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The Relationship Between the Nurses' Perception of the Practice Environment and Patients' Satisfaction

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The Relationship Between the Nurses' Perception of the Practice Environment and
Patients' Satisfaction

by

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A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
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Submitted by:

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Abstract

Nurses' practice environments contribute to patient satisfaction. The practice environment is influenced by work design, workforce development, organizational management practices, and culture. Each of these influential factors is significant to how patients perceive how their treatment as a person and their nursing care. The purpose of this study was to examine the nurse practice environment and determine its impact on patients' satisfaction with care during hospitalization. The objective was to analyze the collected data and use it to gain insight and heighten awareness of how various aspects of the nurse practice environment directly and indirectly impact the patient experience. A demographics form and the Practice Environment Scale of the –Nursing Work Index was electronically sent to participants at a large acute care facility in the Southeast United States. The patient satisfaction data was retrospective in nature and obtained from the Press Ganey Hospital Consumer Assessment of Healthcare Provides and Systems (HCAHPS) survey. Data analysis was conducted using Statistical Package for the Social Sciences (SPSS) software version 22.0. The sample size for this research study was 54. Demographic data indicated that the majority of study participants worked in Critical Care (n=21, 38.9%) and Women's Services (n=13, 24.1%). Of the other units surveyed, responses were as follows: Medical-Surgical (n=9, 16.7%), Behavioral Health (n=8, 14.8%), Surgical Services (n=2, 3.7%) and the Emergency Department (n=1, 1.9%). Years of experience ranged from less than one year to greater than ten years; participants had an average of 3.24 years of nursing experience. The average time on the unit types surveyed was 2.5 years. The mean score for the PES-NWI was 2.88, with a Cronbach's α coefficient of 0.930. ($SD= 12.2$). The scores for each of the subscales were as follows:

Nurse participation in hospital affairs $\alpha= 0.863$, $M= 2.83$ ($SD= 4.73$); Nursing foundations for quality of care $\alpha= 0.779$, $M= 3.01$ ($SD= 3.69$); Nursing manager ability, leadership, and support of nurses $\alpha= 0.861$, $M= 2.97$ ($SD= 3.03$); Staffing and resource adequacy $\alpha= 0.832$, $M= 2.33$ ($SD= 2.42$); Collegial nurse-physician relationships $\alpha= 0.839$, $M= 3.19$ ($SD= 1.44$). The overall hospital patient satisfaction score for likelihood to recommend the hospital was 71.1 for the third quarter, meaning that 71.1% of the patients completing the survey would definitely recommend the facility to others. Of the units surveyed, the scores for likelihood to recommend were as follows: Behavioral health 48.1 (n= 239), Critical Care 85.7 (n= 14), Emergency Department 50.6 (n= 555), Medical-Surgical 70.6, (n= 119), Surgical Services 62.7 (n= 51), and Women's Services 73.3 (n= 15). Findings from this study revealed that nurses feel supported by and trust the ability of their managers, perceive good working relationships with physicians, and do have an opportunity to grow and participate in hospital affairs. Nurses, however, do not feel positively perceive the adequacy of staffing and other resources. Patients report nurses to be courteous, helpful, and attentive. Patients did not report being very satisfied with pain management.

Keywords: nurse work environment, nurse outcomes, practice environment, patient outcomes, quality of care, patient satisfaction, empowerment

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I am very grateful for the opportunity to embark on this journey. I have never been one to set a goal and not do everything I can to accomplish that goal. This experience forced me to live up to that spirit of determination in spite of all of the challenges I faced along the way. I learned that I am more resilient than I ever imagined. I thank God for the opportunity and for placing the right people in my life during this time to encourage and support me as I strived to reach my goal.

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Table of Contents

CHAPTER I: INTRODUCTION

Significance.....	3
Purpose.....	3
Theoretical Framework.....	4
Research Question	6
Summary.....	6

CHAPTER II: LITERATURE REVIEW

Literature Related to Statement of Purpose	7
Literature Related to Theoretical Framework.....	15
Strengths and Limitations of Literature	22
Summary.....	23

CHAPTER III: METHODOLOGY

Study Design.....	24
Setting and Sample	24
Measurement Methods.....	25
Data Collection Procedure	28
Protection of Human Subjects	29
Data Analysis	30

CHAPTER IV: RESULTS

Sample Characteristics.....	31
Major Findings.....	33
Data Analysis	35
Summary.....	37

CHAPTER V: DISCUSSION

Implication of Findings.....	38
Application to Theoretical Framework.....	40
Limitations	41
Implications for Nursing.....	42
Recommendations.....	43
Conclusion	44
REFERENCES	46
APPENDICES	
A: Informed Consent.....	50
B: Nurse Demographic Survey Tool.....	52
C: Practice Environment Scale of the Nursing Work Index	53

List of Tables

Table 1: Demographic Characteristics of Participants.....32

Table 2: Years of Experience of Participants32

CHAPTER I

Introduction

The landscape of today's healthcare industry is changing. The patient experience and the quality of care as perceived by the patient are now the framework for reimbursement and success. Competition is increasing, and hospital costs are being monitored and reduced from every angle. The introduction of the Patient Protection and Affordable Care Act (ACA) ignited a transformation within healthcare that forced greater focus on the issues of cost, safety, quality, affordability, and accessibility of healthcare. Hospital systems are working to establish, implement, and maintain strategies that reduce the cost of care, improve patient care outcomes, and improve patient satisfaction scores.

The shift in operations in healthcare is profoundly significant to the nurse providing direct care at the bedside. Nurses are expected to do more with less and find themselves working in fast-paced environments where patients require more complex care and have multiple comorbidities, where staffing is inadequate, and where the workload is increasing. Additionally, the nursing workforce is declining due to nurse retirement, nurses leaving the profession, and fewer new nurse graduates entering the workforce. Each of these elements negatively impacts the nurse practice environment, nurse job satisfaction, patient outcomes, and patient satisfaction.

The presence and/or absence of particular traits of a healthy work environment are essential to healthcare organizations. Nurses should be able to work in an area that is nurturing to their professional growth and development, is conducive to provision of excellent care, and demonstrates a concern for their overall well-being. The environment should foster trust, intra- and interdisciplinary teamwork, autonomy, and shared decision-

making. These traits describe a healthy work environment according to the American Association of Critical-Care Nurses Healthy Work Environments Initiative (2005). This type of environment would provide the resources, time, and collaboration required to provide safe, high-quality care to patients and improve nurse-sensitive patient outcomes. The state of the nurse practice environment is a direct correlation to the quality of care that patients receive. Care is impacted when equipment is not available or working properly, processes to provide care and communication breakdown, staffing is inadequate, there is little to no visible administrative support, and when there is poor participation in hospital affairs by nurses.

The effect of the composition of the nurse practice environment on patient safety and care outcomes is tremendous. The absence of vital elements of a healthy work environment hinders the ability to provide safe high-quality care and produce desired patient outcomes. Poor quality care manifests in numerous ways to include missed care, falls (with or without injury), pressure ulcers, medication errors, increased length of stay, hospital acquired infections (HAIs), pneumonia, and death. It is important to recognize the relationship between the nurse practice environment, quality of care, patient outcomes, and patient satisfaction. It is even more important to search for modifiable aspects of the care environment, remove barriers, and implement sustainable strategies that will serve to improve care provision and patient outcomes. This, in turn, will improve nurse job satisfaction (decreasing turnover), teamwork, improve patient outcomes and satisfaction, and decrease the cost of care for the patient and the care organization.

Significance

An unhealthy and unsupportive nurse practice environment is a concern of great magnitude and a matter of patient safety. Caring for patients in a work area that does not promote safe, high quality, cost-effective care increases a patient's risk of adverse outcomes, medication errors, falls, and HAIs, and increased length of stay. These are costly, negative outcomes for the patient, the nurse, and the health care organization.

The practice environment of nurses is a major factor in how work is organized and how the workload is managed. Nurses are working in areas where nursing leadership is not visible or accessible, patient ratios are increasing, collegial relationships and communication are poor, and patients require care that is more complex. These types of work conditions do not permit the nurse the time or resources needed to complete thorough assessments or patient education, which leads to missed care and other adverse outcomes.

To improve satisfaction scores hospitals must survey the nurse practice environment, monitor nurse-sensitive outcomes, and make changes that positively influence the relationship between the two. Nursing and other healthcare leaders must develop policies, implement care delivery models, and apply management theories that result in improved nurse job satisfaction, greater nurse retention, and improved patient care outcomes, and increased patient satisfaction.

Purpose

Nurses' practice environments contribute to patient satisfaction. The practice environment is influenced by work design, workforce development, and organizational management practices and culture. The purpose of this study was to examine the nurse

practice environment and determine its impact on patients' satisfaction with care during hospitalization. The objective was to analyze the collected data and use it to gain insight and heighten awareness of how various aspects of the nurse practice environment directly and indirectly impact the patient experience. This experience translates into reported patient satisfaction scores. The ultimate goal was to inform decision making that will produce and maintain work environments that empower professional nursing practice, enhance the quality of nursing care to patients, and improve satisfaction levels for nurses and patients.

Theoretical Framework

This research study involved the nurse practice environment and its impact on the patient's level of satisfaction with care. The presence of certain behaviors in the nurse practice environment support nurse work effectiveness, positive working relationships, and allow the nurse to positively impact the patient's perception of care. Kanter's Theory of Organizational Empowerment was utilized as the theoretical framework for this study. The focus of this theory is on structures within an organization, which work to empower employees, allowing them to work at their maximum ability (Spence-Laschinger, Finegan, Shamian, & Wilk, 2001). While this theory is not a nursing theory, the concept of empowerment is significant to the nurse practice environment, nurse organizational commitment, and patient care outcomes. Empowerment in the nurse practice environment is more likely to result in lower nurse-turnover, more engaged employees, and patients that are better informed and more satisfied with care (Hauck, Quinn-Griffin, & Fitzpatrick, 2011).

According to the theory, there are six required conditions in order for empowerment to occur. The six conditions are access to information, access to support, access to resources, opportunity for growth and advancement, formal power, and informal power; formal and informal power systems being in place grant greater access to the other structures of empowerment (Hauck et al., 2011). In this theory, formal power derives from the characteristics specific to one's job role while informal power is achieved from personal networks and associations within the work setting. Access to the various structures defined in this theory enhance the nurses' ability to better meet job role expectations, enhance work effectiveness, expand critical thinking and problem solving, develop interdisciplinary relationships, and increase organizational commitment (Kuokkanen & Katajisto, 2003; Hauck et al., 2011).

Implementing and maintaining the traits of an empowered practice environment should be a priority for facility and nursing leadership. Leadership has an obligation to assure that nurses recognize these traits and feel empowered so they are able to be a source of power to their patients.

When the practice environment lacks structural or organizational empowerment, the patients, staff, and facility all suffer (Roche, Lamoureux, & Teehan, 2004). Nurses become frustrated, experience burnout, and become disengaged. Patients are not partners in their care, experience negative care outcomes, and lack the resources to properly care for themselves at home. Facilities and organizations are not able to attract first-rate talent, incur increased costs related to care, and experience higher vacancy rates.

Kanter's Theory of Organizational Empowerment was chosen to direct this research because it offers a strategy that managers can utilize to evaluate modifiable

factors to improve the work environment and ultimately the patient experience. The components of the theory focus on behaviors that managers and leaders can perform to improve the practice environment for and commitment of nursing staff. These same components are transformed into behaviors that nurses can execute to empower patients, improve care outcomes, and increase patient reported level of satisfaction while in the care environment.

Research Question

This research study aims to answer the following question:

Is there a relationship between the nurse practice environment and patients' level of satisfaction with care during hospitalization?

Summary

Healthcare has and continues to undergo major restructuring. It is evident from literature and regulatory and accrediting bodies, that nursing is in a unique position to ensure that patients are active, informed partners in their health care decisions. An empowering practice environment promotes shared decision-making, professional growth and development, and higher job satisfaction among nurses. Nurses who are empowered provide satisfactory care to empowered patients who are more likely to adhere to treatment plans and have better health outcomes. Kanter's theory serves as a guide to create a work environment that will have positive outcomes for both the patient and the nurse.

CHAPTER II

Literature Review

The purpose of this study was to determine if there is a relationship between the nurse practice environment and patients' level of satisfaction with care during hospitalization. To identify studies related to the nurse practice environment and patient satisfaction, a literature review was conducted using the following databases: Cumulative Index for Nursing and Allied Health Literature (CINAHL), PubMed, ProQuest, MEDLINE, and Google search engine. The following keywords were used when conducting the literature review and search: nurse work environment, nurse practice environment, patient outcomes, patient safety, and patient satisfaction, and empowerment. The articles chosen were peer-reviewed research journal articles published between 2000 and 2015 and some were cited as a reference in the original articles.

Literature Related to Statement of Purpose

Roche and Duffield (2010) compared the work environment of mental health and medical-surgical settings using a secondary analysis design. The data was previously collected in studies focused on the nurse practice environment of medical-surgical units and non-reported data from a study of the work environment of mental health units. The original sample included a total of 102 medical-surgical and mental health units from 24 acute care facilities in two Australian states; data was collected between 2004 and 2006. The response rate was 76.3% of the targeted 3,348 potential participants. The purpose of the research was to investigate the distinct variances in the medical-surgical and mental health nurses' work environments. While the original studies used a variety of

instruments, the current study focused on the domains of the Practice Environment Scale of the Nursing Work Index (PES-NWI) and collected demographic data of the respondents. The PES-NWI assesses and measures traits of the nurse practice environment, which are noted to be supportive of professional nursing practice and present in the culture of a Magnet Accredited facility. This tool, according to the present study, had not been previously used to examine the inpatient mental health setting. The research done by Roche and Duffield (2010) found that mental health nurses viewed the overall work environment positively (mean score of 2.70, compared to 2.5 domain mean). The mental health nurse scored significantly higher in the domains of nurse-physician relationships (mean of 3.13) and adequacy of staffing and resources (mean of 2.58) than the surveyed medical –surgical nurses (2.81 and 2.26 respectively). This could be contributed to (1) the multidisciplinary nature of the care provided to the mental health patient, and (2) the appropriateness of the skill mix on the unit to provide care to the patient population. On the mental health units, nurses were more involved in interdisciplinary rounds and development of the patient plan of care. This helps to create an environment where nurses feel empowered and feel their input is valued. There was also a significant score difference in the domain of participation in hospital affairs; the mental health nurses mean score was considerably lower in this area (2.52 versus 2.65). The research suggests that mental health nurses become more involved in policy adoption and modifications, need greater access to senior organizational leadership, and be provided more career development opportunities. Removing barriers related to this domain and seeking the input of direct care nurses would have profound effects on patient and nurse satisfaction. Engaging nurses in unit and organizational decision-

making would act to improve nurse job satisfaction, enhance delivery of care, improve access to care for patients, and improve the outcomes that patients experience. Mental health nurses also scored lower in the domains of foundations of care and leadership and management. These two areas are related, and connected to nurse involvement in hospital affairs (Roche & Duffield, 2010). Unit-level leadership should be present and available. The leadership should strive to create a practice environment that encourages the sharing of ideas and information, development of preceptors and other staff, continued education and certification, and participation on nurse-led committees. The information shared from this research indicates a strong need to improve the work environment of the mental health nurses in this article. The presence of Magnet characteristics in the nurse practice environment act to prevent burnout and disengagement, create and provide access to professional development opportunities, increase the reported level of job satisfaction, and improve the overall effectiveness of the care provided by these nurses to the mental health patient population.

Boev (2012) conducted a secondary analysis of data investigating the relationship between the nurse perception of the practice environment and patient satisfaction in adult critical care units. The study was conducted in four adult intensive care units (ICUs) in Western New York, and surveyed nurses working in the units as well as patients (or a family member) admitted to the units during the study period. Boev's research had three goals: (1) explore patient perception of their nursing care while in ICU; (2) determine the nurse perception of the work environment in ICU; and (3) examine the relationship between these two variables in the ICU. Instruments used in the study were the Practice Environment Scale of the Nursing Work Index (PES-NWI) and a patient satisfaction

survey developed by Ingersoll. The PES-NWI consists of five different subscales: Staffing and Resource Adequacy, Nurse Participation in Hospital Affairs, Nursing Foundations for Quality of Care, Collegial Nurse-Physician Relations, and Nurse Manager Ability, Leadership, and Support of Nurses. Each of these elements are said to be present in Magnet Accredited facilities. A total of 671 nurse surveys and 1,532 patient surveys were completed during the five-year study period. Study findings indicated that patients were more satisfied with their nursing care overall when nurses were more satisfied with their work environment. Additionally, Boev's analysis showed that when nurses negatively perceived their work environments patients were also less satisfied. On the patient satisfaction survey, nurse friendliness and courtesy had one of the highest scores. Boev found a significant relationship between nurse perception of the leadership and ability of the nurse manager and patient satisfaction. The study also found that when resources and staffing were insufficient and the foundations for quality care were missing or lacking, nurses felt unable to deliver high-quality care.

Kutney-Lee et al. (2009) also explored the relationship between nurse satisfaction with the work environment and patient satisfaction with nursing care. As part of healthcare reform and value-based purchasing (VBP), the Centers for Medicare and Medicaid (CMS) implemented that in order to receive full reimbursement for the care provided, acute care facilities are required to participate in Hospital Consumer Assessment of Healthcare Provides and Systems (HCAHPS) data collection. Therefore, collecting and reporting patient satisfaction data is a major financial incentive for hospitals (Kutney-Lee et al., 2009). This study showed that refining modifiable aspects of

the work environment would improve the patient experience and perception of the quality of care received.

The study used a cross-sectional design and three data sources: HCAHPS, the American Hospital Association Annual (AHA) Survey, and a survey of hospital quality across four states. A total of 430 acute care hospitals in four states (Pennsylvania, California, Florida, and New Jersey) met the study criteria with 20,984 direct care nurses responding to the survey. The average nurse response from each facility was 49. The nurses responded to survey items that comprised three of the five subscales of the PES-NWI to evaluate their work environment and the quality of care provided. Based on the median score of the three subscales, nurse practice environments were categorized as poor, mixed, or better. The subscales used in the study were related to nursing leadership, nurse-physician relationships, and nursing foundations for quality of care. All data used in the study was collected October 2006- June 2007.

The authors of this study found notable significant relationships in their study; the quality of the practice environment (better, mixed, poor) was discovered to be linked to every measure of patient satisfaction. Nurses who worked in poorer environments reported having a heavier workload when facility characteristics were viewed based on the quality of the work environment (5.3 patients versus 4.6 patients). The most important measure of patient satisfaction is whether a patient would definitely recommend the hospital. Patients receiving care in better work environments were more likely to recommend the facility than those who received care in poor work environments (69.9% versus 59.6%). The study shows that when a nurse's workload is decreased by one patient, the practice environment category improves from poor to better and the

percentage of patients that would “definitely recommend” increases as well. There was also a nine-percentage point difference in the mean percentage of patients who rated the hospital a nine or 10 when comparing the quality of the work environment. The nurse practice environment was found to be significantly related to all 10 measures of patient satisfaction. Due to the significance of the relationships between variables in this study, hospitals have a duty to improve based on what is important to the patient. The measures of patient satisfaction demonstrate that the practice environment is important to the patient in that it dictates the manner in which patients interact with and are cared for by the nurse at the bedside. This study provides a strategy by which facilities participating in the HCAHPS data collection can improve patient satisfaction and outcomes. By focusing on and investing in enhancement of the nurse practice environment, even if it is simply by reducing the workload, facilities increase nurse job satisfaction, decrease turnover, and ultimately support the future of nursing. All of these things directly impact patient satisfaction and perception of care.

The new Value Based Purchasing program instated by CMS links the quality of nursing care and the patient’s level of satisfaction with nursing to hospital reimbursement (Shaffer & Tuttas, 2008). This article highlights the necessity of nursing leaders to provide education to nursing team members about the purpose and use of the HCAHPS data. The HCAHPS patient survey is comprised of 27 questions, covering seven domains of the hospital experience. Patients are asked to provide their perspective of the experience in 18 of the 27 questions, and nursing directly impacts six of the seven domains (Shaffer & Tuttas, 2008). This article generates questions and answers of how nursing can respond to HCAHPS results while striving to provide safe, high-quality care.

The new reimbursement program links reimbursement to the incidence of preventable complications that may be a direct result of nursing care or the failure to follow outlined protocols and guidelines. These may be referred to as nurse-sensitive outcomes and include complications such as urinary tract infections, surgical site infection, and inpatient injuries. It is noted by the authors that safe and appropriate nurse staffing levels aide in reducing the occurrence of hospital acquired infections and inpatient mortality. It is evident from the article that nursing not only directly impacts patient care outcomes, but also the hospital bottom line. However, reimbursement is now associated with the attitude, behavior, and communication with the nurse as perceived by the patient (Shaffer & Tuttas, 2008). In a concerted effort to improve patient satisfaction levels with care, it is imperative for nurse leaders to help team members understand the purpose of HCAHPS, how the data is used, and how nursing directly impacts the results. HACAPS data should then be used to construct an action plan or process improvements that not only increase patient satisfaction but also increase job satisfaction for nursing team members. Some of the suggestions found within research include; ensuring safe staffing levels which would permit a lower nurse to patient ratio and increased opportunity to provide more personal care, adoption of best practice methods of care provision to attenuate the occurrence of error or injury, provide the resources needed by nurses to properly care for and educate patients, and continuous review of the data to monitor progress and identify other areas of opportunity (Shaffer & Tuttas, 2008).

The United States is not the only country where patient experience and satisfaction is monitored. Kieft, de Brouwer, Francke, and Delnoij (2014) investigated (1) which aspects of the work environment affected quality of care and the patient experience

from the perspective of Dutch nurses, (2) are these elements associated with the eight essentials of magnetism, and (3) how does the presence of these identified elements result in a positive patient experience. The study sample was comprised of a total of 26 registered nurses who had worked in their role at least two years, and worked in hospitals, nursing homes, home health, or mental health care. The targeted facilities participated in Excellent Care, a Dutch initiative that is based on the essentials of magnetism and is devoted to creating a healthy, innovative nursing practice environment that promotes improvement of quality. Four focus groups were conducted and digitally recorded. The study subjects were asked three questions that discussed the components of daily practice that impact patient experience, how nurses impact patient experiences, and the constraining and facilitating factors in the practice environment that enhance the patient experience. The study participants verbalized a number of facilitating factors that enable them to positively impact patient experience and the quality of care they provide. The facilitating factors found in the practice environment included clinically competent nurses, adequate staffing, practice control and autonomy, patient-centered care, support of nursing leaders, and collaborative collegial and interdisciplinary working relationships. When these factors are present, are positive in nature, and integrated into daily nursing practice they create a healthy, productive environment in which it is easier to anticipate and meet patient needs, thus enhancing the patient experience. Kieft et al. (2014) were able to determine that the facilitating factors identified by the nurse study participants were indeed related to the eight essentials of magnetism as identified by Kramer and Schmalenberg. The factors that hinder the nurses' ability to positively impact patient experiences were cost-effectiveness policy, and transparency and accountability goals.

The nurses communicated that the push to be productive and provide cost-effective care causes patients to be discharged too soon and tasks to be delegated to less experienced nurses. The increase in transparency and reporting was viewed as not being patient-centered and did not focus on improving direct care. Instead, the increased required reporting and data collection only acted to increase administrative workload. The findings of this research showed that when nurses work in areas or units that are under great pressure to be cost-effective and productive, patients tend to have a more negative experience. On the other hand, it determined that when nurses work in a nurturing, patient-centered environment where the nurse is able to exercise his or her nursing judgment, the patient has a more satisfying experience and has better care outcomes. Furthermore, nurses who work in healthy practice environments feel more empowered to influence policy and participate in hospital decision-making affairs. The study concludes by recommending that there be a sustaining link between the facilitating components and polices that direct transparency, nursing practice, cost-effectiveness, and patient care.

Literature Related to Theoretical Framework

A literature review was conducted using Cumulative Index for Nursing and Allied Health Literature (CINAHL), PubMed, ProQuest, MEDLINE, and Google search engine to identify studies, which applied Kanter's empowerment theory to the nurse practice environment and patient satisfaction or outcomes.

Spence-Laschinger et al. (2001) conducted research to better understand the relationship between work satisfaction, job strain, and empowerment using an expanded model of Kanter's structural empowerment. The team hypothesized that psychological empowerment was a direct result of structural empowerment, thus reducing job strain and

increasing job satisfaction. Job strain occurs when there are numerous psychological demands with little control over job performance and expectations. The negative effects of job strain include increased absences, job-related injury, burnout, substance abuse, and preventable errors in care. Job strain affects the nurse and the patient. Psychological empowerment is defined by Spreitzer as the psychological state an employee must experience before managerial structural empowerment interventions can occur and be successful (Spence-Laschinger et al., 2001). The four components of psychological empowerment are meaning, competence, self-determination, and impact. The study recruited 600 nurses (300 females, 300 males) who worked in tertiary care Ontario hospitals and experienced a return rate of 72% (404 questionnaires returned; 210 females, 194 males). Study measures included structural empowerment, psychological empowerment, work satisfaction, and job strain. After thorough data analysis, the study resulted that structural empowerment had a positive, direct influence on psychological empowerment ($p= 0.85$), which resulted in a positive, direct effect on job satisfaction ($p= 0.79$) and a negative impact on job strain ($p= -0.57$). Consistent with Kanter's reasoning, decreased levels of job strain and greater levels of satisfaction are plausible outcomes of the human response to strategies to create an empowering work environment. The results of this research indicated that when empowerment interventions are implemented, nurses are more likely to feel in control of their work and practice, find their work meaningful, have greater confidence in their skill and knowledge, and perform more efficiently. Additionally, the nurses are less likely to sense high levels of job strain, report lower levels of job dissatisfaction, but will rate the quality of care provided to patients higher

because there is greater access to the support, resources, and information required to complete their work.

Hauck et al. (2011) conducted another study that examined the role of structural empowerment in the workplace. The goal of this research was to investigate the relationship between the anticipated turnover of critical care nurses and their opinion of structural empowerment. This descriptive correlational study used the Conditions of Work Effectiveness Questionnaire-II and the Anticipated Turnover Scale to measure perception of empowerment and participant opinion toward voluntarily leaving their current position in the critical care unit. Of the 257-targeted participants, only 98 returned surveys. The study surveyed nurses who worked in one of five types of critical care units in a tertiary hospital in the northeastern United States. The conceptual framework for the research was Spence-Laschinger's structural empowerment framework, which is an extension of Kanter's theory of structural power in organizations. The findings of this study revealed that nurses who perceive themselves as more empowered did not intend to leave their current roles or the profession of nursing; 78.57% of the participants perceive themselves as moderately empowered. When looking closely at the empowerment subscales, access to opportunity scored the highest (mean score of 4.17) followed by support (M= 3.31), information (M= 3.25), and lastly access to resources (M= 3.08). These scores were higher or closer to the upper range when compared to earlier research by Spence-Laschinger. The hospital in the current study was reported to have structures, processes, partnerships, and programs in place that could help to explain and validate high empowerment scores. Some of the interventions already in place, which created an empowered, supportive, and positive work environment included shared governance

councils, a Professional Practice Model, community college and university educational partnerships, Critical Care Fellowship Program, and the Clinical Ladder Program. The evaluation of formal and informal power in the hospital's critical care units was relative to the organizational encouragement to participate in professional organizations, community service, and relationships with other nurses who hold key positions in the organization or facility. The results of this research further validate Kanter's thinking as it relates to the nursing profession and the nurse practice environment. Leader behavior that promotes autonomy, collaborative decision-making, resource adequacy, and professional growth and development, inspires employees to remain in their current job role and enables them to perform more efficiently. In turn, the patient becomes more empowered, is able to rate satisfaction with care higher, and is granted greater access to resources, support, and information.

It has been well documented that the nurse practice environment has significant bearing on both nurse and patient outcomes. Healthy, supportive work settings are very important to patient safety, quality of care provided, and nurse retention and job satisfaction. Breau and Rheaume (2014) performed research to determine if the practice environment and empowerment were predictors of the intent to leave, job satisfaction, and perception of the quality of care among nurses working in intensive care units. The study targeted a total of 1,697 nurses working in ICUs throughout Canada. In the final sample 533 nurses responded to a survey which used instruments to assess the work environment, perception of empowerment, job satisfaction, intent to leave, and nurse perceived quality of care. The tools utilized in the study were the PES-NWI, the Conditions of Work Effectiveness Questionnaire-II, Minnesota Satisfaction

Questionnaire, a two-item survey to measure intent to leave, and the Perceived Quality of Care on the Unit scale. Hierarchical regression analysis was used to examine the relationship between the dependent and independent variables in this study. The Nursing Worklife Model was used as the theoretical framework for this study. In this model, the foundation of the nurse practice environment is Kanter's Theory of Structural Empowerment. The model posits that the presence of empowerment structures support daily practice and positively influence the nurse's perception of the practice environment. These factors motivate the nurse to perform at his or her best to meet patient needs, maintain provision of safe and high quality care, and be committed to achievement of unit and facility goals (Breau & Rheume, 2014).

Survey results conveyed that ICU nurses across Canada worked in a moderately healthy work environment with an overall mean 2.60; nurse-physician relationship was the subscale with the highest mean. ICU nurses also perceived their work environment as being moderately empowering with a mean score of 15.61; the most empowering aspect of the environment was having access to opportunity. Job satisfaction levels measured higher on the external satisfaction scale with a mean of 4.02. The results also revealed that 46% of respondents did not plan to leave their unit or employer over the next year. Nurse rated quality of care as good with a mean of 3.38 (Breau & Rheume, 2014). Using correlation analysis, the authors were able to conclude that when leadership is authentic and integrates structures of empowerment into the workplace, nurses will view the environment as supportive to their efforts and desire to provide high quality care to patients. This enhances job satisfaction and commitment to the unit and the organization.

The concept of empowerment is a factor of influence in the work environment, and the perception of empowerment is influenced by the conditions of the work environment. The leadership style of nurse managers is also known to be related to job satisfaction, retention, and work effectiveness (Roussel, 2013, pp. 480-493). Wong and Laschinger (2013) proposed that authentic leadership positively influenced performance and job satisfaction by way of structural empowerment. The purpose of this research was to test a model which linked the authentic leadership style of nurse managers to job satisfaction, performance, and perception of empowerment acute care nurses. The target population included 600 RNs working full-time and part-time in community and acute care facilities in Ontario, Canada; the response rate was 48% (280 RNs). Data was collected in 2008 over a four-month timeframe. Tools used in the research included the following: (1) Authentic Leadership Questionnaire (ALQ) to assess nurse perception of authentic leadership of the nurse manager where higher scores indicated higher levels of authentic leadership traits; (2) the Conditions of Work Effectiveness Questionnaire II assessed perception of structural empowerment, higher scores suggested a greater feeling of empowerment; (3) the Global Satisfaction Survey assessed the level of job satisfaction; and (4) the General Performance Scale, a self-appraisal survey, was used to assess job performance.

The final model resulted in a statistically significant positive relationship between all paths of the hypothesized model ($p < 0.01$). Authentic leadership is vital to empowerment ($\beta = 0.46$, $p < 0.01$), which in turn had a direct positive effect on performance ($\beta = 0.17$, $p < 0.01$), and job satisfaction ($\beta = 0.41$, $p < 0.01$) (Wong & Laschinger, 2013). The leadership style found within a practice environment is critical to

employee performance, job satisfaction, and perception of empowerment. Having an authentic leader in place facilitates autonomy, accountability, and nurses feeling valued by the leader and the organization. It is advantageous for managers wishing to empower the nursing workforce to be transparent, challenge and be accepting of challenges, provide support and resources, seek the input and ideas of the staff, and share how and why decisions are made. Exercising an authentic leadership style and supporting follower development will transform the nurse practice environment into one where nurses are committed, take ownership of unit-level outcomes, and accomplish their best work.

Spence-Laschinger, Gilbert, Smith, and Leslie (2010) applied Kanter's Theory of Empowerment to patient care. The researchers proposed that empowering practice environments allow nurses to engage in behaviors that empower patients to experience optimal health. The nurse/patient empowerment model in this article, an extension Kanter's theory and Spreitzer's work on psychological empowerment, link nurse structural and psychological empowerment to patient empowerment and guarantees positive outcomes for both the patient and the nurse. Psychological empowerment is communicated as how an employee reacts to a work environment that is empowering. The components of psychological empowerment are autonomy, the ability to impact the organization, job significance, and self-efficacy. These employees are high-functioning and share power. Just as nurses should be afforded limitless access to opportunities and power that allow them to accomplish their work in meaningful ways, patients need unrestricted access to the same components of Kanter's theory in order to feel in control over their health and make informed healthcare decisions. In this model, the constructs of power, access, and opportunity are translated into behaviors the nurse can perform

which empower the patient and grant them increased access to opportunities, resources, and information. Nurses have access to information and resources that patients need to make health care decisions, manage illness, and achieve health goals. To increase a patient's access to support the nurse should assist the patient in identifying support systems while considering patient beliefs and values in the treatment plan, and work to create a healing environment for the patient. Patients and nurses partner to assure the patient has access to resources required to address health concerns and meet goals. The nurse is able to connect the patient to community resources and other disciplines that may be equipped to assist the patient where his or her own personal resources are lacking. Nurses and patients collaborate to enhance the patients' knowledge and skill to manage their health. This may include using current knowledge to solve new problems, using technology to better manage health and illness, and enrolling the patient in classes to assist in management of health. The nurse and the patient are allies in achievement of patient health care goals and attaining optimal health. When the patient is empowered and feels involved in their care decisions, they experience outcomes such as improved self-care activities, decreased use of healthcare services, and overall increased satisfaction with nursing care.

Strengths, Weaknesses, and Gaps of Literature

The literature review identified numerous studies that examined the nurse practice environment and patient satisfaction using the PES-NWI, HCAHPS, and Kanter's Theory of Organizational Empowerment. Nursing care and patient perception of care are influenced by characteristics of the practice setting where care is performed or provided.

There is strong evidence that when nurses are more satisfied with the conditions of the practice environment and are equipped with the foundations of quality care, patients are more satisfied with nursing care. Additionally, the research shows that those modifiable aspects of the work environment empower nurses to perform in ways that empower patients to the benefit of the patient, nurse, and organization.

Limitations of the literature reviewed include: using cross-sectional design which limits the ability to make strong causation statements; using participant samples which do not accurately reflect the nursing workforce, the use of secondary data analysis which may not address the research goals, limitations on generalization of findings, use of self-reporting surveys which inherently inserts bias, and using only hospitals which voluntarily participate in HCAHPS data collection as these hospitals may not be representative of all hospitals and characteristics.

Summary

The literature in this chapter supports that a relationship between the quality of the nurse practice environment and patient satisfaction with care does exist. It is evident from previous research that positive outcomes for the nurse and patient are the direct result of practice environments rated as good or better. Furthermore, when managers and other leadership create work environments that contain those traits of Magnet accredited facilities and act to empower the nurse, the patient is empowered and more likely to experience better care outcomes and report greater satisfaction with nursing care.

CHAPTER III

Methodology

The purpose of this study was to determine if there is a relationship between the nurse practice environment and patients' level of satisfaction with care during hospitalization. This chapter will discuss the study research design, setting, sample, ethical considerations, instruments, data collection, and data analysis.

Study Design

This study used a descriptive, correlational design to determine if there is a relationship between the nurse practice environment and patients' level of satisfaction with nursing care during hospitalization.

Setting and Sample

The setting for this study was an acute care, not-for-profit medical center in the Southeastern United States. The facility is part of a larger, multi-state healthcare system. The medical center offers a range of services including emergency, surgery, cancer heart and vascular, diabetes care, women's health, and wound care. The facility is Magnet Accredited.

Eligible study participants consisted of registered nurses (RNs) working in the facility that provided direct care to the patient population across selected service lines. Participants provided care in the following service lines: Behavioral Health, Critical Care, Emergency Department, Medical-Surgical, Surgical Services Women's Services. Employment status of the nurses was full-time, part-time, and as needed (PRN). Any nurse employed in an administrative role was excluded from the study. The total number of eligible nurses was 355, with 54 nurses agreeing to participate.

Measurement Methods

The instruments used for this study included a demographic survey developed by the researcher, the Practice Environment Scale of the Nurse Work Index (PES-NWI) developed by Dr. Eileen Lake (2002), and the Hospital Consumer Assessment of Healthcare Provides and Systems (HCAHPS) survey for patients.

The demographic data survey was developed by the researcher to obtain characteristics of nurses participating in the research study. The tool collected information of interest about each participant including years of nursing experience, type of unit, and years of service on current unit.

During the nursing shortage of the early 1980s, a number of hospitals demonstrated the ability to attract and retain skilled, knowledgeable, and professional nurses. These hospitals were termed “magnet” because of their attractiveness to nurses (Aiken & Patrician, 2000). The PES-NWI was developed by Dr. Eileen Lake (2002) and is based on the research of the original magnet-designated hospitals conducted by Kramer and Hefner (Li et al., 2007). The goals of Lake’s research were to develop a practice environment scale by which researchers and nurse leaders could determine the amount of influence the work environment had on patient and nurse outcomes, develop reference values for nurse managers (benchmarking data), and to identify and target specific areas of improvement within the work environment (Lake, 2002). The PES-NWI consists of five subscales derived through factor analysis of 1986 NWI data that sampled the original magnet hospitals (Lake, 2002, 2007; Warshawsky & Havens, 2011). The tool is comprised of a 31-item scale used to measure the nurse practice environment in hospitals with focus on the presence of traits that have been identified as key components in

magnet-designated facilities (Lake, 2002; Warshawsky & Havens, 2011). The subscales of the tool include: Nurse Participation in Hospital Affairs; Nursing Foundations for Quality of Care; Nurse Manager Ability, Leadership, and Support of Nurses; Staffing and Resource Adequacy; and Collegial Nurse-Physician Relationships (Lake 2002). Items are scored using a 4-point Likert Scale (strongly agree = 1 to strongly disagree = 4) and ask respondents to rate the level to which they agree that particular traits are present in their current work environment (Lake, 2002). The scale can be used to assess and address conditions at the unit and facility levels (Warshawsky & Havens, 2011).

The PES-NWI has been used in numerous research studies to link the state of the nurse practice environment (staffing, skill mix, leader support, and education) to various aspects of the patient hospital experience such as adverse patient outcomes, falls, medication errors, missed or unfinished tasks, hospital acquired infections, pressure ulcers, and mortality (Sochalski, 2001; Flynn, Liang, Dickson, & Aiken, 2010; Trinkoff et al., 2011; Kelly, Kutney-Lee, Lake, & Aiken, 2013). The tool had been used in a range of settings including magnet and non-magnet facilities (Lake, 2007). The tool has also been used globally to measure and compare the nurse perception of the work environment and its association to organizational and nurse outcomes to include nurse turnover, magnet status, staffing, teaching and profit status, nurse burnout, empowerment, job satisfaction and dissatisfaction, and intent to leave (Warshawsky & Havens, 2011). The PES-NWI is endorsed for use by the National Quality Forum, The Joint Commission, and the National Database of Nursing Quality Indicators (Lake, 2007; Warshawsky & Havens, 2011). The Cronbach's α coefficient for the PES-NWI is 0.82 with the Cronbach's α coefficient for the five subscales ranging from 0.71-0.84 (Lake,

2002). In the literature reviewed for this study, the composite Cronbach's α ranged from 0.80 to 0.90, with subscales ranging from 0.71 to 0.87.

The third instrument used in this study is the HCAHPS survey. In October 2012, CMS implemented a reimbursement program based on the value of services provided to the inpatient population called Value-Based Purchasing (McCaughey, Stalley, & Williams, 2013). The program allows acute care facilities to earn points based on their performance or improvements made on reported quality measures, and reimbursement amounts are linked to the points earned. Facilities earn 30% of these points from the patient experience as captured by HCAHPS surveys (Long, 2012; McCaughey et al., 2013). This survey is completed by patients after discharge from an acute care facility and assesses various aspects of the patient's experience while hospitalized. Patients are randomly chosen to complete the survey, which may be administered by mail, phone, or active interactive voice response. The HCAHPS survey is designed to meet three goals (Long, 2012):

1. Captures and provides meaningful data to consumers that allows them to objectively compare facilities and providers
2. Incentivize efforts to improve quality of care by reporting the data publically
3. Increase public investment in hospital care by enhancing accountability and transparency of the healthcare industry

The HCAHPS survey places emphasis on the interpersonal aspects of care. This translates into interaction and communication with care providers, behaviors of care providers, and how often these interactions or behaviors occurred. Nursing, according to Long (2012), is the main source for making patients feel cared for and feel like a valued

customer. Nursing care on the HCAHPS is assessed by patients in the areas of frequent communication, pain management, responsiveness to calls and needs, medication education, discharge education and preparedness, and willingness to recommend the hospital. Long (2012) proposes numerous strategies which nurse leaders and direct care nurses could implement to improve the patient's perception of nursing care. These strategies, when used consistently by all team members, demonstrate to the patient and families that nursing cares not only about the current health needs of the patient but also about the holistic being that presents with unique needs, beliefs, and values. These tactics aim to positively influence the healthcare consumer making him or her feel valued, cared for, and promote the integrity of the facility within the community. Some of the ideas proposed by Long (2012) to raise HCAHPS scores include nurse-physician rounds to show collaborative care, hourly nurse rounds to assess and proactively meet patient needs or provide education, discuss pain management and goals with patients daily, and conduct follow-up phone calls after discharge to answer questions or address concerns.

The HCAHPS survey assists in identifying gaps and deficiencies in the work environment as they relate to what is important to the patient. As survey results are returned to each participating facility, the feedback should be utilized to continuously improve the patient experience. By removing barriers that prevent direct care nurses from being active participants in their work structure and design, they will be more empowered and contribute to a more satisfying patient experience.

Data Collection Procedure

Each prospective study participant was invited to participate through the acute care facility's email distribution system. Participants received an email containing the

informed consent (Appendix A) and a link to complete the surveys electronically. Those choosing to participate had eight weeks to do so. The informed consent letter included the following elements: research topic, the research purpose, an explanation of voluntary participation and confidentiality, the risks and benefits related to study participation, steps to complete the survey, and the contact information for the researcher. Participants completed a demographics form (Appendix B) and the PES-NWI (Appendix C); the HCAHPS surveys used in this research study was retrospective in nature. Completion of the entire survey should not take longer than 20 minutes. The survey was made available electronically through Survey Monkey software. Survey data and results were kept on the researcher's personal computer which is password protected and stored securely.

Protection of Human Subjects

In 1978, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research adopted a code of ethics and issued the Belmont Report (Polit & Beck, 2012). The report is the foundation for directives concerning research. The Belmont Report communicates three principles by which to base the standards of ethical research: beneficence, respect for human dignity, and justice (Polit & Beck, 2012).

In order to conduct an ethically sound study, the researcher sought approval with the Institutional Review Board of the University and the medical center. Study participants were recruited through electronic communication. Participants were provided a cover letter stating the study purpose, type of data being collected, procedure, risks and benefits, confidentiality, and voluntary participation, and researcher contact information. Participants were informed that data collection was anonymous and survey completion

implied consent. No personal identifiers were collected for this study. There were no incentives for participation, nor any repercussions for non-participation.

Data Analysis

A basic breakdown of the survey results was provided by Survey Monkey. An in-depth statistical analysis was accomplished using IBM Statistical Package for the Social Sciences (SPSS) software version 22.0. Use of this software provided the ability to obtain correlational statistics and determine if a relationship existed between how nurses perceived their work environment and patient satisfaction with nursing care in these environments.

CHAPTER IV

Results

This research study explored the relationship between the nurse practice environment and the patients' level of satisfaction with nursing care during hospitalization. This chapter presents the findings of this study.

Sample Characteristics

The final sample size consisted of 54 completed surveys by participants. The study was open to eligible participants for a total of eight weeks to encourage participation. Of the 54 respondents, the majority of study participants worked in Critical Care (n=21, 38.9%) and Women's Services (n=13, 24.1%). Of the other units surveyed, responses were as follows: Medical-Surgical (n=9, 16.7%), Behavioral Health (n=8, 14.8%), Surgical Services (n=2, 3.7%), and the Emergency Department (n=1, 1.9%). Years of experience ranged from less than one year to greater than 10 years; participants had an average of 3.24 years of nursing experience. The average time on the unit types surveyed was 2.5 years. Tables 1 and 2 illustrate the demographic characteristics and years of experience of participants.

Table 1

Demographic Characteristics of Participants

Type of Unit	<i>n</i>	%
Critical Care	21	38.9
Medical-Surgical	13	24.1
Behavioral Health	9	16.7
Women's Services	8	14.8
Surgical Services	2	3.7
Emergency Department	1	1.9

Table 2

Years of Experience of Participants

	<i>M</i>	<i>SD</i>
Years of nursing experience	3.24	.97
Years on current unit	2.5	1.09

Major Findings

Nurse Work Environment

The PES-NWI is a 31-item survey tool used to measure nurses' perception of their practice environments with focus on those attributes identified as being necessary in a magnet-designated facility (Lake, 2002; Warshawsky & Havens, 2011). Analysis of the participants' survey responses resulted in a total score and scores for each of the five subscales. The subscales measured the nurses' perception of the practice environment in terms of (1) Nurse Participation in Hospital Affairs; (2) Nursing Foundations for Quality of Care; (3) Nurse Manager Ability, Leadership, and Support of Nurses; (4) Staffing and Resource Adequacy; and (5) Collegial Nurse-Physician Relationships.

The mean score for the PES-NWI was 2.88, with a Cronbach's α coefficient of 0.930. The scores for each of the subscales were as follows: Nurse participation in hospital affairs $M= 2.83$ ($SD= 4.73$); Nursing foundations for quality of care $M= 3.01$ ($SD= 3.69$); Nursing manager ability, leadership, and support of nurses $M= 2.97$ ($SD= 3.03$); Staffing and resource adequacy $M= 2.33$ ($SD= 2.42$); Collegial nurse-physician relationships $M= 3.19$ ($SD= 1.44$). The reliability results for this research are within the aforementioned acceptable ranges for the PES-NWI, which further supporting the reliability and validity of this survey instrument.

Patient Satisfaction Scores

The patient satisfaction survey contained questions that focus on nursing care and interaction with the nursing team. This may also be referred to as the nursing domains of the survey. In particular, patients are asked to rate nursing communication, nurse friendliness and courtesy, pain management, getting assistance quickly, and discharge

instructions. Patient responses are scored using a 4-point Likert Scale (never, sometimes, usually, and always); the survey asks to determine how often a scenario occurred while in the hospital. The scores given to each question is the percentage of responding patients who answered “Always” to the question.

Patient satisfaction scores were collected from HCAHPS patient satisfaction surveys. The data used was based on the received date of the survey, which was between July 1, 2016 and September 30, 2016. This timeframe represents the third quarter of Press Ganey survey results and aligned with the timeframe for the nurse survey completion period. The overall hospital patient satisfaction score for likelihood to recommend the hospital was 71.1 for the third quarter. Of the units surveyed, the scores for likelihood to recommend were as follows: Behavioral health 48.1 (n= 239), Critical Care 85.7 (n= 14), Emergency Department 50.6 (n= 555), Medical-Surgical 70.6, (n= 119), Surgical Services 62.7 (n= 51), and Women’s Services 73.3 (n= 15).

Behavioral Health and the Emergency Department do not have HCAHPS questions in their patient surveys. In Behavior Health the questions with the higher scores include friendliness/ courtesy of the nurse (n= 245, 53.9%), helpfulness of the nurse (n= 234, 54.3%), and extent felt ready for discharge (n= 243, 53.9%). The lower scoring questions for this specialty include physical pain was taken care of (n= 227, 44.5%) and prompt response of the nurse to requests (n= 235, 40.4%). In the Emergency Department, the highest scoring question was courtesy of the nurse (n= 559, 60.6%); the lowest scoring item for this specialty was wait time to get into the treatment area (n= 544, 32.4%).

Critical Care had high scores in the areas of nurse's courtesy and respect (n= 14, 92.9%) nurses listen carefully (n= 14, 92.9%), pain was well controlled (n=11, 90.9%), and nurse's attitude toward requests (n= 14, 92.9%). Call button as soon as you wanted (n= 10, 70%) and having a good understanding of how to manage health upon discharge (n= 14, 50%) were the lowest scoring items for this area.

Medical-Surgical had high scores in the areas of nurse courtesy and respect (n= 122, 80.3%) and the staff did everything to help with pain (n= 74, 71.6%). The lowest scoring items were pain was well controlled (n= 73, 46.6%) and having a good understanding of how to manage health upon discharge (n= 122, 38.5%).

Surgical Services had high scores in the areas of nurse courtesy and respect (n= 51, 78.5%), staff did everything to help with pain (n= 43, 79.1%), and discharge information (n= 49, 81.6%). The lowest scoring items for this specialty were call button help as soon as you wanted (n= 49, 49%) and having a good understanding of how to manage health upon discharge (n= 50, 48%).

Women's Services had high scores for nurse courtesy and respect (n= 15, 80%), call button help as soon as you needed it (n= 15, 80%), and discharge information (n= 15, 86.7%). The lowest scoring items for this specialty were pain was well controlled (n= 8, 50%) and staff did everything to help with pain (n= 8, 62.5%)

Data Analysis

Due to the nature of the study design and data collection methods, an analytical correlation between nurse practice environment and patient satisfaction with care while hospitalized could not be determined. However, statistical analysis was performed to acquire information about the nurse practice environment.

A Pearson correlation was conducted to determine if there was a relationship between the subscale measuring the nurse perception of resource and staffing adequacy, and the type of unit nurses worked on. A weak negative correlation was not found to be significant between the unit type and having enough registered nurses to provide quality patient care ($r(-0.041) = 0.769, p > 0.01$). A strong positive correlation was found to be significant between having enough staff to get the work done and having adequate support services to allow the nurse to spend time with his or her patients ($r(0.541) = 0.000, p < 0.01$). A strong positive correlation was found to be significant between having enough registered nurses to provide quality care and having enough staff to get the work done ($r(0.753) = 0.000, p < 0.01$).

A Pearson correlation was conducted to determine if there were significant relationships within the subscale measuring nurse-physician relationships. Each of the questions in this subscale resulted in a weak negative correlation to the type of unit. A strong positive correlation was found to be significant among nurse and physicians having good working relationships, and working as a team ($r(0.673) = 0.000, p < 0.01$). A strong positive correlation that was significant was found among nurse-physician teamwork and collaboration ($r(0.675) = 0.000, p < 0.01$).

A Pearson correlation was conducted to determine if there were significant relationships within the subscale measuring the nurse perception of the manager's abilities. All of the items in this subscale revealed a moderate to strong positive correlation to the type of unit. A strong positive correlation was found to be significant between having a nurse manager who is a good manager and leader, and having a nurse manager who backs the staff in decision making and physician conflict ($r(0.765) =$

0.000, $p < 0.01$). Praise and recognition was also significantly linked to a supportive supervisor ($r(0.545) = 0.000$, $p < 0.01$).

A Pearson correlation was conducted to determine if there were significant relationships within the subscale measuring foundations for quality of care. A strong positive correlation was found to be significant between having a clear theory or stance of nursing that is evident in the patient care environment and having an active quality assurance program ($r(0.528) = 0.000$, $p < 0.01$). Another strong positive correlation was found to be significant among the use of nursing diagnoses and having written, updated patient care plans ($r(0.530) = 0.000$, $p < 0.01$).

A Pearson correlation was conducted to determine if there were significant relationships within the subscale measuring nurse participation in hospital affairs. A strong positive correlation was found to be significant between the opportunity for staff nurses to participate in policy decisions and having an administration that listens and responds to employee concerns ($r(0.592) = 0.000$, $p < 0.01$). A strong positive correlation was found to be significant between opportunities for advancement and staff nurses have the opportunity to serve on hospital and nursing committees ($r(0.417) = 0.002$, $p < 0.01$).

Summary

The results from the analysis of data collected from a sample of nurses working in selected service lines in an acute care facility were presented in this chapter. The relationship between the nurse practice environment and patient satisfaction with care could not be statistically verified attributable to the design and data collection methods of this research study. However, data analysis revealed some significant relationships among the attributes identified as being necessary in a magnet-designated facility.

CHAPTER V

Discussion

The purpose of this study was to determine if there was a relationship between the nurse practice environment and patients' level of satisfaction with care during hospitalization. The objective was to analyze the collected data and use it to gain insight and heighten awareness of how various aspects of the nurse practice environment directly and indirectly impact the patient experience.

Implication of Findings

A statistical relationship could not be verified, however, other inferences can be made. The traits that participants perceived to be most prevalent in the work environment were found within the subscales measuring nurse-physician relationships, foundations for quality care, and the ability and support of the nurse manager. A closer look at these subscales indicated that the nurse participants perceive that the nurses and physicians work well together as a team and collaborate for the care of the patient. The nurses perceive that they work in an area, which has set very clear expectations for professionalism, the standard of care, and patient outcomes by incorporating continuous improvement into the daily delivery of care, providing updated plans of care, offering continuing education opportunities, and supporting new team members with well-designed preceptor program. They also believe that the nurse manager/ supervisory staff are visible, available and supportive of the nursing staff.

Additionally, nurses rated participation in hospital affairs highly. This implies that nurses either participate directly on shared governance committees or they feel they are represented by another participating nurse and/or their nursing leadership. The

relationships of this subscale also reveal that nurses have opportunities to advance their career and realize the benefit of having senior nursing leadership that values their ideas and input. The subscale measuring the perception of having adequate staffing and resources presents the opportunity to create a more suitable and empowering practice environment. While nurses agree that they have time to discuss patients with other nurses and have enough support services that gives them time to spend with a patient, they do not feel strongly that there is enough staff to get the work done or that there are enough registered nurses on the units to provide quality care.

Patient surveys showed that nurses are perceived as friendly, courteous, helpful, and are perceived to listen carefully to patient needs and/or concerns. While the nurses may not feel like they have enough staff present to get their work done, it did not impact their ability to be attentive and show compassion towards their patients. This, in part, happens when nurses are supported by non-licensed team member so they are able to prioritize and effectively organize their work to focus on nursing tasks. The patient is likely to be more satisfied with care when the nurse smiles, is polite, and engages in other behaviors to show they are listening such as providing updates, providing education materials, or even by simply making eye contact. Adequate staffing for the workload and census, great teamwork and appropriate delegation, and a manager who is available and willing to help with patient care when needed also positively influences the patient's perception.

Patients rated pain management low in four out of the six nursing areas surveyed. This is impacted heavily by the patient's subjective pain level, pain tolerance, patient understanding of their pain regimen, and availability of medications. It is imperative that

nurses have the opportunity to teach patients and engage them in their care so they are able to achieve optimal outcomes while hospitalized and continue to reach their goals after discharge. Patients should be encouraged to ask questions and offer input that will enhance their patient experience and increase their overall satisfaction.

Poor organization of the work, broken processes, inadequate staffing, inexperienced staff, poor interdisciplinary communication and relationships, and disengagement are all barriers that decrease the positive perception of the practice environment and decrease the likelihood of positive patient feedback. These barriers, and numerous others, should be considered when designing sustainable changes aimed at empowering the nursing staff to provide an expected quality of care to the patient and create a remarkable experience for the patient every time.

Application to Theoretical Framework

Kanter's Theory of Organizational Empowerment served as the theoretical framework for this study. The six conditions required for employees to be or feel empowered include access to information, access to support, access to resources, opportunity for growth and advancement, formal power, and informal power (Hauck et al., 2011). Kanter's theory focuses on modifiable factors of the work environment which grant greater access to the structures of empowerment thus improving the nurses' perception of the practice environment and the patients' perception of the care received. Items on the PES-NWI questioned the nurse participants about opportunities to grow and advance, and their access to resources, support, and information.

In this study, the subscales with the highest means were nurse-physician relationships ($M = 3.19, SD = 1.44$) and foundations for quality of care ($M = 3.01, SD =$

3.69). The subscale measuring the perception of the nurse manager also scored favorably ($M = 2.97, SD = 3.03$). As it relates to Kanter's theory, the nurse participants have access to information, support, resources, opportunity for growth, and the sources of power required to be empowered. Being empowered in the practice environment gives the nurse a voice to influence his or her own practice and the opportunity to be an advocate and source of empowerment for the patients.

Empowering practice environments encourage nurses to recognize that they are valuable partners in the provision of safe, high-quality care as well as a key investor in the strategies devised to meet unit and facility-level goals.

Empowering nurses with the resources, support, and information needed to care for patients, educate their patients, and prepare them for discharge is fundamental to how patients perceive the care and attention they receive while hospitalized.

Limitations

Limitations for this study were identified based on sample size, study instruments, and data collection methods. This study was open to 355 nurses working in six service lines at the medical center. The final sample size was 54 out of those eligible to complete the survey. Data were collected electronically from participating nurses over an eight-week period using the facilities internal email distribution system. This method of data collection for nurses may have excluded potential participants due constraints of time and access to email while working.

The patient survey instrument was designed for patients to complete after discharge from the medical center. It is randomly distributed and is subjective data. Data collection is highly dependent on completion and return of the survey by the patient.

Therefore, the data may not be a true reflection of the nursing care area if a patient does not return the survey or returns it without answering all the questions. Patients are randomly chosen to receive the survey so not all patients have the opportunity to share their perspective of the nursing care. Because the survey was not built into the electronic survey for this research study, it was more difficult to assess for statistical correlations. Additionally, the Press Ganey survey provided percentages of responses from patient participants versus raw data and some patients may not answer every question on the survey. Having a satisfaction survey for patients to complete in real-time prior to discharge and entered into the electronic survey for this study would have potentially resulted in more reliable correlations.

Implications for Nursing

The intent of this study was to explore the potential relationship between the nurse practice environment and patient satisfaction with nursing care while in the environment. Findings from this study highlight the importance of assuring nurse practice environments are designed to support the presence of the traits of magnetism so that nurses are empowered to perform at their maximum ability so they are ultimately able to provide patients with a remarkable experience and the tools needed to help them reach their health care goals. This means that resources be available, policies and processes be aligned to facilitate workflows, and be a foundation for growth, advancement, and achievement of goals. Barriers such as inadequate staffing, heavy workloads, and ill-designed processes should be considered by nursing and organizational leaders when setting goals to increase patient and nurse satisfaction.

Recommendations

Nurses have the most interaction with patients during their hospital stay. Thus, they have the greatest impact on how patients perceive the care they receive while hospitalized. Assessment and analysis of how nurses perceive their practice environment in relation to how patients perceive their nursing care should be conducted per department or unit in order to more accurately identify modifiable factors that influence nurse and patient perception.

Department and unit-level leadership can initiate some behavior changes and implement new strategies, which would function to improve the perception of the practice environment and the perception of the care provided. Encouraging nursing staff to participate on a Unit Shared Governance committee will open the door for the team to voice their concerns, identify broken processes and systems, and make suggestions in a safe, non-punitive environment. This type of committee should be nurse-driven and focuses on what the team needs in order to get their work done and make the practice environment more satisfying. It may also motivate team members that are more reserved, and/or less engaged, to get involved and share innovative ideas. Having this committee in place will trigger ownership of unit goals, productivity, and outcomes. Nurses should also be encouraged to participate on other Shared Governance committees that may interest them to gain a better understanding of how decisions are made and how changes can be implemented on their home or base unit.

Sharing patient satisfaction scores and survey comments provides nursing staff with some awareness of what patients consider important to them. Having some idea of patient expectations of care during their hospital stay makes it easier to develop a feasible

plan or strategy to better meet patient needs and expectations. This is also an opportunity to recognize “did wells” in regards to patient perception and satisfaction. Having these data results also helps individuals evaluate and modify their own approach to patient interaction.

Patient-Family Advisory Councils are not new to healthcare. Facilities that have adopted a philosophy or model of family-centered care have implemented patient-family advisory councils as a way incorporate the unique family unit and dynamics of patients into their plans of care (Halm, Sabo, & Rudiger, 2006). These councils create a partnership with current and previous patients and families to improve care with emphasis on the perspective and experience of the healthcare consumer. Membership of the councils consists of past and present patients, patient family members, leaders (unit, facility, and organization level), direct care nurses, and other disciplines. Members of the councils are able to participate in and make recommendations towards decisions being made in all aspects of facility and organizational operations (Halm et al., 2006). This would allow patients and their families to help with orientation of new nurses, redesign of processes, and development of educational materials for families. Implementation of councils such as these identifies opportunities for improvement from the viewpoint of the healthcare consumer thus improving nursing care overall. Patient-Family Advisory Councils grant access to resources, information, and support, and are a source of power for the nurse and the patient alike.

Conclusion

The structure of the nurse practice environment impacts the nurse’s ability to perform at his or her best. Thus, patient-reported satisfaction scores are linked to how

well nurses are able to execute their job duties and meet patient goals and expectations. It is important that nurses be empowered by the structure of the practice setting with access to the resources, information, and support they need in order to be a source of power for their patients. Healthcare leaders would benefit from examining what is important to all parties and then engaging direct care nurses, patients, and families to decentralize decision-making and improve the care environment for both nurses and their patients.

References

- American Association of Critical-Care Nurses. (2005). *AACN standards for establishing and sustaining healthy work environments: A journey to excellence*. Retrieved from <http://www.aacn.org/wd/hwe/docs/execsum.pdf>.
- Aiken, L., & Patrician, P. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research*, *49*(3), 146-153.
- Boev, C. (2012). The relationship between nurses' perception of the work environment and patient satisfaction in adult critical care. *Journal of Nursing Scholarship*, *44*(4), 368-375. doi:10.1111/j.1547-5069.2012.01466.x
- Breau, M., & Rheame, A., (2014). The relationship between empowerment and work environment on job satisfaction, intent to leave, and quality of care among ICU nurses. *Dynamics*, *25*(3), 16-24.
- Flynn, L., Liang, Y., Dickson, G., & Aiken, L. (2010). Effects of nursing practice environments on quality outcomes in nursing homes. *Journal of the American Geriatrics Society*, *58*(12), 2401-2406. doi:10.1111/j.1532-5415.2010.03162.x
- Halm, M., Sabo, J., & Rudiger, M. (2006). The patient-family advisory council: Keeping a pulse on our customers. *Critical Care Nurse*, *26*(5), 58-67.
- Hauck, A., Quinn-Griffin, M., & Fitzpatrick, J. (2011). Structural empowerment and anticipated turnover among critical care nurses. *Journal of Nursing Management*, *19*: 269-276. doi: 10.1111/j.1365-2834.2011.01205.x
- Kieft, R., de Brouwer, B., Francke, A., & Delnoij, D. (2014). How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *BMC Health Services Research*, *14*(1), 118-137. doi: 10.1186/1472-6963-14-249.

- Kelly, D., Kutney-Lee, A., Lake, E., & Aiken, L. (2013). The critical care work environment and nurse-reported health care-associated infections. *American Journal of Critical Care, 22*(6), 482-488. doi:10.4037/ajcc2013298.
- Kuokkanen, L., & Katajisto, J. (2003). Promoting or impending empowerment: Nurses' assessments of their work environment. *Journal of Nursing Administration, 33*(4), 209-215.
- Kutney-Lee, A., McHugh, M., Sloane, D., Cimiotti, J., Flynn, L., Neff, D., & Aiken, L. (2009). Nursing: A key to patient satisfaction. *Health Affairs, 28*(4), w669-677. doi:10.1377/hlthaff.28.4.w669
- Lake, E. (2002). Development of the practice environment scale of the Nursing Work Index. *Research in Nursing and Health, 25*(3), 176-188.
- Lake, E. (2007). The nursing practice environment: Measurement and evidence. *Medical Care Research and Review, 64*(Suppl. 2), 104S-122S.
- Li, Y., Lake, E., Sales, A., Sharp, N., Greiner, G., Lowy, E.,... & Sochalski, J. (2007). Measuring nurses' practice environments with the revised nursing work index: Evidence from registered nurses in veterans health administration. *Research in Health & Nursing, 30*(1), 31-44.
- Long, L. (2012). Impressing patients while improving HCAHPS. *Nursing Management, 43*(12), 32-37. doi: 10.1097/01.NUMA.0000422891.99334.68
- McCaughey, D., Stalley, S., & Williams, E. (2013). Examining the effects of EVS spending on HCAHPS scores: A value optimization matrix for expense management. *Journal of healthcare Management, 58*(5), 320-334.

- Polit, D., & Beck, C. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Roche, J., Lamoureux, E., & Teehan, T. (2004). A partnership between nursing education and practice using empowerment model to retain new nurses. *Journal of Nursing Administration, 34*(1), 26-32.
- Roche, M., & Duffield, C. (2010). A comparison of the nursing practice environment in mental health and medical-surgical settings. *Journal of Nursing Scholarship, 42*(2), 195-206. doi: 10.1111/j.1547-5069.2010.01348.x
- Roussel, L. (2013). *Management and leadership for nurse administrators* (6th ed.). Boston, MA: Jones and Bartlett
- Shaffer, F., & Tuttas, C. (2008). HCAHPS: Nursing's moment in the sun. *Nurse Leader, 6*(5), 48-51.
- Sochalski J. (2001). Quality of care, nurse staffing, and patient outcomes. *Policy, Politics, & Nursing Practice, 2*(1), 9-18.
- Spence-Laschinger, H., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *Journal of Nursing Administration, 31*(5), 260-272.
- Spence-Laschinger, H., Gilbert, S., Smith, L., & Leslie, K. (2010). Towards a comprehensive theory of nurse/patient empowerment: Applying Kanter's empowerment theory to patient care. *Journal of Nursing Management, 18*, 4-13. doi: 10.1111/j. 1365-2834.2009.01406.x
- Trinkoff, A., Johantgen, M., Storr, C., Gurses, A., Liang, Y., & Han, K. (2011). Nurses' work schedule characteristics, nurse staffing, and patient mortality. *Nursing Research, 60*(1), 1-8. doi: 10.1097/NNR.0b13e3181fff15d

Warshawsky, N., & Havens, S. (2011). Global use of the practice environment scale of the nursing work index. *Journal of Nursing Administration, 60*(1), 17-31. doi:10.1097/NNR.0b013e3181ffa79c.

Wong, C., & Laschinger, H. (2013). Authentic leadership, performance, and job satisfaction: The mediating role of empowerment. *Journal of Nursing Administration, 69*(4), 947-959. doi:10.1111/j.1365-2648.2012.06089.x.

Appendix A

Informed Consent

Study Title: The Relationship between the Nurses' Perception of the Practice Environment and Patients' Satisfaction

You are being asked to participate in a research study being conducted by Shalonda Brown, a Master of Science in Nursing student at Gardner-Webb University.

Purpose: The purpose of this study is to determine if there is an association between the nurse practice environment and patients' satisfaction with the care received during hospitalization.

Procedure: You are being asked to complete two data collection tools: the Practice Environment Scale of the Nurse Work Index and a Nurse Demographic Survey. The approximate time required to complete both surveys is 20 minutes. Upon completion of the surveys, you have no further obligation to the research. Instructions on how to access and complete the surveys will be provided by the researcher.

Voluntary Participation: Participation in this research study is voluntary. Your decision to participate or not will not impact your employment, or relationship Gardner-Webb University at any time. Should you choose to participate in this research study, you have the right to withdraw at any time without consequence. Additionally, you have the right to refuse to answer any question(s) for any reason, without consequence.

Risks and Benefits: The Institutional Review Board at GWU has determined that participation in this study poses minimal risk to participants. If you, as an employee, experience any type of distress from completing the survey please speak with your nurse manager or to contact the Employee Assistance Program at Novant Health at 1-800-828-2778. There are no direct benefits associated with participating in this study.

If you have questions, want more information or have suggestions, about the research you may contact the researcher at sbrown9@gardner-webb.edu. You may also contact my professor, Dr. Tracy Arnold at tarnold@gardner-webb.edu or at 704-406-4359. If you have concerns about your rights or treatment, or the risks and benefits related to this study you may contact the Gardner-Webb University Institutional Review Board at 704-406-3255.

Confidentiality: Your participation and responses to the survey questions will be anonymous and confidential. Please do not disclose identifying information on the surveys.

All surveys are electronic and will be submitted to an electronic database. This information will be stored on the researcher's password protected personal computer. The collected data and results will be retained by the School of Nursing for 10 years in secured location.

Consent to Participate

Please retain a copy of this consent form for your records.

By completing this survey, you are voluntarily consenting to participate in this research study. If you choose not to participate in this study, please discard this survey.

Appendix B

Nurse Demographic Survey

1. How long have you been a nurse? _____ years
2. What type of unit do you work on most of your scheduled days? _____
 - Critical Care
 - Medical-Surgical
 - Behavioral Health
 - Women's Services
 - Surgical Services
 - Emergency Department
3. How long have you been in your current department? _____years

Appendix C

The Practice Environment Scale of the Nursing Work Index

For each item, please indicate the extent to which you agree that the item is PRESENT IN YOUR CURRENT JOB. Indicate your degree of agreement by circling the appropriate number.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1 Adequate support services allow me to spend time with my patients.	1	2	3	4
2 Physicians and nurses have good working relationships	1	2	3	4
3 A supervisory staff that is supportive of the nurses.	1	2	3	4
4 Active staff development or continuing education programs for nurses.	1	2	3	4
5 Career development/clinical ladder opportunity.	1	2	3	4
6 Opportunity for staff nurses to participate in policy decisions.	1	2	3	4
7 Supervisors use mistakes as learning opportunities, not criticism.	1	2	3	4
8 Enough time and opportunity to discuss patient care problems with other nurses	1	2	3	4
9 Enough registered nurses to provide quality patient care.	1	2	3	4
10 A nurse manager who is a good manager and leader.	1	2	3	4
11 A chief nursing officer who is highly visible and accessible to staff	1	2	3	4
12 Enough staff to get the work done	1	2	3	4
13 Praise and recognition for a job well done.	1	2	3	4
14 High standards of nursing care are expected by the administration	1	2	3	4
15 A chief nursing officer equal in power and authority to other top-level hospital executives	1	2	3	4
16 A lot of team work between nurses and physicians.	1	2	3	4
17 Opportunities for advancement.	1	2	3	4
18 A clear philosophy of nursing that pervades the patient care environment.	1	2	3	4

19	Working with nurses who are clinically competent.	1	2	3	4
20	A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician.	1	2	3	4
21	Administration that listens and responds to employee concerns.	1	2	3	4
22	An active quality assurance program.	1	2	3	4
23	Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).	1	2	3	4
24	Collaboration (joint practice) between nurses and physicians.	1	2	3	4
25	A preceptor program for newly hired RNs	1	2	3	4
26	Nursing care is based on a nursing, rather than a medical, model.	1	2	3	4
27	Staff nurses have the opportunity to serve on hospital and nursing committees.	1	2	3	4
28	Nursing administrators consult with staff on daily problems and procedures	1	2	3	4
29	Written, up-to-date nursing care plans for all patients.	1	2	3	4
30	Patient care assignments that foster continuity of care, i.e., the same nurse cares for the patient from one day to the next.	1	2	3	4
31	Use of nursing diagnoses.	1	2	3	4

Source: Eileen T. Lake. "Development of the Practice Environment Scale of the Nursing Work Index." *Research in Nursing & Health*, May/June 2002; 25(3): 176-188.