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The Effect of Closed versus More Liberal Visitation Policies on Work Satisfaction Beliefs and Nurse Retention.

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The Effect of Closed Versus More Liberal Visitation Policies on Work Satisfaction, Beliefs, and Nurse Retention

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by

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ABSTRACT

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Nurses believe that more liberal visitation policies will cause greater work overload and decrease the quality of patient care. The purpose of this study was to investigate the effect of a liberal visitation policy on work satisfaction, beliefs, and retention of nurses.

In this study, nurses were asked to complete a survey before and after implementation of a more liberal visitation policy. The nurses were surveyed using Stamps (1997) Index of Work Satisfaction and the Boswell Beliefs Inventory. Statistical analyses were conducted to discover nurses level of satisfaction and beliefs related to the new policy.

Results indicate that nurses were more dissatisfied with the components of pay, task requirements, and organizational policy six months after the new policy was implemented. Beliefs about the new policy did not change over the six month period. Increased dissatisfaction with work indicates that the policy did have an effect on work satisfaction of nurses.

Dedication

Dedicated to my husband, children, parents, and mother and father-in-law

in appreciation of their encouragement and support.

Acknowledgement

My sincere appreciation is extended to my Committee Chair, Dr. Barbara May, who worked closely with me on completion of this manuscript. Acknowledgement and appreciation is also extended to Dr. Lois W. Lowry, Dr. Pat Smith, and Dr. Kurt Loess who completed the thesis committee.

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CHAPTER 1

INTRODUCTION

Restructuring and reengineering of the workplace has changed the nature of the work ethic and the responsibility of employers to their employees regarding the meaning of work (Ray, Turkel, & Marino, 2002). Cuilla (2000) indicated that commitment to the employee, investment in the worker, fairness in pay, and provision of good benefits are remnants of the past that have been replaced with a new motto that involves getting the employee to do more for less. Furthermore, the current nursing shortage, managed care, and rising health care costs have wreaked havoc on the nursing workforce. Finally, "media critique of health care practices, the lack of public trust in health care personnel, and diverse career opportunities for women have negatively influenced the profession of nursing" (Ray et al., p. 1). The aforementioned lack of trust may provide impetus for patient families to exert their influence in the health care setting. These efforts may be facilitated through patient centered care initiatives that include more liberal family visitation policies.

Nursing literature indicates a trend toward liberal visitation policies in intensive care units (Carlson, Riegel, & Thomason, 1998; Clarke, 2000; Federwisch, 1998; Halm & Titler, 1990; Hupcey, 1998; Messner, 1998; Ramsey, Cathelyn, Gugliotta, & Glenn, 1999; Roland, Russell, Richards, & Sullivan, 2001; Ryan, 2002; Tarnowski, Harmon, Hanson, & May, 1999). While these policies allow more time for families of hospitalized patients to interact with each other, there are more demands placed on nursing staff to include families in nursing care; thus, interactions with families and patients may be limited. For example, nurses are expected to share information with family members in order to help them cope with a critical care hospitalization and reduce anxiety levels. However, nurses who are already multi-tasking during the current nursing shortage may deal with difficult families by avoiding certain patients and family members, enforcing rigid compliance with visitation policies, or disengaging completely from the emotional needs of families and patients (Hupcey; Tarnowski et al.).

Another major issue is that reactions from nurses could result in excessive attention to clinical aspects of patient care while neglecting the psychosocial aspects (Tarnowski et al., 1999). Nursing behaviors that are detrimental to relationships with families in the intensive care setting are: not referring to the patient by name, labeling the patient or family as hard to get along with, providing care without encouraging the participation of the patient or family member, and not talking or making eye contact with the patient or family. In their defense, nurses indicate that these behaviors are a result of being preoccupied or exceedingly busy during their assigned shift (Hupcey, 1998).

Nurses and other health care providers face an ongoing battle to comply with growing numbers of governmental and professional regulations in order to meet the needs of patients and their families while continuing to provide quality patient care (Ray et al., 2002). Many nurses believe that more frequent visitation of families within the intensive care unit will cause a greater work overload and decrease the quality of patient care. Nurses are concerned specifically about the amount of time it may take to answer increased numbers of questions from family members, the increased amount of time involved in caring for family members as well as patients, difficulty in maneuvering around in already confined patient rooms, and lack of privacy for other patients (ICU Nurses, Personal Communication, March, 2003).

Nurses must often take their meal breaks at their work station due to insufficient time to leave their work unit. While meal breaks are already considered to be short and inadequate, many nurses believe that implementation of a more liberal intensive care unit (ICU) visitation policy may eliminate the break altogether. Other nurses state that they doubt that they will be able to take a break without increased interruption (ICU Nurses, Personal Communication, March, 2003). Nurses stated that, “When you don’t have a chance to get to the restroom for 14 hours and haven’t eaten in 12 hours, you realize how hard it is to be a nurse” (Ray et al., 2002, p. 9). In an American Nurses Association survey (2001) 7,299 respondents concurred stating that nursing staff often care for their patients’ needs and safety before taking care of their own personal and professional needs. Over 5,000 nurses indicated that they were foregoing breaks and meals in order to provide patient care and

felt pressured to accomplish greater amounts of work. Over 4,000 indicated that they work more hours due to mandatory overtime and do not have opportunities to participate in continuing education programs. In addition, 3,762 indicated that they suffered from work related stress.

In 2001, a study completed by Moody, Smith, Creasia, Shattell, and Grindstaff found that more control and autonomy over practice ranked only second in importance to improved staffing. Nurses in ICU fear a loss of autonomy with the continued presence of patient families during the provision of patient care (ICU Nurses, Personal Communication, March, 2003). This sentiment is reflected in statements made by Forte, as documented on Nurseweek.com indicating that,

> Open door policies can also create an atmosphere in which clinicians feel they are being constantly observed. When families are here frequently, as they are on my unit, there's no real down time for the staff to freely discuss how they're feeling, what's going on with families. They are constantly 'on' (Federwisch, 1998, p. 3).

Implementation of a more liberal visitation policy is perceived as an infringement on nursing autonomy if the decision to implement the policy was made prior to consulting all members of front-line nursing staff. Plans to implement the policy continue despite many objections from the front-line. Unfortunately, this creates increased distrust of nursing administration by nurses providing direct patient care (ICU nurses, Personal Communication, March, 2003). Shared governance requires the input of nursing staff prior to the implementation of organizational policies.

Nurses believe that healthcare administrators are out of touch with issues that practicing nurses face on a daily basis. As organizational policies are implemented without adequate input from front-line nursing staff, loss of autonomy occurs. This loss of autonomy has the potential to inhibit the professional status of practicing nurses (ICU nurses, Personal Communication, March, 2003).

Nurses, while taking on increased responsibility, have had an ample opportunity to witness the transition of healthcare from an environment of caring and a refuge for the sick and infirm to corporations that must maintain a profit margin while providing higher pay scales to an executive management team. Concurrently, nursing salaries have marginally kept up with inflation rates (Ray et al., 2002). Personal communication with nurses indicates that though there is reward and

satisfaction in the provision of patient care, they feel frustrated to know that nurses doing comparable work in other regions of the country are earning more money (Personal Communication, ICU Nurses, March, 2003).

Finally, perceptions of professional status are an important factor in work satisfaction of nursing staff and quality of patient care (Aiken, 2002). Though bonus and incentive pay is always welcome, personal communication with practicing nurses reveals that nurses feel that the amount is paltry next to the income generated by nursing services. This perceived lack of pay is directly related to professional status in light of the assertion that while there is ample focus on profit margins and rising executive pay, nurses are considered more of a liability than an asset to the healthcare organization (Ray et al., 2002).

Purpose of the Study

The purpose of this study was to investigate the effect of a liberal visitation policy on work satisfaction of nurses in an adult intensive care setting prior to and after implementation of a more liberal visitation policy. Additionally, beliefs about liberal family visitation were assessed in an effort to measure the potential effect of beliefs on satisfaction with the work environment. Finally, a comparison of turnover and vacancy rates was conducted in order to discern how implementation of the policy has affected nurse staffing levels.

Theoretical Framework

Hospital policy has an important influence on nursing satisfaction and subsequent retention of nursing staff. Nurses' satisfaction with the variables of pay, autonomy, professional status, task requirements, interaction with physicians and peers, and organizational policy may be altered with the implementation of a more liberal visitation policy. Beliefs of nurses about more liberal visitation policies may have an effect on the variables of work satisfaction because of changes in the work environment. The theoretical framework for this study displays antecedents that affect nurses'

satisfaction which are measured by the Index of Work Satisfaction and the Boswell Beliefs Inventory, leading to the consequences of nurse retention or turnover and vacancies. (Figure 1).

Conceptual Model

The Neuman Systems Model is a conceptual framework for nursing that is based upon the concepts of stress and actual and potential reactions to stress. The client system in the model, an individual or a group, is represented wholistically and multidimensionally. Physiological, psychological, sociocultural, developmental, and spiritual variables of the system are depicted as interactive and responding to internal or external stressors upon the system at any given point in time (Neuman, 1995). The model is applicable to this study because it establishes a link between a nursing system and its continuous relationship to factors within the environment. Interventions to ensure the optimal health of the system are used based upon available data that reveal the needs of the system. The system is depicted as a circle surrounded by lines of defense (Figure 2).

> A functionally interactive relationship exists jointly among all lines of defense and resistance, as each line individually contains the five system variables and protects the system components pertaining to it. Input, output, and feedback across these boundary lines (environmental exchanges) provide corrective action to change, enhance, and stabilize the system, with the goal of achieving an optimal wellness level (Neuman, p. 25).

In this study, adult intensive care unit nurses comprise the subsystem within the greater hospital system. The stressor to the system is the change to the work environment that may occur through implementation of more liberal family visitation policies. If internal stressors and external stressors cause damage to the normal line of defense, the outcome may be a decrease in nurse satisfaction, and ultimately affect nurse retention. Current beliefs of nurses related to more frequent and longer family visitation may be an additional stressor.

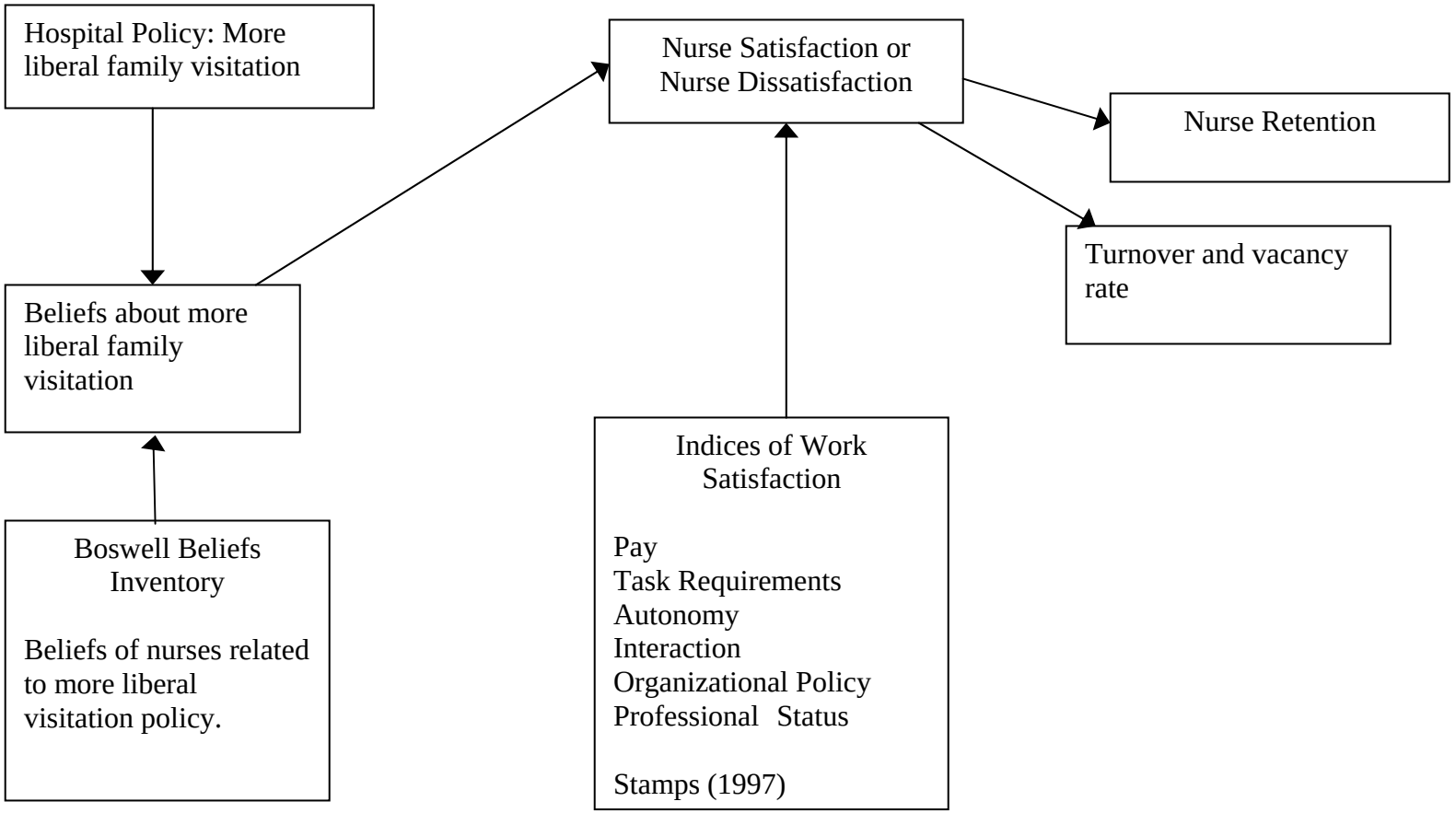

Figure 1. Theoretical Framework

The model depicts three lines of defense to protect the system. The flexible line of defense serves as a buffer by preventing environmental stress from having an effect upon optimal functioning. This line is flexible, so it can expand and contract to provide greater or lesser protection. Impact of a major stressor has the potential to reduce the effectiveness of the buffer system by allowing an attack on the normal line of defense (Neuman, 1995). The normal line of defense is the patterns and beliefs of nurses that have evolved over time and serves to protect the system from stressors. When the normal line of defense is damaged, signs of dissatisfaction with the work environment ensue leading to sickness within the system.

Neuman (1995) discussed five variables that comprise a system. Application of these variables to the nursing system are as follows: 1). physiological, referring to structure and function of the nursing unit as a whole; 2). psychological, encompassing nursing beliefs about more liberal family visitation and perceptions of satisfaction with work; 3). sociocultural aspects that relate to interaction between nurses, physicians, and family members; 4). developmental stages that reflect professional status and autonomy; and 5). spirituality that manifests itself through the influence of beliefs related to the work environment and frequent communication with physicians, peers, and patient families.

The environment of the system reflects both internal and external influences. The internal environment is comprised of forces and interactive influences that are intrapersonal (Neuman, 1995). Beliefs related to more liberal visitation policies coupled with internal communication about these variables comprise the internal environment. The external environment, both interpersonal and extrapersonal, contains all forces and interactive influences that are outside of the system (Neuman). Persons involved in nursing administration and patient families exist in the external environment. The exchanges between the internal and external environments are the ingredients of the created environment; a mix of intrapersonal, interpersonal, and extrapersonal communication. The created environment is dynamic and represents the client's unconscious mobilization of all system variables to achieve system integration, stability, and integrity (Neuman).

Optimal health of the system in achieved through continuous exchange between the system and the environment (Neuman, 1995). Therefore, frequent exchange with nurses in this system regarding their response to implementation of the more liberal visitation policy is essential to the health of the system. This is a fundamental belief of Neuman who indicated that "the major concern for nursing is keeping the client system stable through accuracy both in assessing the effects and possible effects of environmental stressors and in assisting in client adjustments required for an optimal wellness level" (p. 33). Actions taken by individuals in both the internal and external environment should be aimed at assisting the system to achieve an optimal level of health.

Three areas of intervention are described in the Neuman Systems Model. Primary intervention seeks to intervene before a stressor occurs; secondary interventions are instituted after the invasion of a stressor; and tertiary intervention seeks to promote adaptation after multiple stressor invasions. Two of these have been implemented. The first, primary intervention, was achieved through the creation of committees and workgroups to outline nursing preferences and gain feedback from nurses about more liberal family visitation policies. Despite this, nurses within the system indicated displeasure with the policy (ICU Nurses, Personal Communication, March, 2003). The goal of secondary intervention strategies is to "provide appropriate treatment of symptoms to obtain optimal client system stability or wellness and energy conservation. (Neuman, 1995, p. 34)" Changes that may occur as a result of the current study of work satisfaction and nursing beliefs related to more liberal family visitation serve as a secondary intervention strategy. Tertiary prevention occurs when the system returns to stability and continues as a form of maintenance of wellness.

Five variables occur and are considered concurrently in all system circles.

Psychological - Perceptions of work. Example: beliefs about more liberal family visitation policies, and perceptions of satisfaction with six variables measured on the Index of Work Satisfaction.

Physiological - Overall health of nursing system; elements that enable the organization or nursing system to accomplish goals. Example: number of nursing staff, and number of beds.

Sociocultural - Social, political, and economic culture of the workplace. Example: participation in decisions related to organizational policy, interaction among peers, physicians and family members, pay.

Developmental - Degree to which the nursing system has evolved. Example: Nursing autonomy and professional status.

Spiritual - Purpose, mission, and philosophy of the nursing system. Example: Creation of a healthy work environment, fostering participation in organizational issues, respect for individuals, and a reflection of moral, ethical, and legal standards in professional practice.

Kelley & Sanders, (1995).

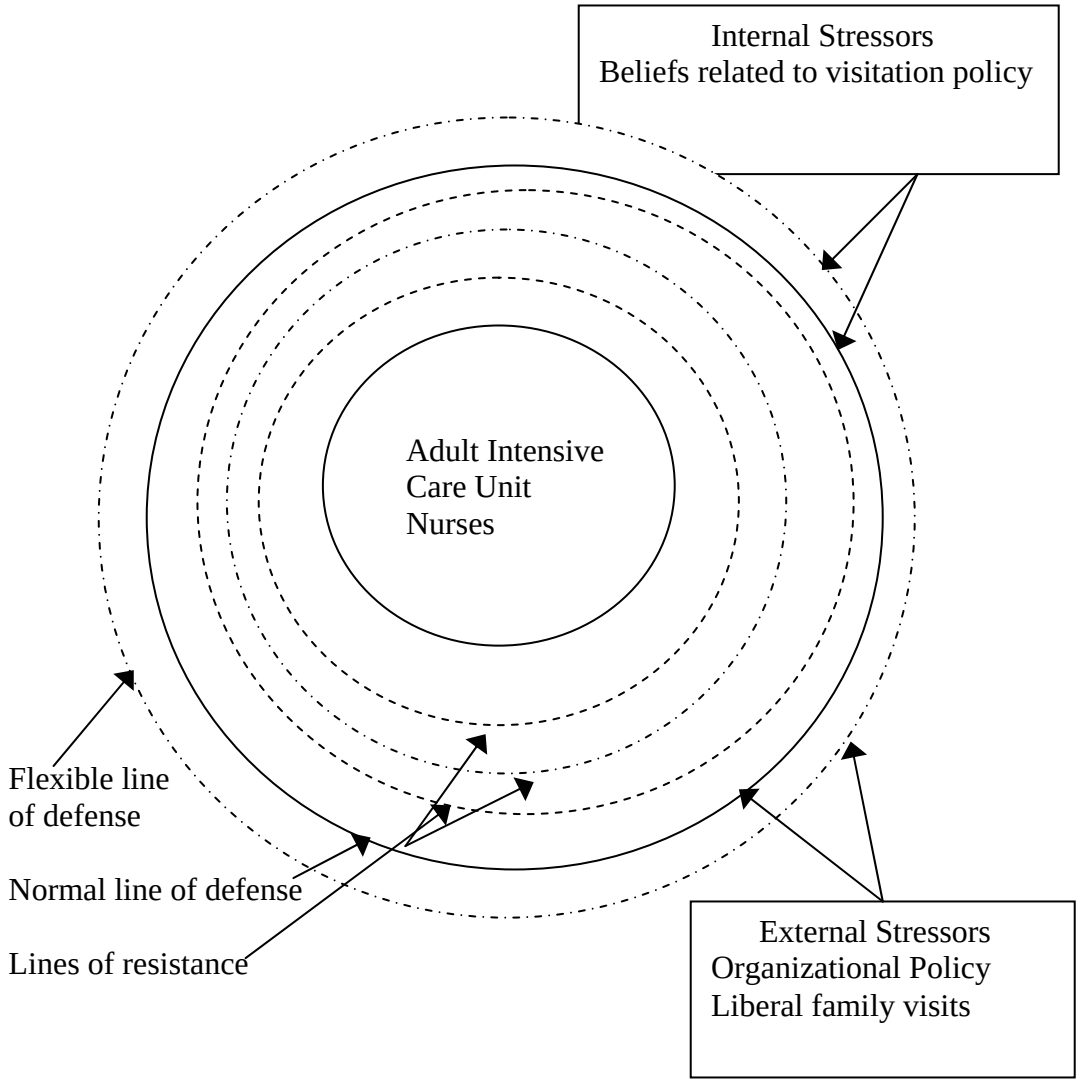

Figure 2. Conceptual Model Based Upon the Neuman Systems Model

Research Questions

1. What is the perception of nurse satisfaction with the work variables of autonomy, task requirements, interaction, pay, professional status, and organizational policy in an ICU with closed versus liberal visitation policies?
2. What effect does implementation of a liberal visitation policy have on work satisfaction of nurses working in the intensive care unit?
3. What are the beliefs of intensive care unit nurses about more liberal family visitation?
4. What changes in beliefs occur after more liberal visitation policies are implemented?
5. What effect does implementation of a more liberal visitation policy have on nurse retention?

Definitions of Major Variables and Terms

Closed visitation policy: A policy that places restrictions on the time or length of time that a patient may receive visitors.

Liberal visitation policy: A policy that allows for less restriction on the time or length of time that a patient may receive visitors.

Nurse satisfaction: A favorable perception of the nurse's work environment as it relates to the variables of pay, autonomy, task requirements, organizational policies, interaction, and professional status (Stamps, 1997).

Pay: The dollar remuneration and fringe benefits received for work done (Stamps, 1997).

Autonomy: Amount of job related independence, initiative, and freedom either permitted or required in daily work activities (Stamps. 1997).

Task requirements: Tasks or activities that must be done as a regular part of the job (Stamps, 1997).

Organizational Policies: Management policies and procedures put forward by the hospital and nursing administration of this hospital (Stamps, 1997).

Interaction: Opportunities presented for both formal and informal social and professional contract during working hours (Stamps, 1997).

Professional Status: Overall importance or significance felt about the job, both in the nurse's view and in the view of those with whom the nurse has contact (Stamps, 1997).

Belief: The state of believing or acceptance that certain things are true; an opinion, expectation or judgment (Neufeldt, 1997).

Significance

Buerhaus asserted that today's nursing shortage is unique because, unlike in past nursing shortages, quality and competition are now present. The cost of shortages are increasing because healthcare organizations are in a more competitive environment and without adequate nurse staffing, they risk the loss of markets and patients. Whereas in the past nurses were once needed for production of labor, they are now a vital factor in high quality outcomes. The current labor supply has been almost exhausted with a smaller number of registered nurses entering the profession. Of those in the market, a large number are retired or working in some other occupation with no intention of returning to nursing practice (as cited in Lindeman, 2000). This, coupled with a declining interest in nursing due to the expansion of career opportunities for women in traditionally male-dominated professions presents problems for healthcare organizations that depend on nursing to achieve numerous goals related to the provision of quality patient care (Buerhaus, 2001).

Although the work of nurses is essential to the provision of quality patient care, hospital workforce management has only enhanced the disappointment of nurses and compromised the ability of organizations to maintain adequate staffing levels and subsequently, continuous provision of quality patient care (Aiken et al., 2001). Correcting issues that alter the trend towards a decline in the recruitment of individuals to nursing and the flight of registered nurses from the profession requires respect, communication, increased visibility of administrators, and the encouragement of shared governance. "Cooperation between management and staff is at the heart of organizational harmony" (Ray et al., 2002, p. 4).

Satisfaction with work enhances job performance, productivity, and staff retention. Retention is the most important correlate with work satisfaction (Shader, Broome, Broome, West, & Nash,

2001). Alternatively, turnover of nursing staff may be measured by the number of people who leave their job for another job or leave the profession entirely. Though this is an easy means of measuring behavioral expressions of dissatisfaction in the workplace, “this does not provide much insight into the process involved in turnover, nor does it allow intervention or prevention of turnover” (Stamps, 1997, p. 53).

Implementation of a more liberal visitation policy creates change in the work environment that can be stressful for front-line nursing staff (Messner, 1998). As previously discussed, this environmental stressor has the potential to penetrate the protective walls of the nursing system with detrimental results. To promote satisfaction with the workplace and nursing practice, it is important for nurses to play a significant role in implementation of policies that effect changes in the work environment. “While nurses can agree to a more liberal visitation policy, they also want a voice in policy development and implementation” (Ryan, 2002, p. 3).

The struggle to maintain professional status and autonomy in the face of rapid change in organizational policies and increasing regulations is daunting. At a time when career options for women are multiplying, the profession of nursing is at risk of losing many of its members. The current image is perceived negatively due to increasing workload and perceptions of poor monetary compensation for services (Lindeman, 2000). Furthermore, organizations and nursing units have differing work environments and the work environment has a direct influence on job satisfaction and retention of nurses (Tumulty, Jernigan, & Kohut, 1994). With the current staffing shortage, nurses struggle with increasing demands on their time and increased responsibility in the health care setting. More liberal visitation policies have the potential to further increase the workload of practicing nurses.

Summary

Chapter 1 discussed the problem of increased workload for front line nursing staff and its impact on the quality of patient care. Rationale for increased workload and subsequent dissatisfaction with the work variables of autonomy, task requirements, professional status,

interaction, pay and organizational policies was discussed in relation to closed versus more liberal visitation policies. The theoretical framework that guides this study was presented and the application of Neuman's Systems Model was discussed. Five research questions were developed based upon the problem statement and significance of the study. Variables and terms commonly used in this study were defined.

CHAPTER 2

REVIEW OF LITERATURE

Chapter 2 includes discussion of the literature related to more liberal visitation policies. A discussion of work satisfaction is presented with particular attention focused on the variables measured by Stamps and Piedmonts' Index of Work Satisfaction. Beliefs of nurses about more frequent family visitation are also discussed.

Work Satisfaction

Previous studies examining nurse work satisfaction have yielded numerous solutions to nurse dissatisfaction, yet no individual study professes to contain the ideal solution. One study recommended seeking out creative methods of rewarding nurses for their contribution in assisting the organization to reach its goals rather than rely on bonuses, pay, and weekend differentials (Shader et al., 2001). Experimenting with a differentiated pay structure, DeGroot, Burke, and George (1998) found that the amount of pay a nurse receives is not a sole determinant of work satisfaction. While shared governance, a means of staff nurse participation in organizational policy decisions, has long been considered a source of work satisfaction, Anthony (2004) asserted that it has not been consistently identified as a source of work satisfaction. Shader et al. reinforces the need for nurse executives to encourage self-esteem and promote feelings of professional value in staff nurses. The importance of relationships in the work setting has been documented in a study which suggests that "a cohesive peer group may compensate for other frustrations from the work environment" (Tumulty et al., 1994, p. 89).

Creation of a positive work environment is essential in achieving work satisfaction and retention of nursing staff. In order to achieve this environment, nurses must be valued for their role in patient care and their role in the health care organization (Nevidjon & Erickson, 2001). Stamps (1997) asserted that satisfaction stems from perceptions of the work environment, compensation for work, autonomy, and professional status. This was supported by Bennett and Nkongho (1990) in an

assessment of staff nurses that indicated that autonomy, salaries, schedules, a perceived credibility gap, and lack of professional respect were factors leading to a nursing shortage at that time (as cited in Nevidjon & Erickson, 2001). More recently, the Nurse Executive Center (as cited in Shader et al., 2001) concurs, stating that reasons for nurse dissatisfaction and subsequent turnover include lack of sufficient pay, inability to participate in decision-making, lack of professional recognition and educational opportunities, poor interpersonal relationships with administration and peers, and lack of support. Aiken (2002) asserted,

> Nurses in hospitals, because of their employment status, are agents of the bureaucracy but hold professional values and seek peer relationships with other professionals and professional modes of organizing their work. Nurses are accountable to both the bureaucratic structure as headed by management and professional structure exemplified and headed by physicians (p. 62).

Because nurse work satisfaction is a factor in patient perceptions of quality care, hospital administrators, accrediting agencies, insurers, and regulators should take action to ensure that an adequate nursing staff is available to protect patients and to improve the quality of care (Needleman et al., 2002). In a study of 1,268 nurses, patient perceptions of quality of care and their contact with nursing staff corresponded to the nurse's relationship with work. Subsequently, patients who were on units where nurses had a positive relationship with work were more satisfied with all aspects of patient care and less satisfied on units where nurses were dissatisfied and expressed intentions of quitting (Leiter, Harvie, & Frizzell, 1998). Hospitals with exemplary nurse practice environments, where nurses have satisfactory levels of autonomy and good interactions with physicians, have a higher rate of patient satisfaction. Increased investment in nurse staffing and professional practice environments lead to fewer adverse patient events that result in increased length of hospital admission, increased intensive care days, and additional treatments for illness (Aiken, 2002). One survey indicates that:

> Americas' Registered Nurses feel that deteriorating working conditions have led to a decline in the quality of nursing care. Specifically, 75% of nurses surveyed feel the quality of nursing

> care at the facility in which they work has declined over the past two years, while 56% of the nurse respondents surveyed believe that the time they have available for patient care has decreased (American Nurses Association, 2001).

In the same survey, nurses also indicated that they would feel uncomfortable if a family member or loved one was cared for in the organization in which they were employed and over 54% of respondents indicated that they would not recommend nursing as a profession to their children or friends (American Nurses Association). A person's decision to become a nurse stems from a desire to provide compassionate and competent care. When this does not occur and the nurse views the work as frustrating and meaningless, these feelings are communicated in a manner which is readily sensed as nurses interact with patients (Leiter et al., 1998) .

Professional Status

Greater autonomy for nurses to act within their scope of professional practice, have control over support services, and personnel assistance to provide quality patient care can be achieved by health care organizations. These provisions give nurses the opportunity to practice within their specialties while assuming ownership of knowledge and technological advances leading to improved professional status within the organization (Aiken, 2002). Often the role of the nurse is defined by the relationship of nursing practice to physicians. Nurses may still be considered to be handmaidens of physicians (Nevidjon & Erickson, 2001). One study concluded that "working well with members of an interdisciplinary team is strongly associated with nurses being able to act with professional autonomy" (Rafferty, Ball, & Aiken, 2001, p. 20).

Task Requirements

The professional nurse is an important stakeholder in an organization. Therefore, nurses should be active participants in controlling the work environment and making decisions that are necessary in order to define their scope of practice and perform professional tasks (Anthony, 2004). Nurses in one study indicated that though they had left needed nursing care undone at the end of

their shift, nearly half of the nurses spent time on tasks that did not require nursing expertise such as delivering of food trays, transporting patients, and completing housekeeping tasks (Aiken, Clarke, & Sloane, 2002). Such situations contribute to the disillusionment and frustration of nurses; however, nurses continue to believe that their work is valuable in making a difference in the lives of others (Ray et al., 2002). Nurses in all facets of professional practice find dissatisfaction with the amount of paperwork that must be completed in the provision of patient care. This may contribute to the flight of nurses from acute care settings (Nevidjon & Erickson, 2001). The American Nurses Association survey (2001) reported that nurses are "discouraged and saddened" by what they do not have time to provide for their patients while so many feel "powerless to effect change necessary for safe, quality, patient care."

Autonomy

Shared governance is derived from a broad set of perspectives that includes organizational, management, and sociological theories. The earliest groundwork for shared governance had its roots in the human resource era of organizational theories after a departure from scientific forms of management (Anthony, 2004). Empowerment of nurses includes participation in decision-making and moving the decision-making process and subsequent accountability to the bedside or other areas of service (McNeese-Smith, 1995).

Organizational Policy

Shared governance is a vital element in assuring nurse satisfaction with changes in organizational policy and restructuring of services to achieve better quality of care or financial stability. This is evidenced by a study where satisfaction with the work environment, participation in policy decisions, and accessibility of nurse managers deteriorated because of administrations' lack of consultation with front line staff prior to organizational restructuring (Aiken et al., 2000). A trust relationship in healthcare organizations is created when administrators and practicing nurses make organizational decisions as a team. Lack of trust in health care organizations has contributed to the

need for transformation of nursing through increased respect for nursing staff, visibility of leadership, communication, and engaging nursing in participative decision-making (Ray et al., 2002). “Hospital managers too often look to outside managerial consultants to solve clinical care problems when clinicians in their own institutions could solve these problems with appropriate support from management” (Aiken et al., 2002, p. 9).

Pay

Perceptions of lack of sufficient pay are a factor in attrition of nurses from the profession Fletcher (2001). Further, the current nursing shortage creates a drive to increase nursing pay. Beurhaus (as cited in Lindeman, 2000) indicated that:

> Hospitals send signals to nurses that they are raising wages and nurses tell them whether those wages are enough by their decisions to supply more labor. If people are deciding between several occupations, they will consider economic factors and the prospect of higher wages will influence their choice (p. 5).

The lack of competitive wages for nurses creates a disadvantage for the profession as the number of career opportunities for women increases (Staiger, Auerbach, & Buerhaus, 2001). Additionally, mergers, downsizing, and the struggle to increase profits has resulted in a dissatisfied work force that perceives the bottom line as expansion of services to gain market share and fosters the degradation of the function of nursing from one of a caring profession to that of a devalued caregiver employed for the sake of organizational profits (Fletcher, 2001).

Interaction

Professional interaction with other health care professionals is also a significant factor in job satisfaction. Nurses who provide poor care, portray a negative attitude, or suffer job burnout create dissatisfaction for coworkers (Fletcher, 2001; McNeese-Smith, 1999; Tumulty et al., 1994). Staff nurses who perceive the work environment to be more positive report higher job satisfaction than those who perceive the work environment to be more negative (Tumulty et al., 1994). Moody et al.

(2001) revealed that workload demands related to inadequate staffing and lack of support secondary to negative attitudes from peers and administrators were aspects of nursing that compelled nurses to leave their current position. Nurses indicated that improvements in staffing coupled with an increase in autonomy and control over their own professional practice would enhance their perception of nursing.

Liberal Visitation Policies

Restrictions on critical care policies were imposed in 1965 due to recommendations made by the Unites States Public Health Department indicating that visitation in ICU's should be restricted to immediate family members for short periods of time (Roland et al., 2001). Since that time, ample research has been completed to ascertain trends in intensive care visitation policies. Restriction of family visitation as an intensive care unit standard was confirmed by Youngner, Coulton, Welton, Juknialis, & Jackson (1984). A study specific to patients with acute myocardial infarction conducted by Kirchoff (1982) revealed that the majority of responding facilities allowed visitation at one to two hour intervals. Stockdale and Hughes (1990) revealed that there were also restrictions in the number of visitors allowed into the intensive care unit at any given time as well as age restrictions of visitors. Despite the prevalence of these policies in the 1980s, additional studies conducted within the same time period indicated that there were discrepancies among nursing beliefs related to those policies that affected adherence to the policy. Hickey and Lewandowski (1988) found that only a small percentage of nurses adhered to the organizations' visitation policy because the nurses believed that more frequent visitation was important to patient recovery. Though this belief was prevalent, the nurses reported being emotionally exhausted due to more frequent involvement with family members (Hickey & Lewandowski). Conversely, others found that nurses believed that more frequent family visitation was not very important to patient recovery (Halm & Titler, 1990). As to visitation of young children, the ability of the patient to establish a rapport with the nurse was a significant determinant of child visitation (Clarke, 2000).

More recently, in a survey of 882 nurses representing 50 states, visitation policies were examined and results revealed that the majority of visitation policies continued to allow family visitation for a duration of only 10 minutes every 2 hours. Open visitation at the discretion of the nurse was the second most common policy. Only a small percentage reported open visitation polices. The majority of the nurses reported that they deviated from the policy of their organization. This deviation was due to a variety of factors including patient condition such as physical deterioration or dying, desires or needs as evidenced by increased confusion or inability to speak English; patient situations such as new admission or post-procedure status; visitor factors such as arrival from out of town or lack of transportation; and nurses' workload. In addition, nurses reported deviations from the policy by easing of age restrictions, the number of visitors allowed, and relationship requirements. Two nurses reported allowing patients to receive visitation from pets (Carlson et al., 1998).

Alternatively, visiting by family members has often been reported as a source of stress for nurses because their primary focus involves meeting the needs of critically ill patients rather than families (Halm & Titler, 1990). It is the nurse's role as the holistic care giver to meet the needs of the family as well as the patient (Roland et al. 2001). However, nurses view patient and family needs separately rather than holistically when deviating from formal visitation policies (Tarnowski et al., 1999).

Professional practice that adheres to the wholistic practice of nursing provides significant benefits. Though nursing ranks very high as a trusted profession in the United States, public perception related to increased stress experienced by nurses may enhance the desire of well family members to stay with hospitalized family members in order to promote safety (Nevidjon & Erickson, 2001). During hospitalization of a critically ill family member, families permitted to provide some level of care may have decreased feelings of helplessness and lack of control (Roland et al., 2001). Critical care nurses have increased opportunity to enhance family strengths, identify dysfunctional patterns that may hamper recovery, and augment coping in both the present and future family crises (Tarnowski et al., 1999). And finally, sharing of patient health information can enhance coping

skills and reduce anxiety levels of family members during an episode of critical care hospitalization (Tarnowski et al.).

Beliefs of Nurses

Several studies reveal a variety of beliefs that are common in critical care nurses. One belief is that critical care nurses do not perceive liberal visitation as important to the recovery of critically ill patients (Halm & Titler, 1990; Kirchhoff, Pugh, Calame, & Reynolds, 1993). A second belief is that restricted visitation offers increased opportunity for rest that is needed for patient healing (Carlson et al., 1998; Halm & Titler). Third, liberalization of visitation policies will interfere with the ability of the nurse to provide nursing care (Halm & Titler; Kirkhhoff et al.; Ramsey et al., 1999; Ryan, 2002). Fourth, few nurses perceive the role of family as a provider of basic care such as bathing and backrubs (Halm & Titler). The fifth, belief is that more liberal visitation policies have the potential to lead to adverse physiological events (Carlson et al; Clarke, 2000; Federwisch, 1998; Roland et al., 2001). Finally, some nurses believe that visitation policies should not be enforced when the ability of the patient to recover is at stake (Carlson et al.; Halm & Titler; Hupcey, 1998; Ramsey et al.).

Beliefs of critical care nurses related to more liberal visitation policies, perceptions of overwork, and difficulty in dealing with difficult patients has the potential to cause nurses to exhibit negative behaviors without understanding the negative impact on families (Hupcey, 1998). Ryan (2002) asserts that with more liberal visitation policies, nurses will feel more constraint, become less service oriented, and a decrease in patient and family satisfaction will be measured. Alternatively, administrators strive to implement the liberalization of visitation policies because of the belief that it improves visitor satisfaction while concurrently shortening hospital lengths of stay (Roland et al., 2001; Ryan).

The findings of previous research indicate that there is disagreement about what constitutes the need for more frequent if not open family visitation policies. To date, though health care organizations have polices in place, the magnitude of enforcement of these polices is at the discretion of the nurse. The ability to use personal discretion is a factor in professional status and

autonomy, yet nurses at the site for this study express dissatisfaction with this organizational policy (Personal communication, ICU Nurses, March 2003). Kirchhoff et al., (1993) asserted that modifications in visitation policies would be unsuccessful unless negative perceptions of nursing staff are changed. “Other studies indicate that open visitation increases nurses’ job satisfaction by providing positive feedback from family members and by decreasing stress caused by family and patient dissatisfaction (Roland et al., 2001, p. 19). For these reasons, nursing beliefs related to more liberal visitation polices and an assessment of work satisfaction before and after implementation of the policy is important to ascertaining success of the policy while maintaining satisfaction of nurses in the workplace.

Summary

In Chapter 2, the literature concerning satisfaction with the variables of autonomy, professional status, organizational policy, task requirements, pay, and professional interaction was presented. The concept of intensive care unit family visitation policies from their inception in 1965 to the present was discussed. Trends in organizational policy were presented along with prominent nursing beliefs and how these beliefs affect deviation from formal policy. In addition, the necessity of satisfaction with work to enhance retention of nursing staff has been indicated as a factor in the ability to provide quality patent care.

CHAPTER 3

RESEARCH APPROACH AND DESIGN

Chapter 3 includes the research design for this study. A description of the sample and setting for the study is also presented. Instruments used in this study are presented along with methods used for scoring. Procedures for data collection and protection of human subjects are discussed. The chapter concludes with a discussion of data analysis.

Research Design

This study was a quasi-experimental study measuring the effects of a more liberal visitation policy on nurse satisfaction and nurse beliefs. Data were obtained from a voluntary, nonprobability, convenience sample of full- and part-time nurses in an adult intensive care unit. The first data were collected immediately prior to implementation of the more liberal visitation policy. A second set of data were collected six months after the policy was implemented.

Setting and Sample

The study was conducted in the flagship hospital of a group of eight hospitals located in the southeast. As a Level 1 Trauma Center, the organization has established a mission to become the health care provider as well as employer of choice in the region. One strategy to achieve this goal is the implementation of a patient-centered care initiative that involves more liberal visitation policies.

This study specifically focused on the adult intensive care unit which currently accommodates 38 patients. The facility began an expansion of the department in October, 2003. When completed in March, 2005, the department will house 12 additional beds in which to care for critically ill patents. Currently the critical care department employs 108 registered nurses.

At the time of the initial data collection, the intensive care unit visitation policy allowed family members to visit a patient for 30 minutes every two hours. The first visit occurred at 8:00 a.m. with the final visit being 10:30 p.m.. The more liberal visitation policy, implemented six

months prior to the second data collection, allows two visitors to visit during the day between 8:30 a.m. and noon, 2:00 p.m. until 6p.m., and 8:30 p.m. to 10:30 p.m.. Between the hours of 8:30 p.m. and 8:30 a.m. the ICU is closed. One family member is allowed to stay with a patient from 10:30 p.m. until 6:30 a.m.. Visitors to the ICU must wear a badge that identifies the room number they have permission to visit. Badges may be exchanged between visitors but this must be completed in the ICU waiting room. Exceptions to the limits for visitation are made on rare occasions and include imminent death or post surgical status. Although the guidelines of the policy are posted for visitors to peruse, families are also oriented to the policy by family advocates.

Instruments

Index of Work Satisfaction

The Index of Work Satisfaction (Stamps, 2001) was used to measure job satisfaction in the adult intensive care unit. The Index of Work Satisfaction (IWS) is a 59-item instrument that has two parts. Each section is designed to assess nurses' work satisfaction by measuring six components of satisfaction: pay, autonomy, task requirements, organizational policies, professional status and interaction. Part A utilizes paired comparisons and respondents are encouraged to choose the variable of work satisfaction from 15 pairs of components that has the most significance on their level of work satisfaction. Part B measures satisfaction with each of the components using a group of 44 attitude items, each of which has met the statistical criteria for inclusion. Interaction, one component measured on this part of the IWS, may be divided into subscales: satisfaction with nurse to nurse and satisfaction with nurse to physician relationships. All responses for Part B are measured on a seven-point scale Likert scale, where for negatively worded statements, seven indicates that the nurse strongly disagrees. In contrast, for positively worded statements, seven indicates that the nurse strongly agrees (Stamps, 2001). The Cronbach's alpha coefficient is 0.82 for the entire scale. The internal reliabilities of the six subscales range from 0.52 to 0.81 (Stamps, 1997).

To calculate results for Part A, the paired comparison section of the questionnaire, a frequency table was constructed using SPSS 11.0 for Windows. The frequency value for each

component was then converted manually to a number that indicated the ranking as the total percentage of the sample that actually made a choice for that pair of components. The percentages were calculated to three decimal places. These percentages were then converted to standard deviations based on the normal distribution of responses using a Z-table. Through the use of the Z-table, weight was given to those components that were ranked most important by respondents. The component weighting coefficient for each component was then calculated by totaling the sum of the Z-table values for each component and dividing by the number five, which was the number of comparisons made. The final step in calculating the component weighting coefficient was the elimination of negative values which was achieved by adding 3.100 (Stamps, 2001).

Scoring of Part B was accomplished through multiplying the score for each response by the total number of nurses giving that response. The subtotals were than tallied for each item. Next, the total score for each item was divided by the number of respondents for that item to obtain an average score for that particular item. The component score was obtained by adding the average scores for each component. To obtain the mean component score, the component score was then divided by the total number of statements for that particular component (Stamps, 2001).

The score for the Index of Work Satisfaction was then calculated by multiplying the component weighting coefficient for each component from Part A by the mean score for each component in Part B. The result obtained is the component adjusted score which weights the satisfaction of each component by the level of importance placed on each component by the respondents (Stamps, 2001).

To calculate the work satisfaction value, the component adjusted scores were tallied and divided by the number of components which is six. The IWS value is an indicator of both level of importance and current level of satisfaction. The range for the IWS is from 0.9 to 37.1 with most scores falling in the area of 12 (Stamps, 2001).

In order to ascertain what the final numeric values mean, the numbers are compared with designated quartile ranges for each section (Stamps, 1997). The ranges for Part A and Part B may be

viewed in Table 1 (Stamps, 2001). To further assure that the numerical value has meaning, note that the researcher labeled the quartiles by ranking.

Table 1

Quartiles and Rankings for the Index of Work Satisfaction Scale

	Not important	Moderately unimportant	Moderately important	Highly Important
Part A	0.9 – 2.0	2.1 – 3.1	3.2 – 4.2	4.3 – 5.3
	Not satisfied	Moderately unsatisfied	Moderately satisfied	Highly satisfied
Part B	44 - 112	113 – 180	181 – 248	249 - 308
Component adjusted Scores	0.9 – 9.9	10.0 – 19.0	19.1 – 28.1	28.2 – 37.1
IWS	0.5 – 10.3	10.4 – 20.0	20.1 – 29.7	29.8 – 39.7

Boswell Beliefs Inventory

A Beliefs Inventory, constructed by the researcher to measure nursing beliefs related to more liberal visitation policies, includes statements about beliefs derived from the literature in Chapter 2. The instrument consists of six statements measured on a Likert, seven-point scale where one indicates that the nurse strongly agrees and seven indicates that the nurse strongly disagrees. Two open-ended questions asked the nurses to discuss some issues and concerns they may have with a more liberal visitation policy and what changes may need to occur in order to ensure the success of the policy.

Using SPSS 11.0 for Windows, a frequency table of responses to each of the six beliefs was constructed. Frequent responses indicating high levels of agreement were ranked as the most prevalent belief of the sample. Less frequent responses indicating lesser levels of agreement were

considered least prevalent among beliefs of the sample. Statements to the two open-ended questions were sorted into categories according to their similarities. Prevalent themes were identified. Other responses were listed separately for consideration of their applicability to the study when discussing results.

Procedures

The data were collected by distributing questionnaires in each nurses' employee mailbox. After completion of the questionnaire, each nurse was instructed to place the form into an envelope that was provided and drop into a box designated for collection. The researcher visited the facility at frequent intervals to collect the completed surveys. Though the nurses' completion of the instrument served as their informed consent, a copy of the informed consent document describing the purpose and process of the study was also distributed. Telephone numbers to contact the researcher in case the nurse had questions or concerns were provided. A personal letter from the researcher was also attached to the questionnaire thanking each nurse for participation in the study.

Protection of Human Subjects

Institutional Review Board permission was obtained from the sponsoring university and by the healthcare facility prior to the onset of the study. The subject was under minimal risk by agreeing to participate in the study and the rights and privacy of each subject were protected. Subjects were instructed not to make any identifying marks on the surveys. Subjects were also encouraged to cease completion of the questionnaire and withdraw from the study if discomfort in answering the questions was experienced in any way. Information obtained on the surveys was held confidential by the investigator.

Subjects were informed that they may not directly benefit from the study but that potential changes in organizational policies as a result of the study may be of benefit to them or other nurses who choose to work in the department in the future. Collected surveys were assigned numerically and alphabetically to the respective group for the collection time period. All data were reported in

the aggregate in order to maintain subject confidentiality. The data will be stored for 10 years in a locked file in an office at the researchers' home.

Data Analysis

Descriptive statistics were used to describe the demographic characteristics of both samples. Data were analyzed manually using the Index of Work Satisfaction Scoring Workbook (2001) and SPSS 11.0 for Windows. An independent t-test of means was conducted to ascertain the significance of difference between nurse responses in April and October.

Summary

The research design of the study was discussed in Chapter 3. A description of the setting for the study and the study sample were included. Important aspects of the research instruments were discussed. The procedure for data collection and protection of human subjects had also been included in addition to a discussion of data analysis.

CHAPTER 4

PRESENTATION OF THE DATA

Introduction

The purpose of this study was to investigate the effect of a liberal visitation policy on work satisfaction and beliefs of nurses related to more liberal family visitation policies in an adult intensive care unit. The study also examined the effect of satisfaction with work and beliefs on turnover and vacancy rates in an effort to learn about how the policy has affected nurse staffing levels. Five research questions were posed:

1. What is the perception of nurse satisfaction with the work variables of autonomy, task requirements, interaction, pay, professional status, and organizational policy in an ICU with closed versus liberal visitation policies?
2. What effect does implementation of a liberal visitation policy have on work satisfaction of nurses working in the intensive care unit?
3. What are the beliefs of intensive care unit nurses about more liberal family visitation?
4. What changes in beliefs occur after more liberal visitation policies are implemented?
5. What effect does implementation of a more liberal visitation policy have on nurse retention?

Chapter 4 includes discussion of the descriptive findings and data analysis for each set of data collection. The data are presented in accordance with the order in which they were collected. Where possible, the data are presented in table format to allow more precise comparison of similarities and differences between groups. Beliefs of nurses related to more liberal visitation policies are presented and prominent themes about nursing beliefs related to more liberal visitation policies are discussed.

Demographics

The sample for the first data collected immediately prior to implementation of a more liberal visitation policy included 42 nurses. The age range of the nurses was 23 to 56 years with a mode of

32 years. Twenty-five nurses indicated they had a Bachelor of Nursing (B.S.N.) degree while 10 nurses held an Associate of Applied Science in Nursing (A.A.N.). One nurse held a nursing diploma and three had achieved a B.S.N. in addition to a second degree in another area of study. Two nurses in the sample held a master's degree. The length of practice ranged from three months to 417 months. The mean length of time in practice as a registered nurse was 25.67 months. The length of time working at the facility ranged from three months to 228 months with the mean length of time of employment in the facility as 18.64 months. Forty of the nurses identified themselves as Caucasian. Twenty-one of the nurses worked from 7 p.m. to 7 a.m. and 19 worked from 7 a.m. to 7 p.m.

The sample for the second set of data collected six months after implementation of the more liberal visitation policy included 24 nurses. The age range of nurses was 23 to 51 years with a mode of 29 years. Sixteen nurses indicated that they held a B.S.N. and four nurses were A.A.N.'s. One nurse had earned a bachelor's degree in another area of study and two nurses were master's prepared. The length in time of practice ranged from six months to 276 months with a mean length in time of 26.25 months. The length of time working at the facility ranged from three months to 228 months with the mean length of time of employment in the facility as 21.67 months. Twenty-two of the nurses identified themselves as Caucasian. Thirteen of the nurses indicated that the shift worked most often was 7 p.m. to 7 a.m. and 10 worked from 7 a.m. until 7 p.m.

Nurse Satisfaction

Question One

The first research question asked: What is the perception of nurse satisfaction with the work variables of autonomy, task requirements, interaction, pay, professional status, and organizational policy in an ICU with closed versus liberal visitation policies? To answer this question, the Index of Work Satisfaction (IWS) was administered just prior to implementation of the policy and just after the policy was implemented. The first data collection was in the beginning of April, 2003, just prior to implementation of the policy and data were collected again in late October to early November, 2003, six months after implementation of the policy. This time frame was chosen to allow nurses

time to adjust to the new policy. As this was not a longitudinal study, there is no guarantee that nurses who completed the first questionnaire also completed the second questionnaire.

Part A presented the nurses with a list of paired comparisons from which the component that had the most important affect on work satisfaction was to be selected. The responses were calculated to obtain a component weighting coefficient that, when ranked in quartiles, serves as indication of which components are most important. In the first data collection period, nurses ranked all six components as only moderately important. In the second data collection, the component of pay was ranked highly important. The components of task requirements and organizational policies decreased in their level of importance while autonomy, professional status, and interaction remained unchanged (Table 2 and Table 3).

Table 2

Nurse Satisfaction Component Scores Prior to Implementation of Liberal Visitation Policies in the Intensive Care Unit, April, 2003 (n = 42)

Component	April	Quartile	Ranking
Pay	3.49	3	Moderately important
Autonomy	3.37	3	Moderately important
Task requirements	3.32	3	Moderately important
Organizational policies	3.65	3	Moderately important
Professional status	3.43	3	Moderately important
Interaction	3.33	3	Moderately important

Table 3

Nurse Satisfaction Component Scores After Implementation of Liberal Visitation Policies in the Intensive Care Unit, October, 2003 (n = 24)

Component	October	Quartile	Ranking
Pay	4.44	4	Highly important
Autonomy	3.51	3	Moderately important
Task requirements	2.69	2	Moderately unimportant
Organizational policies	2.70	2	Moderately unimportant
Professional status	3.99	3	Moderately important
Interaction	3.55	3	Moderately important

Part B, the second portion of the IWS, is a 44-item Likert scale which measured nurses' satisfaction with the component measured in Part A. Scores obtained from this section give two types of information: the component scale score and the mean score for each component. The mean score serves as a measure of satisfaction for each component. Comparison of scores from both sets of data indicate that satisfaction with task requirements and organizational policy had decreased significantly whereas satisfaction with pay had increased. Numerical values for changes in satisfaction with professional status, autonomy, and interaction were not significant.

Final calculation of the component adjusted score, an indicator of satisfaction based upon level of importance of each of the components, support these findings. Though nurses ranked task requirements and organizational policies as not as important in the October data, there was a significant decrease in satisfaction with task requirements and organizational policies in comparison to April. In addition, though there was a slight decrease in the level of satisfaction with autonomy, an increase was found in satisfaction with professional status (Table 4 and Table 5).

Table 4

Nurse Satisfaction Component Adjusted Scores Prior to Implementation of Liberal Visitation Policies in the Intensive Care Unit, April, 2003 (n=42)

Component	April	Quartile	Ranking
Pay	9.00	1	Not satisfied
Autonomy	15.97	2	Moderately unsatisfied
Task requirements	11.95	2	Moderately unsatisfied
Organizational policies	12.70	2	Moderately unsatisfied
Professional status	17.08	2	Moderately unsatisfied
Interaction	15.42	2	Moderately unsatisfied

Table 5

Nurse Satisfaction Component Adjusted Scores After Implementation of Liberal Visitation Policies in the Intensive Care Unit, October, 2003 (n=24)

Component	October	Quartile	Ranking
Pay	9.77	1	Not satisfied
Autonomy	14.67	2	Moderately unsatisfied
Task requirements	8.15	1	Not satisfied
Organizational policies	9.34	1	Not satisfied
Professional status	18.75	2	Moderately unsatisfied
Interaction	15.83	2	Moderately unsatisfied

Question Two

The second question asked what effect implementation of a liberal visitation policy has on work satisfaction of nurses working in the intensive care unit. This question was answered by calculating the total IWS score. This score was calculated by summing the six component adjusted scores and dividing by six, the total number of components. The total IWS score for April was 13.69 which is in the second quartile range indicating that nurses were unsatisfied with work at a moderate level. The total IWS score for October was 12.75. Although ranking lower in the second quartile, this score was consistent with the score in April score indicating that nurses were moderately unsatisfied with work.

An independent t-test of means was then conducted to learn if the difference in total IWS scores was statistically significant. With $p < .05$, the results were found to be significant; however, consideration must be given to the variation in sample size (see Table 6).

Table 6

t-test of Means Indicating Statistical Significance of Total Index of Work Satisfaction Scores

	Mean	SD	T	df	*p*
Work satisfaction score					
Prior to implementation (n = 42)	3.97	.472	3.451	64	.001
After implementation (n = 24)	4.37	.419			

Stamps (2001) asserted that in addition to the recommended scoring process, it is important to examine frequency distributions of responses for each component. This is done to gain an even better understanding of the data obtained. The following tables have been included as a summary of the frequency distribution for each component. Percentages are consolidated into strongly agree/agree, unsure, and disagree/strongly disagree categories.

As the data in Table 7 indicate, less than half of the nurses in April indicated that the present salary was satisfactory. In October, the number of nurses indicating that they did not agree that salary was satisfactory nearly doubled. Although a large percentage indicated in April that nursing personnel were dissatisfied with pay, an even larger percentage stated the same in October. The percentage of nurses who indicated that pay is fair in comparison with other hospitals dropped dramatically while a concurrent increase of nurses who disagreed that pay is fair in comparison with other hospitals occurred. In April and October, nurses indicated that they believe that an upgrading of pay schedules was needed at the hospital.

Table 7

Frequency Distribution for Satisfaction with Pay Before and After Implementation of a More Liberal Visitation Policy in an Intensive Care Unit

Items	Strongly agree/agree		Unsure		Disagree/ Disagree strongly	
	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct
My present salary is satisfactory.	35.7	13.0	19	9.0	45.2	78.0
It is my impression that a lot of nursing personnel at this hospital are dissatisfied with their pay.	76.2	91.0	9.5	4.0	14.3	4.0
Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable.	14.3	4.0	14.2	0	71.5	96.0
The present rate of increase in pay for nursing service personnel at this hospital is not satisfactory.	83.3	83.0	4.8	4.0	11.9	13.0
From what I hear about nursing service personnel at other hospitals, we at this hospital are being fairly paid.	11.9	4.0	16.7	9.0	71.4	87.0
An upgrading of pay schedules for nursing personnel is needed at this hospital.	95.2	82.0	0	9.0	4.8	9.0

As shown in Table 8, the percentage of nurses indicating that they agree that nursing is not widely recognized as an important profession was 64.2% in April and 65% in October. Conversely,

the percentage of nurses indicating that they are unsure that what they do in their job is really important decreased from April to October, while the number of nurses disagreeing with the statement nearly tripled. The number of nurses who feel proud to talk to other people about what they do on their job decreased by 18.7% while the percentage of those who disagreed with this statement nearly doubled. While 47.6% of the first sample indicated that they would go into nursing if they had the decision to make again, in October, 65% of the sample indicated they would not. A reasonably high percentage of the April and October sample indicated that they believe that their job requires skill and know-how with the greater percentage being in October.

Table 8

Frequency Distribution for Satisfaction with Professional Status Before and After Implementation of a More Liberal Visitation Policy in an Intensive Care Unit

Items	Strongly agree/agree		Unsure		Disagree/ Disagree strongly	
	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct
Nursing is not widely recognized as being an important profession	64.2	65.0	9.5	21.0	26.2	13.0
Most people appreciate the importance of nursing care to hospital patients	42.9	41.0	14.3	9.0	42.9	50.0
There is no doubt whatever in my mind that what I do on my job is really important.	85.8	83.0	9.5	4.0	4.8	13.0
What I do in my job does not add up to anything really significant	4.8	13.0	2.4	22.0	92.8	65.0
It makes me proud to talk to other people about what I do in my job.	66.7	48.0	14.3	17.0	19.0	35.0
If I had the decision to make all over again, I would still go onto nursing	47.6	26.0	16.7	9.0	35.7	65.0
My particular job doesn't really require much skill or know how.	2.4	4.0	19.0	0	78.6	96.0

The percentage of nurses indicating that they are unsure if they are supervised more closely than necessary more than tripled from April to October (see Table 9). The majority of nurses in both samples believed that they had sufficient input into the program of care for each patient. Nurses who were frustrated in April because they believed that their activities seem programmed for them nearly doubled from April to October while those nurses disagreeing with this statement almost doubled. Also, the percentage of nurses who believed they have freedom to make important decisions and receive support from their supervisor dropped by almost half from April to October.

Table 9

Frequency Distribution for Satisfaction with Autonomy Before and After Implementation of a More Liberal Visitation Policy in an Intensive Care Unit

Items	Strongly agree/agree		Unsure		Disagree/ Disagree strongly	
	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct
I feel I am supervised more closely than is necessary.	4.8	13.0	7.1	39.0	88.1	48.0
I feel I have sufficient input into the program of care for each of my patients.	69.1	59.0	16.7	14.0	14.3	27.0
I have too much responsibility and not enough authority.	40.5	45.0	23.8	32.0	35.7	23.0
On my service, my supervisors make all the decisions. I have little direct control over my own work.	11.9	13.0	11.9	22.0	76.2	65.0
A great deal of independence is permitted, if not required, of me.	64.3	56.0	14.3	22.0	19.1	22.0
I am sometimes frustrated because all of my activities seem programmed for me.	14.3	26.0	19.0	35.0	64.3	39.0
I am sometimes required to do things on my job that are against my better professional nursing judgment.	33.4	39.0	7.1	22.0	59.5	39.0
I have the freedom in my work to make important decisions as I see fit, and I can count on my supervisors to back me up.	42.9	26.0	23.8	22.0	33.3	52.0

As indicated in Table 10, 100% of nurses believed that there was a significant gap between the administration of the hospital and the daily problems of nurse service in October as compared to 92.8% in April. The percentage of nurses indicting that there were not enough opportunities for advancement in the hospital rose sharply from April to October. Nurses disagreeing that administrative decisions at the hospital interfere with patient care in April dropped by nearly half by October while the number that agreed with this statement remained fairly constant at both times of data collection.

Table 10

Frequency Distribution for Satisfaction with Organizational Policy Before and After Implementation of a More Liberal Visitation Policy in an Intensive Care Unit

Items	Strongly agree/agree		Unsure		Disagree/ Disagree strongly	
	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct
The nursing staff has sufficient control over scheduling their own shifts in my hospital.	40.5	30.0	21.4	22.0	38.1	48.0
There is a great gap between the administration of this hospital and the daily problems of the nursing service.	92.8	100.0	2.4	0	4.8	0
There are not enough opportunities for advancement Of nursing personnel at this hospital.	57.1	74.0	26.2	17.0	16.7	9.0
There is ample opportunity for nursing staff to participate in the administrative decision-making process.	16.7	13.0	16.7	17.0	66.6	70.0
Administrative decisions at this hospital interfere too much with patient care.	42.8	48.0	21.4	35.0	35.7	17.0
I have all the voice in planning policies and procedures for this hospital and my unit that I want.	11.9	13.0	28.6	30.0	59.5	57.0
The nursing administration generally consult with the staff on daily problems and procedures.	16.6	9.0	7.1	4.0	76.3	87.0

Table 11 indicates that while the percentage of nurses agreeing with the statement that they could do a better job if they did not have so much to do all the time decreased by 21.1%, the number of nurses disagreeing with the statement dropped 38.5%. Nurses indicating that they were satisfied with the activities they do on the job dropped by 37.8% while those disagreeing with this statement increased by 16.4%. The majority of nurses indicated in October that they do not have plenty of time to discuss patient care problems with other nursing service personnel while the majority agree in both time periods that they could deliver better care if they had more time with each patient.

Table 11

Frequency Distribution for Satisfaction with Task Requirements Before and After Implementation of a More Liberal Visitation Policy in an Intensive Care Unit

Items	Strongly agree/agree		Unsure		Disagree/ Disagree strongly	
	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct
There is too much clerical and "paperwork" required of nursing personnel in this hospital.	85.8	96.0	7.1	0	7.2	4.0
I think I could do a better job if I did not have so much to do all the time.	61.9	83.0	16.7	13.0	21.4	4.0
I am satisfied with the type of activities that I do on my job.	85.8	48.0	4.8	26.0	9.6	26.0
I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.	40.5	35.0	26.2	22.0	33.3	78.0
I have sufficient time for direct patient care.	50	30.0	16.7	26.0	33.4	43.0
I could deliver much better care if I had more Time with each patient.	83.4	78.0	4.8	9.0	11.9	13.0

The percentage of nurses in Table 12 who indicated that there was a lot of "rank consciousness" on their unit increased by more than half from April to October while the percentages for other statements for nurse to nurse interaction remained fairly constant. Conversely,

the percentage of nurses indicating disagreement with the statement that physicians in general cooperate with the nursing staff on the unit increased by more than 50%. The frequency percentage for other statements in the nurse to physician component were not highly variable.

Table 12

Frequency Distribution for Satisfaction with Interaction Before and After Implementation of a More Liberal Visitation Policy in an Intensive Care Unit

Items	Strongly agree/agree		Unsure		Disagree/ Disagree strongly	
	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct
Nurse to Nurse						
The nursing service on my service pitch in and help one another out when things get in a rush.	92.9	96.0	2.4	4.0	4.8	0
It is hard for new nurses to feel 'at home' on my unit.	35.7	45.0	14.3	23.0	50.0	32.0
There is a good deal of teamwork and cooperation between various levels of nursing personnel on my service.	83.3	74.0	9.5	17.0	7.2	9.0
The nursing personnel on my service are not as friendly and outgoing as I would like.	9.6	17.0	16.7	4.0	73.8	78.0
There is a lot of "rank consciousness" on my unit: nurses seldom mingle with those with less experience different types of educational preparation.	9.5	22.0	14.3	4.0	76.1	74.0
Nurse to Physician						
Physicians in general cooperate with the nursing staff on my unit.	61.9	48.0	23.8	22.0	14.3	30.0
There is a lot of teamwork between doctors and Nurses on my own unit.	61.9	52.0	19.0	13.0	19.0	35.0
I wish the physicians here would show more respect for the skill and knowledge of nursing staff.	71.4	65.0	14.3	9.0	14.3	26.0
Physicians at this hospital generally understand and appreciate what the nursing staff does.	42.8	43.0	21.4	9.0	35.7	48.0
The physicians at this hospital look down too much on nursing staff.	42.8	35.0	9.5	22.0	47.6	43.0

Beliefs Related to More Liberal Family Visitation

Questions Three and Four

Research questions three and four queried the beliefs of intensive care unit nurses about more liberal family visitation and changes in their beliefs after the policy was implemented. To answer these questions, a frequency analysis was constructed to calculate beliefs and changes in beliefs related to more liberal visitation policies using SPSS 11.0 for Windows. There were several differences in beliefs from April to October as indicated in Table 13. For consistency, ranking of percentages is expressed as strongly agree/agree, unsure, and disagree/strongly disagree. In an effort to identify statistically significant differences, an independent t-test of means between groups was conducted and no significant differences were identified.

Table 13

Beliefs of Intensive Care Unit Nurses About More Liberal Visitation Policies

Items	Strongly agree/agree		Unsure		Disagree/ Disagree strongly	
	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct	n=42 Apr	n=24 Oct
I believe that liberal visitation is important to the recovery of critically ill patients.	60.0	67.0	19.0	29.0	21.0	4.0
Less family visitation time gives the patient more time to rest and heal.	31.0	33.0	24.0	21.0	45.0	46.0
Longer and more frequent visits by family members will interfere with nursing care.	74.0	63.0	10.0	25.0	16.0	12.0
I do not believe that family members should help with non-nursing care such as bathing and back rubs.	10.0	12.0	7.0	21.0	83.0	67.0
I believe that allowing families to visit at more frequent intervals can cause more physical problems for my patients.	31.0	54.0	31.0	25.0	38.0	21.0
I believe that families should be allowed to visit a patient with minimal restriction if the patient has a poor chance of recovery.	91.0	84.0	2.0	8.0	7.0	8.0

Responses to the two open ended questions were then examined. In April, four prominent themes were identified. The first was the potential for adverse physiologic events such as increased wound infections, increased shortness of breath by patients requiring the use of supplemental oxygen therapy, patient agitation, and lack of sufficient rest when families visit for long periods of time. One nurse stated, “Patients need time to rest. Two hours a shift is not enough. Patients often hate to ask family to leave when they are tired.” The second theme involved concerns over increased family complaints. Nurses indicated they believe that families do not understand prioritization of tasks related to patient care and often have unrealistic goals that are contrary to patient wishes. Additionally, nurses indicated they believe that they will be “scrutinized” more closely by families while completing patient care, as well as being interrupted more frequently by families who request care for their loved one. Another part of this theme is the belief that problems will arise if families exhibit a “lack of understanding or are unwilling to accept certain aspects of care that the patient needs.” The third theme expressed by nurses was nursing concern over the time needed to take care of patient families. Such care would involve as one nurse stated, “fetching water” and blankets, being required to interrupt patient care to address questions, and a general lack of control over visitation. The fourth and final theme centered on patient confidentiality issues. Items of concern within this theme were the increased presence of families in the hallway of the ICU during emergent situations allowing families to gaze into another patient’s room and overhear discussions about the health status of other patients.

Four themes were also generated from surveys received in October. Confidentiality of patients continued to be an important theme because of families clustered in ICU hallways. Second, there is a variation in the extent to which all nurses and family members abide by the new policy. One nurse indicated, “Each unit/nurse has a different interpretation of the policy – in neuro ICU the family can stay around the clock – if another MICU or SICU nurse gets pulled there and follows the policy, the family gets upset because “the other nurses let us stay during the shift change.” Another nurse stated, “Not all nurses or families abide by the visitation policy; this

makes the working nurse look bad to families and makes families upset." The third theme involves lack of sufficient space in patient rooms for the provision of nursing care when family members are present. This is described as "always having to step over things to get to the patient." The fourth theme involved the families' lack of adherence to hospital policy and subsequent lack of consideration for the patient. This theme is comprised of statements such as "lack of family cooperation with orders/policies – NPO orders, hand washing, using the call light for help rather than come by the nursing station, using patient bathrooms, ringing cell phones, eating and drinking in front of patients who by doctors' orders are restricted from food and fluids by mouth, and "waking up a post-op patient – families are sometimes more concerned about themselves than the patient."

Question Five

The fifth research question queries what effect more liberal visitation policies have on nurse retention. The total number of registered nurses practicing in the ICU in April was 107. The vacancy rate was not available. Currently, the ICU employs 108 registered nurses and the vacancy rate is 4.2%. The turnover rate for this time period was unavailable. Comparison of work schedules indicates that several nurses left the ICU but according to one nurse administrator, no nurses were lost due to the implementation of the new more liberal family visitation policy.

Summary

Nurses in the ICU expressed a lower level of work satisfaction since the implementation of the new more liberal family visitation policy. Specific components where statistically significant differences were identified are task requirements, organizational policies, and pay. Nurses expressed that though they believe that family visitation is important to the recovery of critically ill patients, the additional visitation interferes with nursing care and causes more physical problems for the patient. Nurses also expressed the belief that minimal restriction in visitation should be allowed if

the patient has a poor chance of recovery; however, these beliefs about more liberal family visitation policies were not statistically significant.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The purpose of this study was to investigate the effect of a liberal visitation policy on work satisfaction of nurses in an adult intensive care setting prior to and after implementation of a more liberal visitation policy. Additionally, beliefs about liberal family visitation were assessed in an effort to measure the potential effect of beliefs on satisfaction with the work environment. These determinants provide feedback to hospital administration about what nurses feel is important for satisfaction in the workplace and open an avenue to mutual agreement about changes that may need to occur to make implementation of a more liberal visitation policy successful while also enhancing the retention of valuable nursing staff.

In this chapter, the findings of this study are summarized and discussed. The findings will be discussed in relation to the theoretical framework and conceptual model. Limitations of the study are discussed. Implications of the study are applied to the areas of administration, education, practice, and research.

Summary and Discussion of the Findings

The majority of nurses in pre- and post-survey held B.S.N. degrees. The average length of time in practice for nurses in both samples was just over two years. The majority of nurses in April and October were 29 to 32 years of age and worked from 7 p.m. until 7 a.m.. The response rate for the first data collection was 38.8% and for the second, 22%. The decrease in the response rate for the data sampling may be related to the decreased satisfaction of nurses with task requirements. The survey may have been viewed as another task to be completed and/or they may have lacked the time to complete it.

Work Satisfaction

Studies exploring nurse work satisfaction have found a trend toward nurses' dissatisfaction with pay and task requirements (Amos, Hu, & Herrick, 2003; DeGroot et al., 1998; Fletcher, 2001). The importance of satisfaction with pay is supported by studies indicating that benefits and salary were important factors in nurse retention (McNeese-Smith, 1999; Moody et al., 2001). In this study, prior to implementation of the more liberal visitation policy in April, nurses ranked the variables of pay, autonomy, professional status, task requirements, professional interaction, and organizational policy as moderately important. Six months after the policy was implemented, nurses indicated that pay was highly important and task requirements and organizational policy were moderately important. Although nurses in April and October were not satisfied with pay, they were more satisfied in October than in April. This may be a result of specialty pay for intensive care unit nurses that was implemented prior to the second data collection.

Other studies show that nurses desire a reduction in time spent doing paperwork and other non-nursing functions and more time to provide patient care (Nevidjon & Erickson, 2001; Moody et al., 2001, Ray et al., 2002). Because of the increasing business of nurses, 56% of respondents (n = 7,299) to an American Nurses Association (2001) survey indicated that they believed that the time they had available for patient care decreased. This research study revealed that nurses were only moderately unsatisfied with task requirements and organizational policies in April. In October nurses indicated they were not satisfied. As task requirements increased, a concurrent increase in dissatisfaction with organizational policy and pay was found. While an overwhelming majority of nurses in both samplings indicated that they believe there is too much paperwork and too little time for patient care, a smaller percentage (48%) indicated in October that they were satisfied with the activities they do on the job. The nurses in October also indicated that they do not have the time or opportunity to discuss patient care problems with other nursing service personnel.

Empowerment of nurses and participation in the development of organizational policies is imperative. Dissatisfaction with organizational policy and subsequent lack of support for nursing care has a significant impact on nurse satisfaction and nurse-assessed quality of care. The work of

Aiken et al. (2002) illustrates the importance of renewed attention to the clinical missions of healthcare organizations, increased administrative engagement with nursing staff, and recognition of the important roles that nurses play in patient outcomes. “Organizational climate in hospitals, and specifically organizational support for nursing care that is potentially modifiable, has been an undervalued determinant of poor patient outcomes and nurse recruitment and retention failure” (Aiken et al., 2002, p. 9).

Empowerment of nurses includes encouraging their involvement in decision-making and moving decision-making and accountability to the bedside or other areas of nursing service. Empowerment affects budgeting, policies, procedures, standards and position descriptions, and the entire governance system (McNeese-Smith, 1995). Responses for nurses before and after a visitation policy change indicate that nurses may feel lack of control over their professional practice because of organizational policies. In April, 92.8% of the sample indicated that they believe there is a great gap between the administration of the hospital and the daily problems of nursing services; the number increased to 100% by October. While nurses indicated that the opportunities for advancement were limited, they also indicated that there is little opportunity for participation in the administrative decision-making process in the organization as a whole and within their department. The majority of nurses in April and October indicated that the decisions made by administration interfere with nursing care.

Other studies have also alluded to the lack of acknowledgement of nursing as an important profession (Nevidjon & Erickson, 2001; Moody et al., 2001; Ray et al. 2002; Staiger et al., 2001). Despite this, the majority of responses for both samples indicated that it makes them “feel proud to talk with other people about what I do in my job”. This is in contrast to Nevidjon and Erickson (2001) who indicated that nurses share in the shaping of opinions that others have about nursing and they may discourage their children from choosing nursing as a career choice. In this study, the majority of nurses in April and October indicated that they do not believe that nursing is recognized widely as an important profession though they have no doubt that what they do in their job is important and requires a great deal of skill and knowledge.

Nurses have expressed a desire to have more control and autonomy over nursing practice, patient care, ancillary staff, rules and regulations, and over their professional lives. A prevalent concern was the lack of power that nurses had over their own practice (Moody et al., 2001). Research on Magnet Hospitals indicates that organizational characteristics that attract and retain nurses include professional practice models for delivery of care with autonomy and responsibility for decision-making (Aiken, 2002; Lashinger, Shamian, & Thomson, 2001). The majority of nurses in this study, both in April and October, disagreed that supervisors make all the decisions and that they have little direct control over work.

Study findings indicate that working well with members of an interdisciplinary team is strongly associated with nurses being able to act with professional autonomy (Aiken, 2002; Laschinger et al., 2001). Satisfaction with professional interaction was ranked as moderately unsatisfactory in this study. In this study, the majority of nurses in April and October responded positively to statements related to professional interaction among co-workers. Responses to professional interaction with physicians in October indicate a drop in the percentage of nurses that believe that physicians in general cooperate with nursing staff on the unit while the percentage of nurses indicating a high level of team work with physicians also decreased. The majority of nurses in April and October indicated that they wish that physicians would show more respect for the skill and knowledge of nursing staff.

Beliefs Related to More Liberal Family Visitation

Several studies herald nurses as gatekeepers that limit family visitation to protect patients' physiological status and promote rest (Carlson et al., 1998; Clarke, 2000; Federwisch, 1998; Halm & Titler, 1990; Hickey & Lewandowsi, 1988; Kirchhoff et al., 1993; Tarnowski et al., 1999). Findings from this study indicate that nurses believe that more liberal family visitation is important to the recovery of critically ill patients and disagree that less family visitation allows more time for the patient to rest and heal. Conversely, the number of nurses who believed who allowing families to visit at more frequent intervals can cause more physical problems for patients increased after the

visitation policy was implemented. The reason for this discrepancy may be due to factors discussed as limitations of the study.

More liberal visitation policies give nurses increased opportunities to individualize family visiting and take advantage of the support that families offer to each other (Tarnowski et al., 1999). Additionally, other studies indicate that implementation of a more liberal visitation policy improved family and patient perceptions of quality of care thus increasing nurses' job satisfaction by the provision of positive feedback from family members (Ramsey et al., 1999; Roland et al., 2001). Despite this, the belief that longer and more frequent family visitation will interfere with nursing care is supported by previous research (Halm & Titler, 1990; Roland et. al.). Nurses in this research study concurred, with the majority of nurses April and October indicating that they believe that longer and more frequent visits by family members is detrimental to their accomplishment of nursing tasks.

A major concern of families is the desire to perform personal care for their loved one (Roland et al., 2001). Physicians, patients, family members and nurses have been found to have similar perceptions about what tasks are beneficial for families to provide. These include the provision of emotional support, helping the patient to eat, and giving the patient a backrub or a bath. Few nurses believe that family members should provide this type of care (Halm & Titler, 1990). An overwhelming majority of the nurses in this study disagree with this statement. This result may be easily understood in light of the fact that nurses in this study expressed increased dissatisfaction with task requirements after the implementation of the policy.

Past studies indicate that deviations from the policy occur for reasons such as travel time of family, patients' post-procedure status, or patient wishes (Carlson et al., 1998; Halm & Titler, 1990). Other studies have shown that nurses deviate from formal visitation polices when patient status requires them to do so (Carlson et al.; Halm & Titler; Hickey & Lewandowski, 1988; Hupcey 1998; Kirchhoff et al., 1993; Ramsey et al., 1999; Youngner et al., 1984). Nurses in this study concurred indicating that they believe that families should be allowed to visit a patient with minimal restriction if the patient has a poor chance of recovery.

Nursing concerns related to the issue of patient confidentiality during family visitation is not new (Carlson et al., 1998). Confidentiality of patient information can be breached by families seated in crowded waiting rooms as well as assembled in ICU corridors. In this study, an overwhelming majority of nurses in the April and October sample expressed the same concern, stating that in emergent situations, families often peer into rooms as they stroll to visit family members. Additionally, the nurses indicated that they believe that patient families may overhear professional discussions related to care or view patient records in error at the nurses station.

Theoretical Framework Application

The theoretical framework for this study posited that a hospital policy enabling more liberal family visitation and nursing beliefs about the policy would affect nurse satisfaction. Nurse satisfaction is composed of beliefs related to the policy and perceptions of satisfaction with pay, task requirements, autonomy, interaction, organizational policy, and professional status. Ultimately, nurse satisfaction could result in nurse retention as evidenced by lower turnover and vacancy rates.

Statistically significant differences were found in responses to perceptions of work satisfaction. Specifically, the variables for which statistically significant change occurred were pay, task requirements, and organizational policies. On the other hand, responses to statements about nurses' beliefs about more liberal visitation policies did not reveal statistically significant differences from April to October indicating that there was no significant change in nurse perceptions about the policy. Given these facts, it cannot be conclusively stated that nursing beliefs related to the policy affect perceptions of work satisfaction. However, the fact that the majority of nurses in April and October indicated that they believe that more frequent family visitation will interfere with nursing care indicates that there may be some relationship between beliefs about the policy and task requirements. In April and October, the majority of nurses indicated that they could do a better job if they had more time with each patient. Also, they indicated that there is too much paperwork required of nursing personnel. Furthermore, nurses believed they could do a better job if they did not have so much to do all the time. Finally, the increase in dissatisfaction with task requirements is relevant

because statements made by nurses in response to an open ended question indicated that having to take the time to care for families by providing water and blankets was a concern for these nurses. Therefore, although beliefs about a more liberal policy change were not statistically significant to work satisfaction, there may be an effect on work satisfaction evidenced by the statistical significance of task requirements to work satisfaction.

Pay has not been found to be a significant factor in work satisfaction (DeGroot et. al, 1998); however, perceptions of lack of sufficient pay are a factor in attrition of nurses from the profession (Fletcher, 2001). In this study, the majority of nurses in April and October indicated that their present salary is not satisfactory and that an upgrading of pay schedules for nursing personnel was needed. In fact, 96% of nurses in October indicated that considering what is expected of nursing service personnel, the pay they receive is not reasonable. The increase in dissatisfaction with pay after implementation of the more liberal visitation policy may be further evidence that the policy has had an effect on work satisfaction.

Recurring concepts in the defining of shared governance are autonomy, empowerment, leadership, decision-making, and control over practice. Previous studies examining the organizational, work environment and job satisfaction outcomes of shared governance have not been conclusive regarding benefits to the nursing workforce. Furthermore, debate exists about whether shared governance is more effective at the organizational or unit level (Anthony, 2004). Wherever it occurs, nurses must be encouraged to participate in the decision-making process in order to bridge the perceived gap between nursing administration and nurses practicing at the bedside. In this study, 92.8% of nurses in April indicated that there is a great gap between the administration of the organization and the daily problems of nursing service compared to 100% in October. The majority of nurses in April and October denied that there was ample opportunity to participate in the administrative decision-making process. Nurses in April and October also indicated that administrative decisions interfere with nursing care while also denying that nursing administrators consult with staff on daily problems and procedures.

Conceptual Model Application

Neuman (1995) asserted that there are five variables that are considered concurrently in all lines of defense surrounding a system (see Figure 3): psychological, physiological, sociocultural, developmental, and spiritual. The outer flexible line of defense, has the potential to be damaged if further dissatisfaction with the sociocultural variables of autonomy, professional status, and interaction occurs. The normal line of defense has been penetrated since the implementation of the more liberal visitation policy. Dissatisfaction with the physiological and developmental variables of pay, task requirements, and organizational policy is pressing upon the internal lines of resistance. The fact that the turnover and vacancy rates have remained low is an indicator that this stressor has not yet had an effect on the core of the system.

Conclusions of the Study

The results of this study support previous studies that indicate that task requirements and organizational policies are important to work satisfaction of nurses (Aiken, 2002; Aiken et al., 2002; Laschinger et al., 2001; Leiter et al., 1998; Moody et al., 2001; McNeese-Smith, 1995; Nevidjon & Erickson, 2001; Ray et al., 2002; Shader et al., 2001; Tumulty et al., 1994). Though pay has not been found to be a determinant of work satisfaction, in this study, it was found to be a highly important source of dissatisfaction. Greater dissatisfaction with these three work components occurred after implementation of the more liberal visitation policy. This is an indicator that when nurses are dissatisfied with changes in policy, other work satisfaction factors become more significant.

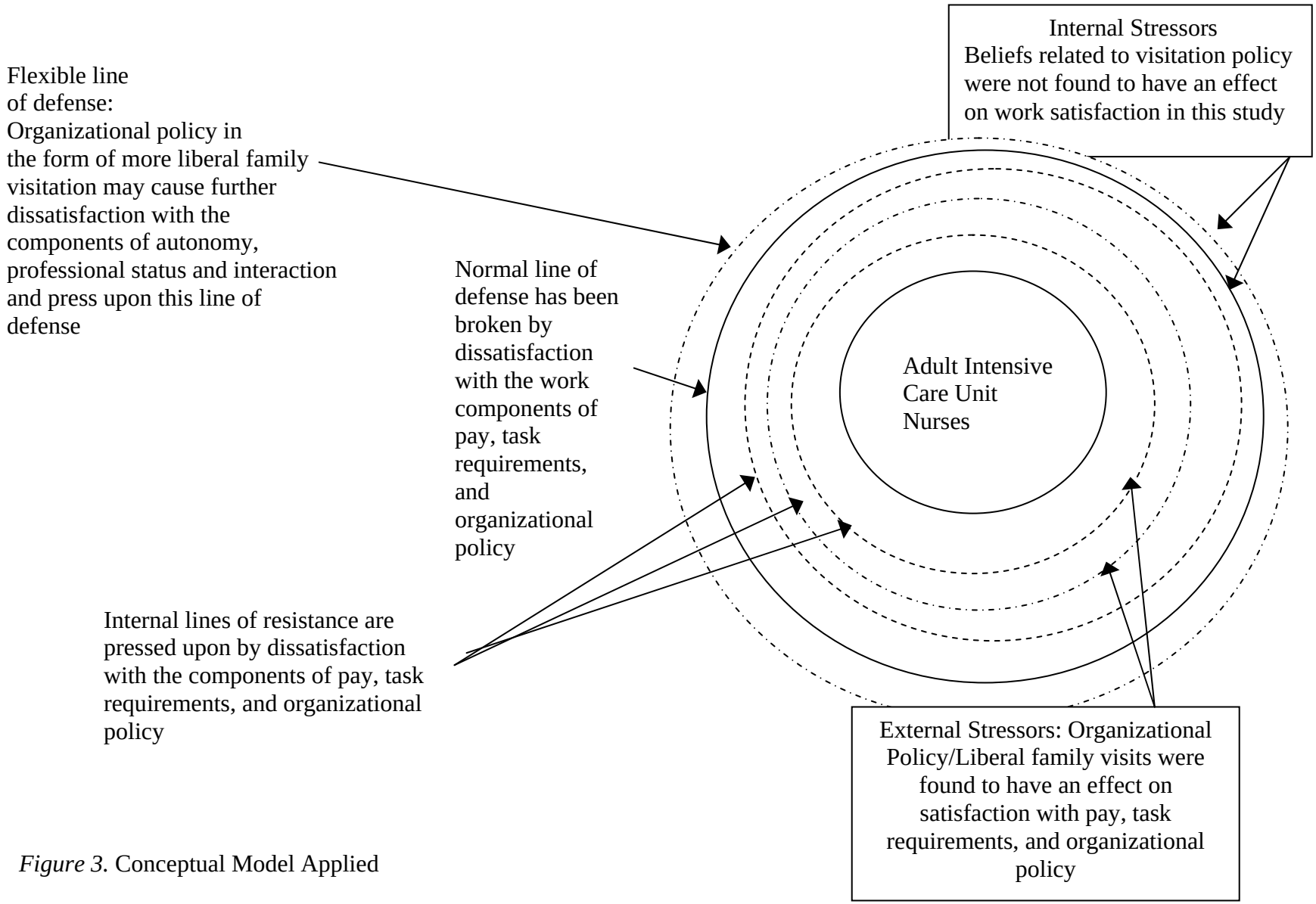

Figure 3. Conceptual Model Applied

The investigator expected beliefs about more liberal visitation to change pre- and post-survey because nurses would have had an opportunity to invalidate their concerns over the six month period from April to October. The fact that this did not occur supports other studies that indicate that nurses believe that increased family visitation will cause more physical problems for patients and interfere with nursing care (Carlson et al.1998; Clarke, 2000; Halm & Titler, 1990; Hickey & Lewandowski, 1988; Kirchhoff et al., 1993; Messner, 1996; Stockdale & Hughes, 1990; Youngner et al., 1984). In this study, confidentiality was identified as an additional concern for nurses before and after implementation of the more liberal visitation policy.

Limitations

The generalizability of this study is limited by the following factors: 1). the study was conducted with a small, voluntary convenience sample 2). a control group was not established 3). sample size was unequal 4). the results are specific to the hospital in which the study was conducted 5). the Boswell Beliefs Inventory was constructed by the researcher and has no standard reliability and validity 6). data indicating both vacancy and turnover rates for the intensive care unit were not available in April and October

Recommendations

Administration

Transformation of nursing is derived from respect, communication, visibility of administrators, and the encouragement of participative decision-making (Ray et al., 2002). Lack of supportive administrators as well as peers has been found to be a negative aspect of the nursing profession (Moody et al., 2001). “With the pressures currently facing hospitals, however, organizational profitability rather than staff nurturance often becomes the priority in practice” (Leiter et al., 1998, p. 1616). However, Aiken et al., (2000) stressed the importance of renewed attention to the clinical missions of hospitals, greater managerial engagement with clinicians, and recognition to the roles that nurses play in the achievement of quality patient outcomes. Rather than look to outside

consultants to solve clinical care problems, administrators must seek the knowledge of clinicians and provide proper support for resolution (Aiken et al., 2000).

In this study, nurses from both samples expressed discontent about facets of the more liberal visitation policy that administration, by virtue of authoritative power, can help resolve. One example is consistent adherence to the policy. Nurses expressed a desire for a formal policy dealing with family members who "knowingly violate rules, disregard infection control measures, and push boundaries with closed ICU times." Nurse administrators must seek out the perceptions of nursing and feedback for ideas to resolve the issue. Subsequent cooperation of nursing administration and bedside nurses in an ad hoc committee to develop policies to resolve this and future issues must occur.

Education

From the patient care perspective, critical care nurses need advanced skills in assisting families in crisis. Incorporation of these skills into nursing curricula would help nurses acquire these skills. Nurses must learn when and to whom to refer families for specialized treatment (Tarnowski et al., 1999). Education regarding crisis intervention should be an ongoing process (Roland et al., 2001).

Continued education of staff is important in changing staff perceptions about new policies (Carlson et al., 1998; Halm & Titler, 1990; Messner, 1996). Nurses in this study indicated that they believe that continued education of family members and nursing staff is needed to ensure the success of the more liberal visitation policy. Nurses should also be a part of the teaching process through the design and implementation of education programs for both staff and families.

Practice

Nurses have the ability to enhance perceptions of organizational policy, pay, and task requirements by their participation in the decision-making process. This can occur through

participation in ad hoc committees, performance improvement initiatives, and quality assurance practices.

Additionally, nurses have the ability to use research to gain increased knowledge about caring for visiting family members, family dynamics, and crisis intervention as well as issues related to organizational policies. Exploration of current research is essential to establishing methods and standards of practice and patient care that is effective. Knowledge gained can be used to provide timely and realistic feedback about these policies.

Research

This was an initial study into the investigation of the effect of more liberal visitation policies on the work satisfaction, beliefs, and retention of ICU nurses. Additional research must be conducted to further support these findings. A larger sample size would enhance the generalizablity of findings. A longitudinal study could explore changes in the work satisfaction and beliefs of nurses over time. Additionally, further research needs to be conducted with patients and family members concerning their perceptions about changes in more liberal visitation policies.

In conclusion, this study has identified a change in organizational policy as the source of increased dissatisfaction of nursing staff. Previous studies have indicated a variety of factors that may contribute to work dissatisfaction. Though the source of dissatisfaction may be individualized, the current shortage of nurses begs for discovery of what truly creates satisfaction with nursing practice. It is through this discovery that an increase in our numbers might be realized.

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APPENDICES

Appendix A

Permission to Use Index of Work Satisfaction

February 18, 2003

Suzanne Boswell
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Kingsport, TN 37663

To Whom It May Concern:

This letter gives Suzanne Boswell permission to use the copyrighted Index of Work Satisfaction. It maybe re-published in its original form or a modified form.

Sincerely,

Doreen Masi
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Appendix B

The Index of Work Satisfaction Questionnaire ©

Part A (Paired Comparisons)

Listed and briefly defined below are six terms or factors that are involved in how people feel about their work situation. Each factor has something to do with "work satisfaction". We are interested in determining which of these is **most important** to you in relation to the others.

Please carefully read the definitions for each factor as given below:

- ➔ ***Pay*** -- dollar remuneration and fringe benefits received for work done
- ➔ ***Autonomy*** -- amount of job related independence, initiative, and freedom, either permitted or required in daily work activities.
- ➔ ***Task Requirements*** -- tasks or activities that must be done as a regular part of the job
- ➔ ***Organizational Policies*** -- management policies and procedures put forward by the hospital and nursing administration of this hospital
- ➔ ***Interaction*** -- opportunities presented for both formal and informal social and professional contact during working hours
- ➔ ***Professional Status*** -- overall importance or significance felt about your job, both in your view and in the view of others

Instructions*:* These factors are presented in pairs on the next page. A total of 15 pairs are presented: this is every set of combinations. No pair is repeated or reversed. For each pair of terms, decide which one is *more important* for your job satisfaction or morale, and check the appropriate box. For example, if you feel that Pay (as defined above) is more important than Autonomy (as defined above), check the box for Pay.

It will be difficult for you to make choices in some cases. However, please do try to select the factor which is more important to you. Please make an effort to answer every item; do not go back to change any of your answers.

Part A (Paired Comparisons, Continued)

Please choose the one member of the pair which is *most important* to you.

1.	☐	Professional Status	or	☐ Organizational Policies
2.	☐	Pay Requirements	or	☐ Task Requirements
3.	☐	Organizational Policies	or	☐ Interaction
4.	☐	Task Requirements	or	☐ Organizational Policies
5.	☐	Professional Status	or	☐ Task Requirements
6.	☐	Pay	or	☐ Autonomy
7.	☐	Professional Status	or	☐ Interaction
8.	☐	Professional Status	or	☐ Autonomy
9.	☐	Interaction	or	☐ Task Requirements
10.	☐	Interaction	or	☐ Pay
11.	☐	Autonomy	or	☐ Task Requirements
12.	☐	Organizational Policies	or	☐ Autonomy
13.	☐	Pay	or	☐ Professional Status
14.	☐	Interaction	or	☐ Autonomy
15.	☐	Organizational Policies	or	☐ Pay

Part B (Attitude Questionnaire)

The following items represent statements about how satisfied you are with your current nursing job. Please respond to each item. It may be very difficult to fit your responses into the seven categories; in that case, select the category that *comes closest* to your response to the statement. It is very important that you give your *honest* opinion. Please do not go back and change any of your answers.

Instructions: Please circle the number that most closely indicates how you feel about each statement. The *left* set of numbers indicates degrees of *agreement*. The *right* set of numbers indicates degrees of *disagreement*. For example, if you strongly agree with the first item, circle 1; if you agree with this item, circle 2; if you moderately agree with the first statement, circle 3. The middle response (4) is reserved for feeling neutral or undecided. Please use it as little as possible. If you moderately disagree with this first item, you should circle 5; to disagree, circle 6; and to strongly disagree, circle 7.

Part B (Attitude Questionnaire, Continued)

Remember: The more strongly you feel about the statement, the further from the center you should circle, with agreement to the left and disagreement to the right. Use 4 for neutral or undecided if needed, but please try to use this number as little as possible.

		Agree						Disagree
1.	My present salary is satisfactory.	1	2	3	4	5	6	7
2.	Nursing is not widely recognized as being an important profession.	1	2	3	4	5	6	7
3.	The nursing personnel on my service pitch in and help one another out when things get in a rush.	1	2	3	4	5	6	7
4.	There is too much clerical and "paperwork" required of nursing personnel in this hospital.	1	2	3	4	5	6	7
5.	The nursing staff has sufficient control over scheduling their own shifts in my hospital.	1	2	3	4	5	6	7
6.	Physicians in general cooperate with nursing staff on my unit.	1	2	3	4	5	6	7
7.	I feel that I am supervised more closely than is necessary.	1	2	3	4	5	6	7
8.	It is my impression that a lot of nursing personnel at this hospital are dissatisfied with their pay.	1	2	3	4	5	6	7
9.	Most people appreciate the importance of nursing care to hospital patients.	1	2	3	4	5	6	7
10.	It is hard for new nurses to feel 'at home' in my unit.	1	2	3	4	5	6	7
11.	There is no doubt whatever in my mind that what I do on my job is really important.	1	2	3	4	5	6	7
12.	There is a great gap between the administration of this hospital and the daily problems of the nursing service.	1	2	3	4	5	6	7
13.	I feel I have sufficient input into the program of care for each of my patients.	1	2	3	4	5	6	7
14.	Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable.	1	2	3	4	5	6	7
15.	I think I could do a better job if I did not have so much to do all the time.	1	2	3	4	5	6	7
16.	There is a good deal of teamwork and cooperation between various levels of nursing personnel on my service.	1	2	3	4	5	6	7

Part B (Attitude Questionnaire, Continued)

Remember: The more strongly you feel about the statement, the further from the center you should circle, with agreement to the left and disagreement to the right. Use 4 for neutral or undecided if needed, but please try to use this number as little as possible.

	Agree				Disagree		
17. I have too much responsibility and not enough authority.	1	2	3	4	5	6	7
18. There are not enough opportunities for advancement of nursing personnel at this hospital.	1	2	3	4	5	6	7
19. There is a lot of teamwork between nurses and doctors on my own unit.	1	2	3	4	5	6	7
20. On my service, my supervisors make all the decisions. I have little direct control over my own work.	1	2	3	4	5	6	7
21. The present rate of increase in pay for nursing service personnel at this hospital is not satisfactory.	1	2	3	4	5	6	7
22. I am satisfied with the types of activities that I do on my job.	1	2	3	4	5	6	7
23. The nursing personnel on my service are not as friendly and outgoing as I would like.	1	2	3	4	5	6	7
24. I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.	1	2	3	4	5	6	7
25. There is ample opportunity for nursing staff to participate in the administrative decision-making process.	1	2	3	4	5	6	7
26. A great deal of independence is permitted, if not required, of me.	1	2	3	4	5	6	7
27. What I do on my job does not add up to anything really significant.	1	2	3	4	5	6	7
28. There is a lot of “rank consciousness” on my unit: nurses seldom mingle with those with less experience or different types of educational preparation.	1	2	3	4	5	6	7
29. I have sufficient time for direct patient care.	1	2	3	4	5	6	7
30. I am sometimes frustrated because all of my activities seem programmed for me.	1	2	3	4	5	6	7
31. I am sometimes required to do things on my job that are against my better professional nursing judgment.	1	2	3	4	5	6	7

Part B (Attitude Questionnaire, Continued)

Remember: The more strongly you feel about the statement, the further from the center you should circle, with agreement to the left and disagreement to the right. Use 4 for neutral or undecided if needed, but please try to use this number as little as possible.

		Agree						Disagree
32.	From what I hear about nursing service personnel at other hospitals, we at this hospital are being fairly paid.	1	2	3	4	5	6	7
33.	Administrative decisions at this hospital interfere too much with patient care.	1	2	3	4	5	6	7
34.	It makes me proud to talk to other people about what I do on my job.	1	2	3	4	5	6	7
35.	I wish the physicians here would show more respect for the skill and knowledge of the nursing staff.	1	2	3	4	5	6	7
36.	I could deliver much better care if I had more time with each patient.	1	2	3	4	5	6	7
37.	Physicians at this hospital generally understand and appreciate what the nursing staff does.	1	2	3	4	5	6	7
38.	If I had the decision to make all over again, I would still go into nursing.	1	2	3	4	5	6	7
39.	The physicians at this hospital look down too much on the nursing staff.	1	2	3	4	5	6	7
40.	I have all the voice in planning policies and procedures for this hospital and my unit that I want	1	2	3	4	5	6	7
41.	My particular job really doesn't require much skill or "know-how".	1	2	3	4	5	6	7
42.	The nursing administrators generally consult with the staff on daily problems and procedures.	1	2	3	4	5	6	7
43.	I have the freedom in my work to make important decisions as I see fit, and can count on my supervisors to back me up.	1	2	3	4	5	6	7
44.	An upgrading of pay schedules for nursing personnel is needed at this hospital.	1	2	3	4	5	6	7

Appendix C

Liberal Visitation Policies
Beliefs of Nurses Working in an Adult Intensive Care Unit

Please read the following statements carefully and indicate by completely filling in the circle whether you agree or disagree to each statement:

	Strongly Agree						Strongly Disagree
1. I believe that liberal visitation is important to the recovery of critically ill patients	O	O	O	O	O	O	O
2. Less family visitation time gives the patient more time to rest and heal	O	O	O	O	O	O	O
3. Longer and more frequent visits by family members will interfere with nursing care	O	O	O	O	O	O	O
4. I do not believe that family members should help with non-nursing patient care such as bathing or backrubs	O	O	O	O	O	O	O
5. I believe that allowing families to visit at more frequent periods for longer intervals can cause more physical problems for my patients.	O	O	O	O	O	O	O
6. I believe that families should be allowed to visit a patient with minimal restriction if the patient has a poor chance of recovery.	O	O	O	O	O	O	O

Please take a moment to write your response to the following questions:

7. What are some issues and concerns that you may have about a more liberal visitation policy?

8. What are changes that need to be made in order to make a more liberal visitation policy successful?

VITA

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