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PROFESSIONAL NURSE CHARACTERISTICS AND UNIT CHARACTERISTICS AS PREDICTORS OF JOB SATISFACTION WITH WORK IN THAILAND

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by
Suthida Masuthon

Dedication

This dissertation is dedicated to the memory of my father and to my family who mean the world to me for their continuing and unlimited love and support.

Acknowledgments

This dissertation represents the tremendous support and commitment of many people to the advancement of knowledge and higher education in nursing. I would like to first express my indebtedness to the chair of my dissertation committee, Professor William L. Holzemer, for his immeasurable knowledge and guidance, support, patience, generosity, and opportunities he kindly offered to me throughout my program of study. Without his efforts, my success in completing this degree would have not happened.

I would like to extend my deepest appreciation to my other committee members: Professor Catherine M. Waters, a magnificent teacher and mentor for her consistently enormous support, advice, understanding, and belief in me during the toughest times; for her encouragement cheering me on; for her dedication to ensuring my completion; and for her guidance in helping me broaden my understanding of the autonomy concept. I also would like to give a very special acknowledgment to Professor Anita L. Stewart, an exceptional teacher, whose expertise in measurement I could always depend on for prompt and substantial feedback on my dissertation and issues related to measurement. It is my privilege to have had a great opportunity in gaining more knowledge on measurement development.

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Special thanks are due several of my colleagues and friends in Thailand and in the U.S.; Joungrak Ultrarachakit, Dr. Jonpajong Phengjard, Dr. Supreeda Monkong, Jintana Siriwarasai, Dr.Wasana Kirdpol, Rudee Pungbangkadee, Kanita Hanprasittham, Tasana Taweekun, Somtawin Sirireuang, Assist. Prof. Patcharin Nintachan, Assist. Prof. Huong Nguyen, Assist. Prof. Jyu Lin Chen, Fran Strzempko, Akemi Yamasaki, Liz Macera, and Teri Lindgren, for their time and effort in helping me in the process of preparing and translating the measurements. My very special and private word of thanks goes to Dr. Naris Kitnarong, whom I have had the privilege of getting to know in the past year, for his vast and unlimited support. My thank also goes to Dr. Chaluntorn Peeyasombat, for his help in measurement preparation and technical computer support.

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Abstract

This study investigated factors predicting job satisfaction of registered nurses in a teaching and tertiary hospital in Thailand. A descriptive survey design was used. Three measurements, including The Organizational Job Satisfaction Scale, Dempster Practice Behavior Scale (DPBS), and Leader Effectiveness & Adaptability Description (LEAD) were translated into Thai before being distributed along with demographic data to participants. This study included 49 head nurses and 614 registered nurses. The results showed that autonomy was the most important variable that predicted job satisfaction. Participants reported having high level of overall autonomy with moderate to high on six subscales, including self-determinism, self-governance, independence, competency, accountability, and moral reflection. However, the participants reported having moderate level of overall job satisfaction with low level on pay/reward subscale.

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CHAPTER 1: INTRODUCTION AND CONCEPTUAL FRAMEWORK

The first chapter describes the purpose, specific aims, research questions, problems, background and significance. The conceptual framework and definitions used in the study are given in order to clarify their meanings as well.

Introduction

Job satisfaction among nurses has been researched worldwide for many decades. There are studies supporting the relationships among employee satisfaction, productivity and performance, participation in decision making, retention and health (Hinshaw & Atwood, 1983; Snarr & Krochalk, 1996; Tappen, 2001). Health care systems are changing; many have moved toward managed care; and others have reduced their work force which potentially have a great impact on nurses by requiring new roles and responsibilities. The goal of this study is to explore factors predicting nurses' job satisfaction in the Thailand healthcare system which is undergoing health care administration and policy changes.

Specific Aims:

The purpose of this study is to examine whether personal characteristics or unit characteristics contribute to job satisfaction among registered nurses (RNs) at a large teaching hospital in Thailand (see Figure 1).

The specific aims of this study are to examine the relationships among the following variables:

Dependent variable: Job satisfaction

Independent variables:

Personal characteristics: gender, age, marital status, education, years of experience, work status, shift of work, perception of autonomy, and registered nurses' perception of leadership style of head nurses.

Unit characteristics: type of unit

The findings may help redesign organizational policy, RNs' roles and responsibilities, and eventually improve quality of patient care, provider and organizational outcomes.

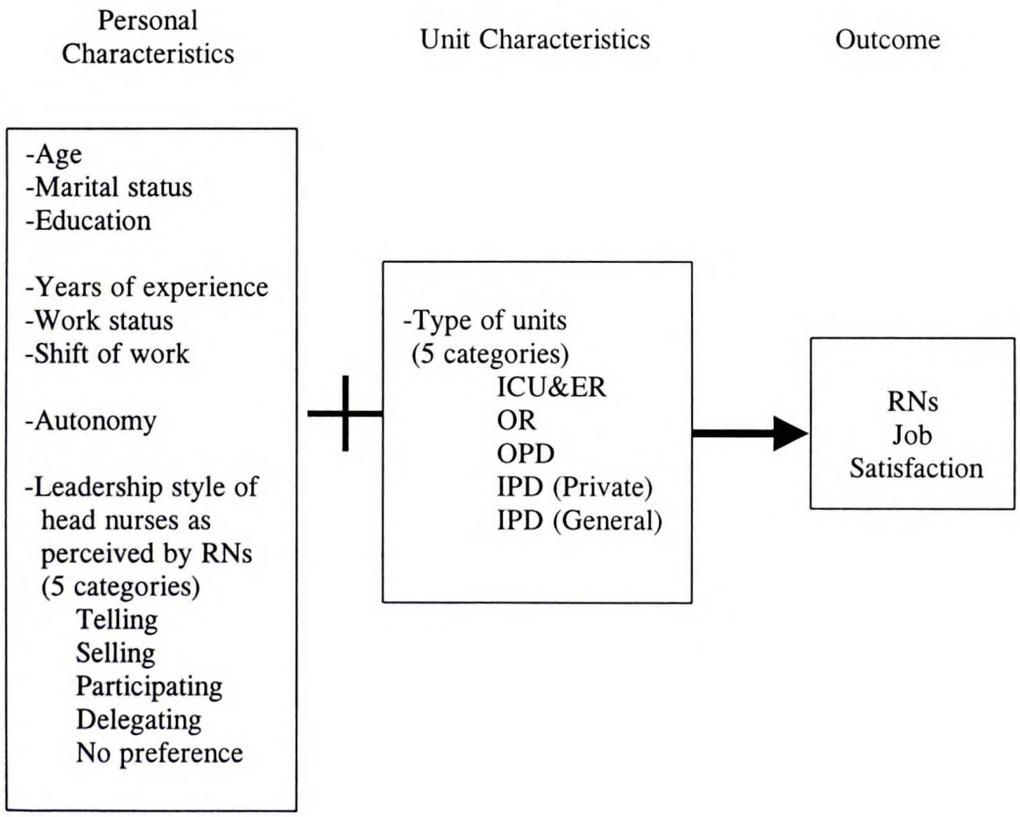


Figure 1 Conceptual Framework

Research questions:

1. What are personal job satisfaction and autonomy of registered nurses and unit characteristics of a sample of head and registered nurses working in a 1,200-bed, teaching tertiary hospital?
2. Are there unit differences in perceived leadership, autonomy and job satisfaction among staff nurses?
3. What are the contributors of staff nurse demographic characteristics, perceived leadership of head nurses, and type of unit to job satisfaction among registered nurses?

Background and Significance:

The problems of nursing shortage and high turnover rates have been major concerns among nurse administrators for many years. While numerous factors have been linked with turnover, nurse job satisfaction is one of the most often mentioned (Alexander, Lichtenstein, Oh, & Ullman, 1998; Curry, Wakefield, Price, Mueller, & McCloskey, 1985; D. Irvine, Sidani, & Hall, 1998; Weisman, Alexander, & Chase, 1981). The importance of job satisfaction is obvious for managers to be concerned with since employees that have high job satisfaction skip work less and are less likely to resign (Gillies, 1994). Employee satisfaction is a crucial success factor in any organization's performance. It directly affects financial performance and satisfied customers (McBride, 2002). Moreover, the belief that satisfied employees are more productive and have better health and live longer than those less satisfied has been a basic tenet among managers for years. For decades, studies on job satisfaction have been conducted to determine factors conducive to job satisfaction in many settings for.

The management of health care organizations worldwide has become increas complex as new structures and corporate arrangements have emerged in response to rapidly and dramatically changing environment. The registered nurses (RNs) work is being affected by these changes in terms of recruiting and retaining RNs. One of critical factors, the high rate of turnover, has been a major concern of administrativ teams for many years. All organizations have some turnover. However, turnover refers to the loss of staff the organization does not want to lose, such as knowledgea competent, and experienced personnel because it can lead to another problem, a disruption in the efficient running of the organization. A high turnover rate also lea increased retaining, recruiting, selecting, and training costs.

The ultimate goal of healthcare providers is to provide high-quality and cost effective care (Aiken & Patrician, 2000). In the milieu of rapid changes in the healt delivery system both in the United States (US) (Ferris, Rowland, & Buckley, 1990) worldwide (Ekintumas, 1999; Majorie & Srisuphan, 1990), hospital administrators implementing several strategies, such as restructuring, redesigning, merging and downsizing systems (Rice, 2001). The ever-changing, dynamic nature of health care creating the need for more autonomy in nursing roles, responsibilities and work pat (Wunderlich, Sloan, & Davis, 1996).

All of these changes have increased the stress for all healthcare personnel, particularly registered nurses (RN), who now have new roles and responsibilities th require advanced educational preparation and experience (Havens, 1994; Laschinge Havens, 1997). Nursing administrators are looking for ways to help improve the environment in which patient care outcomes are managed, enhance nurses' work lif

sense of professionalism, and reduce personnel problems, such as nursing shortages, high turnover, job dissatisfaction, and absenteeism (Laschinger & Havens, 1997).

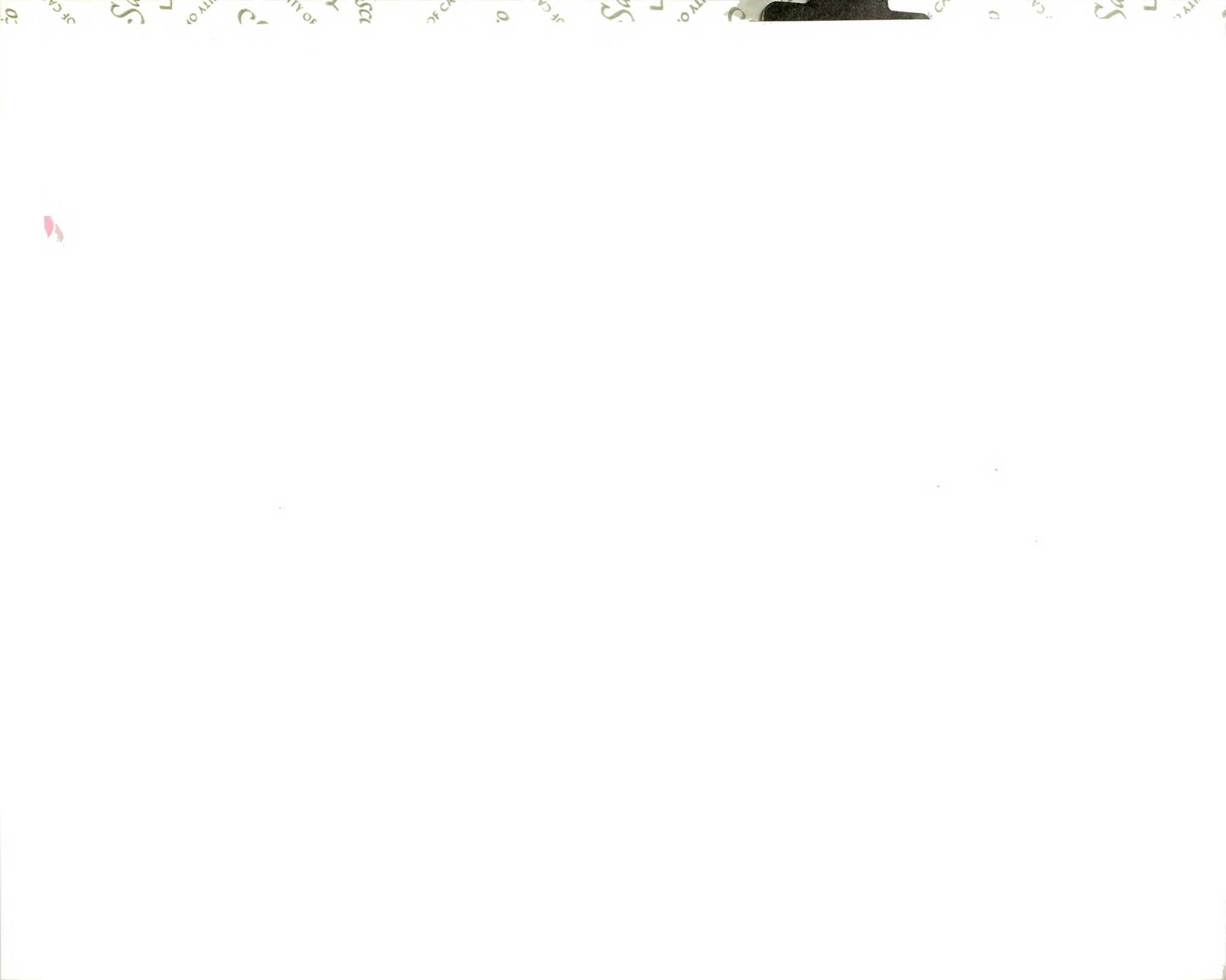
In the healthcare arena, registered nurses are the largest health care profession and they constitute the highest variable cost of health care. Faced with these numerous changes, some have become disappointed, frustrated, dissatisfied, burnout, and withdraw from the profession. Burned-out registered nurses who remain in the organization react to their workload by reducing effort. Patient safety and quality are believed to be negative consequences of the current situation for the nursing workforce. To minimize this obvious obstacle, enhancing registered nurses' job satisfaction is paramount.

Theoretical Frameworks

Since the concept of job satisfaction is complicated, there is no single theory that can completely explain this phenomenon. The conceptual framework for this study (Figure 1) is based on reviewed literature, research and existing theories. Drawing from these, a framework was developed that would help to understand and explain the phenomenon of job satisfaction and how to motivate it. Some of the most important and most commonly used theories are: (1) the principles of scientific management, (2) the hierarchy of need theory, (3) existence-relatedness-growth, and (4) two–factor theory or motivator-hygiene theory.

The Principles of Scientific Management: Federick Taylor (1856-1915)

The first of these theorists to consider what motivated people about work satisfaction is Federick Taylor, an engineer working in the American industry. His theory was published in 1911, Taylor's main concern was to increase efficiency and find



out how to encourage employees to work harder (Simpson & Sears, 1985; Warr & Wall, 1975). He pointed out that managers had reliable and useful information concerning the capacity and efficiency of their machine, while they had no information about their employees (Warr & Wall, 1975). His theory presents research linking job satisfaction with a variety of both individual and organizational variables. It was mainly focused on worker satisfaction based on the assumption that individuals would be motivated to do their work well if rewards were directly related to their performance of carefully planned tasks. However, managers often fragmented and inappropriately used this theory for productivity rather than worker satisfaction purposes, a dramatic difference in focus.

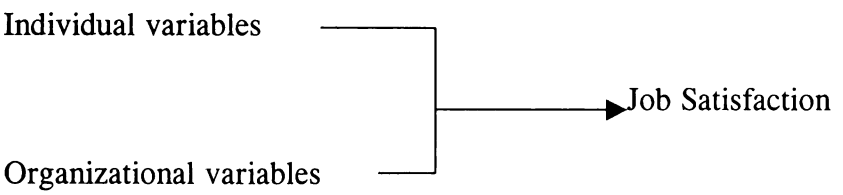


Figure 2: The Principles of the Scientific Management Model

The Hierarchy of Need theory: Abraham Maslow (1908-1970)

No one would argue the fact that human beings exhibit basic needs whose fulfillment is prerequisite for the survival and development of the organism. It may be said that most human beings themselves establish set patterns for meeting these basic needs. Maslow proposed his idea that individuals attempt to satisfy upper level needs. He suggested that persons are motivated by a hierarchy of needs, beginning with physiologic needs, then progressing to safety, belongingness and love, self-esteem, and finally to self-

actualizing needs. Lower-level needs, e.g., physiological, safety, and belongingness and love which are satisfied externally, will always drive behavior before higher-level needs (internally satisfied needs, e.g., self-esteem and self-actualization) will be addressed. Once a lower level factor is secure, it will no longer be a motivating force (Latting, 1991). Based on Maslow's theory, if we want to motivate someone, we need to understand where that person currently is on the hierarchy and focus on satisfying those needs at or above that level.

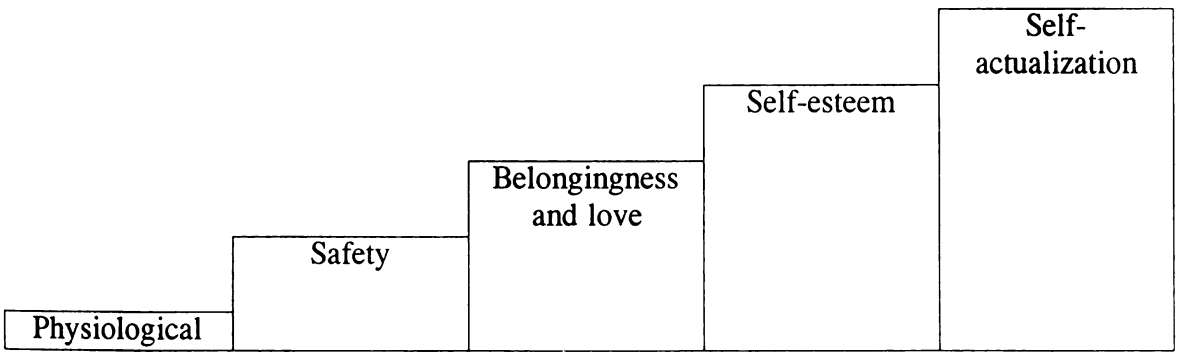


Figure 3: The Hierarchy of Need Model

However, Maslow's theory was sometimes found not to apply and not to explain some particular situations, since some cultures do not rank the needs by Maslow's order, such as Spain and Japan which place social needs before physiological needs (Hampton, Summer, & Webber, 1987; Robins, 1991). Nevis found that in China, belongingness and love come first in that culture and that the notion of self-actualization is conceived, not in an individualistic way, but in the sense of self as within and serving a larger community (Hampton et al., 1987). The societies who may value altruism and volunteerism, helping others without regard to personal benefit, such as financial

rewards, consider this to be a higher form of need satisfaction (Hampton et al., 1987; Latting, 1991).

Existence-Relatedness-Growth Theory (ERG Theory)

Clayton Alderfer developed the ERG theory by reworking Maslow's theory in 1969. Alderfer proposed that levels of need should be categorized into three levels instead of five as in Maslow's model. These levels are existence, which includes both Maslow's physiological and safety needs; relatedness, including Maslow's belongingness need; and growth, consisting of Maslow's self-esteem and self-actualization needs (E. J. Sullivan & Decker, 1992). Alderfer's model proposes the assumption that more than one need may be operative at the same time and needs do not go by order from low to higher needs. This makes the ERG theory less rigid and more flexible applicability.

Two -Factor Theory or Motivator-Hygiene Theory: Federick Herzberg (born 1923)

Traditionally, job satisfaction and job dissatisfaction were viewed as opposite ends of the same continuum. However, Herzberg's view is totally different. He developed a new theory called two-factor theory or motivator-hygiene theory in 1966. The central proposition of this theory is that the determinants of job satisfaction are qualitatively different from the determinants of job dissatisfaction. He viewed job satisfaction and dissatisfaction not as polar opposites on the same continuum but two separate and sometimes unrelated phenomena (Gray & Starke, 1980; Hampton et al., 1987; Latting, 1991; Porter, Lawler III, & Hackman, 1975; Robins, 1991; Stamps & Piedmonte, 1986; E. J. Sullivan & Decker, 1992; Truman, 1994; Warr & Wall, 1975).

Herzberg called the factors described employees' feelings with good times as satisfiers or motivators (which, when present, cause satisfaction) because they were associated with feeling good and with an increased desire to achieve improved job performance (Hampton et al., 1987). These motivators include achievement, recognition, work itself, responsibility, advancement and growth (Gray & Starke, 1980; Hampton et al., 1987; Latting, 1991). On the other hand, he called the other factors that described employees' feelings with bad times dissatisfiers or hygiene factors (which, when not present, cause dissatisfaction) because they were associated with feeling bad (Hampton et al., 1987). These factors include company policy and administration, supervision, relationship with supervisor, relationship with peers, work conditions, salary, benefits, job security, status, and personal life (Gray & Starke, 1980; Hampton et al., 1987).

Herzberg stated that the opposite of satisfaction is not dissatisfaction since removing dissatisfying characteristics from a job does not necessarily make the job satisfying. Similarly, it is possible to increase job satisfaction without lowering job dissatisfaction. He proposed that the opposite of satisfaction is no satisfaction and the opposite of dissatisfaction is no dissatisfaction as shown below:

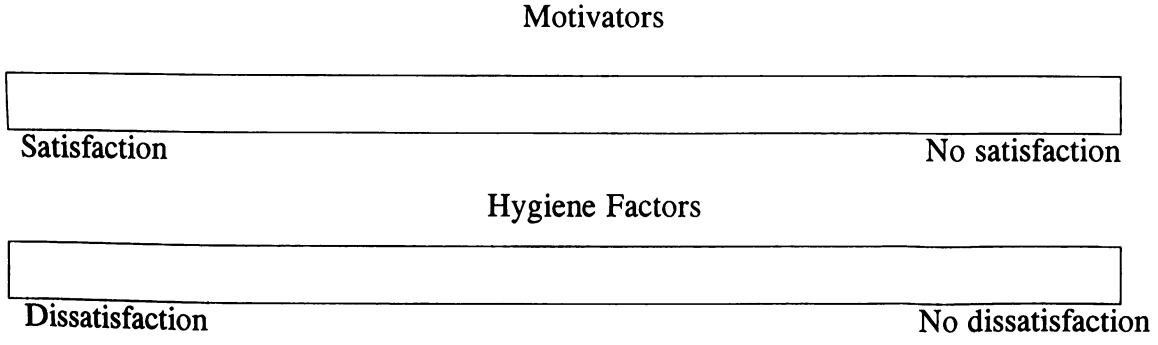


Figure 4: Herzberg's Two-Factor Theory Model

In Herzberg's view, to enhance motivation, managers should focus on designing the work itself to yield feelings of achievement, recognition, and responsibility because the absence of motivation factors causes the lack of satisfaction. Sullivan & Decker (1992) found that employees who experience job satisfaction are likely to perform their jobs effectively. Dissatisfied employees are more likely to be absent, file grievances, or quit (Sullivan and Decker (1992). Munro (1983) reported that for nurses achievement, recognition, and challenge were the primary motivating factors for nurses.

Herzberg's theories may or may not leave conflicts while measuring the levels of either motivators or hygiene factors since one factor may be a motivator factor for one person and not for others.

Definition of Job Satisfaction

Job satisfaction can be defined in many different ways. Conrad and Parker defined job satisfaction as a match between what individuals perceive they need and what rewards they perceive from their jobs. According to Kramer and Hafner, job satisfaction is a fluctuating attitudinal state that a person holds about his or her job. Others have described job satisfaction as a general attitude towards one's job and the difference between the amount of rewards workers receive and the amount they believe they should receive (Robins, 1991). Gillies (1994) described job satisfaction as one's affective response to the job. Locke and Vroom believed that job satisfaction reflects a degree of congruity between a worker's expectations of the job and experience of the job (as cited in Gillies, 1994).

Summary

Some theories were discussed to explain the phenomenon of job satisfaction. Each theories above has pros and cons. After reviewing these theories, the conceptual framework for this study was developed based on the Principles of Scientific management model. To be applicable, factors contributed to job satisfaction were conceptually separated into two categories, personal and unit characteristics (see Figure 1).

CHAPTER 2: LITERATURE REVIEW

This chapter explores which factors are predictors of job satisfaction and hov satisfaction affects health care outcomes. Results of reviewing the literature for facto that contribute to job satisfaction was clustered into two categories, including indivi characteristics and organizational characteristics as presented earlier in the conceptu framework (Figure 1).

Predictors of job satisfaction

Job satisfaction in nursing research was first conducted at the University of Minnesota in 1940 by Nahm (Chung, Samuels, & Alexander, 2003). He reported fa affecting job satisfaction included income, hours of work, relationships with supervi interest in work, family, social relationships, and opportunities for advancement. Si job satisfaction was also found to be an important element predicting organizational outcomes, particularly lower turnover rate, this concept has been researched extensi ever since.

Blegen (1993) conducted meta- analysis on 48 studies focusing on nurses' jol satisfaction and the variables most frequently associated with it. She found that the thirteen variables often linked with nurses' job satisfaction ; they are stress, commit communication with supervisor, autonomy, recognition, routinization, communicati fairness, locus of control, age, years of experience, and education. However, she f autonomy was the variable most often cited as a cause of job satisfaction for nurses (Blegen, 1993). Another meta-analysis on job satisfaction was later conducted by Ir and Evans in 1995. The variables found most to be related to job satisfaction were

content or environment and nurse managers (Irvine and Evans, 1995). Recently, Gormley (2003) conducted a study using meta-analysis to identify factors affecting job satisfaction with nurse faculty. She reported that factor that appeared to significantly affect nursing faculty job satisfaction was the perception/expectation of the leader's role (Gormley, 2003).

Many individual and organizational factors have been found to be related to job satisfaction, such as age (Njuki, 2001); years of experience (Combey & Alexander, 1998); marital status (Yaktin, Azoury, & Doumit, 2003); education (Tuanyang, 2001); autonomy (Finn, 2001; O'Rourke, Allgood, VanDerslice, & Hardy, 2002); professional status (Njuki, 2001); salary (Njuki, 2001; Pinchan, 2001; Tongpreum, 2001; Yaktin et al., 2003); promotion or career advancement (Yaktin et al., 2003); interpersonal relationship (Tongpreum, 2001); work environment and organizational structure (Wagner & Huber, 2003); and leadership style (Thermsirikunchai, 2001).

Individual characteristics:

When individuals enter an organization, Robins has said they are a bit like cars, either new or used (Robins, 1991). Some have low mileage while others are well worn, having experienced a number of rough roads. This implies that people will enter any organization with certain existing characteristics that will influence their behavior at work. These personal characteristics are age, sex, years of experience, education, marital status, individual perception of how they perceive their jobs and needs, values and attitudes, and ability. These factors all impact on an employee's behavior and there is little management can do to alter them. Organizations sometimes can produce nothing

unless employees contribute productive activities and an attitude that gets the work done (Hampton et al., 1987).

Job Satisfaction and Demographic Variables

Simson and Sear (1985) found that male nurses experienced greater job satisfaction than females. This may be because the males advance more rapidly than the female nurses. In 2001, Njuki (2001) studied factors related to job satisfaction among nurses by using self-administered questionnaires and found that age, salary, and job status were significantly associated with job satisfaction. Junior nurses reported having low satisfaction toward pay and professional promotion. Congruently, Yaklin et al. (2003) explored personal characteristics and job satisfaction among 421 nurses in Lebanon and found that nurses younger than 30 years were more dissatisfied with having fewer opportunities to attend continuing education courses and their salary.

Cavanagh found salary not to be a statistically significant predictor of job satisfaction (Cavanagh, 1990), although other studies have stated salary was an important predictor (Cowin, 2002; Njuki, 2001; Pinchan, 2001; Tongpreum, 2001; Yaktin et al., 2003). Njuki stated junior nurses reported having low satisfaction in relation to their pay. Pinchan (2001) explored job satisfaction of 150 male nurses in the nursing profession working in the Northern part of Thailand. He found that male nurses were the most dissatisfied with salary while they were satisfied with work environment (Pinchan, 2001). Tongpreum's findings (2001) supported other research that salary was strongly related to job satisfaction. She examined the relationship between job satisfaction and personal characteristics, working conditions, and opinions on government health system

reforms of 171 health personnel in one province in Thailand. Salary led to the lowest satisfaction score while interpersonal relationships, on the other hand, led to the highest (Tongpreum, 2001). Cowin (2002) studied the effects of nurses' job satisfaction on retention among nurses in Australia. Results showed that new nurses identified the issue of pay as significantly related to dissatisfaction (Cowin, 2002). Butler and Person also found that registered nurses ranked monetary rewards as the most influential aspect of job satisfaction.

Tuangyang (2001) investigated factors related to job satisfaction among nurses in a community hospital in one province in Thailand; 150 participants were surveyed and it was found that education was related to job satisfaction. The nurses having higher degrees reported having more satisfaction. Another personal characteristic, marital status, was also found to be related to job satisfaction in one study, where it was revealed that single nurses were more dissatisfied with their job (Yaktin et al., 2003). Combey and Alexander (1998) explored the relationship of organizational variables of structure, technology, and environment with job satisfaction among 1,669 licensed nursing personnel employed with the public health department in a southeastern state in the U.S. Their findings showed significant relationships between job satisfaction and years of experience and organizational structure. The longer the nurses work in this organization, the more they likely repoted having more job satisfaction.

Autonomy

Williams found that registered nurses ranked autonomy as the most important factor of their job satisfaction. The findings from Finn and O'Rourke et al., (2002) also

supported the relationship between autonomy and job satisfaction. Nursing autonomy is considered the hallmark of professional nursing status and has been found to be an important contributor to improving job satisfaction (Blegen, 1993; Finn, 2001), enhancing a sense of professionalism (Fulton, 1997; Hart & Rotem, 1995; Schutzenhofer, 1987, 1988), and reducing turnover and absenteeism (Curran & Miller, 1990; Laschinger, Sabiston, & Kutszcher, 1997). Autonomy has been shown also to be a significant factor improving quality of nursing care and patient outcomes at magnet hospitals in the United States (Aiken & Patrician, 2000).

The roots of the concept of autonomy are derived from the Greek words *autos* meaning "self" and *nomos* meaning rule, governance, or law (Ballou, 1998; J. S. Dempster, 1994; Taylor, 1999). The earliest documentation of the concept of autonomy stems from ancient Greek history regarding the relationship between Athens and her allies in the Delian League in the Fifth Century B.C. (Ballou, 1998). According to Ballou, the term *autonomia* referred to a state that is free to determine the norms by which it wants to live. This term was used by weaker states in opposition to despotism; it portrayed the quality of states or individuals that were under the shadow of a superior power, but still enjoyed self-determinism, even if it resulted in death; it represented the quality of an individual who lived by his or her own law; and referred to an individual's ability to prepare for the protection of his or her integrity.

This concept of autonomy was first established in America in 1914 by Cadazo, who stated that human adults with sound minds have a right to determine what is done to their body (Taylor, 1999). According to the *Collins Cobuild English Dictionary* (1995), autonomy is one's ability to make decisions about what to do rather than being influenced

by someone else or being told what to do. *Webster's Dictionary* (1991) described autonomy as the quality or state of being self-governing, the right of self-governing, self-directing freedom, and moral independence. From this lexicon perspective, autonomy means self-rule and denotes the right of an individual to control his or her actions and functions, and his or her ability to make choices (Dempster, 1994).

Different disciplines view autonomy from different perspectives. From an economic perspective, autonomy refers to economic efficiency, satisfaction, and fairness (Rice, 2001). The philosopher Kant viewed autonomy, which he considered the highest principle of all virtue and happiness, as morality and the freedom to self-govern (Schneewind, 1998). For ethicists, autonomy is the basis for the value placed on respect for persons and for issues related to informed consent and refusal of treatment (Castellucci, 1998; Hertz, 1996; Moskop, 1987). From an ethical perspective, an autonomous person deliberates and chooses a course of action in accordance with his or her life plan (self-determined behavior) and is able to act deliberately and freely on those choices (Hertz, 1996). Social psychologists view autonomous actions as those that are intentional, chosen, and an expression of one's self; they believe that situational and personal factors can foster or constrain autonomy (Deci & Ryan, 1987). Based on these perspectives, four dimensions of autonomy emerge: (a) autonomy as a free action, which implies that the choice one makes is voluntary—free from coercion; (b) autonomy as authenticity, which refers to the idea that the choices made by individuals are consistent with their values and beliefs; (c) autonomy as a deliberate choice, which implies that careful reflection, introspection and evaluation have occurred; and (d) autonomy as a moral reflection, which implies that autonomous decisions are consistent with the values

of a person's beliefs and that the person accepts the morality of the decision and is comfortable with the outcome upon reflection (Castellucci, 1998).

Autonomy in Nursing

From a professional occupation perspective, autonomy is the ability of members of an occupational group to control their activities without outside interference; it is the practice of one's occupation in accordance with one's education, with members of that occupation governing, defining, and controlling their activities in the absence of external controls (Schutzenhofer, 1987). Autonomy has been studied sporadically in health care for several decades in various contexts from the perspectives of patients, nurses and other health care professionals, and health care institutions and systems. Autonomy is valued as an essential factor in the development of professionalism in health care (Schulz & Schulz, 1988; Wright, 1986). Each health care professional possesses expertise that involves specialty education and training to perform his or her roles, obligations and responsibilities. For example, professional autonomy for physicians has been described as the ability to deliver medical care to patients without the uninvited imposition of outside influence (Mirvis, 1993).

Nursing, too, is based on a specialized body of knowledge that enables nurses to address human responses free from the boundary of dependent medical practice (Mundinger, 1980). To effectively exercise autonomous nursing actions, however, is complicated since the development of a sense of autonomy can be shaped by individual personality or external factors. In the early 1960s in the US, autonomy was believed to be an important dimension in the role of the nurse practitioner (Dachelet & Sullivan, 1979).

In the presence of autonomy, other criteria that define a profession are usually visible (Dachelet & Sullivan, 1979). These criteria are a long period of specialized education, such as a degree or program of education; a service orientation; the right to privileged communication; a specialized body of knowledge; and autonomy from supervision and social control (Schriner & Harris, 1994) In addition to nurses having a sense of autonomy, they must also promote autonomous decision-making for patients and their surrogates when it comes to their health care needs (Castellucci, 1998). According to the *Code for Nurses*, nurses should provide environmental situations and resources promoting self-fulfillment by respecting a patient's right to self-determination and autonomy (American Nurses' Association, 1976).

Nursing autonomy has been defined in various ways in the nursing literature, but appears to share a common thread: the freedom to make choices, decisions, or select a course of action without external control. The Cumulative Index to Nursing and Allied Health Literature (CINAHL) searchable index entered autonomy in its headings in 1983 and defined it as the right and privilege to make independent decisions; entered in 1992 as a heading, it defined professional autonomy as the quality or state of being independent or self-directing, especially in making decisions, enabling professionals to exercise judgment as they see fit during the performance of their jobs. Mass and Jacox (1977) provided early perspectives of autonomy in nursing, which they viewed as the condition of self-determination and direction without outside control (Mass & Jacox, 1977). Others have defined autonomy as the extent to which nurses feel comfortable in taking initiative and responsibility in hospitals (Pankratz & Pankratz, 1974); as making and being responsible for the execution of self-directed decisions within a complex and

multi-layered system of team roles (Fulton, 1997); and as authority and accountability for patient care and unit operations, involving the right to make decisions and take responsibility for outcomes (Blegen et al., 1993).

Autonomy, according to Kramer (1974), means the freedom to act on what you know; so if you are not competent, you cannot function autonomously. Autonomy in nursing has been used interchangeably with independence, responsibility, accountability, self-determination, self-regulation, self-governance, self-control, and self-sufficiency (Dachelet & Sullivan, 1979). Three attributes have been identified to characterize professional nursing autonomy: (a) voluntariness, which refers to the presence of choice, freedom from coercion, and unrestrained thought or movement; (b) individuality, which addresses human uniqueness and a sense of self, and knowledge of needs and goals; and (c) self-direction, which involves guiding or controlling one's own destiny (Hertz, 1996). According to Kramer and Schmalenberg (1993), necessary prerequisites for nursing autonomy are competence, trust, and a flat, debureaucratized organizational structure. Competence refers to both "high tech" and "high touch," and the wisdom of knowing which is needed and how to blend the two to meet each patient's unique needs (Kramer & Schmalenberg, 1993). Thus, nurses acting autonomously must be competent, informed, and able to act voluntarily.

In sum, autonomy has been defined differently depending on how it is applied and measured by researchers, making interpretation of its meaning imprecise. Many studies assessed autonomy in nursing as a global concept, assessing nurses' general perceptions of their autonomy. The concept of autonomy was generally operationalized as participation in decision-making; limitations of physicians' prescribing power;

comparison of nursing care delivery models; assessment of specific patient care activities and unit operation characteristics, decision-making differences between staff nurses and nurse managers; and the examination of the institution's organizational structure. The only clear connotation of the concept of autonomy is that it includes an array of subconcepts that are used interchangeably.

The salient subconcepts of autonomy in nursing proposed by this investigator are (a) self-determinism—to make choices voluntarily and act freely regarding professional nursing activities; (b) self-governance—the authority to self-direct and self-rule over professional nursing activities; (c) independence—self-control and self-sufficiency over professional nursing activities without external control, but in collaboration with others; (d) competence—the ability to carry out professional nursing activities based on education and experience; (e) accountability—taking responsibility for professional nursing activities; and (f) moral reflection—careful introspection and evaluation of professional nursing activities that are consistent with the values and beliefs of nursing's professional regulatory body.

More significantly, York and Fecteau (1987) demonstrated that nurses' senses of autonomy could be increased at John Hopkins Hospital, Baltimore, through participative decision making in primary nursing (Ferguson, 1996). Similarly, Maram, Schegal and Bevis (1974) stated that reorganizing staff nursing at a unit level, such as assigning a patient to a single nurse, can help nurses gain a greater sense of responsibility. This would lead to creative decision making by increasing autonomy and decreasing task routinization, resulting in higher job satisfaction.

Leadership

Job satisfaction is a complex concept. Individuals bring various values and needs to their work. An individual's job satisfaction is a result of personal characteristics. Management of one's leadership style in the work setting influence this interaction. Thermsirikulchai (2001) studied the relationships between staff nurses' job satisfaction with the head nurses' leadership behavior and job empowerment. She reported there were statistically significant positive correlations between staff nurses' job satisfaction and the leadership behavior of their head nurses ($r = .57$, $p < .01$).

Leadership has long been studied, but the focus has shifted over time. Leadership can be interpreted differently depending on the perspective and elements focused on. Leadership is the process of influencing people to accomplish goals (Huber et al., 2000). It can be defined as a relationship founded on trust and confidence that encourages followers to take risk (Meyer, 2002). Leadership style, the behavior of the leader is defined as the manner in which leaders carry out work accomplished through other people.

Today, leaders in health care organizations, operated in an environment that is experiencing dramatic changes with respect to cost containment, a need for increased productivity, more sophisticated customers, more advanced technology, and high employee turnover rates. Thus, for this study, Situational Leadership Theory, considered to be appropriate and easily understood, was employed. This model was used by leaders to recognize the current behavior of followers and motivate, facilitate, and encourage them to obtain the highest levels of performance.

Hersey and Blankchard developed this instrument in 1976 based on the "Life Cycle Theory" which is now known as "Situational Leadership Theory." They expanded Fiedler's Contingency Model which stated that a leader is the most effective when he or she matches the leadership style (relationship-oriented or task oriented) to situational factors.

Task Behavior – Oriented Leadership Styles: The extent to which a leader organizes and defines the roles of individuals and members of his/her group by explaining what activities each is to do as well as when, where and how tasks are to be accomplished. It is further characterized by the extent to which a leader defines patterns of organization, formalizes channels of communication, and specifies ways of getting jobs accomplished.

Relationship Behavior – Oriented Leadership Styles: The extent to which a leader engages in personal relationships with individuals or members of the group (Hersey, Blanchard, & LaMonica, 1976b).

To be a good leader is to know your followers, their abilities, and willingness to perform tasks at all times. In the Hersey and Blankchard theory of situational leadership, they emphasized the behavior of a leader as related to a specific task, and the readiness and willingness of followers to achieve the tasks. Four distinct leadership styles; "telling," "selling," "participating," and " delegating;' are specified according to the readiness and ability of the followers (see Figure 5 and 6).

The appropriate leadership style as related to the readiness of the follower were depicted in Figure 5 and 6 below:

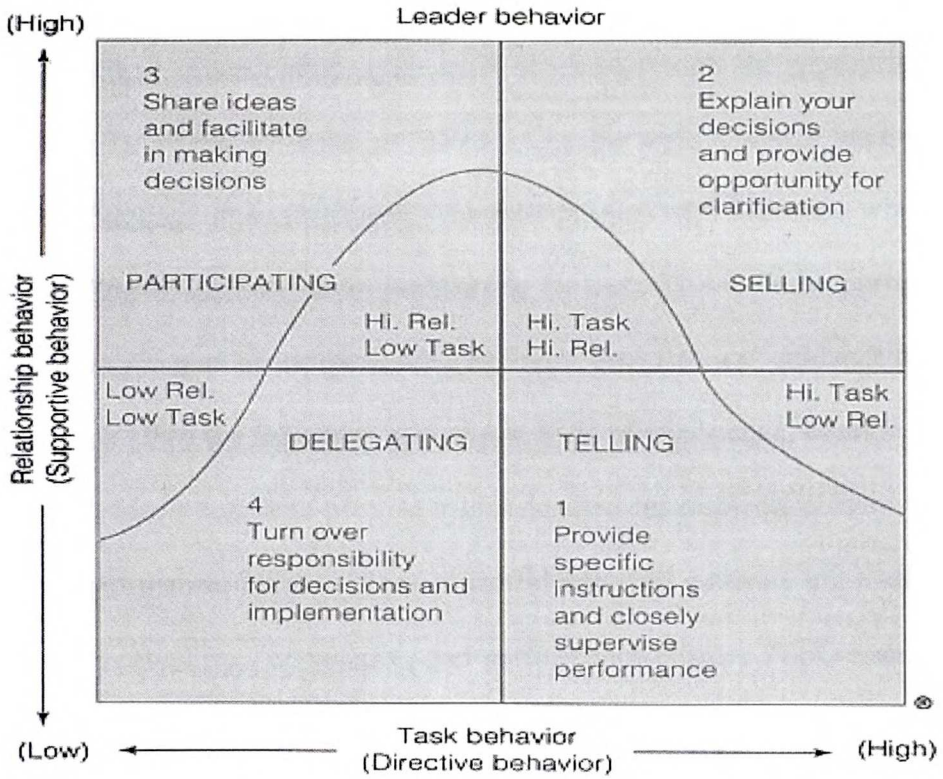


Figure 5: Situational Leadership Theory. *Note:* From *Effective leadership and And management in nursing* by E.J. Sullivan and P.J.Decker, 2001, Upper Saddle River, New Jersey: Prentice Hall.

High	Moderate		Low
R1	R2	R3	R4
Able and willing or Motivated	Able but Unwilling or Insecure	Unable but Willing or Motivated	Unable and Unwilling or Insecure

Figure 6: Follower Readiness

By drawing a line from the follower's readiness level from R4-> R3-> R2 -> R1 straight up to the curve of leadership styles, each block represents the appropriate choice for action (Figure 7). "Telling" is the preferred leadership style to match readiness level 1. Leaders use a "telling" style (high task, low relationship) with followers who are unable and unwilling or insecure about performing the task. This style is appropriate when the followers are new or inexperienced and need direction and guidance to accomplish the task since the followers have a low level of experience, confidence, and knowledge. The leader's role is to provide useful detailed instructions, closely supervise the follower's performance, create a sense of confidence, and cultivate knowledge and skills to increase motivation, competence, and performance (Figure 7) (Keenan, et al., 1990; Meyer, 2002; Reed, 1992; Zurlinden & Bongard, 1991).

Participating				**Selling**			
Follower		Leader		Follower		Leader	
Able	yes	Task	low	Able	no	Task	high
Willing	no	Relationship	high	Willing	yes	Relationship	high
Delegating				**Telling**			
Follower		Leader		Follower		Leader	
Able	yes	Task	low	Able	no	Task	high
Willing	yes	Relationship	low	Willing	no	Relationship	low

Figure 7: Leadership Styles and Follower's Readiness (Based on Hersey and Blanchard' Situational Leadership Theory)

"Selling" is the preferred leadership style for followers in level 2. "Selling" (high task, high relationship) (Figure 7) is used with followers who are unable but are willing or confident in performing the task. This style is useful when followers are more responsible, experienced, and willing to do the tasks, but may lack the necessary skills needed for independence in the given situation. It is important to note that followers at this level are committed and actively attempting to perform the task. This allows leaders to provide moderate to high direction and supportive feedback. Encouraging followers to express their feelings, suggesting ways for them to solve problems while using supportive feedback can increase the followers' motivation.

"Participating" is the preferred leadership style for followers at level 3, those having the ability and developing the confidence to independently perform tasks. Leaders use this "participating" style (low task, high relationship) with followers who are able but are unwilling or lacking in confidence in performing the task. Followers at this level have knowledge, but may be reluctant to move forward without support. The leader's role is to give a little direction, but provide much encouragement, confidence building, communication, and a supportive environment to move the followers toward greater autonomy.

"Delegating" is the desired leadership style for followers at level 4. Followers have demonstrate autonomy, knowledge, skill, and competence needed to achieve the tasks and having responsibility for directing their own behaviors. "Delegating" is employed with followers who are both able and willing and have confidence in performing the task. The leader's role is to provide objectives for general guidance and request final reports.

Alexander, Weisman, and Chase (1982) stated that the leadership style of head nurses is an important determinant of staff nurses' perceptions of autonomy. Head nurses viewed as responsive to the needs of staff nurses were associated with reports of high levels of autonomy. Leadership style can be identified as autocratic, democratic, laissez faire, and collaborative or participative (Loveridge, 1996). In the autocratic style, the leader assumes the role of commander and issues directives that are supposed to be achieved without hesitation. Alternatively, in a democratic style of leadership, the group members reserve for themselves the final authority to make any decisions. In the laissez faire style, the leader provides information when asked, however, performance is not evaluated or affected either negatively or positively. According to a collaborative or participatory style, all members are believed to have talents and contributions to make regarding goal setting and the plans and strategies used to achieve those goals. Thus, it is the leader's responsibility to motivate everyone to contribute their best in order to gain high quality decisions.

Unit characteristics:

Any job normally requires interaction with co-workers and bosses, following organizational rules and policies, meeting performance standards, and living with the working conditions. Robins (1991) stated that employees tend to prefer moderate mentally challenging jobs that give them opportunities to use their skills and abilities and offer a variety of tasks, freedom, and feedback on how well they are doing. Too little challenge creates boredom, however too much challenge creates frustration and feelings

of failure. Under conditions of moderate challenge, most employees will experience pleasure and satisfaction.

Employees are concerned with their work environment, pay systems, promotion policies, and supportive and friendly colleagues or co-workers. Different organizations or different units in the same hospital (e.g. ward culture) have been found to have a relationship to job satisfaction. Weismann found that nurse's job satisfactions differed between hospitals (Weisman, Alexander, & Chase, 1980; Weisman et al., 1981). Similarly, the study of Kramer and Schemalenberg in1991 found that job satisfaction was closely linked with organizational culture and a climate that fostered responsibility, warmth and support, all of which contributed to a high-level of job satisfaction. Studies from Pinchan (2001) and Tongpreum (2001) also reported that the work environment was related to job satisfaction (Pinchan, 2001; Tongpreum, 2001). Also, size is found to be related to the perception of the employee regarding job satisfaction. The larger the hospital, the lower level of job satisfaction among staff nurses (Ullman,1967).

Job Satisfaction as a Predictor of Health Care Outcomes

Job satisfaction can be considered to be both an independent and a dependent variable. Job satisfaction is an important predictor for quality of life, burnout, turnover, absenteeism, performance, and productivity among nurses (Cimete, Gencalp, & Keskin, 2003).

A dramatic transformation of the financial, organizational, and political structure of health care occurred in the 1990's not only in the author's country, Thailand, but also in the United States and throughout the world. This transformation is generating change

across the country at all levels of health care. Management of health care organizations has become increasingly complex, as new structures have emerged in response to the rapidly and dramatically changing environment. At such a chaotic time, in order to solve problems appropriately, one important thing that we, the health care provider should be really concerned about is being able to assess where reality is and where it is likely to be headed.

This author has worked as a staff nurse in a Department of Nursing, that is supervised by the Faculty of Medicine where physicians are in charge, and there remain major problems in recruiting and retaining registered nurses. Many studies support the relationship between job satisfaction and nursing turnover and the nursing shortage, so enhancing nurses' job satisfaction is truly crucial. Larrabee, Janney, and Ostrow (2003) investigated the relationship between nurse job satisfaction and intent to leave among 90 registered nurses, and found that the major predictor of intent to leave was job dissatisfaction (Larrabee et al., 2003). Similarly, Ingersoll, et al (2002) examined job satisfaction and commitment to the work settings of 1,271 registered nurses practicing in New York. The RNs reported their intent to leave nursing within the next five years (Ingersoll, Olsan, Cates, DeVinney, & Davis, 2002).

When any organization loses an experienced nurse, the knowledge and skills gleaned over years of practice are difficult to replace and the cost to an organization in recruiting, orienting and training a replacement can be high. The estimated cost of replacing new staff members can run as high as 50% of that person's annual salary. This is not surprising when considering the costs of recruiting, orienting, and training a replacement nurse (Ferris, Rowland & Buckley, 1990). In the United States, the average

annual turnover rate of hospital nurses in the managed care era has ranged from 18% to 25%. The growing difficulty with filling budgeted vacant nursing positions, plus the cost of nurse turnover (estimated to be as high as $20,000 to fill a single vacant position), have become a major concern in health care institutions (Curran, & Miller, 1990). More importantly, if that person is replaced with someone who has poorer judgement or less experience, quality of care suffers and complications may increase (Dracup, 1999).

Job satisfaction among professional nurses has long been recognized as an important correlate of nurse performance, quality patient care, and cost savings (Davidson, Folcarelli, Crawford, Duprat, & Clifford, 1997; Weisman et al., 1980). Several studies have shown that employees who are dissatisfied with their jobs are prone to health problems, both physical, ranging from headaches to heart disease, and psychological (Blegen et al., 1993). Burnout has also found to be related to job satisfaction in a study among community-based nurses (Jansen, Kerkstra, Abu-Saad, & Van der Zee, 1996). And is also a response to chronic occupational stress (Sullivan, 1993). As a result, health problems occurring among registered nurses could decrease their well-being and ability to work. Kalliath and Morris (2002) assessed the impact of job satisfaction on burnout among 203 nurses employed by a general community hospital located in the midwestern U.S. The results showed that job satisfaction was a significant predictor of burnout (Kalliath & Morris, 2002).

Cimete, Gencalp, and Keskin (2003) studied the relationship between quality of life and job satisfaction among 501 nurses and found that quality of life was positively correlated with job satisfaction (Cimete et al., 2003). On the other hand, increased satisfied employees lead to satisfied citizens, which is beneficial over all since these

people will hold more positive attitudes toward life in general and make for a society of more psychologically healthy people. The results in some studies regarding relationships between job satisfaction and registered nurses' well-being might be helpful for nurse managers and should give rise to their concern for creating a positive, enjoyable, flexible and supportive workplace and so on. Exploring the concept of job satisfaction is critical in the healthcare industry since it eventually affects costs, turnover rates, and quality of care in the organization.

CHAPTER 3: METHODOLOGY

This chapter describes the research design, methods, sample, measurements, questionnaire, human subject protection, procedure, protocols, and methods of analysis in this study. The overall purpose of this study is to explore whether personal characteristics or unit characteristics are better predictors of the registered nurse's job satisfaction within the workplace.

Research Design and Methods:

Design: A descriptive, survey design was used. All head nurses and registered nurses currently employed in a 1200-bed teaching and tertiary hospital in Bangkok, Thailand, providing ambulatory, out and in-patient care to all age groups of patients were surveyed. The data were collected with questionnaires designed to obtain demograpgic data, their perception of autonomy, leadership styles of the head nurses, and job satisfaction. The survey method was adopted because of its appropriateness for meeting the study purpose as well as for the protection of confidentiality of the study participants.

Setting: Data collection took place in Ramathibodi Hospital, a 1,200- bed teaching and tertiary hospital in Bangkok, Thailand over a month's period from July to August, 2003. Ramathibodi Hospital provides medical treatment and care to people not only in Bangkok, but also from other provinces. The Nursing Department, which is governed by the Faculty of Medicine at Mahidol University, and provides services ranging from primary care to advanced tertiary care. It is responsible for all nursing services at Ramathibodi Hospital, which serves 3,500 outpatients per day and has 1,200 in patient beds. Home care is provided for selected convalescent and terminally ill patients, and community health care services are provided in certain urban and rural

areas. The Director of the Department of Nursing is responsible for services, education (Ramathibodi School of Nursing), and research. The services are divided based on tasks characteristics into five categories: 1) intensive care unit and emergency unit (ICU & ER); 2) ambulatory unit, general practice and outpatient unit (OPD); 3) operating room (OR); 4) inpatient unit private wards (IPD Private); and 5) in patient general wards (IPD General).

1) Intensive care unit and Emergency unit (ICU & ER). Staff nurses provide extremely vital care and emergency services for patients with serious or sudden disorders at any time, 24 hours a day. There are nine wards under this cateogory.

2) Ambulatory unit, general practice and outpatient unit (OPD) comprise seven wards. Staff nurses help doctors serve 3,500 outpatients per day. The ambulatory unit is responsible for home care visits to selected convalescent and terminally ill patients in certain urban and rural areas.

3) Operating room (OR). Staff nurses assist doctors while they perform surgery. There are 11 wards under this cateogory.

4) Inpatient private wards (IPD Private). Staff nurses perform nursing care for patients who are hospitalized in a private room. The patients' relatives were allowed to stay with the patient 24 hours. There are 14 wards under this cateogory.

5) Inpatient general wards (IPD General). Staff nurses perform nursing care for all patients who are hospitalized on the wards. Patients' relatives are allowed to be with the patients only during meal times. There are 25 wards under this cateogory.

These five categories provide care in ten clinical nursing divisions, directed by coordinators. The ten clinical nursing divisions are obstetric and gynecological; surgical;

medical; pediatric; eye-ear-nose-throat; psychiatric; ambulatory care; general practice; operation; and Sirikit Medical Center.

Sample and Sample Size: The participants of this study were all registered nurses and head nurses currently working in the hospital. Normally, there are 70 wards, however, during the data collection period, only 67 wards were available. Four wards were clustered together (Obstetric I-II and Nursery I-II) since some parts of the building needed to be remodeled after an engine explosion. Each ward has one head nurse with responsibility for three to 35 registered nurses. Head nurses work collaboratively with higher administrative teams to bring hospital policy to registered nurses; with nurse educators to help provide mentors for nursing students; and with staff nurses to perform nursing care.

After receiving permission from the Committee on Human Research of both UCSF and Ramathibodi Hospital, the Director of the Nursing Department was contacted to obtain a list of names of all registered nurses (925 RNs) and head nurses (67 HNs). All of the 925 registered nurses currently employed in non-administrative positions and all of the 67 head nurses were given questionnaires. The participants were asked to read a cover letter explaining the objectives of the study. This cover letter included an assurance that confidentiality would be maintained, since asking registered nurses to evaluate their head nurses leadership styles is a sensitive issue. For a multiple linear regression model, based on 15 variables presented in the conceptual framework (see Figure 1), a sample size of 285 should be enough to have 80% power to detect at a = 0.050 an increase in R^2 of 0.0200.

Instruments: The four instruments are demographic survey, measurement of Organizational Job Satisfaction Scale, autonomy (DPBS: The Dempster Practice Behaviors Scale), and leadership style (LEAD: Leader Effectiveness & Adaptability Description). The instrument packet (see Appendix D (for head nurses, English version), E (for registered nurses, English version), F (for head nurses, Thai version) and G (for registered nurses, Thai version) required approximately 50 minutes to complete.

1. **Demographic Data:** Participants were asked to fill out the demographic data regarding their gender, age, marital status, educational degree, years of experience, unit of employment, position rank, work status, and shift of work to reassure that they met the requirements. This part took one minute to complete.

   Years of experience reflects how long the participants worked as nurses or head nurses in this hospital.

   Position rank indicates a type of career ladder linked to education, years of experience, and salary. Generally, new registered nurses holding Baccalaureate degree who is hired by any hospital belonging to the governmental system starts with rank 3, two years later, they can move up to rank 4. Each rank has many levels identified by salary. Moving from rank 4 to 5 depends on their salary increases each year. However, it is not necessary to move to each level in order since some staff can move faster depending on how effective, and qualified their work is. For example, any staff nurse can move from rank 4, level 1 to rank4, level 3 instead of moving up from level 1 to 2, based on their head nurse's evaluation. From rank 5, to move up to a higher rank, a nurse needs to submit a qualified paper reporting their work, responsibility, projects, plans and so on.

Work status has 4 types: governmental officer, non-governmental, composed of temporary employee, permanent employee, and university employee. Although all registered nurses were working in the same hospital since 2001, some organizational policies have changed in response to the impact of the Asian economic crisis that occurred in 1997. To decrease national expenditure, Thai government policy makers asked governmental organizations, including this hospital to be privatized as soon as possible. In order to be privatized no later than 2005, this hospital has adopted many strategies including a new system of hiring staff in response to this new situation.

Before 2001, the hospital was hiring staffs as government officers. Registered nurses who were hired from the year 2001 to the present, can be either a temporary employee, permanent employee, or university employee. The major differences between governmental and non-governmental officers are salary, facilities and benefits. Governmental employees earn less salary, almost half, what non-governmental ones receive for the same rank, however, governmental employees receive full healthcare cost reimbursement. This healthcare benefit covers themselves, their parents, wives /husbands, and children. They also receive pensions after retiring, while non-governmental officers get annual bonuses instead.

For non-governmental officers, based on a new hiring system, the first status is temporary employee. This employee will be evaluated every six months in order to move up to become a permanent employee, and then a university

employee in an orderly fashion. For both temporary employees or permanent employees, it is somewhat like they are working under a probationary period.

Shift of work was divided into three 8-hour shifts at this hospital. The morning shift is from 7.00 AM to 3.00 PM; the afternoon shift is from 3.00 PM to 11.00 PM; and the night shift begins at 11.00 PM and goes until 7.00AM.

2. **Organizational Job Satisfaction Scale:** This instrument was designed to measure specific dimensions of job satisfaction among nurses. The original version was developed by Slavitt and colleagues in 1978, known as the Revised Attitude Scale to Measure Occupational Satisfaction of Hospital Nurses. The Slavitt scale consisted of 48 items related to job satisfaction with nurses' respective work situations. The instrument was developed based on the theoretical writings of Maslow (1954), Mayo (1945), Herzberg (1959), Vroom (1964), and Hulin and Smith (1965) (cited by Sauter et al., 1997). Factor analysis produced seven subscales: pay, autonomy, task requirements, administration, interaction, professional status, and doctor-nurse relationships.

Through a 5-year instrumentation project, from 1983-1985, Hinshaw and Atwood selected 32 of the items for use in a study of anticipated turnover among nursing staff. These 32 items were known as the Work Satisfaction Scale. Further revision by Hinshaw and Atwood resulted in the 27-item Organizational Job Satisfaction Scale with a 6-point Likert scale (Sauter et al., 1997). Responses could range from "6" representing participants having the lowest agreement to "1" representing participants having highest agreement in reference to each item. Overall, the higher the score, the loweer the extent of job satisfaction. The possible score range is between 27 to 162. The modifing version consists of 4 subscales: pay/reward, professional status, interaction/cohesion, and

administration. The Cronbach's alpha coefficients for the subscales ranged from .69 to .81, with a total instrument coefficient of .87 (Sauter et al., 1997).

The Pay/Reward subscale composes of 8 items, including items numbered 4,8,12,15,16,25,27, and 28. This subscale focused on nurses' perceived adequacy of and satisfaction with their salaries. Sample items from this subscale are " Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable" and "My present salary is satisfactory."

The Professional Status subscale consists of 7 items, including items numbered 1,2,5,6,13,24, and 26. This subscale assesses perceptions about the importance of one's job and how interesting the job is for the nurse. Sample items from this subscale are "There is no doubt whatever in my mind that what I do on my job is really important" and "Even if I could make more money in another hospital nursing hospital, I am more satisfied here because of the working conditions."

The Interaction/Cohesion contained 7 items, including items numbered 9,14,17,19,21,22, and 23. This subscale assesses the perceptions of how well nurses work together and get along. Sample items from this subscale are "There is a good deal of teamwork and cooperation between the various nursing staff on my unit" and "New employees are not quickly made to 'feel at home' on my unit."

The last subscale, Administration consists of 6 items, including items numbered 3,7,10,11,18, and 20. This subscale assesses perceptions of how nursing administration cared about the nursing staff and how the nursing staffs were included in decision making. Sample items from this subscale are "I have enough opportunities to make administrative decisions in planning procedures and policies for my unit." and "The

nursing administrators generally consult with the staff on daily problems and procedures."

However, for this study, one more item (item number 28) was added to explore if the participants felt their needs were met on the wards they worked on. Furthermore, to eliminate confusion while expressing their feelings, the original way of scoring was reversed consequently, responses were formatted to range from "1" (participants having the lowest agreement) to "6" (participants having the highest agreement). Thus, the higher the score is, the greater the extent of job satisfaction revealed. The possible score range was between 28 to 168. Participants took 15 minutes to complete this part.

3. The Dempster Practice Behaviors Scale (DPBS), a paper and pencil instrument, has been widely used by over 40 researchers in the US and other countries. The instrument is designed to measure the extent of autonomous behaviors in practice (Dempster, 1990). The DPBS is a 30-item instrument, with a 5-point Likert response scale that summated scoring. Responses could range from "1" representing participants having the lowest agreement and "5" representing participants having the highest agreement regarding each item. Five items must be reverse scored. These items are 8, 13, 17, 26, and 28. Overall, the higher the score, the greater the extent of autonomy. The possible score range is between 30 and 150. The instrument focuses on overt and covert behaviors, actions, and conduct related to the extent of an individual's autonomy in a practice setting.

This instrument was intentionally to be used not only within the nursing profession but outside of nursing as well. To avoid possible response bias, autonomy was not included in the title of the measure, which was developed to fill a gap in the dearth of

valid and reliable instruments that specifically assess behaviors and actions related to autonomy in practice.

Theoretical literature and empirical studies of autonomy were critically reviewed for conceptual analysis and identification of dimensions. This deductive pursuit was supplemented by an inductive study, utilizing a grounded theory approach, with in-depth interviews of 28 subjects to elicit qualitative data associated with autonomous practice behaviors. A conceptual schema, developed from the retroductive triangulation of deductive and inductive findings, identified four theoretical unmeasured dimensions of readiness, empowerment, actualization, and valuation related to autonomy in practice. Based on the conceptual schema, item formulation emerged through content analysis of the qualitative study data and the theoretical/empirical literature.

The initial 40-item DPBS, along with three existing instruments to test for convergent and discriminant validity, was distributed to 1,000 practicing RNs (Dempster, 1990). There was an adequate response rate of 57% (n = 569) from 48 states and the District of Columbia. Nurses in advanced practice (nurse practitioners) comprised 60% of the returns with other categories of RNs making up to the remaining 40%. Practice sites and specialty areas were diverse.

The content validity index of the initial 40-item DPBS was calculated from ratings of seven content experts and had the maximum value of 1.00 according to Dempster (1990). Based on the 569 usable responses, exploratory and confirmatory factor analyses with orthogonal varimax rotation and alpha factoring were performed. Consequently, the 40-item instrument was reduced to 30 items. Construct validity was established through construction of a multitrait-multimethod (MTMM) matrix. Through

the MTMM matrix, convergent validity of the DPBS was demonstrated with another autonomy tool of a different measurement method, and discriminant validity was demonstrated with tools of different traits and measurement methods.

Evidence of the 30-item DPBS internal consistency reliability was reported via the Cronbach's alpha coefficient (r = .95) with an overall inter-item correlation mean of .39. The corrected item-total correlation range was .45 to .73 (J.S. Dempster, 1990). Participants took 20 minutes to complete this part.

4. Leader Effectiveness & Adaptability Description (LEAD)

The Leader Effectiveness & Adaptability Description (LEAD) was developed by Hersey and Blankchard (Hersey, Blanchard, & LaMonica, 1976a; Hersey et al., 1976b) to evaluate the perception of a leaders' effectiveness and adaptability named, in terms of "telling," "selling," "participating", or "delegating," and to indicate whether the style is appropriate in various situations.

The LEAD is used to score both the "LEAD Self" and "LEAD Other" instruments. When participants are scoring the "LEAD Self" instrument, the results will be information about their own perception of their leadership style. On the other hand, if they are scoring "LEAD Other" instrument, the results will provide information about how their leadership style is perceived by others. There are 12 management situations and 4 optional actions for each circumstances. For example, Situation # 1 "Your subordinates are not responding lately to your friendly conversation and obvious concern for their welfare. Their performance is in a tailspin." Alternative action, the leader would.... (a) Emphasize the use of uniform procedures and the necessity for task accomplishment; (b)

Be available for discussion but would not push for involvement; (c) Talk with followers and then set goals; and (d) Intentionally not intervene.

Scoring

The 12- case questionnaire determines the primary style of leadership, and the styles used most frequently (Hersey & Blanchard, 1988; Hersey et al., 1976a, 1976b; Wolf, 1996). To identify the primary style, the first step is to transfer the circled alternative actions for each of the twelve situations from the LEAD instrument to the corresponding numbered situations in Figure 8. Then total the number of the circled actions for each of the four vertical columns and write their sums next to "Totals."

ALTERNATIVE ACTIONS

SITUATIONS	(1)	(2)	(3)	(4)	Group Readiness Described in Situations
1	A	C	B	D	R1
2	D	A	C	B	R2
3	C	A	D	B	R3
4	B	D	A	C	R4
5	C	B	D	A	R1
6	B	D	A	C	R2
7	A	C	B	D	R3
8	C	B	D	A	R4
9	C	B	D	A	R1
10	B	D	A	C	R2
11	A	C	B	D	R3
12	C	A	D	B	R4
Totals					
	Telling (S1)	Selling (S2)	Participating (S3)	Delegating (S4)	

Figure 8: Determining Style

The next step is to refer to columns (1) through (4) in Figure 8. Transfer the total for each column to the box in the corresponding quadrant in the model below, e.g., write the column (1) total in the box in the S1 quadrant; the column (2) total in the box in the S2 quadrant; the column (3) total in the box in the S3 quadrant; and the column (4) total in the box in the S4 quadrant.

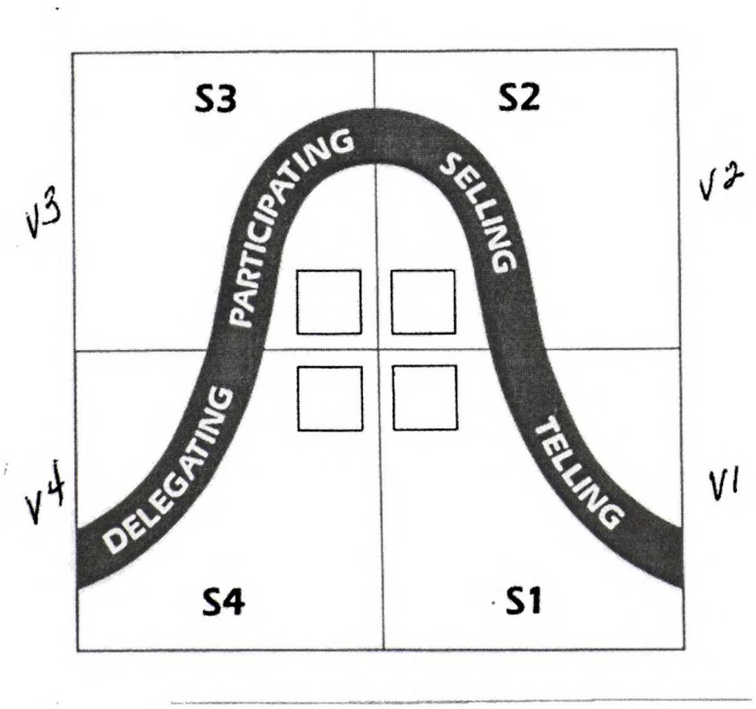


Figure 9: Determining Style

Finally, we can interpret the results of the scoring to identify the primary style, the secondary style, and style range.

Primary Style is the style that the leader tended to use most frequently. The quadrant in Figure 9 which has the greatest number of responses indicate the primary style.

Style adaptability measures the degree to which the leader varies his or her style appropriately to the readiness level of the follower in specific situation. To determine the leadership styles adaptability, circle the scores in Figure 10 below that correspond to the alternative action choices made for each situation in Figure 8. For example, if for situation #1 alternative action choice "A" was chosen, circle "3" under column "A." Next, add the numbers in each vertical and write their sums next to "Subtotals." Finally, add the subtotals for columns "A," "B," "C," and "D" to calculate "Leadership Style Adaptability" and write this number in the box provides.

ALTERNATIVE ACTIONS

SITUATIONS	A	B	C	D
1	3	1	2	0
2	3	0	2	1
3	2	1	0	3
4	2	0	3	1
5	0	2	3	1
6	1	2	0	3
7	0	3	1	2
8	3	1	0	2
9	0	2	3	1
10	2	0	1	3
11	0	3	1	2
12	1	3	0	2
Subtotals	+	+	+	=

Leadership Style Adaptability [ ] V5

Figure 10: Leadership Style Adaptability

The weighting of a 0 to 3 is based on behavioral sciences concepts. The adaptability scores range from 0 to 36. The lower range of scores, 0-23, indicates a need for self-development to improve both the ability to diagnose readiness and to use appropriate leader behavior. The middle range of scores, 24-29, reflects a moderate degree of adaptability. Scores in this range usually indicate a pronounced primary leadership style with less flexibility into secondary styles. While the higher range of scores, 30-36, indicates a leader with a high degree of adaptability. The leader accurately diagnoses the ability and willingness of the follower for the situation and adjusts accordingly (Hersey & Blanchard, 1988; Hersey et al., 1976a, 1976b; Wolf, 1996).

The LEAD was standardized on the responses of 264 managers in a North American sample. The 12 item total correlations for the adaptability score range from .11 to .52, and 10 of the 12 coefficients (83%) were .25 level or higher, reflecting on the internal consistency of the instrument.

The stability of the LEAD was moderately strong. In two administrations, across a 6-week interval, 75% maintained their secondary style. The correlation coefficients between pre- and post- scores for the primary and secondary styles were both .71 and each was significant ($p < .01$). Moreover, the pre- and post- correlation for the adaptability scores was .69 ($p < .01$) (Wolf, 1996). The LEAD remained relatively stable across time. The stability of the scale was clearly established. Face validity was based upon a review of the items and content validity emanated from the procedures employed to create the original set of items (Hersey et al., 1976a, 1976b; Wolf, 1996). This section took 10 minutes for completion.

Instrument Translation: Before distributing the questionnaire, the instruments were rechecked and validated by five American doctoral nursing students and seven Thai doctoral nursing students in the US to verify the instruments were understandable and appropriate in terms of the wording and ability to relevantly capture the concepts and subscales of this study. The instruments then were translated into the Thai language. The clarification of both versions were rechecked and validated by two Thai nurse administrators, as content experts, for assuring the instruments had content validity and two bilingual persons for assessing the appropriateness of back translation. The complete Thai version questionnaire was distributed to ten Thai registered nurses to be tested before the data collection began.

For head nurses, the questionnaire was divided into two parts (Appendix D). The first part contained questions for demographic data, including gender, age, marital status, degree of education, years of nursing experience, unit of employment, and position. The second part of the questionnaire was an instrument evaluating their own leadership style.

For registered nurses, the questionnaire was divided into four parts (Appendix E). The first part contained questions for demographic data, including gender, age, marital status, degree of education, years of nursing experience, unit of employment, position, employee status, and shift rotation. The second part of the questionnaire consisted of three instruments measuring the three major concepts for this study: LEAD, DPBS and Organizational Job Satisfaction Scale respectively.

The LEAD instrument assumes the head nurses were involved in each of the following twelve situations. Each situation had four alternative actions the head nurse might initiate. The head nurses were asked to circle only one letter of the alternative

action choices which they thought would most closely describe their own behavior in the situation presented. The registered nurses, on the other hand, were asked to circle only one of the alternative action choices which they thought would most closely describe their head nurses' behavior in the situation presented. Since the LEAD instrument was developed to measure the leadership styles evaluated by either the leaders themselves or their subordinates, superior(s), and peers or associates, comparing one's self-perception of leadership style with the perceptions of others can be very useful.

Procedure and Protocols:

Human subject approval was obtained from the Dean and the Chairman of the Committee on Human Research, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok, Thailand in May 21, 2003 (Appendix B). The Ramathibodi approval was submitted to the Committee on Human Research at University of California, San Francisco to attain UCSF approval, approved in July 9, 2003 (Appendix A), before the study took place. Once this was accomplished, the director of the nursing department at Ramathibodi hospital was contacted formally by a letter with the two approvals attached. A permission letter from the director of the nursing department was obtained to be presented to the 67 head nurses. Finally, the 67 head nurses were approached individually.

The questionnaires for the head nurses and registered nurses were sent to them along with a cover letter having their names on it to ensure that no one was missed. The questionnaires were packed separately in an envelope for each person and delivered to the hospital by the investigator, along with a copy of the permission letter obtained from the director of the nursing.

The investigator visited every ward introducing herself; explaining the aims, the importance and advantages of the study; detailing the questionnaires; and inviting head nurses and registered nurses to participate in this study. Most head nurses asked to distribute the questionnaires to their staffs working on their wards themselves. Only a few wards asked for their coordinators to distribute the questionnaires to their wards.

According to the cover letter, participants were informed of the details of the questionnaire and the right to withdraw from the study at any time. Each participant was told to remove the cover letter which had their name on it and asked to put the completed questionnaire in a separately sealed envelope, and then to place it in an envelope provided for each ward within two weeks.

Since registered nurses were asked to evaluated their head nurses styles and to fill out demographic data with handwritten infomation, to assure their feelings of security, the completed questionnaires were collected every evening by the investigator. Most of the registered nurses did remove the cover letter before inserting the completed questionnaire into the sealed envelope provided, before putting them into the ward envelope.

Some head nurses provided space on their ward for the investigator to collect the completed questionnaires. Most of the head nurses kept the completed questionnaires completed by their registered nurses in an envelope placed in their offices for the investigator to pick up.

All returned questionnaires were checked for completion. 66 of 67 wards (98.5%) participated in this study. Only one ward with registered nurses did not return any questionnaires. There were 925 registered nurses (RNs) currently employed in this

hospital, however only 845 RNs were eligible because 80 of the RNs could not be reached due to maternity leave, study leave, and on vacation. 614 RNs (73%) completed the survey, while 49 of 66 head nurses (HNs) (75%) returned completed questionnaires. The data were then analyzed.

Data Analysis:

Questionnaire items were hand scored and then coded for computer analysis. Negative items were recoded. Assessed data were analyzed by Statistical Package for Social Science, SPSS Version 10. After data cleaning, descriptive statistics were calculated to achieve mean, standard deviation, ranges, frequency and percentages.

Since the measurements used for this study were translated into the Thai language, instrument analysis, such as Cronbach's alpha reliability coefficient were examined for job satisfaction and autonomy. Item-scale correlated was tested in order to prove the measurements had strong initial psychometric properties in describing this study.

Primary leadership styles were identified based on 66 wards and five types of unit, characterized by work tasks which were composed of intensive care and emergency care (ICU & ER), operating rooms (OR), outpatient (OPD), Inpatient Private wards (IPD Private), and Inpatient general wards (IPD General). Leadership adaptability was calculated and leveled. The agreement between head nurses and staff nurses perception of primary leadership styles of the head nurses was calculated. The agreement on the degree of overall adaptability was examined.

The study's research questions were 1) What are personal job satisfaction and autonomy of registered nurses and unit characteristics of a sample of head and registered

nurses working in a 1,200-bed, teaching tertiary hospital? 2) Are there unit differences in perceived leadership, autonomy and job satisfaction among staff nurses? And 3) What are the contributors of staff nurse demographic characteristics, perceived leadership of head nurses, and type of unit to job satisfaction among registered nurses? were tested, using the SPSS statistical procedure of correlation, including Kappa statistic and a hierarchical multiple regression was utilized in the analysis.

Variables were entered as a block. Demographic characteristic--age, marital status, and education as Block 1, work characteristic-- years of experience, work status, and shift of work as Block 2, autonomy were entered as Block 3, leadership styles were entered as Block 4, and types of unit were entered as Block 5 against the dependent variable, job satisfaction.

CHAPTER IV: RESULTS

This chapter presents the findings based on statistical analysis. The overall purposes were 1) to describe the demographic characteristics of the participants in term of personal and unit levels; 2) to find out if there is any difference among those characteristics on leadership styles, autonomy and job satisfaction; and 3) to examine various predictors of job satisfaction.

Since the measurements used for this study were first translated into the Thai language, instrument analysis, focusing on job satisfaction and autonomy were examined to assure that the measurements were proven to have strong psychometric properties for this study. Cronbach's alpha reliability coefficient was performed for 28 items on the overall job satisfaction summated scale and four subscales, and for 30 items on the overall autonomy summated scale and six subscales. In order to have strong psychometric properties, each item should contribute substantially to the total. Item convergence is supported if the corrected item-scale correlations are at least .30. A test called "item-total correlations" was also performed to determine whether items in the same scale correlated to at least .30 with the sum of the other items in the scale, which provides a minimum standard for item convergence. For job satisfaction, item-scale correlations ranged from - .17 to .55; the Cronbach's alpha was 0.82. The Cronbach's alpha for the autonomy scale was 0.88 with item-scale correlations ranging from .06 to .66.

Items having item-scale correlations less than .30 were deleted. The item with the lowest item-scale correlation was first deleted, one at a time, until all items met this criteria (Stewart & Ware, 1998). For job satisfaction, nine items, including items number

15, 8, 9, 16, 4, 12, 27, 25, and 28, not meeting this criteria were deleted respectively. The final scale had 19 items with the Cronbach's alpha of 0.85 with the corrected scale-item correlations ranged from .31 to .54. For autonomy, six items, including items number 13, 8, 17, 26, 28, and 29, not meeting this criteria were eliminated. The final scale had 24 items with the Cronbach's alpha of 0.91 with the corrected scale-item correlations ranged from .30 to .68 (see Table 1).

Table 1: Measurements Properties

								Measurement Properties in Sample of RN's (N=614)					
Concept	Measure	Scales/ subscales, number of items each	Possible range	Observed range	Range of item-scale correlations	Mean (SD)	Alpha	Item (s) deleted	New Possible range	New Observed range	New Range of item-scale correlations	New Mean (SD)	New Alpha
Job satisfaction	Organizational Job Satisfaction Scale (1-6 Likert response scales, summated ratings scales)	Summary score (28)	28-168	45-151	-.17 - .55	103.48 (12.41)	0.82	15,8,9, 16,4,12, 27,25, 28	19-114	29-107	.31 - .54	76.92 (10.35)	0.85
		Pay/reward (8) [4,8,12,15,16, 25,27,28]	8-48	12-39	-.45 - .54	22.84 (4.17)	0.52	15,28	6-36	6-31	.44 - .65	13.04 (4.37)	0.76
		Professional status (7) [1,2,5,6,13,24, 26]	7-42	8-42	.36 -.57	28.87 (4.75)	0.73	-	-	-	-	-	-
		Interaction (7) [9,14,17,19,21,22, 23]	7-42	8-41	.25 - .68	30.23 (4.98)	0.80	9	6-36	6-36	.56 - .70	26.51 (4.59)	0.83
		Administration (6) [3,7,10,11,18, 20]	6-36	7-34	.33 -.54	21.55 (3.99)	0.71	-	-	-	-	-	-

								Measurement Properties in Sample of RN's (N=614)					
Concept	Measure	Scales/ subscales, number of items each	Possible range	Observed range	Range of item-scale correlations	Mean (SD)	Alpha	Item (s) deleted	New Possible range	New Observed range	New Range of item-scale correlations	New Mean (SD)	New Alpha
Autonomy	Dempster Practice Behaviors Scale (DPBS) (1-5 Likert response scales, summated ratings scales)	Summary score (30)	30-150	75-14	.06 - .66	109.56 (10.53)	0.88	13,8,17, 26,28,29	24-120	60-118	.30 - .68	91.65 (9.79)	0.91
		Self-determinism (2) [4, 20]	2-10	3-10	.40	7.58 (1.16)	0.57	-	-	-	-	-	-
		Self-governance (8) [6,8,12,17,21,24,28 ,29]	8-40	14-38	-.05 -.46	27.11 (3.20)	0.55	29,12,6, 21,24	3-15	3-15	.40 -.53	9.09 (2.16)	0.64
		Independence (6) [2,7,11,13,18, 26]	6-30	10-28	.02 -.40	21.39 (2.60)	0.42	13, 26,18	3-15	5-15	.33 - .47	11.35 (1.58)	0.59
		Competency (7) [3,9,10,14,16, 22,25]	7-35	18-35	.25 -.60	26.72 (3.15)	0.75	22	6-30	15-30	.49 - .62	23.78 (2.82)	0.79
		Accountability (2) [1,30]	2-10	5-10	.38	8.63 (1.02)	0.55	-	-	-	-		-
		Moral reflection (5) [5,15,19,23,27]	5-25	11-23	.30 - .58	18.85 (2.39)	0.69	-	-	-	-		-

The overall job satisfaction score was considered as moderate level with a mean of 76.92 (S.D.=10.35). Participants rated their perceptions toward job satisfaction on a scale from 29 to 107 with a possible range of 19 to 114. The satisfaction with pay/reward was scored at a low level with a mean score of 13.04 (S.D.=4.37) while the professional status, interaction, and administration subscales were scored at a moderate level with a mean score of 28.87 (S.D.=4.75), 26.51 (S.D.=4.59) 24.07, and 21.55 (S.D.=3.99) respectively. The possible score of pay/reward ranged from 6-36 with an actual score of 6-31. The professional status subscales ranged from 8-42, out of a possible score of 7-42. The interaction subscales score varied from 6-36, out of a possible score of 6-36. The administrative score ranged from 7-34, out of a possible score of 6-36. Cronbach's alpha coefficient for job satisfaction was good with an alpha of 0.85.

It was found that the overall autonomy score was considered to be at a high level with a mean score of 91.65 (S.D.=9.79). Participants rated their perceptions regarding autonomy from 60 to118 with a possible range of 24 to 120. The mean of the subscales were calculated as shown in Table 1. Five subscales, composed of self-determinism, independence, competency, accountability, and moral reflection were rated at a moderate level, with only the self-governance subscale was rated at a high level. For the self-determinism scale, the scores varied from 3-10, out of a possible score of 2-10 and the mean score was 7.58 (S.D.=1.16). Self-governance had a mean of 9.09 (S.D.=2.16) and out of a possible score of 3 to 15, the score ranged from 3-15. The mean score for independence was 11.35 (S.D.=1.58), out of a possible score of 3-15, with an actual range of 3-15. For the competency subscale, the mean was 23.78 (S.D.=2.82), with a possible range of 6 to 30 and the score varied from 15-30, while accountability had a mean of 8.63

(S.D. = 1.02), out of a possible score of 2-10 and with an actual score of 5-10. The last subscale, moral reflection had a mean of 18.85 (S.D. =2.39), with an actual score of 11-25, while the possible score was 5-25. The total scale, Cronbach's alpha coefficient, a method to examine reliability for the autonomy scale, was 0.92.

To have better and easier interpretation, all scales on job satisfaction and autonomy were transformed so that the lowest possible score was 0 and the highest possible score 100, using the following formula (Stewart and Ware 1998):

$$100 \times \frac{\text{(observed score - minimum possible score)}}{\text{(maximum possible score - minimum possible score)}}$$

For example, according to Table 1, new mean overall job satisfaction scale was 60.97, derived from {100X [(76.92-19)/ (114-19)]}. Using the same formula, new means for pay/reward, professional status, interaction/cohesion, and administration were 23.47, 62.49, 68.37, and 51.83 respectively). The new means of overall autonomy scale, self-determination, self-governance, independent, competency, accountability, and moral reflection were 70.47, 69.75, 50.75, 69.58, 74.08, 82.88, and 69.25 respectively. New scales and subscales based on the same possible score are presented in graphs (Appendix H and I).

There were 925 registered nurses (RNs) currently employed in a teaching and tertiary hospital in Bangkok, however only 845 RNs were eligible because 80 of the RNs could not be reached due to maternity leave, study leave, and on vacation. 614 RNs (73%) complete the survey. Personal characteristics of the participants including gender, marital status, degree of education, position rank, work status, shift rotation, age, and years of experiences are displayed in Table 2.

Table 2: Sample Characteristics of RNs (N=614)

Characteristic	Frequency (Percent)
Gender*	
Female	611 (99.5)
Male	3 (.5)
Marital status	
Single	496 (80.9)
Married	117 (19.1)
Education	
Baccalaureate	540 (88.1)
Masters	73 (11.9)
Position rank**	
Rank 3	96 (15.6)
Rank 4	57 (9.3)
Rank 5	78 (12.7)
Rank 6	81 (13.2)
Rank 7	1 (0.2)
Rank 8	14 (2.3)
Not reported	287 (46.7)
Work status	**Frequency**
Government official	311 (50.7)
Other	302 (49.3)
Shift of work	**Frequency**
Only day shift	133 (21.7)
Rotate shift	480 (78.3)
Age	
Range	21-57
Mean (SD)	30.49 (8.22)
Years of experience	
Range	1-32
Mean (SD)	8.26 (7.82)

There were only 3 male registered nurses (0.50%) participating in this study, while the majority group (99.50%, n= 611) of the participants were female. Most of them (80.90%, n=496) were single and 88.10% of the participants (n=540) held a Baccalaureate degree. The participants identified their current positions as ranked from 3 to 8, however the largest number of the participants (46.70%, n=287) did not report their rank. Rank reflects a type of career ladder linked to education, years of experience, and salary. Only 21.7% (n=133) of the participants reported working only the day shift; while most reported (78.30%, n=480) that they were rotated across shifts. The age of participants ranged from 21 to 57 years (mean =30.49, S.D. = 8.22). The sample reported working from 1 to 32 years, with a mean of 8.26 years (S.D.=7.82) employed as a nurse.

There were 66 wards in this hospital and each ward has one head nurse (HN), however only 49 HNs (75%) participated in the study. Personal characteristics of the HNs including of gender, marital status, degree of education, age, and years of experiences (see in Table 3).

Table 3: Sample Characteristics of HNs (N=49)

Characteristic	Frequency (Percent)
Gender*	
Female	49 (100.00)
Marital status	
Single	25 (52.1)
Married	20 (41.7)
Other	3 (6.3)
Education	
Baccalaureate	28 (58.3)
Master	20 (41.7)
Age	
Range	30-59
Mean (SD)	49.33 (6.43)
Years of experience	
Range	8-35
Mean (SD)	25.71 (6.48)

All head nurses (HNs) were female. Half of them (52.10%, n=25) were single and held a Baccalaureate degree (58.30%, n= 28). The age of the HNs ranged from 30 to 59 years (mean = 49.33, S.D. = 6.43). The HNs reported working from 8 to 35 years, with a mean of 25.71 years (S.D. =6.48).

Based on task characteristics, 66 wards can be categorized into five types of unit: 1) intensive care unit and emergency unit (ICU & ER); 2) ambulatory unit, general practice and outpatient unit (OPD); 3) operating room (OR); 4) inpatient unit which is composed of private rooms (IPD Private); and 5) in patient general wards (IPD General). The sample size of registered nurses and head nurses are presented in Table 4. All head nurses from ICU & ER; OR; OPD; and IPD (Private) participated in the study; while there were 32 % (n=8) of the HNs from IPD (General) who returned the survey.

Table 4: Sample Size by Unit

	ICU & ER (9 wards)	OR (7 wards)	OPD (11 wards)	IPD (Private) (14 wards)	IPD (General) (25 wards)	Total (66 wards)
RNs	101	105	65	107	236	614
HNs	9	7	11	14	8	49
Total	**110**	**112**	**76**	**121**	**244**	**663**

LEAD measurement was used to determine the primary leadership style of the head nurse either perceived by the head nurses themselves (HNs) or by the registered nurses (RNs) on their wards. Perceived primary leadership styles may be the same or different when comparing HNs rating themselves and their RNs' evaluations their. The

most frequent style performed by the HNs was described as their primary style; including "telling," "selling," "participating," and "delegating." However, given the 12 situations and the four alternative choices, some HNs and RNs reported equally as perceiving the HNs having two or three leadership styles. To solve this problem, the investigator added another choice: "no preference" means no primary style. Primary leadership style of the HN as perceived by RNs and HNs are shown in Table 5.

Table 5: Leadership Styles of HNs

Leadership style of head nurses	**Frequency (Percent) as perceived by RNs (N=614)**	**Frequency (Percent) as perceived by HNs (N=49)**
Telling	69 (11.20)	0
Selling	205 (33.40)	21 (42.90)
Participating	192 (31.30)	22 (44.90)
Delegating	56 (9.10)	0
No preference	92 (15.00)	6 (12.20)

One-third of the registered nurses (33.40%, n=205) described the primary leadership style of their head nurses as the "selling style," while 31.30% (n=192) of the RNs evaluated their head nurses' primary leadership styles as the "participating style".

For this study, 49 of 66 head nurses returned the survey, evaluating their own primary leadership styles. The head nurses described themselves equally as having a "participating" and "selling" leadership (44.90%, n=22 and 42.90, n=21 respectively).

None of the head nurses judged themselves as having either telling or delegating styles, while 12.20% (n=6) of the head nurses reported no primary style.

The LEAD measurement was also used to determine whether the HNs were able to vary their leadership style appropriately to the readiness level of RNs in a specific situation, called "Adaptability." The possible adaptability scores ranged from 0-36 and can be categorized as poor, having scores from 0-23, moderate, having scores from 24-29, and high, having scores from 30-36.

Poor adaptability indicates a need for self-development to improve both ability to diagnose task readiness and to use appropriate leadership behavior. Moderate adaptability denotes having less flexibility to use leadership style appropriately. High adaptability signifies an ability to accurately diagnosis the ability and willingness of the RNs for a situation and to adjust accordingly.

Table 6: Adaptability Scores of HNs perceived by RNs and HNs

Adaptability Scores	**RNs (N=614)**	**HNs (N=49)**
Range	10-31	16-32
Mean (SD)	21.95 (4.29)	25.51 (2.75)
Possible range	0-36	0-36

Adaptability scores as perceived by RNs ranged from 10 to 31, with a mean of 21.95 (S.D. = 4.29). The adaptability scores as perceived by the HNs varied from 16-32, with a mean of 25.51 (S.D. = 2.75) (Table 6).

Due to the RNs' perception of their HNs, degree of adaptability, only poor and moderate degrees were reported from the 66 wards, while the HNs reported having poor, moderate and high degree of adaptability (Table 7).

Table 7: Adaptability Degree of HNs by Wards

Adaptability Degree	**Frequency (Percent) reported by RNs**	**Frequency (Percent) Reported by HNs**
Poor (0-23)	48 (72.7)	8 (16.3)
Moderate (24-29)	18 (27.3)	38 (77.6)
High (30-36)	0	3 (6.1)
Total	**66 (100)**	**49 (100)**

48 of 66 wards (73%), RNs reported their HNs having poor adaptability. On average RNs from 18 wards (27%) reported the adaptability degree of their HNs as moderate, while none of them reported high degree. Head nurses, on the other hand, reported having three degrees of adaptability. 78% (N=38) of HNs described themselves as having a moderate degree, 16% (N=8) reported their adaptability as poor, and three out of 48 HNs (6%) identified themselves having a high degree (Table 7).

There are 66 wards in this hospital. Each ward has one head nurse. Since the head nurses were asked to evaluate their leadership styles while the registered nurses were asked to identified their head nurses' leadership styles. As can be seen, the results reported by the HNs and the RNs were different. The agreement between head nurses and registered nurses perceptions of the primary leadership styles of the head nurses, based on wards as a unit of analysis, was calculated (Table 8). The agreement between perceived leadership style of head nurses and staff nurses was 45 %. There was 54.5%

agreement for the "selling" (12 of 22) and 45.5% agreement for the "participating" style (10 of 22).

Table 8: Agreement of Primary Leadership Styles of Head Nurses Evaluated by Head Nurses and Registered Nurses

	Primary Leadership Styles by Head Nurses			**Total**
	Selling	Participating	No Primary	
Primary Leadership Style of Head nurses Perceived by Registered Nurses				
Telling	1	1	0	2
Selling	**12**	7	4	23
Participating	7	**10**	1	18
Delegating	1	0	1	2
No Primary	0	4	**0**	4
Total	21	22	6	**49**

The degree of leadership adaptability were categorized into three levels as poor, moderate and high (Table 9). There was 35.9% (14/49) agreement between the head nurses' perception and staff nurses' perception that head nurses had a moderate level of adaptability. Only three of the head nurses rated themselves as leaders having high adaptability while eight of them evaluated themselves as having poor adaptability. The registered nurses, on the other hand, considered their head nurses' leadership adaptability

as poor and moderate only. Therefore, the agreement on the degree of overall adaptability was 35% [(3+14=17)/49= .35]

Table 9: Agreement on Adaptability Degree of Leadership Rated by 49 Head Nurses and Registered Nurses Categorized by 66 Wards.

Degree of adaptability	**Degree of adaptability rated by head nurses**			**Total**
	Poor	Moderate	high	
Degree of adaptability rated by registered nurses				
Poor	**3**	24	2	29
Moderate	5	**14**	1	20
Total	8	38	3	**49**

In order to determine whether unit characteristics—type of unit affects perception of job satisfaction, the descriptive data from the demographics of both RNs and HNs are presented based on the five types of unit as shown in Tables 10 and 11.

Table 10: Unit Differences in demographic of RNs

Unit Characteristics	ICU & ER (N=101)	OR (N=105)	OPD (N=65)	IPD (Private) (N=107)	IPD (General) (N=236)
Mean age ±SD	27.74±5.70	31.95±9.10	41.67± 9.20	27.48± 6.01	29.35± 6.57
Percent of Marital Status					
Single	92.10	67.30	58.50	85.00	86.40
Married	7.90	32.70	41.50	15.00	13.60
Percent of education					
Baccalaureate	90.10	86.70	75.40	91.60	89.80
Master and Other	9.90	13.30	24.60	8.40	10.20
Mean Years of experience ±SD	5.54±5.43	9.89± 8.79	8.97± 8.48	5.41±5.68	7.03± 6.11
Percent of Work Status					
Government	36.60	59.60	96.90	37.40	46.20
Other	63.40	40.40	3.10	62.60	53.80
Percent of Shift of Work					
Day shift	2.00	48.10	98.50	2.80	5.90
Rotate shift	98.00	51.90	1.50	97.20	94.10
Leadership Style	Selling	Participating	Participating	Selling	Selling

Unit Characteristics	ICU & ER (N=101)	OR (N=105)	OPD (N=65)	IPD (Private) (N=107)	IPD (General) (N=236)
% Leadership Style					
% Telling	6.90	20.00	15.40	5.60	10.60
% Selling	43.60	13.30	32.30	41.10	34.70
% Participating	34.70	27.60	38.50	32.70	28.80
% Delegating	4.00	17.10	6.20	6.50	9.70
% NoPreference	10.90	21.90	7.70	14.00	16.10

Differences in mean age and years of experience among registered nurses working on the five types of unit were tested using an ANOVA model. Alpha of .05 was divided by five to minimize Type I error. There were significant main effects ($F=53.236$, df 4,608, $p= .000$; and $F=53.236$, df 4,608, $p=.000$ for mean age and mean years of experience respectively). Registered nurses working at OPD were the oldest group; RNs from the OR were older than RNs in ICU & ER, IPD (Private), and IPD (General). There was no difference in mean age among RNs working in ICU &ER, IPD (Private), and IPD (General). RNs from OR and OPD had more years of experience than others, but there was no mean years of experience among RNs working at ICU&ER, IPD (Private), and IPD (General).

Most RNs working in ICU&ER, OR, IPD (Private), and IPD (General) were single while RNs from OPD were almost equally divided between being single and married. More than 75% of RNs working across all five types of units held a Baccalaureate degree. Almost 100 % of RNs from OPD worked as government officers.

While RNs working in ICU&ER, IPD (Private), and IPD (General) had more non-government officers.

Only RNs from the OR reported working on the day shift equally with rotated shifts. Less than six % of RNs from ICU&ER, IPD (Private), and IPD (General) worked only on the day shift while almost 100 % of RNs from OPD worked on the day shift.

RNs working in the OR and OPD reported having their head nurses' style as "participating" while RNs from ICU&ER, IPD (Private), and IPD (General) reported having their HNs' style as " selling" (Table 10).

Table 11: Unit Differences in demographic of HNs

Unit Characteristics	**ICU & ER (N=9)**	**OR (N=7)**	**OPD (N=11)**	**IPD (Private) (N=14)**	**IPD (General) (N=8)**
Mean age ±SD	50±5.34	54.14±5.70	45.27±7.79	48.69±5.72	51.00±4.60
Percent of Marital Status					
Single	22.20	28.60	81.80	61.50	50.00
Married	66.70	57.10	18.20	30.80	50.00
Other	11.10	14.30	0	7.70	0
Percent of education					
Baccalaureate	88.90	71.40	45.50	46.20	50.00
Master and Other	11.10	28.60	54.50	53.80	50.00
Mean Years of experience±SD	25.22±6.26	30.86±4.74	21.82±7.73	25.54±5.87	27.37±4.47

Unit Characteristics	ICU & ER (N=9)	OR (N=7)	OPD (N=11)	IPD (Private) (N=14)	IPD (General) (N=8)
Leadership Style	Participating	Selling	Selling	Selling	No Primary
% Leadership Style					
% Telling	0	0	0	0	0
% Selling	34.00	72.00	46.00	50.00	50.00
% Participating	56.00	14.00	36.00	36.00	50.00
% Delegating	0	0	0	0	0
% No Preference	10.00	14.00	18.00	14.00	0

Differences in mean age and years of experience among head nurses working on the five types of unit were tested using an ANOVA model with Alpha of .05. There was no significant main effects ($F=2,567$, df 4,43, $p= .052$; and $F=2.533$, df 4,43, $p=.054$ for mean age and mean years of experience respectively). Less than 30 % of head nurses working in ICU &ER and OR were single; more than 60 % of HNs from OPD and IPD (Private) were single; while HNs from IPD (General) were equally divided between being single and married. More than 50 % of HNs from OPD, IPD (Private) and IPD (General) held a Master's degree, while less than 30% of HNs working in ICU&ER and OR reported holding a Master's degree (Table 11). Three of the five types of unit, OR, OPD and IPD (Private), reported their leadership style as "selling" while the HNs from ICU&ER reported themselves having a " participating" style, and IPD (General) evaluated their own leadership style as " no primary"

Differences in mean autonomy scores by demographic variables were tested using an ANOVA model (see Table 12). Alpha of .05 was derided by five to minimize type I error. There were significant differences for Government employees (p=0.003). Government workers reported higher autonomy scores than non government.

Table 12: Relationship of Autonomy to Personal Characteristics

Characteristics	Mean	S.D.	F	df	p
Sex					
Female (N=611)	91.64	9.77	0.352	1,612	0.553
Male (N=3)	95.00	14.53			
Marital status					
Single (N=496)	91.15	9.75	6.515	1,611	0.011
Married (N=117)	93.70	9.72			
Education					
BS (N=540)	91.50	9.57	0.854	1,611	0.356
MS and other (N=73)	92.63	11.32			
Employment					
Government (N=311)	92.79	10.20	8.954	1,611	0.003
Other (N=302)	90.44	9.20			
Shift of Work					
Day shift only(N=133)	92.63	11.08	1.771	1,611	0.184
Rotate (N=480)	91.36	9.39			

Differences in mean autonomy scores by age and years of experience were tested

using Pearson Correlation Coefficients (see Table 13). There were statistically significant correlations between age, years of experience and autonomy. However, both age and years of experience were slightly correlated with autonomy. The older the registered nurse was, the more autonomy they perceived (r=.093). Also, the longer they worked as nurses, the more autonomy they had (r=.102).

Table 13: Relationship of Autonomy to Age and Years of Experience (Pearson Correlation Coefficients)

Variables	**Autonomy**
Age (years) (N=612)	.093**
Years of Experience (N=613)	.102**

**p<.01

Differences in mean job satisfaction scores by demographic variables were tested using an ANOVA model (see Table 14). Alpha of .05 was divided by five to minimize Type I error. There was no significant difference among the variables.

Table 14: Relationship of Job Satisfaction to Personal Characteristics

Characteristics	Mean	S.D.	F	df	p
Sex					
Female (N=611)	76.95	10.35	0.879	1,612	0.349
Male (N=3)	71.33	10.02			
Marital Status					
Single (N=496)	77.07	10.48	0.639	1,611	0.425
Married (N=117)	76.22	9.80			
Education					
BS (N=540)	77.01	10.17	0.270	1,611	0.604
MS and Other (N=73)	73.34	11.64			
Employment					
Government (N=311)	76.20	10.40	2.988	1,611	0.084
Other (N=302)	104.01	12.18			
Shift of Work					
Day shift only (N=133)	75.99	10.27	1.336	1,611	0.248
Rotate (N=480)	77.16	10.37			

Difference in mean job satisfaction scores by age and years of experience were tested using Pearson Correlation Coefficients (see Table 15). There were no significant relationship of job satisfaction with either age or years of experience.

Table 15: Relationship of Job Satisfaction to Age and Years of Experience (Pearson Correlation Coefficients)

Variables	Job Satisfaction	p
Age (years) (N=612)	-.063	0.117
Years of Experience (N=613)	-.065	0.110

**p<.01

Two leadership styles were reported by the staff nurses (see Table 16). Those that felt that their HN's leadership style as "participatory" were married, Master's prepared, governmental, and day shift only nurses.

Table 16: Relationship of Leadership Style to Personal Characteristics

Characteristics	Primary Leadership style
Sex	
Female (N=611)	Selling (33.40%)
Male (N=3)	No Primary
Marital status	
Single (N=496)	Selling (34.50%)
Married (N=117)	Participating (36.80%)

Characteristics	Primary Leadership style
Education	
BS (N=540)	Selling (34.40%)
MS and Other (N=73)	Participating (34.20%)
Employment	
Government (N=311)	Participating (32.8%)
Other (N=302)	Selling (37.70%)
Shift of Work	
Day shift only (N=133)	Participating (33.10%)
Rotate (N=480)	Selling (35.60%)

Differences in age by type of perceived head nurse leadership style were calculated (see Table 17 and 18). There was a significant main effect (F=3.919, df 4, 607, p=0.004). The Bonferoni' Post Hoc's test showed that the older the nurses were, the more likely they reported their head nurses as a "delegating" leader. Younger nurses were more likely to report their head nurses as "selling" leaders.

Table 17: Relationship of Leadership Style to Age

Primary Leadership Styles	Mean	S.D.	N	F	df	p
Overall	30.49	8.22	612	3.919	4, 607	0.004
Telling	32.23	9.00	69			
Selling	29.17	7.29	205			
Participating	30.82	8.66	191			
Delegating	33.18	8.99	56			
No Primary	29.78	7.62	91			

Table 18: Bonferoni Post-Hoc's of Leadership Styles to Age

(I) Primary Leadership Style	(J) Primary Leadership Style	Mean Age Difference (I-J)	Sig
Telling	Selling	3.07	.070
	Participating	1.4	1.000
	Delegating	-.95	1.000
	No Primary	2.45	.599
Selling	Telling	-3.07	.070
	Participating	-1.66	.437
	Delegating	-4.01	.011
	No Primary	-.61	1.000
Participating	Telling	-1.41	1.000
	Selling	1.66	.437
	Delegating	-2.36	.574
	No Primary	1.04	1.000
Delegating	Telling	.95	1.000
	Selling	4.01	.011
	Participating	2.36	.574
	No Primary	3.40	.143
No Primary	Telling	-2.45	.599
	Selling	.61	1.000
	Participating	-1.04	1.000
	Delegating	-3.40	.143

Differences in years of experience by type of perceived head nurse leadership style were tested using ANOVA model (see Table 19 and 20). There was a significant main effect ($F=3.625$, df 4, 608, $p=0.006$). The Bonferoni' Post Hoc's test showed that the longer the nurses worked, the more likely they reported their head nurses as "delegating" leaders. Younger nurses were more likely to describe their head nurses as "selling" leaders.

Table 19: Relationship of Leadership Style to Years of Experience

Primary Leadership Styles	Mean	S.D.	N	F	df	p
Overall	8.26	7.82	613	3.625	4, 608	0.006
Telling	10.01	8.52	69			
Selling	6.97	6.92	205			
Participating	8.49	8.02	191			
Delegating	10.55	8.67	56			
No Primary	7.92	7.63	92			

Table 20: Bonferoni Post-Hoc's of Leadership Style to Years of Experience

(I) Primary Leadership Style	(J) Primary Leadership Style	Mean Difference in Years of Experience (I-J)	Sig
Telling	Selling	3.05	.049
	Participating	1.52	1.000
	Delegating	-.54	1.000
	No Primary	2.09	.908
Selling	Telling	-3.05	.070
	Participating	-1.66	.437
	Delegating	-4.01	.011
	No Primary	-.61	1.000
Participating	Telling	-1.52	1.000
	Selling	1.53	.507
	Delegating	-2.06	.806
	No Primary	.57	1.000
Delegating	Telling	.54	1.000
	Selling	3.59	.022
	Participating	2.06	.806
	No Primary	2.63	.458
No Primary	Telling	-2.09	.908
	Selling	.96	1.000
	Participating	-.57	1.000
	Delegating	-2.63	.458

Difference in job satisfaction and autonomy by type of unit are presented in Table 21 and 22. There were no significant differences for both job satisfaction (F= 2.653, df 4,609, p=.032) and autonomy (F=1.431, df 4,609, p=.222).

Table 21: Unit Differences in Autonomy of RNs

Unit	Mean	SD	N	F	df	p
Overall	91.65	9.79	614	1.431	4,609	.222
ICU and ER	90.47	8.70	101			
OR	92.20	10.86	105			
OPD	93.95	10.12	65			
IPD Private	91.20	8.63	107			
IPD General	91.49	10.09	236			

Table 22: Unit Differences in Job Satisfaction of RNs

Unit	Mean	SD	N	F	df	p
Overall	76.92	10.35	614	2.653	4,609	.032
ICU and ER	77.82	10.31	101			
OR	74.08	11.23	105			
OPD	77.86	8.84	65			
IPD Private	78.03	9.45	107			
IPD General	77.04	10.58	236			

Differences in job satisfaction by type of perceived head nurse leadership style were calculated (Table 23). There was a trend (p=0.03).

Table 23: Job Satisfaction as a Function of Leadership Style of RNs

Unit	Mean	SD	N	F	df	p
Overall	76.92	10.35	614	2.687	4,609	.031
Telling	74.99	10.91	69			
Selling	78.82	10.76	205			
Participating	76.57	9.45	192			
Delegating	75.80	11.70	56			
No Primary	75.77	9.49	92			

Difference in autonomy by type of perceived leadership style were calculated (Table 24). There was no significant main effect (F=.605, df 4, 609, p=.659).

Table 24: Autonomy as a Function of Leadership Style of RNs

Unit	Mean	SD	N	F	df	p
Overall	91.65	9.79	614	.605	4,609	.659
Telling	92.74	9.96	69			
Selling	92.08	8.80	205			
Participating	91.29	10.46	192			
Delegating	90.45	10.72	56			
No Primary	91.37	9.80	92			

Table 25: Hierarchical Multiple Regression Predicting of Job Satisfaction (N=611)

Independent Variables	Standardized final Beta	R^2	U0[	sr^2	df	F	s[
Overall		**.273**			**14.862**	**15.575**	**.000**
Block 1:		.004	.004				.486
Age	.137			.00060			.471
Marital Status	-.023			.00040			.564
Education	.004			.00002			.913
Block 2:		.006	.002				.727
Years of Experience	-.174			.00100			.361
Work Status	.087			.00340			.097
Shift of work	-.033			.00040			.573
Block 3:		.247	.241				.000
Autonomy	.497			.23910			

Independent Variables	Standardized final Beta	R^2	U0[	sr^2	df	F	s[
Block 4:		.261	.014				.027
Leadership Styles	.134			.00640			.022
-Selling &Telling	.072			.00190			.210
-Participating & Selling							
-Delegating & Telling	.057			.00190			.210
-No Primary & Telling							
	.031			.00050			.537
Block 5:		.273	.011				.054
Type of Units							
-ICU&ER VS OR	.129			.00760			.013
-OPD VS OR	.090			.00420			.063
-IPD Private VS OR	.129			.00760			.013
-IPD General VS OR	.130			.00610			.025

A hierarchical multiple regression was calculated for predicted job satisfaction from demographic variables (Block 1), work characteristics (Block 2), autonomy (Block 3), leadership style (Block 4), and type of unit (Block 5) to explore what contributes to the variance in job satisfaction. Overall, the model explained 27.3% (R^2) of the variance in job satisfaction (Table 25). Only Block 3, Autonomy had a statistically significant contribution to explaining the total variance. Perceived autonomy explained 24% of the 27.3 % (sr^2 = .239). There were so significant relationships between demographic data, leadership style, or type of unit.

Summary Results

Seventy-three percent of the participants returned the completed survey. After data cleaning, descriptive statistics were calculated. Two measurements were tested. Some items of the original measurements were deleted to have better psychometric properties. Correlation, ANOVA, and hierarchical multiple regression were performed.

In general, the participants were primarily registered nurses, young, single and held baccalaureate degrees. They described themselves as working as nurses for an average of 8.26 years (S.D.=7.82). The majority of the group rotated across shifts. They reported working equally as governmental and non-governmental employees of the hospital. The head nurses who participated in this study were all women with an average mean age of 49.33 (S.D.= 6.43) and mean years of experience of 25.71 (S.D. 6.43). 50% were single and held a Baccalaureate degree.

The majority of registered nurses described their head nurses' leadership styles as "selling" and "participating" and as having a poor degree of adaptability. The longer the RNs worked in this hospital, the more likely they were to report their HNs as

"delegating" leaders. Younger nurses were more likely to describe their HNs as " selling" leaders.

Registered nurses rated their perception of autonomy as high. Age and years of experience were positively but only slightly correlated with autonomy. The older the nurses were, the more likely they were to report having higher autonomy. Similarly, the longer they worked, the more they perceived higher autonomy. RNs working as government officers also reported higher autonomy than non-government.

Although overall job satisfaction was rated as moderate, pay/reward as a subscale was rated as low, while the other subscales were also rated as moderate. Besides perceived autonomy, there were no relationships among other the variables and job satisfaction either based on each of the five types of unit or in general.

Nine conceptual independent variables represented by 15 predictors in Figure 1 were tested in a multiple regression model. Only perceived autonomy as a personal characteristic was significantly related to job satisfaction and explained 24% of the variance in job satisfaction.

The findings of this investigation suggest that the personal characteristic, perceived autonomy contributed to variation in job satisfaction. Although the RNs working in this hospital reported having high autonomy, however, the overall job satisfaction of this study was still considered as moderate, particularly on pay/ reward. It is imperative for administrative teams to investigate other factors for improving job satisfaction, and lowering job turnover rates which will benefit the organization eventually.

CHAPTER V: DISCUSSION AND CONCLUSION

This study was conducted to explore perceptions of job satisfaction of those registered nurses currently working at Ramathibodi hospital, a teaching and tertiary hospital in Bangkok, Thailand, from July to August, 2003. The specific aims of this study are to examine whether personal characteristics: sex, age, marital status, education level, position rank, work status, perceived autonomy, perceived leadership style or unit characteristics: types of unit are better predictors of registered nurses' job satisfaction within their workplace.

Interpretation the Findings of the Study

During the past five years, Ramathibodi Hospital, one of Thailand's very famous hospitals, has undergone dramatic change due to budget cuts and the government to privatization for the organization. This means the administrative team needs to learn how to survive their own. Since 1997, there has been high competition among many healthcare organizations. In order to survive, as a health care organization, Ramathibodi hospital, needs to provide the highest quality of care with reasonable prices and appropriate timeliness.

Based on statistical data from this hospital, the nurse turnover rate has increased every year from 1995 to 2002. There were 8-12 % staff nurses leaving the hospital every year. Moreover, because of the impact of the economic crisis, the hospital proposed early retirement strategies, and reducing government manpower to decrease national expenditures. In order to provide the highest and most modern level of quality care with

limited staffing, it is crucial that they balance cutting costs with ensuring high job satisfaction for their employees.

The findings revealed that overall job satisfaction among registered nurses working in this hospital was considered moderate. However, the satisfaction toward payment/ reward was rated as low. Among personal characteristics, perceived autonomy was the most important variable, explaining 24 % of the variance in job satisfaction.

In contrast to other studies, under personal characteristics, the majority of the participants were young, single, and held BSN degree. According to the Thai educational system, one of the requirements for all governmental colleges or universities is that all students enrolled in their institute must be less than 25 years old. In order to be accepted in a governmental institute, most students who finish high school continue their higher education right away. Normally, it takes four years to graduate. Before enrolling in the nursing program at Ramathibodi School of Nursing, all applicants have to sign contracts agreeing to work in this hospital for at least two years after graduation.

Most registered nurses hold a BSN degree, but although there is a government policy to encourage career advancement, the opportunities are small. Usually, there are only 2-3 openings every year for a nurse to take study leave for higher degree. Any staff can apply if the seats are not filled. From my own experience, if staff nurses want to pursue a higher degree as full time students, they need to manage their own time working the evening or night shifts.

Autonomy, the most important predictor of job satisfaction, was significantly related to age, years of experience, and work status. To perform the best nursing care in this competitive era, nursing administrators need nurses who can work autonomously.

Thai nurses reflect female careers worldwide. Due to Thai culture, most women are raised to be obedient, quiet, and more polite than men. Traditionally, only men got a chance to study since all teachers were monks. There was a taboo for Thai women not to touch or even stand close to a monk. This is one reason why men dominate since they were the ones who earned money to support their families. However, things have changed, and women have more opportunities to study, earn money and support themselves. Women, nowadays, are more educated and can earn their own living, and lately, they have been asking for their own voice.

Younger persons were taught to be more respectful to others who were more senior in Thai culture. This is why nurses who get older and work longer reported significantly higher autonomy. Based on the governmental system, nurses who work as governmental officers derive more security than non governmental officers. It is very hard to expel governmental officers from the hospital if they did not do anything really bad. This might be a reason to explain why they scored themselves higher in autonomy. Another reason why RNs working as governmental officers reported higher autonomy is the hiring system of the hospital was changed in 1990, and non government officers represented most of the new and younger employees.

Implications of the Findings for Nursing

The findings may help nursing professionals, nurse administrators, educators and researchers to review policy, revise curriculum and expand more variables in order to help improve the nursing profession through strategies that still keep enhancing autonomy. Although there were no significant relationships between unit characteristics

and job satisfaction, administrators should be concerned with both factors since overall job satisfaction was still reported as moderate, and in particular, pay/ reward was still rated low.

Although this study did not find any relationship between leadership style and job satisfaction like some studies, this matter should not be overlooked. Silver and Wang (2001) used the LEAD measurement to identify the impact of Taiwanese leadership styles on the productivity of Taiwanese business organizations. The results showed that successful companies were more likely to have a greater percentage of adaptive leaders than unsuccessful companies (Silverthrone & Wang, 2001). Based on Hersey and Blanchard's theory, the four styles of leadership represented the readiness, willingness and ability of registered nurses and the head nurses to mobilize resources to obtain organizational goals. For this study, no head nurses reported having "delegating" as their primary style as RNs did. Delegating, according to the two theorists, is a style that implies the registered nurses have high autonomy and need only a little guidance to perform taks. Gaps may occur if the readiness, willingness and the HNs' ability are not similarly perceived. For example, there might be some conflicts if the RNs reported the HN having 'selling" while the HN reported her style as "delegating" or other styles. The need for guidance are different depending on the style of leadership. Practically, if the perceived leadership style from the RNs and the HNs was not perfectly matched, the RNs may feel they were too little or too closely supervised. This can lead to job dissatisfaction. If staffs do not feel satisfied in their job, how would they be able to provide care necessary to ensure patients' satisfaction.

Limitations of the Study

This study was conducted in only one teaching and tertiary hospital, thus the findings may not be generalized to other settings or could have missed an important predictor. The measurements used in this study were originally developed in the U.S., but they were translated into another language for use in another country which may or may not have different concepts and culture. The measurements were developed many years ago. Some items may be outdated and need to be revised. The translation process and culturally different perceptions regarding the concepts may have affected the scores and should be closely monitored since they might be misunderstood or misinterpreted. Self-administered self report questionnaires were used and the investigator was unable to talk to all the participants. Some participants may or may not have been clear about the questionnaires.

Recommendation

To improve job satisfaction, future research may wish to expand more on other unit characteristics, leadership issues and so on. Other research strategies such as qualitative should be considered.

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Appendix A

UCSF CHR

COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
www.research.ucsf.edu/chr/index.htm
chr@research.ucsf.edu
(415) 476-1814

CHR APPROVAL LETTER

TO: William L. Holzemer, R.N., Ph.D.
Box 0608

Suthida Masathon, RN, MS
635 Irving St., Apt. #5

RE: Professional Nurse Characteristics and Unit Characteristics as Predictors of Job Satisfaction with Work in Thailand

The Committee on Human Research (CHR) has reviewed and approved this application to involve humans as research subjects. This included a review of all documents attached to the original copy of this letter.

Specifically, the review included but was not limited to the following documents:
Thai Consent Form, dated 7/3/03
English Consent Form, dated 7/3/03

The CHR is the Institutional Review Board (IRB) for UCSF and its affiliates. UCSF holds Office of Human Research Protections Federalwide Assurance number FWA00000068. See the CHR website for a list of other applicable FWA's.

APPROVAL NUMBER: H642-23248-01. This number is a UCSF CHR number and should be used on all correspondence, consent forms and patient charts as appropriate.

APPROVAL DATE: July 9, 2003 EXPIRATION DATE: July 9, 2004 Expedited Review

GENERAL CONDITIONS OF APPROVAL: Please refer to www.ucsf.edu/ora/chr/gen_cond_appvl.htm for a description of the general conditions of CHR approval. In particular, the study must be renewed by the expiration date if work is to continue. Also, prior CHR approval is required before implementing any changes in the consent documents or any changes in the protocol unless those changes are required urgently for the safety of the subjects.

HIPAA "Privacy Rule" (45CFR164): This study does not involve access to, or creation or disclosure of Protected Health Information (PHI).

Sincerely,

Susan H. Sniderman, M.D.
Chair, Committee on Human Research

cc:

Appendix B

Ramathibodi CHR

คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล
ถนนพระราม ๖ กทม. 10400
โทร. (662) 245-5704, 201-1296 โทรสาร (662) 246-2123

Faculty of Medicine, Ramathibodi Hospital, Mahidol University
Rama VI Road, Bangkok 10400, Thailand
Tel. (662) 245-5704, 201-1296 Fax (662) 246-2123

Documentary Proof of Ethical Clearance Committee on Human Rights Related to Researches Involving Human Subjects
Faculty of Medicine,Ramathibodi Hospital,Mahidol University

0200/2003 (I)

Title of Project	Professional Nurse Characteristics and Unit Characteristics as Predictors of Job Satisfaction with Work in Thailand
Protocol Number	ID 05-46-35
Principal Investigator	Miss.Suthida Masuthon
Official Address	Department of Nursing Faculty of Medicine,Ramathibodi Hospital Mahidol University

The aforementioned project has been reviewed and approved by Committee on Human Rights Related to Researches Involving Human Subjects, based on the Declaration of Helsinki.

Signature of Chairman Committee on Human Rights Related to Researches Involving Human Subjects Prof.Krisada Ratana-olarn,M.D.,FRCST,FICS.

Signature of Dean

Prof.Prakit Vathesatogkit,M.D.,ABIM,FRCP.

Date of Approval May 21,2003

Appendix C

Permission letter From Director of Nursing

Department of Nursing,

Faculty of Medicine, Ramathibodi Hospital,

Bangkok, Thailand.

April 21, 2003

The Committee on Human Research

University of California, San Francisco,

Office of Research Administration,

3333 California, Suite 315

San Francisco, CA 94143

Dear The Committee on Human Research,

The purpose of this letter is to provide full support for Miss Suthida Masuthon, RN., Ph.D.(c), a doctoral student of the University of California, School of Nursing, to collect the data at Ramathibodi Hospital.

According to the Ph.D. work of Miss Masuthon (Professional Nurse Characteristics and Unit Characteristics as Predictors of Job Satisfaction with Work in Thailand), this work will involve survey of head nurses and registered nurses.

I am aware of this project and have provided full support for her doctoral work. I have given my signature for permission to access to data collection in all nursing units in my hospital.

Sincerely,

Supanee Sanadisai

(Associate Professor Supanee Sanadisai)

Director of Nursing Department

Appendix D

Questionnaire for Head Nurses English Version

Demographic data

Please check the choices or fill in blank that is the most accurate as of this date

1. Gender

   ___ Female ___ Male

2. Age_____ years

3. Marital Status

   ___Single ___Married ___Other _____

4. Highest nursing degree held:

   ___ Diploma

   ___ Baccalaureate

   ___ Master

   ___ Doctorate

   ___ Other(please specify)_____

5. Years of nursing experience_____ years

6. Unit of employment _____

Questionnaire

I. LEAD

Assume you are involved in each of the following twelve situations. Each situation has hour alternative actions the you might initiate. Read each item carefully. Think about what you would do in each circumstance. Then, based on your experience, circle the letter of the alternative action choice which you think would most closely describe the your behavior in the situation presented. **Circle only one choice.**

Situation	**Alternative actions** This leader would.....
1. Followers are not responding lately to this leader's friendly conversation and obvious concern for their welfare. Their performance is declining rapidly.	A. Emphasize the use of uniform procedures and the necessity for task accomplishment. B. Be available for discussion but would not push for involvement. C. Talk with followers and then set goals. D. Intentionally not intervene.
2. The observable performance of this leader's group is increasing. The leader has been making sure that all members were aware of their responsibilities and expected standards of performance.	A. Engage in friendly interaction, but continue to make sure that all members are aware of their responsibilities and expected standards of performance. B. Take no definite action. C. Do what could be done to make group feel important and involved. D. Emphasize the importance of deadlines and tasks
3. This leader's group is unable to solve a problem. The leader has normally left them alone. Group performance and interpersonal relations have been good.	A. Work with the group and together engage in problem solving. B. Let the group work it out. C. Act quickly and firmly to correct and redirect. D. Encourage the group to work on the problem and be supportive of their efforts.

Situation	**Alternative actions** This leader would.....
4. This leader is considering a change. The leader's followers have a fine record of accomplishment. They respect the need for change.	A. Allow group involvement in developing the change, but would not be too directive. B. Announce changes and then implement with close supervision. C. Allow the group to formulate its own direction. D. Incorporate group recommendations, but direct the change.
5. The performance of this leader's group has been dropping during the last few months. Members have been unconcerned with meeting objectives. Redefining roles and responsibilities has helped in the past. They have continually needed reminding to have their tasks done on time.	A. Allow the group to formulate its own direction. B. Incorporate group recommendations, but see that objectives are met. C. Redefine roles and responsibilities and supervise carefully. D. Allow group involvement in determining roles and responsibilities, but would not be too directive.
6. The leader stepped into an efficiently run organization. The previous administrator tightly controlled the situation. The leader wants to maintain a productive situation, but would like to begin humanizing the environment.	A. Do what could be done to make the group feel important and involved. B. Emphasize the importance of deadlines and task. C. Intentionally not intervene. D. Get the group involved in decision making, but see that objectives are met.
7. The leader is considering changing to a structure that will be new to the group. Members of the group have made suggestions about needed change. The group has been productive and demonstrate flexibility in its operations.	A. Define the change and supervise carefully. B. Participate with the group in developing the change, but allow members to organize the implementation. C. Be willing to make changes as recommended, but maintain control of implementation. D. Avoid confrontation; leave things alone.

Situation	**Alternative actions** This leader would.....
8. Group performance and interpersonal relations are good. This leader feels somewhat insecure about not providing direction to the group.	A. Leave the group alone. B. Discuss the situation with the group and then initiate necessary changes. C. Take steps to direct followers toward working in a well-defined manner. D. Be supportive in discussing the situation with the group, but not too directive.
9. The leader has been appointed to head a task force that is far overdue in making requested recommendations for change. The group is not clear on its goal. Attendance at sessions has been poor. Their meetings have turned into social gatherings. Potentially, they have the talent necessary to help.	A. Let the group work out its problems. B. Incorporate group recommendations, but see objectives are met. C. Redefine goals and supportive carefully. D. Allow group involvement in settings goals, but would not push.
10. Followers, usually able to take responsibility, are not responding to the leader's recent redefining of standards.	A. Allow group involvement in redefining standards, but would not take control. B. Redefine standards and supervise carefully, C. Avoid confrontation by not applying pressure; leave the situation alone. D. Incorporate group recommendations, but see that new standards are met.

Situation	**Alternative actions** This leader would.....
11. This leader has been promoted to a new position. The previous manager was uninvolved in the affairs of the group. The group has adequately handled its tasks and direction. Group interrelations are good.	A. Take steps to direct followers toward working in a well-defined manner. B. Involve followers in decision making and reinforce good contributions. C. Discuss past performance with the group and then examine the need for new practices. D. Continue to leave the group alone.
12. Recent information indicates some internal difficulties among followers. The group has a remarkable record of accomplishment. Members have effectively maintained long-range goals. They have worked in harmony for the past year. All are well qualified for the task.	A. Try out your solution with followers and examine the need for new practices. B. Allow group members to work it out themselves. C. Act quickly and firmly to correct and redirect. D. Participate in problem discussion while providing support for followers.

Appendix E

Questionnaire for Registered Nurses English Version

Demographic data

Please check the choices or fill in blank that is the most accurate as of this date

1. Gender

___ Female ___ Male

7. Age _____ years

8. Marital Status

___Single ___Married ___Other _____

9. Highest nursing degree held:

___ Diploma

___ Baccalaureate

___ Master

___ Doctorate

___ Other(please specify)_____

5. Years of nursing experience_____ year

6. Unit of employment _____

7. Present Position _____

8. Employee status: ___Government officer ___Permanent employee

___Temporary employee ___Private employee

___Other, specify_____

9. Shift Rotation

___ Day shift only

___ Other shift

Questionnaire

II. LEAD

Assume your head nurse is involved in each of the following twelve situations. Each situation has hour alternative actions the head nurse might initiate. Read each item carefully. Think about what the head nurse would do in each circumstance. Then, based on your experience with the head nurse, circle the letter of the alternative action choice which you think would most closely describe the behavior of the head nurse in the situation presented. **Circle only one choice.**

Situation	**Alternative actions** This leader would.....
1. Followers are not responding lately to this leader's friendly conversation and obvious concern for their welfare. Their performance is declining rapidly.	A. Emphasize the use of uniform procedures and the necessity for task accomplishment. B. Be available for discussion but would not push for involvement. C. Talk with followers and then set goals. D. Intentionally not intervene.
2. The observable performance of this leader's group is increasing. The leader has been making sure that all members were aware of their responsibilities and expected standards of performance.	A. Engage in friendly interaction, but continue to make sure that all members are aware of their responsibilities and expected standards of performance. B. Take no definite action. C. Do what could be done to make group feel important and involved. D. Emphasize the importance of deadlines and tasks
3. This leader's group is unable to solve a problem. The leader has normally left them alone. Group performance and interpersonal relations have been good.	A. Work with the group and together engage in problem solving. B. Let the group work it out. C. Act quickly and firmly to correct and redirect. D. Encourage the group to work on the problem and be supportive of their efforts.

Situation	**Alternative actions** This leader would.....
4. This leader is considering a change. The leader's followers have a fine record of accomplishment. They respect the need for change.	A. Allow group involvement in developing the change, but would not be too directive. B. Announce changes and then implement with close supervision. C. Allow the group to formulate its own direction. D. Incorporate group recommendations, but direct the change.
5. The performance of this leader's group has been dropping during the last few months. Members have been unconcerned with meeting objectives. Redefining roles and responsibilities has helped in the past. They have continually needed reminding to have their tasks done on time.	A. Allow the group to formulate its own direction. B. Incorporate group recommendations, but see that objectives are met. C. Redefine roles and responsibilities and supervise carefully. D. Allow group involvement in determining roles and responsibilities, but would not be too directive.
6. The leader stepped into an efficiently run organization. The previous administrator tightly controlled the situation. The leader wants to maintain a productive situation, but would like to begin humanizing the environment.	A. Do what could be done to make the group feel important and involved. B. Emphasize the importance of deadlines and task. C. Intentionally not intervene. D. Get the group involved in decision making, but see that objectives are met.
7. The leader is considering changing to a structure that will be new to the group. Members of the group have made suggestions about needed change. The group has been productive and demonstrate flexibility in its operations.	A. Define the change and supervise carefully. B. Participate with the group in developing the change, but allow members to organize the implementation. C. Be willing to make changes as recommended, but maintain control of implementation. D. Avoid confrontation; leave things alone.

Situation	**Alternative actions** This leader would.....
8. Group performance and interpersonal relations are good. This leader feels somewhat insecure about not providing direction to the group.	A. Leave the group alone. B. Discuss the situation with the group and then initiate necessary changes. C. Take steps to direct followers toward working in a well-defined manner. D. Be supportive in discussing the situation with the group, but not too directive.
9. The leader has been appointed to head a task force that is far overdue in making requested recommendations for change. The group is not clear on its goal. Attendance at sessions has been poor. Their meetings have turned into social gatherings. Potentially, they have the talent necessary to help.	A. Let the group work out its problems. B. Incorporate group recommendations, but see objectives are met. C. Redefine goals and supportive carefully. D. Allow group involvement in settings goals, but would not push.
10. Followers, usually able to take responsibility, are not responding to the leader's recent redefining of standards.	A. Allow group involvement in redefining standards, but would not take control. B. Redefine standards and supervise carefully, C. Avoid confrontation by not applying pressure; leave the situation alone. D. Incorporate group recommendations, but see that new standards are met.

Situation	**Alternative actions** This leader would.....
11. This leader has been promoted to a new position. The previous manager was uninvolved in the affairs of the group. The group has adequately handled its tasks and direction. Group interrelations are good.	A. Take steps to direct followers toward working in a well-defined manner. B. Involve followers in decision making and reinforce good contributions. C. Discuss past performance with the group and then examine the need for new practices. D. Continue to leave the group alone.
12. Recent information indicates some internal difficulties among followers. The group has a remarkable record of accomplishment. Members have effectively maintained long-range goals. They have worked in harmony for the past year. All are well qualified for the task.	A. Try out your solution with followers and examine the need for new practices. B. Allow group members to work it out themselves. C. Act quickly and firmly to correct and redirect. D. Participate in problem discussion while providing support for followers.

I. DPBS (The Dempster Practice Behaviors Scale)

Please carefully read and think about each statement below. Then, for each statement, mark the response that best indicate how true that statement is for you in your current practice. **Make one check mark for each item.**

1=Not at all true, 2=Slightly true, 3=Moderately true, 4=Very true,
5=Extremely true

	Agreement				
Item In my practice I...	Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
1. ... take responsibility and am accountable for my actions.	1	2	3	4	5
2. ... have developed the image of myself as an independent professional	1	2	3	4	5
3. ... base my actions on the full scope of my knowledge and ability	1	2	3	4	5
4. ... self-determine my role and activities	1	2	3	4	5
5. ... derive satisfaction from what I do	1	2	3	4	5
6. ... take control over my environment and situations I confront	1	2	3	4	5
7. ... am valued for my independent actions.	1	2	3	4	5

Item In my practice I…	Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
8. … am constrained by bureaucratic limitations.	1	2	3	4	5
9. … provide quality services through my actions.	1	2	3	4	5
10. … am confident in my abilities to perform my role independently.	1	2	3	4	5
11. … have been professionally socialized to take independent action	1	2	3	4	5
12. … function with the authority to do what I know should be done	1	2	3	4	5
13. … have too many routine tasks to exercise independent action.	1	2	3	4	5
14. … have a sense of professionalism.	1	2	3	4	5
15. … have the rights and privileges I deserve.	1	2	3	4	5
16. … have the professional experience needed for independent action.	1	2	3	4	5

Item In my practice I…	Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
17. … am restrained in what I can do because I am powerless.	1	2	3	4	5
18. … collaborate with others outside my field when I feel there is a need.	1	2	3	4	5
19. … derive feelings of self-respect and esteem from what I do.	1	2	3	4	5
20. … make my own decisions related to what I do.	1	2	3	4	5
21. … possess ownership of my practice; that is, my role belongs to me.	1	2	3	4	5
22. … have the power to influence decisions and actions of others.	1	2	3	4	5
23. … have a sense of self-achievement.	1	2	3	4	5
24. … am provided with a legal basis for independent functioning.	1	2	3	4	5
25. … demonstrate mastery of skills essential for freedom of action.	1	2	3	4	5

Item In my practice I...	Not at all true 1	Slightly true 2	Moderately true 3	Very true 4	Extremely true 5
26. ... have my activities and actions programmed by others.	1	2	3	4	5
27. ... have the respect of those in other disciplines.	1	2	3	4	5
28. ... cannot optimally function because I do not have legal status.	1	2	3	4	5
29. ... establish the parameters and limits of my practice activities.	1	2	3	4	5
30. ... accept the consequences for the choices I make.	1	2	3	4	5

III. Job satisfaction

The following statements are about your feelings toward job satisfaction. Please circle the appropriate response, which is closest to your feelings. On a scale from 1 to 6, please indicate your level of agreement with each statement. **Make one check mark for each item.**

1=Strongly disagree, 2=Disagree, 3=Tend to disagree, 4=Tend to agree, 5=Agree, 6=Strongly agree

Item	Strongly disagree 1	Disagree 2	Tend to Disagree 3	Tend to agree 4	Agree 5	Strongly agree 6
1. When I am at work in this hospital, the time generally goes by quickly	1	2	3	4	5	6
2. I am often bored because my job routine	1	2	3	4	5	6
3.There is a great gap between the administration of this hospital and the daily problems of the nurse service	1	2	3	4	5	6

Item	Strongly disagree 1	Disagree 2	Tend to Disagree 3	Tend to agree 4	Agree 5	Strongly agree 6
4. Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable	1	2	3	4	5	6
5. It makes me proud to talk to other people about what I do on my job	1	2	3	4	5	6
6. There is no doubt whatever in my mind that what I do on my job is really important	1	2	3	4	5	6
7. I have enough opportunities to make administrative decisions in planning procedures	1	2	3	4	5	6
8. An upgrading of pay schedules for nursing personnel is needed at this hospital	1	2	3	4	5	6

9. New employees are not quickly made to "feel at home" on my unit	1	2	3	4	5	6
10. There is ample opportunity for nursing staff to participate in the administrative decision-making process	1	2	3	4	5	6
11. There are plenty of opportunities for advancement of nursing staff at this hospital.	1	2	3	4	5	6
12. The present rate of increase in pay for nursing service personnel at this hospital is not satisfactory	1	2	3	4	5	6
13. What I do my job does not add up to anything significant	1	2	3	4	5	6
14. Nursing personnel at this hospital do a lot of bickering and backbiting	1	2	3	4	5	6

Item	Strongly disagree 1	Disagree 2	Tend to Disagree 3	Tend to agree 4	Agree 5	Strongly agree 6
15. Considering the high cost of hospital care, every effort should be made to hold nursing personnel salaries about where they are, or at least not to increase them substantially	1	2	3	4	5	6
16. Excluding myself, it is my impression that a lot of nursing service personnel at this hospital are dissatisfied with their pay	1	2	3	4	5	6
17. There is a good deal of teamwork and cooperation between the various nursing staff on my unit	1	2	3	4	5	6

Item	Strongly disagree 1	Disagree 2	Tend to Disagree 3	Tend to agree 4	Agree 5	Strongly agree 6
18. There is no doubt that the hospital administrative staff cares a good deal about its employees, nursing personnel included	1	2	3	4	5	6
19. The nursing personnel on my service do not hesitate to pitch in and help one another out when things get in a rush	1	2	3	4	5	6
20. The nursing administrators generally consult with staff on daily problems and procedures	1	2	3	4	5	6
21. The nursing personnel on my service do not often act like "one big happy family"	1	2	3	4	5	6

Item	Strongly disagree 1	Disagree 2	Tend to Disagree 3	Tend to agree 4	Agree 5	Strongly agree 6
22. There is a lot of "rank consciousness" on my unit; nursing personnel seldom mingle with others of lower ranks	1	2	3	4	5	6
23. The nursing personnel on my service are not as friendly and outgoing as I would like	1	2	3	4	5	6
24. Even if I could make more money in another hospital nursing situation, I am more satisfied here because of the working conditions	1	2	3	4	5	6
25. My present salary is satisfactory	1	2	3	4	5	6

Item	Strongly disagree 1	Disagree 2	Tend to Disagree 3	Tend to agree 4	Agree 5	Strongly agree 6
26. If I had the decision to make all over again, I would still choose my line of work	1	2	3	4	5	6
27. From what I hear from and about nursing service personnel at other hospitals, we at this hospital are being fairly paid	1	2	3	4	5	6
28. I work on the unit of choice	1	2	3	4	5	6

Thank you so very much for your times and efforts.

Appendix F

Questionnaire for Head Nurses Thai Version

มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก

โรงเรียนพยาบาล

17 กรกฎาคม 2546

เรื่อง ขอความร่วมมือในการตอบแบบสอบถาม

เรียน หัวหน้าหอผู้ป่วยที่นับถือ

ดิฉัน นางสาวสุธิดา มาสุธน ข้าราชการระดับ 6 สังกัดภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี กำลังศึกษาระดับปริญญาเอก สาขาการบริหารพยาบาล ณ. โรงเรียนพยาบาล มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก ดิฉันกำลังดำเนินการวิจัยเพื่อเสนอเป็นวิทยานิพนธ์เรื่อง Professional Nurse Characteristics and Unit Characteristics as Predictors of Job Satisfaction with Work in Thailand.

ดิฉันจึงเรียนมาเพื่อขอความร่วมมือจากท่าน กรุณาตอบแบบสอบถามในการวิจัยนี้ทุกข้อ ผู้วิจัยจะนำข้อมูลของท่านไปวิเคราะห์โดยรวมและขอรับรองว่าจะไม่มีผลเสียต่อการปฏิบัติงานของท่าน และคาดว่าผลการวิจัยสามารถนำไปพัฒนาวิชาชีพพยาบาลได้ต่อไป

ดิฉันหวังเป็นอย่างยิ่งว่าจะได้รับความร่วมมือจากท่านในการตอบแบบสอบถามในครั้งนี้ และขอให้ท่านส่งคืนฝ่ายการพยาบาลภายใน 1 สัปดาห์ และขอขอบพระคุณมา ณ โอกาสนี้

ขอแสดงความนับถือ

สุธิดา มาสุธน

(นางสาวสุธิดา มาสุธน)

ข้อมูลทั่วไป

(Demorgraphic Data)

1. เพศ

___หญิง

___ชาย

2. อายุ_____ ปี

3. สถานภาพสมรส

___โสด ___คู่ ___อื่นๆ _____

4. การศึกษาสูงสุดของท่าน

___ประกาศนียบัตรพยาบาลอนามัย และผดุงครรภ์

___ปริญญาตรีทางการพยาบาล หรือเทียบเท่า

___ปริญญาโท สาขา_____

___ปริญญาเอก

___อื่นๆ ระบุ_____

5. ท่านปฏิบัติงานพยาบาลมาเป็นเวลา _____ ปี

6. ท่านปฏิบัติงานหอผู้ป่วย_____

7, ตำแหน่ง _____

คำชี้แจง แบบสอบถามต่อไปนี้เป็นการประเมินรูปแบบการบริหารงานของตัวท่านเอง ตามสถานการณ์ที่กำหนด สมมุติท่านกำลังเผชิญกับ 12 สถานการณ์ดังกล่าว แต่ละสถานการณ์มีทางเลือกปฏิบัติ 4 ทางเลือก **กรุณาวงกลมรอบตัวอักษรที่ตรงกับความคิดเห็นของท่านมากที่สุด**

พฤติกรรมผู้นำของหัวหน้าหอผู้ป่วย

สถานการณ์	ทางเลือกปฏิบัติ ท่านจะ...
1. ผู้ใต้บังคับบัญชาไม่ตอบสนองต่อความเอาใจใส่และการสนทนาที่เป็นมิตรของหัวหน้า หอผู้ป่วย, ไม่ปฏิบัติตามต่อสิ่งที่ได้มีการพูดคุย กับหัวหน้าหอผู้ป่วยเนื่องจากคำนึงถึงแต่ ผลประโยชน์ของตนเอง นอกจากนี้ประสิทธิภาพการปฏิบัติงานก็ลดต่ำลงอย่างรวดเร็ว	ก.เน้นการใช้กระบวนการที่เป็นมาตรฐานและจำเป็นต่อการทำงานนั้น ให้สำเร็จ ข.พร้อมที่จะให้คำปรึกษาแต่ไม่บังคับ ค.พูดคุยกับผู้ใต้บังคับบัญชาและกำหนดจุดหมาย ง.ไม่เข้าไปแทรกแซงอย่างเด็ดขาด
2. หัวหน้าหอผู้ป่วยได้ชี้แจงให้ทุก ๆ คนเข้าใจถึงความรับผิดชอบและมาตรฐานของงานที่ต้อง การอย่างชัดเจนผลงานของผู้ใต้บังคับบัญชาเริ่มดีขึ้น	ก.เข้าไปมีส่วนร่วมอย่างเป็นมิตร แต่คงยังทำให้ทุกคนเข้าใจถึง ความรับผิดชอบและมาตรฐานของงานที่ต้องการอย่างต่อเนื่อง ข.ไม่ดำเนินการใด ๆ เลย ค.ทำในสิ่งที่ควรทำเพื่อให้กลุ่มรู้สึกถึงความสำคัญและการมีส่วนร่วม ง.เน้นถึงความสำคัญของเวลาที่ต้องการให้งานและภารกิจที่ต้องการทำ ให้สำเร็จ

สถานการณ์	ทางเลือกปฏิบัติ ท่านจะ...
3. โดยปกติหัวหน้าหอผู้ป่วยให้ผู้ใต้บังคับบัญชา ปฏิบัติงานกันเอง,ความสัมพันธ์ของกลุ่มยังอยู่ในระดับที่ดี แต่ขณะนี้กลุ่มไม่สามารถแก้ปัญหาที่พบอยู่ได้	ก.ทำงานอยู่รวมกับกลุ่มในการแก้ปัญหา ข.ปล่อยให้กลุ่มแก้ปัญหานั้นเอง ค.เข้าแก้ไขปัญหาและกำหนดทิศทางใหม่อย่างรวดเร็วและมั่นใจ ง.กระตุ้นให้กลุ่มแก้ปัญหาและสนับสนุนในสิ่งที่ทางกลุ่มได้กระทำ
4. ผลงานของผู้ใต้บังคับบัญชาที่ผ่านมาอยู่ใน ระดับที่ดีหัวหน้าหอผู้ป่วยกำลังพิจารณาถึง ความจำเป็นของการปรับปรุงและการเปลี่ยนแปลงในระบบผู้ใต้บังคับบัญชาเองก็ตระหนักถึงความจำเป็นในการเปลี่ยนแปลงดังกล่าว	ก.อนุญาตให้กลุ่มมีส่วนร่วมในการเปลี่ยนแปลงโดยทางอ้อม ข.ประกาศการเปลี่ยนแปลงและการปฏิบัติงานโดยการดูแลอย่างใกลชิดจากผู้ตรวจการ ค.อนุญาตให้กลุ่มกำหนดแนวทางของกลุ่มเอง ง.รวบรวมข้อแนะนำของกลุ่ม แต่กำหนดการเปลี่ยนแปลง ด้วยตนเอง
5. ในช่วง 3-4 เดือนที่ผ่านมา ประสิทธิภาพของ ผู้ใต้บังคับบัญชาลดลง, ผู้ใต้บังคับบัญชาไม่สนใจ ต่อวัตถุประสงค์ของการประชุม,จะต้อง ให้มีการเตือนเสมอเพื่อให้งานเสร็จตามกำหนด	ก.ให้กลุ่มกำหนดทิศทางของตนเอง ข.รวบรวมข้อแนะนำของกลุ่ม แต่ดูว่าวัตถุประสงค์ได้รับการ ตอบสนองหรือไม่ ค.ปรับเปลี่ยนหน้าที่และความรับผิดชอบและดูแลอย่างใกล้ชิด ง.อนุญาตให้กลุ่มมีส่วนร่วมในการกำหนดหน้าที่และความรับผิดชอบ ทางอ้อม

สถานการณ์	ทางเลือกปฏิบัติ ท่านจะ...
6. หัวหน้าหอผู้ป่วยเข้ามาสู่องค์กรที่มีการ ดำเนิน งานอย่างมีประสิทธิภาพ ซึ่งผู้บริหารคนก่อนได้ควบคุมอย่างเข้มงวด หัวหน้าหอผู้ป่วยต้องการที่จะรักษาประสิทธิภาพขององค์กรไว้ในขณะเดียวกันก็ต้องการสร้างบรรยากาศที่เป็นมิตรมากขึ้น	ก.ทำในสิ่งที่ควรทำเพื่อให้กลุ่มรู้สึกถึงความสำคัญและการมีส่วนร่วม ข.เน้นความสำคัญของการกำหนดเวลาและงาน ค.ไม่เข้าแทรกแซงใด ๆ อย่างเด็ดขาด ง.ให้กลุ่มมีส่วนร่วมในการตัดสินใจเพื่อให้บรรลุวัตถุประสงค์
7. หัวหน้าหอผู้ป่วยกำลังพิจารณาถึงการเปลี่ยน แปลงของโครงสร้างซึ่งเป็นสิ่งใหม่สำหรับกลุ่ม, ผู้ใต้บังคับบัญชาซึ่งมีความยืดหยุ่นในการ ปฏิบัติงานและประสิทธิผลของงานที่ผ่านมาอยู่ในระดับดี ได้เสนอสิ่งที่จำเป็นต่อเปลี่ยนแปลง	ก.กำหนดการเปลี่ยนแปลงและดูแลอย่างระมัดระวัง ข.เข้ามามีส่วนร่วมในการกำหนดการเปลี่ยนแปลงและให้สมาชิกกลุ่ม ดูแลการดำเนินการเอง ค.เต็มใจให้มีการเปลี่ยนแปลงตามที่ได้รับคำแนะนำแต่ยังคงควบคุมการดำเนินการเอง ง.หลีกเลี่ยงการเผชิญหน้า ปล่อยให้เป็นไปเอง
8. ประสิทธิภาพและความสัมพันธ์ของกลุ่มอยู่ในระดับที่ดี แต่หัวหน้าหอผู้ป่วยรู้สึกไม่มั่นใจในการที่ไม่ได้กำหนดทิศทางการทำงานของกลุ่ม	ก.ไม่ดำเนินการใด ๆ ข.พูดคุยถึงสถานการณ์กับทางกลุ่มและเริ่มต้นการเปลี่ยนแปลงที่จำเป็น ค.ชี้นำให้ผู้ใต้บังคับบัญชาให้ทำงานในลักษณะที่มีการกำหนดไว้เป็น อย่างดี ง.สนับสนุนการพูดคุยเกี่ยวกับสถานการณ์กับทางกลุ่มแต่เป็นไปในลักษณะการออกคำสั่งที่ไม่มากเกินไป

สถานการณ์	ทางเลือกปฏิบัติ ท่านจะ...
9. หัวหน้าหอผู้ป่วยได้รับการแต่งตั้งให้เป็นหัวหน้าของคณะทำงานซึ่งมีความล่าช้าอยู่ สมาชิกของคณะทำงานรับรู้และเข้าใจเกี่ยวกับ เป้าหมายของงานเพียงเล็กน้อย การประชุม จึงเป็นการพบปะพูดคุยเป็นส่วนใหญ่ แต่ในความ เป็นจริง พวกเขามีความสามารถที่จะช่วยทำงานได้	ก.ปล่อยให้ทางกลุ่มแก้ปัญหาด้วยตัวเอง ข.รวบรวมคำแนะนำของกลุ่มแต่ทำให้บรรลุวัตถุประสงค์ ค.กำหนดเป้าหมายใหม่ และสนับสนุนอย่างระมัดระวัง ง.อนุญาตให้กลุ่มมีส่วนร่วมในการกำหนดเป้าหมายโดยไม่เป็นการบังคับ
10. ตามปกติผู้ใต้บังคับบัญชามีความสามารถและรับผิดชอบดี แต่ไม่ตอบสนองต่อมาตรฐานที่มีการ กำหนดขึ้นมาใหม่	ก.อนุญาตให้กลุ่มมีส่วนในการกำหนดมาตรฐานใหม่แต่ไม่ปล่อยให้ ควบคุม ข.กำหนดมาตรฐานใหม่และดูแลอย่างระมัดระวัง ค.หลีกเลี่ยงการเผชิญหน้าโดยไม่กดดันกลุ่มแต่ปล่อยให้สถานการณ์ ดำเนินไปเอง ง.รวบรวมคำแนะนำของกลุ่มที่ทำให้บรรลุมาตรฐานใหม่

11. หัวหน้าหอผู้ป่วยได้เลื่อนตำแหน่งไปสู่ตำแหน่งใหม่ ซึ่งผู้บริหารคนก่อนหน้านี้ไม่ยุ่งเกี่ยวกับเรื่องใดๆ ภายในกลุ่ม แต่กลุ่มมีการ ปฏิบัติหน้าที่และกำหนดทิศทางของกลุ่มที่ดี ความสัมพันธ์ภายในกลุ่มก็ดีเช่นกัน	ก.ชี้นำผู้ใต้บังคับบัญชาให้ทำงานในลักษณะที่มีการกำหนดไว้เป็นอย่างดี ข.เข้าไปมีส่วนเกี่ยวร่วมกับผู้ใต้บังคับบัญชาในการตัดสินใจและให้การ สนับสนุนที่ดี ค.พูดคุยถึงผลงานในอดีตที่ผ่านมากับกลุ่มและตรวจสอบหาความจำเป็น ของการปฏิบัติแนวใหม่ ๆ ง.ปล่อยให้กลุ่มเป็นไปอย่างที่เป็นอยู่
12. กลุ่มมีผลงานในอดีตที่ดีเยี่ยม สมาชิกใน กลุ่มปฏิบัติเพื่อให้บรรลุวัตถประสงค์ระยะยาวอย่างมีประสิทธิภาพ และประสานงานกันเป็น อย่างดี นอกจากนี้สมาชิกในกลุ่มยังมีคุณสมบัติที่ดีสำหรับงานที่ทำอยู่ แต่จากข้อมูลล่าสุดพบว่า มีความขัดแย้งเกิดขึ้นในกลุ่ม	ก.ลองใช้วิธีแก้ปัญหาของตัวหัวหน้าหอผู้ป่วยเองและตรวจสอบถึง ความจำเป็นสำหรับแนวปฏิบัติใหม่ ๆ ข.ปล่อยให้กลุ่มแก้ปัญหาด้วยตัวเอง ค.เข้าไปแก้ไขอย่างรวดเร็วและมั่นใจและกำหนดแนวทางใหม่ ง.เข้าไปมีส่วนร่วมในการพูดคุยเกี่ยวกับปัญหาและสนับสนุนผู้ใต้บังคับ บัญชา

Appendix G

Questionnaire for Registered Nurses Thai Version

มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก

โรงเรียนพยาบาล

17 กรกฎาคม 2546

เรื่อง ขอความร่วมมือในการตอบแบบสอบถาม

เรียน พยาบาลวิชาชีพที่นับถือ

ดิฉัน นางสาวสุธิดา มาสุธน ข้าราชการระดับ 6 สังกัดภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี กำลังศึกษาระดับปริญญาเอก สาขาการบริหารพยาบาล ณ. โรงเรียนพยาบาล มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก ดิฉันกำลังดำเนินการวิจัยเพื่อเสนอเป็นวิทยานิพนธ์เรื่อง Professional Nurse Characteristics and Unit Characteristics as Predictors of Job Satisfaction with Work in Thailand.

ดิฉันจึงเรียนมาเพื่อขอความร่วมมือจากท่าน กรุณาตอบแบบสอบถามในการวิจัยนี้ทุกข้อ ผู้วิจัยจะนำข้อมูลของท่านไปวิเคราะห์โดยรวมและขอรับรองว่าจะไม่มีผลเสียต่อการปฏิบัติงานของท่าน และคาดว่าผลการวิจัยสามารถนำไปพัฒนาวิชาชีพพยาบาลได้ต่อไป

ดิฉันหวังเป็นอย่างยิ่งว่าจะได้รับความร่วมมือจากท่านในการตอบแบบสอบถามในครั้งนี้ และขอให้ท่านส่งคืนฝ่ายการพยาบาลภายใน 1 สัปดาห์ และขอขอบพระคุณมา ณ โอกาสนี้

ขอแสดงความนับถือ

สุธิดา มาสุธน

(นางสาวสุธิดา มาสุธน)

ข้อมูลทั่วไป

(Demorgraphic Data)

1. เพศ

___หญิง

___ชาย

2. อายุ_____ ปี

6. สถานภาพสมรส

___โสด ___คู่ ___อื่นๆ _____

7. การศึกษาสูงสุดของท่าน

___ประกาศนียบัตรพยาบาลอนามัย และผดุงครรภ์

___ปริญญาตรีทางการพยาบาล หรือเทียบเท่า

___ปริญญาโท สาขา_____

___ปริญญาเอก

___อื่นๆ ระบุ_____

8. ท่านปฏิบัติงานพยาบาลมาเป็นเวลา _____ ปี

6. ท่านปฏิบัติงานหอผู้ป่วย_____

7, ตำแหน่ง _____

8. สถานภาพการจ้างงาน: ___ข้าราชการ ___ ลูกจ้างประจำ ____ลูกจ้างชั่วคราว

___พนักงานมหาวิทยาลัย ___ อื่นๆ โปรดระบุ_____

9. ช่วงเวลาการจ้างงาน

___เฉพาะรอบเช้าเท่านั้น

___ทั้งสามรอบ, เช้า, บ่าย, และดึก หมุนเวียนกัน

___อื่น ๆ โปรดระบุ_____

แบบสอบถาม

คำชี้แจง ข้อความต่อไปนี้เป็นการสำรวจระดับความคิดเห็นของท่านต่อ รูปแบบการบริหารงานของหัวหน้าหอผู้ป่วย สมมุติหัวหน้าหอผู้ป่วยของท่านกำลังเผชิญกับ 12 สถานการณ์ดังกล่าว แต่ละสถานการณ์มีทางเลือกปฏิบัติ 4 ทางเลือก ท่านคิดว่าหัวหน้าหอผู้ป่วยของท่านจะเลือกปฏิบัติอย่างไร

กรุณาวงกลมรอบตัวอักษรที่ตรงกับความคิดเห็นของท่านมากที่สุด

พฤติกรรมผู้นำของหัวหน้าหอผู้ป่วย

สถานการณ์	ทางเลือกปฏิบัติ หัวหน้าหอผู้ป่วยของท่านจะ...
1. ผู้ใต้บังคับบัญชาไม่ตอบสนองต่อความเอาใจใส่และการสนทนาที่เป็นมิตรของหัวหน้าหอผู้ป่วย, ไม่ปฏิบัติตามต่อสิ่งที่ได้มีการพูดคุยกับหัวหน้าหอผู้ป่วยเนื่องจากคำนึงถึงแต่ผลประโยชน์ของตนเอง นอกจากนี้ประสิทธิภาพการปฏิบัติงานก็ลดต่ำลงอย่างรวดเร็ว	ก.เน้นการใช้กระบวนการที่เป็นมาตรฐานและจำเป็นต่อการทำงานนั้น ให้สำเร็จ ข.พร้อมที่จะให้คำปรึกษาแต่ไม่บังคับ ค.พูดคุยกับผู้ใต้บังคับบัญชาและกำหนดจุดหมาย ง.ไม่เข้าไปแทรกแซงอย่างเด็ดขาด
2. หัวหน้าหอผู้ป่วยได้ชี้แจงให้ทุก ๆ คนเข้าใจถึงความรับผิดชอบและมาตรฐานของงานที่ต้องการอย่างชัดเจน ผลงานของผู้ใต้บังคับบัญชาเริ่มดีขึ้น	ก.เข้าไปมีส่วนร่วมอย่างเป็นมิตร แต่คงยังทำให้ทุกคนเข้าใจถึง ความรับผิดชอบและมาตรฐานของงานที่ต้องการอย่าง ต่อเนื่อง ข.ไม่ดำเนินการใด ๆ เลย ค.ทำในสิ่งที่ควรทำเพื่อให้กลุ่มรู้สึกถึงความสำคัญและการมีส่วนร่วม ง.เน้นถึงความสำคัญของเวลาที่ต้องการให้งานและภารกิจที่ต้องการทำ ให้สำเร็จ

สถานการณ์	ทางเลือกปฏิบัติ หัวหน้าหอผู้ป่วยของท่านจะ...
3. โดยปกติหัวหน้าหอผู้ป่วยให้ผู้ใต้บังคับบัญชาปฏิบัติงานกันเอง, ความสัมพันธ์ของกลุ่มยังอยู่ในระดับที่ดี แต่ขณะนี้กลุ่มไม่สามารถแก้ปัญหาที่พบอยู่ได้	ก.ทำงานอยู่รวมกับกลุ่มในการแก้ปัญหา ข.ปล่อยให้กลุ่มแก้ปัญหานั้นเอง ค.เข้าแก้ไขปัญหาและกำหนดทิศทางใหม่อย่างรวดเร็วและมั่นใจ ง.กระตุ้นให้กลุ่มแก้ปัญหาและสนับสนุนในสิ่งที่ทางกลุ่มได้กระทำ
4. ผลงานของผู้ใต้บังคับบัญชาที่ผ่านมาอยู่ในระดับที่ดี หัวหน้าหอผู้ป่วยกำลังพิจารณาถึงความจำเป็นของการปรับปรุงและการเปลี่ยนแปลงในระบบ ผู้ใต้บังคับบัญชาเองก็ตระหนักถึงความจำเป็นในการเปลี่ยนแปลงดังกล่าว	ก.อนุญาตให้กลุ่มมีส่วนร่วมในการเปลี่ยนแปลงโดยทางอ้อม ข.ประกาศการเปลี่ยนแปลงและการปฏิบัติงานโดยการดูแลอย่างใกลชิดจากผู้ตรวจการ ค.อนุญาตให้กลุ่มกำหนดแนวทางของกลุ่มเอง ง.รวบรวมข้อแนะนำของกลุ่ม แต่กำหนดการเปลี่ยนแปลงด้วยตนเอง
5. ในช่วง 3-4 เดือนที่ผ่านมา ประสิทธิภาพของผู้ใต้บังคับบัญชาลดลง, ผู้ใต้บังคับบัญชาไม่สนใจต่อวัตถุประสงค์ของการประชุม,จะต้องให้มีการเตือนเสมอเพื่อให้งานเสร็จตามกำหนด	ก.ให้กลุ่มกำหนดทิศทางของตนเอง ข.รวบรวมข้อแนะนำของกลุ่ม แต่ดูว่าวัตถุประสงค์ได้รับการ ตอบสนองหรือไม่ ค.ปรับเปลี่ยนหน้าที่และความรับผิดชอบและดูแลอย่างใกล้ชิด ง.อนุญาตให้กลุ่มมีส่วนร่วมในการกำหนดหน้าที่และความรับผิดชอบทางอ้อม
6. หัวหน้าหอผู้ป่วยเข้ามาสู่องค์กรที่มีการดำเนินงานอย่างมีประสิทธิภาพ ซึ่งผู้บริหารคนก่อนได้ควบคุมอย่างเข้มงวดหัวหน้าหอผู้ป่วยต้องการที่จะรักษาประสิทธิภาพขององค์กรไว้ในขณะเดียวกันก็ต้องการสร้าง บรรยากาศที่เป็นมิตรมากขึ้น	ก.ทำในสิ่งที่ควรทำเพื่อให้กลุ่มรู้สึกถึงความสำคัญและการมีส่วนร่วม ข.เน้นความสำคัญของการกำหนดเวลาและงาน ค.ไม่เข้าแทรกแซงใด ๆ อย่างเด็ดขาด ง.ให้กลุ่มมีส่วนร่วมในการตัดสินใจ เพื่อให้บรรลุวัตถุประสงค์

สถานการณ์	ทางเลือกปฏิบัติ หัวหน้าหอผู้ป่วยของท่านจะ...
7. หัวหน้าหอผู้ป่วยกำลังพิจารณาถึงการเปลี่ยนแปลงของโครงสร้างซึ่งเป็นสิ่งใหม่สำหรับกลุ่ม, ผู้ได้บังคับบัญชาซึ่งมีความยืดหยุ่นในการปฏิบัติงานและประสิทธิผลของงานที่ผ่านมาอยู่ในระดับดีได้เสนอสิ่งที่จำเป็นต่อเปลี่ยนแปลง	ก.กำหนดการเปลี่ยนแปลงและดูแลอย่างระมัดระวัง ข.เข้ามามีส่วนร่วมในการกำหนดการเปลี่ยนแปลงและให้สมาชิกกลุ่ม ดูแลการดำเนินการเอง ค.เต็มใจให้มีการเปลี่ยนแปลงตามที่ได้รับคำแนะนำแต่ยังคงควบคุมการดำเนินการเอง ง.หลีกเลี่ยงการเผชิญหน้า ปล่อยให้เป็นไปเอง
8. ประสิทธิภาพและความสัมพันธ์ของกลุ่มอยู่ในระดับที่ดี แต่หัวหน้าหอผู้ป่วยรู้สึกไม่มั่นใจในการที่ไม่ได้กำหนดทิศทางการทำงานของกลุ่ม	ก.ไม่ดำเนินการใด ๆ ข.พูดคุยถึงสถานการณ์กับทางกลุ่มและเริ่มต้นการเปลี่ยนแปลงที่จำเป็น ค.ชี้นำให้ผู้ได้บังคับบัญชาให้ทำงานในลักษณะที่มีการกำหนดไว้เป็น อย่างดี ง.สนับสนุนการพูดคุยเกี่ยวกับสถานการณ์กับทางกลุ่ม แต่เป็นไปในลักษณะการออกคำสั่งที่ไม่มากเกินไป
9. หัวหน้าหอผู้ป่วยได้รับการแต่งตั้งให้เป็นหัวหน้าของคณะทำงานซึ่งมีความล่าช้าอยู่ สมาชิกของคณะทำงานรับรู้และเข้าใจเกี่ยวกับเป้าหมายของงานเพียงเล็กน้อย การประชุมจึงเป็นการพบปะพูดคุยเป็นส่วนใหญ่ แต่ในความเป็นจริงพวกเขามีความสามารถที่จะช่วยทำงานได้	ก.ปล่อยให้ทางกลุ่มแก้ปัญหาด้วยตัวเอง ข.รวบรวมคำแนะนำของกลุ่มแต่ทำให้บรรลุวัตถุประสงค์ ค.กำหนดเป้าหมายใหม่ และสนับสนุนอย่างระมัดระวัง ง.อนุญาตให้กลุ่มมีส่วนร่วมในการกำหนดเป้าหมายโดยไม่เป็นการบังคับ

สถานการณ์	ทางเลือกปฏิบัติ หัวหน้าหอผู้ป่วยของท่านจะ...
10. ตามปกติผู้ใต้บังคับบัญชามีความสามารถและรับผิดชอบดี แต่ไม่ตอบสนองต่อมาตรฐานที่มีการกำหนดขึ้นมาใหม่	ก.อนุญาตให้กลุ่มมีส่วนในการกำหนดมาตรฐานใหม่แต่ไม่ปล่อยให้ควบคุม ข.กำหนดมาตรฐานใหม่และดูแลอย่างระมัดระวัง ค.หลีกเลี่ยงการเผชิญหน้าโดยไม่กดดันกลุ่มแต่ปล่อยให้สถานการณ์ดำเนินไปเอง ง.รวบรวมคำแนะนำของกลุ่มที่ทำให้บรรลุมาตรฐานใหม่
11. หัวหน้าหอผู้ป่วยได้เลื่อนตำแหน่งไปสู่ตำแหน่งใหม่ ซึ่งผู้บริหารคนก่อนหน้านี้ไม่ยุ่งเกี่ยวกับเรื่องใด ๆ ภายในกลุ่ม แต่กลุ่มมีการปฏิบัติหน้าที่และกำหนดทิศทางของกลุ่มที่ดี ความสัมพันธ์ภายในกลุ่มก็ดีเช่นกัน	ก.ชี้นำผู้ใต้บังคับบัญชาให้ทำงานในลักษณะที่มีการกำหนดไว้เป็นอย่างดี ข.เข้าไปมีส่วนเกี่ยวร่วมกับผู้ใต้บังคับบัญชาในการตัดสินใจและให้การสนับสนุนที่ดี ค.พูดคุยถึงผลงานในอดีตที่ผ่านมากับกลุ่มและตรวจสอบหาความจำเป็น ของการปฏิบัติแนวใหม่ ๆ ง.ปล่อยให้กลุ่มเป็นไปอย่างที่เป็นอยู่
12. กลุ่มมีผลงานในอดีตที่ดีเยี่ยม สมาชิกในกลุ่มปฏิบัติเพื่อให้บรรลุวัตถุประสงค์ระยะยาวอย่างมีประสิทธิภาพและประสานงานกันเป็นอย่างดี นอกจากนี้สมาชิกในกลุ่มยังมีคุณสมบัติที่ดีสำหรับงานที่ทำอยู่ แต่จากข้อมูลล่าสุดพบว่ามีความขัดแย้งเกิดขึ้นในกลุ่ม	ก.ลองใช้วิธีแก้ปัญหาของตัวหัวหน้าหอผู้ป่วยเองและตรวจสอบถึง ความจำเป็นสำหรับแนวปฏิบัติใหม่ ๆ ข.ปล่อยให้กลุ่มแก้ปัญหาด้วยตัวเอง ค.เข้าไปแก้ไขอย่างรวดเร็วและมั่นใจและกำหนดแนวทางใหม่ ง.เข้าไปมีส่วนร่วมในการพูดคุยเกี่ยวกับปัญหาและสนับสนุนผู้ใต้บังคับ บัญชา

ความมีเอกสิทธิ์ทางการพยาบาล

คำชี้แจง ข้อความต่อไปนี้เป็นการสำรวจระดับความคิดเห็นของท่านต่อความมีเอกสิทธิ์ทางการพยาบาล แบบสอบถามเป็นแบบมาตราส่วนประเมินค่า

กรุณาวงกลมรอบตัวเลขที่ตรงกับความคิดเห็นของท่านมากที่สุด

1=ไม่เป็นความจริงเลย, 2=เป็นความจริงเล็กน้อย

3=เป็นความจริงปานกลาง, 4= เป็นความเป็นจริงมาก, 5= เป็นความเป็นจริงมากที่สุด

ระดับความคิดเห็น

ข้อความ ในทางปฏิบัติงานของข้าพเจ้า ข้าพเจ้า.....	ไม่เป็นความจริงเลย 1	เป็นความจริงเล็กน้อย 2	เป็นความจริงปานกลาง 3	เป็นความจริงมาก 4	เป็นความจริงมากที่สุด 5
1. มีความรับผิดชอบต่องานและการกระทำของข้าพเจ้า	1	2	3	4	5
2. ได้พัฒนาภาพพจน์ของตัว ข้าพเจ้าเองให้มีความเป็นวิชาชีพ	1	2	3	4	5
3. ได้ปฏบัติงานอย่างเต็มที่ตามความความรู้และความสามารถ	1	2	3	4	5
4. กำหนดบทบาทและกิจกรรมด้วยตัวของข้าพเจ้า เอง	1	2	3	4	5
5.					

ข้อความ ในทางปฏิบัติงานของข้าพเจ้า ข้าพเจ้า.....	ไม่เป็นความจริงเลย 1	เป็นความจริงเล็กน้อย 2	เป็นความจริงปานกลาง 3	เป็นความจริงมาก 4	เป็นความจริงมากที่สุด 5
5. ได้รับความพึงพอใจจากสิ่งที่ข้าพเจ้าได้กระทำ	1	2	3	4	5
6. สามารถควบคุมสิ่งแวดล้อมและสถานการณ์ต่างๆ ที่ข้าพเจ้าเผชิญ	1	2	3	4	5
7. รู้สึกมีคุณค่าจากการกระทำที่เป็นอิสระของข้าพเจ้า	1	2	3	4	5
8. ถูกจำกัดโดยข้อกำหนดของทางราชการ	1	2	3	4	5
9. ปฏิบัติงานให้การบริการอย่างมีคุณภาพ	1	2	3	4	5
10. มีความมั่นใจในความสามารถของตนเองต่อการปฏิบัติงานอย่างเป็นอิสระ	1	2	3	4	5
11.จากกรอบวิชาชีพข้าพเจ้าปฏิบัติงานอย่างมีอิสระ	1	2	3	4	5

ข้อความ ในทางปฏิบัติงานของข้าพเจ้า ข้าพเจ้า.....	ไม่เป็นความจริงเลย 1	เป็นความจริงเล็กน้อย 2	เป็นความจริงปานกลาง 3	เป็นความจริงมาก 4	เป็นความจริงมากที่สุด 5
12. ปฏิบัติหน้าที่ตามอำนาจความรับผิดชอบเพื่อกระทำในสิ่งที่ข้าพเจ้าคิดว่าควรจะกระทำ	1	2	3	4	5
13. มีงานประจำมากเกินกว่า ที่จะปฏิบัติงานอย่างเป็นอิสระ	1	2	3	4	5
14. มีความรู้สึกเป็นวิชาชีพ	1	2	3	4	5
15. ได้รับสิทธิและประโยชน์พิเศษตามที่สมควรได้รับ	1	2	3	4	5
16. มีประสบการณ์ในวิชาชีพที่จำเป็นเพียงพอต่อการปฏิบัติงาน	1	2	3	4	5
17. ถูกจำกัดความสามารถในสิ่งที่ควรทำเพราะว่าขาดอำนาจ	1	2	3	4	5
18. ประสานงานกับบุคคลอื่น ในสายงานอื่นเมื่อข้าพเจ้ารู้สึกว่ามีความจำเป็น	1	2	3	4	5

ข้อความ ในทางปฏิบัติงานของข้าพเจ้า ข้าพเจ้า.....	ไม่เป็นความจริงเลย 1	เป็นความจริงเล็กน้อย 2	เป็นความจริงปานกลาง 3	เป็นความจริงมาก 4	เป็นความจริงมากที่สุด 5
19. รู้สึกภูมิใจและนับถือตนเองต่อสิ่งที่ข้าพเจ้าได้กระทำ	1	2	3	4	5
20. ตัดสินใจในสิ่งที่กระทำด้วยตนเอง	1	2	3	4	5
21. รู้สึกเป็นเจ้าของในงานที่ปฏิบัติ	1	2	3	4	5
22. มีอำนาจในการตัดสินใจต่อการปฏิบัติงานของผู้อื่น	1	2	3	4	5
23. รับรู้ถึงความสำเร็จของตนเอง	1	2	3	4	5
24. ได้รับการรับรองด้านกฎหมายสำหรับการปฏิบัติงานที่เป็นอิสระ	1	2	3	4	5
25. ได้แสดงถึงความรู้และความชำนาญที่เป็นส่วนสำคัญ สำหรับปฏิบัติงานอย่างเป็นอิสระ	1	2	3	4	5

ข้อความ ในทางปฏิบัติงานของข้าพเจ้า ข้าพเจ้า.....	ไม่เป็นความจริงเลย 1	เป็นความจริงเล็กน้อย 2	เป็นความจริงปานกลาง 3	เป็นความจริงมาก 4	เป็นความจริงมากที่สุด 5
26. หน้าที่และการปฏิบัติงาน ของข้าพเจ้าถูกกำหนดโดย ผู้อื่น	1	2	3	4	5
27. เคารพในศาสตร์สาขาอื่น ๆ	1	2	3	4	5
28. ไม่สามารถปฏิบัติงานได้ดีที่สุดเพราะว่าข้าพเจ้าไม่มี สิทธิทางกฎหมาย	1	2	3	4	5
29. กำหนดขอบเขตและข้อจำกัดสำหรับการปฏิบัติงานของข้าพเจ้า	1	2	3	4	5
30. ยอมรับผลที่เกิดขึ้นจากการกระทำของข้าพเจ้า	1	2	3	4	5

ความพึงพอใจในการปฏิบัติงานในวิชาชีพ

คำชี้แจง ข้อความต่อไปนี้เป็นการสำรวจระดับความคิดเห็นของท่านต่อความพึงพอใจในการปฏิบัติงานในวิชาชีพแบบสอบถามเป็นแบบมาตราส่วนประเมินค่า

กรุณาวงกลมรอบตัวเลขที่ตรงกับความคิดเห็นของท่านมากที่สุด

1=ไม่เห็นด้วยมากที่สุด, 2=ไม่เห็นด้วย 3=ค่อนข้างไม่เห็นด้วย,
4=ค่อนข้างเห็นด้วย, 5=เห็นด้วย, 6=เห็นด้วยมากที่สุด

ระดับความคิดเห็น

ข้อความ	ไม่เห็นด้วยมากที่สุด 1	ไม่เห็นด้วย 2	ค่อนข้างไม่เห็นด้วย 3	ค่อนข้างเห็นด้วย 4	เห็นด้วย 5	เห็นด้วยมากที่สุด 6
1. ข้าพเจ้ารู้สึกว่าเวลาผ่านไปอย่างรวดเร็วเมื่อทำงานที่โรงพยาบาลแห่งนี้	1	2	3	4	5	6
2. บ่อยครั้งที่ข้าพเจ้ารู้สึกเบื่อเพราะว่างานที่ทำอยู่เป็นงานประจำ (routine job)	1	2	3	4	5	6
3. การบริหารงานของฝ่ายบริหารโรงพยาบาล นี้ไม่สอดคล้องกับปัญหาประจำวันที่เกิดขึ้นของการให้บริการด้านพยาบาลอยู่มาก	1	2	3	4	5	6

ข้อความ	ไม่เห็นด้วยมากที่สุด 1	ไม่เห็นด้วย 2	คอนข้างไม่เห็นด้วย 3	คอนข้างเห็นด้วย 4	เห็นด้วย 5	เห็นด้วยมากที่สุด 6
4. คาตอบแทนของวิชาชีพสมเหตุสมผลเมื่อเปรียบเทียบกับความคาดหวังของการให้บริการด้านการพยาบาลของโรงพยาบาลนี้	1	2	3	4	5	6
5. ข้าพเจ้าภูมิใจเมื่อได้คุยกับบุคคลอื่นถึงงานที่ข้าพเจ้าทำอยู่	1	2	3	4	5	6
6. ข้าพเจ้าแน่ใจว่างานที่ข้าพเจ้ากระทำอยู่นี้มีความสำคัญจริง ๆ	1	2	3	4	5	6
7. ข้าพเจ้าได้รับโอกาสอย่างเพียงพอในการตัดสินใจเกี่ยวกับการจัดการในกระบวนการวางแผนการพยาบาล	1	2	3	4	5	6
8. คาตอบแทน (เงินเดือน) ของพยาบาลโรงพยาบาลนี้ควรได้รับการปรับปรุงให้ดีขึ้น	1	2	3	4	5	6

ข้อความ	ไม่เห็น ด้วย มากที่สุด 1	ไม่เห็น ด้วย 2	ค่อนข้าง ไม่เห็นด้วย 3	ค่อนข้าง เห็นด้วย 4	เห็นด้วย 5	เห็นด้วย มาก ที่สุด 6
9. ผู้ปฏิบัติงานใหม่ในหน่วยงานของข้าพเจ้าไม่สามารถปรับตัวให้คุ้นเคยต่อหน่วยงานของข้าพเจ้าได้อย่างรวดเร็ว	1	2	3	4	5	6
10. พยาบาลมีโอกาสอย่างเพียงพอในการมีส่วนร่วมในกระบวนการตัดสินใจของการบริหารงานอย่างมาก	1	2	3	4	5	6
11. พยาบาลในโรงพยาบาลนี้มีโอกาสก้าวหน้าอย่างมาก	1	2	3	4	5	6
12. ในปัจจุบัน อัตราการปรับเงินรายได้สำหรับพยาบาลที่โรงพยาบาลนี้ไม่เป็นที่น่าพึงพอใจ	1	2	3	4	5	6
13. สิ่งที่ข้าพเจ้าได้กระทำในงานของข้าพเจ้ามิได้เพิ่มความสำคัญใด ๆ	1	2	3	4	5	6
14. พยาบาลที่โรงพยาบาลมีการโต้แย้งและให้ร้ายกันอย่างมาก	1	2	3	4	5	6

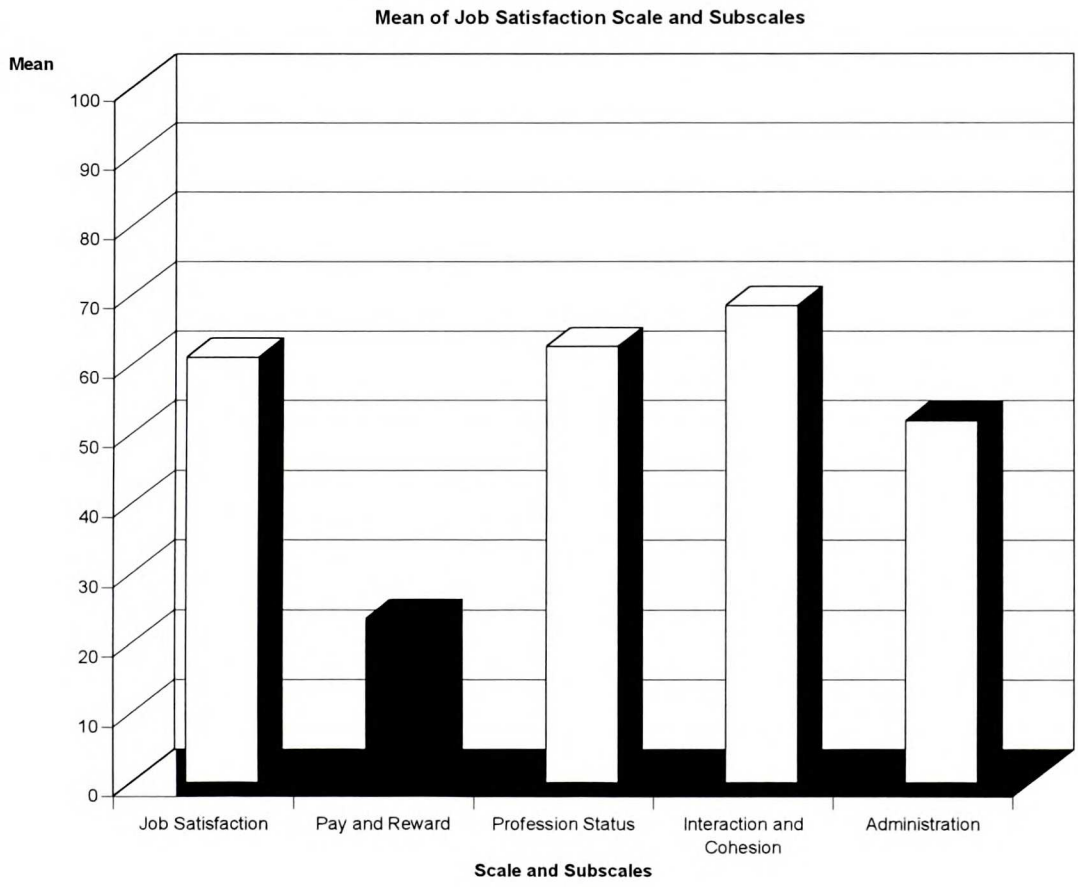
15. เมื่อพิจารณาถึงต้นทุนการบริหารโรงพยาบาลที่สูง, ยังไม่สมควรปรับเงินเดือนพยาบาล	1	2	3	4	5	6
16. ข้าพเจ้ารู้สึกว่าพยาบาลจำนวนมากในโรงพยาบาลแห่งนี้ไม่พึงพอใจกับค่าตอบแทนที่ได้รับ	1	2	3	4	5	6
17. พยาบาลที่อยู่ในหน่วยของข้าพเจ้ามีการร่วมมือและทำงานร่วมกันที่ดี	1	2	3	4	5	6
18. ผู้บริหารของโรงพยาบาลดูแลพนักงาน และพยาบาลเป็นอย่างดี	1	2	3	4	5	6
19. พยาบาลในหน่วยของข้าพเจ้าให้การช่วยเหลือกันเป็นอย่างดีเมื่องานมีความเร่งรีบ	1	2	3	4	5	6
20. ปกติผู้บริหารการพยาบาล จะปรึกษากับคณะทำงานในเรื่องที่เกี่ยวข้องกับปัญหาประจำวันและกระบวนการพยาบาล	1	2	3	4	5	6

21. บ่อยครั้งที่พยาบาลในหน่วยของข้าพเจ้าไม่รู้สึกถึงความเป็นครอบครัวเดียวกัน	1	2	3	4	5	6
22. มีการแบ่งชั้นวรรณะอย่างมากในหน่วยของข้าพเจ้า บุคลากรพยาบาลไม่ค่อยร่วมกลุ่มกับเจ้าหน้าที่ในระดับต่ำกว่า	1	2	3	4	5	6
23. พยาบาลในหน่วยของข้าพเจ้าไม่มีความเป็นมิตรเท่าที่ข้าพเจ้าคิดอยากให้เป็น	1	2	3	4	5	6
24. แม้ว่าข้าพเจ้าจะสามารถได้รับรายได้ที่มากกว่าจากโรงพยาบาลอื่น ข้าพเจ้ายังคงพึงพอใจ ที่จะทำงานทโรงพยาบาลแห่งนี้	1	2	3	4	5	6
25. ข้าพเจ้าพึงพอใจในเงินเดือนที่ได้รับในปัจจุบัน	1	2	3	4	5	6
26. ถ้าข้าพเจ้ามีโอกาสตัดสินใจอีกครั้งหนึ่ง ข้าพเจ้าก็ยังคงเลือกงานที่ทำอยู่ในปัจจุบัน	1	2	3	4	5	6
27. จากที่ได้รับทราบจากพยาบาลที่โรงพยาบาลอื่นพยาบาลที่โรงพยาบาลนี้ได้รับรายได้อย่างยุติธรรม	1	2	3	4	5	6

ข้อความ	ไม่เห็น ด้วย มากที่สุด 1	ไม่เห็น ด้วย 2	ค่อนข้าง ไม่เห็นด้วย 3	ค่อนข้าง เห็นด้วย 4	เห็นด้วย 5	เห็นด้วย มาก ที่สุด 6
28. ข้าพเจ้าปฏิบัติงานใน วอร์ดที่ตนเองเลือก	1	2	3	4	5	6

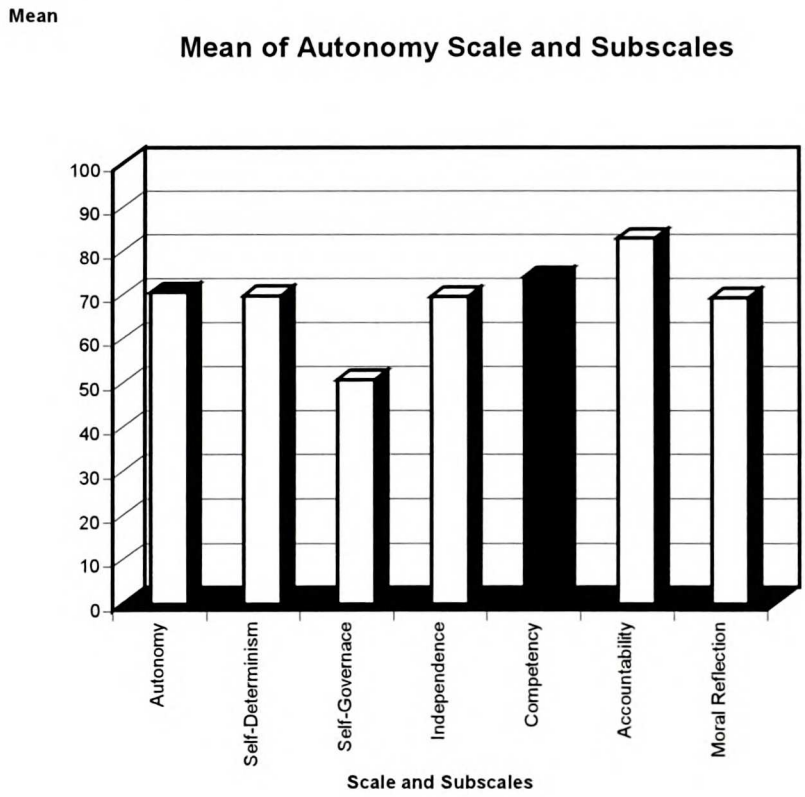
Appendix H

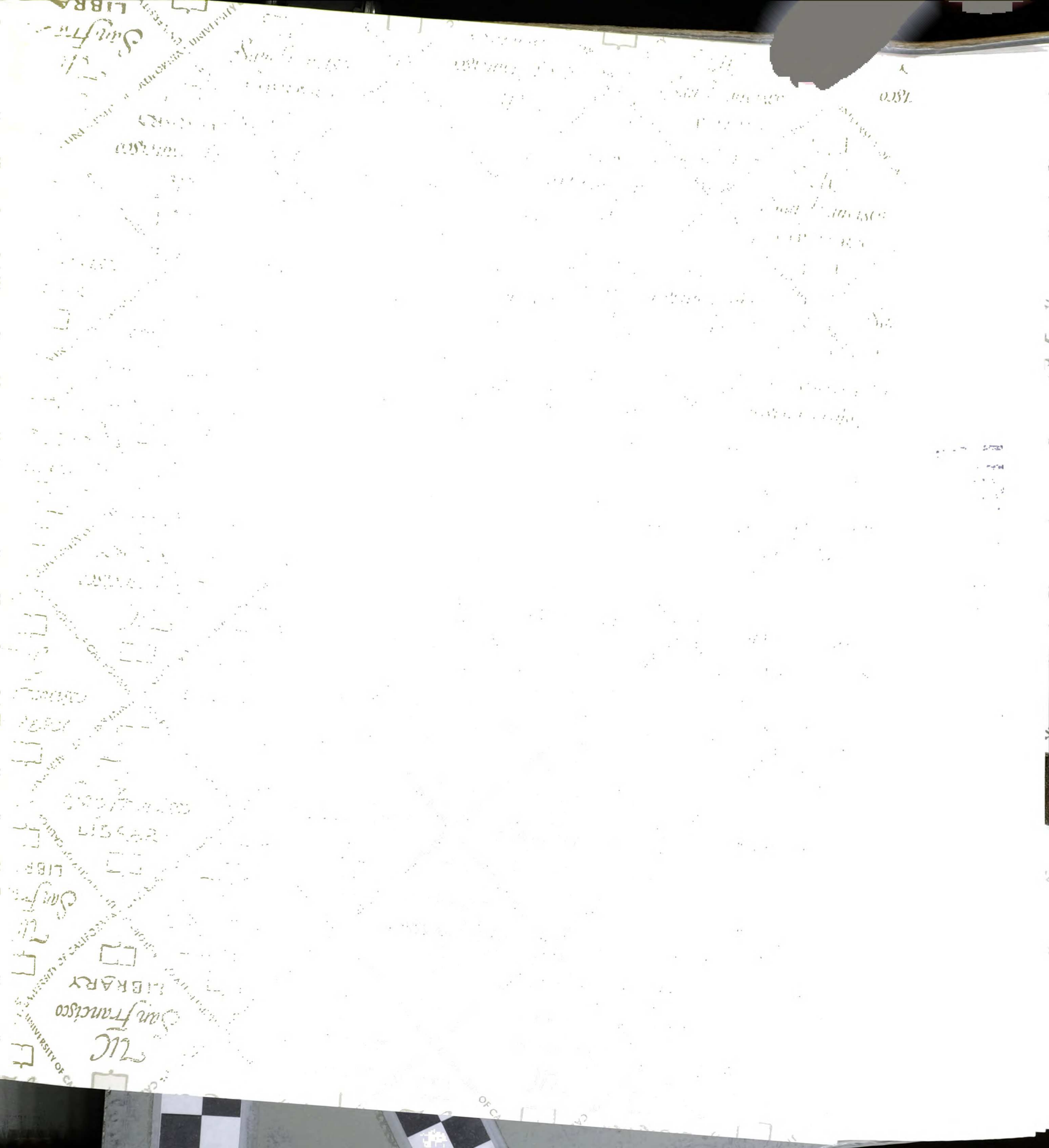
Mean Job Satisfaction


Mean of Job Satisfaction Scale and Subscales
Mean
100
90
80
70
60
50
40
30
20
10
0
Job Satisfaction
Pay and Reward
Profession Status
Interaction and Cohesion
Administration
Scale and Subscales

Appendix I

Mean Autonomy


Mean
Mean of Autonomy Scale and Subscales
100
90
80
70
60
50
40
30
20
10
0
Autonomy
Self-Determinism
Self-Governace
Independence
Competency
Accountability
Moral Reflection
Scale and Subscales



For reference

Not to be taken from the room.

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3 1378 00731 4993