. Furthermore, the literature identified minimal research on the relationship between employees (including nurses), and upper levels of management. Further exploration of this area would begin to address the limited literature about the quality of that relationship. These relationships were demonstrated to significantly affect a number of other variables within this research and it is for these reasons that more research would be advantageous in helping to improve individual outcomes. However, the high level of ambiguity surrounding supervisors that was being experienced by nurses was a concern and further research to understand the interrelationships between supervisor-employee exchanges and communication processes, and ambiguity surrounding supervisors, is necessary and would be a worthwhile contribution to the body of knowledge.

Another significant finding of this research was the importance of nurse relationships with colleagues. This was an unanticipated finding and additional research into the specific characteristics of this relationship, and the interplay of this with other variables representative of social capital, and the resulting impact upon commitment, would be beneficial. For example, one area requiring further research involves those nurses who identify only one or no contacts to approach to assist in problem-solving, and the reasons for, and consequences of, such minimal networks. Moreover, other sources of social support for nurses and how they are of assistance, is an important area for further investigation.
The findings of this research alluded to the reported negative impact that organisational policies and procedures had upon the work environment and nurse outcomes, such as perceptions of empowerment. Further examination into the effects of these, as well as further differences between organisational policy and practice, is warranted and may assist in furthering understanding of many of the issues examined in this research, particularly how potential differences impact upon organisational commitment.

The findings from this research indicated that some nurses did not wish to remain with their organisation in their current capacity and some had intentions to move to a different organisation, or reduce their work to a part-time capacity within the next one to five years. Further research into the reasons for this would build upon existing literature, but most importantly, further research into how variables representing social capital, such as the quality of relationships and organisational culture, and social networks may help in these situations, to confirm and extend the findings of this research, would be promising.

A significant gap was identified in the research pertaining to the problem-solving processes used by nurses, and the role of social networks in assisting with problem-solving. The literature on the relationship that these have with other outcomes such as commitment is also minimal. Although this research did not examine the problem-solving processes of nurses in depth, this research did identify that social networks positively impacted upon the effectiveness of problem-solving processes. It also identified that nurses sought assistance from particular sources for their knowledge and experience as opposed to other reasons such as friendships or contacts who were in close proximity. Therefore, more detailed research is necessary into the problem-solving social networks of nurses, and the social networks used by nurses for a variety of other purposes. Specifically, further research into populations of employees with minimal to no network contacts, and the reasons for these, is essential.
Finally, further research on the variables examined here, but extended to nurses working in alternate contexts such as aged care, other medical offices, and throughout the community and even in international contexts, would be beneficial. The reason for this is because a hospital environment is much larger and busier, and exhibits many more factors that typically do not apply in non-hospital environments, such as exposure to sensitive and more serious customer health cases. It is unknown whether the results from this research are exclusive to a hospital environment or would apply to all environments in which nurses work.

8.8 Conclusion

This research has examined and demonstrated the importance that social capital and relationships have upon the commitment of nurses to their organisation. Results identified that nurses were slightly uncommitted to the organisation. Two of the many identified factors that may have contributed to this low level of commitment to the organisation included the perceived poor relationships that nurses possessed with their supervisor, and higher levels of organisational management. Within the wealth of research which highlights the importance of good organisational relationships and the resulting positive outcomes of these, this research has identified several new and important areas for improvement and further research. One area of significant contribution was the need for further research into the social networks used by employees when attempting to solve work-related problems. This research specifically identified that social networks positively influenced problem-solving effectiveness. Furthermore, this research identified that nurses choose network contacts with the necessary knowledge and experience to successfully assist them with solving problems. Another area of significant contribution was the simultaneous application of the three dimensions of Nahapiet and Ghoshal’s (1998) model (of relational, cognitive and structural) and social capital at the organisational level. This application identified a need for further research into the social capital of employees from a collective perspective using all three dimensions simultaneously in order to add insight into the complex
and interdependent relationship between these dimensions. Together, this research has made a significant contribution to the literature on social capital, organisational behaviour and nursing, and highlighted the importance of improving organisational relationships in the quest to improve commitment to the organisation, which may assist in understanding how to improve the retention of nurses.
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APPENDIX 1: OVERALL RESEARCH PROJECT

The research contained in this thesis forms one part of a much larger research project that was conducted by the author and two senior researchers. The following information gives an overview of the larger project and demonstrates how this thesis fits into that project and the role played by the author.

The overall research project aimed to explore management practices within the public health care sector in Australia and the effect of these on a number of employee outcomes including commitment, using a Social Capital Theory perspective. Areas of particular importance to the project included:

- The quality of nurse relationships and their impact upon a number of nursing outcomes (relational and structural social capital);
- The organisational practices in place to support the development of relationships (cognitive social capital);
- Theoretical knowledge about social capital in an organisation;
- Gaps between organisational policies and organisational practices;
- Identification of how public sector health resources meet the needs of the public;
- What factors influence nurses to leave their organisation or the nursing profession;
- A greater understanding of nurse outcomes from nurses working in the Australian public sector including:
  - Family-work balance, work-family balance, stress, and well-being,
  - Communication practices and ambiguity surrounding promotions, supervisors, and patients,
  - Organisational culture and organisational identification,
  - Job performance, and satisfaction with organisational policies, practices, and work roles,
  - Quality of supervisory relationships and problem solving social networks,
  - Perceived autonomy and empowerment,
  - Normative, continuance and affective commitment.

There were two chief investigators (CIs) and one PhD student (the author) in the team. The two chief investigators (CIs) were responsible for overseeing the integrity of the academic study and for supervising the PhD student. Chief Investigator 1 had full administrative responsibility for the management of the project. The role of the chief investigators was to explore singular social capital concepts using smaller relationships between concepts, with a particular focus on individual outcomes such as stress and well-being.

The role of the PhD student was to explore the impact that a number of outcomes had on nurse commitment by looking at a more comprehensive picture of social capital at one time. Specific duties included responsibility for a comprehensive review of the literature, the writing of a PhD thesis, meeting and assisting with
presentations at the research site, and any required reviews of related concepts for organisational staff that arose during the research project (e.g. mentoring etc).

Regarding the data collection and analysis, the student and all chief investigators were at the research site informing, distributing and collecting surveys for a period of nearly six months. The student conducted the inputting and analysis of data and identification and writing-up of the findings for the PhD-identified part of the study. The chief investigators undertook their own analysis of the wider data for the larger project.

Regarding the focus groups and interviews, organisational management at the hospital being investigated strictly permitted only chief investigator 1 to undertake and facilitate the focus groups and interviews. They would not allow the student researcher to conduct these. To ensure sufficient and consistent coverage of the area under investigation for the purposes of this thesis, a specially developed question was asked by the chief investigator at each of these sessions. Accordingly, the student was not allowed to be present for the collection of data during interviews and focus groups. However, the student was permitted access to transcribe the verbatim results of that data collection and all analyses of these was undertaken by the student. Transcription and analysis of the remaining questions were undertaken by the chief investigators for their own research purposes.

The undertaking of two interviews with senior administrative staff at the organisational site for the identification of relevant documents was conducted solely by the student and all analysis of that data was also undertaken by the student.

Therefore, the student conducted all data collections with the exception of interviews and focus groups due to restrictions by management of the research site, and undertook all data inputting and analysis on her own. Separate analyses of all the data collected from the research were conducted by the chief investigators and used in their own publications.
APPENDIX 2: RESEARCH QUESTIONS AND HYPOTHESES

RQ₁ What is the impact of variables that display qualities of relational, cognitive and structural social capital on the role ambiguity, perceived empowerment, and affective commitment of nurses?

RQ₂ Who are the members of nurses’ problem-solving social networks and what is the strength of the ties between contacts?

RQ₃ How effective are nurses’ problem-solving social networks and what is the role of supervisors in this network?

RQ₄ What differences exist between organisational policy and organisational practice regarding variables that display qualities of relational, cognitive and structural social capital, and work outcomes such as role ambiguity, perceived empowerment, and affective commitment of nurses?

Leader-member exchange and communication processes

H₁ There is an inverse relationship between the quality of the supervisor-employee relationship and its communication processes (LMX and communication processes) and role ambiguity towards customers (customer ambiguity) for nurses.

H₂ There is a positive relationship between the quality of the supervisor-employee relationship and its communication processes (LMX and communication processes) and dimensions of empowerment (meaning and competence, self-determination, and impact) for nurses.
\[ H_3 \] There is a positive relationship between the quality of the supervisor-employee relationship and its communication processes (LMX and communication processes) and affective commitment for nurses.

**Role ambiguity**

\[ H_4 \] There is an inverse relationship between ambiguity surrounding customers (customer ambiguity) and dimensions of empowerment (meaning and competence, self-determination, and impact) for nurses.

\[ H_5 \] There is an inverse relationship between ambiguity surrounding customers (customer ambiguity) and affective commitment for nurses.

\[ H_{11} \] There is an inverse relationship between role ambiguity surrounding supervisors (supervisor ambiguity) and empowerment (meaning and competence, self-determination, and impact) for nurses.

\[ H_{12} \] There is an inverse relationship between ambiguity surrounding supervisors (supervisor ambiguity) and affective commitment for nurses.

**Empowerment**

\[ H_6 \] There is a positive relationship between the dimensions of empowerment (meaning and competence, self-determination, and impact) and affective commitment for nurses.
Culture

H₈ There is an inverse relationship between organisational culture (teamwork, morale, information flow and involvement, and meetings) and dimensions of role ambiguity (customer ambiguity and supervisor ambiguity) for nurses.

H₉ There is a positive relationship between organisational culture (teamwork, morale, information flow, and involvement, and meetings) and dimensions of empowerment (meaning and competence, self-determination, and impact) for nurses.

H₁₀ There is a positive relationship between organisational culture (teamwork, morale, information flow, and involvement, and meetings) and affective commitment for nurses.

Commitment

H₇ There is a significant relationship between the independent variable and work-related outcomes (LMX and communication processes, customer ambiguity, competence and meaning, self-determination and impact) and affective commitment for nurses.

H₁₃ There is a significant relationship between the independent variables and work-related outcomes (teamwork, morale, info flow and involvement, customer role ambiguity, supervisor role ambiguity, meaning and competence, self-determination, and impact) and affective commitment for nurses.
APPENDIX 3: SURVEY INSTRUMENT

Survey of nurse retention: A social capital perspective

Part A. Characteristics about you and your career (please circle)

1. What is your gender? Male Female
2. What is your age? .................................................................
3. What is your position? LM CN RN EN AIN
   OTHER.................................................................
4. How long have you held this role? (weeks, months, years) ..............................................
5. What is your employment status? FT PT Pool Nurse
6. What type of ward are you in? Medical/Surgical Emergency Specialty (e.g. ICU)
7. How long have you worked at the X Hospital? (weeks, months, years)
651 cont. over the page
8. What previous positions have you held at X Hospital? ............................................................
9. What positions have you held in other Hospitals? .................................................................
10. How long have you been in nursing? ......................................................................................
11. What is your highest level of education? Y12 Undergraduate
   Postgraduate TAFE Hospital Certificate Other...............................................
12. Are you presently undertaking any study? Yes No If yes, please specify

Part B. The quality of your relationship with your nurse line manager (LM) and how this affects your ability to do your job (Please circle)

<table>
<thead>
<tr>
<th></th>
<th>1 = Strongly disagree</th>
<th>2 = Disagree</th>
<th>3 = Slightly disagree</th>
<th>4 = Slightly agree</th>
<th>5 = Agree</th>
<th>6 = Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Rarely does my LM communicate with me about my job.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I rarely engage in impromptu discussions with my LM.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I often discuss my work with my LM.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Most of the communications I have with my LM are through memos or other written directions.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued over the page
17. I receive the majority of information about my job through formal meetings with my LM.  
18. Much of the communication I have with my LM is through impersonal means such as the telephone or emails.  
19. My LM communicates with me about my work so that we can agree upon the best actions for me to take.  
20. My LM prefers to communicate why we do things instead of just telling us to do it.  
21. My LM communicates with me about how to do my job and does not just tell me how to do it.  
22. My LM communicates to me how what I do fits into the organisation’s overall effort.  
23. At my workplace, nurses exchange ideas and information with the LM freely and easily.  
24. At my job, communication flows both from the LM to and from me to the LM.  
25. At my job, communication flows both to and from the LM.  
26. I am certain which specific nursing strengths I should present to my patients.  
27. In my job, I am certain how much service I should provide to my patients.  
28. I am certain of what I am expected to do for my patients.  
29. I am certain how far my LM will go to back me up in my decision-making.  
30. I am certain to what extent my LM is open to hearing my point of view.  
31. I am certain how satisfied my LM is with me.  
32. My LM is satisfied with my work.  
33. My LM understands my work problems and needs.  
34. My LM knows how good I am at my job.  
35. My LM is willing to use her/his power to help me solve work problems.  
36. I have a good working relationship with my LM.  
37. My LM is willing to help me at work when I really need it.  

Part C. Your problem-solving networks

38. Think about how many work-based nursing problems you have faced in the past week. How many people did you approach? (please circle)

| 0 | 1 | 2 | 3-5 | 6-10 | 11+ |
---|---|---|-----|-----|-----|

Continued over the page
39. Who do you normally approach with frustrating work-based, unresolved issues? You may use more than one person/position regularly. Please place a (1) next to the position/person you approach the most and a (2) next to the position/person you approach the next most. Place an N (for never) next to those positions/persons you never approach.

........ (a) Nurse unit manager
........ (b) Clinical nurse
........ (c) After-hours coordinator
........ (d) Clinical educator/facilitator
........ (e) Nurse educator
........ (f) Nurse preceptor
........ (g) Other nurse (same ward)
........ (h) Other nurse (different ward)
........ (i) Other medical professional
........ (j) Nurse friend (not at X Hospital)
........ (k) Non-nurse friend
........ (l) Family
........ (m) Other

40. Please list up to 5 trusted persons from whom you regularly receive information, advice or other resources that help you to solve work related clinical problems. If there are less than five, answer as many as appropriate.

<table>
<thead>
<tr>
<th>Person (initials)</th>
<th>Relationship (nurse, friend, etc.)</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

41. How well do you know each of the persons you have listed? (please tick)

<table>
<thead>
<tr>
<th>Person (initials)</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Fairly well</th>
<th>Very well</th>
<th>Closely</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>B</td>
<td></td>
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<tr>
<td>C</td>
<td></td>
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<td>D</td>
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<tr>
<td>E</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

42. If you did not approach your LM for assistance, could you explain why?
.................................................................................................................................................................
.................................................................................................................................................................
.................................................................................................................................................................

43. How useful was your network in helping you to solve workplace clinical problems? (Please circle)

Not at all    Only slightly    Fairly useful    Very useful    Extremely useful

Continued over the page
### Part D. Your work environment at X Hospital (Please circle)

<table>
<thead>
<tr>
<th></th>
<th>1=Strongly disagree</th>
<th>2=Disagree</th>
<th>3=Slightly disagree</th>
<th>4=Slightly agree</th>
<th>5=Agree</th>
<th>6=Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>People I work with are direct and honest with each other</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>45</td>
<td>People I work with accept criticism without becoming defensive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>46</td>
<td>People I work with resolve disagreements cooperatively.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>47</td>
<td>People I work with function as a team.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>48</td>
<td>People I work with are cooperative and considerate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>49</td>
<td>People I work with constructively confront problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>50</td>
<td>People I work with are good listeners.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>51</td>
<td>People I work with are concerned about each other.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>52</td>
<td>X Hospital nurses and management work together well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>53</td>
<td>X Hospital management motivates me to put in my best effort.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>54</td>
<td>X Hospital management respects its nurses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>55</td>
<td>X Hospital management treats its nurses in a consistent and fair manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>56</td>
<td>Working at X Hospital feels like being part of a family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>57</td>
<td>There is an atmosphere of trust at X Hospital.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>58</td>
<td>X Hospital management motivates me to be efficient and productive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>59</td>
<td>I get enough information from X Hospital management to understand the big picture.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>60</td>
<td>When X Hospital made changes to work practices, the reasons why were always made clear.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>61</td>
<td>I know what’s happening in wards outside of my own.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>62</td>
<td>I get the information I need to do my job well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>63</td>
<td>I have a say in decisions that affect my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>64</td>
<td>I am asked to make suggestions about how to do my job better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>65</td>
<td>X Hospital management values the ideas of employees at every level.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>66</td>
<td>My opinions count in this questionnaire.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>67</td>
<td>Decisions made at meetings get put into action.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>68</td>
<td>Everyone takes part in discussions at meetings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>69</td>
<td>Our discussions in meetings stay on track.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>70</td>
<td>Time in meetings is time well spent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>71</td>
<td>Meetings tap the creative potential of the people present.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*Continued over the page*
### Part E. Your perceptions towards your work and general well-being (Please circle)

<table>
<thead>
<tr>
<th></th>
<th>1=Strongly disagree</th>
<th>2=Disagree</th>
<th>3=Slightly disagree</th>
<th>4=Slightly agree</th>
<th>5=Agree</th>
<th>6=Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>72</td>
<td>I have significant autonomy in determining how I do my job.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>I can decide on my own how to go about doing my work.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
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<tr>
<td>74</td>
<td>I have considerable opportunity for independence and freedom in how I do my job.</td>
<td>1 2 3 4 5 6</td>
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</tr>
<tr>
<td>75</td>
<td>My impact on what happens in my ward is large.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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</tr>
<tr>
<td>76</td>
<td>I have a great deal of control over what happens in my ward.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>77</td>
<td>I have significant influence over what happens in my ward.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>78</td>
<td>I am confident about my ability to do my job.</td>
<td>1 2 3 4 5 6</td>
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<td>79</td>
<td>I am self-assured about my capabilities to perform my work</td>
<td>1 2 3 4 5 6</td>
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<td>80</td>
<td>I have mastered the skills necessary for my job.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>81</td>
<td>The work I do is very important to me.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>82</td>
<td>My job activities are personally meaningful to me.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>83</td>
<td>The work I do is meaningful to me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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</tr>
<tr>
<td>84</td>
<td>I would be very happy to spend the rest of my career with X Hospital.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>85</td>
<td>I do not feel like ‘part of the family’ at X Hospital.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>X Hospital has a great deal of personal meaning for me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>87</td>
<td>I feel a strong sense of belonging to X Hospital.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>88</td>
<td>I feel strong ties with X Hospital.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
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<tr>
<td>89</td>
<td>I feel proud to work for X Hospital.</td>
<td>1 2 3 4 5 6</td>
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<td>90</td>
<td>I am sufficiently acknowledged in X Hospital.</td>
<td>1 2 3 4 5 6</td>
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</tr>
<tr>
<td>91</td>
<td>I am glad to be a member of X Hospital.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
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<tr>
<td>92</td>
<td>I plan to leave my present nursing position? (please circle)</td>
<td>Yes within the next year</td>
<td>No plans within the next year</td>
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<tr>
<td>93</td>
<td>I plan to work part time in nursing within the next year</td>
<td>1 2 3 4 5 6</td>
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<td>94</td>
<td>I plan to work part time in nursing within the next five years</td>
<td>1 2 3 4 5 6</td>
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95. The best thing about working at X Hospital is:

……………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………

Continued over the page
96. The worst thing about working at X Hospital is:
.........................................................................................................................................................
.........................................................................................................................................................
.........................................................................................................................................................

97. The one thing X Hospital management has to change for me to remain committed to X Hospital is:
.........................................................................................................................................................
.........................................................................................................................................................
.........................................................................................................................................................

Thank you for taking the time to complete this survey
and provide your valuable opinions.
APPENDIX 4: SURVEY INFORMATION SHEET

Research project title: Nurse retention: A social capital perspective
Principal Researcher: Dr. Yvonne Brunetto
Associate Researcher(s): Dr. Rod Farr-Wharton, Dr. Nils Timo, Natasha Currant

You are invited to participate in this research project. The purpose of the project is to identify factors that influence nurses who leave the nursing profession and/or the X Hospital. Your involvement is vital to understanding the issues that nurses confront every day in the clinical environment. The attached questionnaire is designed to identify areas of concern that can influence nurses’ perceptions of empowerment and decisions on leaving or staying in the nursing profession and/or X Hospital. This study is designed to identify those areas of greatest concern to nurses and to address them through a new system of management that is aimed at increasing the quality and effectiveness of relationships in the workplace and your general work environment.

Your participation in this project is voluntary. If you do not wish to take part you are not obliged to do so. Furthermore, your relationship with X Hospital and Griffith University will not be affected by your decision whether or not to complete the questionnaire. All information will be kept confidential to the researchers. You do not have to provide written consent to participate in the study as the information provided in the questionnaire cannot be linked to you. Your consent to participate is implied by returning the questionnaire in the attached envelope. This questionnaire has been reviewed and approved by the X Hospital Human Research Ethics Committee and the Griffith University Human Research Ethics Committee.

If you have any further questions about this study, please contact Dr. Yvonne Brunetto on 07 555 28302 or Ms. Natasha Currant on 0410 471 742.
Focus group information sheet

Research project title: Nurse retention: A social capital perspective
Principal Researcher: Dr. Yvonne Brunetto
Associate Researcher(s): Dr. Rod Farr-Wharton, Dr. Nils Timo, Natasha Currant

You are invited to participate in this research project. The purpose of the project is to identify factors that influence nurses’ perception of empowerment in their work. Your involvement is vital to understanding the issues that nurses confront every day in the clinical environment. This study is designed to identify those areas of greatest concern to nurses and to address them through a new system of management that is aimed at increasing the quality and effectiveness of relationships in the workplace and your general work environment.

Your participation in this project is voluntary. If you do not wish to take part you are not obliged to do so. Furthermore, your relationship with X Hospital and Griffith University will not be affected by your decision whether or not to participate in this focus group. This questions asked in this focus group have been reviewed and approved by the X Hospital Human Research Ethics Committee and the Griffith University Human Research Ethics Committee.

If you have any further questions about this study, please contact Dr. Yvonne Brunetto on 07 555 28302 or Ms. Natasha Currant on 0410 471 742.
Focus group consent form

Research project title: Nurse retention: A social capital perspective
Principal Researcher: Dr. Yvonne Brunetto
Associate Researcher(s): Dr. Rod Farr-Wharton, Dr. Nils Timo, Natasha Currant

By signing below I confirm that I have read and understood the information sheet and in particular have noted that:

- I understand that my involvement in this research will include participating in a focus group of approximately 15 minutes duration;
- I have had any questions answered to my satisfaction;
- I understand the risks involved:
- I understand that there will be no direct benefit to me from my participation in this research;
- I understand that my participation in this research is voluntary;
- I understand that any information which could identify me will be kept confidential to the researcher and that no identifying information will be used in any publications arising from the research;
- I understand that if I have any additional questions I can contact the research team;
- I understand that I am free to withdraw at any time, without comment or penalty;
- I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3875 5585 (or research-ethics@griffith.edu.au) if I have any concerns about the ethical conduct of the project; and
- I agree to participate in the project.

Name

________________________________________________________

Signature

________________________________________________________

Date

______ / ______ / ______
APPENDIX 7:  FOCUS GROUP PROTOCOL

Name of participant: …………………………………………………………………………………………………………………
Date: ……………………………………  Time: …………….

Demographics:
1. Gender?  Male   Female
2. Age?   ……………………………………………………………………
3. Current position?  LM   CN   RN   EN   AIN  OTHER………………………………………………………………
4. Length of time in role? (weeks, months, years) ………………………………
5. Employment status?  FT   PT   Pool Nurse

Introduction:
Facilitator:  This research I am doing is about understanding the factors that affect your commitment to this organisation. Of particular interest to us is how empowered you feel in your work.

Before we begin, do you have any overview comments about the research?

Empowerment:
1. What factors most affect your perception of empowerment in this organisation?
2. Can you tell me why you think this?

Summary:
Facilitator:  Are there any final comments you would like to make about your perception of empowerment?

Thank you for your contribution to this research.
Research project title: Nurse retention: A social capital perspective  
Principal Researcher: Dr. Yvonne Brunetto  
Associate Researcher(s): Dr. Rod Farr-Wharton, Dr. Nils Timo, Natasha Currant

You are invited to participate in this research project. The purpose of the project is to identify factors that influence nurses’ perception of empowerment in their work. Your involvement is vital to understanding the issues that nurses confront every day in the clinical environment. This study is designed to identify those areas of greatest concern to nurses and to address them through a new system of management that is aimed at increasing the quality and effectiveness of relationships in the workplace and your general work environment.

Your participation in this project is voluntary. If you do not wish to take part you are not obliged to do so. Furthermore, your relationship with X Hospital and Griffith University will not be affected by your decision whether or not to participate in this focus group. This questions asked in this interview have been reviewed and approved by the X Hospital Human Research Ethics Committee and the Griffith University Human Research Ethics Committee.

If you have any further questions about this study, please contact Dr. Yvonne Brunetto on 07 555 28302 or Ms. Natasha Currant on 0410 471 742.
Interview consent form

Research project title: Nurse retention: A social capital perspective
Principal Researcher: Dr. Yvonne Brunetto
Associate Researcher(s): Dr. Rod Farr-Wharton, Dr. Nils Timo, Natasha Currant

By signing below I confirm that I have read and understood the information sheet and in particular have noted that:

- I understand that my involvement in this research will include participating in an interview of approximately 15 minutes duration;
- I have had any questions answered to my satisfaction;
- I understand the risks involved:
- I understand that there will be no direct benefit to me from my participation in this research;
- I understand that my participation in this research is voluntary;
- I understand that any information which could identify me will be kept confidential to the researcher and that no identifying information will be used in any publications arising from the research;
- I understand that if I have any additional questions I can contact the research team;
- I understand that I am free to withdraw at any time, without comment or penalty;
- I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3875 5585 (or research-ethics@griffith.edu.au) if I have any concerns about the ethical conduct of the project; and
- I agree to participate in the project.

Name

____________________________________________________

Signature

____________________________________________________

Date

_______ / _______ / ______

368
APPENDIX 10: INTERVIEW PROTOCOL

Name of participant: …………………………………………………………………………………………………………………
Date: ………………………………………… Time: ……………

Demographics:
1. Gender? Male Female
2. Age? …………………………………………………………………
3. Current position? LM CN RN EN AIN OTHER………………………………………
4. Length of time in role? (weeks, months, years) ………………………………………
5. Employment status? FT PT Pool Nurse

Introduction:
Facilitator: This research I am doing is about understanding the factors that affect your commitment to this organisation. Of particular interest to us is how empowered you feel in your work.

Before we begin, do you have any overview comments about the research?

Empowerment:
1. What factors most affect your perception of empowerment in this organisation?
2. Can you tell me why you think this?

Summary:
Facilitator: Are there any final comments you would like to make about your perception of empowerment?

Thank you for your contribution to this research.
## APPENDIX 11: ROTATED FACTOR MATRIX AND SCREE PLOT
### FOR MODEL 1

Rotated factor matrix for Model 1

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Variable</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
<th>Factor 6</th>
<th>Factor 7</th>
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Scree plot for Model 1

Scree Plot
### APPENDIX 12: ROTATED FACTOR MATRIX AND SCREE PLOT FOR MODEL 2

**Rotated factor matrix for Model 2**

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**Scree plot for Model 1**

![Scree Plot](image)
# APPENDIX 13: RELIABILITY ESTIMATES DETAILING CRONBACH’S ALPHA SCORE FOR EACH VARIABLE

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