THE IMPACT OF HEALTH CARE REFORMS ON

COMMUNITY HEALTH NURSES' ATTITUDES
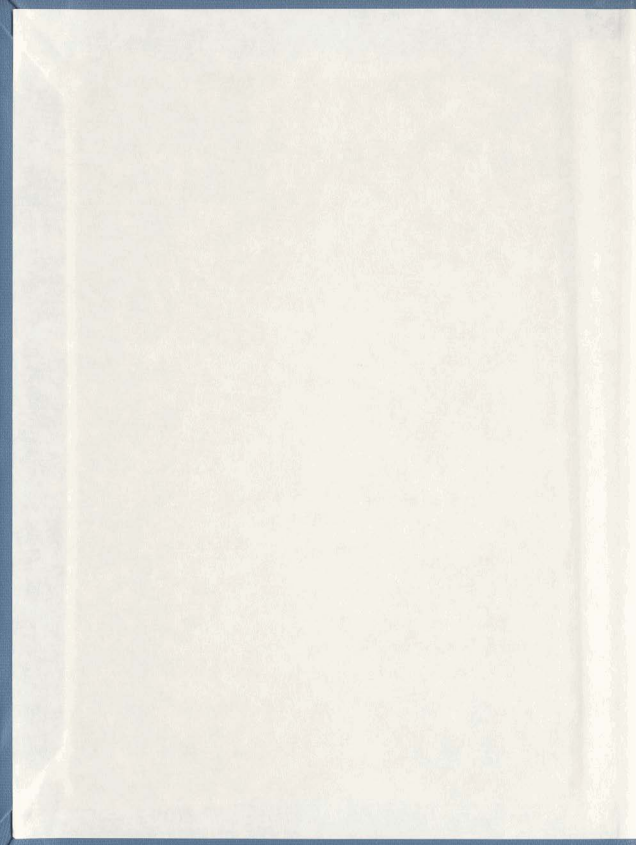
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The Impact of Health Care Reforms on Community Health Nurses' Attitudes

by

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Abstract

A descriptive correlational design was used to investigate community health nurses' perceptions of the impact of health care reforms and their work-related attitudes and behavioral intentions following a period of regionalization of community health services in Newfoundland and Labrador. The relationships between and among the key study variables (i.e., personal characteristics and staffing issues, perceived impact of reforms, work-related attitudes, and behavioral intentions) were also examined. The Conceptual Model of Behavioral Intentions (CMBI) was used as the framework for this study.

The sample consisted of 170 community health nurses (i.e., 151 staff nurses and 19 managers) working with regional health and community services boards. A response rate of 52.8% was achieved. The majority of respondents were female (98.2%) and ranged in age from 25 to 57 years, ($\underline{M}$[1] = 40.66, $\underline{SD}$ ± 7.78). Data collection occurred from October to December, 2000 using a mailed-out questionnaire (i.e., Employee Attitudes Survey).

Study findings indicated that community health nurses were neither totally negative nor positive about the overall impact of health care reforms. Respondents were most negative about the quality of care, emotional climate of

[1] This document follows the style requirements of the fourth edition of the Publication Manual of the American Psychological Association.

the workplace, and safety concerns, and were most positive about the importance of reforms, standards of care, and practice-related issues. Respondents were divided on whether or not they believed that employers had violated psychological contracts, were neither completely satisfied nor dissatisfied with managerial support and interdisciplinary relations since restructuring, were slightly satisfied with their jobs, were slightly committed to their organizations, and were uncertain about whether or not they would stay with current employers. Study findings also demonstrated that community health nurses in management positions were significantly more positive about practice-related issues and standards of care, less likely to perceive psychological contract violations, and more committed to their organizations than staff nurses.

Study findings provided partial support for the major assumptions of the CMBI. All of the reform impact variables (i.e., importance of reforms, emotional climate, practice-related issues, quality of care, safety concerns, and standards of care) were significantly and positively related to the intervening attitudes (i.e., psychological contract violations, restructuring satisfaction, job satisfaction, and organizational commitment) and behavioral intentions (i.e., intent to stay). As well, all of the intervening attitudes depicted moderate to strong, positive correlations with each other and with behavioral intentions. With the exception of job level (i.e., managers vs. staff nurses), most personal characteristics and staffing issues variables did not influence the intervening attitudes. However,

employment status and age were found to influence behavioral intentions.

Contrary to the causal, linear process proposed by the CMBI, study findings failed to confirm organizational commitment as a key predictor of behavioral intentions. During regression analysis, emotional climate surfaced as the key predictor of behavioral intentions. Also, personal characteristics (i.e., age and employment status) emerged as better predictors of behavioral intentions than some intervening attitudes (i.e., restructuring satisfaction and organizational commitment). More specifically, emotional climate of the workplace, job satisfaction, psychological contract violation, age, and employment status combined to explain 53.4% of the variance in behavioral intentions. Similarly, emotional climate surfaced as the best predictor for all intermediate outcomes (i.e., intervening attitudes), with the exception of restructuring satisfaction.

The results of this study support some of the findings from previous research and suggest that health care reforms can have both negative and positive consequences for community health nurses, and their work-related attitudes and behavioral intentions. However, due to study limitations, generalizability of the findings to other community health nurse populations is cautioned. There is a need for further investigation in order to develop a greater insight into other factors possibly influencing community health nurses' work-related attitudes and behavioral intentions.

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CHAPTER 1

Introduction

In response to escalating health care costs in the 1980s, governments and health care organizations have turned to reform strategies such as system downsizing, restructuring, re-engineering, and regionalization. Within the Canadian context, massive health care reforms have been implemented in every province and territory (Attenborough, 1997; Decter, 1997; Jackson, 1995; Shamian & Lightstone, 1997; Vail, 1995). These reforms have resulted in major adjustments in managerial structures, staffing levels, skill-mix, and roles and responsibilities, especially in acute care institutions (Decter; Leatt, Baker, Halverson, & Aird, 1997; Lynch, 1993; Vail).

In the community health sector, the major impetus has been placed on regionalization of health services across Canada. The objective of regionalization is to provide services that address community needs in the most effective and efficient manner possible (Attenborough, 1997; Bruce, 1996; Decter, 1997). In the 1990s, community health organizations were also experiencing a significant paradigm shift, with a greater emphasis being placed on health promotion and disease prevention, increased community participation, and the social determinants of health (Chalmers, 1995; Clarke, Beddome, & Whyte, 1993; Newfoundland [NF] Department of Health, 1994, 1997b; Orchard, Smillie, & Meagher-Stewart, 2000; Reutter & Ford, 1996, 1998).

It is conjectured that nurses, one of the largest groups of health care providers, have been significantly affected by health care reforms. While there has been a gradual increase in research studies examining nurses' perceptions of the impact of reforms in acute care settings, limited research has been conducted with community health nurses. There is some evidence to suggest that community health nurses' concerns are growing about the emotional climate of the workplace, practice-related issues, safety issues, standards of care, and quality of care (Corey-Lisle, Tarzian, Cohen, & Trinkoff, 1999; Parry-Jones et al., 1998; Reutter & Ford, 1998; Shindul-Rothschild, Berry, & Long-Middleton, 1996; Traynor, 1995; Way, 1995). However, little attention has been given to community health reforms and their potential impact on provider outcomes (e.g., psychological contract violation, job satisfaction, organizational commitment, intent to stay, etc.).

The current study complements the research being conducted with health care providers in the acute care sector in Newfoundland and Labrador. The focus of this study was to document community health nurses' perceptions of the impact of health care reforms in the aftermath of regionalization efforts. A second study focus was to determine community health nurses' attitudes (i.e., psychological contract violation, restructuring and job satisfaction, and organizational commitment) toward the work environment and employing organizations, as well as their behavioral intentions (i.e., intent to stay).

Background and Rationale

The main objective of regionalization is to promote better coordination of local services (Decter, 1997; Shamian & Lightstone, 1997). Efforts have been directed toward attaining a seamless system by integrating hospital and community services. The objective of these endeavors is to consolidate hospital services and expand community-based services (Chalmers, 1995; Decter; Shamian & Lightstone). Unfortunately, there has not been a corresponding increase in community-based services to keep pace with decreased institutional services, especially in terms of nursing staff levels and funding (Attenborough, 1997; Jackson, 1995; Shamian & Lightstone; Vail, 1995).

Research on community health nurses suggest that reforms have had far-reaching effects, ranging from decreased job security, decreased morale, increased stress and frustration to decreased job satisfaction (Corey-Lisle et al., 1999; Ellenbecker & Warren, 1998; Parry-Jones et al., 1998; Rafael, 1999; Reutter & Ford, 1998; Traynor, 1995; Way, 1995). Other studies have identified positive outcomes of health care reforms, such as new and challenging roles, more staff and client involvement in decision-making, greater community involvement, better interdisciplinary approaches to care, and greater staff empowerment (Corey-Lisle et al.; Ellenbecker & Warren; Reutter & Ford, 1998).

Despite some inconsistencies between studies, the findings suggest that multiple factors (i.e., job-related, work environment, and personal characteristics)

exert separate and interactive effects on provider outcomes. Meta-analyses of studies conducted with nurses working in acute care settings provide evidence for the much stronger influence of job-related and work environment factors on job satisfaction than economic or psychological/individual factors (Blegen, 1993; Irvine & Evans, 1995). Studies exploring the job satisfaction of community health nurses have supported some of the findings reported by Blegen and Irvine and Evans. Specifically, autonomy, empowerment, close nurse-client relationships, satisfaction with peers and supervisors, social support, self-esteem, prestige, and job importance have been identified as some of the key factors influencing the job satisfaction of community health nurses (Cumbey & Alexander, 1998; Dunkin, Juhl, Stratton, Geller, & Ludtke, 1992; Juhl, Dunkin, Stratton, Geller, & Ludtke, 1993; Lucas, McCreight, Watkins, & Long, 1988; Lynch, 1994; Moore & Katz, 1996; Parahoo & Barr, 1994; Riordan, 1991; Rout, 2000; Savorgnani, Haring, & Galloway, 1993; Stewart & Arklie, 1994). Similar factors have been found to impact upon community health nurses' intent to stay (Dunkin et al.; Hughes & Marcantonio, 1991).

According to Mueller and Price's (1990) model of employee turnover, the strongest determinants of nurse turnover are job satisfaction, organizational commitment, and intent to stay. There is also strong support in the research literature for the presence of significant relationships among job satisfaction, organizational commitment, and intent to stay (Blegen, 1993; Borda & Norman,

1997; Irvine & Evans, 1995; Parasuraman, 1989). Limited research support exists in the business literature for the influence of perceived violations of psychological contracts (i.e., employee perception that the employer has violated the terms of the informal agreement forged between both parties upon hiring) on levels of job satisfaction, organizational commitment, and intent to stay (Robinson & Rousseau, 1994; Turnley & Feldman, 1998, 1999). Given the tremendous costs of nurse turnover in relation to employee morale, quality of client care delivered, and the success of new programs and services, information on the impact of health care reforms on employee attitudes and behaviors is crucial. However, research of this nature is limited, especially in community health settings. There is an obvious need for further research in this area.

Problem Statement

Prior to regionalization and restructuring in the community health sector, the authority for public health services rested solely with the government (J. Dawe, personal communication, October 24, 2000). In an attempt to strengthen local health services and curtail costs, the Government of Newfoundland and Labrador devolved authority to newly formed regional community health boards (J. Dawe, personal communication, October 24, 2000; NF Department of Health, 1994, 1997a). Between 1993 and 1996, regional boards assumed responsibility for coordinating, managing and delivering community-based services within their

respective geographical areas. During this time, regional institutional boards were also established to manage acute care services (Davis, 1998/1999).

In addition to decentralization of authority, centralization was a major component of regionalization. More specifically, regional community health boards replaced traditional public health units and merged existing programs, such as continuing/home care and drug dependency under one umbrella (NF Department of Health, 1994). As well, the home support program for seniors was transferred from the Department of Social Services to the Department of Health, and ultimately, to regional community health boards; and, personal care homes were transferred to the health boards (NF Department of Health, 1997b). Finally, the Department of Social Services was integrated with the Department of Health in April of 1998, forming the Department of Health and Community Services. Further devolution of authority to the board level occurred as a result of this integration, and regional community health boards were replaced by regional health and community services boards.

Only one local study on registered nurses' perceptions of health care reforms included community health nurses in the sample (Way, 1995). It was interesting to note that while most respondents to the 1995 survey were neither negative nor positive about the overall impact of health care reforms, community health nurses tended to be more positive than their counterparts working in other clinical areas. While the 1995 study provided useful baseline data, there is no

comparable information on how community health nurses perceive the impact of these reforms today.

In a prospective, longitudinal study, Parfrey and colleagues are currently exploring the impact of restructuring on employees (i.e., registered nurses, licensed practical nurses, allied health professionals, physicians, managers, and support workers) working in acute care hospitals in Newfoundland and Labrador. Preliminary findings from data collected in June 1999 indicated a significant worsening of nurses' attitudes toward the overall impact of reforms since 1995 (Way & Gregory, 2000). Respondents were most negative about quality of care, emotional climate, and standards of care. Study findings also demonstrated that nurses felt that psychological contracts had been violated, were generally dissatisfied with most aspects of restructuring, were neither totally satisfied nor dissatisfied with their jobs, had a slightly low or neutral level of commitment to their organizations, and were uncertain about whether they would stay with current employers.

It has been suggested that even though reforms are implemented with good intentions, the disadvantages of such changes may outweigh the advantages in the early years of reforms (Davis, 1998/1999; Lewis et al., 2001; Lomas, Woods, & Veenstra, 1997). The challenge for many nurses is to continue to provide quality care while trying to deal with the stress and uncertainty of a work environment undergoing extensive reform. While there is a

growing research base on factors influencing the job satisfaction of community health nurses, there are limited research studies exploring the impact of health care reforms on their work-related attitudes and behavioral intentions. The present study was designed to address some of these concerns (i.e., community health nurses' perceptions of the impact of reforms and their work-related attitudes and behavioral intentions) within the proposed Conceptual Model of Behavioral Intentions (CMBI).

The CMBI is based on the integrated causal model of nurse turnover behaviors (Mueller & Price, 1990; Price & Mueller, 1986) and the consequences of psychological contract violations (Turnley & Feldman, 1998, 1999). The CMBI identifies several factors which influence behavioral intentions (i.e., intent to stay). These factors include determinants (i.e., impact of health care reforms or job-related and work environment factors), covariates (i.e., intervening attitudinal states which include psychological contract violations, restructuring satisfaction, job satisfaction, and organizational commitment), and correlates (i.e., select personal characteristics and staffing issues). The covariates also constitute the intermediate outcomes which exert a direct and indirect effect on behavioral intentions, similar to the determinants. The proposed relationships among study variables are outlined in the research questions.

Purpose and Research Questions

The purpose of the current study was to investigate community health nurses' perceptions of the impact of reforms and work-related variables following a period of regionalization of community health services in Newfoundland and Labrador. A second purpose was to identify the predictors of intermediate outcomes and behavioral intentions.

This study was designed to address the following questions:

1. How do nurses working in community health settings currently perceive the impact of health care reforms (i.e., importance of reforms, emotional climate, practice-related issues, quality of care, safety concerns, and standards of care)?

2. What are community health nurses' levels of psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and behavioral intentions (i.e., intent to stay)?

3. Are the impact of health care reform variables significantly related to intermediate outcomes (i.e., psychological contract violation, restructuring satisfaction, job satisfaction, and organizational commitment), and behavioral intentions?

4. Are there significant relationships between intermediate outcomes and behavioral intentions?

5. Are perceptions of the impact of health care reforms, intermediate outcomes, and behavioral intentions a function of key personal characteristics (i.e., age, gender, education, region of employment, primary area of responsibility, current position, nursing experience, current position tenure, and employment status) and staffing issues (i.e., district caseload, absenteeism due to sick leave, and staffing adequacy)?

6. What factors investigated in the current study are the best predictors of intermediate outcomes and behavioral intentions?

CHAPTER 2

Literature Review

Health care reforms have created massive changes in the Canadian health care system. In order to appreciate the impact of these reforms on community health nurses, greater insight is needed into factors influencing provider outcomes. This literature review is divided into four sections. The first section presents a discussion of the overall implications of health care reforms for community health services. The second section presents an overview of the impact of health care reforms on provider outcomes. The third section presents a review of the literature dealing with factors influencing community health nursing outcomes, (i.e., psychological contract violation, job satisfaction, organizational commitment, and intent to stay). The last section consists of a discussion of the conceptual framework for this study.

Health Care Reforms: Implications for Community Health

Health care reforms have far-reaching effects on health care organizations that are striving to balance the quality of care with the cost of providing care. The reform strategies of downsizing, re-engineering, restructuring, and regionalization have been implemented by health care organizations across Canada. Despite the pervasiveness of such reforms, little attention has been given to their potential impact on organizational, provider, and

client outcomes, especially for the community health sector. The discussion that follows provides an overview of the reforms that have occurred in community health settings at the national and provincial levels. A brief summary is also provided on the experiential data and research findings that address some of the consequences of health care reforms.

National Level

Many of the health care reforms in the community health sector have been driven by the overall climate of financial restraint in Canada. Regionalization was the most common reform strategy adopted by Canadian provinces (Attenborough, 1997; Decter, 1997; Lomas, Woods, et al., 1997; Vail, 1995). This downsizing strategy has been dominated by institutional and community board mergers or consolidations in a defined geographic region directed toward enhancing the coordination of local services (Decter; Lomas, Woods, et al.; Shamian & Lightstone, 1997).

Decentralization is characteristic of regionalization, with decision-making authority devolved to the local level from provincial governments (Lomas, Woods, et al., 1997). Local health authorities are expected to have a better understanding of their region's health needs and greater success in fostering public participation. It has also been conjectured that regionalization will result in more effective and efficient use of health care dollars, while at the same time

deliver more comprehensive health care services. Despite the wide-spread use of regionalization, more research is needed to address important issues. Vail (1995) suggested that special attention should be given to appropriate funding levels for variant population sizes across regions, determining the appropriate balance between local autonomy and provincial control, how well the goals of regionalization are being met, and the resulting impact on organizational, client, and provider outcomes.

The movement to streamline hospital services and expand community-based services is driven by the operant mandate to have a more efficient and effective integration of all health care services (Chalmers, 1995; Shamian & Lightstone, 1997). This shift in focus has resulted in reduced inpatient capacity and shorter hospital stays (Decter, 1997; Shamian & Lightstone). With a greater emphasis on the delivery of home care services to diverse groups with increasingly complex needs, less time and resources are available to community-based providers for other practice roles such as health promotion and community development activities (Chalmers). There has also been a reduction in certain community health nursing services, with some provinces eliminating home visiting of all first time mothers and infants due to questionable cost-effectiveness (Chalmers).

It has been questioned whether adequate funds have been transferred to the community health sector to support the increasing acuity levels of clientele

(Attenborough, 1997; Jackson, 1995; Shamian & Lightstone, 1997; Vail, 1995). Some authors have cautioned that unless community services are established to meet the needs of clients who are discharged early, hospitals may experience a revolving-door phenomenon of readmissions (Shamian & Lightstone).

Provincial Level

Dramatic changes have occurred over the past decade in the community health care delivery system in Newfoundland and Labrador. It was during the early 1990s that the province, challenged by a weak economy and decreased federal transfer payments, earnestly began to address the health care funding crisis (J. Dawe, personal communication, October 24, 2000; NF Department of Health, 1994). Regionalization was the dominant health care reform strategy adopted by the Government of Newfoundland and Labrador (Davis, 1998/1999; J. Dawe, personal communication, October 24, 2000; NF Department of Health, 1994). According to Government legislation passed on January 1, 1994, regional community health boards were solely responsible for fulfilling the community health mandate (i.e., health promotion, health protection, continuing care, mental health, and addictions services) (J. Dawe, personal communication, October 24, 2000; NF Department of Health, 1997a).

Regional community health boards were seen as a means of improving the quality of health care delivered in the province (NF Department of Health,

1994). The decision was made to have separate community and institutional boards, except in Northern regions with large geographic areas and sparse populations where the boards were combined (Davis, 1998/1999; Davis & Tilley, 1996). The rationale for this separation was based on the importance attached to promoting health and preventing disease (J. Dawe, personal communication, October 24, 2000; NF Department of Health, 1997a).

Four regional community health boards were formed under *The Department of Health Act*. The St. John's Regional Community Health Board was formed in September 1993 and merged three distinct service providers: the St. John's & District Health Unit, the St. John's Home Care Program, and St. John's Drug Dependency Services. The Central Regional Community Health Board was formed in February 1994, which merged the Central Newfoundland Public Health Unit, the Gander and District Continuing Care Program, and the Drug Dependency Services (NF Department of Health, 1994). Establishment of the remaining boards followed with the formation of the Eastern Regional Community Health Board in April 1995 (H. Lawlor, personal communication, March 2001), and the Western Regional Community Health Board in January 1996 (J. Rumboldt, personal communication, October 2001). In January of 1995, two additional regional health boards were formed and made responsible for both institutional and community health services (i.e., Grenfell Regional Health Services Board and Health Labrador Corporation) (NF Department of

Health, 1997b).

Health care reform continued in the community health sector in April 1995 with the transfer of the home support program for seniors from the Department of Social Services to the Department of Health (NF Department of Health, 1997b). The regional community health boards are now delivering this program. In addition, personal care homes, previously administered by the Department of Health, were transferred to the health boards as part of their continuing care program in July 1996 (NF Department of Health, 1997b). These programs are now accessed through the single entry system using a standardized assessment process.

Regional community health boards use a wellness model of health and endorse a population health approach which addresses all the factors that determine health: income and social status, social support networks, education, biology, genetics, the environment, and the formal health system (NF Department of Health, 1997b). Supporting a population health approach, further health care reform for the community health care sector continued on April 1, 1998 with the integration of major components of the Department of Social Services with the Department of Health to form the Department of Health and Community Services. As a result of this change, Child Welfare and Community Corrections Services (Open Custody), and Family and Rehabilitative Services were transferred to and delivered under the regional community health boards,

thus expanding their mandate (NF Department of Health, 1997b). This integration provided clients with a coordinated, single entry access to services.

Empirical Data

Limited empirical research has been conducted to assess the implications of health care reforms for the community health sector. Most research has focused on downsizing, restructuring, and re-engineering reform strategies in the acute health care sector in Canada (Decter, 1997; Jackson, 1995; Leatt et al., 1997; Shamian & Lightstone, 1997). The following discussion summarizes the perceived impact of reforms from representatives of both institutional and community health boards across Canada.

In a commentary on health care reforms in Newfoundland and Labrador, Davis (1998/1999), the Chief Executive Officer with the Health Care Corporation of St. John's, identified the positive outcomes of regionalization as greater autonomy, accountability, staff involvement in decision-making, community involvement, and ability to use resources more wisely. In contrast, increased anxiety and uncertainty among staff and physicians, and the stress of limited financial resources to meet identified needs were noted as some of the negative outcomes.

Lomas, Woods, et al. (1997) conducted a review of the devolution of authority for health care in each Canadian province via a mail survey of

members ($\underline{N}$ = 514) of 62 boards in five provinces (three with established boards and two with immature boards). The findings indicated that all provinces, with the exception of Ontario, were at various stages of decentralizing decision-making authority to local health boards. It was noted that most boards had limited authority and were unable to determine core services or raise funds for service financing. In addition, the authors reported that the degree of allocated authority across provincial jurisdictions varied from low to high (i.e., deconcentration, decentralization, and devolution, respectively). The authors concluded that most boards fall within the deconcentration or decentralization categories, and are forced to deal with the competing demands of three parties (i.e., government, provider groups, and the community).

In a subsequent article, Lomas, Veenstra, and Woods (1997a) reported on the backgrounds, resources, and activities of board members. The findings revealed that respondents were mostly employed in sectors other than health care or social services and had previous experience on some type of board. Respondents also rated their orientation and training in general governance strategies (i.e., roles and responsibilities, and effective participation) considerably better than health-related matters (i.e., priority setting, health care needs assessment, and health care legislation and guidelines). As well, the most available information for decision-making was related to service costs and utilization, while the least available information was related to key informants'

opinions, service benefits, and citizens' preferences. Finally, board activity was dominated by setting priorities and assessing needs, followed by ensuring effectiveness and efficiency of services. What is significant about these findings is that board members were inadequately prepared (i.e., educational and experiential backgrounds) to deal with important issues within their mandate.

Lomas, Veenstra, and Woods (1997b) also reported on the motivation, attitudes and approaches of board members. Survey results indicated that the board members' main concern was with the inadequacy of data for decision-making, even though most felt that they made good decisions which were superior to those previously made by the provincial government. While board members were equally divided in their attitudes toward their respective provincial governments (i.e., restrictive nature of provincial rules), most believed that their priority was to represent and to be accountable to the local population.

Lewis et al. (2001) investigated the opinions of elected and appointed board members in Saskatchewan about health care reforms, regionalization, and the progress made toward achieving greater local effectiveness and efficiency. A total of 275 board members of the 30 district health boards participated in the survey. Few differences were found between elected and appointed board members' perceptions of key issues. Overall, the results indicated that board members supported the general goals of health care reform and believed that the changes had been positive. The vast majority of respondents believed that

extensive reforms were necessary and that devolution of authority had resulted in increased local control and better quality health-related decisions. In addition, most respondents felt that the local boards had the respect and support of the public, reflected local values, were more responsive to overall local wishes as opposed to individual stakeholders (i.e., health care providers, interest groups, or government), and perceived health care reforms as having been designed to improve health rather than reduce spending. In contrast, most respondents felt that there was no clear vision of the reformed system, believed that the boards were legally responsible for things over which they had inadequate control, and felt that board activities were too restricted by rules laid down by the provincial government. The authors concluded that issues and concerns related to health care reforms and regionalization are similar across provincial jurisdictions.

Summary

Health reforms have been implemented by health care organizations across Canada. Most of the literature dealt with the various changes that have occurred in the acute care sector, with little attention given to community health reforms and their potential impact on providers. It is apparent that there is a two-sided nature to health reforms. On the positive side, health reforms are allowing providers to take on new and challenging roles, greater staff involvement in decision-making, greater community involvement, and greater ability to use

resources more wisely. On the other hand, increased anxiety and uncertainty, and stress related to limited financial resources to meet identified needs have been some of the negative consequences of these reforms. More evaluation is warranted to fully understand the impact of health care reforms on providers and to document the extent to which reforms are actually meeting expected goals.

Impact of Health Care Reforms: Provider Outcomes

Organizational trends such as using fewer nursing personnel or not increasing nursing staff to parallel greater client acuity and/or expanding health needs are being identified as potential threats to the quality of client care (Decter, 1997; Jackson, 1995; Shamian & Lightstone, 1997). It has been suggested that cost reduction strategies, such as organizational downsizing, re-engineering, and restructuring can lead to a number of negative provider outcomes such as burnout, loss of trust, and lower productivity (Leatt et al., 1997; Lynch, 1993). In contrast, positive outcomes identified include an increased focus on interdisciplinary approaches to client care, staff empowerment, and increased staff and client participation in decision-making (Attenborough, 1997; Donaldson, 1995; Gogag, 1996; Jackson).

The following discussion presents a brief overview of key findings from studies conducted with nurses working in various health care settings, which also included a small percentage of community health nurses. An overview is also

presented on key findings from studies that focused only on community health nurses.

Diverse Health Care Settings

Most of the studies identified from the research literature examined the impact of reforms on acute care providers. A few of these studies included community health nurses in the sample. While some studies found that nurses had an overall negative attitude toward the impact of health care reforms (Shindul-Rothschild et al., 1996), other studies found that nurses were neither totally negative nor positive about the overall impact of reforms (Corey-Lisle et al., 1999; Way, 1995).

Despite some differences between studies, the findings suggest that most nurses have concerns about the impact of health care reforms on the emotional climate of the workplace, quality of care, standards of care, and staffing and workload issues (Corey-Lisle et al., 1999; Shindul-Rothschild et al., 1996; Shindul-Rothschild, Long-Middleton, & Berry, 1997; Way, 1995). There is also some support for the negative impact of reforms on employee attitudes, such as job satisfaction (Corey-Lisle et al.). Furthermore, there is some indication that community health nurses have more positive attitudes towards reforms that their counterparts in other clinical areas (Shindul-Rothschild et al., 1996; Way, 1995), and that management personnel have more positive attitudes than staff nurses

(Way, 1995).

Using a descriptive, correlational survey design, Way (1995) obtained baseline data on perceptions about the impact of health care reforms from a stratified random sample ($\underline{N}$ = 333) of staff nurses and nurse managers in Newfoundland and Labrador. Community health nurses were included in this sample (i.e., 19 community health nurses and 45 nurses working across settings including community health). A researcher-developed instrument, the Impact of Health Care Reform Scale (IHCRS), assessed the importance of health care reforms, quality of care and safety concerns, practice-related issues, standards of care, and the emotional climate of the workplace. Study findings indicated that most respondents were neither negative nor positive about the overall impact of health care reforms. Comparatively, nurses viewed importance of reforms, practice-related issues, and safety issues more positively than quality of care, the emotional climate, and standards of care. In addition, community health nurses tended to be more positive than their counterparts working in other clinical areas. As well, older, higher educated nurses tended to view all aspects of reforms more positively than younger and less educated nurses. Similarly, nurse managers working in all clinical areas tended to view all aspects of reforms more positively than staff nurses.

Using a descriptive survey design, Shindul-Rothschild et al. (1996) investigated perceptions of downsizing, restructuring, the use of unlicensed

personnel, quality of care, and provider and patient/client outcomes in a non-probability sample ($\underline{N}$ = 7,355) of nurses in the United States. Although most respondents worked in acute care settings, the sample included nurses working in community settings. The American Journal of Nursing Patient Care Survey was used to assess changes in organizational structure, and the process and outcomes of nursing care. The majority of respondents reported structural changes such as increased unit/bed closures, reduction in nurses providing direct patient care, increased patient assignments, and cross-training of nursing staff. Most respondents identified significant changes in nursing care delivery (i.e., less time to provide all aspects of nursing care, including teaching, comforting, meeting basic care needs, ensuring continuity of care, and documenting care). Significant changes were also noted in a number of patient outcomes, including increased re-admissions and patient/family complaints, and decreased lengths of stay. In addition, the majority of nurses indicated that the quality of care was below professional standards. It was also noted that the sub-sample of home/community nurses ($\underline{n}$ = 474) were generally more positive than sub-acute care nurses on their ability to meet professional standards and provide quality care.

Using a sub-sample ($\underline{N}$ = 2,032) of nurses from the 1996 study, Shindul-Rothschild et al. (1997) investigated the best predictors of nurse ratings of quality of care present in organizations. During logistic regression analysis, it was

possible to accurately predict 88% of those with good to excellent ratings and 80% of those with poor or very poor ratings. Predictors of high-quality ratings included not reducing nursing staff, retaining nurse executives, time to provide basic nursing care, able to meet professional standards, more positive patient outcomes (i.e., fewer family/patient complaints, ulcers/skin breakdown, patient injuries, medication errors, and complications), and a greater tendency to stay in nursing. The best predictors of quality were nurse staffing levels and status of nurse executives. What was significant in the re-analysis was the large discrepancy between poorer and higher quality care institutions with regard to the proportion experiencing registered nurse reductions (i.e., 82% vs. 45%, respectively) and loss of nurse executive (i.e., 49% vs. 32%, respectively).

Corey-Lisle et al. (1999) surveyed a stratified random sample of registered nurses ($\underline{N}$ = 4,438) working in different settings in 10 American states. The mail-out questionnaire collected information on substance abuse, working conditions, well-being, and other lifestyle and behavioral practices. Content analysis was performed on qualitative comments ($\underline{n}$ = 375) that centred around perceptions of changes in the health care system and the impact of these changes on nursing practice. Written comments were provided by hospital and non-hospital nurses who were mostly in clinical positions and had diploma or associate degree preparation. Content analysis of the qualitative data revealed five major themes: "reduced reimbursement", "job security", "reduced staffing",

"demands of paperwork", and "decreased morale". One major theme that emerged from the data was the perception that most organizations, especially hospitals, moved to curtail or reduce costs without giving due consideration to possible negative implications for patient and provider groups. Many respondents noted that budget cuts often translated into replacing nurses with lower skilled assistant personnel and/or reduced staffing levels. Nurses also indicated that their sense of job security was lessened while their workloads increased. Both of these factors were believed to have negative repercussions for the quality of patient care. The interaction of nurse staff reductions, increased job insecurity and increased workload were perceived to have led to decreased morale, higher levels of stress and frustration, and reduced job satisfaction. Despite these overall negative outcomes, some respondents did indicate that health care changes provided greater opportunities for individual and professional growth. The authors warned that study findings should be interpreted cautiously because not all of the participants were specifically asked to comment on health care reforms.

Community Health Settings

Most study findings indicated that community health nurses have concerns about the impact of reforms on the emotional climate of the workplace, quality of care, standards of care, and workload (Ellenbecker & Warren, 1998;

Parry-Jones et al., 1998; Rafael, 1999; Reutter & Ford, 1998; Traynor, 1995). These findings concur with those from samples of nurses working across a variety of health care settings. Despite the negative aspects of reforms, some studies have also documented positive outcomes (Ellenbecker & Warren; Rafael; Reutter & Ford, 1998). There are also conflicting findings on the positive or negative impact of organizational change and reforms on community health nurses' job satisfaction (Parry-Jones et al.; Traynor; Woodcox, Isaacs, Underwood, & Chambers, 1994).

In a longitudinal study with four data collection points spanning a three year period, Woodcox et al. (1994) explored public health nurses' perceptions prior to and following reorganization of the Nursing Division of the Hamilton-Wentworth Department of Public Health Services in Ontario. The crucial innovation involved moving from a generalist service to population-based services (e.g., infants, adolescents, elderly, etc.). Using standardized instruments, perceived impact was assessed in terms of job design (i.e., task identity and significance, skill variety, autonomy, and feedback), job satisfaction (i.e., work, pay, promotion, supervision, and coworkers), and role stress (i.e., conflict, ambiguity, and overload). A response rate of 80% ($\underline{N}$ = 92) was obtained at time 1, followed by a response rate of 58% ($\underline{N}$ = 54) for all subsequent time periods. The findings revealed significant differences in public health nurses' overall job satisfaction and most satisfaction components, with the

exception of job promotion. In general, the greatest differences were between time 4 and all three previous time periods (i.e., higher satisfaction at time 4). In contrast, no significant differences were noted in overall job design. Task identity (i.e., importance attached to one's work) was the only component of job design to experience a significant change (i.e., decreased from time 1 through time 3, followed by a significant increase from time 3 to time 4). As well, no significant differences were observed in overall role stress and most of its components, with the exception of role conflict (i.e., significant decrease between times 2 and 3 versus a significant increase between time 4 and times 1 and 3). The inconsistent findings and the failure of any variable to achieve projected levels for administrative significance (i.e., 0.5 change from baseline scores) led the authors to conclude that organizational changes had little to no impact on public health nurses' perceptions of job satisfaction, job design, and role stress.

Traynor (1995) conducted a descriptive, longitudinal study to assess the job satisfaction and morale of nurses following changes in the organization and funding of community health care in the British National Health Service. A researcher-developed instrument, Measure of Job Satisfaction (MJS), was used to collect data. The MJS consists of five content areas (i.e., personal satisfaction, workload, professional support, pay and prospects, and training), and an open-ended section. Nurses from three community trusts completed the MJS annually over three years, resulting in response rates of 64% ($\underline{N}$ = 749) in

year 1, 56% ($\underline{N}$ = 706) in year 2, and 54% ($\underline{N}$ = 675) in year 3. All levels of management were also interviewed, with 24 participating in years 1 and 3, and 6 participating in year 2. The findings revealed a significant decline over time in district nurses' overall job satisfaction. Workloads, pay, and promotion prospects were the sources of greatest dissatisfaction. In contrast, health visitors were less satisfied with promotion prospects in year 2, but more satisfied with pay and workloads by year 3. Practice nurses were the most satisfied of all the three staff groups. The qualitative comments revealed that many nurses were concerned about constraints placed on their ability to provide high standards of care, and the growth in administrative and clerical duties. In addition, respondents commented on the degree of suspicion and hostility towards reforms, especially in the first year. In contrast, the management group perceived system changes positively, despite the increased pressure for them and their staff. The author stressed the importance of improved communication between management and front-line nursing staff during organizational change.

In a descriptive study, Reutter and Ford (1998) investigated perceptions of practice changes in a sample of public health nurses ($\underline{N}$ = 28) working in six health units serving urban and rural populations in Alberta. A semi-structured schedule was used to guide individual and focus group interviews. Participants identified several factors that had a direct impact on their practice, including: protocol changes, budget cuts, changing community needs and demographics,

health care system restructuring, and increasing use of other professionals to provide health promotion activities. Following application of content analysis to the data sets, five common themes emerged: a) "pulling back" (i.e., staff reductions and increased workloads necessitated refocusing of efforts on mandated programs, leaving less time for nurse-client encounters or participation in select activities); b) "from hands on to arms length" (i.e., transition from direct to more indirect involvement with clients; for example, spending more time acting as a resource person and doing office work); c) "handing over responsibility" (i.e., encouraging clients to take greater initiative); d) "developing working partnerships" (i.e., facilitating working partnerships with clients and other community agencies/providers); and, e) "doing less surveillance" (i.e., responding to needs identified by clients and/or other professionals). While these findings suggest that some changes are perceived to threaten client accessibility to public health nurses, especially for health promotion and illness prevention, other changes are seen as increasing collaboration and client control. The authors cautioned against generalizing the findings to all public health nurses due to the small, convenience sample.

Using an exploratory, descriptive design, Ellenbecker and Warren (1998) examined home care nurses' ($\underline{N}$ = 16) perceptions of the impact of recent system changes on their practice. Six separate focus groups were held with nurses working in various regions of Massachusetts. Content analysis of the data

identified three major change areas, with positive and negative aspects, including health care system, patient population, and nurse response. The positive side to identified changes involved the development of new services, improved communication and collaboration among health care providers, and a growing sense of personal pride related to unique management styles, advocacy initiatives, clinical skills, and community building. In contrast, increased system complexity, demand for documentation, competition for service delivery, patient acuity levels, and stress and frustration were seen as negative aspects of change. The use of a small, convenience sample limits the generalizability of this study's findings.

Using a descriptive correlational design, Parry-Jones et al. (1998) examined changes in selected job-related and work environment factors two years following implementation of a care management model in a sample of social workers (n = 276), community nurses (n = 65), and community psychiatric nurses (n = 62) working in social and health service agencies in Wales. A researcher-developed questionnaire, consisting of closed and open-ended questions, was used to collect data on stress, satisfaction and practice variables. The vast majority of survey respondents reported increases in stress levels, workload, level of responsibility, and amount of administrative work. In contrast, the findings indicated significant decreases in job satisfaction and several practice-related factors (i.e., time for client contact, morale of colleagues,

confidence about the future of community care, satisfaction with work conditions, feeling valued as an employee, and sense of personal achievement). While the sample was divided on perceived improvement or deterioration in the quality of communication with management, slightly less than one-half felt that service quality had declined and they were less able to manage workloads. The authors noted that the low response rate impedes the conclusiveness of the findings.

Using a feminist, postmodern oral history approach, Rafael (1999) examined the work and struggles of public health nurses ($\underline{N}$ = 30) in Southern Ontario during downsizing (i.e., cutbacks in health programs, staff, and management personnel). Accompanying the downsizing were significant changes in public health nursing, with district nursing (i.e., nurses were responsible for meeting the total needs of assigned districts) replaced by program-focused practice (i.e., nurses were responsible for meeting the needs of the target population addressed by individual programs). Data were collected via face-to-face interviews and five focus groups. Participants identified both positive and negative consequences of the changes experienced in public health nursing practice. On the negative side, participants felt that nursing had lost its voice in decision-making due to the practice divisions along multiple program as opposed to disciplinary lines, competition with peers for scarce resources, and having to report to non-nursing managers. Additional negatives included a reduction in nursing services to schools, a reduction in home visiting, job losses,

and overall distancing of nurses from consumers. In contrast, program-specific services were viewed by some participants as increasing nurses' ability to provide higher quality care than was possible when responsible for the needs of a large geographical area. Additional positives included the development of creative partnerships with consumers, new practice opportunities, and increased community involvement. The author concluded that the pervasiveness of the changes in public health nursing had eroded nurses' feelings of autonomy and empowerment which may have far-reaching implications for the future of nursing practice.

Summary

The previous review of the literature provides some insight into the impact of health care reforms on community health nurses. Although there is limited empirical research on the implications of reforms for provider outcomes in the community health setting, the evidence suggests that reforms may negatively impact the emotional climate of the workplace, staffing levels, workload, quality of care, standards of care, and employee attitudes, among others. In contrast, there is also support for increased opportunities for nursing staff (i.e., more involvement in decision-making and a greater sense of empowerment). More research is obviously needed to develop a greater understanding of the full impact of health care reforms on provider outcomes.

Factors Influencing Provider Outcomes

Numerous models have been developed to help explain the type and importance of various factors influencing nurse turnover behavior (e.g., Irvine & Evans, 1995; Mueller & Price, 1990; Parasuraman, 1989; Price & Mueller, 1981, 1986; etc.). In general, most models depict a causal, linear process and incorporate determinants (e.g., job-related characteristics, work environment, economic, etc.), intervening attitudes (e.g., psychological contract violations, job satisfaction, organizational commitment, intent to stay, etc.), intervening behaviors (e.g., intent to stay/leave, etc.), and correlates (e.g., personal and work-related characteristics, etc.). Many studies have used modified versions of a particular causal model to guide the research process.

Research studies investigating factors believed to influence provider outcomes is growing. Study findings suggest that multiple factors exert separate and interactive effects on provider outcomes (i.e., job satisfaction, organizational commitment, and intent to stay). However, no studies were identified that addressed the nature and importance of perceived psychological contracts between employees and employers in the health care field, or the potential negative effects subsequent to their violations. A greater awareness of key influencing factors is crucial in order to successfully implement various health care system changes in the future. The following discussion provides a review of the literature addressing select outcomes (i.e., psychological contract violation,

job satisfaction, organizational commitment, and intent to stay).

Psychological Contract

A psychological contract has been described as a set of beliefs or *perceptions regarding reciprocal obligations* between an employee and an employing organization (Cavanagh, 1996; Morrison & Robinson, 1997; Robinson & Rousseau, 1994; Rousseau, 1990). It can be understood as a set of expectations that the employee forms pertaining to what the employer should be *offering (e.g., job security, fair wages, appreciation, promotion, etc.)* in return for certain employee actions (e.g., hard work, loyalty in exchange for future promises, etc.). Importantly, the key factor differentiating psychological contracts from other types of contracts is that both employee and employer obligations are *defined from the employee's* perspective (Robinson & Rousseau), and is thus highly subjective (Rousseau, 1990).

An important distinction is made in the literature between two types of psychological contracts (i.e., transactional and relational) (Rousseau, 1990). Transactional contracts are short-term and involve specific exchanges on which monetary value can be placed (e.g., hard work for pay raises, etc.). In contrast, relational contracts involve more open-ended exchanges that establish and maintain a relationship (e.g., long-term commitment, hard work, and loyalty by the employee in exchange for job security, training, and promotion, etc.). The

literature suggests that psychological contracts govern the behavior of the employee towards the employer and changes or violations in these contracts can have crucial implications for the employee-employer relationship.

Psychological contract violations occur when the employee perceives that *the employer has not fulfilled promised obligations (Morrison & Robinson, 1997;* Robinson, Kraatz & Rousseau, 1994; Robinson & Rousseau, 1994). Because of the limited attention given to conditions facilitating contract violations, Morrison and Robinson proposed a model outlining the processes preceding violations. *This model identifies many factors that influence the movement from unmet* expectations to a contract breach to contract violations. Psychological contract violations differ from unmet expectations in terms of the intensity of the emotional response. As well, a perceived breach refers to the cognition that *employers have failed to meet one or more obligations comprising the* psychological contract. In contrast, violation refers to the emotional and affective states that follow when one feels that the employer has failed to meet the terms of the psychological contract. Thus, it is the meaning that the employee *associates with a breach of contract that ultimately determines perceptions of* contract violations.

Health care reforms such as downsizing and restructuring have the potential to dramatically change psychological contracts, and increase the *likelihood of violations.* Turnley and Feldman (1998, 1999) found support for

increased levels of psychological contract violations in firms undergoing major restructuring in the business sector. Some of the documented consequences of contract violations in the business sector include decreased job satisfaction, increased job insecurity, negative attitudes toward the organization, loss of organizational loyalty and commitment, loss of trust, poor individual performance, and increased intent to leave the organization (Cavanagh, 1996; Robinson & Rousseau, 1994; Turnley & Feldman, 1998, 1999). Despite the potential negative impact of perceived contract violations on the employment relationship, no research studies were identified from the health care literature that investigated the impact of health care reforms on providers' psychological contracts or the consequences of such violations.

The following discussion presents an overview of studies that have explored the nature of psychological contract violations and factors responsible for their occurrence. Study findings are also presented on possible consequences of contract violations, and the role played by situational factors in mitigating the impact of such violations on employee behaviors and attitudes.

Contextual/personal factors and contract violations. In a longitudinal study of a sample ($\underline{N}$ = 96) of alumni from a master of business administration (MBA) program, Robinson et al. (1994) explored changes in perceived employee and employer obligations, and the impact of employer violations on perceived obligations. Data were collected three weeks prior to graduation and after two

years of employment. A researcher-developed instrument, based on interviews with personnel and human resources managers, assessed employees' beliefs regarding obligations to their employers (i.e., overtime, loyalty, volunteering to do nonrequired tasks, advance notice of termination, willingness to accept transfers, refusing to support competitors, protection of proprietary information, and minimum of a two year stay) and their employers' obligations to them (i.e., advancement, high pay, merit pay, training, job security, career development, and support with personal problems). Employer violations were measured with a single item which asked respondents to indicate how well their employers had fulfilled obligations. Test-retest analysis found moderate to high levels of reliability for the study instruments. Factor analysis confirmed that both employee and employer obligations could be categorized as either transactional or relational. The findings revealed that perceived employee obligations to their employers declined over time, while perceived employer obligations to employees significantly increased. The findings also indicated that perceived employer violations had a strong negative impact on employee obligations. In contrast, employer violations did not significantly affect employer obligations. The authors concluded that study findings suggest that an important relationship exists between managers' actions and employees' perceptions and fulfilment of their obligations.

In a longitudinal study, Robinson and Rousseau (1994) investigated the

occurrence of psychological contract violations in a sub-sample of MBA alumni ($\underline{N}$ = 209) immediately following recruitment and after two years of employment. Psychological contract violation was measured in three ways (i.e., a five-point scale, a yes/no item, and an open-ended item asking respondents to expand on employers' contract violations). The findings indicated that a majority of respondents (54.8%) had experienced at least one case of contract violation by employers. Content analysis of the data revealed ten distinct categories of violations (i.e., training/development, compensation, promotion, nature of job, job security, feedback, management of change, responsibility, people, and other). The most frequently mentioned violations included training/development, compensation, and promotion. In addition, the data suggested that employees who took steps to remedy the perceived violation were more likely to report higher levels of contract fulfilment than those who did not seek remedial action. The use of single-item measures and the omission of the notion of reciprocity in the psychological contract measures were identified as study limitations by the authors. In addition, generalization of the findings to other employee populations is cautioned.

Turnley and Feldman (1998) conducted a descriptive study ($\underline{N}$ = 541) to investigate the nature and extent of psychological contract violations for employees working in corporations undergoing significant organizational restructuring/downsizing/mergers/acquisitions. The convenience sample

included managers and executive-level personnel from three sites (i.e., bank, state agency, and alumni of a graduate business school). The researcher-developed four-item scale used to measure psychological contract violations (i.e., overall violations and discrepancies in rewards and commitments) was found to have high internal consistency (i.e., alpha = 0.86). Perceived violations were assessed in terms of 16 job factors derived from previous research (i.e., job security, input into decisions, opportunities for advancement, health care benefits, responsibility and power, base salary, feedback, overall benefits, organizational support for personal problems, regularity of pay raises, job challenge and excitement, supervisor support for work problems, career development, training, retirement benefits, and bonuses for exceptional work). Items were rated on a five-point scale ranging from -2 (received much more than promised) to +2 (received much less than promised). Situational variables (i.e., procedural justice or fairness of organizational decision-making policies, likelihood of future violations, and quality of work relations with supervisors and colleagues), believed to buffer the impact of strong employee reactions to psychological contract violations, were rated dichotomously (low or high). Results indicated that approximately 25% of the sample experienced psychological contract violations. When the situation was perceived to be outside the organization's control, respondents did not report contract violations. In contrast, when the organization's actions were perceived to be deliberate and

unnecessary, respondents were more likely to report contract violations. In addition, managers working in organizations that had undergone significant restructuring were much more likely to report violations than those working in more stable work environments. As well, managers in restructured firms were significantly more likely to identify problems with job security, input into decision-making, opportunities for advancement, health care benefits, and amount of responsibility and power. Finally, situational factors mitigating the impact of psychological contract violations included high procedural justice in relation to layoff procedures, pay raises and promotions; low likelihood of future violations; and positive working relationships with supervisors. Based on the findings, the authors concluded that clearer communications and efforts to build cohesive relationships between staff and supervisors were needed to buffer the negative consequences of psychological contract violations.

In a subsequent study, Turnley and Feldman (1999) re-examined the relationships among violations of employees' psychological contracts and their consequences, as well as the effects of select situational factors on these relationships. In this study, a fourth group of expatriates and managers in international business ($\underline{n}$ = 263) was added to the original sample ($\underline{n}$ = 541). The consequence of psychological contract violation variables were measured using the same scales reported by Turnley and Feldman (1998). Situational variables included availability of attractive employment alternatives, the external

justification of the contract violation, and the degree of procedural justice in the employer's decision-making practices. The findings indicated that psychological contract violations occurred more frequently and were more intense among respondents working in environments involved in downsizing or restructuring, particularly in relation to the aspects of job security, compensation (i.e., promised and actual pay raises, salaries, and bonuses), and advancement opportunities.

Consequences of contract violations. Robinson and Rousseau (1994) examined the impact of psychological contract violations on employees' attitudes and behaviors using a sub-sample of MBA alumni ($\underline{n}$ = 96). Data were collected with researcher-developed instruments that were found to be reliable and valid. Instruments measured careerism orientation (i.e., an employee's orientation toward the employer as an instrumental stepping stone up the career path), trust (i.e., the employee's degree of trust in the employer), satisfaction (i.e., employee satisfaction with both work and the organization), psychological contract violation, and remaining with one's employer (i.e., intention to remain and actual turnover). Greater psychological contract violations were strongly associated with lower levels of satisfaction, trust, and intent to remain with the employer, but moderately associated with actual turnover. Perceived contract violations accounted for approximately 16% of the variance in the length of time an employee intended to stay with the employer. Furthermore, careerism moderated the relationship between violations and trust, but did not affect the

impact of violations on satisfaction, intentions to remain, or actual turnover. The authors concluded that contract violation might have the same negative impact on employees who plan a long-term organizational tenure or those who view current employers as a stepping stone to career advancement.

Turnley and Feldman (1998) also investigated the consequences of psychological contract violations for employees ($\underline{N}$ = 541) in firms undergoing significant restructuring/downsizing. Four well-established tools with good reliability assessed the consequences of contract violations (i.e., exit, voice, loyalty, and neglect behaviors). The findings indicated that higher levels of psychological contract violations were significantly associated with lower levels of loyalty and higher exit, voice, and neglect behaviors. Additionally, managers working in firms undergoing restructuring were much more likely to intend to quit their jobs, more likely to be looking for new jobs, and less likely to be loyal to their employers than their counterparts working in more stable work environments. Furthermore, managers who perceived a high degree of procedural justice (i.e., in relation to layoff procedures and pay raises and promotions), low likelihood of future violations, and good relationships with supervisors and coworkers were significantly more likely to remain loyal to their organizations, less likely to quit or engage in job search behaviors, and less likely to engage in voiced objections to upper management. In contrast, only managers who perceived a low likelihood of future violations and good working

relationships with coworkers were significantly less likely to engage in neglect behaviors.

In a subsequent study, Turnley and Feldman (1999) re-examined the relationships among perceived psychological contract violations, their consequences, and the buffering effects of select situational factors in a sample of managerial-level personnel ($\underline{N}$ = 804). The findings indicated that the greater the level of psychological contract violations, the more likely managers were to have considered leaving the organization, voiced their objections to upper management, and neglected in-role job performance. In addition, reduced loyalty was found to be associated with higher contract violations. Furthermore, the findings revealed that all the situational variables had a moderating influence on the relationship between contract violations and exit behaviors (i.e., managers were more likely to search for other job opportunities when contract violations were high, attractive job alternatives were available, insufficient justification existed for the organization's actions, and procedural justice was low). In contrast, the relationships between psychological contract violations and voice, loyalty, or neglect behaviors were not moderated by situational factors. Additionally, gender, age, and tenure were not related to contract violations.

Summary. Psychological contract is a relatively new concept in the theoretical and research literature. It has been conjectured that psychological contracts are important components of the employee-employer relationship, and

perceived violations of these contracts can erode that relationship. There appears to be consistent empirical support for the negative influence of psychological contract violations on employee trust, job satisfaction, job security, organizational loyalty, and likelihood of remaining with current employers.

Despite the limited attention given to psychological contracts within the health care field, restructuring of the work environment of nurses has the potential to increase perceived violations. In a theoretical overview, Cavanagh (1996) stressed the importance of creating "new" psychological contracts for nurses which are built on mutual benefits and shared values between employee and employer in today's ever-changing health care environment. It is imperative that more research is conducted to examine the impact of health care reforms on factors influencing the formation and violation of community health nurses' psychological contracts.

Job Satisfaction

Job satisfaction has been defined as an affective response to one's job or specific aspects of the job (Mowday, Steers, & Porter, 1979; Price & Mueller, 1986). Both satisfaction with various job components (e.g., pay, workload, relations with coworkers and supervisors, etc.) and overall job satisfaction have been assessed in research studies (Price & Mueller, 1986). This construct has received attention in all major turnover models (Alexander, Lichtenstein, Oh, &

Ullman, 1998; Curry, Wakefield, Price, Mueller, & McCloskey, 1985; Irvine & Evans, 1995; Mueller & Price, 1990; Parasuraman, 1989; Price & Mueller, 1986).

A number of operational measures have been developed to assess the various components of job satisfaction (e.g., Index of Job Satisfaction, Staff Satisfaction Scale, Nursing Job Satisfaction, Job Satisfaction Scale, McCloskey/Mueller Satisfaction Scale, etc.). Within the context of health care reforms, job satisfaction has received a great deal of attention due to its strong association with such outcomes as nurse performance, quality patient care, and cost savings (Davidson, Folcarelli, Crawford, Duprat, & Clifford, 1997; Kramer & Schmalenberg, 1991a, 1991b). Increased job satisfaction has been associated with greater employee involvement in decision-making, a workplace open to employee suggestions, opportunities for career development and promotion, workplace autonomy, and work diversity (Blegen, 1993; Irvine & Evans, 1995; Kramer & Schmalenberg, 1991a, 1991b).

While there is an extensive research base on nurses' job satisfaction in acute health care settings, research studies in the community health sector is growing. The following discussion reviews key meta-analytic study findings across settings. Special consideration is then given to study findings from nurses working in community health settings.

Meta-analytic studies. Two meta-analytic studies were identified from the literature that summarized the key factors influencing nurses' job satisfaction.

Study findings suggest that job satisfaction is influenced by both contextual and personal factors to varying degrees (Blegen, 1993; Irvine & Evans, 1995).

Using data derived from 48 studies conducted with 15,048 staff nurses, Blegen (1993) examined the magnitude and direction of the relationship between job satisfaction and the 13 variables most frequently associated with it. It was noted that a small number of these studies involved community health nurses. Four of these variables were personal attributes (i.e., age, education, years experience, and locus of control), and the others were organizational features or job attitudes (i.e., stress, commitment, supervisor communication, autonomy, recognition, routinization, peer communication, fairness, and professionalism). The findings indicated that greater job satisfaction was most strongly related to less stress and greater organizational commitment. Greater communication with supervisors, greater autonomy and recognition/feedback, less routinization, and greater communication with peers were moderately related to greater job satisfaction. Greater professionalism and greater perceived salary and benefit fairness depicted low to moderate associations with higher job satisfaction levels, respectively. With regard to the personal characteristics, less external locus of control depicted a low to moderate association with greater job satisfaction, while older age, more years of experience, and less education depicted low but significant correlations with greater job satisfaction. Blegen discussed the complexity of the job satisfaction construct and the need for further research to

examine the separate and interactive effects of influencing factors.

In a second meta-analytic study, Irvine and Evans (1995) used a modification of Mueller and Price's (1990) integrated causal model of turnover behavior to categorize the most important determinants of job satisfaction for all nursing groups. The model proposes that economic (i.e., pay and alternate employment opportunities), sociological/structural (i.e., job content and work environment), and psychological (i.e., age, work experience, and organizational tenure) variables would exert a direct effect on job satisfaction. The findings indicated that most of the job content factors (i.e., less routinization, greater autonomy and feedback, and less role conflict and ambiguity) depicted moderate to strong correlations with greater job satisfaction, with work overload the only exception (i.e., low negative association). A similar trend was observed with the work environment factors. That is, more positive supervisory relations, greater leadership, less stress, greater advancement opportunities, and greater participation in decision-making depicted moderate to strong correlations with job satisfaction. The observed effects of economic and psychological variables were less pronounced (i.e., low negative for greater employment opportunities; and low positive for age, years experience and organizational tenure), with the exception of pay which depicted a moderate, positive correlation with job satisfaction.

In summary, most study findings included in the meta-analyses supported

the stronger influence of contextual, as opposed to personal factors on the job satisfaction of nurses. Interestingly, it is the contextual factors (e.g., job content, work environment, etc.) not the personal ones that administrators and nurse managers have the power to control through such strategies as job design, appropriate leadership, and human resource management practices. The discussion that follows highlights some of the key findings from studies conducted with nurses working in community settings.

Community health settings. A few studies identified from the literature investigated the overall job satisfaction of different types of nurses working in community health settings. Besides overall satisfaction, some authors focused on nurses' ratings of the different dimensions or components of job satisfaction. The differences observed across studies, in part, seemed to be a function of the diverse instruments used to measure satisfaction. Despite these differences, social interactions, job importance, and autonomy surfaced as important components of the job for community health nurses (Dunkin et al., 1992; Juhl et al., 1993; Lucas et al., 1988; Lynch, 1994; Riordan, 1991; Savorgnani et al., 1993).

Using a survey design, Lucas et al. (1988) investigated the influence of job-related factors and personal characteristics on the job satisfaction of public health nurses ($\underline{N}$ = 741) working in South Carolina. A 76-item questionnaire, developed by Stember, Ferguson, Conway, and Yingling (1978) for public health

staff, was used to measure satisfaction in terms of 12 job categories (i.e., job security, supervision, interpersonal relationships, influence, recognition, achievement, organizational policies, working conditions, job importance, job mechanics, communication, and salary/benefits). Study findings indicated that the top four variables were job importance, interpersonal relationships, achievement, and supervision. The nurses were least satisfied with job mechanics, recognition, salary/benefits, and working conditions. Further inquiry into job mechanics revealed that the amount of paperwork was creating most of the dissatisfaction. Participants with high levels of job satisfaction were more likely to have a masters of public health, to not take work home, and to be nurse administrators. Further, low positive correlations were noted between job satisfaction and years in nursing, years in the organization, and age.

Using a descriptive correlational design, Riordan (1991) examined predictors of job satisfaction in a random sample of nurses ($\underline{N}$ = 104) working in community health, school health, and home health from three mid-western cities in the United States. Overall job satisfaction was measured with the Index of Job Satisfaction, and the dimensions of satisfaction (i.e., task requirements, organizational requirements, social interaction, pay, autonomy, and prestige) were measured with the Staff Satisfaction Scale (SSS). Good reliability scores were obtained for both instruments in previous uses with health care workers. The findings revealed strong correlations among the subscales of the SSS. As

well, greater prestige (i.e., perception of overall importance of one's position) depicted a strong correlation with overall job satisfaction. Greater autonomy, social interaction, and organizational requirements were also moderately correlated with greater job satisfaction. None of the personal characteristics (i.e., years on the job, age, and education) nor task requirements and pay were found to significantly correlate with overall job satisfaction. During regression analysis, prestige surfaced as the only significant predictor of job satisfaction, accounting for 27.6% of the variance. Study findings are limited due to the high intercorrelations among the predictor variables.

Shuster (1992) used a non-experimental, cross-sectional design to study the factors influencing the job satisfaction of staff nurses ($\underline{N}$ = 129) working in 24 urban and rural home health care agencies in a southeastern state. The Nursing Job Satisfaction (NJS) scale assessed job satisfaction along five dimensions (i.e., job enjoyment, quality of care, care comfort measures, job interest, and time to do one's job). While an acceptable internal consistency was generated for the total NJS scale (alpha = .85), only job enjoyment and time to do one's work had an alpha level above .70. Data were also collected on select personal characteristics (e.g., education level, full-time/part-time/contractual status, age, current position tenure, etc.) and time spent in direct and indirect care activities. The findings indicated that home care nurses were moderately satisfied with their jobs overall. Although respondents reported a moderate amount of job

enjoyment, they were somewhat dissatisfied with the amount of time available to do their jobs. With regard to personal characteristics, only age exerted a positive influence on job satisfaction (i.e., older nurses evidenced higher job satisfaction than their younger counterparts). Finally, nurses who spent more time in direct client care activities were significantly more satisfied with their jobs than those who spent more time in indirect care activities.

Dunkin et al. (1992) conducted a descriptive correlational study to investigate the job satisfaction of community health nurses ($\underline{N}$ = 258) working in rural North Dakota. Job satisfaction was assessed using a researcher-developed instrument based on the Job Satisfaction Scale (JSS) by Stamps and Piedmonte (1986). This instrument assessed the importance of, as well as current satisfaction with, seven job-related components (i.e., task requirements, organizational requirements/climate, professional status, salary, autonomy, interaction, and benefits/rewards). The findings revealed that community health nurses were satisfied with their jobs overall, with those with more years of practice reporting greater satisfaction. The most satisfying job components were professional status, autonomy, interactions, and organizational climate, while benefits/rewards, task requirements, and salary were ranked as the most dissatisfying aspects. As well, community health nurses with more years of education tended to be significantly more satisfied with task requirements and the organizational climate. Significantly, importance ratings were much higher

than satisfaction ratings. Community health nurses perceived professional status to be of greatest importance, followed by interactions, salary, autonomy, organizational climate, task requirements, and benefits/rewards.

Using a descriptive-correlational study design, Juhl et al. (1993) investigated the job satisfaction of 111 public health nurses and 146 home health nurses working in a rural midwestern state. A modified version of the JSS (Stamps & Piedmonte, 1986) was used to assess job satisfaction. The findings indicated that overall, public health nurses were somewhat more satisfied than home health nurses. Both groups identified professional status, autonomy, and interaction as the three most satisfying job components, while task requirements, benefits/rewards, and salary were ranked as the most dissatisfying aspects. However, group differences surfaced regarding the importance ratings of the job satisfaction dimensions. Public health nurses rated interaction as the most important, followed by salary, professional status, autonomy, organizational climate, benefits/rewards, and task requirements. Home health nurses perceived professional status to be of greatest importance, followed by interaction, salary, autonomy, organizational climate, task requirements, and benefits/rewards. Finally, administrators did not differ significantly from either staff group on satisfaction, but evidenced a couple of significant differences on importance ratings (i.e., higher ratings for organizational climate and professional status than staff). The authors concluded that the differences noted between

public health and home health nurses may be the result of variations in their salaries, roles, and responsibilities.

Using a descriptive correlational design, Savorgnani et al. (1993) investigated recruitment, job satisfaction, and retention factors in a sample of home health nurses ($\underline{N}$ = 107) working in Illinois. A researcher-developed questionnaire, based on the literature and content validated, was used to measure various aspects of recruitment, satisfaction, and retention. Information was also collected on select personal characteristics (i.e., age, marital status, race, number of children, average number of persons per household, educational level, years of nursing experience, geographic location of workplace, employment status, administrative duties, speciality area and preparation). The findings indicated that word-of-mouth referral and newspaper ads were the main sources of recruitment information. The most important reasons for selecting employment in home healthcare included flexible schedules, one-on-one patient care/satisfaction, salary, autonomy, decreased stress, job location, opportunity to serve, and job availability, respectively. The majority of respondents (89%) were moderately to very satisfied with home healthcare work overall and planned to stay in this area of nursing (66.4%). With regard to occupational satisfaction, only autonomy was rated as slightly to moderately satisfying. Other aspects of satisfaction receiving neutral responses included interaction with nurse colleagues, professional status, task requirements, and nurse-physician

interaction. Furthermore, results revealed that nurses' satisfaction was determined primarily by working conditions, type of nursing assignment, and company policy.

In a descriptive study, Lynch (1994) investigated the job satisfaction of home health nurses ($\underline{N}$ = 66) from three health agencies in the United States. The McCloskey/Mueller Satisfaction Scale (MMSS) was used to measure job satisfaction along three theoretical dimensions, including safety rewards (i.e., extrinsic rewards, scheduling, and family/work balance), social rewards (i.e., satisfaction with coworkers and interaction), and psychological rewards (i.e., professional opportunities, praise/recognition, and control/responsibility). The MMSS has established reliability and validity. The findings indicated that most nurses were moderately to very satisfied with safety rewards, with the exception of childcare facilities which evidenced moderate dissatisfaction. Similar findings were observed for the components of social rewards; most nurses were satisfied with coworkers and interaction opportunities. Finally, respondent scores tended to be evenly distributed across the scale steps (i.e., satisfied, neutral, and dissatisfied) for several dimensions of psychological rewards. Significantly, the greatest source of satisfaction was praise and recognition (i.e., 68%). Based on the results, the author stressed the need for supervisors to be cognizant of good interpersonal communication techniques and management styles. The author discussed generalizability limitations due to the small sample size and the

appropriateness of the MMSS for home health care nurses.

The research literature suggests that some negative consequences of health care reforms (e.g., decreased perceived support, increased frustration and anxiety, greater stress, etc.) have reduced nurses' job satisfaction. Several researchers have explored the separate and interactive effects of job-related and work environment factors, as well as personal characteristics, on the job satisfaction of community health nurses. Consistent empirical support has been found for the effects of stress, the presence of supportive work environments, or both stress and support on job satisfaction (Boswell, 1992; Jansen, Kerkstra, Abu-Saad, & van der Zee, 1996; Moore & Katz, 1996; Moore, Lindquist, & Katz, 1997; Parahoo & Barr, 1994; Rout, 2000; Stewart & Arklie, 1994).

Boswell (1992) carried out a descriptive correlational study to explore the relationship between job-related stress and job and work satisfaction in a sample of nurses ($\underline{N}$ = 51) who worked at official state and public health agencies in Texas. The NJS scale was used to measure job satisfaction. The Work Satisfaction Scale (WSS) assessed five dimensions of work satisfaction (i.e., pay/reward, professional status, interaction/cohesion, administration, and task requirements). The Job Stress Scale (JSS) assessed job stress in select categories (i.e., competence, physical environment, staffing, team respect, time priorities, emotional support, competence feelings, and patient outcome). The findings revealed that two components of job satisfaction (i.e., greater perceived

quality of care and greater time to do one's work) depicted moderate to strong correlations with less perceived stress (i.e., most identified components). With regard to work satisfaction and stress, low to moderate correlations were obtained between greater understanding of task requirements and less perceived stress (i.e., all components of stress were not an issue besides competence feelings). The interaction/cohesion component of work satisfaction was positively and moderately correlated with less stress (i.e., less stress from competence issues, staffing adequacy, and setting priorities to facilitate time management). Overall, the findings suggested that increased satisfaction with quality of care, time available to complete one's job, and competence in completing task requirements were significantly associated with lower levels of job-related stress.

Parahoo and Barr (1994) conducted a descriptive study to explore the job satisfaction of community nurses ($\underline{N}$ = 36) working with persons with a mental handicap (CNMH), in the United Kingdom. A researcher-developed, 25-item open-ended questionnaire was used to construct a profile of CNMHs, their clients, and selected practices. Two of the questions focused on possible factors influencing job satisfaction/dissatisfaction. Findings indicated that most nurses rated satisfaction levels as high (57%) or very high (22%). The qualitative comments revealed that satisfaction levels were determined by a combination of job characteristics and environmental factors. Multidisciplinary teamwork was

most frequently identified as contributing to job satisfaction, followed by involvement with clients, progress of clients, varied aspects of work, autonomy, and appreciation of clients, respectively. In contrast, heavy caseload was the single most identified factor contributing to dissatisfaction followed by administrative work, lack of resources, lack of communication, lack of recognition from other staff, and lack of support from management, respectively. Based on the findings the authors discussed the complex interactional nature of factors affecting job satisfaction, but noted the limitations of using a small sample and frequency data.

Using a descriptive correlational design, Stewart and Arklie (1994) explored the interrelations among support, work-related stressors, job satisfaction, and burnout of community health nurses. Questionnaires were distributed to all community health nurses working full-time for the Nova Scotia Department of Health and Fitness, resulting in a response rate of 68% ($\underline{N}$ = 101). Data were collected with the Staff Burnout Scale for Health Professionals (i.e., satisfaction with work, interpersonal tension, physical illness, and unprofessional patient relationships), three subscales of the NJS scale (i.e., work enjoyment, quality of care, and time to care), the Norbeck Social Support Questionnaire (i.e., total and average functional support, and work-related support), and the Nursing Stress Scale (i.e., uncertainty, poor work environment, difficult clients, conflict, insufficient time, and insufficient support). Findings indicated that spouse,

family, friends, and work associates were the key sources of support, with emotional and affirmational the main support types. The three main sources of stress were insufficient time for client care (i.e., too many non-nursing tasks required, not enough staff), poor work environment (i.e., insufficient opportunity to express anger and frustration, unpredictable staffing, lack of value placed on work), and difficult clients (e.g., demanding, angry or depressed clients, etc.). Other sources of stress included perceived lack of support from supervisors and heavy workload. Strain and illness were the primary sources of burnout, whereas work enjoyment (i.e., work valued by clients, independent practice, and goal setting with clients) and provision of quality care were the dominant sources of job satisfaction. Greater overall support was significantly associated with greater job satisfaction, and less stress and burnout. As well, lower stress levels were significantly associated with less burnout and greater job satisfaction. During regression analysis, two work stress factors (i.e., positive work environment and adequate time) and overall functional support combined to explain 50.8% of the variance in job satisfaction. The work environment factor exerted the greatest influence on satisfaction levels.

Jansen et al. (1996) conducted a descriptive correlational study to explore the effects of job-related factors and personal characteristics on the job satisfaction of 310 community nurses and 92 community nurse auxiliaries in the Netherlands. Job-related factors (i.e., time pressure, autonomy, job clarity, skill

variety, task identity, possibilities for growth at work, feedback, and task significance) were measured with a modified version of the Job Diagnostic Survey. Personal characteristics (i.e., preferences, coping strategies, experienced social support, and biographical characteristics) were measured with the Utrecht Coping List and Organizational Stress Questionnaire. Job satisfaction was assessed along eight dimensions (i.e., quality of care, general work satisfaction, supervisory satisfaction, satisfaction with peers, patient-contact, patient-assignment, clarity, and growth at work). During regression analysis, job-related variables (i.e., greater skill variety, more opportunities for growth at work, greater task significance, less time pressure, and greater feedback) accounted for 37% of the explained variance in job satisfaction. The preference and support variables (i.e., greater preference for career and skill variety, and greater support from head nurses and peers) accounted for an additional 17% of the explained variance in job satisfaction.

Moore and Katz (1996) conducted a descriptive correlational study exploring home health care nurses' ($\underline{N}$ = 67) level of work-related stress, self-esteem, social intimacy (support), and job satisfaction. The convenience sample included nurses working in three health care agencies undergoing mergers and rightsizing, in the midwestern United States. Four reliable instruments (i.e., Nursing Stress Scale, Rosenberg Self-Esteem Scale, Social Intimacy Scale, and the JSS) were used to measure perceptions of work-related stress, self-esteem,

social intimacy, and job satisfaction, respectively. Findings indicated that the highest stressor for the home health nurses was the lack of time to complete all case management activities and paperwork. Increased job satisfaction was significantly and moderately correlated with less stress, greater self-esteem, and greater support. Furthermore, higher self-esteem depicted a strong correlation with greater support. None of the personal characteristics (i.e., education level, sex, marital status, age, time employed as a nurse, nursing position, and position tenure) influenced job satisfaction. Comparatively, the stress levels of the home health nurses did not differ significantly from those of acute care surgical nurses surveyed in a previous study following a two hospital merger.

In a subsequent study, Moore et al. (1997) investigated the same variables in a larger sample of home health nurses ($\underline{N}$ = 253). Comparatively, increased job satisfaction was significantly, moderately correlated with less stress, greater self-esteem, and greater support; and greater self-esteem was moderately associated with greater support. Finally, personal characteristics were not found to affect job satisfaction levels. The authors postulated that interventions, such as support groups and consistent activities for nurses to share experiences, could result in lower levels of work-related stress, higher levels of job satisfaction, and greater self-esteem.

Using an exploratory correlational design and the staff of a state public health department, Cumbey and Alexander (1998) examined the relationships

among three organizational variables (i.e., structure, technology, and environmental uncertainty). The final sample included 800 registered nurses, 31 licenced practical nurses, and 7 who did not indicate their job category. A modified version of the Leifer and Huber (1977) scale was used to assess structure in three dimensions (i.e., formalization, vertical participation, and horizontal participation), and the researcher-adapted Overton, Schneck, and Hazlett (1977) scale assessed technology (i.e., variability, instability, and uncertainty). The Environmental Uncertainty Scale and the MMSS were used to measure uncertainty and job satisfaction, respectively. Good reliability and validity were reported for all study instruments. Study findings revealed moderate levels of overall job satisfaction. Greater vertical and horizontal participation were strongly correlated with higher levels of job satisfaction, and greater formalization was moderately related to lower levels of job satisfaction. Technology and environmental uncertainty were not significantly related to job satisfaction. Years of experience with the public health department depicted a low positive relationship with job satisfaction. During multiple regression analysis, structure emerged as the critical predictor of job satisfaction, accounting for 41% of the explained variance. Based on the findings, the authors emphasized the importance of creating more flexible work environments and facilitating staff involvement in decision-making in relation to the job satisfaction of public health nurses.

Using survey data obtained from a random sample of health care providers working in the northwest of England, Rout (2000) examined the best predictors of job satisfaction in a subset of district nurses ($\underline{n}$ = 79). Job satisfaction was measured with the JSS and job stress with a researcher-developed scale. Other data collection instruments included the Bortner Type A Questionnaire (i.e., stress-prone personalities) and the Ways of Coping Checklist (i.e., approach to stressful situations). District nurses were most satisfied with the amount of job variety and their coworkers, and least satisfied with promotion opportunities and relations between managers and coworkers. The greatest job stressors included time pressure, administrative responsibility, having too much to do, things not under direct control, interruptions, keeping up with organizational change, dealing with terminally ill patients and their relatives, taking work home, and lack of resources. In addition, district nurses scored moderately high on Type A behavior and coped with stressful situations by expressing their feelings to someone, concentrating on what had to be done, and speaking to an authority figure to resolve problems. During regression analysis, four stressor factors combined to explain 31% of the variance in satisfaction levels, with demographic, Type A behavior, and coping variables failing to enter the equation. Specifically, high job demands and lack of communication, working environment (e.g., no appreciation, lack of support, undervalued, etc.), and career development (e.g., task variety, goal achievement, etc.) were

predictive of high levels of job dissatisfaction. Conversely, less patient problems were predictive of high levels of job satisfaction. The author cautioned against generalizability of the findings due to the small sample size.

Summary. Study findings suggest that job-related and work environment factors have a significant influence on the job satisfaction of community health nurses. Consistent with the meta-analytic findings of Blegen (1993) and Irvine and Evans (1995) several job-related and work environment factors (e.g., stress, supportive structures, autonomy, interaction/communication, job importance, etc.) depicted moderate to strong relationships with job satisfaction (e.g., Boswell, 1992; Jansen et al., 1996; Juhl et al., 1993; Lucas et al., 1988; Lynch, 1994; Riordan, 1991; Shuster, 1992; Stewart & Arklie, 1994). As well, personal characteristics (i.e., age, education, years in nursing, and organizational tenure) were shown to have variant, but mainly weaker, effects on job satisfaction (Cumbey & Alexander, 1998; Lucas et al.; Riordan; Shuster). These findings also concur with those of Blegen and Irvine and Evans.

Organizational Commitment and Behavioral Intentions

A review of relevant literature revealed varied conceptualizations of organizational commitment. As a theoretical construct, organizational commitment has been described as consisting of behavioral or attitudinal components, or a combination of both. The unidimensional conceptual definition

(i.e., combination of attitudinal and behavioral components) proposed by Mowday et al. (1979) is the one most often cited in the literature. These authors defined organizational commitment as the relative strength of an individual's identification with and involvement in a particular organization. These authors also noted that commitment is composed of three related dimensions (i.e., a strong belief in and acceptance of the organization's goals and values, a willingness to exert considerable effort on behalf of the organization, and a strong desire to remain as a member of the organization).

While earlier models of turnover behavior depicted organizational commitment as a unidimensional construct (Mowday, Porter, & Steers, 1982; Price & Mueller, 1981; Weisman, Alexander, & Chase, 1981), later models separated the attitudinal and behavioral components (Curry et al., 1985; Mobley, 1982; Mobley, Griffeth, Hand, & Meglino, 1979; Mueller & Price, 1990; Price & Mueller, 1986). As a result of this conceptual separation, commitment was seen as being more reflective of an employee's loyalty to an organization, whereas intent to stay or leave was more reflective of an employee's behavioral intentions. This conceptual separation is captured in Mueller and Price's integrated causal model on nurses' voluntary turnover behavior. In this model, intent to stay is defined as the behavioral aspect of commitment (i.e., a person's perception of the probability of maintaining employment with the current organization). The Mueller and Price model also depicts the highly subjective

attitudinal components of job satisfaction and organizational commitment as

preceding the behavioral component of intent to stay, which is postulated to exert

the greatest influence on turnover behavior.

More recently, it has been argued that restructuring of organizations has

altered the nature of the workplace, as well as employee-employer relationships.

Meyer, Allen, and Topolnytsky (1998) argued that organizational commitment

has been drastically altered in the aftermath of massive changes, and proposed

a multidimensional definition of commitment consisting of three major

components (i.e., affective, normative, and continuance). Affective commitment

refers to a person's emotional attachment to their organization, continuance

commitment reflects a person's perception of the costs and risks associated with

leaving their present organization, and normative commitment refers to a

person's sense of obligation and responsibility to their employing organization

(Meyer et al.). While affective and normative commitment reflect the attitudinal

components of commitment, continuance commitment is very similar to the intent

to stay/leave construct.

Research efforts have been directed toward examining the effects of

various job-related and work environment factors (e.g., organization climate,

communication, leadership behaviors, interdisciplinary relationships, role conflict,

centralized versus decentralized organizational structure, etc.), employee

attitudes (e.g., job/work satisfaction, motivation, etc.), and personal

characteristics (e.g., age, current position tenure, organizational tenure, etc.) on organizational commitment and behavioral intentions. Inconsistencies have been noted in the literature regarding the relationship (i.e., magnitude, indirect or direct) of these factors to organizational commitment and/or intent to stay. The following discussion summarizes the findings from meta-analytic studies and research conducted with community health nurses. The discussion is organized according to the organizational commitment and intent to stay/leave constructs.

Organizational commitment. Several authors (e.g., Mathieu & Zajac, 1990; Mowday et al., 1982; Mueller & Price, 1990; Parasuraman, 1989; Price & Mueller, 1986) have found support for the strong effect of determinants (i.e., job-related and work environment factors) on organizational commitment. These authors have also reported that study findings suggest that personal characteristics have a minimal to no effect on commitment. One meta-analytic study was identified that examined the impact of determinants and personal characteristics on commitment (Mathieu & Zajac).

In a meta-analytic study of 174 independent samples, Mathieu and Zajac (1990) examined the antecedents and correlates of organizational commitment. The antecedent variables were comprised of personal characteristics (i.e., age, sex, education, marital status, position tenure, organizational tenure, perceived personal competence, ability, salary, Protestant work ethic, and job level), job characteristics (i.e., skill variety, task autonomy, challenge, and job scope),

organizational characteristics (i.e., size and centralization), group/leader relations (i.e., group cohesiveness, task interdependence, leader initiating structure, leader consideration, leader communication, participative leadership), and role states (i.e., role ambiguity, conflict, and overload). Findings indicated that most personal characteristics only depicted low correlations with organizational commitment. With regard to job characteristics, greater skill variety and challenge was moderately correlated with greater organizational commitment, whereas greater job scope depicted a strong association with greater commitment. As well, greater task interdependence, leader initiating structure, leader consideration, and participative leadership were moderately related to greater commitment. Greater leader communication was also strongly correlated with greater commitment. All of the role state variables were moderately and negatively correlated with commitment. However, organizational characteristics such as size and centralization were only slightly related to commitment.

There is also empirical support for the positive relationships among various work-related attitudes, especially job satisfaction and organizational commitment (e.g., Blegen, 1993; Corser, 1998; Mathieu & Zajac, 1990; Mowday et al., 1982; Mueller & Price, 1990; Parasuraman, 1989; Price & Mueller, 1986). In the business sector, Turnley and Feldman (1998, 1999) also found support for the negative impact of psychological contract violation on managers' commitment to their organizations, especially during periods of extensive

restructuring. Two meta-analytic studies (Blegen; Mathieu & Zajac) and one review of the health care literature (Corser) were identified that examined some of these relationships.

In a meta-analysis of studies conducted with nurses, Blegen (1993) found that a strong positive correlation existed between job satisfaction and organizational commitment. In a review of research studies conducted with acute care nurses and other providers, Corser (1998) reported that high levels of organizational commitment have been consistently and significantly associated with greater job satisfaction. Mathieu and Zajac (1990) examined the influence of additional correlates or covariates (i.e., overall and internal motivation, job involvement, stress, occupational commitment, union commitment, overall job satisfaction, and degree of satisfaction with intrinsic and extrinsic rewards, supervision, promotion, pay, coworkers, and the work itself) on organizational commitment. The findings indicated that higher overall motivation and internal motivation, greater job involvement, greater occupational commitment, greater overall job satisfaction, and a greater satisfaction with supervision were strongly associated with greater organizational commitment. As well, less stress, greater satisfaction with coworker relations, greater promotion opportunities, and higher pay depicted moderate correlations with greater organizational commitment.

Mathieu and Zajac (1990) also examined some of the consequences of organizational commitment. Higher job performance (i.e., others' ratings and

output measures) and greater attendance (e.g., days attended, duration, total number of days absent) were associated with greater commitment, but the relationships were low. Low to moderate correlations were also observed between greater commitment and less perceived job alternatives, less work-related tardiness, and lower turnover. The strongest correlations were observed between greater commitment and less intent to search or leave. Support for the significant association between organizational commitment and select outcomes is also found in the health care literature. Corser (1998) reported that studies have documented a significant relationship between higher levels of commitment and greater job satisfaction and job performance, fewer incidents of job tardiness, less job strain and burnout, and lower turnover rates.

In summary, organizational commitment is recognized as an important nurse outcome which has implications for health care organizations. There appears to be a consensus that job-related and work environment variables have stronger relationships with commitment than individual/personal characteristics. As well, job satisfaction has a consistent positive relationship with organizational commitment. Although the number of research studies exploring the factors influencing and the consequences of organizational commitment of acute care nurses is growing, no similar studies were identified that had sampled community health nurses. A greater understanding of the factors influencing community health nurses' organizational commitment and behavioral intentions, particularly

in the context of health care reforms, is crucial for community-based health care organizations.

Intent to stay. Intent to stay has been defined as the desire to remain within an organization or the perceived likelihood of an individual staying within an organization (Cavanagh, 1990; Yoder, 1995). The varied conceptualizations define intent to stay as an attitude (i.e., an individual perception) and/or a behavior. Many of the studies reviewed have used single-item measures of intent to stay, whereas other studies have utilized multidimensional tools (e.g., Turnley & Feldman, 1998).

A recurring theme in the literature pertaining to nurses' intent to stay and turnover behavior is the causal process between job satisfaction, organizational commitment, and intent to stay. Much of the recent research on intent to stay/leave has stemmed from the empirical and theoretical literature supporting the assumption that intent to stay/leave is the single best predictor of voluntary nurse turnover behavior (Borda & Norman, 1997; Cavanagh, 1990; Irvine & Evans, 1995; Mueller & Price, 1990; Parasuraman, 1989). There is some empirical support for the strong direct effect of commitment on intent to stay/leave (e.g., Mathieu & Zajac, 1990; Meyer & Allen, 1997; Mueller & Price; Parasuraman; Price & Mueller, 1986). There is less support for the direct effect of commitment on turnover behavior (e.g., Mueller & Price; Parasuraman; Price & Mueller, 1986).

In a meta-analytic study, Irvine and Evans (1995) investigated the relationships among job satisfaction, behavioral intentions, and nurse turnover behavior. Study findings indicated a strong positive relationship between behavioral intentions and nurse turnover suggesting that as nurses develop their intentions to leave, they are inclined to follow through with turnover behavior. Findings also revealed a strong negative relationship between job satisfaction and behavioral intentions but a small negative relationship between job satisfaction and turnover, indicating that behavioral intentions acted as a mediator between job satisfaction and turnover behavior. A meta-analysis conducted by Hellman (1997) also supported the negative relationship between job satisfaction and intent to leave.

There is some evidence in the literature supporting the impact of psychological contract violations on intent to stay/leave. That is, intent to leave has been identified as a possible consequence of psychological contract violations. Lower intentions of staying with a current employer has been found to be strongly associated with higher perceived levels of contract violations (Robinson & Rousseau, 1994; Turnley & Feldman, 1998, 1999). In addition, Turnley and Feldman (1998, 1999) have found support for the buffering effects of select situational variables (e.g., availability of job alternatives, procedural justice in relation to layoffs and promotions, etc.) on intent to stay/leave.

Much of the research on intent to stay/leave or nurse retention has been

conducted within the acute care setting. Only two studies were found in the literature that dealt with the intent to stay/leave of community health nurses. Study findings suggest that intrinsic rewards (Hughes & Marcantonio, 1991) and job-related and work environment factors (Dunkin et al., 1992) are important predictors of intent to stay/leave.

In a descriptive correlational study, Hughes and Marcantonio (1991) examined the impact of intrinsic and extrinsic rewards and select personal characteristics on intentions of remaining with current employers. A stratified random sample of nurses working in hospital ($\underline{n}$ = 387), home health ($\underline{n}$ = 379), or public health ($\underline{n}$ = 389) settings in Illinois was derived from a larger state-wide sample of nurses. A researcher-developed questionnaire was used to assess extrinsic rewards (i.e., hourly wage, total benefits package, percentage of different shifts worked, number of monthly weekend shifts, and travelling distance to work) and intrinsic rewards (i.e., use of clinical skills, continuing education hours, job scope and responsibilities, and specialty certification). Information was also collected on select personal characteristics (i.e., gender, age, marital status, number of children, race, basic education preparation, years of nursing experience, years with current employer, hourly work-week, and enrollment in an education program). Finally, willingness to remain with current employers was assessed via an open-ended question. The findings revealed that the groups were very similar on most personal characteristics, with the

exception of a greater tendency for hospital nurses to have higher basic education preparation than either home health or public health nurses. Overall, hospital nurses were likely to receive the most benefits; public health nurses received more or similar benefits to home health nurses; and home health nurses reported the greatest opportunity to use clinical skills. During logistic regression analysis, two intrinsic rewards (i.e., greater skill use and narrower job scope) and one personal characteristic (i.e., more nursing experience) surfaced as the best predictors of hospital staff nurses' willingness to remain with their employer. Comparatively, one intrinsic reward (i.e., greater skill use) and one extrinsic reward (i.e., fewer weekend shifts per month) combined to predict home health nurses' and public health nurses' willingness to stay with their current employer. The authors noted that the findings suggest that non-monetary motivators may be critical determinants of job retention.

Dunkin et al. (1992) also investigated the relationship between job satisfaction and retention in a sample of community health nurses ($\underline{N}$ = 258) working in rural North Dakota. A researcher-developed instrument assessed reasons for practicing in rural areas, intent to stay, and reasons for leaving. Study findings revealed that future intentions of staying with current employers was significantly associated with greater satisfaction with autonomy, professional status, interactions, benefits and rewards, organizational climate, and task requirements. In contrast, plans to stay were not associated with salary

satisfaction. As well, longer anticipated lengths of stay was significantly associated with higher overall satisfaction levels. Finally, job availability and spouse relocation exerted the greatest influence on nurses' choice of current position and the decision to leave current employers, respectively.

In summary, attitudinal factors such as job satisfaction and organizational commitment have been found to influence intent to stay directly, while personal and contextual factors (e.g., age, experience, job level, workload, job stress, autonomy, work environment, etc.) have an indirect influence on nurses' intent to stay. It has been suggested that high turnover rates negatively affect employee morale, the quality of client care, and the success of new programs and services (Cavanagh, 1990; Fisher, Hinson, & Deets, 1994; Johnson, 1995; Jolma, 1990). Based on the possible negative implications of nurse turnover behavior for health care organizations, a greater understanding of the concept of intent to stay is crucial. More research is needed to explore factors influencing community health nurses' intent to stay, as well as the impact of health care reform on nurses' intent to stay and turnover behavior.

Summary

The previous review provides some insight into the various factors influencing work-related attitudes (i.e., psychological contract violation, job satisfaction, and organizational commitment) and behavioral intentions (i.e.,

intent to stay/leave and job search). Although there is a growing amount of empirical research related to community health nurses' job satisfaction, much less attention has been given to other provider outcomes (i.e., psychological contract violation, organizational commitment, and intent to stay). Overall the literature suggests that multiple factors, both personal and contextual (i.e., job-related and work environment), exert separate and interactive effects on provider outcomes. In general, empirical findings suggest that job-related (e.g., job scope, task identity, autonomy, job importance, etc.) and work environment (e.g., work-related stress, supportive structures, interaction/communication, coworker relationships, role conflict and overload, etc.) factors more strongly influence provider outcomes than personal factors (e.g., age, education, years in nursing, organizational tenure, etc.). There is an obvious need for more research into the factors that influence community health nurse outcomes (i.e., psychological contract violation, job satisfaction, organizational commitment, and intent to stay).

Discussion

Regionalization of health services was conceived as the most conducive approach to improving effectiveness and reducing inefficiencies pervading the Canadian health care system. Survey findings suggest that board members perceive the devolution of authority to regional structures as one approach to

facilitating the coordination and integration of health services and enhancing their responsiveness to local needs. It is also apparent that there may be few cost savings with regional boards forced to confront many obstacles while attempting to meet their respective mandates. The most glaring challenges identified in the literature were the limited power devolved to regional structures, inadequate access to relevant information to make important decisions, inadequate preparation and experience of board members for decision-making about health-related matters, and difficulty achieving a meaningful balance between conflicting priorities (i.e., health promotion and community-based services versus home care for higher acuity clients with diverse needs).

While only a few studies have examined the impact of health reforms on community health providers, it is conjectured that nurses, the largest group of health care providers, will be most affected by these reforms. Research findings suggest that system changes have had both positive and negative repercussions for community health nurses. Some research studies have reported on the negative outcomes of reforms (e.g., greater anxiety and uncertainty, greater perceived stress, insecurity, loss of trust, decreased job satisfaction, greater burnout, decreased productivity, etc.), while others have identified positive outcomes (e.g., greater autonomy, new and challenging roles, more staff and client involvement in decision-making, greater community involvement, better interdisciplinary approaches to care, greater staff empowerment, etc.).

The review of the literature highlighted the complex nature of provider outcomes and the multiple factors influencing them. The variant conceptualizations and operational measures of provider outcomes (i.e., job satisfaction, organizational commitment, and intent to stay) makes meaningful cross-study comparisons more difficult. Despite these inconsistencies, the empirical data suggest that multiple factors (i.e., job-related, work environment, and personal characteristics) exert separate and interactive effects on most provider outcomes. Furthermore, research findings suggest that contextual factors (i.e., job-related and work environment) have a much stronger influence on provider outcomes than personal factors.

While there is some empirical support for the role played by psychological contracts in the business work environment, there is limited evidence of the importance of specific job-related and work environment factors for increasing or decreasing perceived contract violations. Nevertheless, there are indications that more extensive restructuring and perceptions of employer control over significant changes may very well increase perceived contract violations. Significantly, no studies were identified that addressed the nature and importance of psychological contracts and the conditions for their violations, as well as the consequences, in the health care field.

Given the predicted nursing shortage and ever-changing work environments, it is imperative that health care organizations develop a greater

understanding of the potential implications of system changes for all providers. More research is needed to examine the major premises of integrated causal models of nursing turnover, and to determine the importance of specific job-related and work environment factors in the aftermath of major restructuring initiatives. This is particularly important for the community health sector where there have been limited research efforts directed towards examining the impact of health care reforms on provider groups, especially community health nurses.

Conceptual Framework

Several models have been developed to explain the importance of various factors postulated to influence nurse turnover behavior (e.g., Alexander et al., 1998; Curry et al., 1985; Irvine & Evans, 1995; Mueller & Price, 1990; Parasuraman, 1989; Price & Mueller, 1981, 1986; Weisman et al., 1981). Despite some variations between the causal models of nursing turnover, most of them incorporate determinants (e.g., job-related and work environment, etc.), intervening attitudes (e.g., job satisfaction, organizational commitment, etc.), intervening behaviors (e.g., intent to stay/leave, etc.), and correlates (i.e., personal characteristics or attributes). These models postulate that the intervening variables affect each other and depict a causal, linear process (i.e., job satisfaction having a greater effect on commitment than intent to stay, and commitment exerting a greater effect on intent to stay than actual turnover).

Empirical support for the interrelationships between the intervening attitudes and behaviors have been fairly consistent, while the evidence is less convincing with regard to the impact of attitudes and behavioral intentions on actual turnover.

The original turnover models proposed by Price and Mueller (1981, 1986) were modified based on new theoretical insights derived from empirical findings. Mueller and Price (1990) proposed an integrated model to explain the influence of various economic factors (i.e., pay, supply/demand of local labor market, employee's perception of external opportunity structure, and training), psychological factors (i.e., explicitness of the decision, publicity of the decision with friends, range of choice available at the time of the decision, and the extent to which external constraints affected the choice), and sociological factors (i.e., routinization, autonomy, feedback, work group cohesion, work load, task identity, work motivation, professionalism, kinship responsibility, and community participation) on voluntary turnover. The intervening variables are job satisfaction, organizational commitment, and intent to stay, while the outcome variable is voluntary turnover.

In the Mueller and Price (1990) integrated model, the determinants or predisposing factors (i.e., job-related and work environment) were proposed to exert a separate and interactive effect on each intervening variable. As well, intervening variables affect each other, with job satisfaction having a greater effect on commitment than intent to stay, and commitment exerting a greater

effect on intent to stay than on actual turnover. Finally, personal characteristics or attributes were defined as exogenous variables which influenced intervening variables to a considerably lesser degree.

Despite its documented importance in the business sector, very little consideration has been given to the covariate attitude of psychological contract violations. Based on a review of the literature and research findings, Turnley and Feldman (1998, 1999) proposed that major corporate restructuring would have significant ramifications for the conditions under which psychological contracts would be more susceptible to violation. The authors proposed that a linear relationship existed between psychological contract violations, select situational factors (i.e., availability of attractive employment alternatives; procedural justice during layoffs, pay raises and promotion decisions; likelihood of future violations; quality of relationships with supervisors; and quality of relationships with colleagues), and negative reactions to or consequences of contract violations (i.e., increased exit behaviors, increased voiced objections to upper management, decreased loyalty to the organization, and greater neglect of in-role responsibilities). Specifically, the situational factors were expected to moderate the type and intensity of contract violations, as well as to buffer the impact of perceived contract violations on possible consequences. Turnley and Feldman (1998, 1999) reported finding some empirical support for the major hypotheses of their model.

The conceptual model used in this study, the CMBI, is presented in Figure 1. The CMBI is based on the integrated causal models of nurse turnover (Mueller & Price, 1990; Price & Mueller, 1986) and Turnley and Feldman's (1998, 1999) model of the consequences of psychological contract violations. This model depicts the hypothesized relationships among correlates, determinants, covariates or intermediate outcomes, and behavioral intentions. The determinants exert a separate and interactive effect on intermediate outcomes and behavioral intentions. Importantly, it is proposed that intermediate outcomes moderate the impact of determinates on successive outcomes and behavioral intentions. Each intermediate outcome directly influences the other, exerts an indirect effect on other intervening attitudes through the one immediately following it, and exerts a separate and interactive effect on behavioral intentions. Finally, correlates (i.e., personal characteristics and staffing issues) influence behavioral intentions directly and indirectly through determinants and intermediate outcomes.

Definitions

This section presents the definitions used for the various concepts included in the current study. The following discussion is organized according to the major components of the CMBI.

Determinants. The determinants selected for investigation in the current

study were limited to the overall perceptions of the impact of health care reforms. The term reforms refers to multi-level changes that have been occurring within the health care system and diverse settings. More specifically, the determinants included perceptions of the importance of reforms and other job-related and work environment factors (i.e., emotional climate of the workplace, practice-related issues, quality of care, safety concerns, and standards of care) (Way, 1995).

Correlates. The correlates (i.e., personal characteristics and staffing issues) selected for investigation in this study included key extraneous variables which could potentially explain any variations in community health nurses' perceptions of the impact of health care reforms, work-related attitudes, and behavioral intentions. Personal characteristics in this study included age, gender, education, region of employment, primary area of responsibility, current position, years experience, current position tenure, and employment status. Staffing issues included district caseload, absenteeism due to sick leave, and staffing adequacy. Many of these variables were consistent with those investigated in previous research on work-related attitudes and behavioral intentions (i.e., Blegen, 1993; Cumbey & Alexander, 1998; Irvine & Evans, 1995; Lucas et al., 1988; Mathieu & Zajac, 1990; Mueller & Price, 1990; Price & Mueller, 1981, 1986; Shuster, 1992).

Intermediate outcomes. The intermediate outcomes (i.e., work-related attitudes) investigated in the current study included psychological contract

violation, restructuring satisfaction, general job satisfaction, and organizational commitment. The definitions for these variables were based on the work of a variety of authors.

Psychological contracts consist of individuals' beliefs or perceptions regarding reciprocal obligations between themselves and employing organizations (Rousseau, 1989, 1990). Employee expectations pertaining to employer obligations to them (e.g., job security, fair wages, appreciation, etc.) in return for employee actions (e.g., hard work, loyalty, etc.) form the basic tenets of psychological contracts (Robinson & Rousseau, 1994; Rousseau, 1989). Violations of psychological contracts occur when employees perceive that employers have failed to meet one or more obligations (Robinson & Rousseau; Rousseau, 1989, 1990). It is also postulated that psychological contract violations influence both employee attitudes and behaviors, and often lead to strong emotional and affective states which have negative implications for the employment relationship (Morrison & Robinson, 1997; Rousseau, 1989).

Satisfaction with restructuring initiatives was limited to perceptions of managerial support and interdisciplinary relations (Way, 1999a) in the current study. Relations with supervisors is a key component of job satisfaction scales (e.g., MMSS, JSS, MJS, etc.). As a job-related or work environment factor, relations with supervisors has been shown to depict moderate to strong associations with overall job satisfaction (Blegen, 1993; Irvine & Evans, 1995;

Traynor & Wade, 1993). Recent research studies in community health have also found support for the important influence of interdisciplinary relations on job satisfaction (Ellenbecker & Warren, 1998; Parahoo & Barr, 1994; Reutter & Ford, 1998; Traynor & Wade).

Job satisfaction was conceptualized in a variety of ways in the literature. It has been identified as a key variable in causal models of nursing turnover behavior. Price and Mueller's (1986) definition of job satisfaction was used for the current study. These authors approached job satisfaction from a global perspective and define it as the degree to which an individual likes his or her job (i.e., an attitude).

Mowday et al. (1979) define organizational commitment as an attitudinal state which is reflective of active relations with an organization. It is defined as the strength of an individual's identification with and involvement in an organization, and is characterized by belief and acceptance of the organization's goals and values, a willingness to give extra effort on behalf of the organization, and a desire to remain a member of the organization.

Behavioral intentions. Intent to stay measured behavioral intentions in the current study. Intent to stay refers to an individual's perception of the likelihood of staying with their current organization. This study used Turnley and Feldman's (1998, 1999) definition of exit behaviors to assess behavioral intentions (i.e., intention to quit and actual job search behaviors).
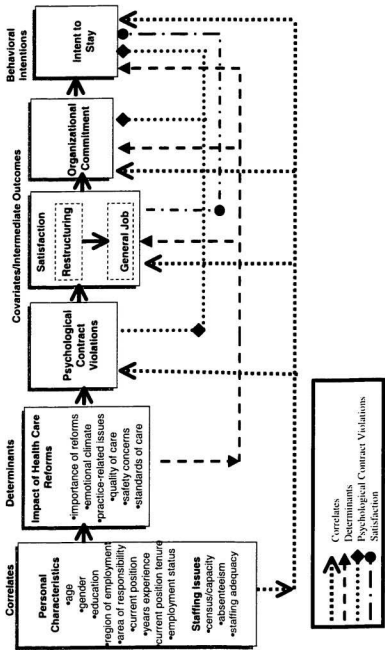
Figure 1: Conceptual Model of Behavioral Intentions

Source: Way, C., Gregory, D.M., Barrett, B., & Parfrey, P.S. (1999). Conceptual Model of Behavioral Intentions. St. John's: Memorial University of Newfoundland, Faculty of Medicine.

CHAPTER 3

Methodology

This study used a descriptive correlational design to investigate the impact of health care reforms on community health nurses working in the province of Newfoundland and Labrador. The interrelationships among the key study variables (i.e., personal characteristics and staffing issues, perceived impact of health care reforms, psychological contract violation, job satisfaction, organizational commitment, and intent to stay) were also examined. This chapter provides an overview of the sample, instruments, procedure, ethical considerations, data analysis, and limitations.

Population and Sample

The target population for this study was all registered nurses currently working in community health settings in the province of Newfoundland and Labrador. The term community health nurse refers to nurses directly affiliated with community-based programs (e.g., home care, continuing care, public health, etc.). For the purpose of this study, nurses employed with private health care agencies and other non-profit organizations were excluded. The accessible population was restricted to community health nurses who met the following inclusion criteria: (a) name recorded on an updated mailing list of the Association of Registered Nurses of Newfoundland and Labrador (ARNNL), (b) consented to

participate in nursing research on the annual registration renewal form and, (c) currently working with Regional Health and Community Services Boards, Grenfell Regional Health Services Board, or Health Labrador Corporation in staff or management positions.

The total size of the accessible population was 322, including 290 staff nurses and 32 nurse managers. Because response rates less than 50 percent are common with mailed out questionnaires, the decision was made to include the total accessible population in the survey. A total of 151 community health staff nurses and 19 managers returned the questionnaires, resulting in a 52.07% and 59.38% response rate, respectively (i.e., an overall response rate of 52.8%). The final sample size of 170 was adequate based on power analysis. Specifically, with a power level of .80 and an alpha level of .05, a sample size of 126 was needed to achieve an estimated medium effect of .25 for bivariate correlation tests (Polit & Hungler, 2000). Using the same power and alpha levels, a sample size of 126 (i.e., medium effect size of .50) was needed for two-group tests of difference (Polit & Hungler). Finally, using the same power and alpha levels, a sample size of 124 (i.e., medium effect size of .13) was needed for multiple regression analysis with 10 independent or predictor variables (Cohen, 1988).

Procedure

Questionnaires were mailed to all community health nurses working in the province who met the inclusion criteria. Data were collected from October to December, 2000. An explanatory cover sheet presenting the purpose and a brief overview of the study was attached to the front of the Employee Attitudes Survey (EAS) (see Appendix A). The ARRNL provided support and facilitated data collection by generating a list of potential staff nurses by registration number and matching region. In addition, the ARRNL contacted the various Health and Community Services Boards and generated a list of potential managers by registration number. ARRNL registration numbers were recorded on the questionnaires for the purpose of including the same people in a future survey. The questionnaires plus return envelopes with postage stamps were mailed to potential participants from the ARRNL. Approximately three weeks were allotted for participants to complete the questionnaires. Reminder letters (see Appendix B) were mailed out at this time. Both the cover sheets of the questionnaires and the reminder letters were printed on ARRNL letterhead.

Instruments

The EAS was used for data collection. The EAS is comprised of a General Information sheet, a Staffing Issues form, and six scales: Organizational Commitment Questionnaire (OCQ), Psychological Contract

Violation (PCV) scale, Intent to Stay (IS) scale, General Job Satisfaction (GJS) scale, Restructuring Satisfaction (RS) scale, and Revised Impact of Health Care Reform Scale (RIHCRS). A brief overview is presented on each section of the survey instrument, as well as reliability and validity findings.

General Information/Staffing Issues

A general information and staffing issues section was included in the EAS to elicit data on key extraneous variables which could potentially explain any variations in nurses' perceptions and attitudes. Information was collected on select personal characteristics (i.e., primary area of responsibility, current position, nursing experience, current position tenure, employment status, region of employment, education, gender, and age) and staffing issues (i.e., staffing patterns, workload, incidence of illness and work-related injuries, and perception of staffing adequacy in individual organizations).

OCQ

The OCQ, developed by Mowday et al. (1979), was used to assess community health nurses' overall commitment to an organization. The nine-item version was selected for use in the current study. Items are rated on a seven-point scale, ranging from (1) strongly disagree to (7) strongly agree, with higher scores indicating greater levels of commitment. Factor analysis has confirmed

the construct validity of the scale (i.e., unidimensional construct), and alpha coefficients were reported to range from .84 to .90 (Mowday et al., 1979). The OCQ has been used extensively in studies with health care providers, especially nurses. In a repeat survey of the nurses participating in Way's (1995) study, Way and Gregory (2000) reported a high internal consistency (α = .92) for the OCQ.

PCV Scale

Psychological contract violation was measured with the PCV scale developed by Turnley and Feldman (1998). The PCV scale is a four-item scale that assessed transactional and relational aspects of psychological contracts. The PCV scale is comprised of 3 positively worded items and 1 negatively worded item. Items are rated on a five-point Likert scale, ranging from (1) very poorly fulfilled, very infrequently, much less than promised, or much less than it should to (5) very well fulfilled, very frequently, much more than promised, or more than it should. Negatively worded items were reverse scored prior to data entry. Higher scores indicated less likelihood of perceived contract violations. Turnley and Feldman (1998) reported that the PCV scale had high internal consistency (α = .86). Way and Gregory (2000) also reported a very good internal consistency (α = .75) for the PCV scale.

IS Scale

The IS scale was adapted from the Intent to Quit and Job Search scales developed by Turnley and Feldman (1998). This three-item scale was used to measure the likelihood of nurses staying with their present employers, potential for leaving if another job opportunity occurred, and search efforts for another job. The IS scale is comprised of 1 positively worded item and 2 negatively worded items. Items are rated on a five-point scale, and ranged from (1) very unlikely/infrequently to (5) very likely/frequently, with higher scores indicating a higher intent to stay. Negatively worded items were reverse scored prior to data entry. The alpha coefficient reported for this scale was .92 (Turnley & Feldman, 1998). Way and Gregory (2000) also reported a very good internal consistency (α = .73) for the IS scale.

GJS Scale

The three-item GJS scale of the Job Diagnostic Survey, developed by Hackman and Oldman (1975), was used to measure nurses' overall job satisfaction. The items are rated from (1) strongly disagree to (7) strongly agree, with higher scores indicating greater levels of job satisfaction. The GJS scale has been used extensively in studies assessing nurses' job satisfaction, with reported alpha reliabilities $\geq$.76. Way and Gregory (2000) also reported a very good internal consistency (α = .78) for the GJS scale.

RS Scale

      The RS scale, developed by Way (1999a), was used to measure nurses' satisfaction with managerial support and interdisciplinary relations in the health care system. The RS scale is comprised of five items which are rated on a six-point scale, ranging from (1) strongly disagree to (6) strongly agree, with higher scores indicating greater satisfaction with restructuring efforts. Way and Gregory (2000) reported a high internal consistency ($\alpha = .89$) for the RS scale.

RIHCRS

      The RIHCRS (Way, 1999b) is a modified version of the IHCRS developed by Way (1995). The 28-item RIHCRS was designed to measure nurses' perceptions of the impact of health care reforms in six content domains (i.e., importance of reforms, emotional climate of the workplace, practice-related issues, quality of care concerns, safety concerns, and standards of care concerns). Minor modifications were made to the RIHCRS to increase the relevancy and applicability of certain items for community health settings.

      The RIHCRS is comprised of 15 positively worded items and 13 negatively worded items. Each item is rated on a six-point Likert scale, ranging from (1) strongly disagree (6) to strongly agree. Negatively worded items were reverse scored prior to data entry. Higher scores indicate more positive attitudes toward the impact of health care reforms.

In a stratified random survey of registered nurses, Way (1995) reported on the strong validity and reliability of the original IHCRS. Construct validity was supported by the strong, positive correlations between the subscales and total scale (range: r = .64 to .90), and exploratory and confirmatory factor analysis (i.e., 7-factor solution explained 59.3% the total variance). The alpha coefficient for the total scale was .87, with ranges between .61 to .79 for the subscales. In a subsequent study of acute care nurses, Pyne (1998) also reported that the IHCRS had good construct validity and reliability. The total scale was reported to have an internal consistency of .83, with ranges from .46 to .67 for the subscales. Way and Gregory (2000) also reported that the RIHCRS had good validity and reliability. Factor analysis supported the construct validity of the scale, with items loading on six factors representing theoretical meaningful clusters. As well, the total scale had an internal consistency of .87, with ranges from .60 to .82 for the subscales.

Ethical Considerations

Approval for this study was received from the Human Investigation Committee of Memorial University (see Appendix C). A letter of support for this study was also obtained from the ARNNL (see Appendix D). The ARNNL mailed the questionnaires to all nurses working in the community setting.

The purpose of the study was outlined on the cover sheet of the EAS.

Potential participants were assured of complete anonymity and confidentiality of responses. ARNNL registration numbers were recorded on the questionnaires but there was no way for the researcher to match registration numbers with personal identifiers (i.e., names or addresses). All identifying information was retained by the ARNNL to ensure confidentiality of responses. Participation was voluntary and consent was assumed by the return of the completed questionnaire.

Data Analysis

Data were coded and entered into the Statistical Package for the Social Sciences (SPSS) for analysis. There was a minimal amount of missing data, thus cases were deleted selectively on a variable by variable basis. Descriptive statistics were used to examine personal characteristics and staffing issues and the distribution of individual items, sub-scales, and total scale scores. One-way analysis of variance (ANOVA) and the t-test for independent groups were used to identify group differences for the subscales and total scores. The Bonferroni and Tamhane multiple comparison procedures were used to identify differences in group means for ANOVA. The appropriate bivariate correlation coefficient, Pearson's r or Spearman's rho (i.e., depending on the severity of score skewness), was used to determine the relationship between variables. An alpha

level of .05 was selected as the significance level for tests of association and difference.

Stepwise multiple regression analysis, using a sequential or hierarchical approach based on the logic of the CMBI, was used to determine the best predictors of psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay. Only independent variables found to exert a significant effect on intermediate outcomes and behavioral intentions were included in the regression analysis. The internal consistency of all EAS scales was also assessed with Cronbach's alpha.

Limitations

The use of the entire accessible population in the province increases the representativeness of the sample and the generalizability of the findings. However, the low response rate of 52.8% limits the extent to which study findings could be confidently generalized to all community health nurses in the province. An additional study limitation was the use of self-report instruments to collect data, as well as the possibility of collaboration among respondents working at the same site.

CHAPTER 4

Results

Study findings are presented in four sections. The first section presents a descriptive profile of the sample and key study variables. The second section summarizes the relationships among variables. The third section presents the results of multiple regression analysis. The final section discusses the reliability and validity of the instruments based on study findings.

Descriptive Profile

This section presents an overview of study findings on the personal characteristics of respondents. Study findings are also presented on the variables addressing staffing issues. Finally, descriptive findings are presented on key study variables: overall impact of health care reforms, restructuring and general job satisfaction, psychological contract violation, organizational commitment, and intent to stay.

Personal Characteristics

Tables 1 and 2 summarize key sample characteristics. The majority of respondents had a baccalaureate or higher educational level (63.5%), were primarily responsible for direct care (74.7%), were employed on a full-time permanent basis (77.1%), had 10 or more years of nursing experience (80%),

Table 1

Personal Characteristics ($\underline{N}$ = 170)[1]

Characteristic	$\underline{n}$	%
Education		
Diploma/certificate	62	36.5
Baccalaureate	99	58.2
Masters	9	5.3
Primary Area of Responsibility		
Direct Care	127	74.7
Management	19	11.2
Other (Coordinator/consultant)	24	14.1
Employment Status		
Full-time Permanent	131	77.1
Part-time Permanent	20	11.8
Temporary/Casual	19	11.2
Nursing Experience		
< 5 years	13	7.6
5 - 9 years	21	12.4
10 - 19 years	59	34.7
≥20 years	77	45.3
Current Position Tenure		
≤ 2 years	43	25.3
3 - 4 years	30	17.6
5 - 9 years	35	20.6
≥10 years	62	36.5

[1] Sample size is a function of missing data.

Table 2

Personal Characteristics and Staffing Issues ($\underline{N}$ = 170)[1]

Characteristic	$\underline{n}$	%
Personal Characteristics		
Region of Employment		
St. John's	37	21.8
Eastern	32	18.9
Central	46	27.1
Western	29	17.1
Labrador/Northern	26	15.3
Gender		
Female	167	98.2
Male	3	1.8
Staffing Issues		
District Caseload		
< 50 clients	22	16.8
50 - 100 clients	51	38.9
> 100 clients	58	44.3
Sick Leave (Annual)		
0 days	32	19.9
1 - 2 days	41	25.5
3 - 4 days	25	15.5
5 - 6 days	24	14.9
$\geq$ 7 days	39	24.2

[1] Sample size is a function of missing data.

and held their current positions for 5 or more years (57.1%). Respondents were fairly evenly distributed across regions, with the largest percentage located in Central (27.1%). The majority of respondents were female (98.2%). The mean age of the sample was 40.66 (SD ± 7.78) and ranged from 25 to 57 years.

Staffing Issues

Respondents provided information on their district client caseload and personal sick leave days. A significant percentage of respondents worked in *districts with a client caseload greater than one hundred (44.3%). The majority* of respondents reported 3 or more days of sick leave over the past year (54.6%).

Respondents were also asked how they felt about select staffing issues in their organizations. Most respondents indicated that the staffing situation was *inadequate for meeting client care requirements (67%) and casual nursing staff* or call backs were sometimes (38.5%) or often (35.9%) needed to bring the staff/client ratio up to adequate levels. As well, a significant percentage of respondents felt that the current availability of nursing staff for client care was less than prior to restructuring/downsizing (49%). Most respondents also reported that they frequently missed coffee/lunch breaks (55%). On a more positive note, a majority of respondents were never or rarely required to work on their days-off (81.3%). Finally, annual leave requests were never or rarely denied (91.7%).

Impact of Health Care Reforms

The areas addressed under the impact of health care reforms included
the importance of reforms, the emotional climate of the workplace, practice-
related issues, quality of care, safety concerns, and standards of care. Table 3
presents the means, standard deviations, and weighted means for the subscales
and total score. The findings suggested that most community health nurses
were neither totally negative nor positive about the overall impact of health care
reforms ($\underline{M}$ = 3.47). The findings also indicated that respondents were most
positive about the importance of reforms, standards of care, and practice-related
issues, respectively. Conversely, respondents were most negative about the
quality of care, followed by the emotional climate of the workplace and safety
concerns.

Table 4 displays the weighted means for the total and subscale scores of
the RIHCRS for community health nursing staff (i.e., direct care providers and
coordinators/consultants) and managers. Due to the close proximity of the
coordinators/consultants/ and managers (see Appendix E), the
means and the absence of any significance differences, the
decision was made to combine direct care providers and coordinators/
consultants into one group (i.e., staff nurses). The independent samples t-test
revealed few differences between staff and management personnel. The
findings indicated that community health nurses in management positions

Table 3

Mean and Standard Deviation Scores for the RIHCRS ($\underline{N}$ = 170)[1]

Subscales	$\underline{M}$	$\underline{SD}$	Weighted[a] $\underline{M}$	Range[b]
Importance of Reforms	17.3	3.04	4.33	1 - 6
Workplace Issues				
Emotional Climate	23.17	7.38	3.31	1 - 6
Practice-Related	14.19	4.75	3.55	1 - 6
Quality/Safety Concerns				
Quality of Care	11.67	3.71	2.92	1 - 6
Safety Concerns	16.68	4.08	3.34	1 - 6
Standards of Care	14.48	4.26	3.62	1 - 6
Overall Impact of Reforms	97.25	21.43	3.47	1 - 6

Note. RIHCRS = Revised Impact of Health Care Reform Scale.

[1] Sample size is a function of missing data.

[a] Subscale scores were summed and divided by the number of items to generate a weighted mean for comparison purposes.

[b] The rating scale for all of the subscales ranged from a low of (1) to a high of (6), with a mean of 3.5.

Table 4

Impact of Health Care Reform Variables by Job Level

Scales	Staff[1] Weighted (M)	Managers[2] Weighted (M)	t
Importance of Reforms	4.29	4.64	-1.87
Workplace Issues			
Emotional Climate	3.27	3.60	-1.28
Practice-Related	3.45	4.30	-3.02**
Quality/Safety Concerns			
Quality of Care	2.91	2.99	-0.34
Safety Concerns	3.34	3.27	0.38
Standards of Care	3.56	4.12	-2.19*
Overall Impact of Reforms	3.44	3.72	-1.45

[1] Sample size for the staff was 151. [2] Sample size for the managers was 19.

* $p < .05$, ** $p < .01$

were significantly more positive about practice-related issues, t (165) = -3.02, $p <$ .01, and standards of care, t (165) = -2.19, $p < .05$, than staff nurses.

The following presentation of findings is organized according to each subscale of the RIHCRS. The percentage of positive and negative responses reflect a collapsing of all levels of agreement (positive) and disagreement (negative), respectively.

Importance of reforms. With regard to health care reforms, most community health nurses' perceptions of the importance of reforms were positive (M = 4.33). Individual items making up this subscale provide greater insight into respondents' perceptions. More specifically, most community health nurses indicated that they believed that community-based care is a positive step (87.6%), appreciated the challenges facing their profession (94.8%), and felt empowered to be an active participant in affirming an important future role for their profession (74.5%). However, a significantly smaller percentage indicated that they understood the importance of downsizing/restructuring (49.1%).

Emotional climate. Most community health nurses viewed the emotional climate of the workplace in a negative light (M = 3.31). Individual items comprising the subscale provide greater insight into respondents' perceptions. More specifically, most respondents felt frustrated with the reduced level of care due to increased workloads (59.1%), found their jobs less satisfying and challenging since restructuring of the health care system (70.8%), felt that they

rarely received appreciation or recognition for what they did (63.4%), and believed that increased demands and stress in the workplace had led to unpleasant working relations with coworkers and other health care providers (54.5%) and had engendered a sense of disillusionment and low morale (84%). On a more positive note, most respondents indicated that the presence of a supportive environment enabled them to give that "extra" effort when their job demanded it (64.8%) and felt that it was not difficult to be motivated to act as client advocates (67.7%).

Practice-related issues. Overall, most community health nurses were neither totally negative nor positive about practice-related issues ($\underline{M}$ = 3.55). Most respondents felt that system changes had provided health care providers with an opportunity to have more control over their practice (55.1%), as well as opportunities (e.g., in-services, workshops, etc.) to keep current with latest developments (61.2%). Additionally, although most respondents felt that staff met regularly with management to discuss workplace concerns (58.8%), a smaller percentage believed that staff met regularly with management to identify ways to resolve problems and build on strengths (48.8%).

As noted earlier, community health nurses in management positions were significantly more likely to have positive attitudes toward practice-related issues than staff nurses. The areas with the greatest observed differences were perceptions of professional development opportunities and staff-supervisor

relations. More specifically, a significantly higher percentage of community health managers than staff nurses indicated that they were being provided with opportunities (e.g., in-services, workshops, etc.) to keep current (i.e., 84.2% and 58.3%, respectively). Furthermore, significantly more managers than staff believed that the staff met regularly with management to discuss workplace concerns (i.e., 94.8% and 54.3%, respectively) and to identify ways to resolve problems and build on strengths (i.e., 84.3% and 44.3%, respectively).

Quality of care. The mean score ($\underline{M}$ = 2.92) indicated that a significant number of community health nurses had concerns regarding the quality of care being provided in their organizations. Most respondents did not believe that supplies/resources were adequate to ensure client comfort (82.8%), however most felt that it was still possible to meet clients' basic care needs (54.4%). Furthermore, most respondents felt that due to increasing acuity levels it was not possible to adequately assess/meet clients' emotional/psychosocial needs (73.6%). As well, most respondents believed that clients do not have reasonable access to health services since downsizing/restructuring (59.3%).

Safety concerns. The mean score ($\underline{M}$ = 3.34) indicated that most community health nurses were divided about safety concerns in the workplace. Most community health nurses felt that agency procedures were being performed in a safe and competent manner (85.3%) and that the necessary physical (72.8%) and human (51.4%) resources were available to provide safe

care. In contrast, a much smaller percentage of community health nurses felt
that adequate teaching and counselling is being provided to clients and their
families prior to discharge (23.8%), and that adequate community resources
were always available for clients following hospital discharge (10.6%).

Standards of care. The mean score ($\underline{M}$ = 3.62) indicated that community
health nurses were slightly more positive than negative about the standards of
care present in their organizations. Most respondents felt that in-service
education on new policies/procedures were sufficient to avoid placing clients at
risk (66.9%) and that it was possible to meet professional care standards despite
increased acuity levels and reduction in the number of home visits (57.5%). In
contrast, most respondents believed that it was often necessary to lower care
standards due to overwhelming workload demands (62.7%) and felt that clients
were more susceptible to potential harm from errors or delays due to increased
demands in the workplace (72.2%).

As noted previously, nurses in management positions were significantly
more positive about standards of care than staff nurses. The area with the
greatest observed difference was the adequacy of in-service education on new
policies/procedures. More specifically, a significantly higher percentage of
managers than staff nurses felt that in-service education on new policies/
procedures were sufficient to avoid placing clients at risk (i.e., 89.5% and 64%,
respectively).

Work-Related Variables

The PCV scale, the RS scale, the GJS scale, and the OCQ were used to measure work-related attitudes. The IS scale assessed behavioral intentions. The mean, standard deviation, and weighted mean scores for the scales based on the total sample are presented in Table 5. The weighted means for the scales for each major group (i.e., management personnel and staff), as well as the independent samples t-test results, are summarized in Table 6. The findings revealed few differences between staff and management personnel. Study findings are organized according to each work-related variable.

Psychological contract violation. The weighted mean score ($\underline{M}$ = 3.02) for the PCV scale indicated that community health nurses were divided on whether or not they believed the organization had violated psychological contracts (see Table 5). The individual items of the PCV scale present a more complete picture of respondents' attitudes. On a positive note, 53% of the total sample felt that employers had fulfilled original commitments made to them upon hiring, with 51.5% indicating that employers only infrequently failed to meet commitments made to them. Although most respondents (69.3%) felt that the amount of rewards received from the organization matched what was promised, a significant number (66.3%) indicated that the amount of rewards received was lower than their expectations.

Table 5

Mean and Standard Deviation Scores for the PCV, RS, GJS, OCQ,

and IS Scales ($\underline{N}$ = 170)[¹]

Scales	$\underline{M}$	$\underline{SD}$	Weighted[a] $\underline{M}$	Range
Contract Violation (PCV)	12.06	2.54	3.02	1 - 5
Satisfaction				
Restructuring (RS)	17.19	6.28	3.44	1 - 6
General Job (GJS)	14.75	3.64	4.92	1 - 7
Commitment (OCQ)	40.70	11.22	4.52	1 - 7
Intent to Stay (IS)	10.92	7.37	3.47	1 - 5

Note. PCV = Psychological Contract Violation; RS = Restructuring Satisfaction; GJS = General Job Satisfaction; OCQ = Organizational Commitment Questionnaire; IS = Intent to Stay.

[¹] Sample size is a function of missing data.

[a] Subscale scores were summed and divided by the number of items to generate a weighted mean for comparison purposes.

Table 6

Work-Related Variables by Job Level

Scales	Staff[1] Weighted (M)	Managers[2] Weighted (M)	t
Contract Violation (PCV)	2.96	3.43	-3.02**
Satisfaction			
Restructuring (RS)	3.38	3.94	-1.82
General Job (GJS)	4.92	4.87	0.17
Commitment (OCQ)	4.44	5.17	-2.44*
Intent to Stay (IS)	3.42	3.83	-1.77

[1] Sample size for the staff was 151. [2] Sample size for the managers was 19.

* $p < .05$, ** $p < .01$

Community health nurses in management positions were significantly less likely to perceive psychological contract violations than staff nurses. t (160) = -3.02, p < .01. More specifically, a significantly higher percentage of managers than staff nurses (i.e., 79% and 48%, respectively) indicated that employers only infrequently failed to meet the commitments made to them when they were hired. Conversely, a significantly lower percentage of managers than staff nurses (i.e., 31.6% and 70.7%, respectively) felt that the amount of rewards received was less than their expectations.

Restructuring satisfaction. Study findings indicated that most community health nurses were neither completely satisfied nor dissatisfied with managerial support and interdisciplinary relations (M = 3.44). There were no significant differences observed between managers and staff. t (163) = -1.82, p > .05. The individual items of the RS scale provide some insight into how respondents viewed restructuring initiatives.

With regard to managerial support, most respondents tended to be dissatisfied with the visibility and accessibility of management personnel since restructuring (57.7%). Respondents were divided on their satisfaction with the degree to which managers sought input on professional care standards and with the amount of information received on organizational changes. Finally, most respondents were generally satisfied with interdisciplinary approaches to client care (61.7%), but were divided on their satisfaction with the amount of time spent

dealing with interdisciplinary conflicts.

Job satisfaction. Study findings indicated that community health nurses were slightly satisfied with their jobs (M = 4.92), with no significant differences observed between managers and staff, t (167) = 0.17, p > .05. Responses to individual items of the GJS scale indicated that most respondents were very satisfied with their jobs (74%) and the type of work in their jobs (84%). In contrast, only 46.2% of respondents believed that their coworkers were satisfied with their jobs.

Organizational commitment. The findings suggested that most community health nurses were slightly committed to their organizations (M = 4.52). Individual items making up this scale provide greater insight into community health nurses' perceptions. Most respondents indicated that they really cared about the fate of their organization (80.5%), were willing to give that extra effort to ensure organizational success (64.2%), were proud to be a part of the organization (64.7%), and were happy with their choice to select it over others (61.2%). A smaller percentage of respondents felt that their values and those of their organization were similar (55.8%), could tell their friends that their organization was great to work for (52.4%), and was the best of all possible organizations to work for (57.1%). On the negative side, only 42.9% of respondents felt that their organization inspired them to perform the best on the job, and 68.3% would not accept any type of job assignment to remain employed

with the organization.

Community health managers were significantly more committed to their organizations than staff nurses, t (168) = -2.44, p < .05. A significantly larger proportion of managers than staff nurses were willing to give that extra effort to ensure organizational success (i.e., 89.5% and 60.9%, respectively), and felt that the organization inspired the best job performance from them (i.e., 57.9% and 41%, respectively). As well, a significantly larger percentage of managers than staff nurses were willing to tell their friends that the organization was great to work for (i.e., 68.5% and 50.3%, respectively), and felt that their values and those of their organization were similar (i.e., 79% and 53%, respectively).

Intent to stay. The findings suggested that most community health nurses were uncertain about whether or not they would stay with current employers (M = 3.47). There were no significant differences observed between managers and staff, t (166) = -1.77, p > .05. More specifically, the majority of respondents indicated that they would likely stay with their current employer (70.4%) and had not seriously engaged in job search activities (63.9%). However, respondents were divided on whether they would stay if another employment opportunity became available (i.e., 34.3% would likely leave and 42.6% were unsure).

Interrelationships Among Study Variables

This section examines the effect of the various correlates including personal characteristics (i.e., age, gender, education, region of employment, job level, current position, nursing experience, current position tenure, and employment status) and staffing issues (i.e., district caseload, absenteeism due to sick leave, and staffing adequacy) on the perceived impact of health care reforms, psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay. ANOVA and the t-test for independent groups were used to identify group differences for the subscales and total scores. The Bonferroni and Tamhane multiple comparison procedures were used to identify differences in group means for ANOVA. An alpha level of .05 was selected as the significance level for all tests of difference.

When appropriate, the relationships among major study variables were also examined. Pearson's r was used to determine the relationship among variables. The non-parametric Spearman's rho was used when the assumptions for Pearson's r were violated. An alpha level of .05 was selected as the significance level for the tests of association.

Reform Impact and Personal Characteristics/Staffing Issues

The findings revealed few significant differences for the reform impact variables across most correlates (i.e., personal characteristics and staffing

issues). No significant differences were observed for education level, employment status, years of nursing experience, region of employment, age, absenteeism due to sick leave, or staffing adequacy. Analysis was not conducted for gender due to the small number of males (i.e., 3 in total). The only personal characteristic, besides job level (i.e., managers versus staff nurses), observed to influence the reform impact variables was current position tenure. Community health nurses who were in their current jobs for 3 to 4 years tended to be more positive about practice-related issues than those who held current positions for 10 years or more, $F (3, 163) = 3.38$, $p < .05$.

Additionally, the only staffing issues variable observed to influence the reform impact variables was district caseload. More specifically, community health nurses with a district caseload of less than 50 and between 50 to 100 clients tended to be more positive about the emotional climate of the workplace than those with a district caseload of greater than 100 clients, $F (2, 127) = 5.88$, $p < .01$. Community health nurses with a district caseload of 50 - 100 clients tended to be more positive about practice-related issues than those with district caseloads of greater than 100 clients, $F (2, 126) = 4.16$, $p < .05$. Furthermore, community health nurses with a district caseload of less than 50 clients tended to be more positive about the overall impact of reforms than those with a district caseload of greater than 100 clients, $F (2, 121) = 4.44$, $p < .05$.

PCV, RS, GJS, OC, IS and Personal Characteristics/Staffing Issues

Besides job level, no additional correlates were observed to influence community health nurses' ratings on psychological contract violation (PCV), restructuring satisfaction (RS), general job satisfaction (GJS), and organizational commitment (OC). The only significant effects observed were for employment status and age on intent to stay (IS). That is, older respondents and those with permanent positions were significantly more likely to intend to stay with current employers than younger respondents, $r = .20$, $p < .05$, and those with temporary or casual positions, $t (166) = 2.70$, $p < .01$.

Reform Impact and PCV, RS, GJS, OC, and IS

Table 7 summarizes the correlation findings between the total and subscale scores of the RIHCRS and work-related variables (i.e., PCV, RS, GJS, OC, and IS). There were statistically significant, positive relationships among all major components of the RIHCRS and work-related variables. Most of these relationships were in the moderate to strong range. The exceptions were the importance of reforms and quality of care variables which depicted low to moderate correlations with most work-related variables. The findings suggest that community health nurses with more positive perceptions about the impact of health care reforms were also more likely to feel that the organization had fulfilled its commitments, more satisfied with health care restructuring efforts and

their jobs, more committed to their organizations, and more likely to stay with their current employer.

Based on the coefficient of determination (i.e., r^2), the importance of reforms accounted for 7.8%, 11.6%, 10.2%, 16.8%, and 9.6% of the variance in psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay, respectively. The emotional climate of the workplace accounted for 44.9%, 53.3%, 30.3%, 46.2%, and 33.6% of the variance in psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay, respectively. Practice-related issues accounted for 33.6%, 54.8%, 14.4%, 34.8%, and 20.3% of the variance in psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay, respectively. Quality of care concerns accounted for 14.4%, 7.3%, 3.6%, 13.0%, and 4.4% of the variance in psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay, respectively. Safety concerns accounted for 24.0%, 28.1%, 16.8%, 24.0%, and 21.2% of the variance in psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay, respectively. In addition, standards of care concerns accounted for 24.0%, 34.8%, 14.4%, 24.0%, and 18.5% of the variance in psychological contract violation, restructuring satisfaction, general job

Table 7

Correlation of RIHCRS with PCV, RS, GJS, OC, and IS (N = 170)[1]

Variable	PCV r	RS r	GJS r	OC r	IS r
Importance of Reforms	.28***	.34***	.32***	.41***	.31***
Workplace Issues					
Emotional Climate	.67***	.73***	.55***	.68***	.58***
Practice-Related	.58***	.74***	.38***	.59***	.45***
Quality/Safety Concerns					
Quality of Care	.38***	.27***	.19*	.36***	.21**
Safety Concerns	.49***	.53***	.41***	.49***	.46***
Standards of Care	.49***	.59***	.38***	.49***	.43***
Overall Impact of Reforms	.63***	.72***	.52***	.67***	.57***

Note. RIHCRS = Revised Impact of Health Care Reform Scale; PCV = Psychological Contract Violation; RS = Restructuring Satisfaction; GJS = General Job Satisfaction; OC = Organizational Commitment; IS = Intent to Stay.

[1] Sample size is a function of missing data.

* $p < .05$. ** $p < .01$. *** $p < .001$

satisfaction, organizational commitment, and intent to stay, respectively. Finally, the overall impact of reforms accounted for 39.7%, 51.8%, 27.0%, 44.9%, and 32.5% of the variance in psychological contract violation, restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay, respectively.

PCV, RS, GJS, OC, and IS

Statistically significant, positive relationships were observed among all of the work-related variables (see Table 8). Psychological contract violation depicted moderate to strong correlations with restructuring satisfaction, $r = .67$, $p < .001$, general job satisfaction, $r = .45$, $p < .001$, organizational commitment, $r = .64$, $p = < .001$, and intent to stay, $r = .56$, $p < .001$. Moderate to strong correlations were also observed between restructuring satisfaction and general job satisfaction, $r = .51$, $p < .001$, organizational commitment, $r = .63$, $p < .001$, and intent to stay, $r = .57$, $p < .001$. As well, moderate to strong correlations were observed between general job satisfaction and organizational commitment, $r = .57$, $p < .001$, and intent to stay, $r = .55$, $p < .001$. Finally, organizational commitment evidenced a moderate to strong correlation with intent to stay, $r = .60$, $p < .001$.

In terms of the coefficient of determination (i.e., r^2), psychological contract violation accounted for 44.9%, 20.3%, 41.0%, and 31.4% of the variance in

Table 8

Correlations Among PCV, RS, GJS, OC, and IS Scales (N = 170)[1]

Variable	PCV r	RS r	GJS r	OC r
Contract Violation (PCV)	---	---	---	---
Restructuring Satisfaction (RS)	.67***	---	---	---
General Job Satisfaction (GJS)	.45***	.51***	---	---
Organizational Commitment (OC)	.64***	.63***	.57***	---
Intent to Stay (IS)	.56***	.57***	.55***	.60***

Note. PCV = Psychological Contract Violation; RS = Restructuring Satisfaction; GJS = General Job Satisfaction; OC = Organizational Commitment; IS = Intent to Stay.

[1] Sample size is a function of missing data.

*** $p < .001$

restructuring satisfaction, general job satisfaction, organizational commitment, and intent to stay, respectively. Restructuring satisfaction accounted for 26.0%, 39.7%, and 32.5% of the variance in general job satisfaction, organizational commitment, and intent to stay, respectively. General job satisfaction accounted for 32.5%, and 30.3% of the variance in organizational commitment and intent to stay, respectively. Finally, organizational commitment accounted for 36% of the variance in intent to stay.

Predictors of Outcome

Stepwise multiple regression analysis was used to identify significant predictors of intermediate outcomes (i.e., psychological contract violation, restructuring satisfaction, general job satisfaction, and organizational commitment) and behavioral intentions (i.e., intent to stay). Different combinations of predictor variables were used to identify the best regression model for each outcome variable. The reform impact variables (i.e., importance of reforms, emotional climate, practice-related issues, quality of care, safety concerns, and standards of care) were entered first as a group, followed by the covariates of each intermediate outcome variable, and finally the correlates (i.e., personal characteristics and staffing issues). The tabular presentations of the results are restricted to the final regression models for each outcome variable (see Tables 9 and 10).

Psychological Contract Violation

The first level modelling focused on examining the predictive power of the reform impact variables and correlates on perceived contract violation. Correlation analysis demonstrated significant positive relationships between all of the reform impact variables and psychological contract violation. Only one of the correlates (i.e., job level) was found to influence contract violation.

During the first step of regression analysis, emotional climate and practice-related issues combined to explain 44.6% of the variance in perceived contract violation. Emotional climate entered the regression equation first, accounting for 42.6% of the variance. This variable was followed by practice-related issues which accounted for an additional 2.0%. Importance of reforms, quality of care, safety concerns, and standards of care failed to enter the regression equation.

When job level was added at the second step, it also failed to enter the regression equation. The percent of variance explained by the impact variables remained unchanged following the addition of job level. The results of the final model are presented in Table 9.

Restructuring Satisfaction

The second level modelling considered the predictive power of the reform impact variables, psychological contract violation, and correlates on restructuring

satisfaction. Restructuring satisfaction depicted significant positive correlations with all of the reform impact variables and psychological contract violation. None of the correlates were found to influence restructuring satisfaction, and therefore were not entered into the regression analysis.

During the first step of regression analysis, practice-related issues, emotional climate, quality of care, and safety concerns combined to explain 64.6% of the variance in restructuring satisfaction. Practice-related issues entered the regression equation first, accounting for 53.9% of the variance. This variable was followed by emotional climate, quality of care, and safety concerns which accounted for an additional 8.1%, 1.4%, and 1.2%, respectively. Importance of reforms and standards of care failed to enter the regression equation.

When psychological contract violation was added at the second step, it surpassed quality of care and safety concerns in predictive power. The final model revealed that practice-related issues, emotional climate, contract violation, quality of care, and safety concerns combined to explain 68% of the variance in restructuring satisfaction (see Table 9). Practice-related issues entered the regression equation first, accounting for 54.5% of the explained variance. This variable was followed by emotional climate, contract violation, quality of care, and safety concerns which contributed an additional 7.9%, 3.2%, 1.4%, and 1.0%, respectively.

Table 9

Stepwise Multiple Regression on PCV, RS, and GJS (N = 170)[1]

	Multiple R	Adj. R^2	R^2 change	F Value	p
Variable		Contract Violation			
Emotional Climate	.653	.423	.426	112.23	.000
Practice-related Issues	.668	.439	.020	60.53	.000
		Restructuring Satisfaction			
Practice-related Issues	.739	.542	.545	178.76	.000
Emotional Climate	.790	.619	.079	122.95	.000
Contract Violation	.810	.650	.032	93.73	.000
Quality of Care	.819	.662	.014	74.31	.000
Safety Concerns	.825	.670	.010	61.79	.000
		General Job Satisfaction			
Emotional Climate	.571	.322	.326	71.65	.000
Restructuring Satisfaction	.596	.347	.029	40.54	.000

Note. PCV = Psychological Contract Violation; RS = Restructuring Satisfaction; GJS = General Job Satisfaction

[1] Sample size is a function of missing data.

General Job Satisfaction

The third level modelling considered the predictive power of the reform impact variables, psychological contract violation, restructuring satisfaction, and correlates on general job satisfaction. All of the reform impact variables, as well as contract violation and restructuring satisfaction, depicted significant positive correlations with job satisfaction. None of the correlates were found to influence job satisfaction, and therefore were not entered into the regression analysis.

During the first step of regression analysis, only one reform impact variable (i.e., emotional climate) entered the regression equation, accounting for 32.4% of the variance in general job satisfaction. Importance of reforms, practice-related issues, quality of care, safety concerns, and standards of care failed to enter the equation.

When perceived contract violation was added at the second step, it failed to enter the regression equation. Restructuring satisfaction was entered at the third step. The final model revealed that emotional climate and restructuring satisfaction combined to explain 35.5% of the variance in general job satisfaction (see Table 9). Emotional climate entered the regression equation first, accounting for 32.6% of the variance. This variable was followed by restructuring satisfaction which accounted for an additional 2.9%.

Organizational Commitment

The fourth level modelling considered the predictive power of the reform impact variables, psychological contract violation, restructuring satisfaction, general job satisfaction, and correlates on organizational commitment. Correlation analysis demonstrated significant positive relationships between organizational commitment and all of the reform impact variables, as well as contract violation, restructuring satisfaction, and job satisfaction. Only one of the correlates (i.e., job level) influenced commitment.

During the first step of regression analysis, emotional climate and practice-related issues combined to explain 48.1% of the variance in organizational commitment. *Emotional climate and practice-related issues* accounted for 45.8% and 2.3% of the explained variance, respectively. Importance of reforms, quality of care, safety concerns, and standards of care failed to enter the equation.

When perceived contract violation was added at the second step, emotional climate remained the best predictor of organizational commitment. Additionally, importance of reforms now entered the regression equation. Emotional climate, contract violation, and importance of reforms combined to explain 55.8% of the variance in commitment, contributing 48.4%, 6.2%, and 1.2%, respectively.

When restructuring satisfaction was added at the third step, importance of

reforms failed to enter the regression equation. The third model revealed that emotional climate, psychological contract violation, and restructuring satisfaction combined to explain 56.3% of the variance in commitment, contributing 48.5%, 6.3%, and 1.5%, respectively.

When general job satisfaction was entered at the fourth step, it surpassed psychological contract violation in predictive power and restructuring satisfaction failed to enter the regression equation. Emotional climate, general job satisfaction, and psychological contract violation combined to explain 60.1% of *the variance in commitment, contributing 48.5%, 6.9%, and 4.7%, respectively.*

The correlate (i.e., job level) was entered at the fifth step, but failed to enter the regression equation. The percentage of explained variance remained unchanged. The results of the final model are presented in Table 10.

Intent to Stay

The fifth level modelling considered the predictive power of the reform impact variables, psychological contract violation, restructuring satisfaction, *general job satisfaction,* organizational commitment, and correlates on intent to stay. Intent to stay depicted significant positive correlations with all impact variables, as well as psychological contract violation, restructuring satisfaction, general job satisfaction, and organizational commitment. Only two correlates (i.e., *employment* status and age) had a significant influence on intent to stay.

Table 10

Stepwise Multiple Regression on OC and IS ($\underline{N}$ = 170)[1]

Variable	Multiple $\underline{R}$	Adj. $\underline{R}^2$	$\underline{R}^2$ Change	$\underline{F}$ Value	$\underline{p}$
		Commitment			
Emotional Climate	.697	.482	.485	139.66	.000
Job Satisfaction	.744	.548	.069	91.39	.000
Contract Violation	.775	.593	.047	73.35	.000
		Intent to Stay			
Emotional Climate	.607	.365	.369	85.95	.000
Job Satisfaction	.664	.434	.073	57.70	.000
Contract Violation	.697	.475	.044	45.59	.000
Age	.718	.501	.030	38.22	.000
Employment Status	.730	.517	.018	32.68	.000

Note. OC = Organizational Commitment; IS = Intent to Stay

[1] Sample size is a function of missing data.

During the first step of regression analysis, only emotional climate entered the equation to explain 34.4% of the variance in intent to stay. Importance of reforms, practice-related issues, quality of care, safety concerns, and standards of care failed to enter the regression equation.

When perceived contract violation was added at the second step, it combined with emotional climate to account for 42.8% of the variance in intent to stay. Emotional climate accounted for 36.9% of the variance in intent to stay, and psychological contract violation accounted for an additional 5.9%.

When restructuring satisfaction was added at the third step, it combined with emotional climate and psychological contract violation to account for 44.5% of the variance in intent to stay. Emotional climate, psychological contract violation, and restructuring satisfaction contributed 36.8%, 6.0%, and 1.7% of the explained variance, respectively.

When general job satisfaction was added at the fourth step, restructuring satisfaction failed to enter the regression equation. General job satisfaction combined with emotional climate and psychological contract violation to account for 48.3% of the explained variance in intent to stay. Emotional climate, general job satisfaction, and psychological contract violation contributed 36.8%, 7.1%, and 4.4% of the explained variance, respectively.

When organizational commitment was entered at the fifth step, it failed to enter the regression equation. The correlates (i.e., employment status and age)

were entered into the regression equation at the last step. The final model revealed that emotional climate, general job satisfaction, psychological contract violation, age, and employment status combined to explain 53.4% of the variance in intent to stay (see Table 10). Emotional climate entered the regression equation first, accounting for 36.9% of the explained variance in intent to stay. This variable was followed by general job satisfaction, psychological contract violation, age, and employment status which contributed an additional 7.3%, 4.4%, 3.0%, and 1.8%, respectively.

Reliability and Validity of Study Instruments

The reliability and validity of the RIHCRS and PCV, RS, GJS, OCQ, and IS scales were also examined for the study population. Cronbach's alpha was used to assess internal consistency. The intercorrelations among subscale and total scores assessed the construct validity of the RIHCRS.

RIHCRS

Within the current sample, the total instrument had an alpha coefficient of .92, indicating a high level of internal consistency. Alpha coefficients for the subscales ranged from .41 to .86: importance of reforms (.41), quality of care (.60), safety concerns (.64), standards of care (.75), practice-related issues (.80), and emotional climate (.86). These findings indicate that the total scale and the

subscales have a fair to very good internal consistency.

Most of the intercorrelations among the subscales were statistically significant and within the moderate to strong range (see Table 11). The only exception was the low correlation between importance of reforms and standards of care. The findings suggest that the subscales are related and represent distinct dimensions of the impact of health care reforms (i.e., good discriminatory power). In summary, the intercorrelations among the subscales and the subscales to total scale suggest that the RIHCRS has good construct validity.

PCV, RS, GJS, OCQ, and IS Scales

Alpha coefficients were also generated for the scales measuring psychological contract violations (i.e., PCV scale), restructuring satisfaction (i.e., RS scale), general job satisfaction (i.e., GJS scale), organizational commitment (i.e., OCQ), and intent to stay (i.e., IS scale). The internal consistency for the PCV scale (α = .82), RS scale (α = .90), GJS scale (α = .80), OCQ (α = .91), and IS scale (α = .80) was quite strong in the current sample.

Summary

Study findings indicated that community health nurses in this study were neither totally negative nor positive about the overall impact of health care reforms six to seven years following regionalization of community health

Table 11

Correlations Among RIHCRS and Subscales ($\underline{N}$ = 170)[1]

Variable	EC	PR	QC	SI	SC	RIHCR
Importance of Reforms (IR)	.43***	.47***	.40***	.35***	.29***	.59***
Emotional Climate (EC)		.70***	.50***	.62***	.74***	.90***
Practice-Related (PR)			.37***	.52***	.56***	.79***
Quality of Care (QC)				.61***	.53***	.69***
Safety Issues (SI)					.66***	.81***
Standards of Care (SC)						.82***

Note. RIHCRS = Revised Impact of Health Care Reform Scale.

[1] Sample size is a function of missing data.

*** $\underline{p}$ < .001

services. Respondents were most positive about the importance of reforms, standards of care, and practice-related issues, respectively. In contrast, respondents were most negative about the quality of care, emotional climate of the workplace, and the adequacy of safety measures, respectively. Study findings also demonstrated that community health nurses in management positions were significantly more positive about practice-related issues and standards of care than staff nurses. Additionally, only current position tenure and district client caseload were observed to influence nurses' perceptions about the impact of reforms. More specifically, current position tenure influenced practice-related issues and district client caseload influenced emotional climate of the workplace, practice-related issues, and perceptions of the overall impact of reforms.

The findings also demonstrated that community health nurses were slightly satisfied with their jobs and were slightly committed to their organizations. On the other hand, community health nurses were divided on whether or not they believed the organization had violated psychological contracts, were neither completely satisfied nor dissatisfied with managerial support and interdisciplinary relations since restructuring, and were uncertain about whether or not they would stay with their current employer. The findings also indicated that community health nurses in management positions were significantly less likely to perceive psychological contract violations and were significantly more committed to their

organizations than staff nurses. Most correlates were not found to influence work-related variables (i.e., psychological contract violation, restructuring satisfaction, job satisfaction, and organizational commitment). The only exceptions were the effects of employment status and age on intent to stay.

All of the work-related variables were significantly and positively related to the total RIHCRS score and its subscales. That is, less likelihood of contract violations, higher levels of restructuring and job satisfaction, greater organizational commitment, and greater intent to stay were associated with more positive perceptions of the importance of reforms, the emotional climate of the workplace, practice-related issues, quality of care, safety measures, and standards of care. As well, all of the work-related variables depicted significant, positive relationships with each other.

Different combinations of impact of reform variables and covariates emerged as significant predictors of psychological contract violation, job satisfaction, and organizational commitment. In all cases, none of the correlates were observed to be high in predictive power. One impact variable (i.e., emotional climate) emerged as a significant predictor of psychological contract violation, accounting for 42.6% of the total variance. A second impact variable (i.e., practice-related issues) contributed an additional 2.0% to the explained variance in psychological contract violation. With regard to restructuring satisfaction, one impact variable (i.e., practice-related issues) emerged as a

significant predictor, accounting for 54.5% of the total variance. A combination of three impact variables (i.e., emotional climate, quality of care, and safety concerns) and one covariate (i.e., psychological contract violation) contributed an *additional 13.5% to the explained variance in restructuring satisfaction.* In addition, emotional climate emerged as a significant predictor of job satisfaction, accounting for 32.6% of the total variance. One covariate (i.e., restructuring satisfaction) contributed an additional 2.9% to the explained variance.

With regard to organizational commitment, one impact variable (i.e., emotional climate) and two covariates (i.e., job satisfaction and psychological contract violation) combined to explain 48.5% and 11.6%, respectively, of the *explained variance in commitment.* Furthermore, the regression findings on intent to stay revealed that one impact variable (i.e., emotional climate) was the best predictor variable, accounting for 36.9% of the total variance. Two covariates (i.e., job satisfaction and psychological contract violation) and two correlates (i.e., age and employment status) combined to explain an additional 11.7% and 4.8%, respectively, of the explained variance in intent to stay.

CHAPTER 5

Discussion

The current study addressed community health nurses' perceptions of the impact of health care reforms and their work-related attitudes and behavioral intentions. The CMBI was used as the conceptual framework for this study.

The CMBI proposes that several factors influence behavioral intentions (i.e., intent to stay). These factors include determinants (i.e., perceptions of the impact of health care reforms or job-related and work environment factors), covariates or intermediate outcomes (i.e., intervening attitudinal states), and correlates (i.e., personal characteristics and staffing issues). It is proposed by the CMBI that the determinants, covariates or intermediate outcomes, and the correlates exert a direct and indirect effect on behavioral intentions. The following discussion of study findings is organized according to the major components of the CMBI and the relationships depicted by it.

Determinants

The determinants selected for this study included perceptions of the importance of reforms, emotional climate of the workplace, practice-related issues, quality of care, safety concerns, and standards of care. A focus of this study was community health nurses' current perceptions of the impact of health care reforms. In the current study, community health nurses were neither totally

negative nor positive about the overall impact of reforms. The areas receiving the most positive ratings were the importance of reforms, standards of care, and practice-related issues, respectively. In contrast, community health nurses were most negative about the quality of care, followed by the emotional climate of the workplace and safety concerns. These findings are similar to those reported by Way (1995) and Way and Gregory (2000) on the most positive and negative areas of reform impact for nurses working in the province.

Studies of community health nurses in other geographical areas provide additional support for concerns about the impact of reforms on select job-related and work environment factors. In particular, several authors have found support for community health nurses' growing concerns about the negative impact of reforms on the emotional climate of the workplace (i.e., morale, work relations, and frustration), practice-related issues (i.e., autonomy and supervisor relations), quality of care (i.e., accessibility of services), and standards of care (e.g., Corey-Lisle et al., 1999; Ellenbecker & Warren, 1998; Parry-Jones et al., 1998; Rafael, 1999; Reutter & Ford, 1998; Traynor, 1995).

In the current study, the most problematic area for community health nurses was the negative impact of system reforms on the quality of care available to clients. Even though a goal of health care reforms such as regionalization is to improve the quality of health care, some authors have suggested that the development of community-based services have not kept

pace with decreasing institutional services, and therefore quality health care is at stake (Attenborough, 1997; Jackson, 1995; Shamian & Lightstone, 1997; Vail, 1995). Several research studies have documented community health nurses' concerns regarding the impact of reforms on the quality of care (Corey-Lisle et al., 1999; Parry-Jones et al., 1998; Rafael, 1999; Ruetter & Ford, 1998; Shindul-Rothschild et al., 1996, 1997; Traynor, 1995; Way, 1995).

In the current study, the general perception was that supplies/resources were inadequate to ensure client comfort, increasing acuity levels made it more difficult to address clients' emotional and psychosocial needs, and clients did not always have reasonable access to health care services. Similarly, Rafael (1999) and Reutter and Ford (1998) reported that public health nurses were concerned about the changed focus of their practice from direct to more indirect contact with clients following major restructuring in community health. Significantly, the nurses in the Reutter and Ford (1998) study reported having less time for direct involvement with clients, resulting in a more needs-oriented practice as opposed to one focused on illness prevention and health promotion activities. Comparatively, Parry-Jones et al. (1998) found that both community-based social workers and nurses perceived decreases in the quality of care and their ability to manage workloads following the introduction of a care management model.

Changes in the emotional climate of the workplace were also a significant

concern of the community health nurses participating in the current study. Specifically, most respondents felt that their jobs were less satisfying and challenging, and that they rarely received recognition or appreciation. A *significant percentage of community health nurses also reported feeling* frustrated with the reduced level of care being provided due to increased workloads, and felt that increased workplace stress and demands were responsible for unpleasant working relations and low morale. In a qualitative study of nurses' perceptions of the impact of reforms on practice, Corey-Lisle et al. (1999) also found support for the perceived negative impact of increased workloads on the level of care, stress and frustration, morale, and job *satisfaction. There is additional support in the literature for the negative impact* of reforms on the emotional climate of the work environment (e.g., Davis, 1998/1999; Ellenbecker and Warren, 1998; Leatt et al., 1997; Parry-Jones et al., 1998; Traynor,1995). In two studies of managers and executives subjected to varying degrees of restructuring, Turnley and Feldman (1998, 1999) found that those working in firms with more extensive restructuring were more likely to report negative impacts on organizational and supervisor support, and the *challenge and excitement of the job.*

Despite the negative consequences of reforms, the current study also provides support for positive outcomes, especially concerning the importance of reforms and improved practice opportunities. Specifically, most respondents

believed that community-based care was a positive step and facilitated greater control over nursing practice. As well, they were appreciative of the professional challenges facing them, were empowered to participate in affirming an important future role for the profession, and felt that adequate opportunities were present *for keeping current with latest developments.* Comparable findings on some of the positive impact of reforms (i.e., greater individual and professional growth opportunities, new and challenging roles, and improved communication and greater collaboration with clients, health care providers, and other community *partners) have been reported by several authors (Corey-Lisle et al., 1999;* Ellenbecker & Warren, 1998; Rafael, 1999; Reutter & Ford, 1998).

It is also interesting to note that the current study findings indicate that community health nurses in management positions are significantly more positive about practice-related issues and standards of care than staff nurses. Similar findings were reported by Traynor (1995) and Way (1995) who found that nurse managers tended to be more positive about the impact of most health care reforms.

Intermediate Outcomes and Behavioral Intentions

Intermediate outcomes selected for investigation in the current study included psychological contract violation, restructuring satisfaction, general job satisfaction, and organizational commitment. Intent to stay measured behavioral

intentions. One of the research questions in this study examined community health nurses' ratings of intermediate outcomes and their likelihood of staying with current employers. The following discussion of study findings is organized according to each outcome and intent to stay (*i.e., behavioral intentions*).

Psychological Contract Violation

In the current study, community health nurses were divided on whether or not they believed the organization had violated psychological contracts. Conflicting findings are reported in the literature. Turnley and Feldman (1998) found that only 25% of the managers and executives working for organizations *that had undergone varying degrees of restructuring reported contract violations*. In contrast, Robinson and Rousseau (1994) found that 54.8% of their sample of MBA graduate alumni experienced at least one case of contract violation by employers. As well, Way and Gregory (2000) reported that approximately 51% of their sample of acute care nurses felt that their psychological contracts had been violated. No other studies were identified from the literature that investigated the psychological contract violations of nurses.

More specifically, most community health nurses in the current study reported that employers had fulfilled original commitments made to them upon hiring and only infrequently failed to meet commitments. While the amount of rewards received matched what was promised, it was lower than expectations.

Similar findings on the greater likelihood of perceived violations with monetary-related matters (e.g., base salary, overall benefits, regularity of pay increases, etc.) were reported by Robinson and Rousseau (1994) and Turnley and Feldman (1998, 1999).

In the current study, nurses in management positions were significantly less likely to perceive psychological contract violations than staff nurses. No studies were identified from the literature that explored nurses' level of contract violation according to job level (i.e., management vs. staff).

Restructuring Satisfaction

In the current study, findings indicated that community health nurses were neither completely satisfied nor dissatisfied with restructuring initiatives. In contrast to this study, Way and Gregory (2000) reported that most nurses in their sample were generally dissatisfied with most aspects of restructuring.

In this study, community health nurses were most dissatisfied with the visibility and accessibility of management personnel since restructuring. Respondents were also divided on their levels of satisfaction with how well management sought input on professional care standards and provided input on organizational changes. Comparatively, Dunkin et al. (1992) and Juhl et al. (1993) found that community health nurses were neither satisfied nor dissatisfied with the organizational climate (i.e., opportunities for input into decision-making,

governance, and policy development; and leadership styles and structural constraints). Other researchers have reported that community health nurses were either slightly dissatisfied (Parahoo & Barr, 1994; Rout, 2000; Stewart & Arklie, 1994) or neither satisfied nor dissatisfied with managerial support (Jansen et al., 1996). *Interestingly, Parry-Jones et al. (1998) found that community social workers and nurses believed that a significant improvement had occurred in the quality of communication with managers following implementation of a care management approach to service delivery.*

In the current study, respondents were mostly satisfied with the interdisciplinary approach to care but divided on the amount of time spent dealing with interdisciplinary conflicts. Comparatively, other researchers have found support for community health nurses' satisfaction with the increased focus *on interdisciplinary care subsequent to health care reforms* (Ellenbecker & Warren, 1998; Juhl et al., 1993; Parahoo & Barr, 1994; Reutter & Ford, 1998).

Job Satisfaction

In the current study, community health nurses were slightly satisfied with their jobs. Similarly, Way and Gregory (2000) reported that nurses in their sample were neither totally satisfied nor dissatisfied with their jobs. In contrast, other studies of community health nurses indicated that nurses had moderate *(Cumbey & Alexander, 1998; Jansen et al., 1996; Lynch, 1994; Shuster, 1992)* to

high satisfaction levels (Parahoo & Barr, 1994).

Only a few studies investigated job satisfaction following organizational change. In the Parry-Jones et al. (1998) study, most of the staff reported experiencing a decrease in job satisfaction (51%) and satisfaction with overall work conditions (57%). In contrast, Woodcox et al. (1994) found that the satisfaction levels of public health nurses did not evidence significant changes over time following transition from a generalist to a specialist service deliver system. In addition, cross-study comparisons were difficult due to the variety of instruments used to assess job satisfaction.

It is also interesting to note that the mean job satisfaction scores for *management personnel and staff nurses did not differ significantly* in the current study. Juhl et al. (1993) also did not find any significant difference in the job satisfaction levels of nurse administrators and staff nurses.

Organizational Commitment

The current study's findings indicated that community health nurses were slightly committed to their organizations. Similarly, Way and Gregory (2000) reported a slightly low or neutral level of commitment in a sample of acute care nurses working in restructured organizations. In addition, study findings indicated that community health managers were significantly more committed to their organizations than staff nurses. No other studies were found that

investigated the organizational commitment of community health nurses within the context of health care reforms.

Intent to Stay

In the current study, findings indicated that community health nurses were uncertain about whether they would stay with current employers. The same level of intent to stay was reported by Way and Gregory (2000). In addition, the current study failed to find significant differences between managers and staff nurses with regard to their intentions of staying with current employers (i.e., behavioral intentions). No other studies were identified from the literature that investigated the impact of health care restructuring on community health nurses' behavioral intentions. However, three studies from the business literature (Robinson & Rousseau, 1994; Turnley & Feldman, 1998, 1999) reported that employees working in organizations that had undergone extensive restructuring were more likely to intend to leave or engage in job search behaviors than those working in more stable work environments.

Factors Influencing Intermediate Outcomes and Behavioral Intentions

The CMBI proposes that determinants, intermediate outcomes, and correlates exert a direct and indirect effect on behavioral intentions. As well, the model depicts a causal, linear process with intermediate variables influencing

each other and intervening between preceding and subsequent variables. The current study investigated the relationships between and among key study variables. The following discussion is organized according to the various relationships outlined in the CMBI.

Determinants, Outcomes, and Intentions

A focus of the current study was to examine the effects of determinants on intermediate outcomes and behavioral intentions. The following discussion is presented according to each intermediate outcome and intent to stay.

Psychological contract violation. The study findings revealed moderate to strong, positive relationships between the psychological contract violation score and the total RIHCRS and most subscale scores. The only exception was the importance of reforms subscale which depicted a low, positive correlation with psychological contract violation. In other words, community health nurses with more positive perceptions about the overall impact of reforms (i.e., job-related and work environment factors) were also more likely to feel that the organization had fulfilled its commitments to them.

There were no studies identified from the health care literature that investigated the impact of reforms or other job-related and work environment factors upon community health nurses' psychological contracts. However, two studies (Turnley & Feldman, 1998, 1999) from the business literature provided

support for the relationship between the impact of reforms (i.e., job-related and *work environment factors) and psychological contracts.* These authors found that employees working in organizations that had undergone extensive restructuring were more likely to report psychological contract violations than their counterparts in more stable firms. In addition, Turnley and Feldman (1998, 1999) identified situational factors that mitigated against strong reactions to contract violations (i.e., positive working relationships with supervisors and a greater sense of procedural justice). These findings provided further support for the strong relationships observed in the current study between psychological contract violation and the emotional climate of the workplace and practice-related issues.

Restructuring satisfaction. This study's findings indicated that restructuring satisfaction had moderate to strong, positive relationships with the total RIHCRS and most subscale scores. The only exception was quality of care which depicted a low, positive correlation with restructuring satisfaction. These findings indicated that higher levels of restructuring satisfaction were significantly associated with more positive perceptions of the impact of health care reforms (i.e., job-related and work environment factors).

There is some support in the literature for the relationship between job-related and *work environment factors and community health nurses' satisfaction* with restructuring efforts, as was depicted in the current study. Study findings

suggest that most community health nurses have concerns about the negative impact of restructuring initiatives on the emotional climate of the workplace, quality of care, and standards of care (Ellenbecker & Warren, 1998; Parry-Jones et al., 1998; Reutter & Ford, 1998; Traynor, 1995). Other studies have identified both negative and positive practice-related changes (e.g., increased workload, increased documentation burden, less time for client contact, development of new roles, improved communication and collaboration, etc.) following restructuring initiatives (Ellenbecker & Warren; Parry-Jones et al.; Reutter & Ford, 1998).

 Job satisfaction. The current study's findings indicated that job *satisfaction had moderate to strong, positive relationships with the total RIHCRS* and most of the subscales, with the exception of quality of care which depicted a low, positive relationship. The findings suggested that community health nurses with more positive perceptions about the impact of reforms (i.e., job-related and work environment factors) were more likely to have higher job satisfaction levels.

 Aspects of the emotional climate of the workplace (e.g., interpersonal relationships, supervision, organizational climate, supportive work environments, etc.) have been reported to influence community health nurses' job satisfaction (Juhl et al., 1993; Lucas et al., 1988; Lynch, 1994; Riordan, 1991; Stewart & Arklie, 1994). In addition, practice-related factors (e.g., job mechanics, autonomy, organizational requirements, benefits/rewards, time to do one's work,

etc.) have also been found to influence the job satisfaction of community health nurses (Boswell, 1992; Juhl et al.; Lucas et al.; Riordan). These findings add credence to the observed relationships between job satisfaction and the emotional climate of the workplace and practice-related issues in the current study.

Organizational commitment. In the current study, moderate to strong, positive relationships were observed between organizational commitment and the total RIHCRS and all subscale scores. These findings suggest that community health nurses with more positive perceptions about the impact of health care reforms are more likely to have higher levels of commitment to their organizations.

No studies were identified from the literature that investigated the impact of health care reforms (i.e., job-related and work environment factors) on organizational commitment. However, in a meta-analytic study Mathieu and Zajac (1990) reported that various aspects of the work environment (e.g., higher motivation, higher job involvement, greater satisfaction with coworkers and supervisors, greater promotional opportunities, less stress, etc.) have been found to be significantly associated with higher levels of organizational commitment.

Intent to stay. The current study's findings demonstrated moderate to strong, positive relationships between behavioral intentions (i.e., intent to stay) and the total RIHCRS and most subscale scores. The only exception was

quality of care which depicted a low, positive correlation with organizational commitment. These findings suggest that community health nurses with more positive perceptions about the impact of reforms are more likely to stay with current employers.

No studies were identified from the literature that investigated the impact of reforms (i.e., job-related and work environment factors) on community health nurses' behavioral intentions. However, it has been reported that select job-related and work environment factors (i.e., greater skill use, satisfaction with autonomy and interactions, benefits, and organizational climate) have been associated with community health nurses' intentions to stay with current employers (Dunkin et al., 1992; Hughes & Marcantonio, 1991). As well, Robinson and Rousseau (1994) reported that perceived contract violations accounted for 16% of the variance in the length of time an employee intended to stay with the employer.

Interactive Effects

According to the CMBI, intermediate outcomes have a direct and indirect effect on behavioral intentions. It is also proposed that the intermediate outcomes covary or affect each other. One of the research questions of this study investigated these proposed relationships.

The current study's findings revealed moderate to strong, positive

relationships among all intermediate outcomes, and between intermediate

outcomes and behavioral intentions. Specifically, lower levels of psychological

contract violations are moderately to strongly associated with greater

restructuring and general job satisfaction, higher levels of organizational

commitment, and greater intent to stay with current employers. No studies were

identified from the health care literature that investigated these relationships.

However, similar findings were reported in the business literature by Robinson

and Rousseau (1994) and Turnley and Feldman (1998, 1999). These authors

found that higher levels of psychological contract violations were strongly

associated with lower levels of job satisfaction, less organizational loyalty, and a

greater likelihood of quitting or engaging in job search behaviors.

Likewise, all other intermediate outcomes (i.e. restructuring satisfaction,

job satisfaction, and organizational commitment) and behavioral intentions

strongly influenced each other in a positive manner. Comparable findings have

been reported in the research literature. Some authors have found support for

the negative impact of restructuring initiatives on community health nurses' job

satisfaction (Corey-Lisle et al., 1999; Parry-Jones et al., 1998). Blegen (1993)

reported that greater job satisfaction was strongly related to greater

organizational commitment. Using samples of nurses, Irvine and Evans (1995)

and Parasuraman (1989) reported a significant association between greater job

satisfaction and greater intent to stay. Robinson and Rousseau (1994) also

supported the positive relationship between greater job satisfaction and greater
intent to stay in a sample of MBA graduates. Similarly, Turnley and Feldman
(1998, 1999) found support for the presence of a positive relationship between
greater loyalty and greater intent to stay in a sample of managers and
executives.

Correlates, Determinants, Outcomes, and Intentions

One of the research questions examined the effects of correlates (i.e.,
personal characteristics and staffing issues) on determinants, intermediate
outcomes, and behavioral intentions. The findings indicated that the correlates
selected for investigation in this study had minimal to no effects on major study
variables. One personal characteristic (i.e., current position tenure) and one
staffing issue (i.e., district caseload) was found to exert a minimal effect on
select determinants. Specifically, community health nurses who were in their
current jobs for 3 to 4 years tended to be more positive about practice-related
issues than those who held current positions for 10 or more years. In contrast,
Way (1995) failed to find significant differences for any of the reform impact
variables based on current position tenure. No other studies were found in the
literature that investigated the effects of current position tenure on community
health nurses' perceptions of reforms.

Study findings also suggested that community health nurses with smaller

district caseloads tended to view the emotional climate of the workplace, practice-related issues, and the overall impact of reforms more positively than those with larger caseloads. Although no studies were identified from the literature that examined the effects of workload on community health nurses' perceptions of the reforms, a common theme was increased stress and demands from greater workloads following restructuring (Corey-Lisle et al., 1999; Reutter & Ford, 1998; Shindul-Rothschild et al., 1996; Traynor, 1995).

In the current study, no support was found for the effects of personal characteristics and staffing issues on intermediate outcomes. Although there is some empirical support for the influence of personal characteristics, the findings tend to be inconsistent across studies and the impact, when detected, minimal. Several authors failed to identify significant effects for personal characteristics on intermediate outcomes (e.g., Moore & Katz, 1996; Riordan, 1991; Rout, 2000; Shuster, 1992; Turnley & Feldman, 1998, 1999). In contrast, Blegen (1993) reported a low association between greater job satisfaction and increased age, more years of experience, and less education. Similarly, Irvine and Evans (1995) and Lucas et al. (1988) reported that greater job satisfaction depicted low correlations with higher age, more years of experience, and greater organizational tenure. Cumbey and Alexander (1998) and Shuster also reported low associations between higher levels of job satisfaction and higher age and greater organization tenure. Mathieu and Zajac (1990) reported that age,

gender, education, position tenure, organizational tenure, and job level were significantly associated with organizational commitment. No studies investigating the influence of staffing issues on intermediate outcomes were identified from the literature.

In the current study, significant effects were observed for the influence of employment status and age on behavioral intentions (i.e., intent to stay). The findings suggested that older community health nurses and those with permanent positions were significantly more likely to intend to stay with current employers than younger nurses and those with temporary or casual positions. Written comments provided by some of the respondents indicate that benefits, seniority, hours of work, location of work, and the lack of other available community-based nursing jobs were some of the reasons for staying with current employers. No comparable studies conducted with community health nurses were identified from the literature.

Predictors of Intermediate Outcomes and Behavioral Intentions

An important focus of the current study was to identify the best predictors of intermediate outcomes and behavioral intentions. The following discussion is organized according to the relevant intermediate outcome and behavioral intentions (i.e., intent to stay).

Psychological Contract Violation

The CMBI postulates that the determinants (i.e., job-related and work environment factors) most affected by reforms would have a direct effect upon perceived violations of psychological contracts. Specifically, it was anticipated that more positive perceptions of health care reforms would result in lower levels of perceived psychological contract violations. It was also conjectured that the correlates (i.e., personal characteristics and staffing issues) would only have a minimal effect on perceptions of contract violations.

This study's findings revealed that two determinants (i.e., emotional climate of the workplace and practice-related issues) emerged as the only significant predictors of psychological contract violation. Thus, partial support was provided for the influence of the determinants (i.e., impact of health care reforms) on contract violations. In contrast, there was no support for the effects of personal characteristics and staffing issues on contract violations.

In the current study, emotional climate surfaced as the best predictor of psychological contract violation (i.e., 42.6% of the explained variance), followed by practice-related issues. This finding suggested that community health nurses' perceptions of the impact of reforms on the emotional climate of the workplace (e.g., staff relations, morale, motivation to act as client advocate, recognition received, etc.) and practice-related issues (e.g., control, education opportunities, meetings with management, etc.) influenced the nature and occurrence of

psychological contract violations. Although no comparable studies were identified from the health care literature, there is some empirical support in the business sector. Turnley and Feldman (1998) reported that positive working relations with supervisors mitigated against strong reactions to psychological contract violations.

Restructuring Satisfaction

According to the causal process of the CMBI, it was conjectured that the determinants (i.e., impact of reforms or job-related and work environment factors) would directly affect satisfaction with restructuring (i.e., managerial and interdisciplinary relations). It was also expected that psychological contract violation would act as an intervening variable between the determinants and restructuring satisfaction. In addition, the correlates (i.e., personal characteristics and staffing issues) were expected to only exert a minimal influence on restructuring satisfaction.

This study's findings provide support for the direct influence of the determinants on community health nurses' restructuring satisfaction levels. Practice-related issues and emotional climate surfaced as the two best predictors of restructuring satisfaction (i.e., accounting for 54.5% and 7.9% of the explained variance, respectively). Psychological contract violation, quality of care, and safety issues, respectively, contributed an additional 5.6% to the

explained variance. In contrast to expectations, a couple of determinants (i.e., practice-related issues and emotional climate) had a more direct effect on the restructuring satisfaction levels of community health nurses than psychological contract violation. *In fact, contract violation only acted as an intervening variable* between restructuring satisfaction and two determinants (i.e., quality of care and safety issues). In addition, none of the correlates were predictive of restructuring satisfaction.

No studies were identified in the literature that investigated the predictive power of various job-related and work environment factors on community health nurses' restructuring satisfaction. Additionally, no studies were found in the *literature that investigated the predictive power of psychological contract violation* and personal characteristics or staffing issues on restructuring satisfaction.

General Job Satisfaction

The CMBI postulates that determinants would influence job satisfaction directly, as well as indirectly through restructuring satisfaction. The causal process depicted by the model presents restructuring satisfaction as a significant *intervening variable between the determinants, psychological contract violations,* and job satisfaction. Therefore, it was expected that restructuring satisfaction would surpass the determinants and psychological contract violation in predictive power. The current study's findings were counter to expectations. One of the

determinants (i.e., emotional climate), as opposed to restructuring satisfaction, surfaced as the key predictor of job satisfaction. Thus, the findings do not support the moderating role of restructuring satisfaction.

This study's findings provided partial support for the effects of determinants on community health nurses' job satisfaction levels. Similar to restructuring satisfaction and psychological contract violation, emotional climate continued to emerge as the best predictor of job satisfaction (i.e., 32.6% of the explained variance). There is strong empirical support for the influence of the emotional climate of the workplace (e.g., communication, work relations, stress, recognition, etc.) on job satisfaction levels (Blegen, 1993; Juhl et al., 1993; Lucas et al., 1988). Other studies have also documented the predictive power of the emotional climate (i.e., prestige, positive work environment, support, and structure) for community health nurses' job satisfaction (Cumbey & Alexander, 1998; Jansen et al., 1996; Riordan, 1991; Rout, 2000; Stewart & Arklie, 1994).

In the current study, no support was found for the effects of psychological contract violation on job satisfaction. Although this finding is contrary to expectations, no comparable studies were identified in the health care literature. As well, only one study from the business literature reported on the strong association between greater psychological contract violations and lower levels of job satisfaction (Robinson & Rousseau, 1994).

Additionally, no support was found for the effect of personal

characteristics or staffing issues on job satisfaction. Although this finding is contrary to expectations, there are inconsistent reports in the literature. Some authors have found support for the influence of personal characteristics (e.g., experience, age, organizational tenure, etc.) on community health nurses' job satisfaction levels (Cumbey & Alexander, 1998; Lucas et al., 1988; Shuster, 1992), while others have failed to document a significant influence (Moore & Katz, 1996; Moore et al., 1997; Riordan, 1991).

In the current study, general job satisfaction was not well predicted (i.e., 35.5% of the explained variance) by selected variables. A possible reason for this could be that the CMBI is based on study findings with nurses working in acute health care settings (i.e., variations in the priority assigned to key job-related and work environment factors). Furthermore, there may be a need for a more specific tool to assess community health nurses' job satisfaction, such as the one developed by Traynor and Wade (1993).

Organizational Commitment

It was further conjectured that the determinants (i.e., job-related and work environment factors) would have a direct effect on organizational commitment, as well as an indirect effect through job satisfaction. According to the causal process depicted by the CMBI, job satisfaction is identified to be a significant intervening variable between the determinants, psychological contract violation,

restructuring satisfaction, and organizational commitment. This study's findings confirmed the influence of job satisfaction on organizational commitment, but contrary to expectations job satisfaction did not moderate the predictive effects of one of the determinants (i.e., emotional climate).

As observed with other intermediate outcomes, the emotional climate of the workplace continued to emerge as the best predictor of organizational commitment (i.e., accounting for 48.5% of the explained variance), followed by job satisfaction and psychological contract violation. This finding provides partial support for the influence of the determinants on community health nurses' organizational commitment. Similarly, Mathieu and Zajac (1990) reported that select aspects of the work environment (e.g., motivation, satisfaction with supervisors and coworkers, stress, etc.) influenced organizational commitment. In the current study, no other determinants affected organizational commitment. No studies were identified in the literature that investigated the predictive power of job-related and work environment factors on community health nurses' organizational commitment.

In partial support of the CMBI, when psychological contract violation was entered into the regression equation for organizational commitment, it moderated the effects of one of the determinants (i.e., practice-related issues), but not emotional climate. Similarly, at a later regression step restructuring satisfaction moderated the effects of one determinant (i.e., importance of reforms), but not

emotional climate or psychological contract violation. Job satisfaction moderated the predictive effects of both psychological contract violation and restructuring satisfaction, as was expected. No correlates (i.e., personal characteristics or staffing issues) affected organizational commitment. Contrary to expectations, the emotional climate of the workplace remained the best predictor of community health nurses' organizational commitment at all steps of the regression equation.

Some study findings have supported the effects of psychological contract violation and job satisfaction on commitment. Turnley and Feldman (1998, 1999) reported that higher levels of psychological contract violations were significantly associated with lower levels of loyalty. As well, other authors (Blegen, 1993; Mathieu & Zajac, 1990; Mueller & Price, 1990; Price & Mueller, 1986) have found support for the strong effects of job satisfaction on organizational commitment.

Intent to Stay

It was conjectured that the determinants would directly influence behavioral intentions (i.e., intent to stay), as well as indirectly through organizational commitment. According to the CMBI, organizational commitment is presented as a significant intervening variable between determinants, psychological contract violation, restructuring satisfaction, job satisfaction, and intent to stay.

Contrary to expectations the current study's findings failed to support the premise that organizational commitment is the best predictor of intent to stay, and plays a key moderating role between determinants and other intermediate outcomes. However, the findings provide support for the effect of determinants on community health nurses' intent to stay. Again in contrast to predictions, the dominant influence of the emotional climate was evident (i.e., accounting for 36.9% of the explained variance). Emotional climate was then followed by job satisfaction, psychological contract violation, age, and employment status, respectively.

Although restructuring satisfaction did not moderate the effects of psychological contract violation on intent to stay, job satisfaction did moderate the effects of psychological contract violation and restructuring satisfaction. Additionally, as predicted correlates (i.e., age and employment status) exerted minimal effects on community health nurses' intent to stay.

Few studies were identified from the literature that investigated the intent to stay of community health nurses. These studies reported the influence of various job-related and work environment factors (e.g., greater skill use, the number of weekends per month required to work, satisfaction with autonomy, interactions, benefits, etc.) on community health nurses' intent to stay (Dunkin et al., 1992; Hughes & Marcantonio, 1991). Using samples of MBA graduates and executive-level employees, Robinson and Rousseau (1994) and Turnley and

Feldman (1999) found that greater psychological contract violations were related to greater intentions to quit. In addition, Turnley and Feldman (1998) reported that aspects of the emotional climate of the workplace such as good relationships with supervisors and coworkers were associated with less likelihood of quitting or engaging in job search behaviors. These findings provided support for the predictive power of the emotional climate of the workplace and psychological contract violation, as found in the current study.

Implications of Findings for the CMBI

The current study's findings provide partial support for the major assumptions of the CMBI. Overall, the findings support the premise that behavioral intentions (i.e., intent to stay) are influenced by a variety of factors including determinants (i.e., impact of health care reforms or job-related and work environment factors), covariates or intermediate outcomes (i.e., various attitudinal states), and correlates (i.e., personal characteristics and staffing issues).

Contrary to the major assumptions of the CMBI, the current study's findings failed to confirm that organizational commitment is a key predictor of behavioral intentions (i.e., intent to stay), or is a key intervening variable between determinants, psychological contract violation, restructuring satisfaction, job satisfaction, and behavioral intentions. These findings are in contrast to those

reported by Mueller and Price (1990), Parasuraman (1989), and Price and Mueller (1981). However, there are some indications that organizational commitment may not always moderate the effect of job satisfaction on intent to stay (Curry et al., 1985; Price & Mueller, 1986).

This study's findings provided partial support for the effect of the determinants (i.e., importance of reforms, emotional climate, practice-related issues, quality of care, safety concerns, and standards of care) on intermediate outcomes (i.e., attitudinal states) and behavioral intentions. That is, not all the determinants (i.e., importance of health care reforms and standards of care) had an effect on the various attitudinal states or behavioral intentions. On the other hand, the emotional climate of the workplace emerged as a key predictor for most intermediate outcomes and behavioral intentions. More research is needed to investigate the predictive power of community health nurses' perceptions of health care reforms for their attitudes and behavioral intentions.

The current study's findings also provide minimal support for the causal, linear process depicted by the CMBI. It was conjectured that the intermediate outcomes would have greater effects on behavioral intentions than determinants and correlates. However, this assumption was not completely supported by the current study's findings. The findings indicated that one determinant (i.e., emotional climate) surfaced as a key predictor for behavioral intentions. Similarly, some personal characteristics (i.e., age and employment status) were

found to be better predictors of behavioral intentions than some intermediate outcomes (i.e., restructuring satisfaction and organizational commitment).

It was also conjectured that intermediate outcomes would exert a separate and interactive effect on each other, as well as behavioral intentions. That is, each successive attitude (i.e., psychological contract violation, restructuring satisfaction, job satisfaction, and organizational commitment) would act as a key intervening variable for the attitude preceding it, and therefore would moderate the effect of the one preceding it. However, study findings provided little support for this assumption. Only one attitude (i.e., job satisfaction) was found to consistently moderate the effects of the attitudes preceding it (i.e., restructuring satisfaction and contract violation).

In the current study, job satisfaction levels were found to have a relatively low predictive power. As well, only two variables (i.e., emotional climate and restructuring satisfaction) combined to explain the variance in general job satisfaction. The low predictive power of the variables in relation to job satisfaction warrants further investigation. It might be more meaningful to assess community health nurses' satisfaction with specific dimensions of their job, as opposed to the global approach used in this study.

Furthermore, study findings provide partial support for the CMBI assumption that correlates (i.e., personal characteristics and staffing issues) exert a significant effect on attitudes and behavioral intentions. The findings

indicated that age and employment status were key predictors of community health nurses' behavioral intentions, but only to a small degree (i.e., 4.8% of the explained variance). No other personal characteristics or staffing issues were found to affect intermediate outcomes or behavioral intentions. The minimal influence of the personal characteristics on attitudes and behavioral intentions is supported in the literature (Mueller & Price, 1990; Turnley & Feldman, 1998, 1999).

Summary

The current study investigated community health nurses' perceptions of the impact of health care reforms, their work-related attitudes, and behavioral intentions following a period of regionalization of community health services. A second focus of this study was to identify key predictors of intermediate outcomes and behavioral intentions. The CMBI provided the conceptual framework for this study.

The current study's findings on community health nurses' perceptions of the impact of reforms and their current levels of psychological contract violation, restructuring satisfaction, job satisfaction, organizational commitment, and behavioral intentions were, in general, supported by the literature. Additionally, despite the dearth of studies investigating community health nurses' organizational commitment and behavioral intentions, the key relationships

observed in this study were also supported in the literature.

The current study's findings provide some support for the major premises of the CMBI. The findings confirm that behavioral intentions (i.e., intent to stay) are the result of a complex interaction between the perceived impact of health care reforms, work-related attitudes, and personal characteristics. More specifically, the emotional climate, job satisfaction, contract violation, age, and employment status emerged as the best predictors of community health nurses' behavioral intentions in the current study. In contrast to model predictions, the relative effects of each variable on behavioral intentions did not follow the proposed causal, linear process. That is, certain determinants (i.e., emotional climate and practice-related issues) were found to have greater predictive powers than most intermediate outcomes. As well, some of the personal characteristics (i.e., age and employment status) surfaced as better predictors of behavioral intentions than certain attitudes (i.e., restructuring satisfaction and organizational commitment). Finally, not all of the intermediate outcomes exerted separate and interactive effects on each other and/or behavioral intentions. These findings stress the importance of further investigation of the CMBI with other community health nurse populations.

CHAPTER 6

Limitations and Implications

This chapter presents a discussion of the limitations and implications of the study findings. The first section summarizes this study's limitations. The second section presents an overview of the implications for nursing practice, education and research.

Limitations

The small sample size and a slightly more than 50% response rate made it difficult to draw firm conclusions from the findings. However, the representativeness of the sample and the generalizability of the findings was increased by including the entire accessible population in the survey.

The study findings provided useful insights into community health nurses' perceptions of the impact of health care reforms and their work-related attitudes (i.e., psychological contract violation, restructuring satisfaction, job satisfaction, and organizational commitment) and behavioral intentions (i.e., intent to stay) following a period of regionalization of community health services. However, the exclusion of nurses working with private community nursing agencies from the sample limits the generalizability of study findings to all community health nurses in the province of Newfoundland and Labrador.

Furthermore, there was no baseline data on community health nurses'

work-related attitudes and behavioral intentions prior to regionalization efforts. Therefore, study findings could be due to other factors besides the perceived impact of health care reforms. When comparing the current findings to other studies involving community health nurses, there is a need to consider other influencing factors such as the socioeconomic and political environments. The collection of qualitative data would help to enhance our understanding of other potential influencing factors.

A further limitation to the study's findings is the instruments used to assess the dependent variables. There was a conspicuous absence of validated measurement tools in the literature for assessing key job-related and work environment variables in community health settings. Consequently, most of the tools used in the current study were adopted from other disciplines or were primarily developed for acute health care settings. Despite this limitation, all of the scales used in the current study demonstrated good internal consistency.

Finally, the use of self-report instruments in the current study could have introduced some response bias. Besides the variable responses based on individual interpretation of scale items, the possibility existed for collaboration between respondents at the same work site. These extraneous effects could reduce the validity of study findings, as well as their generalizability to other populations of community health nurses.

<u>Implications</u>

Data from the current study have implications for three areas of nursing (i.e., practice, education, and research). The following discussion is organized according to the relevant nursing domain.

<u>Practice</u>

This study has shown that community health nurses have varied perceptions about the impact of health care reforms (i.e., importance of reforms, emotional climate, practice-related issues, quality of care, safety issues, and standards of care). More specifically, community health nurses in this study were most negative about the quality of care and the emotional climate of the workplace, and most positive about the importance of reforms and standards of care. Additionally, the findings indicated that some of these perceptions of job-related and work environment factors significantly influenced community health nurses' work-related attitudes (i.e., psychological contract violation, restructuring satisfaction, job satisfaction, and organizational commitment) and behavioral intentions (i.e., intent to stay).

An interesting finding of the current study was that the emotional climate of the workplace emerged as the best predictor for all attitudes (i.e., with the exception of restructuring satisfaction) and behavioral intentions of community health nurses. It is this variable, as opposed to personal characteristics, that

managers and employers have the greatest ability to influence through initiatives such as program changes and leadership approaches. In addition, greater awareness of the current study's and comparable study findings can give community health nurses more insight not only into key factors influencing their work but also ways in which they could assume some responsibility for improving the workplace (e.g., providing support to coworkers, initiating contact with supervisors to facilitate needed organizational changes, etc.).

Study findings can also provide managers with information on the aspects of community health nurses' work that require improvement and/or change. The need for autonomy, multidisciplinary approaches, appreciation, recognition, professional development opportunities, adequate resources, improved communication, and coworker and supervisor support are crucial to improving the climate of the workplace and facilitating more positive work-related attitudes and a greater likelihood of staying with current organizations.

Other concerns of the nurses in the current study related to staffing adequacy and the stress and frustration of increased workloads. A significant study finding was that community health nurses with larger caseloads were less positive about the emotional climate of the workplace, practice-related issues, and the overall impact of reforms than those with smaller caseloads. These findings highlight the importance of using appropriate workload measurement tools and educating both staff nurses and managers on how to facilitate effective

management of variant workloads. The impact of increased workloads on work-related attitudes and behavioral intentions must also be considered.

Study findings also highlighted the importance of developing further insight into factors influencing community health nurses' work-related attitudes and behavioral intentions. It would prove beneficial for managers and employers to implement strategies directed towards the improvement of community health nurses' work-related attitudes. The findings also stress the importance of having managers more visible and accessible to staff nurses, and also more motivated to listen to community health nurses' concerns and ideas. If managers practised good interpersonal techniques and involved staff in various organizational changes, community health nurses' perceptions of reforms and other work-related attitudes could become more positive.

The findings also suggest that employers should be cognizant of community health nurses' expectations of them and ensure that rewards, both intrinsic and extrinsic, are proportional to desired actions (e.g., hard work, loyalty, etc.). Employers also need to become more active in identifying and addressing the stressors affecting community health nurses. The introduction of stress reduction and management programs could reduce perceptions of psychological contract violations, and increase job satisfaction and organizational commitment levels. Finally, employers must become more cognizant of key factors influencing community health nurses' intent to stay and implement effective

retention strategies (e.g., offering more permanent positions as opposed to temporary or casual, etc.).

Education

The insights provided by this study's findings can provide nurse educators with a greater appreciation of crucial topics for present and future curricula. Students should be made aware of community health nurses' current perceptions of the overall impact of health care reforms and their implications for various work-related attitudes and behavioral intentions. The socio-political context of nursing must be a key component of curriculum frameworks. Education on the various health care reforms occurring in the community health setting and possible future trends will help students become more cognizant of the challenges facing community health nurses and the entire nursing profession.

In the current study, community health nurses were neither totally negative nor positive about the overall impact of reforms. That is, many nurses felt that reforms had both negative and positive consequences. Significantly, most respondents indicated that they did not understand the importance of reforms such as downsizing/restructuring. Educators need to discuss the two-sided nature of health care reforms and help students develop a greater appreciation for the changing context of health care in all settings. Similarly,

inservice education should be conducted with staff nurses and managers to increase their understanding and acceptance of reform strategies implemented by their particular organization. With most community health nurses in this study indicating that they felt empowered to be active participants in affirming an important future role for their profession, it is important that nurses develop an awareness of the nontraditional social activist role and become change agents in the reform process.

Study findings indicated that the emotional climate of the workplace surfaced as the best predictor of work-related attitudes and behavioral intentions, with the exception of restructuring satisfaction. In addition, most community health nurses had concerns about the negative impact of reforms on the emotional climate of the workplace and the quality of care. These findings suggest that educators should strive to increase students' awareness of the importance of the work environment, especially the emotional climate, for facilitating positive work-related attitudes.

Negative and positive aspects of the work environment need to be discussed, as well as strategies for improving the organizational climate and working conditions. Educators should focus on building upon the strengths of the workplace. For example, problem-solving exercises could be used to help students generate possible solutions for overcoming the negative aspects of the work environment. Students should also be encouraged to incorporate these

solutions into their clinical practice.

Given the importance assigned to staff-supervisor relationships by the community health nurses in the current study, effective leadership skills should be taught in the classroom (i.e., effective communication, participative leadership, active listening, and supportive behaviors). As well, students should be encouraged to identify factors influencing community health nurses' work-related attitudes and behavioral intentions, and generate possible strategies to improve nurse retention in community health settings.

Research

The current study's findings support the important influence of community health nurses' perceptions of the impact of health care reforms on their work-related attitudes and behavioral intentions. Study findings also provide insight into how community health nurses perceive the impact of reforms, and their current levels of work-related attitudes and behavioral intentions. More research is needed to develop a greater understanding of how current and future health care reforms may impact community health nurses' practice, as well as their work-related attitudes and behavioral intentions.

As well, more studies are needed to identify additional factors that may influence perceptions, attitudes, and behavioral intentions. Certainly, health care organizations require more empirical data to evaluate whether reform initiatives

are actually meeting expected goals and to monitor their impact on nurses (i.e., psychological contract violations, restructuring satisfaction, job satisfaction, commitment, and intent to stay). Knowledge obtained from additional research studies would help facilitate informed decision-making, especially with regard to appropriate strategies for enhancing nurses' work-related attitudes and behavioral intentions. For example, since study variables were found to predict only 35.5% of the explained variance in community health nurses' job satisfaction, there are obviously other factors affecting this work-related attitude. Greater insight into key influencing factors is essential for developing the most appropriate programs for increasing community health nurses' job satisfaction levels. Similarly, further research exploring key job-related and work environment factors affecting community health nurses' behavioral intentions would help employers and managers to identify the most effective strategies for increasing nurse retention levels.

Qualitative inquiries into community health nurses' perceptions of the impact of health care reforms and their work-related attitudes and behavioral intentions would add richness to the current study's findings and help answer the "why" of study results. Qualitative inquiry would also provide explanations with regard to why managers were more positive than staff nurses on some of the study variables. In addition, since the current study only provides a snapshot of perceptions of health care reforms, work-related attitudes and behavioral

intentions, longitudinal studies would give a greater insight into these key aspects of community health nurses' work life.

Furthermore, the current study has implications for theory-building. Since study findings provided only partial support for the conceptual framework used (i.e., the CMBI), more research using this model is warranted. Data obtained from the current and future research projects would help make the necessary modifications to the CMBI so that it would be appropriate for community health nursing. The use of other models of nurse turnover behavior in future research studies would also provide useful information about the most appropriate conceptual frameworks. Additionally, model testing with cross-sectional data is limited. Interpretations of the logic of the CMBI would be strengthened by using longitudinal data and relying on path analysis versus multiple regression analysis. Finally, more research is needed in order to identify the most appropriate instruments to assess the key study variables in the current study and for refinement of existing tools such as the Employee Attitudes Survey (EAS).

Summary

As with all research, the current study had limitations in relation to the internal and external validity of the findings. Some key limitations of this study's findings included a low response rate, voluntary nature of the sample, and the

use of self-report data. All of these factors limits the generalizability of study findings beyond the current sample.

Despite these limitations, study findings have important implications for nursing practice, education, and research. Study findings provided knowledge of community health nurses' perceptions of health care reforms, and their work-related attitudes and behavioral intentions, as well as a greater insight into factors influencing these attitudes and behaviors. The findings also indicated that the emotional climate of the workplace was a key predictor of community health nurses' work-related attitudes (i.e., with the exception of restructuring satisfaction) and behavioral intentions. Therefore, the current study provides crucial information for employers, managers, and nurses on various aspects of community health nurses' work environment.

Implications of the findings for nursing education include the need to make students aware of the impact of reforms on community health nurses and the socio-political environment surrounding nursing. Education related to community health nurses' work-related attitudes and behavioral intentions, and possible influencing factors is also warranted. Additionally, students should be cognizant of the positive and negative aspects of reforms, as well as possible solutions to preventing or modifying possible negative consequences.

Finally, the current study's findings have important implications for health care research, including the need for further inquiries with community health

nurses undergoing similar reforms. Qualitative research and longitudinal studies would also help gain a better insight into the meaning of health care reforms for community health nurses and increase the nursing profession's knowledge about key factors influencing work-related attitudes and behavioral intentions. Additional research is also needed to modify conceptual frameworks, such as the CMBI, in order to make them more appropriate for guiding research with community health nursing populations.

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Appendix A

Cover Sheet and Employee Attitudes Survey

You Will Only Be Heard If You Respond!

Colleague:

You have been selected to participate in a study exploring the impact of health care reforms on nurses working in community settings. Similar studies have occurred in the past (i.e. 1995, 1998, 1999), but most of the efforts have focused on nurses working in acute care settings.

Since the mid-1990s a number of significant changes have occurred in the provincial health care system as a result of downsizing and restructuring initiatives. For community health, restructuring has been realized through the formation of the Community Health Boards and the expansion of the Community Health Boards' mandate through the addition of new programs and the integration of some services previously delivered by the Department of Human Resources and Employment. We are **extremely** interested in your personal experiences with and opinions of reforms during this time. It is important that you answer the questions yourself and that the questionnaire is not shared with your nursing colleagues.

ARRNL registration numbers are recorded on the questionnaires for the purpose of including the same people in a future survey. **There is no way for the researchers to match registration numbers with personal identifiers (i.e. names or addresses).** All identifying information has been retained by the ARRNL to ensure confidentiality of responses.

We hope that you will take this opportunity to express your views. Your input is desperately needed. If we get the desired response rate, the information will be made available to those interested.

Enclosed is an envelope (postage pre-paid) for you to return the completed questionnaire. Thank you for taking the time to help us with this project.

The deadline reply date is November 17, 2000

General Information

The information that you provide in this section will be helpful in determining how representative the sample is in terms of the community health nursing workforce. It will also facilitate comparisons across areas of practice and within and among regions. Please **ONLY CIRCLE ONE RESPONSE** for Questions 1 thru 10.

PLEASE DO NOT
WRITE IN THIS
SECTION.

CODE

1. Occupation:

   (1) Public Health Nurse
   (2) Community Health Nurse
   (3) Continuing Care/Home Care Nurse

   _____

2. Primary Area of Responsibility:

   (1) Direct Care
   (2) Administration (includes management)
   (3) Education (Inservice/Consumer)

   (4) Other (please specify)_____

   _____

3. Position Held:

   (1) Administrator
   (2) Educator
   (3) Researcher
   (4) Staff/Clinician

   (5) Other (please specify) _____

   _____

4. Total Number of **Years Experience** in Health Care:

   (1) Less than 1 year   (4) 5 to 9 years
   (2) 1 to 2 years   (5) 10 to 19 years
   (3) 3 to 4 years   (6) 20 years or greater

   _____

5. Total number of **Years in Current Position**:

   (1) Less than 1 year   (4) 5 to 9 years
   (2) 1 to 2 years   (5) 10 to 19 years
   (3) 3 to 4 years   (6) 20 years or greater

   _____

CODE

6. Nature of Employment:

    (1) Full-Time (permanent)
    (2) Full-Time (temporary)
    (3) Part-Time (permanent)
    (4) Part-Time (temporary)
    (5) Casual
    (6) Not Employed

_____

7. Geographic Region of Workplace:

    (1) Eastern 1 (St. John's)
    (2) Eastern 2 (Avalon)
    (3) Eastern 3 (Peninsulas)
    (4) Central (East West)
    (5) Western
    (6) Labrador
    (7) Northern

    8. Other (please specify) _____

_____

8. Educational Background: (**Circle one only, i.e. highest level**)

    (1) Diploma/Certificate
    (2) Baccalaureate
    (3) Masters
    (4) Doctorate

    (5) Other (please specify) _____

_____

9. Gender:

    (1) Male
    (2) Female

_____

10. Age in years: _____

_____

Part I: Staffing Adequacy

Research findings suggest that the incidence of illnesses and work-related injuries increase among nursing staff during periods of restructuring/downsizing. We are particularly interested in what is happening at the district level with regard to staffing patterns, workload, and incidence of illnesses and work-related injuries.

(a) Please provide estimates on each of the following items:

- District's client caseload: <50 _____   50 - 100 _____   >100 _____

- Average client caseload per CHN: _____

- Average ratio of RNs to LPNs: _____

- Number of **personal** sick-leave
  days over the past year: _____

- Proportion of **personal** sick days due
  to work-related injuries: _____

(b) Use the following scale to rate how you feel about staffing issues in your organization. Again it is important that you respond to all items. Please **circle the number** that best captures your position.

- Overall, **how adequate** is the staffing situation in your district for meeting client care requirements?

1	2	3	4	5
Extremely short: quality of client care has suffered	Short but quality of client care not affected	Adequate	More than adequate	Excellent

- **How often** does your district require the services of casual RNs and/or call backs to bring the staff/client ratio up to adequate levels?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Almost Always

- Overall, how does the current availability of RN staff for client care **compare** with the period prior to health care restructuring downsizing?

1	2	3	4	5
Much less than previously	Less than previously	About the same	More than previously	Much more than previously

- **How often** during the past year have you been required to return to work on your days-off against your wishes?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Almost Always

- **How often** have you had your annual leave requests denied over the past one to two years?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Almost Always

- **How often** have you had to miss lunch/coffee breaks over the past one to two years?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Almost Always

Part II: Organizational Commitment

In this section of the questionnaire we are interested in how you would rate your commitment to your present employer. It is important that you respond to all items. Please **circle the number** that best describes your present position.

Use the following scale to rate your degree of agreement/disagreement with each statement:

1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Neither Disagree or Agree	5 Slightly Agree	6 Moderately Agree	7 Strongly Agree

	Strongly Disagree						Strongly Agree
11. I am willing to put in a great deal of effort beyond that normally expected in order to help this organization be successful.	1	2	3	4	5	6	7
12. I talk up this organization to my friends as a great organization to work for.	1	2	3	4	5	6	7
13. I would accept almost any type of job assignment in order to keep working for this organization.	1	2	3	4	5	6	7
14. I find that my values and the organization's values are very similar.	1	2	3	4	5	6	7
15. I am proud to tell others that I am part of this organization.	1	2	3	4	5	6	7
16. This organization really inspires the very best in me in the way of job performance.	1	2	3	4	5	6	7
17. I am extremely glad that I chose this organization to work for over others I was considering at the time I joined.	1	2	3	4	5	6	7
18. I really care about the fate of this organization.	1	2	3	4	5	6	7
19. For me this is the best of all possible organizations for which to work.	1	2	3	4	5	6	7

Part III: Psychological Contract Violation/Intentions

Use the following scales to rate how you feel about your organization. Again it is important that you respond to all items. Please **circle the number** that best captures your position.

20. Overall. then. **how well** has your organization fulfilled the commitments that were made to you when you were hired?

1	2	3	4	5
Very Poorly Fulfilled	Poorly Fulfilled	Neutral	Fulfilled	Very Well Fulfilled

21. Overall. then. **how often** has your employer failed to meet the commitments that were made to you when you were hired?

1	2	3	4	5
Very Infrequently	Infrequently	Neutral	Frequently	Very Frequently

22. Considering all of your job factors together. how does the amount of rewards that you actually receive from your organization **compare** to the amount of rewards that your organization promised you?

1	2	3	4	5
Much Less Than Promised	Less Than Promised	About the Same As Promised	More Than Promised	Much More Than Promised

23. Overall. how does the amount of rewards (both financial and non-financial) you receive from your organization **compare** to the amount that you think it should provide? The amount my organization supplies is:

1	2	3	4	5
Much Less Than It Should	Less Than It Should	About As Much As It Should	More Than It Should	Much More Than It Should

24. Considering the impact of downsizing restructuring on the health care system. how likely is it that you will stay with your current employer?

1	2	3	4	5
Very Unlikely	Unlikely	Unsure	Likely	Very Likely

25. I would consider leaving my present position if another employment opportunity presented itself?

1	2	3	4	5
Very Unlikely	Unlikely	Unsure	Likely	Very Likely

26. How often have you put any serious effort into searching for a new job (e.g. checking newspapers or ads, making calls, sending resumes, etc.)?

1	2	3	4	5
Very Infrequently	Infrequently	Neutral	Frequently	Very Frequently

Part IV: Satisfaction

In this section of the questionnaire we are interested in your overall satisfaction with your job as well as select areas related to managerial restructuring within your organization. Again it is important that you respond to all items. Please **circle the number** that best describes your present position.

Use the following scale to rate your degree of agreement/disagreement with each statement:

1	2	3	4	5	6	7
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree

General Satisfaction	Strongly Disagree					Strongly Agree	
27. Generally speaking, I am very satisfied with this job.	1	2	3	4	5	6	7
28. I am generally satisfied with the kind of work I do in this job.	1	2	3	4	5	6	7
29. Most people in this job are very satisfied with the job.	1	2	3	4	5	6	7

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Use the following scale to rate your degree of agreement/disagreement with each statement:

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree

Downsizing/Managerial Restructuring

		Strongly Disagree					Strongly Agree
30.	I am generally satisfied with the visibility and accessibility of management personnel since restructuring.	1	2	3	4	5	6
31.	I am generally satisfied with the degree to which management seeks input on professional care standards.	1	2	3	4	5	6
32.	I am generally satisfied with the amount of information inservice provided to help prepare me for changes related to restructuring (e.g. job responsibilities, transfer of functions, etc.)	1	2	3	4	5	6
33.	I am generally satisfied with the interdisciplinary approach to patient/client care in my organization.	1	2	3	4	5	6
34.	I am generally satisfied with the amount of time spent dealing with interdisciplinary conflicts.	1	2	3	4	5	6

Part V: Health Care Reform

In this section of the questionnaire we are interested in knowing how you view the changes that have occurred in the health care system. The content of the statements include overall impressions about the impact of health care reforms, as well as some specifics with regard to quality and safety concerns, workplace conditions, and professional issues. It is important that you respond to all items. Please **circle the number** that best describes your present position.

Use the following scale to rate your degree of agreement/disagreement with each statement:

1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Slightly Agree	5 Moderately Agree	6 Strongly Agree

	Strongly Disagree					Strongly Agree
35. I understand the importance of downsizing and restructuring the community health care system in this province.	1	2	3	4	5	6
36. Health care reforms have not placed sufficient emphasis on maintaining quality care standards.	1	2	3	4	5	6
37. Patients/clients have reasonable access to health care services despite downsizing and managerial restructuring efforts.	1	2	3	4	5	6
38. The movement towards community based care is a positive step in helping facilitate greater patient/client accountability and responsibility.	1	2	3	4	5	6
39. Changes in the community health care system have given health care providers the opportunity to gain greater control over their practice.	1	2	3	4	5	6
40. Supplies/resources are often not adequate to ensure patient/client comfort.	1	2	3	4	5	6
41. Despite personnel reductions, it is still possible to meet patients'/clients' basic care needs.	1	2	3	4	5	6

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree

	Strongly Disagree				Strongly Agree	
42. Because of overwhelming workload demands, it is often necessary to lower care standards.	1	2	3	4	5	6
43. I am confident that patients/clients and family members receive adequate teaching and counselling in preparation for discharge.	1	2	3	4	5	6
44. Due to increasing acuity levels, it is not possible to adequately assess or meet patients'/clients' emotional/psychosocial needs.	1	2	3	4	5	6
45. I am confident that my agency procedures are being performed in a safe and competent manner.	1	2	3	4	5	6
46. Because of inadequate inservice education on new policies/procedures, I believe patients/clients are being placed at risk.	1	2	3	4	5	6
47. Patients/clients are more susceptible to potential harm from delays or errors due to increased demands and stressors in the work place.	1	2	3	4	5	6
48. Most of the time we have the necessary **physical resources** (e.g. equipment, supplies, facilities) to provide safe care.	1	2	3	4	5	6
49. Most of the time we have the necessary **human resources** (i.e. nurses, LPNs, physicians, allied health professionals, and support staff) to provide safe care.	1	2	3	4	5	6
50. Adequate health care resources are not always available in the community for patients/clients upon discharge.	1	2	3	4	5	6

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree

	Strongly Disagree				Strongly Agree

51. At my workplace, staff meet regularly with management to discuss workplace concerns.

    1   2   3   4   5   6

52. At my workplace, staff meet regularly with management to identify ways to resolve problems and build on strengths.

    1   2   3   4   5   6

53. At my workplace, opportunities are provided to keep current with latest developments through reading and attending workshops, inservices, and teleconference sessions.

    1   2   3   4   5   6

54. Because I feel powerless to change things where I work, it is difficult to be motivated to act as an advocate for patients clients.

    1   2   3   4   5   6

55. *Due to increased acuity and reduction in the number of home visits, it is not always possible to meet professional care standards.*

    1   2   3   4   5   6

56. As a consequence of recent changes in the *community health care system, I can appreciate* the challenges facing my profession.

    1   2   3   4   5   6

57. As a consequence of recent changes in the community health care system, I feel empowered *to be an active participant in affirming an* important future role for my profession.

    1   2   3   4   5   6

58. Because I work in a supportive environment, I am able to give that 'extra' effort when my job *demands it.*

    1   2   3   4   5   6

59. Due to the heavy workload in my workplace, I feel really frustrated with the reduced level of care that is provided.

    1   2   3   4   5   6

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree

		Strongly Disagree				Strongly Agree
60.	Although I strive to give/ensure consistent and competent care. I rarely receive appreciation or recognition for what I do.	1	2	3	4	5	6
61.	Increased demands and stress in the workplace have led to unpleasant working relationships with co-workers and other health care providers.	1	2	3	4	5	6
62.	In the aftermath of restructuring efforts. I find that my time management skills have become more important.	1	2	3	4	5	6
63.	Increased demands and stress in the workplace have engendered a sense of disillusionment and low morale.	1	2	3	4	5	6
64.	Since restructuring of the community health care system. I find my job more satisfying and challenging.	1	2	3	4	5	6

Appendix B

Reminder Letter

You Will Only Be Heard If You Respond!

Colleague:

Approximately three to four weeks ago you were asked to participate in a study exploring the impact of health care reform on nurses working in community settings.

This letter is a reminder that your participation in this study is highly valued and needed. We hope that you will take this opportunity to express your views by returning your completed questionnaire in the envelope (postage pre-paid) previously provided to you.

We again stress that there is no way for the researchers to match registration numbers with personal identifiers (i.e. name or address) and that participation is voluntary. All identifying information has been retained by the ARNNL to ensure confidentiality of responses.

If you have already returned your completed questionnaire, we thank you for your participation.

Thank you for taking the time to help us with this project.

Appendix C

Approval from Human Investigation Committee

Memorial
University of Newfoundland

Office of Research and Graduate Studies (Medicine)
Faculty of Medicine
The Health Sciences Centre

September 22, 2000

TO: **Ms. N. Morgan**

FROM: Dr. F. Moody-Corbett, Assistant Dean
Research & Graduate Studies (Medicine)

SUBJECT: Application to the Human Investigation Committee - #00.128

//

The Human Investigation Committee of the Faculty of Medicine has reviewed your proposal for the study entitled **"The Impact of Health Care Reforms on Community Health Nurses' Attitudes"**.

Full approval has been granted for one year, from point of view of ethics as defined in the terms of reference of this Faculty Committee.

For a hospital-based study, it is **your responsibility to seek necessary approval from the Health Care Corporation of St. John's**.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

F. Moody-Corbett, PhD
Assistant Dean

cc: Dr. K.M.W. Keough, Vice-President (Research)
Dr. R. Williams, Vice-President, Medical Services, HCC

Appendix D

Letter of Support from ARNNL

July 26, 2000

Natalie Morgan RN BN
P.O. Box 223
Bay Roberts, NF A0A 1G0

Dear Ms. Morgan:

This is to confirm that the Association of Registered Nurses of Newfoundland and
Labrador (ARNNL) will support in principle and give assistance to your study entitled
The Impact of Health Care Reforms on Community Health Nurses Attitudes which we
understand is the thesis component of your Masters of Nursing program at Memorial
University of Newfoundland. Our assistance will take the form of providing access,
including any necessary reminder letters, to a list of registered nurses employed in
community health settings who have volunteered to participate in research studies. Our
Registrar, Heather Hawkins, will assist you with this.

This study represents another important component of an ongoing research program on
the impact of health reforms on the attitudes of registered nurses that has been supported
by ARNNL since its inception. We wish you success in carrying out the study and look
forward to being informed of the results of your work.

Sincerely yours,

Jeanette Andrews
Executive Director

JA/lc

Appendix E

Group Differences on Reform Impact and Work-Related Variables

Table E1

Reform Impact by Primary Area of Responsibility

Scales	Direct Care[1] Weighted (M)	Coordinator/ Consultant[2] Weighted (M)	t
Importance of Reforms	4.30	4.25	0.28
Workplace Issues			
Emotional Climate	3.27	3.38	-0.48
Practice-Related	3.44	3.57	-0.47
Quality/Safety Concerns			
Quality of Care	2.93	2.84	0.46
Safety Concerns	3.35	3.36	-0.06
Standards of Care	3.60	3.32	1.19
Overall Impact of Reforms	3.45	3.44	0.04

[1] Sample size for the direct care providers was 127.

[2] Sample size for the coordinators/consultants was 24.

Table E2

Work-Related Variables by Primary Area of Responsibility

Scales	Direct Care[1] Weighted (M)	Coordinator/ Consultant[2] Weighted (M)	t
Contract Violation (PCV)	2.94	3.09	-.995
Satisfaction			
Restructuring (RS)	3.30	3.77	-1.69
General Job (GJS)	4.91	4.94	-0.10
Commitment (OCQ)	4.42	4.65	-0.84
Intent to Stay (IS)	3.45	3.23	1.04

[1] Sample size for the direct care providers was 127.

[2] Sample size for the coordinators/consultants was 24.