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A STUDY OF IDEAL AND ACTUAL PROFESSIONAL ROLE CONCEPTIONS OF NURSE ADMINISTRATORS/MANAGERS AND STAFF NURSES

A Dissertation Presented

by

ANNE MARY BOURGEOIS

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

February, 1991

EDUCATION

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A STUDY OF IDEAL AND ACTUAL PROFESSIONAL ROLE CONCEPTIONS OF NURSE ADMINISTRATORS/MANAGERS AND STAFF NURSES

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by

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This dissertation is lovingly dedicated to my mother, Anne, and to the memory of my late father, David. Their encouragement and confidence provided me with personal determination and a desire to grow. Indeed, they have played an essential role in this major life event.

ABSTRACT

A STUDY OF IDEAL AND ACTUAL PROFESSIONAL ROLE CONCEPTIONS OF NURSE ADMINISTRATORS/MANAGERS AND STAFF NURSES

FEBRUARY, 1991

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The primary purpose of this study was to identify the way in which two groups, staff nurses and nurse administrators/managers, each conceptualize the ideal and actual role of the registered nurse practicing at the bedside. Data was examined in order to identify similarities and differences in the opinions of the two groups.

A questionnaire with 35 items/situations using a Likert scale was developed. Items/situations were worded to conform to a five-point response format ranging from strongly agree to strongly disagree. The role conception items/situations were designed to measure the respondent's perceptions of what the role should be and perceptions of what actually exists in the practice of the nurse role.

The sample of 300 non-management nurses was randomly selected using 50 percent of the professional nurses from each unit. Nurse administrators/managers comprised a smaller number than non-managers, therefore, the questionnaire was given to this entire group.

Noteworthy findings of the study include that (a) staff nurses and nurse administrators/managers agreed in their perception of what comprises the actual professional role of the nurse practicing at the bedside, (b) both groups also agreed in their perception of what comprises the ideal professional role of the staff nurse practicing at the bedside, (c) the staff nurses and nurse administrators/managers agreed in their perception of what comprised the actual bureaucratic role of the nurse practicing at the bedside, (d) the groups agreed in their perceptions of what comprised the ideal bureaucratic role of the nurse practicing at the bedside, and (e) there is a significant difference between the ideal and actual role conceptions within both the bureaucratic and professional concepts. Simply stated, the respondents of this study do not believe that nursing is being practiced the way nursing should be practiced.

Implications of the study are presented and discussed, and recommendations for further study are provided.

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INTRODUCTION

A. Background of the Problem

The tight fiscal environment in which health care finds itself today necessitates that nurse executives take a long, hard look at the utilization of both human and material resources. A primary focus of such an examination is the role and use of professional nursing staff.

The role conceptions held by nurses practicing in managerial and non-managerial positions have been formulated as the result of education and experience. Minehan (1977) states that nurses learn how one behaves as a nurse, and the manner in which they can expect to be responded to as a nurse through nursing education programs. In the work situation, role conceptions develop as a direct result of personal experiences, observations of others' behavior, and from listening to what is said about nursing and nursing practice (Taunton & Otteman, 1986). Because the education and experiences of nurses in management and non-management roles differ, there is a reason to presume that the role conceptions of these groups may also differ. To date, studies identifying

discrepancies between role expectations and role conceptions have predominantly been limited to work with new graduate nurses and nurse educators (Kramer, McDonnell, & Reed, 1972; Corwin, 1960 (a) (b); Seybolt, Pavett, & Walker, 1978; Benner & Kramer, 1972; Lewandowski & Kramer, 1980). A review of the literature finds little available in the area of role expectations and role conceptions across and within groups of nurse administrators/managers and groups of professional nurses practicing at the bedside. Differences between how one expects to perform and how one actually performs has been shown to influence effectiveness and satisfaction (Kramer, McDonnell, & Reed, 1972; Corwin, 1960; Seybolt, Pavett, & Walker, 1978; Benner & Kramer, 1972; Lewandowski & Kramer, 1980; Pieta, 1976; and Taunton, 1983). Therefore, it behooves nurse administrators/managers, looking to change the performance expectations for the professional nurse, to have a clear understanding of the role conceptions held by staff nurses and how these relate to their own conceptions.

Research related to role conceptions of the nurse began to appear in the literature at the same time that hospitals became a primary employment

setting for nurses. The initial exploration of role concept of the nurse was carried out by Habenstein and Christ (1955). They reported findings based upon interviews with 162 general duty nurses in several midwestern hospitals. Therein, they described three types of role conceptions: "professionalizer", "traditionalizer", and "utilizer".

Although similar to the work of Habenstein and Christ, Corwin (1960) described nursing role conceptions as being professional, bureaucratic, and service. In general, he believed these three components to be distinct from those described by Habenstein and Christ. Corwin (1960) defined the bureaucratic role of the nurse as being associated with loyalty to hospital administration. The professional role was defined as implying loyalty to the standards ascribed to by the profession of nursing. The service role connoted loyalty to the patient and the patient's psychological welfare. As a sociologist, Corwin's (1961) research interest centered on bureaucratic-professional role conflict, a dominant issue in the field of role theory at the time. Primary interest centered on the role deprivation that occurred when nurses who were

socialized into a professional subculture and its system of role expectations worked in a bureaucratic environment where the demands of role enactment contradicted their role conceptions.

Kramer (1970) used much the same theoretical frame of reference as Corwin. Her research indicated that baccalaureate degree nurses, who had a high bureaucratic role conception and who professed greater loyalty to the bureaucracy, were more successful in their positions in hospital nursing than those who had a lower bureaucratic role conception.

Pieta (1976) modified Corwin's tool and examined the role conceptions of nurses as perceived by senior nursing students, their faculties, and head nurses. She found differences in the perceptions of what should be practiced and what is practiced within and across all groups. Minehan (1977) also used Corwin's research instrument as the basis to study role. She suggested modifying much of Corwin's language so that it would more closely reflect the language of nursing practice in the 1970s. She concluded that the validity of the Corwin tool had decreased and attributed this occurrence to changing values and changing role conceptions within nursing. Taunton and

Otteman (1986), in their study "The Multiple Dimensions of Staff Nurse Role Conception," also questioned the validity of Corwin's three concepts. However, they concluded that two of the concepts, bureaucratic and professional, were not as ambiguous as the service concept. They maintained that bureaucratic and professional conflicts remain potential sources of stress for today's staff nurses.

The studies suggested that a difference exists between the manner in which the role of the nurse practicing at the bedside is conceptualized in theory and carried out in practice. Therefore, the literature leads to the conclusion that both ideal and actual role conceptions must be surveyed in order to fully grasp the significance of this problem.

The literature contains little information about studies illustrating consensus or lack of consensus between and among management and non-management nurses with regard to their actual and ideal conceptions of the role of the nurse practicing at the bedside. This is significant in that three separate but interrelated forces currently impacting upon the health care system have intensified the problem of role discrepancy in nursing. First, there is a nursing shortage that is

reaching crisis proportions in many geographical areas. Consequently, individuals are looking to develop ways to accomplish the work nurses do with less nurses available. Secondly, there is a movement within the ranks of nursing to create a hierarchy of care givers by redefining and classifying the role expectations of nurses. In turn, this has heightened the need to expedite examination of the conception of the staff nurse role. Thirdly, nursing salaries have become prohibitive, necessitating a decrease in the number of professional nurses used to staff patient care units in hospitals.

B. Problem Statement

Differences between the way in which staff nurses and nurse administrators/managers conceptualize the ideal and actual role of the registered nurse practicing at the bedside are not known. Nursing educators, executives, and leaders from across the country have articulated their views of professional nursing practice. The literature is rich in definitions of nursing practice and beliefs about the appropriate work of nurses (Henderson, 1961, 1967; Ciske, 1971; Christman, 1987; Kelly, 1981; Jacox, 1969; Halloran, 1980). However, it is known that the

written word oftentimes conflicts with actual practice, and nurses at the bedside experience role confusion. The purpose of this study was to identify the way in which two groups, staff nurses and nurse administrators/managers, each conceptualize the ideal and actual role of the registered nurse practicing at the bedside. Data was examined in order to identify similarities and differences in the opinions of the role conceptions within and between the two groups.

C. Research Questions

The research questions examined in this study are similar to those used by Pieta (1976). They surveyed role conceptions for and across two groupings of the sample population. The groups were constructed according to positions held within the participating institution and included (a) staff nurses, and (b) nurse administrators/managers. The research questions were:

1. What are the perceptions of the ideal nursing role conceptions within each of the groups?

2. What are the perceptions of the actual practice of the nursing role conceptions within each of the groups?

3. To what extent is there a difference between the ideal and actual role conceptions, a role discrepancy, within each of the groups?

4. To what extent are there differences in the perceptions of the ideal nursing role conceptions between each of the groups?

5. To what extent are there differences in the perceptions of the actual practice of the nursing role conceptions between each of the groups?

6. Are the differences between ideal and actual on each variable in the staff nurses any different from or equivalent to the differences between ideal and actual on each variable of the nurse administrators/managers?

D. Significance of the Study

The role of the professional nurse practicing at the bedside is of vital importance to the well-being of hospitals. Cost and quality of patient care are directly influenced by the manner in which the professional nurse is utilized. In turn, appropriate use should lead to improved retention and recruitment of professional nursing staff. The issues of cost, quality, recruitment, and retention can be positively effected only when nurses in staff and management

positions are able to articulate a consensus regarding the role of the professional nurse at the bedside.

The research questions examined in this study are crucial in defining this role. The way in which nurses responded to the questions posed in the research tool helped to determine similarities and differences in actual and ideal role conceptions of nurses at various levels in an organization. When differences in perceptions occurred, the variables causing these differences were identified. This information was gathered and examined in order to develop a basis upon which nursing practice can be restructured and appropriate roles to support nurses can be defined. If staff nurses and the nurse administrators/managers who supervise them do not agree on the role of the nurse, role ambiguity, dissatisfaction, and disillusionment can result or can be perpetuated.

E. Definition of Terms

Registered Nurse - the generic term used to describe nurses in management and non-management positions, all licensed to practice by the Board of Registration in Nursing.

Staff Nurse - an individual who is licensed as a registered nurse and is employed by a hospital as a care provider, planning and directing care or caring for a patient or a group of patients.

Nurse Administrator/Manager - an individual who is licensed as a registered nurse and is employed by a hospital as a supervisor of nursing staff in the administration of nursing care on a single or a group of patient care units.

Role Conception - the internal representation of the role expectations held by an individual at a specified time, including cognitions, values, anticipated manuevers, and responses as measured by bureaucratic and professional role conception scales.

Ideal Role Conception - expectations which the research subjects perceive should exist in the practice of the nursing role as measured by bureaucratic and professional role conception scales.

Bureaucratic - refers to the administrative rules and regulations which describe the nurse's job in a specific organization; it suggests primary loyalty to the hospital administration (Berkowitz & Malone, 1968).

Professional - refers to the occupational principles which transcend the location of a specific hospital; it suggests primary loyalty to the nursing profession (Berkowitz & Malone, 1968).

Actual Role Conception - expectations the research subjects perceive to be practiced in the nursing role.

Bureaucratic - (as defined for Ideal Role Conception).

Professional - (as defined for Ideal Role Conception).

Role Discrepancy - the extent to which the perceptions of the study participants of the ideal role differs from the perceptions of the study participants of the actual role conception (Pieta, 1976).

F. Limitations

This study was limited to staff nurses and nurse administrators/managers in a 371-bed, tertiary care, university hospital in Massachusetts. Therefore, results of this study are applicable only to the participating institution. Inferences may be drawn to nurses in similar institutions; however, replication of this study is strongly recommended.

The study was limited to the participant's perceptions of the ideal and actual role conceptions of nursing and did not measure performance of the role.

CHAPTER II

REVIEW OF THE LITERATURE

A. Introduction

Since the 1965 American Nurses Association position paper on professional nursing was published, there has been ongoing debate over what constitutes the role of the professional nurse. This debate has been fueled by the shortage of nurses, by the addition of multiple non-nursing tasks to professional nursing staff roles, and, more recently, by the crisis in the cost of health care and the American Medical Association's (AMA) proposal to add registered care technicians to hospital staff (1987).

This chapter includes a review of (a) role theory, role conceptions, and role confusion; (b) historical perspectives as they relate to role development in nursing; (c) the professional and bureaucratic work place and its impact on role development in nursing; (d) the scope of nursing practice and its relationship to role development; and (e) recent factors contributing to role changes in nursing.

B. Role Theory and Role Conception

A review of the social science literature looking at role theory indicates diversity, and even ambiguity, in the definition of role (Gross, Mason, & MacEachern, 1966; and Eisenstadt et. al, 1967). Psychologists use the term "role" to refer to the actual behavior demonstrated by a person in a given position. Roles are associated with positions themselves and not with the persons who occupy the positions.

Sociologists appear to see role as encompassing both cognitive and operational behaviors. Eisenstadt et al. (1967) define role as the constellation of factors organizing an individual's position in society in some generally socially approved patterns and goals. All cultures are organized around social positions. In turn, the individuals who occupy these positions perform specialized actions. Roles consist of norms specifying the rights of one party and the corresponding obligations of the counter position.

Mead (1949), one of the earliest role theorists, was instrumental in developing the concepts of role taking. A role defines the way in which an individual occupying a certain position is expected to behave, or

a model for organizing the attitudes and behaviors of the individual occupying the position. Therefore, these attitudes and behaviors will become congruous with those of other individuals in similar positions.

Newcomb et al. (1965) believe that personality and prescribed roles are interdependent. According to their theory, the internalization of the role results in changes in personality. They believe that a given personality may be one determining factor in an individual's occupational choice and that an individual's personality can be modified by a given type of organizational structure. The bureaucratic work organization and its affect upon an individual's personality are variables in their theory. They conclude that people who work in a bureaucratic environment over a long period of time tend to take on the values of the organization.

Getzels and Thelen (1968) discuss role in terms of role expectations. They believe that these expectations define for the individual what she/he should and should not do as an incumbent in a particular role. Social behaviors develop as an individual attempts to cope with the integration of (a) an environment composed of patterns of

expectations associated with a given role, and (b) behavior consistent with one's own independent pattern of needs. Getzels and Thelen believe that an individual must choose whether to fulfill her/his individual needs or the requirements of the role within the organization. Such a choice may potentiate dissatisfaction and frustration. If an individual is to adequately perform in a role, certain information must be made available concerning role expectations. This information is acquired through intentional instruction and/or incidental learning in the socialization process. When an individual's role conception or role enactment is congruent with that of others in similar positions, acceptance occurs. When there is a lack of congruence over the privileges, obligations, responsibilities, and powers inherent in a position or role, then role conflict may ensue. Role conflict can exist between two persons in similar roles or between a person and the role itself (Sarbin, 1954).

When the occupant of a role fails to meet the expectation for that role, other members of the role set usually bring pressures upon the individual in order to achieve conformity. These role pressures,

acts which attempt to influence the focal person, may include withholding rewards, such as promotions and monetary increases, and rejection of the focal person by other role members. However, attitudes are difficult to perceive. Therefore, it is possible for individuals to function within a role, yet have role conceptions incongruent with those of other members of the role set. Role strain, the felt difficulty in fulfilling role obligations, may result when this occurs.

An individual exposed to conflicting role expectations, to the degree that fulfillment of both is realistically impossible, experiences a conflict situation. Role strain develops as external role pressures are perceived to be in conflict with the individual's role conceptions. Sarbin (1954) interprets the individual's reaction to conflict according to two other methods. The first is a process called "hierarchization" in which a person decides that certain role obligations have priority over other conflicting obligations. The second method one may use in an attempt to resolve a conflict situation is through the use of "segregation;" reacting to each role obligation separately.

Biddle and Thomas (1966) state that compromise may occur in conflict resolution. The individual may choose an action which is partly, not fully, consistent with either set of opposing prescriptions. This type of solution is similar to what Kramer (1968) refers to as adaptive role strategies or integrative responses and what Deutscher and Montague (1956) refer to as integration.

Role has been defined many ways. However, the generally accepted definition is that it is the behavior or set of activities of any person who occupies a particular office or status. It may be an assigned role, without reference to differences and skills, such as mother or American. Or, it may be an achieved role determined by skills and education, such as nurse or teacher. Kramer (1974) writes, "A role is a set of expectations about how a person in a given position in a particular social system should act" (p. 54). As such, roles involve the expectations of others who make up a role set.

Merton (1957) coined the term role set and defined it as being all the relationships directly involved with a particular social position. The term is further defined to include those who develop

beliefs, attitudes and expectations about what a person should or should not do as part of a role (Payne, 1982). The role set is made up of (a) the target or focal person, the person to whom communication is directed, and (b) the sender of the communication. The received role and a sent role may differ from one another. This is dependent upon the expectations of the receiver and sender, their attitudes and beliefs, and is strongly influenced by their interpersonal relationship.

Role episode, a cyclic and ongoing process, encompasses role expectations, sent role, received role, and role behavior. Various attitudes and beliefs found in the role set can lead to distortions and role conflict. Role conflict occurs when two or more sets of expectations, incompatible with each other, result in anxiety and tension for the target person.

The greater the diversity of opinion of role set members, the greater chance the target person has of experiencing role stress (Snoek, 1966). Role stress, which includes role conflict, role ambiguity, role overload, role incompetence, and role over-qualification is often associated with role strain or

the subjective feelings arising from role stress (Hardy, 1978). According to Goode (1960) role strain is normal given an individual's multiple role demands, relationships, and time constraints.

Roles provide a point of reference for identifying and predicting perceptions and behaviors, for communicating, and for measuring and controlling social norms. Everyone fulfills a number of roles at any one time; each one accompanied by its own set of expectations. When expectations conflict, or are mutually exclusive, stress and strain result.

Resolution of role stress and strain begins with identification of the problem source and identifying possible corrective action. Depending upon organizational climate, a target person might decide to negotiate with other role members in order to bring about resolution. Maintaining the status quo or leaving the role are some other alternatives that may be considered.

Early research about role problems among staff nurses focused on role conception. The definition of staff nurse role conception espoused by Corwin (1960), the internal representation of expectations held by staff nurses for their own behavior and the behavior

of other staff nurses in providing care to clients, is the definition used by this author and other researchers in studying the construct (Bevis, 1975; Benner & Kramer, 1972; Corwin & Taves, 1962; Kramer, 1966, 1968a, 1968b, 1970; Kramer, McDonnell, & Reed, 1972; Lewandowski & Kramer, 1980; Minehan, 1975). That definition is consistent with the general definition of role conception provided by Biddle (1979). From an interpretive study utilizing interviews with general duty nurses, Habenstein and Christ (1955) identified three types of role conceptions: professionalizer, traditionalizer, and utilizer. Corwin (1960) described three components of a staff nurse's role conception: professional, service, and bureaucratic. These were believed to be similar to the conceptual types reported by Habenstein and Christ. Corwin found that a nurse's role conception related to the type of educational program attended. He incorporated into his research tool, designed to measure role conception, a mechanism for quantifying role deprivation in the work setting as reported by nurses. He reported that role deprivation was also related to the type of educational program attended.

Recent research related to role conception of staff nurses has been based on the structure proposed by Corwin. In 1966, Kramer began reporting results from a series of studies about the socialization of new graduate nurses into their first work experience. Role conception and role deprivation were dependent variables in her research. She investigated the relationship between role conception and success in hospital nursing, the linkage between role deprivation and attrition from the profession, and the effect of length of employment on role conception and role deprivation (Kramer, 1966, 1968a, 1968b, 1970; Kramer, McDonnell, & Reed, 1972). Benner and Kramer (1972) and Lewandowski and Kramer (1980) explored differences in role conceptions between nurses in special care units and nurses in other types of patient care units in hospitals. Kramer, McDonnell, and Reed (1972) studied the relationship between and among role conception, job success, and self-actualization. Findings from these studies indicated that nurses who left the practice of nursing because of job dissatisfaction had experienced greater role deprivation than those who continued to practice and that their role conception included high commitment to the professional component of nursing practice.

During her 1983 study, attempting to develop a staff nurse role conception tool, Taunton identified 15 basic dimensions of staff nurse role conception. However, she suggested that some dimensions might be more relevant than others and noted that a general purpose research instrument with 15 subscales is not practical. Findings from this study confirm the complexity of staff nurse role conception. Additionally, the information obtained also indicated that bureaucratic-professional role conflicts remain potential sources of stress for today's staff nurses and the operational definitions and instruments used by past researchers might not have reflected the real diversity of expectations among staff nurses.

In summary, the above section has presented role theory as defined by sociologists, behaviorists, and role theorists. Role theory and related research were presented to the extent required to define, describe, and support the construct used in the study. Several studies which define the construct of role conception have also been cited. Also presented were studies suggesting the need to modify the earlier framework used to study staff nurse role conception.

C. Historical Perspectives of Development of the Role of the Nurse

The role of the nurse has always been bound to culture and especially to the status of women. Initially, nursing was performed in monasteries by nuns, usually with little or no monetary rewards. Taunton (1983) reports that at the time of the Protestant Reformation, patients were transferred from the care of the Church to tax-supported institutions. There, nurses were poorly paid servants without the hope of any rewards.

Nursing has gained much of its status and impetus during the time of wars. During the Crimean War, Florence Nightingale's (1860) conception of nursing as an occupation became recognized. She envisioned nursing as a science and an art to be practiced with devotion.

Role confusion became an issue in nursing during both World War I and World War II when the need for support help for nurses became evident. Reverby (1987) reports that, in an effort to protect its own integrity, nursing was very slow to respond to this need. Nursing opinion shifted toward acceptance of the necessity to train and supervise attendant nurses

during the years between the two World Wars. Absence of unified support resulted in lack of consistency in the education and use of these individuals.

By the 1930s, registered nurses were becoming responsible for assuring that the complex system of hospital care was actually being delivered. Registered nurses became hospital supervisors. They guided and oversaw patients and hospital workers through the daily maze of activities, procedures, tests, and tasks.

At an increasing rate during the Second World War and immediate postwar years, nursing moved farther away from the patient's bedside. Care became more complicated, and nurses gained new technical skills and bureaucratic authority. This resulted in hospitals increasingly turning to yet another new category of nursing worker, the licensed practical or vocational unpaid nurse. A hospital management poll in August 1945 reported that 85 percent of the administrators queried wanted practical nurses in their institutions, particularly when graduate nurses were not available (Reverby, 1987).

In the late 1950s and early 1960s, attempts were made to reduce the amount of time registered nurses

spent doing office work. The unit clerk position was established and supervised by nurses. Since the 1960s, numerous support roles for nursing have evolved, i.e., nursing aides, nurse extenders, patient care technicians, operating room technicians, mental health counselors, and so forth.

The movement of nursing toward professionalism has always been part of the broader social movement of women to achieve status. This has been an important difference between nursing and those professions that did not have to combat minority group status. Nursing was defined as an occupation subordinate to medicine; routine tasks were performed upon the order of the physician.

Presently, in an expression of concern about the shortage of nurses to deliver care at the bedside, the AMA proposes to prepare a non-nurse bedside caregiver (1987). Under the title Registered Care Technologist (RCT), these persons would be responsible for implementing physician orders at the bedside. This apprenticeship-like program is proposed to have two educational components, each lasting nine months. The first program would prepare a basic technologist for licensure; the second would certify an advanced technologist to provide critical technical care.

In summary, the role of the nurse has been defined by societal needs during each moment in history. Culture and the status of women have also influenced the role of the nurse. Nursing's inability to articulate its role has over the years resulted in the evolution of numerous ill-defined "support" roles.

D. Professional and Bureaucratic Workers in Nursing

Professionals are educated to make individual judgments and to function autonomously; they are committed to uphold the ethical standards of their profession and to practice according to the scientific tenets of their disciplines. Yet, as employees of organizations, they have certain obligations as well (Ketefian, 1985). Etzioni (1964) pointed out the inherent incompatibilities of these two sets of expectations and the resultant conflicts.

Students of the sociology of occupations have long recognized the inherent contradictions between the professional and bureaucratic orientation to work. Prominent among the problems identified is that of new members who have socialized into a professional work orientation and must be integrated into an organizational system that supports a bureaucratic orientation toward work (Kramer, 1974; Lortie, 1958;

Wagenschein, 1950). Problems exist for any system attempting to convert young professionals into efficient, functioning members of the organization. Problems also exist for the young professionals themselves as they endeavor to adjust to the demands of the system (Snyder, 1982).

The nurse's dilemma in a bureaucracy is stated succinctly by Saunders (1954). He points out that the nurse is in fact an employee, a white collar worker, not a ministering angel, but rather a skilled technician who provides total care of patients. He observes that the characteristics of nursing include a highly diversified type of education and activity, and an ambiguous status resulting from high skill and poor rewards. He concludes that nursing is the only profession in which most of the important decisions are made by those <u>outside</u> the profession; that is, by the doctor and the hospital administrator. Because of their traditional training in hospitals, nurses tend to be conservative and are not innovators; they are members of an organized bureaucracy. While 50 years ago nurses were self-employed in private duty nursing, autonomously directing their own professional activities and working alone in a home setting with

one patient at a time, today, they sell their services for a number of hours per week to perform routine tasks for large numbers of patients and are, consequently, unconnected with decision processes effecting patient care. In summary, Saunders believes that the nurse's current self-perception does not give recognition to the fact that nurses have lost professional status and have become employees of an organized bureaucracy.

Recent development and change in nursing provides a perspective within which to view the current role confusion in the occupation. Two major trends (a) increasing bureaucratization of the occupation, placing nurses in the role of an employee of the hospital, and (b) increasing professionalization, spearheaded by powerful segments within the occupation, have been somewhat effective in raising the status of the occupation. Consequently, conflicts and disagreements with other occupations have erupted as a result of rapidly changing duties. Both of these trends have been at the expense of the traditional service orientation of nursing. Bureaucratization, required for the mass administration of care to patients, has lead to impersonality, rigid routine,

task orientation, increasing administrative duties, and less intimate contacts with patients. Professionalization has required increased specialization, technical proficiency, and medical knowledge. In turn, this has diverted the attention of nurses from the traditional service orientation toward achievement of prestige within the medical community. The consequences of these changes and divergent trends can be observed in the role confusion in nursing.

Benne and Bennis (1959) described three areas of tension within nursing. The first area of tension is what they refer to as the nurse's "blurred self-image." They point out that "real" nursing is considered to be bedside care. Nurses bring this image into nursing school and often the schools do not dislodge it even when the schools try to do so. However, the nurse is actually required to perform four major types of duties (a) technical, (b) administrative, (c) organizational, and (d) educational. Consequently, there is a sharp discontinuity between the nurse's self-image and the actualities of her work life. Benne and Bennis refer to this discontinuity as "role deprivation" which

refers to nurses' frustration due to the fact that they do not perform skills which they expected to perform and which they were trained to perform.

The second major conflict which these authors describe is a "nurse-doctor conflict." They believe this is one of the most poignant tensions within nursing because of misunderstandings on both sides. In the process of professionalization, nurses have formed an alliance with behavioral sciences while doctors are still primarily oriented to the biological sciences. The dilemma of a nurse is that while one earmark of a professional person is the autonomy to exercise independent judgment within certain areas of the work life, many doctors still expect nurses to behave only as obedient extensions of their own professional judgment. Benne and Bennis conclude that:

> . . . on the one hand we find schools of nursing and professional nursing associations reinforcing the nurse's self-image of an autonomous professional person, sharing substantial equality in appropriate judgement about treatment processes. On the other hand we find doctors, perhaps reinforced by neglect of the study of nursing, if not by contrary indoctrination, with their professional education ignoring or controverting this self-image of professional person or colleague which many nurses hold. (p. 382)

The third area of conflict is the "nurse-supervisor conflict." They cite complete lack of agreement between how supervisors prefer nurses to spend their time and how nurses actually said they spent their time.

These authors find much of the confusion in nursing produced by the hospital reward system itself. When nurses were asked what they would hope to get as a reward and what they realistically predicted to get, almost no correlation was found, indicating that nurses do not get what seems important to them. According to Saunders (1954), nurses indicated that if they were to quit nursing they would most miss most "relationships with patients," "personal gratification," "professional reasons," and "hospital atmosphere and routine," in that order. The authors conclude that the factors that are most missed are not the ones over which supervisors have control. The intensity of this current nursing dilemma is increased in that these emerging bureaucratic and professional trends are not entirely compatible, with the first demanding a measure of authority and status that the second does not warrant.

In a 1968 study, Kramer concluded that individuals who were professionalized in an institution of higher education were likely to experience major changes in role conception when employed in a bureaucratic health agency. The shift in value orientation is attributed to a shift from school or professional centered models to a work centered model. Kramer suggests there is inherent worth in both bureaucratic and professional principles of work organization. She suggests the deliberate blending of these seemingly divergent role concepts by integration of some concepts in order to develop professional role models capable of adapting and functioning within bureaucratic organizations (Davis, 1972).

Physicians, administrators, and registered nurses themselves have had ongoing difficulty defining the scope of practice of the professional nurse. It should be noted that the traditional humanitarian oriented concept of nursing is being confronted and replaced by emerging professional and bureaucratic concepts.

In conclusion, the professional nurse becomes imbued with a rather specific orientation toward her

functions as a practitioner. This orientation frequently contradicts the prevailing orientation of the actual work situation, which tends to follow a bureaucratic orientation. Attempts to merge the antithetical work orientations often result in role strain, tension, or conflict. It is suggested that a new synthesis might occur as a result of the interaction between role expectations and role perceptions (Murphy, 1971).

E. Scope of Nursing Practice

The scope of nursing practice as defined by various legal and administrative structures is another area that supports poor definition and ambiguity in the interpretation of nursing practice. Scope is usually defined through state nursing practice acts and institutional policies regarding nursing services. A registered nurse is licensed to practice by a state board of nursing. The scope of nursing practice is defined by the nurse practice act of the state in which the nurse is licensed to practice. These laws vary somewhat from state to state with regard to language, but are similar in the manner in which they define practice in very global terms (Kelly, 1974).

Practice acts are written in general, nonspecific terms so that practitioners' roles can evolve without continued need for change in legal definitions (Kelly, 1974). Thus, one's ability to gain a clear understanding of the scope of nursing responsibilities via the generally worded statements found in practice acts and organizational policies is mitigated further by the reality of frequent, individualistic interpretations of these legal definitions.

In addition to definitions in practice acts, the scope of nursing practice is further delineated by professional organizations. According to Anderson (1986), the Massachusetts General Laws, c. 112, 80B defines professional nursing as:

> . . .the performance for compensation of any of these services in observing and caring for the ill, injured or infirm, in applying counsel and procedures to safeguard life and health, in administering treatment or medication prescribed by a physician or dentist, or in teaching or supervising others, which are commonly performed by registered nurses and which require specialized knowledge and skill such as are taught and acquired under the established curriculum in a school for nurses duly approved in accordance with this chapter. (p. 7)

Nurses are further guided in their practice by the institution in which the nurse is employed. Under the doctrine of <u>respondent superior</u>, the

employing institution is responsible for the nurse's actions during his or her period of agency (Southwick, 1978). Institutional policies and position descriptions define the scope of agency groups.

In summary, with general, non-specific practice acts, varying professional nursing definitions, and individual institutional policies, the possibility of differing role concepts becomes clear. Both nurses practicing at the bedside and the supervisors responsible for supervising them might have very different opinions on the role of the staff nurse.

F. Recent Factors Contributing to Role Development

Available data supports the premise that hospitals' demand for increased numbers of professional nurses has evolved as a result of several factors. Recent controls placed upon hospital reimbursement have restricted the ability to generate revenue and to attract patients based upon cost. In light of this, hospital marketing experts are focusing upon nursing, the most labor intensive and highly visible service, to assure consumers that the care provided in their facility is clearly superior (Lobb & Reid, 1987; Buerhaus, 1987; Toohey, Shillinger, & Baranowski, 1985).

With increasing patient acuity, especially in the hospital setting, the presence of skilled nurses has become essential (Aiken, 1982). Aiken contends that nurses are the most versatile employees in a hospital setting. They require minimal supervision, and they can competently perform a wide range of tasks. In addition to nursing functions, a nurse may also perform duties usually assigned to secretarial and clerical personnel, laboratory technicians, pharmacists, physical therapists, respiratory therapists, and social workers. Many of these functions do not require the education and competencies demanded of nurses. However, despite the difficulty in hiring registered nurses, available data indicate that hospitals have not increased their use of licensed practical nurses or nursing aides, nor have they substituted other non-nursing personnel for registered nurses. Rather, they have increased the intensity of registered nurse utilization relative to other staff. For instance, according to the American Hospital Association's The Nursing Shortage: Facts, Figures, and Feelings (1987) data, hospitals have decreased the number of licensed practical nurses and

have shown a 23 percent (69,000 full-time equivalents) decrease in the use of ancillary nursing personnel between 1983 and 1986. During this same period, community hospitals increased their employment of registered nurses by 5.5 percent or 38,000 full-time equivalents. This increase in professional staff, while decreasing non-professional support, has further confused the issue as nurses in the hospital setting continue to perform numerous non-professional tasks.

Beyers (1987) states that nursing, to remain viable and to be viewed as a principle contributor to the system, must develop a set of commonly understood terms or definitions that accurately describe what nurses do. Comprehensive definitions can flow only from an acknowledgement of what it is that is being defined. Beyers (1987) goes on to say, "We have not yet sorted out what is nursing care and what care can be given by associates and assistants. Separating routine personal care, housekeeping, and other aspects of some care from nursing is essential" (p. 74).

At the current time, given the decreased number of professional nurses available to meet growing patient care needs, the system of providing care is being examined and reorganized. Increased patient

acuity and shorter lengths of stay necessitate an organized and systematic approach to patient care activities. Additionally, effective utilization of available resources necessitates an efficient, cost-conscious approach to care. To achieve these goals we will be required to employ higher paid professional nurses capable of appropriately utilizing support services.

G. Summary

This chapter has offered varying perspectives on role theory and role conceptions, developing the framework for the tool used in this study. A summary of the development of various roles in nursing has been shared using an historical perspective, a perspective of the professional in a bureaucratic setting, and the scope of nursing practice. Literature related to these constructs and their impact on the development of the nursing role we see today was also reviewed.

CHAPTER III

METHODS AND PROCEDURE

A. Introduction

The primary objective of this investigation is to determine whether there are differences in conceptions of professional nursing practice between nurses in administrative/managerial positions and nurses who are practicing in staff nurse roles.

This chapter will:

1. restate the research questions to be answered;
2. identify the study population and sample;
3. describe the research instrument;
4. discuss the validity and reliability of the research instrument;
5. present the procedure for collecting data; and,
6. describe the data analysis process.

B. Research Questions

The research questions for each of the role conceptions, bureaucratic and professional, were examined from two perspectives: within and between the groups. The sample population was divided into (a) staff nurses and (b) nurse administrators/managers.

1. What are the perceptions of the ideal nursing role conceptions within each of the groups?

2. What are the perceptions of the actual practice of the nursing role conceptions within each of the groups?

3. To what extent is there a difference between the ideal and actual role conceptions, a role discrepancy, within each of the groups?

4. To what extent are there differences in the perceptions of the ideal nursing role conceptions between each of the groups?

5. To what extent are there differences in the perceptions of the actual practice of the nursing role conceptions between each of the groups?

6. Are the differences between ideal and actual on each variable in the staff nurses any different from or equivalent to the differences between ideal and actual on each variable of the nurse administrators/managers?

C. Population and Sample

The population for this study included both registered nurses in non-management positions and registered nurses in either administrative or management positions employed at a 371-bed, tertiary

care university medical center. The sample of 300 non-management nurses was randomly selected using 50 percent of the professional nurses from each unit. Because the current non-managerial nursing staff was comprised of 40 percent BSN and 60 percent AD/Diploma graduates, it was expected that staff would be proportionately selected for education level (BSN vs. non-BSN). Nurse administrators/managers comprised a smaller number than non-managers (N = 60), therefore, the questionnaire was given to this entire group.

D. Research Instrument

The research instrument (Appendix A) used to collect the data for this study was a self-administered questionnaire. It was accompanied by an explanatory letter from the researcher (Appendix B). The Role Concept Inventory questionnaire, designed by the researcher, contained items/situations composed to elicit the participant's ideal and actual role conceptions. The questionnaire obtained data which could be used to test the research questions related to the purpose of the study.

E. Development of the Research Instrument

Based on a review of studies examining role conceptions in nursing, a questionnaire with 35 items/situations, in a Likert scale format, was developed (Appendix A). Items/Situations were worded to conform to a five-point response, ranging from strongly agree to strongly disagree. Three instruments dealing with the role conceptions of nurses were used as the foundation for this instrument (Corwin, 1960; Pieta, 1976; Taunton, 1983). Some items/situations were retained with minimal language changes. New items/situations were developed by the researcher to reflect the practice of today's nurses. The format used by Pieta (1976) was retained with modifications.

The role conception items/situations were designed to measure the respondent's perceptions of what the role of the practicing bedside nurse should be and perceptions of what actually exists in the practice of the role. Each item/situation was presented in the form of a hypothetical situation which a nurse might encounter in a hospital setting. Each item/situation was followed by two statements, entitled A and B. Statement A sought to measure the respondent's perception of what the role should be.

Statement B sought to measure the perception of what the role actually is. Respondents were asked to indicate their extent of agreement with each statement by selecting one of five responses: strongly agree, agree, undecided, disagree, or strongly disagree. The similarities and differences between these two areas of perception provided information about possible role discrepancy between and among staff nurses and nurses in administrative/management positions. Once the items/situations were defined, a group of nurse experts, 24 nurse executives, were requested to review and offer opinions about the questionnaire. This group of experts concurred with more recent literature findings, suggesting elimination of certain dated items/situations and inclusion of new items/situations depicting more contemporary potential dilemmas (Taunton, 1983; Smith, 1964; Minehan, 1977). Some of the stems used to develop new items/situations were modifications of dimensions defined by Taunton (1983).

F. Validity of the Research Instrument

Validity was determined by giving the 62 items/situations (Appendix C) developed by the researcher to a second group of nurse executives. Additionally, they were given definitions of the three

role conceptions, asked to read each item/situation, and assess which role conception (bureaucratic, professional, or service) they believed each item/situation represented. Twelve items/situations were determined to be invalid since there was no clear majority opinion as to which concept the item/situation represented. Items/situations retained for inclusion in the questionnaire were those selected as measuring the role conception for which they were designed by at least 90 percent of the participants. Responses indicated that items/situations pertaining to the bureaucratic concept were clear. However, respondents found no clear delineation between the service and professional concepts. When analyzing service and professional items/situations, it was noted that close to 50 percent (47 percent) of the participants chose a given item/situation as indicative of the service concept, while the other 53 percent chose the same items/situations as being indicative of the professional concept. This theory was pursued further with this group of experts who agreed that the service and professional role conceptions have become so closely related that they can be considered as one concept. These findings were

supported by recent literature which suggests that the validity of the service concept as found in Corwin's tool has decreased (Minehan, 1977; Taunton, 1983; Smith, 1964). Therefore, the professional concept was redefined as items which measure a commitment to technical, ethical, and educational standards of a profession; a commitment to knowledge as the basis of the profession; the ability to use judgment and power in making decisions regarding nursing care; and a willingness to teach patients about their condition.

The revised tool (Appendix D) was given to a different panel of nurse experts (N = 22) from within the Commonwealth of Massachusetts. This group included 12 nurse administrators (chief nurses of a health care organizations) and 10 deans of nursing education programs. Each item/situation was followed by two role conception categories from which to choose: bureaucratic and professional. Respondents were asked to read each item/situation and assess which role conception, bureaucratic or professional, each item/situation was designed to represent. Items/Situations retained for use in the questionnaire were those selected as measuring the role conception for which they were designed by at least 85 percent of

the participants. Findings revealed that 85 percent of this group felt that 26 items/situations were clearly indicative of the professional concept and 12 items/situations were clearly indicative of bureaucratic concept. These 38 items/situations were retained for inclusion in the Role Conception Inventory.

The revised questionnaire (Appendix E) is designed to measure two concepts: bureaucratic and professional. The 38 items/situations were randomly ordered. Statements A and B, as defined previously, were appended to each item/situation. The instrument was administered to three groups of nurses in order to pilot it for clarity and ease of understanding. The group was comprised of 44 nurses in administrative, education, and staff positions. The group reported that the instrument was easy to understand and complete. They suggested that some items/situations were redundant. The researcher asked that the redundant items/situations be identified. Following this analysis, 35 items/situations were chosen for the final questionnaire (Appendix A); 23 depicting the professional role concept and 12 depicting the bureaucratic role concept.

The two categories of role conception provided a means of isolating two components of a nurse's role. They are described as loyalty or allegiance to (a) the employing hospital as a bureaucracy (bureaucratic role conception), and (b) professional standards and patient welfare (professional role conception). Input from all experts who participated in determining the validity of the tool and Taunton's (1983) work on dimensions of professional practice provided the underpinnings for further redefining the professional role conception.

The professional role conception was further divided into two categories: (a) nurse's choices about a patient's care and welfare which would most likely be predominantly based upon ethical and moral values, and (b) nurse's choices about a patient's care and welfare which would most likely be predominantly based upon knowledge and education. This division provided an opportunity for a more indepth analysis of the professional role conception. Validity was ascertained by employing another panel of nurse experts comprised of executives, educators, and staff nurses, (N = 19). Each nurse expert was provided a list of the items/situations designed to represent the

professional role conception and asked to classify each according to the subdivision they believed characterized each item/situation (Appendix F). Items/situations retained for inclusion within the subdivisions were those selected as measuring a particular subdivision by 85 percent of the participants. Six items/situations (2, 5, 9, 16, 17, and 26) were shown to be indicative of decisions based predominantly upon the nurse's ethical and moral values while nine items/situations (6, 10, 11, 13, 14, 18, 19, 21, and 23) were shown to be indicative of decisions based predominantly upon the nurse's knowledge and education.

G. Reliability

The internal consistency of the two major scales was computed using the Cronbach coefficient alpha formula. The internal consistency computed for role conception was: 0.77 for overall ideal professional, 0.74 for overall actual professional, 0.57 for ideal bureaucratic, and 0.25 for actual bureaucratic. Although the bureaucratic scale has a lower Cronbach alpha score, this may be related to the lower number of items studied (professional = 23; bureaucratic = 12). Further research on this instrument needs to be done.

H. Scoring the Research Instrument

The Role Concept Inventory questionnaire was scored on a five-point scale. Alternative responses were be assigned values from "1" indicating strongly agree to "5" indicating strongly disagree.

The two role conception scales consisted of 12 bureaucratic items/situations and 23 professional items/situations. Professional items were examined as a group and according to the previously described subcategories. Two scores were derived from each item/situation on the scale: a score for the actual role conception and a score for the ideal role conception. The mean difference ($\underline{M}_D$), the difference between the mean of the ideal role conception minus the mean of the corresponding actual role conception was computed for each role conception.

The professional role conception scale was then analyzed according to the following subscales:

1. choices about a patient's care and welfare which would most likely be predominantly based upon the nurse's ethical and moral values.

2. choices about a patient's care and welfare which would most likely be predominantly based upon the nurse's knowledge and education.

Again, two scores were derived from each item/situation on the scale, a score for the actual role conception and a score for the ideal role conception. The mean difference ($\underline{M}_D$), the difference between the mean of the difference between the mean of the ideal role conception minus the mean of the corresponding actual role conception was computed for each role conception.

Bureaucratic items/situations were analyzed using similar procedures. Two scores were derived from each item/situation on the scale: a score for the actual role conception and a score for the ideal role conception. The mean difference ($\underline{M}_D$), the difference between the mean of the ideal role conception minus the mean of the corresponding actual role conception was computed for each role conception.

I. Collection of Data

Prior to conducting this study, a proposal was forwarded to the Nursing Research Committee of the Medical Center. The proposal submitted included the institution-specific form "Application for Approval of Nursing Research;" Chapters I, II, and III of this study; the data collection instrument; the informed consent contract; a narrative containing the method of

distribution; and the collection of both the informed consent and the tools, the methodology to insure anonymity, and the associated time frame for the data collection. Permission to conduct this study was granted by the UMMC Nursing Research Committee (Appendix G).

Packets for each participant included:

1. a cover letter explaining the purpose of the study, requesting participation in the study, and assuring confidentiality (Appendix B);

2. the research instrument (Appendix A); and,

3. an envelope for returning the completed research instrument.

The participants were asked to return their questionnaires, sealed in the envelope provided, to their nurse manager within two weeks; a specific date was provided. The nurse managers were asked to return all collected questionnaires to the researcher. Only questionnaires answered completely, irrespective of the demographic information, were considered for inclusion in the study.

J. Analysis of Data

Data were analyzed using a SPSS program on a Harris 1000 Super Mini-Computer. Descriptive statistics including mean (M), median (Mdn), and standard deviation (SD) were computed for the two ideal and the two actual role conceptions, for the subcategories of the professional conception, and for the two role discrepancies for each group. The data was reported as mean scores, ± SD, and mean differences within each group. The significance of the role discrepancies was evaluated by the Student *t* test. The statistical significance was defined as those differences with a probability (*p* value) of less than or equal to 0.05 under the null hypothesis of no difference. The *t* test assumption of normally distributed errors was evaluated graphically by inspection of frequency histograms. Also, when not normally distributed, a Mann-Whitney U test was done rather than the Student *t* test. Pairwise comparisons in this event were evaluated with multiple Mann-Whitney U Tests, but with a Bonferonni Adjustment for the additive Type I Error due to multiple comparisons. A histogram of each mean score was done to determine if scores were normally distributed.

CHAPTER IV

DATA ANALYSIS

A. Overview

This chapter presents the data analysis of the ideal and actual role conceptions of professional nurses in staff nurse positions and nurse administrator/manager positions. The discrepancies between and among each group are also presented. An overview of demographic data of the research sample is reported. In addition, an explanation of the relationship of the data analysis to each research question is presented.

B. Demographics

Three hundred questionnaires were randomly distributed using 50 percent of the professional nurses from each patient care unit. This method was chosen since approximately 50 percent of nursing staff in the institution studied had either a BSN or MSN, and the other 50 percent of the nursing staff had an ADN or diploma. The entire group of nurse administrators/managers were given questionnaires as they comprised a smaller group (N = 60).

C. Response Rate

Of the 179 questionnaires returned, 134 were staff nurses. This was a response rate of 44.67 percent (134/300). Forty-five were nurse administrators/managers. This was a response rate of 75 percent (45/60). The total response rate was 49.72 percent.

D. Gender

Of the questionnaires returned: 93.30 percent indicated that they were female, 4.47 percent indicated that they were male, and 2.23 did not respond to this question.

E. Highest Education Attained

The highest educational level of respondents was presented in Figure 1. Results revealed: 24.58 percent had a diploma, 12.29 percent had an ADN, 45.81 percent had a BS/BA, and 17.32 percent had a MS/MA.

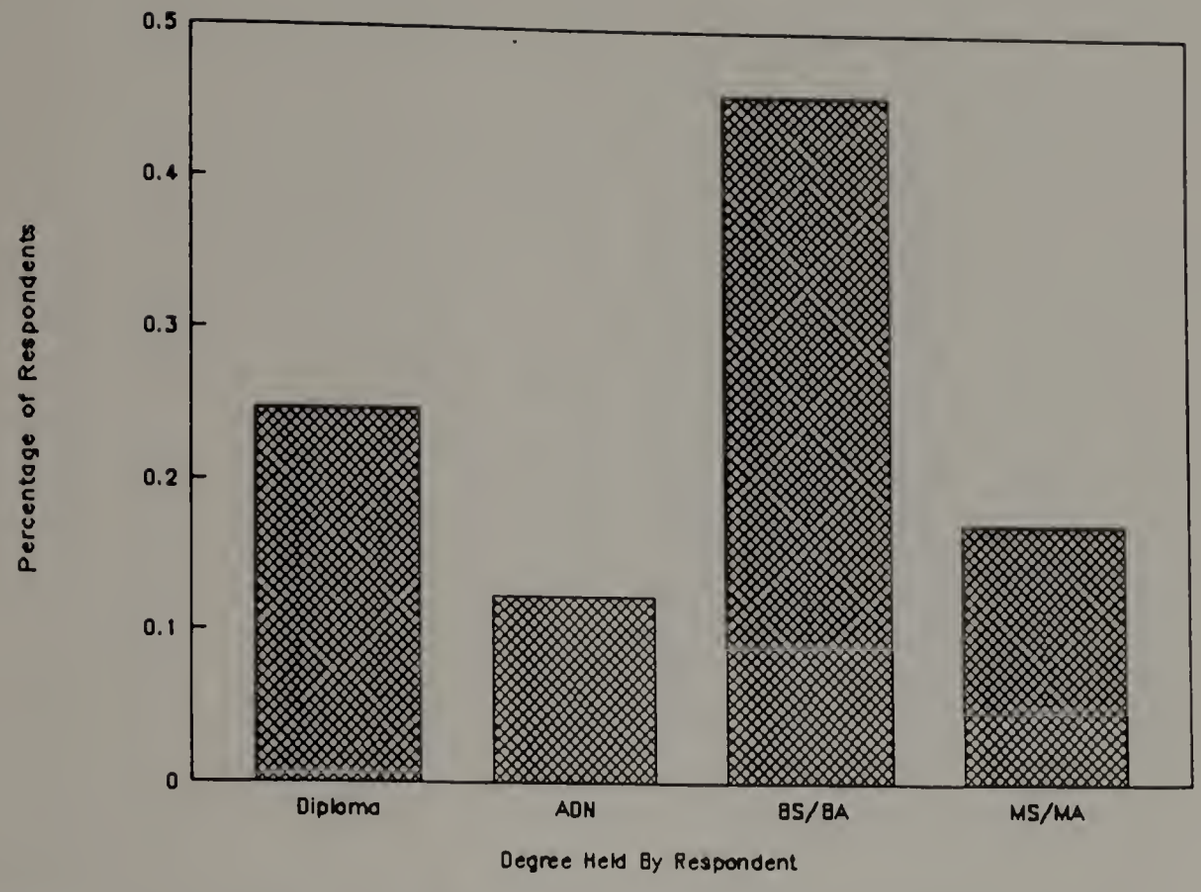

FIG. 1 Highest Education Attained: All Respondents

Of the administrators/managers who responded to the highest education attained question: 8.89 percent had a diploma, 37.78 percent had a BS/BA, and 53.33 percent had a MS/MA. Of the staff nurses employed in the critical care areas that responded to the highest education attained question: 25.93 percent had a diploma, 16.67 percent had an ADN, 50.00 percent had a BS/BA, and 7.40 percent had a MS/MA. Of the staff nurses employed in medical/surgical acute care areas who responded to the highest education attained question: 32.50 percent had a diploma, 16.25 percent had an ADN, 47.50 percent had a BS/BA, and 3.75 percent had a MS/MA. Figure 2 represented these data.

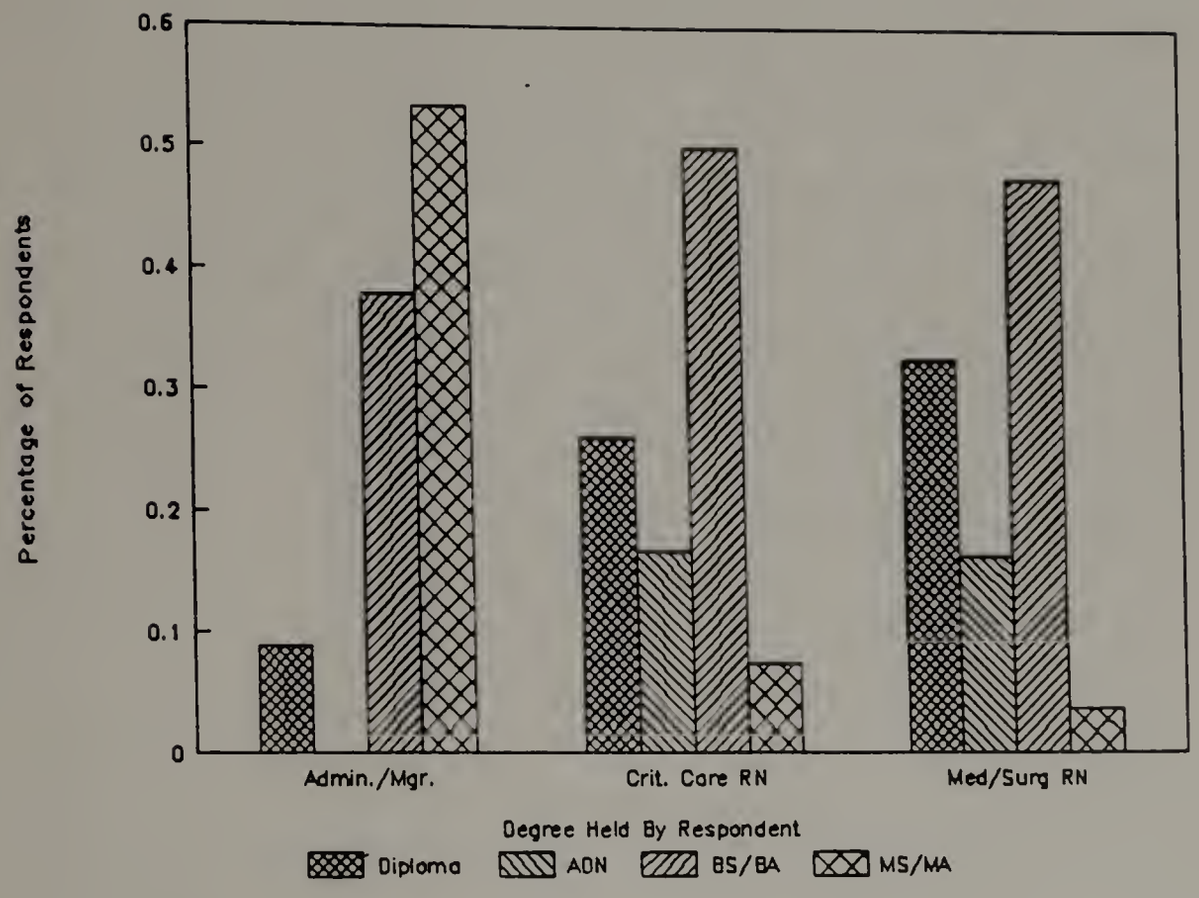

FIG. 2 Highest Education Attained: All Respondents by Category

F. Age

The age distribution of the respondents was as follows: 20 to 25 years (7.82 percent), 26 to 35 years (48.05 percent), 36 to 45 years (30.73 percent), 46 to 55 years (11.17 percent), and 56 to 65 years (2.23 percent). Figure 3 represents these data.

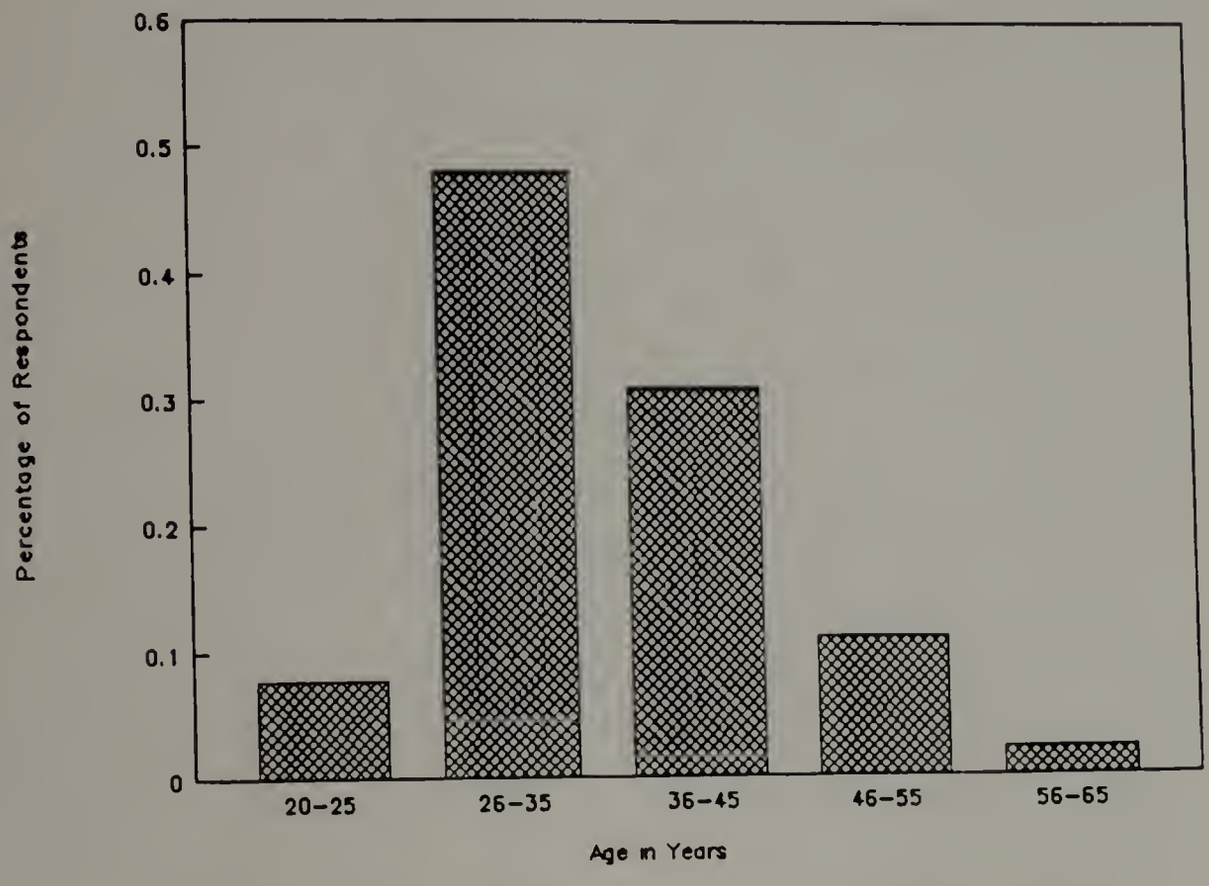

FIG. 3 Age Distribution: All Respondents

G. Years in Nursing

Figure 4 represented the years of practice distribution for nurse respondents: Less than 1 year to 4 years (1.68 percent), 5 to 9 years (26.26 percent), 10 to 14 years (30.17 percent), 15 to 19 years (19.55 percent), 20 to 24 years (8.38 percent), 25 to 29 years (8.94 percent), 30 to 34 years (2.23 percent), 35 and older (1.68 percent), and unanswered (1.11 percent).

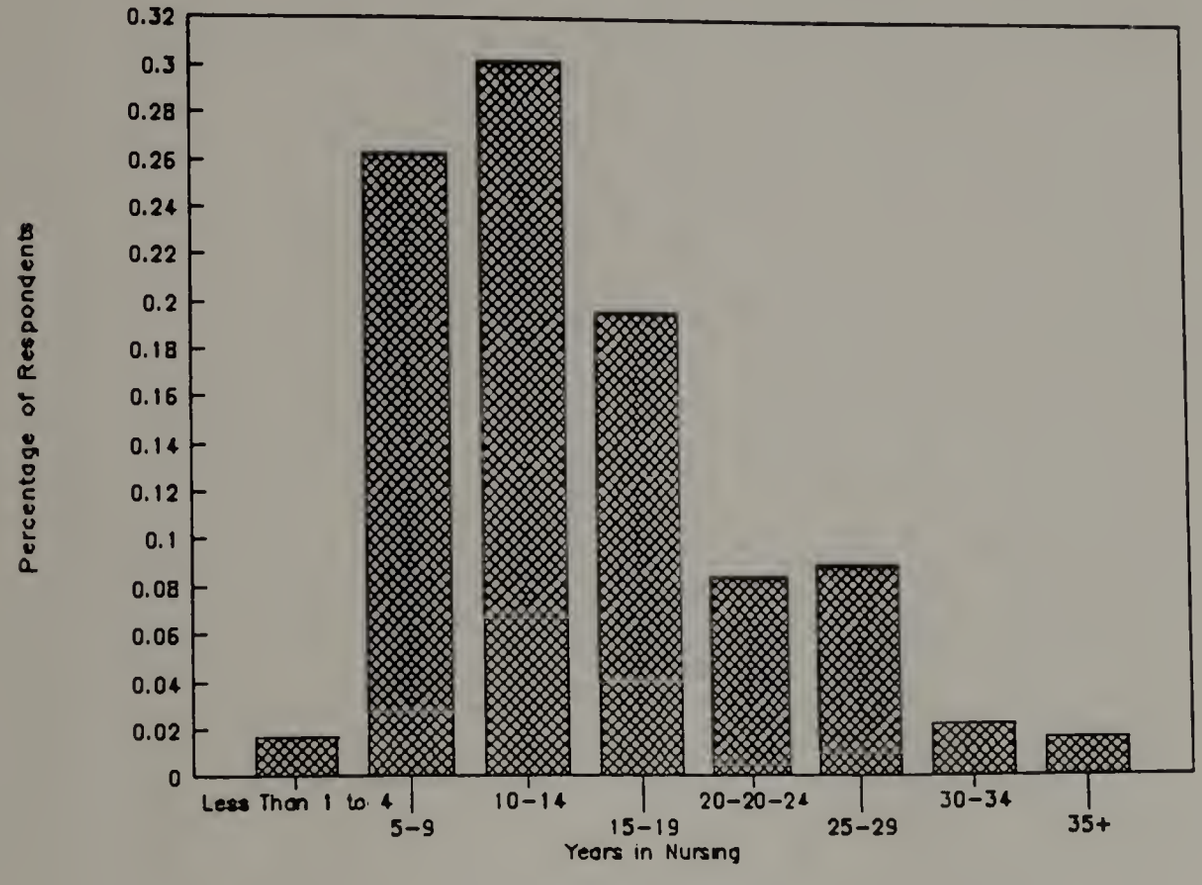

FIG. 4 Number of Years in Nursing: All Respondents

H. Area of Employment

The percentage of respondents who worked in acute care inpatient areas, critical care areas (including emergency, recovery room, and operating room), and nursing administration were as follows: acute care inpatient (45 percent), critical care (30 percent), and nursing administration (25 percent).

I. Research Questions

The questions asked in this study were concerned with the identification of the ideal and the actual role conceptions and the role discrepancies for each group (staff nurses and nurse administrators/ managers). The following questions were asked:

1. What are the perceptions of the ideal nursing role conceptions within each of the groups?

2. What are the perceptions of the actual practice of the nursing role conceptions within each of the groups?

3. To what extent is there a difference between the ideal and actual role conceptions, a role discrepancy, within each of the groups?

4. To what extent are there differences in the perceptions of the ideal nursing role conceptions between each of the groups?

5. To what extent are there differences in the perceptions of the actual practice of the nursing role conceptions between each of the groups?

6. Are the differences between ideal and actual variables in the staff nurses any different from or equivalent to the differences between ideal and actual variables of the nurse administrators/managers?

These six questions were then addressed using the following concepts: the professional concept, the ethical/moral and the knowledge/education sub-divisions within the professional concept, and the bureaucratic concept. Each question was addressed separately.

J. Question 1

What are the perceptions of the ideal nursing role conceptions within each of the groups?

The ideal role conception of both staff nurses and nurse administrators/managers for each of the concepts: overall professional, professional ethical/moral, and professional knowledge/education, was presented in Table 1. The results revealed that the ideal role conception within the overall professional concept of the staff nurses was a mean of 2.03. The ideal role conception within the overall

professional concept of nurse administrators/managers was a mean of 2.03, indicating that the majority of respondents (both staff nurses and nurse administrators/managers) agree or strongly agree in their perception of the ideal professional practice of nursing.

The ideal role conception for the ethical/moral subdivision of the professional concept revealed a mean of 2.53 for the staff nurses. The nurse administrators/ managers group attained a mean of 2.59. This indicated that both groups have somewhat less clarity on their perception of the ideal ethical/moral choices which should be made in their practice of nursing.

The ideal role conception for the knowledge/ education subdivision of the professional concept revealed a mean of 1.77 for staff nurses. The nurse administrator/manager group attained a mean of 1.70. This indicated that the majority in both groups either agreed or strongly agreed in their perception of the ideal practice which should be practiced when dealing with knowledge/education choices.

Table 1 Ideal Role Conception

PERCEPTION	STAFF NURSES MEAN	NURSE ADMINISTRATORS/ MANAGERS MEAN
Overall Professional	2.03	2.03
Ethical/Moral	2.53	2.59
Knowledge/Education	1.77	1.70

The ideal bureaucratic role conception for both groups (staff nurses and nurse administrators/managers) was presented in Table 2. The ideal score for the bureaucratic concept was not normally distributed as identified by the Kolmogorov Smirnov Goodness of Fit Test. Therefore, all analyses which include the ideal score for the bureaucratic concept were reported using non-parametric measures, i.e. Mann-Whitney U. The ideal role conception of the staff nurses for the bureaucratic concept was a median of 2.83. The ideal role conception for the bureaucratic concept of the nurse administrators/ managers was a median of 2.75. This indicated some ambiguity in both groups when dealing with their perceptions of ideal bureaucratic nursing practice.

Table 2 Ideal Bureaucratic Role Conception (Mann-Whitney U)

ROLE		MEDIAN	CASES
Staff Nurse		2.83	134
Nurse Admin./ Manager		2.75	45
U	W	Z	2-TAILED P
2602.5	3637.5	-1.3738	0.1695

K. Question 2

What are the perceptions of the actual practice of the nursing role conceptions within each of the groups?

The actual role conception of both staff nurses and nurse administrators/managers for each of the concepts: overall professional, professional ethical/moral, and professional knowledge/education was presented in Table 3. The results revealed that the actual role conception within the overall professional concept of the staff nurses was a mean of 2.78. The actual role conception within the overall professional concept of nurse administrators/managers was a mean of 2.83, indicating that the majority of respondents (both staff nurses and nurse administrators/managers) were close to being undecided in their perception of what activities comprise the actual professional practice of nursing.

The actual role conception for the ethical/moral subdivision of the professional concept revealed a mean of 2.74 for the staff nurses. The nurse administrators/ managers group attained a mean of 2.77. This is an average score which is close to being undecided which revealed that both groups were undecided in their perception of the actual ethical/moral choices which are made in their practice of nursing.

The actual role conception for the knowledge/ education subdivision of the professional concept revealed a mean of 2.64 for staff nurses. The nurse administrator/manager group attained a mean of 2.67. This indicated that the majority in both groups are leaning toward undecided in their perception of what is actually being practiced when dealing with knowledge/education choices.

Table 3 Actual Role Conception

PERCEPTION	STAFF NURSES MEAN	NURSE ADMINISTRATORS/ MANAGERS MEAN
Overall Professional	2.78	2.83
Ethical/Moral	2.74	2.77
Knowledge/Education	2.64	2.67

The actual bureaucratic role conception for both groups (staff nurses and nurse administrators/managers) was presented in Table 4. The actual score for the bureaucratic concept was not normally distributed as identified by the Kolmogorov Smirnov Goodness of Fit Test. Therefore, all analyses which include the actual score for the bureaucratic concept are reported using non-parametric measures, i.e. Mann-Whitney U. The actual role conception of the staff nurses for the bureaucratic concept was a median of 3.00. The actual role conception for the bureaucratic concept of the nurse administrators/ managers was a median of 3.08. This indicated that the majority of both groups are undecided about what is actually occurring in the actual bureaucratic nursing practice.

Table 4 Actual Bureaucratic Role Conception (Mann-Whitney U)

ROLE		MEDIAN	CASES
Staff Nurse		3.00	134
Nurse Admin./ Manager		3.08	45
U	W	Z	2-TAILED P
2661.0	4404.0	-1.1812	0.2375

L. Question 3

To what extent is there a difference between the ideal and actual role conceptions, a role discrepancy, within each of the groups?

The extent of differences between the ideal and the actual role conception (role discrepancy) within the staff nurse and nurse administrator/manager groups within the overall professional concept was presented in Table 5. Table 5 indicated that the role discrepancy for staff nurses was 0.74. The role discrepancy for nurse administrators/managers was 0.80. Paired *t* tests indicated that there was a significant difference between the ideal and the actual role conceptions within both groups at $p<0.001$.

Data indicated that both the staff nurse and nurse administrator/manager groups believe that professional nursing is not actually being practiced in the way that they perceive nursing should be practiced.

Table 5 Ideal and Actual Professional Role Conceptions for Staff Nurses and Nurse Administrators/ Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Prof.: Staff Nurse	2.03	0.35	2.78	0.40	0.74	17.33*
Prof.: Nurse Adms./ Mgrs.	2.03	0.33	2.83	0.43	0.80	10.47*

*$p<0.001$

The extent of difference between the ideal and the actual role conceptions (role discrepancy) within the staff nurse and the nurse administrator/manager groups within the ethical/moral subdivision of the professional concept was presented in Table 6. Results revealed that the perceived ideal ethical/moral role conception of staff nurses was a mean of 2.53 and the mean perceived actual ethical/moral role conception of the staff nurses

was a mean of 2.74. The perceived ideal ethical/moral role conception of nurse administrators/managers was a mean of 2.59 and the perceived actual ethical/moral role conception of the nurse administrators/managers was a mean of 2.77. The role discrepancy for the staff nurses was 0.22, and the role discrepancy for the nurse administrators/managers was 0.18. The *t* values of 4.05 for staff nurses and 1.90 for nurse administrators/managers were statistically significant ($p<0.001$), indicating that there was a significant difference between the ideal and actual role conceptions within each of the groups.

Table 6 Ideal and Actual Professional Ethical/Moral Role Conceptions for Staff Nurses and Nurse Administrators/Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Ethical/ Moral: Staff Nurse	2.53	0.55	2.74	0.51	0.22	4.05*
Ethical/ Moral: Nurse Adms./ Mgrs.	2.59	0.65	2.77	0.60	0.18	1.90*

*$p<0.001$

The extent of difference between the ideal and the actual role conceptions (role discrepancy) within the staff nurse and the nurse administrator/manager groups within the knowledge/education subdivision of the professional concept was presented in Table 7. Results revealed that the perceived ideal knowledge/education role conception of staff nurses was a mean of 1.77 and the perceived actual knowledge/education role conception of the staff nurses was a mean of 2.64. The role discrepancy was 0.87. The perceived ideal knowledge/education role conception of nurse administrators/managers was a mean of 1.70 and the perceived actual knowledge/education role conception of the nurse administrators/managers was a mean of 2.67. The role discrepancy was 0.97. The t values of 17.22 for staff nurses and 10.84 for nurse administrators/managers were statistically significant ($p<0.001$), indicating that there was a significant difference between the ideal and actual role conceptions within each of the groups.

Table 7 Ideal and Actual Professional Knowledge/ Education Role Conceptions for Staff Nurses and Nurse Administrators/Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Knowledge/ Education: Staff Nurse	1.77	0.41	2.64	0.50	0.87	17.22*
Knowledge/ Education: Nurse Adms./ Mgrs.	1.70	0.33	2.67	0.53	0.97	10.84*

*$p<0.001$

The extent of difference between the ideal and the actual role conceptions (role discrepancy) within the staff nurse and the nurse administrator/manager groups for the bureaucratic concept was presented in Table 8. Results revealed that the perceived ideal bureaucratic role conception of staff nurses was a mean of 2.78 and the perceived actual bureaucratic role conception of the staff nurses was a mean of 2.99. The role discrepancy was 0.21. The perceived ideal bureaucratic role conception of nurse administrators/managers was a mean of 2.68 and the perceived actual bureaucratic role conception of the nurse administrators/managers was a

mean of 3.06. The role discrepancy was 0.38. The *t* values of 5.19 for staff nurses and 6.23 for nurse administrators/managers were statistically significant ($p<0.001$), indicating that there was a significant difference between the ideal and actual role conceptions within each of the groups.

Table 8 Ideal and Actual Bureaucratic Role Conceptions for Staff Nurses and Nurse Administrators/ Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Bureaucratic: Staff Nurse	2.78	0.49	2.99	0.34	0.21	5.19*
Bureaucratic: Nurse Adms./ Mgrs.	2.68	0.38	3.06	0.35	0.38	6.23*

*$p<0.001$

M. Question 4

To what extent are there differences in the perceptions of the ideal nursing role conceptions between each of the groups?

The ideal role conception for each of the concepts: overall professional, professional ethical/moral, professional knowledge/education, and bureaucratic, was presented in Table 9. The results revealed that the ideal role conception within the overall professional concept of the staff nurses was a mean of 2.03. The ideal role conception within the overall professional concept of the nurse administrators/managers has a mean of 2.03. There was not a significant difference between the staff nurses group and the nurse administrator/ manager group in the perceived overall ideal professional role concept (t = 0.05).

Results of the ideal role conceptions for the ethical/moral subdivision of the professional concept of both groups (staff nurses and nurse administrators/ managers) revealed that the ideal professional ethical/moral role conception of staff nurses was a mean of 2.53. The ideal professional ethical/moral role conception of the nurse administrators/mangers was a mean of 2.59. A t value of -0.64 between groups indicated

that there was not a significant difference between the staff nurses and the nurse administrators/managers in the ideal professional ethical/moral role concept.

Results of the ideal role conceptions for the knowledge/education subdivision of the professional concept of both groups (staff nurses and nurse administrators/managers) revealed that the ideal professional knowledge/education role conception of staff nurses was a mean of 1.77. The ideal professional knowledge/education role conception of the nurse administrators/mangers was a mean of 1.70. A $\underline{t}$ value of 1.02 between groups indicated that there was not a significant difference between the staff nurses and the nurse administrators/managers in the ideal professional knowledge/education role concept.

Results of the ideal bureaucratic role conception of both staff nurses and nurse administrators/managers revealed that the ideal role conception for staff nurses for the bureaucratic concept was a mean of 2.78. The ideal role conception of nurse administrators/managers for the bureaucratic concept was a mean of 2.68. The difference in role discrepancies between staff nurses and nurse administrators/managers was not significant ($\underline{t}$ = 1.25).

Table 9 Ideal Role Conception

PERCEPTION	STAFF NURSES MEAN	NURSE ADMINISTRATORS/ MANAGERS MEAN	t VALUE
Overall Professional	2.03	2.03	0.05
Professional Ethical/Moral	2.53	2.59	-0.64
Professional Knowledge/ Education	1.77	1.70	1.02
Bureaucratic	2.78	2.68	1.25

N. Question 5

To what extent are there differences in the perceptions of the actual practice of the nursing role conceptions between each of the groups?

The difference in the perceptions of the actual nursing role conception within the overall professional concept between each group was presented in Table 10. The results revealed that the actual role conception within the professional concept of the staff nurses was a mean of 2.78. The actual role conception within the overall professional concept of the nurse administrators/ managers has a mean of 2.83. There was not a significant

difference between the perceived actual professional role in the staff nurse group (t = -0.81).

Results of the actual role conceptions for the ethical/moral subdivision of the professional concept of both groups (staff nurses and nurse administrators/ managers) revealed that the actual professional ethical/moral role conception of staff nurses was a mean of 2.74. The actual professional ethical/moral role conception of the nurse administrators/managers was a mean of 2.77. A t value of -0.25 between groups for the actual indicated that there was not a significant difference between the staff nurses and the nurse administrators/managers in the actual professional ethical/moral role concept.

Results of the actual role conceptions for the knowledge/education subdivision of the professional concept of both groups (staff nurses and nurse administrators/managers) revealed that the actual professional knowledge/education role conception of staff nurses was a mean of 2.64. The actual professional knowledge/education role conception of the nurse administrators/managers was a mean of 2.67. A t value of -0.41 between groups for the actual indicated that there was not a significant difference between the staff nurses

and the nurse administrators/managers in the actual professional knowledge/education role concept.

Results of the actual bureaucratic role conception for both groups (staff nurse and nurse administrators/ managers) revealed that the actual role conception for staff nurses for the bureaucratic concept was a mean of 2.99. The actual role conception of nurse administrators/managers for the bureaucratic concept was a mean of 3.06. Within the bureaucratic concept, the difference between staff nurses and nurse administrators/ managers was not significant (t = -1.07).

Table 10 Actual Role Conception

PERCEPTION	STAFF NURSES MEAN	NURSE ADMINISTRATORS/ MANAGERS MEAN	t VALUE
Overall Professional	2.78	2.83	-0.81
Professional Ethical/Moral	2.74	2.77	-0.25
Professional Knowledge/ Education	2.64	2.67	-0.41
Bureaucratic	2.99	3.06	-1.07

O. Question 6

Are the differences between ideal and actual variables in the staff nurses any different from or equivalent to the differences between ideal and actual variables of the nurse administrators/managers?

Tables 11 through 14 presented data on whether the differences between the ideal and the actual variables in the staff nurse group were any different from or equivalent to the differences between the ideal and the actual variable of the nurse administrators/managers.

Table 11 presented data which compares the ideal and the actual professional role conception within the staff nurse and nurse administrator/manager groups. This table indicated that the role discrepancy for the professional concept between the ideal and the actual within the staff nurse group is 0.74. The role discrepancy for the professional concept between the ideal and actual within the nurse administrator/manager group was 0.80. Using paired t tests, a t value -0.69 was attained. This indicated that there was not a significant difference in the discrepancies of the groups.

Table 11 Ideal and Actual Professional Role Conceptions for Staff Nurses and Nurse Administrators/ Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Prof.: Staff Nurse	2.03	0.35	2.78	0.40	0.74	-0.69
Prof.: Nurse Adms./ Mgrs.	2.03	0.33	2.83	0.43	0.80	

Table 12 presented data which compares the ideal and actual professional ethical/moral role conception within the staff nurse and nurse administrator/manager groups. This table indicated that the role discrepancy for the professional ethical/moral concept between the ideal and the actual within the staff nurse group is 0.22. The role discrepancy for the professional ethical/moral concept between the ideal and actual within the nurse administrator/manager group was 0.18. Using paired *t* tests, a *t* value 0.38 was attained. This indicated that there was not a significant difference in the discrepancies of the groups.

Table 12 Ideal and Actual Professional Ethical/Moral Role Conceptions for Staff Nurses and Nurse Administrators/Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Ethical/ Moral: Staff Nurse	2.53	0.55	2.74	0.51	0.22	0.38
Ethical/ Moral: Nurse Adms./ Mgrs.	2.59	0.65	2.77	0.60	0.18	

Table 13 presented data which compares the ideal and the actual professional knowledge/education role conception within the staff nurse and nurse administrator/ manager groups. This table indicated that the role discrepancy for the professional knowledge/education concept between the ideal and the actual within the staff nurse group is 0.87. The role discrepancy for the professional knowledge/education concept between the ideal and actual within the nurse administrator/manager group was 0.97. Using paired t tests, a t value -1.04 was attained. This indicated that there was not a significant difference in the discrepancies of the groups.

Table 13 Ideal and Actual Professional Knowledge/ Education Role Conceptions for Staff Nurses and Nurse Administrators/Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Knowledge/ Education: Staff Nurse	1.77	0.41	2.64	0.50	0.87	-1.04
Knowledge/ Education: Nurse Adms./ Mgrs.	1.70	0.33	2.67	0.53	0.97	

Table 14 presented data which compares the ideal and the actual bureaucratic role conception within the staff nurse and nurse administrator/manager groups. This table indicated that the role discrepancy for the bureaucratic concept between the ideal and the actual within the staff nurse group is 0.21. The role discrepancy for the bureaucratic concept between the ideal and actual within the nurse administrator/manager group was 0.38. Using paired *t* tests, a *t* value -2.05 was attained. This indicated that there was not a significant difference in the discrepancies of the groups.

Table 14 Ideal and Actual Bureaucratic Role Conceptions for Staff Nurses and Nurse Administrators/ Managers and Role Discrepancies Within These Groups

	IDEAL		ACTUAL		ROLE DISCREPANCY	t VALUE
	M	SD	M	SD		
Bureaucratic Staff Nurse	2.78	0.49	2.99	0.34	0.21	-2.05
Bureaucratic Nurse Adms./ Mgrs.	2.68	0.38	3.06	0.35	0.38	

P. Summary

The data presented in this chapter have provided findings to each of the research questions. Tables 1 through 14 show the ideal and actual professional and bureaucratic role conceptions and role discrepancies between each group. The findings are as follows:

1. There is not a significant difference between the perceived ideal professional role in the staff nurse group and the perceived ideal professional role in the nurse administrator/manager group. The difference in role discrepancies between these groups is not significant.

2. There is not a significant difference between the perceived actual professional role in the staff nurse group and the perceived actual professional role in the nurse administrator/manager group. The difference in role discrepancies between these groups is not significant.

3. There is not a significant difference between the perceived ideal professional ethical/moral role concept in the staff nurse group and the perceived ideal professional ethical/moral role concept in the nurse administrator/manager group. The difference in role discrepancies between staff nurses and nurse administrators/managers is not significant.

4. There is not a significant difference between the perceived actual professional ethical/moral role concept in the staff nurse group and the perceived actual professional ethical/moral role concept in the nurse administrator/manager group. The difference in role discrepancies between staff nurses and nurse administrators/managers is not significant.

5. There is not a significant difference between the nurse administrators/managers and staff nurses in the ideal professional knowledge/education role conception. The difference in role discrepancies between staff nurses and nurse administrators/managers is not significant.

6. There is not a significant difference between the nurse administrators/mangers and staff nurses in the actual professional knowledge/education role concept. The difference in role discrepancies between staff nurses and nurse administrators/managers is not significant.

7. There is not a significant difference between staff nurses and nurse administrators/managers in their perception of the ideal bureaucratic role concept.

8. There is not a significant difference between staff nurses and nurse administrators/managers in their perception of the actual bureaucratic role concept.

9. The most significant finding of this research is that there is a significant difference between the ideal and actual role conceptions within both groups for each concept: professional, professional ethical/moral, professional knowledge/education, and bureaucratic.

CHAPTER V

RESULTS

A. Introduction

The purpose of this study was to identify the way in which two groups, staff nurses and nurse administrators/managers, conceptualize the ideal and actual role of the registered nurse practicing at the bedside. Data were examined in order to identify similarities and differences in the opinions of the role conceptions within and between the two groups.

Role conceptions were examined by comparing perceptions of staff nurses and nurse administrators/managers regarding the ideal and actual practice of nursing in a 371-bed university, teaching hospital. The following six questions guided the investigation:

1. What are the perceptions of the ideal nursing role conceptions within each of the groups?

2. What are the perceptions of the actual practice of the nursing role conceptions within each of the groups?

3. To what extent is there a difference between the ideal and actual role conceptions, a role discrepancy, within each of the groups?

4. To what extent are there differences in the perceptions of the ideal nursing role conceptions between each of the groups?

5. To what extent are there differences in the perceptions of the actual practice of the nursing role conceptions between each of the groups?

6. Are the differences between ideal and actual variables in the nurse administrators/managers any different from or equivalent to the differences between ideal and actual variables of the staff nurses?

A questionnaire was designed and sent to 300 non-management nurses who were randomly selected using 50 percent of the professional nurses from each patient care unit. This random sampling, as expected, resulted in a return of 50 percent ADN/diploma and 50 percent BSN respondents. Since the management group comprised a smaller number than the non-management group (N = 60), the questionnaire was given to the entire group.

The rationale for this study was developed using social science literature (Mead, 1949; Gross et. al., 1967; Eisenstadt et. al., 1967; Newcomb et. al., 1965; Getzels & Thelen, 1968; and others) as well as role

theory (Sarbin, 1957; Biddle & Thomas, 1966; Kramer, 1974; Hardy, 1978; and Snoek, 1966). Other literature cited included a review of nursing history as it related to role development in nursing, the professional and bureaucratic workplace and its impact on role development in nursing, the scope of nursing practice and its relationship to role development in nursing, and recent factors contributing to role changes in nursing.

This chapter presents a summary of the major findings of the study. Implications of the study are discussed, recommendations from the study are offered, implications for the profession of nursing are reviewed, and areas for further investigation are suggested.

B. Major Findings

The major findings of this study were presented as they relate to the ideal role, the actual role, and the discrepancy between and within each group studied. The professional and bureaucratic concepts were used to facilitate this research. The major findings were:

1. There was not a significant difference between the perceived ideal professional role in the staff nurse group and the perceived ideal professional

role in the nurse administrator/manager group. The difference in role discrepancies between these groups was not significant.

2. There was not a significant difference between the perceived actual professional role in the staff nurse group and the perceived actual professional role in the nurse administrator/manager group. The difference in role discrepancies between these groups was not significant.

3. There was not a significant difference between the perceived ideal professional ethical/moral role concept in the staff nurse group and the perceived ideal professional ethical/moral role concept in the nurse administrator/manager group. The difference in role discrepancies between staff nurses and nurse administrators/managers was not significant.

4. There was not a significant difference between the perceived actual professional ethical/moral role concept in the staff nurse group and the perceived actual professional ethical/moral role concept in the nurse administrator/manager group. The difference in role discrepancies between staff nurses and nurse administrators/managers was not significant.

5. There was not a significant difference between the ideal professional knowledge/education role concept in the staff nurse group and the ideal professional knowledge/education role concept in the nurse administrator/manager group. The difference in role discrepancies between staff nurses and nurse administrators/managers was not significant.

6. There was not a significant difference between the actual professional knowledge/education role concept in the staff nurse group and the actual professional knowledge/education role concept of the nurse administrator/manger group. The difference in role discrepancies between staff nurses and nurse administrators/managers was not significant.

7. There was not a significant difference between the ideal bureaucratic role concept in the staff nurse group and the ideal bureaucratic role concept in the nurse administrator/manager group.

8. There was not a significant difference between the actual bureaucratic role concept in the staff nurse group and the actual bureaucratic role concept in the nurse administrator/manager group.

9. The most significant finding of this research was that there was a significant difference between

the ideal and actual role conceptions within both groups, staff nurses and nurse administrators/managers for each concept: professional, professional ethical/moral, professional knowledge/education, and bureaucratic.

C. Discussion and Implications of Major Findings

The research of Pieta (1976) and Corwin (1960, 1961), upon which this study was based, both indicated differences between nurse administrators/managers and staff nurses regarding their perceptions of the role of the nurse practicing at the bedside. However, data from this study indicated that there was not a significant difference between these groups. Therefore, the rationale for these findings had to be determined. As this researcher further analyzed the earlier studies (Pieta, 1976 and Corwin 1960, 1961), the data supported the conclusion that differences in perception could be related to differences in educational preparation. For instance, Pieta (1976) studied all diploma graduates without degrees and in Corwin's study (1961), only 13 percent of the staff had degrees, while within the institution used for this study, more staff nurses have higher levels of education (50 percent BSN or higher) than in the

groups studied by Pieta (1976) and Corwin (1960, 1961). Another reason might have been that nurses practicing within the institution studied had a clearly delineated framework from which they derived their practice of professional nursing.

Respondents to this study, both nurse administrators/managers and staff nurses, agreed on both the ideal and the actual professional practice of nursing. However, they did not believe that the ideal was being practiced. In fact, the perception of the actual vs. ideal professional role conception in all groups was identified as the area of greatest potential role discrepancy.

The professional role conception as defined in this study had become a primary focus of nursing. For the purpose of this study, the professional concept was defined as the occupational principles which transcend the location of a specific hospital. It suggests primary loyalty to the nursing profession, and thus, to the patient. It referred to the professional practice of staff nurses who care for patients. The findings showed that nurse administrators/managers and staff nurses perceived the professional role in the ideal should be practiced to

the largest extent, i.e. the groups strongly agreed or agreed that the ideal professional concept was the most desirous practice. These data indicated that in the institution used for this study nurse administrators/managers and staff nurses alike had similar perceptions regarding the role of the staff nurse. In an effort to ascertain whether or not variables might have influenced these findings, an analysis of variance was done comparing education, area of work (critical care and acute care), age, and length of time in nursing. There was no significant difference based upon any of the variables studied. The fact that there was no significant difference based on the variables studied indicated that all respondents within the institution used for this study agreed that what should be practiced in the ideal was not actually practiced.

The researcher then defined some of the items studied which during the instrument development were defined as clearly professional. These items were responded to as being professional by 100 percent of the nurses involved in the preliminary evaluation of the questions. The following items/situations were frequently responded to in the ideal as strongly agree

or agree, but in the actual as undecided, disagree, or strongly disagree. In an effort to demonstrate this contradiction, several key items were presented. For instance, in item/situation 4, "Professional nurses at Hospital A spend the majority of their work time providing direct patient care," 78.8 percent of those responding felt (agree or strongly agree) that direct care should be provided by professional staff nurses while only 45.5 percent felt that this was what actually occurs.

In item/situation 6, "Professional nurses are expected and encouraged, based on their unique relationship with the patient, to share as much information about their condition as they believe best for the patient," 78.8 percent felt that nurses should share information with patients (agree or strongly agree), but only 54.2 percent felt that this was actually being done (disagree or strongly disagree).

In item/situation 9, "A professional nurse tries to comply with professional standards even though at times her actions are resented by her peers," 96 percent of those responding felt that nurses should comply with standards despite resentment of peers (agree or strongly disagree), yet when answering as to

what is actually done, 43 percent were either undecided or disagreed with this statement.

In item/situation 12, "A nurse manager believes that professional nurses can assist patients to recover more quickly by helping to alleviate the fears troubling them. Therefore, nurses are rewarded for spending time talking with patients about their concerns," 93 percent felt that nurses should be rewarded for talking with patients (agreed or strongly agreed), while at the same time 74.9 percent either disagreed or strongly disagreed that this actually was being done.

In item/situation 13, "A professional nurse should always ascertain the patient's understanding of the reason for hospitalization before planning nursing care," 96 percent felt that nurses should assess a patient's understanding before providing care (agree or strongly agree), while 50.8 percent were either undecided, disagreed, or strongly disagreed on this point.

In item/situation 14, "A professional nurse should stand up for him/herself and defend nursing actions with sound reasoning and principles," 98 percent felt that nurses should defend their actions

with reasoning and principles (agree or strongly agree), while 35 percent indicated that this was not done in actual practice.

In item/situation 23, "Professional Nurse A always instructs the patient regarding the side effects of medications," 92.7 percent felt that nurses should educate patients of adverse side effects of drug actions (agree or strongly disagree), while 55 percent either strongly disagreed, disagreed, or were undecided about it being done.

In item/situation 30, "The professional nurse at Hospital A establishes goals for nursing care with input from physicians and families," 96 percent felt that nurses should establish patient goals with physicians and families (agree or strongly agree), yet 40 percent were either undecided, disagreed, or strongly disagreed, indicating that they believed this was not done.

In item/situation 31, "A professional nurse includes family members in discharge planning conference," 98 percent felt that nurses should include family members in discharge planning (agree or strongly agree), yet 36 percent were either undecided, disagreed, or strongly disagreed, indicating that they believed this was not done.

In item/situation 32, "The professional nurse recognizes that she is responsible for communicating with peers when they do not follow through on the plan initiated," 96 percent felt that nurses should communicate with peers when they do not follow through on the plan indicated (agree or strongly agree), yet 44 percent indicated that this was not done (disagree or strongly disagree).

In item/situation 33, "When providing information to patients about commercial products, a professional nurse describes a variety of similar products so that a patient can make his/her own decision," 89 percent felt that nurses should discuss product options with patients (agree or strongly agree), while 45 percent indicated that this either was not being done or they do not know if it was being done (undecided, disagree, or strongly disagree).

The reasons for this dichotomy between what the ideal should have been in nursing practice and what was actually practiced was can be related to many issues. This was particularly so in a university teaching institution, such as the one used in this study. The nurse's role as advocate, protecting the best interests of the patient, is challenged by the hospital's mission to prepare practicing physicians.

Nurses are required to complete a great amount of paperwork including report sheets, patient classification information, etc., all quantifiable items. Many of the psychosocial/supportive aspects of the nurse/patient relationship are less quantifiable, and when pressed for time, more likely to be left undone.

Decisions about patient care are usually made during rounds. Nurses might not be an accepted part of this activity. This creates a role discrepancy for the nurse who is educated to believe that their contribution is welcomed and valued. The one group that a nurse predictably feels fully accepted by is his/her peer group. Hence, nurses seem hesitant to address issues that might potentially complicate or harm these support systems relationships.

Kahn (1974) revealed that some degree of role conflict and ambiguity is inevitable in complex organizations. All hospitals are task-oriented, bureaucratic organizations interested in standardized, routine operation. These interests conflict with the ideal practice of professional nursing. The hospital environment is where most nursing practice takes place, yet, the hospital as a bureaucratic

organization deters nurses from practicing autonomously, not allowing nurses to assume responsibility for independent thinking. Autonomy or independent responsibilities is where hospital nursing fell short of professional practice as defined in the literature. According to Aiken (1990); Hendrickson, Doddato, and Kovner (1990); and Jones (1990), nurses have little control over how they practice or even if they practice nursing, instead they are required to do a variety of other tasks mandated to them within the bureaucratic workplace. Literature supports that role conflict in nursing is generated from a variety of sources within the health care system. Aiken (1990) maintained that professional nurses often provide services that should be provided by other health care workers. Other providers include support personnel, i.e. housekeepers, clerical staff, and transport personnel, as well as indirect care providers, i.e. pharmacy, laboratory, social service, physical therapy, and respiratory therapy. Lack of these support services has decreased the amount of time professional nurses can spend in caring for patients. This absence of support personnel also contributes to excessive workloads and frequent overtime for nursing

staff. Ketefian (1985), who studied the effect of role conception and its influence on nursing practice, found that a professional role orientation is not greater in community settings where nurses were able to exercise more independent judgments. She concluded that the organizational setting served to reinforce rather than change the role orientation practice of nurses.

Also, a professional has to be respected and accepted by other professional colleagues. Nursing has had difficulty with the attainment of professional status because of its largely female members and inconsistent education and image. The lack of consistent professional image and education makes attainment of professional behaviors more difficult. Part of nursing's image involves a commitment to the professional supported by the development of the professional self. Cornerstones of practice for the professional are involvement, commitment, and motivation (Styles, 1987). In turn, nursing's image is shaped by the educational process, the practice setting, and society's view of what nurses do. Historically, nurses have been socialized to be dependent, nurturing handmaidens. Following orders

and adhering to routines were hallmarks of the nurses' role. More recently, however, societal trends have broadened many aspects of the nurse's responsibilities. "Socialization to professional nursing involves a process of learning content and skills and internalizing a self-identity appropriate to nurses' specific roles" (Leddy & Pepper, 1985, p. 3). In order to achieve a collective professional identity, nurses must deal with diverse educational backgrounds and refute the assumption that "a nurse is a nurse..." (Leddy & Pepper, 1985, p. 42). Nurses practicing in a bureaucratic setting would be advised to define their practice just as a nurse in independent practice.

Many studies support that a clash of perspectives occurs once the new graduate enters the world of hospital nursing (Corwin, 1960, 1961; Kramer, 1974; Pieta, 1976; Green, 1988). This study differed from earlier findings because a clash of perspectives was noted within all nurses employed at the institution studied who responded to the questionnaire. Nurses, regardless of age, experience, or position, all perceived a role discrepancy.

Results of this study, with all groups agreeing on the ideal practice of nursing, might also have been

reflective of nursing's ability to define itself more clearly as a profession. The profession of nursing had done a lot to get nurses to look at the role of the nurse. Although nurses might now be able to agree on the ideal role of professional nursing, the profession found itself unable to practice the role.

Role related values are domain specific and consist of both an extension of one's personal and professional values into the workplace and shared organizational values. Organizational theory supports that the leaders in an organization are able to define goals and structures to which people are drawn. This researcher contends that the nurses within this institution have similar professional values and, therefore, agree on the role of the professional nurse. The question which must be answered is why nurses feel that they are not able to practice professional nursing.

In studying the bureaucratic concept, findings indicated that there was not a significant difference between staff nurses and nurse administrators/managers in the bureaucratic concept. The nurse administrators/managers did have a greater discrepancy between the ideal and actual bureaucratic concept.

This higher discrepancy in the nurse administrator/ manager group might have occurred for several reasons. All nurse administrators/managers in this study were primarily educated to provide direct patient care, not as supervisors. Nurse administrators/managers in the institution studied did not generally provide direct patient care, so that by virtue of their management positions, they were providing supervision which required them to oversee the administration of care rather than providing the care themselves. Hospitals facing severely limited resources might not have provided these administrators/managers with the ability to support the care that they felt was optimal.

Literature discussed the degree of diversity inherent in nurse executives' positions, thereby supporting the findings that nurse administrators/ managers had more role discrepancy in the bureaucratic concept (Singleton & Nail, 1984; Scalzi, 1990).

Within the bureaucratic concept, there was a significant difference within each groups between what should ideally be practiced and what is actually being practiced. Clearly, the reasons for this dichotomy can be related to many of the previously discussed

issues which relate to professional practice. Role compatibility and conflict between organizational and professional commitment for nurses had been the focus of several studies over the past few decades (Aiken, 1990; Hendrickson, Doddato, and Kovner, 1990; and Jones, 1990). The typical view had been that the professional employee must choose between the profession and the employing organization since the values of each conflict.

In addition to adhering to the rules of the hospital bureaucracy, as a professional group, nurses are subject to both the administrative and policy practices of the medical staff. Nursing must adjudicate between these policies and their own professional code. Richard Hall (1968) in his analysis of structural and attitudinal aspects of professionalism suggested that there is usually an inverse relationship between professionalization and bureaucracy. He argued further, however, that the presence of professionals in organizations can affect the structure of the organization. His study suggested that increased bureaucracy threatens professional autonomy. He maintained that the strong drive for autonomy on the part of a professional may

come into direct conflict with organizationally based job requirements. He also maintained that the organization may be threatened by strong professional aspirations of some of its members. This supported the view held by Kramer (1974) who suggested that there is inherent worth in both bureaucratic and professional principles of work organizations. She suggested the blending of these seemingly divergent role concepts by integration of some concepts in order to develop professional roles capable of adapting to and functioning within bureaucratic organizations (Kramer, 1974).

Nursing is currently undergoing a transition by which institutions that have previously dominated the profession come into conflict in the process of nursing reorganization. Consequently, there are diverse loyalties within nursing and sometimes these are inconsistent. Nurses today appear to articulate a relatively high professional self-concept, but this is sometimes threatened by requirements of the bureaucratic role.

Data in this study indicated that there is a significant difference between the ideal and actual bureaucratic role concept in both the staff nurse and

nurse administrator/manager groups. Staff nurses believe that the bureaucratic concept was practiced less in the ideal than the nurse administrators/ managers; however, the staff nurses believe that the bureaucratic concept is practiced more in the actual than the nurse administrators/managers. This finding might be due to the fact that nurse administrators/ managers were more affected by bureaucratic rules and regulations than the bedside nursing staff.

In summary, while both the staff nurses and the nurse administrators/managers agreed on the ideal practice of nursing, they also agreed that this was not reflected in actual practice. These beliefs might have been due to socialization or education. They might have also been reflective of a inculcation of more professional attributes which were not yet reflected in practice due to the bureaucratic structure of the institutions. Managers probably had slightly more role discrepancy within the bureaucratic concept due to their daily work and their involvement with more bureaucratic rules and regulations.

D. Implications for Nursing

This study has identified significant ambiguity between the ideal practice of professional nursing and the actual practice of professional nursing. It is important for all nurse administrators/managers to examine this issue. Based on the limited findings of this study, it is important that nurse administrators/managers remain alert to this difference. In turn, they must be prepared to intervene so that staff nurses may be properly protected against undue pressure from physicians, administrators, and ancillary departments. Those caught between conflicting expectations are entitled to guidance from their immediate superiors when choices must be made. Nurse administrators/managers must keep communication open between staff nurses and other levels of the organization. Clearly, "If nurses do not define a clearly understood role, they may have difficulty maintaining their precarious professional status because they will not have demonstrated that they possess a unique set of skills" (Rademaker, 1982).

Within a broader framework, nursing leaders must clarify professional values, attributes, goals, and priorities to both nursing and society and help them

form leaders who must educate staff with a basis for choosing to which of the conflicting expectations one should respond. There continues to be much written about the role of the nurse and nursing. One of the more forceful spokespersons is Orlando (1987):

> The nursing profession has the opportunity to choose one of two alternate paths as it enters the 21st century. One is a dependent path; the other is independent. By virtue of a license nurses have authority to practice their profession independently. Yet some nurses, health care policy makers, and administrators of institutions and agencies formulate and implement roles and activities for nurses in order to fulfill the aims of medicine and institutional bureaucracy. This problem "forces" nursing to travel a dependent path. A view is set forth that the problem stems from the collective failure of nursing to articulate and implement a function and product distinct from that of medicine and other professions. Making this distinction is critical to the charting of an independent path. Nursing's past and present are examined in terms of the service nursing does in fact provide for society. This operationally defined role of nursing is presented in marked contrast to the definition of nursing currently being promulgated by the American Nurses' Association. Collective articulation of a distinct function and product are set forth as a prerequisite for nurses to assume professional authority as they practice. This will safeguard consumers of professional nursing as well as the work and future of nursing as an independent profession. (p. 405)

Results of this study indicate very clearly that nurses within the institution studied do not believe that they are practicing nursing as it should be practiced. This group of nurses believe that the independent path as defined by Orlando (1987) is the ideal practice. However, this same group seems to be implementing a dependent role. Again, one solution might be that nursing articulate and implement a function and product distinct from that of medicine and other professions.

E. Recommendations

The following recommendations were derived from analysis of the data attained and should contribute to reducing role discrepancies within nursing.

Nursing education would be advised to plan courses that provide students with more realistic experiences in a hospital setting. The intent of such courses would be to provide students with an opportunity to more closely observe and participate in the real world of staff nursing.

Nursing service administrators should help staff to clearly articulate the role of the professional nurse within individual institutions. The role of the professional vs. the role of the technical nursing

staff in organizations should be made clear. Hospital administrators would be advised to ensure that support departments provide appropriate services, thus preventing nurses from assuming tasks which are clearly non-nursing.

A national plan should be developed by a committee comprised of members from various nursing organizations. Their task would be to address preparation, education, expectations, and levels of nursing practice. Nursing service administrators are advised to assure maximum utilization of modern technology, including electronic data processing and computers, for documentation of patient care. This would help reduce the administrative tasks staff must perform. Nursing service administration might more clearly define the supports needed by nursing staff to assure quality care is provided in the most effective manner, and finally, nursing services would be advised to be organize itself to provide increased support to professional nurses, enabling them to work more effectively.

F. Suggestions for Further Research

This study was limited in that it was purely quantitative in nature. Since data were limited to one institution, results cannot be generalized. Further studies should include numerous and varied institutions from all the areas of the country. Further studies should also include interviews to validate that the perceptions derived from this study are accurate. Literature available reports that nurses are doing many non-nursing functions. Further research to validate that nurses are actually performing non-nursing functions needs to be done. Such studies might investigate the feasibility of others performing non-nursing tasks. Findings of this study might also be validated using observational techniques. A research project should be developed which could use measures of congruity between work expectations and actual work. Since role discrepancy is known to cause job dissatisfaction, it would be beneficial to conduct role and satisfaction studies concurrently. Interviews should be done to ascertain why nurses perceived that they are not practicing what they believe is ideal nursing practice. Research might also address adaptive strategies for nurses to utilize which might help them deal with role disparity or confusion.

G. Conclusion

Findings in this study suggest that role discrepancy is as significant as indicated within much of the literature. Literature also supports that role ambiguity results in dissatisfaction and turnover. Clearly, there is much work to be done concerning role clarification if nurses are to become satisfied with their professional practice.

In conclusion, findings of this study supported the numerous writings which discussed the confusion between role expectations and role performance. Beyers (1987) stated that nursing, to remain viable and to be viewed as a principle contributor to the system, must develop a set of commonly understood terms or definitions that accurately describe what nurses do. Comprehensive definitions can flow only from an acknowledgement of what it is that is being defined. Murphy (1971) related that the professional nurse becomes imbued with a rather specific orientation toward particular functions as a practitioner in the ideal. This orientation frequently contradicts the prevailing orientation of the actual work situation, which tends to follow a bureaucratic/task orientation. Attempts to merge the

antithetical work orientations often results in role conflict. It has been suggested that a new synthesis might occur as a result of the interaction between role expectations and role perceptions (Murphy, 1971). The attention of practitioners, as well as researchers, needs to be directed to accommodate such interactions. Attention also needs to be directed toward the conflicts which are potential problems. Within this framework new knowledge might be derived which has implications for the actual practice of nursing.

APPENDICES

APPENDIX A

NURSING ROLE CONCEPTIONS

INSTRUCTIONS: This section consists of a list of 35 situations in which a nurse might find herself. You are asked to indicate both:

(A) The extent to which you think the situation should be the ideal for nursing.

(B) The extent to which you think the situation actually exists in the hospital.

Notice that two statements require answers for each situation. Consider the statements of what should be the case and of what is actually the case separately; try not to let your answer to one statement influence your answer to the other statement. Give your opinions; there are no "wrong" answers.

Indicate the degree to which you agree or disagree with the statement by circling one of the alternative answers ranging from STRONGLY AGREE - #1, AGREE - #2, UNDECIDED - #3, DISAGREE - #4, and STRONGLY DISAGREE - #5.

STRONGLY AGREE	Indicates that you agree with the statement with almost no exceptions.
AGREE	Indicates that you agree with the statement with some exceptions.
UNDECIDED	Indicates that you could either "agree" or "disagree" with the statement with about an equal number of exceptions in either case.
DISAGREE	Indicates that you disagree with the statement with some exceptions.
STRONGLY DISAGREE	Indicates that you disagree with the statement with almost no exceptions.

DEMOGRAPHIC QUESTIONS

Please check the response appropriate for you.

AGE:
_____ 20 - 25
_____ 26 - 35
_____ 36 - 45
_____ 46 - 55
_____ 56 - 65
_____ 66+

SEX: _____ M _____ F

EMPLOYMENT:

_____ Inpatient
_____ ICU/ED/NELF/Dialysis
_____ Administration/ Management

POSITION:

_____ Staff Nurse
_____ Nurse Administrator/Manager

LENGTH OF SERVICE AT THIS INSTITUTION:

_____ Less than 1 year
_____ 1 - 5 years
_____ 6 - 10 years
_____ More than 10 years

LENGTH OF SERVICE IN NURSING:

_____ Less than 1 year
_____ 1-4 years
_____ 5-9 years
_____ 10-14 years
_____ 15-19 years
_____ 20-24 years
_____ 25-29 years
_____ 30-34 years
_____ 35-39 years
_____ 40-44 years
_____ 45-49 years
_____ 50+ years

EDUCATION: Basic Nursing Education

_____ Diploma
_____ ADN
_____ BSN
_____ MSN
_____ Ph.D.

OTHER:_____
(specify)

EDUCATION: Highest Degree Earned

_____ AD
_____ BS/BA
_____ MS/MA
_____ Ph.D.

OTHER:_____
(specify)

HERE IS AN EXAMPLE		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
Professional nurses in Hospital Z consider the patient's physical, social, and psychological needs when developing a plan of care.						
A. This is what nurse <u>should do</u>.	A.	1	2	3	4	(5)
B. This is what nurses <u>actually do</u>.	B.	1	(2)	3	4	5

BE SURE TO PLACE A CHECK MARK AFTER <u>BOTH</u> STATEMENTS <u>A AND B</u> ACCORDING TO YOUR DEGREE OF AGREEMENT WITH IT...

STITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
1. A professional nurse who is frequently late for work is not being considered for promotion even though she meets position expectations in every other respect.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
2. A professional nurse tries to incorporate her professional ideals and standards into her practice even though they sometimes conflict with hospital regulations.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
3. The nurse manager insists that the rules be followed at all times even if some do not seem practical.						
A. This is what <u>should be done</u>.	A.	1	2	3	4	5
B. This is what is <u>actually done</u>.	B.	1	2	3	4	5
4. Professional nurses at Hospital A spend the majority of their work time providing direct patient care.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
5. A professional nurse refuses to carry out any task or procedure that she believes is not in the best interest of her patient.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
6. Professional nurses are expected and encouraged, based on their unique relationship with the patient, to share as much information about their condition as they believe best for the patient.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
7. Nurse managers, when evaluating professional nurses for promotion, consider length of experience on the job to be the most important factor.						
A. This is what <u>should be done</u>.	A.	1	2	3	4	5
B. This is what is <u>actually done</u>.	B.	1	2	3	4	5
8. A professional nurse observes that another nurse has repeatedly ignored an important hospital rule and reports the finding to the nurse manager.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
9. A professional nurse tries to comply with professional standards even though at times her actions are resented by her peers.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
10. In Hospital C a physician ordered a patient to be up in a chair three times a day. The professional nurse caring for the patient believes that the patient is ready to advance to ambulating. The nurse discusses her opinion with the physician.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
11. When a nurse is considered for promotion, her ability to make decisions and plan care based upon patient needs and scientific principles is weighed strongly.						
A. This is what should be done.	A.	1	2	3	4	5
B. This is what is actually done.	B.	1	2	3	4	5
12. A nurse manager believes that professional nurses can assist patients to recover more quickly by helping to alleviate the fears troubling them. Therefore, nurses are rewarded for spending time talking with patients about their concerns.						
A. This is what should be done.	A.	1	2	3	4	5
B. This is what is actually done.	B.	1	2	3	4	5
13. A professional nurse should always ascertain the patient's understanding of the reason for hospitalization before planning nursing care.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
14. A professional nurse should stand up for him/herself and defend nursing actions with sound reasoning and principles.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
15. Since it is a hospital rule, the professional nurse completes a patient classification tool on every patient she cares for regardless of how busy she is.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
16. A professional nurse substitutes one multi-vitamin preparation for another when temporarily out of stock.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
17. A professional nurse administers a narcotic to a patient who is in pain even though the automatic 72 hour limit on the narcotic has expired.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
18. A professional nurse begins passive exercises to the extremities of a patient who has had a stroke, without a physician's order.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
19. The professional nurse delays treatments ordered by physicians for patients to facilitate patient education activity.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
20. At Hospital X, the hospital policy dictates that the admission data base be completed by a professional nurse. A professional nurse, because she is busy, allows a practical nurse to complete the data base for her and then signs it.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
21. Professional nurses decide whether or not a patient can shampoo his/her hair without a physician's order.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
22. Hospital X is being sued. A professional nurse has been asked to voluntarily offer testimony. She refuses to testify against the hospital because it is her place of employment.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
23. Professional Nurse A always instructs the patient regarding the side effects of medications.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
24. A professional nurse sees other personnel stealing linen and other supplies. She reports this to her supervisor.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
25. A professional nurse brings a list of her strengths and learning needs to the evaluation conference with her nurse manager.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
26. The physician orders a vital sign check every four hours. This patient has been afebrile for 48 hours. The nurse arrives to take his 0200 temperature. The patient is asleep. The nurse decides to let the patient sleep.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
27. According to hospital policy, medications are ordered three times a day: 0900, 1300, and 1700. A patient requests Professional Nurse X to give him his medications with meals which are served at 0800, 1200, and 1800. The professional nurse does not deviate from hospital policy.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
28. Hospital policy states that diet orders must be written by a physician. The physician has not written an order and is unavailable in the operating room. The professional nurse does not deviate from hospital policy.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
29. Although (s)he believes LPN's and nurse extenders can do more, the professional nurse limits the assigned duties of these support personnel to those tasks which are described in their respective job descriptions.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
30. The professional nurse at Hospital A establishes goals for nursing care with input from physicians and families.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
31. A professional nurse includes family members in discharge planning conference.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
32. The professional nurse recognizes that she is responsible for communicating with peers when they do not follow through on the plan initiated.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
33. When providing information to patients about commercial products, a professional nurse describes a variety of similar products so that a patient can make his/her own decision.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
34. Hospitals in this state are implementing multiple cost reduction strategies including giving absolutely no supplies to patients leaving the hospital. Although the professional nurse knows that Mrs. B. has no insurance, she/he decides to adhere to the rules.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
35. Hospital policy states that only registered nurses can write care plans. Therefore, Professional Nurse A always writes care plans herself although other personnel are qualified to do this.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

APPENDIX B

COVER LETTER TO QUESTIONNAIRE

March 23, 1990

Dear Staff Nurse:

I am a doctoral student at UMMC conducting a study concerning the role of the nurse in the hospital setting. You may be aware of the fact that there are numerous definitions of bedside nursing. The purpose of my particular study is to gain an understanding of the actual role vs. the ideal role in nursing practice as perceived by staff and nurse administrators. The information I obtain will facilitate the development of nursing not only at UMMC, but also at the state and national level.

As part of this study, I am asking you to complete the attached questionnaire. It is important for you to understand that you are being asked to evaluate each question from two perspectives: what <u>should</u> occur in the practice of nursing, and what <u>actually</u> does occur in the practice of nursing. Try not to let your answer to one statement influence your answer to the other statement.

This is not a test. There are no right or wrong answers. Please answer the questions the way you really think. There is no place for your name. Please do not sign the questionnaire. Your answers are to be anonymous. No benefit, risk, or change in status is associated with your filling out this questionnaire. Your responses will be reviewed by the investigator and will be analyzed along with those of the other respondents from other units. Any reports from the combined questionnaires will include summaries of the data and in no way will identify individual responses.

Please place your completed questionnaire in the letter-sized envelope provided for your use and seal it. This envelope should then be placed in the attached interoffice envelope addressed to me and placed in the nurse manager's mail box. Please do this by Friday, April 6, 1990.

Needless to say, your cooperation is essential if the study is to be successful. Your willingness to take valuable time for this research is certainly appreciated. I plan to share the information gathered from this study with the nursing staff. I hope you will find this an interesting experience. Your completing the questionnaire will serve as consent to participate in the study.

Thank you very much for your cooperation and participation.

Sincerely,

Anne Bourgeois, RN, M.Ed., MSN
Executive Director of Nursing
(508) 856-4937

APPENDIX C

ROLE CONCEPTION INVENTORY

Instructions. The statements which follow are being considered for inclusion in a Role Conception Inventory. Please assist us in reviewing the content of the statements by providing two ratings for each statement. The conceptual definitions of the categories which the statements are supposed to reflect as well as the rating instructions are listed below.

Categories and Definitions

I. **Bureaucratic Role Conception** - items which measure such characteristics as adherence to fixed rules, punctuality, the importance of tenure, the loyalty to hierarchy of authority in the hospital.

II. **Professional Role Conception** - items which measure commitment to technical, ethical, and educational standards of a profession, items measuring a commitment to knowledge as the basis of a profession, and items which measure the ability to use judgment and power in making decisions regarding nursing care.

III. **Service Role Conception** - items which measure loyalty to the patient as a unique human being. Service items stress such ideals as service to humanity, a willingness to teach patients about their conditions, and a desire to do "bedside" nursing.

Rating Tasks

A. Please indicate the category that each statement best fits by circling the appropriate numeral. (Statements not fitting any category should be placed in Category IV).

B. Please indicate how strongly you feel about your placement of the statement into the category by circling the appropriate number as follows:

1 no question about it
2 strongly
3 not very sure

Statements	Categories	Rating
1. A professional nurse who is frequently late for work is not being considered for promotion even though she meets position expectations in every other respect.	I II III IV	1 2 3
2. A professional nurse tries to incorporate her professional ideals and standards into her practice even though they sometimes conflict with hospital regulations.	I II III IV	1 2 3
3. The nurse manager insists that the rules be followed at all times even if some of them do not seem practical.	I II III IV	1 2 3
4. Professional nurses at Hospital A spend the majority of their work time providing direct patient care.	I II III IV	1 2 3
5. A professional nurse refuses to carry out any task or procedure that she believes is not in the best interest of her patient.	I II III IV	1 2 3
6. Professional nurses are expected and encouraged, based upon their unique relationship with the patient, to share as much information about their condition as they believe best for the patient.	I II III IV	1 2 3
7. Nurse managers, when evaluating professional nurses for promotion, consider length of experience on the job to be the most important factor.	I II III IV	1 2 3
8. A professional nurse observes that another nurse has repeatedly ignored an important hospital rule and reports the finding to the nurse manager.	I II III IV	1 2 3

Statements	Categories	Rating
9. Professional nurses subscribe to and read professional journals and publications in order to update their skills and knowledge.	I II III IV	1 2 3
10. A professional nurse tries to comply with professional standards even though at times her actions are resented by her peers.	I II III IV	1 2 3
11. A professional nurse relies on the opinion of physicians and hospital administrators to determine what good nursing practice is.	I II III IV	1 2 3
12. Professional nurses at Hospital C are strongly encouraged to seek baccalaureate and masters degrees and are given preferential consideration when requesting time off for school.	I II III IV	1 2 3
13. In Hospital C a physician ordered a patient to be up in a chair three times a day. The professional nurse caring for the patient believes that the patient is ready to advance to ambulating. The nurse discusses her opinion with the physician.	I II III IV	1 2 3
14. When a nurse is considered for promotion, her ability to make decisions and plan care based upon patient needs and scientific principles is weighed strongly.	I II III IV	1 2 3
15. A nurse manager believes that professional nurses can assist patients to recover more quickly by helping to alleviate the fears troubling them. Therefore, nurses are rewarded for spending time talking with patients about their concerns.	I II III IV	1 2 3

Statements	Categories	Rating
16. A professional nurse should always ascertain the patient's understanding of the reason for hospitalization before planning nursing care.	I II III IV	1 2 3
17. A professional nurse should stand up for him/herself and defend actions with sound reasoning and principles.	I II III IV	1 2 3
18. The professional nurse completes a patient classification tool on every patient she cares for regardless of how busy she is.	I II III IV	1 2 3
19. A professional nurse substitutes one multivitamin preparation for another when temporarily out of stock.	I II III IV	1 2 3
20. A professional nurse administers a narcotic to a patient who is in pain even though the automatic 72 hour limit on the narcotic has expired.	I II III IV	1 2 3
21. A professional nurse begins passive exercises to the extremities of a patient who has had a stroke, without a physician's order.	I II III IV	1 2 3
22. The professional nurse delays treatments ordered by physicians for patients to facilitate patient education activity.	I II III IV	1 2 3
23. At Hospital X, the admission data base is completed by a professional nurse. A professional nurse, because she is busy, allows a practical nurse to complete the data base for her and then co-signs it.	I II III IV	1 2 3
24. Professional nurses decide whether or not a patient can a shampoo their hair without a physician's order.	I II III IV	1 2 3

Statements	Categories	Rating
25. When interviewing for a new job, the professional nurse should give more consideration to salary than to the method used for nursing care delivery.	I II III IV	1 2 3
26. Professional Nurse A is asked to perform a treatment that is used infrequently on her patient care unit. She arranges to have another nurse, experienced in this area, accompany her while she performs the procedure.	I II III IV	1 2 3
27. Hospital X is being sued. A professional nurse has been asked to voluntarily offer testimony. She refused to testify against the hospital because it is her place of employment.	I II III IV	1 2 3
28. Professional Nurse A always instructs the patient regarding the side effects of medication.	I II III IV	1 2 3
29. A professional nurse sees other personnel stealing linen and other supplies. She reports this to her supervisor.	I II III IV	1 2 3
30. A professional nurse brings a list of her strengths and learning needs to the evaluation conference with her nurse manager.	I II III IV	1 2 3
31. The professional nurse is scheduled for lunch at 1200. She finds that her patient is scheduled to return from the operating room at 1200. She decides to postpone her lunch and wait for her patient to return.	I II III IV	1 2 3
32. The physician orders vital sign check every four hours. This patient has been afebrile for 48 hours. The nurse arrives to take his 0200 temperature. The patient is asleep. The nurse decides to let the patient sleep.	I II III IV	1 2 3

Statements	Categories	Rating
33. According to hospital policy, medications are ordered three times a day: 0900, 1300, and 1700. A patient requests Professional Nurse X to give him his medications with meals which are served at 0800, 1200, and 1800. The professional nurse does not deviate from hospital policy.	I II III IV	1 2 3
34. Hospital policy states that diet orders must be written by a physician. The physician has not written an order and is unavailable in the operating room. The professional nurse does not deviate from hospital policy.	I II III IV	1 2 3
35. Professional nurses on Unit X subscribe to the Journal of Nursing Research.	I II III IV	1 2 3
36. The professional nurse on Unit A always follows the guidelines prescribed by the ANA Code of Ethics for nurses when confronted with ethical problems in their practice.	I II III IV	1 2 3
37. A professional nurse discovers a medication error made by another nurse. She reports this to the nurse involved.	I II III IV	1 2 3
38. The professional nurse limits assigned duties of practical nurses, nurse extenders, and nursing assistants to those tasks which are described in their respective job descriptions.	I II III IV	1 2 3
39. The professional nurse has finished her assignment and is relieved by another professional nurse. There is one-half hour left to the shift. This professional nurse leaves.	I II III IV	1 2 3
40. Professional nurses on Unit X, as a group, determine lunch and coffee assignments.	I II III IV	1 2 3

Statements	Categories	Rating
41. A professional nurse notices that another nurse is avoiding assignments to an AIDS patient. She addresses this issue with her nurse manager.	I II III IV	1 2 3
42. Professional nurses at Hospital X are involved in determining the policies and standards for nursing care.	I II III IV	1 2 3
43. Professional Nurse A refuses to accept a temporary reassignment to a special unit to which she has not been oriented.	I II III IV	1 2 3
44. A professional nurse decides when a patient needs someone to help bathe him.	I II III IV	1 2 3
45. The professional nurse at Hospital A establishes goals for nursing care with input from physicians and families.	I II III IV	1 2 3
46. A professional nurse includes family members in discharge planning conference.	I II III IV	1 2 3
47. A professional nurse recognizes that she is responsible for communicating with peers when they do not follow through on the plan initiated.	I II III IV	1 2 3
48. The hospital supports nurses who present papers on research at conferences by providing financial support for travel.	I II III IV	1 2 3
49. When providing information to patients about commercial products, a professional nurse describes a variety of similar products so that the patient can make his/her own decision.	I II III IV	1 2 3

Statements	Categories	Rating
50. Hospitals in this state are not reimbursed for patient care unless the patient is discharged within the appropriate number of days. After visiting with the patient, the physician has written a discharge order and has authorized that patient wait for her family in the discharge lounge. The professional nurse disagrees with the concept of the discharge lounge. Therefore, she allows the patient to wait in her room until the family arrives.	I II III IV	1 2 3
51. Hospitals in this state are implementing multiple cost reduction strategies including giving absolutely no supplies to patients leaving the hospital. Although the professional nurse knows that Mrs. B has no insurance, she/he decides to adhere to the rules.	I II III IV	1 2 3
52. Professional Nurse X always knocks before entering a room.	I II III IV	1 2 3
53. Professional Nurse A always delegates the writing of care plans to practical nurses although hospital policy states that only registered nurses write care plans.	I II III IV	1 2 3
54. Professional nurses in this hospital have the final responsibility of reviewing patient materials on their unit to assure that the information is correct and used properly.	I II III IV	1 2 3
55. A professional nurse has communicated patient care problems for study by nurses to the research committee.	I II III IV	1 2 3

Statements	Categories	Rating
56. A professional nurse notices another nurse in violation of the ANA Code of Ethics. She reports that nurse to an appropriate structure within the State Association.	I II III IV	1 2 3
57. In Hospital X professional nurses support reimbursement by third party payers for nursing services not ordered by physicians.	I II III IV	1 2 3
58. In Hospital A the policy is that the patient will be discharged by 1000. The patient is ready for discharge except that a Discharge Order has not been written. The professional nurse calls the physician for the discharge order.	I II III IV	1 2 3
59. A professional nurse compares her patient's response to criteria selected from an established protocol.	I II III IV	1 2 3
60. Professional nurses at Hospital A are responsible for completing their own time schedule.	I II III IV	1 2 3
61. A professional nurse notices that other professional nurses are avoiding assignments to a specific patient. Since it is a problem patient, it is decided to draw straws to resolve the issue.	I II III IV	1 2 3
62. A professional nurse discovers a medication error made by another nurse. She reports this to the nurse manager.	I II III IV	1 2 3

APPENDIX D

ROLE CONCEPTION INVENTORY

Instructions. The statements which follow are being considered for inclusion in a Role Conception Inventory. Please assist us in reviewing the content of the statements by providing two ratings for each statement. The conceptual definitions of the categories which the statements are supposed to reflect as well as the rating instructions are listed below.

Categories and Definitions

I. **Bureaucratic Role Conception** - items which measure such characteristics as adherence to fixed rules, punctuality, the importance of tenure, the loyalty to hierarchy of authority in the hospital.

II. **Professional Role Conception** - items which measure commitment to technical, ethical, and educational standards of a profession, items measuring a commitment to knowledge as the basis of a profession, items which measure the ability to use judgment and power in making decisions regarding nursing care, and items which measure a willingness to teach patients about their conditions.

Rating Tasks

A. Please indicate the category that each statement best fits by circling the appropriate numeral. (Statements not fitting any category should be placed in Category III).

B. Please indicate how strongly you feel about your placement of the statement into the category by circling the appropriate number as follows:

1 no question about it
2 strongly
3 not very sure

Statements	Categories	Rating
1. A professional nurse who is frequently late for work is not being considered for promotion even though she meets position expectations in every other respect.	I II III	1 2 3
2. A professional nurse tries to incorporate her professional ideals and standards into her practice even though they sometimes conflict with hospital regulations.	I II III	1 2 3
3. The nurse manager insists that the rules be followed at all times even if some of them do not seem practical.	I II III	1 2 3
4. Professional nurses at Hospital A spend the majority of their work time providing direct patient care.	I II III	1 2 3
5. A professional nurse refuses to carry out any task or procedure that she believes is not in the best interest of her patient.	I II III	1 2 3
6. Professional nurses are expected and encouraged, based upon their unique relationship with the patient, to share as much information about their condition as they believe best for the patient.	I II III	1 2 3
7. Nurse managers, when evaluating professional nurses for promotion, consider length of experience on the job to be the most important factor.	I II III	1 2 3
8. A professional nurse observes that another nurse has repeatedly ignored an important hospital rule and reports the finding to the nurse manager.	I II III	1 2 3

Statements	Categories	Rating
9. Professional nurses subscribe to and read professional journals and publications in order to update their skills and knowledge.	I II III	1 2 3
10. A professional nurse tries to comply with professional standards even though at times her actions are resented by her peers.	I II III	1 2 3
11. A professional nurse relies on the opinion of physicians and hospital administrators to determine what good nursing practice is.	I II III	1 2 3
12. Professional nurses at Hospital C are strongly encouraged to seek baccalaureate and masters degrees and are given preferential consideration when requesting time off for school.	I II III	1 2 3
13. In Hospital C a physician ordered a patient to be up in a chair three times a day. The professional nurse caring for the patient believes that the patient is ready to advance to ambulating. The nurse discusses her opinion with the physician.	I II III	1 2 3
14. When a nurse is considered for promotion, her ability to make decisions and plan care based upon patient needs and scientific principles is weighed strongly.	I II III	1 2 3
15. A nurse manager believes that professional nurses can assist patients to recover more quickly by helping to alleviate the fears troubling them. Therefore, nurses are rewarded for spending time talking with patients about their concerns.	I II III	1 2 3

Statements	Categories	Rating
16. The professional nurses at Hospital A are active members of their professional organizations and frequently request time off to attend meetings, even though this may present scheduling problems for the nurse managers.	I II III	1 2 3
17. A professional nurse should always ascertain the patient's understanding of the reason for hospitalization before planning nursing care.	I II III	1 2 3
18. A professional nurse should stand up for him/herself and defend actions with sound reasoning and principles.	I II III	1 2 3
19. The professional nurse completes a patient classification tool on every patient she cares for regardless of how busy she is.	I II III	1 2 3
20. A professional nurse substitutes one multivitamin preparation for another when temporarily out of stock.	I II III	1 2 3
21. A professional nurse administers a narcotic to a patient who is in pain even though the automatic 72 hour limit on the narcotic has expired.	I II III	1 2 3
22. A professional nurse begins passive exercises to the extremities of a patient who has had a stroke, without a physician's order.	I II III	1 2 3
23. The professional nurse delays treatments ordered by physicians for patients to facilitate patient education activity.	I II III	1 2 3

Statements	Categories	Rating
24. At Hospital X, the admission data base is completed by a professional nurse. A professional nurse, because she is busy, allows a practical nurse to complete the data base for her and then co-signs it.	I II III	1 2 3
25. Professional nurses decide whether or not a patient can a shampoo their hair without a physician's order.	I II III	1 2 3
26. When interviewing for a new job, the professional nurse should give more consideration to salary than to the method used for nursing care delivery.	I II III	1 2 3
27. Professional Nurse A is asked to perform a treatment that is used infrequently on her patient care unit. She arranges to have another nurse, experienced in this area, accompany her while she performs the procedure.	I II III	1 2 3
28. Hospital X is being sued. A professional nurse has been asked to voluntarily offer testimony. She refused to testify against the hospital because it is her place of employment.	I II III	1 2 3
29. Professional Nurse A always instructs the patient regarding the side effects of medication.	I II III	1 2 3
30. A professional nurse sees other personnel stealing linen and other supplies. She reports this to her supervisor.	I II III	1 2 3
31. A professional nurse brings a list of her strengths and learning needs to the evaluation conference with her nurse manager.	I II III	1 2 3

Statements	Categories	Rating
32. The professional nurse is scheduled for lunch at 1200. She finds that her patient is scheduled to return from the operating room at 1200. She decides to postpone her lunch and wait for her patient to return.	I II III	1 2 3
33. The physician orders vital sign check every four hours. This patient has been afebrile for 48 hours. The nurse arrives to take his 0200 temperature. The patient is asleep. The nurse decides to let the patient sleep.	I II III	1 2 3
34. According to hospital policy, medications are ordered three times a day: 0900, 1300, and 1700. A patient requests Professional Nurse X to give him his medications with meals which are served at 0800, 1200, and 1800. The professional nurse does not deviate from hospital policy.	I II III	1 2 3
35. Hospital policy states that diet orders must be written by a physician. The physician has not written an order and is unavailable in the operating room. The professional nurse does not deviate from hospital policy.	I II III	1 2 3
36. Professional nurses on Unit X subscribe to the Journal of Nursing Research.	I II III	1 2 3
37. The professional nurse on Unit A always follows the guidelines prescribed by the ANA Code of Ethics for nurses when confronted with ethical problems in their practice.	I II III	1 2 3
38. A professional nurse discovers a medication error made by another nurse. She reports this to the nurse involved.	I II III	1 2 3

Statements	Categories	Rating
39. The professional nurse limits assigned duties of practical nurses, nurse extenders, and nursing assistants to those tasks which are described in their respective job descriptions.	I II III	1 2 3
40. The professional nurse has finished her assignment and is relieved by another professional nurse. There is one-half hour left to the shift. This professional nurse leaves.	I II III	1 2 3
41. Professional nurses on Unit X, as a group, determine lunch and coffee assignments.	I II III	1 2 3
42. A professional nurse notices that another nurse is avoiding assignments to an AIDS patient. She addresses this issue with her nurse manager.	I II III	1 2 3
43. Professional nurses at Hospital X are involved in determining the policies and standards for nursing care.	I II III	1 2 3
44. Professional Nurse A refuses to accept a temporary reassignment to a special unit to which she has not been oriented.	I II III	1 2 3
45. A professional nurse decides when a patient needs someone to help bathe him.	I II III	1 2 3
46. The professional nurse at Hospital A establishes goals for nursing care with input from physicians and families.	I II III	1 2 3
47. A professional nurse includes family members in discharge planning conference.	I II III	1 2 3

Statements	Categories	Rating
48. A professional nurse recognizes that she is responsible for communicating with peers when they do not follow through on the plan initiated.	I II III	1 2 3
49. The hospital supports nurses who present papers on research at conferences by providing financial support for travel.	I II III	1 2 3
50. When providing information to patients about commercial products, a professional nurse describes a variety of similar products so that the patient can make his/her own decision.	I II III	1 2 3

APPENDIX E

NURSING ROLE CONCEPTIONS

INSTRUCTIONS: This section consists of a list of 38 situations in which a nurse might find herself. You are asked to indicate both:

(A) The extent to which you think the situation should be the ideal for nursing.

(B) The extent to which you think the situation actually exists in the hospital.

Notice that two statements require answers for each situation. Consider the statements of what should be the case and of what is actually the case separately; try not to let your answer to one statement influence your answer to the other statement. Give your opinions; there are no "wrong" answers.

Indicate the degree to which you agree or disagree with the statement by circling one of the alternative answers ranging from STRONGLY AGREE - #1, AGREE - #2, UNDECIDED - #3, DISAGREE - #4, and STRONGLY DISAGREE - #5.

STRONGLY AGREE	Indicates that you agree with the statement with almost no exceptions.
AGREE	Indicates that you agree with the statement with some exceptions.
UNDECIDED	Indicates that you could either "agree" or "disagree" with the statement with about an equal number of exceptions in either case.
DISAGREE	Indicates that you disagree with the statement with some exceptions.
STRONGLY DISAGREE	Indicates that you disagree with the statement with almost no exceptions.

HERE IS AN EXAMPLE		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
Professional nurses in Hospital Z consider the patient's physical, social, and psychological needs when developing a plan of care.						
A. This is what nurse should do.	A.	1	2	3	4	(5)
B. This is what nurses actually do.	B.	1	(2)	3	4	5

BE SURE TO PLACE A CHECK MARK AFTER BOTH STATEMENTS A AND B ACCORDING TO YOUR DEGREE OF AGREEMENT WITH IT...

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
1. A professional nurse who is frequently late for work is not being considered for promotion even though she meets position expectations in every other respect.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
2. A professional nurse tries to incorporate her professional ideals and standards into her practice even though they sometimes conflict with hospital regulations.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
3. The nurse manager insists that the rules be followed at all times even if some do not seem practical.						
A. This is what should be done.	A.	1	2	3	4	5
B. This is what is actually done.	B.	1	2	3	4	5
4. Professional nurses at Hospital A spend the majority of their work time providing direct patient care.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
5. A professional nurse refuses to carry out any task or procedure that she believes is not in the best interest of her patient.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5
6. Professional nurses are expected and encouraged, based on their unique relationship with the patient, to share as much information about their condition as they believe best for the patient.						
A. This is what nurses should do.	A.	1	2	3	4	5
B. This is what nurses actually do.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
7. Nurse managers, when evaluating professional nurses for promotion, consider length of experience on the job to be the most important factor.						
A. This is what <u>should be done</u>.	A.	1	2	3	4	5
B. This is what is <u>actually done</u>.	B.	1	2	3	4	5
8. A professional nurse observes that another nurse has repeatedly ignored an important hospital rule and reports the finding to the nurse manager.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
9. Professional nurses subscribe to and read professional journals and publications in order to update their skills and knowledge.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
10. A professional nurse tries to comply with professional standards even though at times her actions are resented by her peers.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
11. In Hospital C a physician ordered a patient to be up in a chair three times a day. The professional nurse caring for the patient believes that the patient is ready to advance to ambulating. The nurse discusses her opinion with the physician.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
12. When a nurse is considered for promotion, her ability to make decisions and plan care based upon patient needs and scientific principles is weighed strongly.						
A. This is what <u>should be done</u>.	A.	1	2	3	4	5
B. This is what is <u>actually done</u>.	B.	1	2	3	4	5
13. A nurse manager believes that professional nurses can assist patients to recover more quickly by helping to alleviate the fears troubling them. Therefore, nurses are rewarded for spending time talking with patients about their concerns.						
A. This is what <u>should be done</u>.	A.	1	2	3	4	5
B. This is what is <u>actually done</u>.	B.	1	2	3	4	5
14. A professional nurse should always ascertain the patient's understanding of the reason for hospitalization before planning nursing care.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
15. A professional nurse should stand up for him/herself and defend nursing actions with sound reasoning and principles.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
16. Since it is a hospital rule, the professional nurse completes a patient classification tool on every patient she cares for regardless of how busy she is.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
17. A professional nurse substitutes one multi-vitamin preparation for another when temporarily out of stock.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
18. A professional nurse administers a narcotic to a patient who is in pain even though the automatic 72 hour limit on the narcotic has expired.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
19. A professional nurse begins passive exercises to the extremities of a patient who has had a stroke, without a physician's order.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
20. The professional nurse delays treatments ordered by physicians for patients to facilitate patient education activity.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
21. At Hospital X, the hospital policy dictates that the admission data base be completed by a professional nurse. A professional nurse, because she is busy, allows a practical nurse to complete the data base for her and then signs it.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
22. Professional nurses decided whether or not a patient can shampoo their hair with a physician's order.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
23. Hospital X is being sued. A professional nurse has been asked to voluntarily offer testimony. She refuses to testify against the hospital because it is her place of employment.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
24. Professional Nurse A always instructs the patient regarding the side effects of medications.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
25. A professional nurse sees other personnel stealing linen and other supplies. She reports this to her supervisor.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
26. A professional nurse brings a list of her strengths and learning needs to the evaluation conference with her nurse manager.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
27. The physician orders vital sign check every four hours. This patient has been afebrile for 48 hours. The nurse arrives to take his 0200 temperature. The patient is asleep. The nurse decides to let the patient sleep.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
28. According to hospital policy, medications are ordered three times a day: 0900, 1300, and 1700. A patient requests Professional Nurse X to give him his medications with meals which are served at 0800, 1200, and 1800. The professional nurse does not deviate from hospital policy.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
29. Hospital policy states that diet orders must be written by a physician. The physician has not written an order and is unavailable in the operating room. The professional nurse does not deviate from hospital policy.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
30. Although s(he) believes LPN's and nurse extenders can do more, the professional nurse limits the assigned duties of these support personnel to those tasks which are described in their respective job descriptions.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
31. Professional nurses at Hospital A are involved in determining the policies and standards for nursing care.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
32. A professional nurse decides when a patient needs someone to help bathe him.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
33. The professional nurse at Hospital A establishes goals for nursing care with input from physicians and families.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		1 Strongly Agree	2 Agree	3 Undecided	4 Disagree	5 Strongly Disagree
34. A professional nurse includes family members in discharge planning conference.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
35. The professional nurse recognizes that she is responsible for communicating with peers when they do not follow through on the plan initiated.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
36. When providing information to patients about commercial products, a professional nurse describes a variety of similar products so that a patient can make his/her own decision.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5
37. Hospitals in this state are implementing multiple cost reduction strategies including giving absolutely no supplies to patients leaving the hospital. Although the professional nurse knows that Mrs. B. has no insurance, she/he decides to adhere to the rules.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

SITUATION		Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5
38. Hospital policy states that only registered nurses can write care plans. Therefore, Professional Nurse A always writes care plans herself although other personnel are qualified to do this.						
A. This is what nurses <u>should do</u>.	A.	1	2	3	4	5
B. This is what nurses <u>actually do</u>.	B.	1	2	3	4	5

APPENDIX F

ROLE CONCEPTION INVENTORY

INSTRUCTIONS:

The statements which follow are included in a Role Conception Inventory. Please assist in reviewing the content of the statement by providing your choice of category for each statement.

Each statement is concerned with the care and welfare of patients. The decisions regarding the care and welfare of patients are based on one of the following:

I. A choice about a patient's care and welfare which would most likely be predominantly based upon the nurse's ethical and morale values.

II. A choice about a patient's care and welfare which would most likely be predominantly based upon the nurse's knowledge and education.

Rating Task:

Please indicate the category of which each statement falls by circling the appropriate numeral. Statement not fitting any category should be placed in Category III.

Statements	Categories
1. A professional nurse tries to incorporate her professional ideals and standards into her practice even though they sometimes conflict with hospital regulations.	I II III
2. Professional nurses at Hospital A spend the majority of their work time providing direct patient care.	I II III
3. A professional nurses refuses to carry out any task or procedure that she believes is not in the best interest of her patient.	I II III
4. Professional nurses are expected and encouraged, based on their unique relationship with the patient, to share as much information about their condition as they believe best for the patient.	I II III
5. A professional nurse tries to comply with professional standards even though at times her actions are resented by her peers.	I II III
6. In Hospital C a physician ordered a patient to be up in a chair three times a day. The professional nurse caring for the patient believes that the patient is ready to advance to ambulating. The nurse discusses her opinion with the physician.	I II III
7. When a nurse is considered for promotion, her ability to make decisions and plan care based upon patient needs and scientific principles is weighed strongly.	I II III
8. A nurse manager believes that professional nurses can assist patients to recover more quickly by helping to alleviate the fears troubling them. Therefore, nurses are rewarded for spending time talking with patients about their concerns.	I II III
9. A professional nurse should always ascertain the patient's understanding of the reason for hospitalization before planning nursing care.	I II III

Statements	Categories
10. A professional nurse should stand up for him/herself and defend nursing actions with sound reasoning and principles.	I II III
11. A professional nurse substitutes one multi-vitamin preparation for another when temporarily out of stock.	I II III
12. A professional nurse administers a narcotic to a patient who is in pain even though the automatic 72 hour limit on the narcotic has expired.	I II III
13. A professional nurse begins passive exercised to the extremities of a patient who has had a stroke, without a physician's order.	I II III
14. The professional nurse delays treatments ordered by physicians for patients to facilitate patient education activity.	I II III
15. At Hospital X, the hospital policy dictates that the admission data base be completed by a professional nurse. A professional nurse, because she is busy, allows a practical nurse to complete the data base for her and then signs it.	I II III
16. Professional nurses decided whether or not a patient can shampoo his/her hair without a physician's order.	I II III
17. Professional Nurse A always instructs the patient regarding the side effects of medications.	I II III
18. A professional nurse brings a list of her strengths and learning needs to the evaluation conference with her nurse manager.	I II III
19. The physician orders a vital sign check every four hours. This patient has been afebrile for 48 hours. nurse arrives to take his 0200 temperature. The patient is asleep. The nurse decided to let the patient sleep.	I II III

Statements	Categories
20. The professional nurse at Hospital A establishes goals for nursing care with input from physicians and families.	I II III
21. A professional nurse includes family members in discharge planning conference.	I II III
22. The professional nurse recognizes that she is responsible for communicating with peers when they do not follow through on the plan initiated.	I II III
23. When providing information to patients about commercial products, a professional nurse describes a variety of similar products so that a patient can make his/her own decision.	I II III

APPENDIX G

INSTITUTION PERMISSION TO CONDUCT STUDY

UNIVERSITY OF MASSACHUSETTS
AMHERST • BOSTON • WORCESTER

UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER
55 LAKE AVENUE NORTH
WORCESTER, MASSACHUSETTS 01605

2-26-90

Dear Anne Bourgeois,

Your research proposal has been received and reviewed by the Research and Evaluation Committee for the Department of Nursing and the following action has been taken:

[ ] Proposal approved for implementation

[ ] Proposal referred for consideration by:

[ ] Committee for Protection of Human Subjects

[ ] Nursing Administration

[✓] Proposal approved for implementation once the following considerations have been addressed:

Suggestion made by the committee to restate wording in regards to development of your tool that it was 'modeled' after another person's tool rather than 'modified' after. Please complete the last two statements on the application in regards to study abstract and findings.

Thank you for considering the University of Massachusetts Medical Center for your research. Please contact us if we can be of further assistance. Good luck in your endeavors.

Sincerely,
Jean Boucher RN, MS, CRTN
Chairperson, Research and Evaluation Committee

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