CHAPTER-2
LITERATURE REVIEW

Introduction
The concept of nursing work life has not been defined in the available literature adequately. While some articles have proposed frameworks for examining nurses’ work life, no reports of their being tested or evaluated are evident (O’Brien-Pallas & Baumann, 1992). It is found that a number of interrelated factors influence nurses’ work life, as evidenced in several recent reports. It is understood that the quality of work environment and the quality of work life are influenced by factors which are within the organisation or outside the organisation. The literature review is mainly focus on quality of work environment which include demographic and job characteristics and quality of work life indicators.

Quality Work Environment
There is a growing recognition that work-environment factors affect health system performance (Graham S Lowe, 2006). Basically, the work environment factors affect the quality of work life, individual quality of work life outcomes, and organizational outcomes. The study mainly focuses on various factors such as work hours, schedules, time off, professional development and training, job quality, workload, job satisfaction, work team or unit, quality of supervision and management, organizational change, work-life balance, health and well-being, career plans and basic demographic and employment characteristics affect the work environment and work life of healthcare providers particularly nursing staff (Teresa M et el, 1996, Linda Flynn, 2007, L Dugdill and J Springett, 1994). The Canadian Council on Health Services Accreditation now includes quality of work life as one of the four areas it assesses during the accreditation process. As a result, all accredited organizations are expected to take steps to measure, report, and act on quality of work-life indicators. Employee input on the quality of their work lives has been a weak link in this process. Indeed, much needs to be done to develop effective surveys and other consultation mechanisms. Quality of work environment and quality of work life of nursing staff support “building quality workplaces and Strengthening People”. It is notable that quality of work life was the theme of the 2005 Health Boards of Alberta conference. The Health Sciences Association of
Alberta (HSAA) is one of a growing number of health system stakeholders that recognize work-life and work-environment issues as key ingredients in future sustainability.

International Nursing Council has chosen Positive Practice Environments: Quality Workplaces = Quality Patient Care as the theme of International Nurses Day 2007 (Andrea Baumann, 2007) present health systems are increasingly challenged – faced with a growing range of health needs and financial constraints that limit services’ potential to strengthen health sector infrastructures and workforces. The major and global nursing workforce crisis – one marked by a critical shortage of nurses. The reasons for the shortage are varied and complex (Jeanne M Daffron and Sara E Hart, 2001), but key among them are unhealthy work environments that weaken performance or alienate nurses and, too often, drive them away – from specific work settings or from the nursing profession itself.

A study conducted at in the UK (Zurn, Dolea and Stilwell 2005) reports that a survey of London national health service staff showed that when health workers were asked for suggestions to improve their working lives, ‘better pay’ ranked only fourth on their ‘wish list’, behind ‘more staff’, ‘better working conditions’ and better facilities’. However, there is growing recognition that organisational and environmental factors (e.g. job design, patient flow, management style, ward structure, noise/heat levels) must also be addressed in order to stop the increasing spiral of workplace violence.

A study conducted by Academy for Nursing Studies, Hyderabad, 2005 for Training Division, Ministry of Health and Family Welfare, Government of India, India, found that the critical factors which affect the Indian nursing systems are shortage of staff, poor infrastructure and facilities, weak administrative structure, lack of systematic training programmes on the job or off the job, lack of autonomy and gender disparities.

European Communities, 2004 Quality of the working environment and productivity
Research findings and case studies stated that workers, e.g. training; equipment, e.g. personal and collective protective equipment; working environment, e.g. ventilation; product, e.g. reducing the weight of products that are manually lifted organisation, e.g. safer work methods.

The Statement of the American Nurses Association for the Institute of Medicine's Committee on Work Environment for Nurses and Patient Safety (ANA September 24, 2002, Ann E.K.Page, 2004) reported that the conducive work environment should first enable nurses with decision-making authority and professional autonomy at the point of care delivery and in all arenas where decisions related to care delivery are made. Second, provide safe and appropriate nurse staffing levels. Third, all healthcare facilities and agencies should be required to participate in the collection and external reporting of standardized nursing-sensitive data - both to assess the sufficiency of staffing and to quantify the safety and quality of care for consumers and payers. Fourth, it is time to actively invest in research around staffing, fatigue, safety, and outcomes.

Karol Joenks, RN, BSN, RN C March 2005 INR Features "The Nursing Work Environment" Iowa Nurse Reporter states that some of the work related and patients related issues like length of stay, nursing jobs have been restructured to reduce costs, including substitution of less skilled staff for bedside nurses; more frequent turnover of patients, which increases workload for nurses; high turnover of nursing staff, which results in employees who are less familiar with work processes; shifts longer than 8 hours in both hospitals and nursing homes, both due to the nursing staff’s desire to increase compensation and have more scheduling flexibility, and as a result of employers mandating overtime; more interruptions and paperwork to meet insurance and regulatory requirements, as well as administrative and clinical requirements of health care organizations; an expanding array of treatments, interventions and drug therapies that are being introduced at an ever increasing pace. Further, these issues concentrated in terms of work design (what people do) and physical work environments; workforce capacity (Linda McGillis Hall, 2006) or how the workforce is deployed; the safety culture of health care
organizations, e.g. amount of vigilance related to detecting and redressing errors; and management practices and leadership. As hospitals face an increasingly complex list of challenges (e.g. aging population, cost pressures, and increasing concerns for patient safety) there is much to be gained by applying the rich knowledge base from the field of operations management to many of these problems (Sheila Seda).

Evidence indicates that quality work environments (QWEs) are at the heart of the solutions that significantly affect patient outcomes and professional nursing practice (Marc De Greef, Prevent, Belgium Karla Van den Broek, Prevent, Ruben Jongkind, 2004). Findings from a QWEs literature review indicate the nursing leaders must prioritise efforts to improve the culture in the work environment (Graham S Lowe, 2006). Three elements emerged to help nursing leaders set the tone and standard of practice for QWEs: (1) effective communication (2) collaborative relationships, and (3) promoting decision making among nurses. According to a study many of the participants reported the positive characteristics of work environments as being respectful, collaborative, and rewarding.

Quality work environment is basically an outcome of strong and effective leadership skills. In a quality work place the leadership ensures and facilitates goal alignment, trust and commitment, cooperation and teamwork, problem solving and effective dispute resolution. Leaders who effectively communicate are able to make individuals feel like they belong and are accepted and abandon any fears of rejection and abandonment. In making workplaces work better: sailing the seven C’s of collaborative business relationships, Robin emphasises that the seven C’s (courage, consideration, consistency, clarity, commitment, capacity, and competence) provide a platform for building a culture in which teamwork thrives and people are happy, productive, and able to remain resilient in the face of constantly churning whitewaters (Janne Dunham-Taylor and Joseph Z.Pinczuk, 2004). With increasing evidence that respectful, honest, and open communication may decrease medical errors, collaborative relationships may be the single most important element for Quality work environment (Janne Dunham-Taylor and Joseph Z.Pinczuk, 2004).
Promoting decision making among nurses can be accomplished when there is (1) Governance to approve and support the need to improve performance (move from abusive interactions to collegial and non-abusive environments), (2) Position individuals to champion issues, and (3) understand the environment by collecting analysing and acting on data. When nurses are empowered with the decision making process, there is stimulation of thinking, networking of know-how and learning across the organisation, involvement of all in improving processes, identification of ways to provide additional value, and expansion of what the staff believes is possible (Janie Health, Wanda Jobanson and Nancy Blake November 2004). The nursing practice environment reflects the hospital managers’ approaches to organizing nursing care (Lake, 2002). A professional model of nursing care (characterized by a greater involvement of registered nurses with patients, greater decision making authority and flexibility) is considered preferable to a bureaucratic model (characterized by hierarchical authority structure) (Flood and Scott, 1987). An environment that reflects a professional model of nursing care is hypothesized to improve nurse patient interactions and the perceived quality of patient care, which in turn, results in improved patient health outcomes and greater satisfaction with care (Flood 1994 cited in Jane McCusker, Nandini Dendukuri, Linda Gardinal, Johanne Laplante and Linda Bambonye, 2004). Gail A. Wolf and Pamela K Greenhouse 2006, indicate that “nursing leaders agree that creating a positive work environment is highly desirable. The work environment can support or hinder success in any organisation; the healthcare environment is no different”.

**Work Complexity**

The increased complexity and uncertainty of today’s hospital environment will confront nurse leaders and managers during the next decade. Forces and trends such as changing organizational structures, increased knowledge and technology, increased specialization and interdisciplinary collaboration, consumerism, shifting health problems, health- care policy, women in the work force, and nursing education have a part to play. All these affect the nursing profession and the roles, functions, and skill requirements of nurse leaders, managers, and supervisors within hospitals.
It is observed that the nursing workload is distributed unequally across the shifts due to lack of planning of OPD schedule, OT Schedule, non-availability of specialized staff and non-flexible routine work schedule of the hospital. As a result of these the effective working hours increase or decrease. A study found that the adequate number of effective working hours (the hours spent only on patient care) is positively associated with reduction of average length of stay of patient (Thomas A Lang, Margaret and Valerie Olson, August 2004). It was also found that lack of attention is given to practice development and activities that do not promote a professional structure lead to inefficiency in work. Nursing staff also have the responsibility of patient satisfaction (Springett J and L.Dugdill, 1995). To increase satisfaction with nursing care, the care should be tailored for the individual patient. This situation demands a very high level of knowledge, skills and positive attitude from the nursing staff, hence they are required to take very high level of responsibilities in this regard (Naomi E Ervin, 2006).

Highly reliable hospitals for patient care begin with the nursing leaders’ view of the organization as a voluntary association of members who have expertise and choices in their work. Through nurses’ involvement in promoting the collective understanding of the relationships and subtleties of the organisation, more reliable systems will evolve that enhance the work quality of the nurse and promote patient safety (Kathly A. Scott April 2004). The need of today is that the nursing leaders should be prepared to navigate the political and policy-making systems in their countries. In order to influence changes needed to positively impact health systems (Royle J A et al June 2000) and the nursing profession, they need to understand how systems work in the international world of policy-making and politics (Report From ICN/FNIF). The development of an environment in which nurses feel their work is understood and supported and that their professional development is valued is critically important to the success of any effort to enhance the environment for care. A coherent environment needs to exist at both the unit and institutional level (Patricia Reid Ponte, Nancy Kruger and Rsanna DeMarco April 2004).
Healthy workplace
A healthy workplace is most important for a dedicated staff. Most people prefer to work honestly and sincerely and try to give their best to the organization (Joanne Profetto-McGrath et al., 2003). Unfortunately, the situation that exists in many hospitals continues to suppress the honest feelings of the staff. Research demonstrates that nurses are attracted to and retained at their place of employment when opportunities exist that allow them to advance professionally, to gain autonomy and participate in decision-making, while being fairly compensated. Factors in the workplace can be critical in both encouraging retention and in reducing turnover of nurses (Ellen Lanser 2004, Micael N 2004, Lawrence S Levin, 2004, Emily J Wolf 2004, Koichiro Otani and Richard S Kurz 2004, Donna K McNease – Smith, 2001, Mike Nolan, Ulla Lundh and Jayne Brown, 1999, Michael P.O’driscoll, Jon L Pierce and Ann-Marie Coglan, 2006).

Unhealthy work environment
Unhealthy work environments lead to absenteeism, ineffectiveness in healthcare delivery, stress, and discord among healthcare colleagues. Often, characteristics of unhealthy work environments are subtle but can be seen in the way individuals interact on a day-to-day basis with each other. For more than a decade, evidence of unhealthy work environments, such as abusive behaviour (Randy Hodson, Vincent J Roscigno and Steven H Lopez), has been reported. However, there continue to be places in which abusive and disrespectful interactions between colleagues are the norm. Whether the interactions are nurse to nurse, or even patients and families to nurse, the disrespectful and non-collaborative behaviours make for an unhealthy work environment and create negative and unsafe conditions (Janie Health, Wanda Jobanson and Nancy Blake November 2004).
Multiple Work Environments

The nursing staff have to work in multiple work environments which influence their behaviour to a large extent. The details of multiple work environment of a nurse are presented below:

The multiple environments that influence the care providers’ behaviour

<table>
<thead>
<tr>
<th>1. Immediate environment</th>
<th>Interaction with patients and staff members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Personal environment</td>
<td>People with meaningful relationships with the practitioner; personal preferences and values, etc.</td>
</tr>
<tr>
<td>3. Professional environment</td>
<td>Colleagues, professional associations, certifying bodies, licensing or credentialing system and its regulations, etc.</td>
</tr>
<tr>
<td>4. Administrative environment</td>
<td>Rules, regulations and laws that govern provider behaviour, working conditions, facilities, healthcare education programmes, etc.</td>
</tr>
<tr>
<td>5. Educational environment</td>
<td>The opportunities for education that exist, the basic education system, higher education system, healthcare personnel education system and continuing education and other learning opportunities that are available, both formal and informal.</td>
</tr>
<tr>
<td>6. Community environment</td>
<td>How the practitioner’s profession is perceived in the wider local/regional community, in the media and among opinion leaders and decision-makers in health and healthcare</td>
</tr>
<tr>
<td>7. Social environment</td>
<td>The traditions and culture of the larger society</td>
</tr>
<tr>
<td>8. Economic environment</td>
<td>The history of and prevailing economic conditions in the country, especially as they affect healthcare personnel</td>
</tr>
<tr>
<td>9. Political environment</td>
<td>The dominant ideologies, political structures, etc. that set limits on types of political actions that are acceptable.</td>
</tr>
</tbody>
</table>

The above table is adapted from Christel A. Woodward, C. Psych 2000 “Improving provider skills Strategies for assisting health workers to modify and improve skills: Developing quality health care - a process of change”, World Health Organization, Geneva
Quality of work life

The concept of quality of work life (QWL) deals with the issue of how rewarding or satisfying the time spent in the workplace is. As such, QWL may reflect working conditions and contextual issues such as relationships with work colleagues and the intrinsic satisfaction of the job itself. A movement focusing on employee perceptions of job satisfaction and job challenges, health and safety at work, job fulfillment and working conditions and the balance between work and non-work. The movement has promoted such things as flexitime, autonomy, employee participation in decision-making, etc. Underlying this use of QWL is the belief that it enhances employee performance and productivity; however, empirical proof of this relationship is not conclusive. Quality of working life is dependent on the extent to which an employee feels valued, rewarded, motivated, consulted, and empowered. It is also influenced by factors such as job security, opportunities for career development, work patterns, and work life balance.

Khani A, Jaafarpour M, and Dyrekvandmogadam. A explain QWL is essentially a multidimensional concept, and is a way of reasoning about people, work and the organization. It seems that the relationship between QWL and the degree of the nurse’s involvement in their work is a critical factor in achieving higher levels of quality of care delivery. In health care organizations, QWL factors have recently been recognized to significantly influence the performance of staff members, and QWL also refers to strengths and weaknesses in the total work environment. Quality of Work Life (QWL) focuses on the degree to which registered nurses are able to satisfy important personal needs through their experiences in the work organization, while achieving the organization's goals, to make meaningful contributions to their organization.

Preliminary evidence suggests that improvement of QWL is a prerequisite to increasing productivity in hospitals. Thus, QWL is in need of scholarly investigation. Identifying the nurse’s quality of work life can provide critical information for nursing managers in their efforts to design managerial programs that will enhance retention and work productivity.
The first is termed the “work life-home life dimension”, or the interface between the nurse’s work and home life. Since nurses are primarily female, this dimension reflects the role of mother (child care), daughter (elderly parent care), and spouse (family needs, available energy). The work design dimension is the composition of nursing work, and describes the actual work nurses perform. The work context dimension includes the practice settings in which nurses work and explores the impact of the work environment on both nurse and patient systems. Finally, the work world dimension is defined as the effect of broad social influences and change on the practice of nursing.

Blair D. Gifford et.al 2002 pointed out hospitals follow bureaucratic cultural norms which emphasise hierarchical structures, rules, and regulations, and heavy measurements of outcomes and costs may not be the culture most conducive to enhancing nurses’ job satisfaction and commitment. The author considers the quality of work life factors are organisational commitment, job involvement, empowerment (Wet-Hwang and Ann E Rogers, 2006 J Organiz, Behav 2005) and job satisfaction which may reduce the turnover.

Thomas M. Gehring, Jeannette Widmer, Oskar Bänziger & Daniel Marti, 2002 state that consensus exists among professionals from various fields that stress-related psychological or health problems constitute important issues in today’s work environment. The importance of this issue is widely recognized, even in the absence of an agreed-upon definition and operationalisation of the construct of stress. In modern concepts, theories of work requirements and stress have evolved from a unidirectional response to environmental factors) e.g. daily hassles to a complex bi-directional relationship integrating environmental and personal factors such as coping strategies and social support (Kanner, Coyne, Schaefer, & Lazarus, 1991; Lazarus & Folkman, 1984; Thoits, 1995). The researchers mentioned irregular working hours, ‘ineffective’ meetings and extended medical administration as examples of stressors. It can be assumed that large workloads, continual time pressure and related stress are inherent characteristics of today’s high tech medical settings. The challenge of such situations necessitates supervision and specific training programs to increase individual coping and stress management, as well as
efforts for enhancing team development which can be provided by research on the perceived quality of work- and stress-related coping strategies can significantly contribute to a systematic conceptualization and implementation of preventive or health-promoting interventions in work settings.

The above review of literature on work environment and quality of work life brings the following understanding:

All these studies concentrated on multiple variables and each study focused on different variables and overall it could be noticed that a number of variables have been consistently focused on all the researches. The independent variables are demographic variables such as age, experience, occupation, income, designation, type of work, work related issues and job characteristics. Apart from these variables some of the variables like physical conditions like resources availability, adequate nursing staffing and psychological variables like supervisor support, professional development, respectful relationship, etc. are also important according to the studies. The variables primarily operate in the work environment. Any development or change in these variables ultimately affects the quality of work life of the nursing staff. The determinants of the quality of work life emerging from the literature review is work life balance, work stress, absenteeism, communication, job satisfaction, organisational culture, and performance. These variables form the quality of work life indicators and are also called dependent variables.

It is expected that the changes in work environment largely affect the work life of nurses. It can be understood that the quality of work life nurses by looking at the quality of work life indicators like work life balance, work stress, absenteeism, communication, job satisfaction, organisational culture, and performance.
2. FACTORS AFFECTING THE QUALITY OF WORK ENVIRONMENT AND WORK LIFE OF NURSING STAFF

The factors can include all that occur both within and outside the organisation. The significant factors include work life balance, job resources and conditions, training and professional development, work teams and relationships, supervision and management, organisational culture, service quality and patient safety, work place and employees’ health, and employees’ work experiences and plans.

WORK TIME

Time available for personal and family

The employees prefer to work a fixed number of hours in a day/week/month. This is because the staff would like to spend quality time with their family. However, it is not supported many a time due to heavy work load and shortage of staff. In this situation the staff has to work either over time or longer hours. Sometimes the staff do not get a weekly off or weekly holidays. All these issues have an influence on the quality of work life.

Nurses, as providers, interact most with patients, and provide round-the-clock direct patient care. Studies suggest poor patient outcomes, such as increased infections and respiratory failure, occur when there is inadequate nursing staff. Furthermore, nurses thwart medical errors. For example, nursing staff have been shown to intercept almost 90 per cent of medication errors before they reach patients. Although nurses do act as a last barrier to harm, much improvement in their work environment is needed to promote safety (Laura Lin, Bryan A. Liang, January-March 2007). The nature of traditional nursing work presents significant barriers to implementing policies and practices associated with achieving employee work-life balance. Professional advancement through the development of clinical skills in a nurse-led service; and a different working hours’ environment to retain nurses who might otherwise leave nursing. Work life balance policies are directly associated with the working hours of the nursing staff.
Shift System

Three elements of work organisation emerged as pivotal in determining nurses’ working hours and their control over the balance between their work and their home life: the management of work hours; the degree of mutual dependency of nurses within teams; and the nature of patient care. Hospitals usually follow different shift timings. This could be 6 hours, 8 hours, and 12 hours duration. The shift includes formal break timings 15 minutes for tea break and 30-45 minutes for lunch. Often the nursing staff do not avail the break due to heavy workload or shortage of nurses. A study reported (Ann E Rogers, Wei-Ting Hwang, and Linda D Scott, November 2004) among the 5211 shifts there were 534 (10 per cent) shifts in which nurses have no opportunity to sit down for a break or meal and another 2249 (43 per cent) shifts in which nurses reported having the time for break or eat a meal but were not relieved from patient care responsibilities. Nurses were completely free of patient care responsibilities during a break and or meal periods in less than half of the shifts they worked. Also shift timings is one of problems for nurses because the organisations are unable to decide the right shift timings for the nurses sometimes the nursing staff have to cope with long shift hours or have difficulty traveling at odd hours (Lotte Bailyn, Robin Collins and Yang song, 2007).

Break During the work shift

The frequency and timing of breaks may be more important than the actual duration of break period during a work shift. Several studies have shown that shorter, more frequent breaks improve productivity and reduce fatigue in a variety of manufacturing and laboratory settings. Muscle fatigue, lower extremity discomfort, repetitive strain injuries, and eyestrain were also reduced, without any loss of productivity when short additional breaks (eg, 5 minutes every hour, 3 minutes every 27 minutes, and 9 minutes) every 51 minutes were added to regularly scheduled break period (2.15 minute breaks and a 30-minute lunch period or 1.15 minute break and 1.10 minute break plus a 45 minute lunch break). Also, it is reported that 40 per cent of the shifts exceed 12 hours. It was found that 189 errors were reported by 119 (30 per cent) nurses during the 28 day period during the shifts with known break and meal timings (Ann E Rogers, Wei-Ting Hwang, and Linda D Scott, November 2004 cited in Janne Dunham-Taylor and Joseph Z.Pinczuk, 2004).
It could be possible such error can bring the risk to the patients. The nursing supervisors should develop a culture on their units that encourages staff members to take breaks and eat meals free of patient care responsibilities so that the nursing staff able to get breaks.

Overtime

Overtime causes a great deal of concern to nurses working in many different systems, but there are very few studies of how overtime affects outcomes. In a review (McGillis Hall 2004) recommends that employers and professional associations should support accurate measurement and monitoring of the amount of overtime worked in health care settings and that, in future, studies of patient and nurse outcomes in different work environments should include overtime as a component of the theoretical models (Richard L.Daft. 2000, Sarah Wise, Chirs Smith, Raffaella Valsecchi, Frank Mueller and Jonathan Gabe, 2007).

JOB RESOURCES AND CONDITIONS

Resources and Demands

Job resources influence an employee’s quality of work life. Employees’ immediate job situation can either hinder or enable their contributions to their employer’s goals (Jane W Licata et el. 2003). Hospitals face a shortage of all types of resources including human and material resources. Many hospitals are unable to supply required material for even routine patient management. In certain cases the nurses are not provided with the essential safety protection material.

Job Conditions

The present era of cost containment pressures means that nurse executives like Matron, Assistant Matron, Nursing Officers and Senior Nursing Supervisors need to ensure that nurses have a work environment with the characteristics of work known to be linked to job satisfaction, motivation and good outcomes. In healthcare practice improving the relationship between motivational tendencies, professional development and personal development among healthcare professionals would lead to better performance to the employees (Glen, 1998; Lley,2004). The autonomy, communication, adequate time for patient care (Aronowitz and Munzert, 2006) and
the degree of environmental uncertainty are some of the job conditions to contribute to the job satisfaction and work motivation of nursing personnel (Freeman and O’Brien.Pallas, 1998).

**TRAINING AND PROFESSIONAL DEVELOPMENT**

*Training needs*

Opportunities to develop one’s skills, abilities, and scope for career advancement are important job characteristics. The challenge this poses for employers is finding an effective and accessible means for delivering training to relatively small groups of workers. Meeting such diverse training needs may be easier to achieve by initiatives involving cooperation among employers, and professional associations (Herbek A and Francis J Yammarino, 1990).

*Organisational Learning*

Organisational learning (Leda Vassalou, 2001) has been defined as a process of improving organisational actions through better knowledge and understanding (Garvin, 2000). One can say that an organization has learned when it changes its activities in response to new knowledge or insight, typically resulting in improved performance (Garvin, 2000). An organisation that establishes the environment where the knowledge shared mutually and continued professional development is ensured is called a learning organization (Terry Capuano, Joanna Bokovaoy, Deborah Halkins and Kim Hitchings, May 2004, Mary E Tiedenan and Sandra Lookinland June 2004). Healthcare is one of the most knowledge-intensive industries in any country. So it is essential that work environments support ongoing learning and the continuous development and use of employees’ knowledge. This expands our thinking beyond training programs to consider how skills and knowledge are continuously renewed on the job - what is often called a “learning based work environment: use of skills, knowledge, and abilities; being able to take initiative; and learning new ways to do one’s job better (Graham S Lowe, 2006, Joanne McCloshey and Helen K Grace 1994, Chenowthem L., Jeon Y.H., Goff. M & Burke C. 2006, Lisa M Korst, Alea C Eusebio-Augeja, Terry Chamorra, Carolyn E Aydin and Kimberly D Gregory, 2003).
**Performance Appraisals**

Performance appraisals are a standard human resource management practice in most large organizations. While regular feedback on job performance is essential, a formalized annual performance appraisal helps to ensure that supervisors help employees to set, and then achieve, job performance and professional development goals (Muneera Bshier, September 2005). Human resource professionals recognize that employees are better able to fully contribute to the organization’s goals if they receive constructive feedback and support for development through various communication channels, including performance appraisals (Ugur Yavas and Donald J Shemwell, 2001). However, an effective performance appraisal system can be difficult to implement, especially if front-line supervisors are responsible for large numbers of staff as is the case with nursing supervisor. Therefore, the employees’ understanding about performance appraisal systems and how it is perceived by the employees for professional development is important (Christopher McDermott and Gregory N.Stock 2007, John Ovretveit 2005).

**Professionalism**

According to the Healthcare Leadership Alliance (HIA) “the professionalism competency is the ability to align personal and organisational conduct with ethical and professional standards that includes a responsibility in the patient and community, a service orientation, and a commitment to lifelong learning and improvement” (Andrew N Garman, Ruper Evans Mary Katherine Kraue and Jamos Anfossi 2006). A professional can understand the roles and norms where by he/she demonstrates the skills of establishing a role model to others. The professionals could involve themselves in cultivating and managing working relationships with others. Professionals who are dedicated to their work also know to manage themselves. They ensure meaningful contributions to the tasks which they perform. The professionalism can be developed by creating a set of skills and competencies (T.C.Ayre et.el., 2007, Chenowthem L., Jeon Y.H., Goff. M & Burke C. 2006). An employee who joins an organisation at any level can develop the professional competence and try to build on it. Professional building (D Allen 2007) includes higher education, a distinct service or practice discipline, a research based body of knowledge, autonomy (self governance) and accountability, a code of ethics and an
association to organise, serve and speak for members and public welfare (Ellen G Lanser 2001). Nursing staff happen to follow the said approach.

WORK TEAMS AND RELATIONSHIPS

Work Teams or work Units
Both the quality of work life and job performance depend on effective systems and positive relationships within work units. Work units, or teams, are the basic building blocks of organizations (Lawrence S Levin, 2004). Many studies highlight team work and its importance in the organisation. Team work will bring better results than individual work. It has been observed that nursing staff work alone in many situations where team work could be possible (Peg Thomas 2002). Apart from this the working relationships, and rules, policies and processes also influence how work gets done at the unit level (Pat Dixon, Alison Pickand and Heather Robson, 2002, Jeanette Lves Erickson, Glenys A Hamilton, Dorothy E Jones and Marianne Ditomassi, 2003). The possible work teams of nurses could be members such as Infection control committee, Waste Disposal Management committee, Medical Audit committee, Quality Assurance and Quality control team, and other committees. In addition to the above, creating positive change to move a leadership team forward in a learning environment would improve the team relations (Karen S Hill, 2003).

Relationships and patient care
The work teams and work relationships affect work life and performance of the staff. Effective teamwork and positive workplace relations are essential ingredients of quality health care—and the quality of work life for those who provide healthcare services (Susanne Yeaked et el 2003, Christian M Graf, et el. 2003). Nurses manage the care of multiple patients in environment where interruptions to work processes, barriers in communication, and inefficiencies in supply and resource access are the norm. Barriers and distractions in the healthcare environment make it highly difficult for the nurses to know the needs of patients and to make timely clinical decisions on behalf of patients. If working relationships between the team members are ineffective, or worse, dysfunctional, the potential for quality of nursing care will be threatened. The philosophy of caring for “our”
patients vs. “your” patients is an important prerequisite to develop any sense of teamwork (Patricia Potter and Eileen Grant, 2004, Victoria J skorupski and Ruth E Rea, 2006).

**Respectful Relationships:**
Respect is a moral principle that implies valuing another person’s essential dignity and worth. Respectful workplace relationships contribute to employees’ psychological well-being and to teamwork. Effective communication and collaboration depend on mutual respect (Graham S Lowe, 2006). Many factors affect the mutual respect of among the nurses because of lower professional status about the profession (Laura Lin, Bryan A. Liang, January-March 2007). Secondly the profession also suffers from a gendered understanding of the role. Even a student nurse perceives that nursing is a girl’s job and accepts that there will be very few carrier advancement opportunities Melanie Wilson, 2002, Pui-Mum Lee, Poh wah Khong and Dhanjoo N Ghista, 2006, Ali Mohammad Mosadegh Rad, 2006). Yet, Heather K. Spence Laschinger indicates, “Nursing staff felt that managers did not show concern or deal with the staff in a sensitive and trustful manner regarding decisions affecting their jobs” (Heather K Spence Laschinger, 2004). On the other hand, the positive work environment increases nurses’ perception on respect, resulting in positive outcomes for both the nurse and the organisation (Shari S Cohen 2005, Ellen G Lanser 2003).

**SUPERVISORS AND MANAGEMENT**

*Resources and Support for Supervisory Roles*
Supervision plays a crucial role in nursing management (Deboarab J Kelly, January 2004). Majority of the supervisors are senior staff. The primary responsibilities of the supervisors is to understand the need of the staff, provide necessary resources, facilitate the process, guide and coach the staff, assess the performance and ensure smooth functioning of the department. But in a situation they are not provided with authority and hence they are unable to satisfy their job requirements. In certain situations the supervisors themselves are unable to cope with work requirements (Barrie D. Pettman and Gerard Tavernier, 1976, Patricia Potter and Eilen Grant,
2004, Joe Kavanaugh, Jo Ann Duffy and Juliana Lilly, 2006). This is due to the organisational climate and the work culture.

**Immediate Supervisors**

Supervision is one of important aspects of nursing life. The nursing supervisors are expected to do carry out many functions which will aid in providing timely and constructive feedback to the nurses. The supervisors job involves assessing the nursing staff performance, helping them to achieve work-life balance, supporting their career development, encouraging the them to be innovative, listening to and acting upon their suggestions and ideas, encouraging teamwork, creating a work environment free of harassment, discrimination and sharing information, etc. Motivation, leadership skill development, and a responsive environment relate to staff nurses’ self-efficacy development (George et. al., 2002, Iley, 2000) are other important roles of supervisors (Zydziunaite Vilma and Katiliute Egle, 2007).

**Consultation with Employees**

In knowledge-based organizations, it is essential for managers to tap into employees’ ideas and provide opportunities for them to contribute to decisions affecting their work lives. Involving employees in these ways benefits performance and gives employees a much greater sense of “ownership” about their jobs and the organization’s goals particularly those that concentrate on workplace safety, service improvement, work process improvement, team effectiveness, workplace health promotion, and quality of work-life improvement.

**Mutual recognition**

Nurses are concerned about recognition which has a positive effect on patients and their families and the organisation as whole (Pat Dixon, Alison Pickand and Heather Robson, 2002). In addition, they want to have opportunities to grow and develop competency in a variety of areas because it is satisfying to master new skills and it opens new career doors (Barbara Hensinger, et.el, 2004). The management values should guide human resource policies and practices. There is a growing recognition among management experts that excellent organizations have
cultures that value employees (and physicians, volunteers, and student interns, in the case of health care) as core assets.

**Nurse patient Ratio**

Varying intensive care unit nurse–patient ratios also have an effect on patient outcomes. For example, fewer nurses at night caused an increased risk for specific postoperative pulmonary complications in patients undergoing hepatectomy surgery (Dimick, Swoboda, Pronovost, & Lipsett, 2001). There was also a significant increase in complications and use of resources, such as intubations, with patients receiving postoperative care in the intensive care unit with a nurse–patient ratio of 1 to 3 or higher. Surgical patients have also experienced a higher risk of death and injury from infections and other preventable complications when fewer nurses care for them (Aiken et al., 2002). Importantly, it was also found in this study that nurses in hospitals with low nurse–patient ratios are more than twice as likely to experience job related burnout and dissatisfaction with their jobs when compared to nurses in hospitals with the highest nurse–patient ratios, also adequate staffing has direct impact on the patient outcomes (Suliman W. A. 2006, Linda Burnes Bolton, et al. 2003).

**Span of control**

This refers to the number of people reporting to a single manager, supervisor or leader. Span of control may be influenced by the degree to which the staff perform similar functions, geographical proximity and the degree to which direction, control and co-ordination are required by staff. It describes the number of ‘layers’ in the hierarchy of an organisation and has been the subject of debate among organisational theorists for many years (Barrie D. Pettman and Gerard Tavernier, 1976, Matthew Smith and Beth Engelbrecht, 2001, Cedric B. Finch, Dr. D. K. Sharma, Dr. R. C. Goyal 1999). McGillis Hall 2004 concludes that there is evidence to suggest that span of control influences performance measures that have been found to affect patient outcomes. It also has a moderating effect between leadership and performance, with wider spans of control appearing as detrimental to the relationship between managers and staff. The review argues that there is a need to develop an instrument for measuring span of control.
NURSING LEADERSHIP

Addressing the challenges facing the nursing profession, including the impact of constantly changing health systems and nurses’ work environments, requires effective leadership (Robert J House, Sep. 1971) and management abilities at all levels – organisational, local, regional and national. The pool of current and future nurse leaders is diminishing (Ann E Tourangeau, 2003, Robert W cooper et el 2003). Leadership development is a critical aspect for positive and sustainable change today and into the future. Nurses who are or will be in key leadership and management positions need to be prepared to manage rapid change in a globalised and technologically driven world and a world with limited financial and human resources (Marylene Gagne and Edward L deci, 2005). Today’s and tomorrow's nurse leaders and managers need to demonstrate competence (Ziaul Huq, 1996, Sharon C Bolton, 2003) in such areas as strategic thinking and planning, staff development and management, performance appraisal systems, organisation culture and development, communication, negotiation, interpersonal relations, problem-solving, conflict resolution, customer service, equipment and resource management, quality improvement, safety and disaster planning, financial management, networking, politics and policy development, teamwork, and fundraising.

Nurse leaders in executive level collaborative (Pat Reid Ponte, Et.el. 2003) management and policy positions must not only exhibit excellence in the above competencies, but also understand global governance and finance mechanisms, regulation, how to network and how to build alliances and coalitions to politically leverage and articulate the value of nursing with key players in national, regional and international organisations (Richard W Redman, 2006). These nurse leaders need to be prepared to navigate the political and policy-making systems in their countries (Report from ICN/FNIF 2007, John Ovretveit 2005). Highly reliable hospitals for patient care begin with the nursing leaders’ view of the organization as a voluntary association of members who have expertise and choices in their work. Through nurses’ involvement in promoting the collective understanding of the relationships and subtleties of the organisation, more reliable systems will evolve.
that enhance the work of the nurse and promote patient safety (Katry A. Scott April 2004).

Organisational success in obtaining its goals and objectives depends on managers and their leadership style. By using appropriate leadership styles, managers can affect employee job satisfaction, commitment and productivity (Kelly A. Goudreau and Jacalyn Hardy, 2006). Leadership style can be viewed as a series of managerial attitudes, behaviours, characteristics and skills based on individual and organizational values, leadership interests and reliability of employees in different situations (Mosadeghrad, 2003). It is the ability of a leader to influence subordinates to performing at their highest capability (Marjorie Beyers, 2006, Liisa Knokkanen and Jouko Katajisto, 2003, Heather K Spence, et el. 2003). These aspects capture the extent to which management respects workers, operates with honesty and integrity, promotes efficiency, and has open lines of communication with employees (Aronson et al. 2003).

ORGANISATIONAL CULTURE
The culture of a work organisation drives the behaviour of its employees. Culture is the set of values specific to a work unit (Mallick and Jurstedt, 1996). These values embody certain assumptions about work, working together, commitment to the work (Thomas Joseph McCabe and Thomas N Garavan, 2008, Sue Jackson, 1999) and how things should be done given specific contexts. These values, in turn, drive the nursing staff to work together in a critical situation and allow them to work within the framework of rules and regulations of the hospital (Doreen K Frusti, Kathryn M Niesen and June K Campion 2006, Shannom K Pieper 2003).

SERVICE QUALITY AND PATIENT SAFETY
Safety Culture
Hospital Administrators are currently struggling with the challenges associated with reducing medical errors and improving patient safety. It is necessary to have a system improvement “concentrated effort” on the part of many individuals, from patients to policymakers (Kathleen L. Mc Fadden, Gregory N Stock, and Charles R. Gowen III, 2006). These general assessments need to be complemented with an
understanding of how workplace behaviour contributes to safety and quality goals. It is necessary to understand what would happen in their area if someone made an error that put patient or client safety at risk. Would the error be reported? Would the team learn from the mistake? Would co-workers and management take appropriate action to ensure it did not happen again? The issues raised by these questions form the core of a safety culture (Sandrine Cueille 2006). Creating a safety culture in healthcare involves making patient safety (Nancy Kruger, Ann C. Hurley and Michael Gustafson, 2006) the number one priority within the hospital and having the commitment as well as the ability to address patient safety issues. Rather than apply the traditional approach of “naming, shaming, and blaming” when errors occur, a safety culture encourages and supports shared reporting of errors openly in non-punitive, positive environment. This idea means that the culture supports the idea that anyone can make mistakes. This strategy depends on shared values and norms of behaviour articulated by top management and translated into effective work practices (Gabla et.al 2003). The joint commission on Accreditation of healthcare organisations (JCAHO) has recently approved 2003 National Patient Safety Goals, “To address this complex issue of errors, healthcare organisations and professionals must collaborate in identifying barriers to and strategies for improving patient safety” (Mary Miner Hansen Et.el. 2003).

**Service quality**

Quality and safety (Margareta Jensen Lundquist and Asa Axelsson, 2007) are priority goals in health care delivery in fact many Indian hospitals are trying improve the quality systems and measure the hospital performance (Usha Manjunath, Bhimaraya A. Metri and Shalini Ramachandran, 2007, Clare Chow – Chua and Mark Goh, 2002). The organisation is expected to maintain quality and standards up to the satisfaction of patients (Eva Lindberg, and Urban Rosenqvist, 2005, Jean Ann Seago, et el. 2006, Donald E Determer, 2001, Kenneth W kizer, 2001). It is necessary to assess the quality from time to time with standard scale.( Anne E. Tomes and Stephen Chee Peng Ng, 1995, Karin Newman, Uvanney Maylor and Bal Chansarkar, 2001, Ugur Yavas and Donald J Shemwell, 2001, A.F. Al-Assaf, 1996). Every employee in the organisation should know the impact of err in healthcare delivery. Patient safety and security are the main components in service

WORKPLACE AND EMPLOYEE HEALTH

Workplace and Employee Health

Having a healthy and safe work environment is a basic aspiration of all workers (Richardson and John Thompson, 1995). There is ongoing concern that health care workplaces, compared with other industries, not only pose a higher level of health and safety risks to workers, but in turn affect the capacity to deliver quality health care. High rates of absenteeism, injury, and work stress are healthy workplace indicators (Kris Siddharthan, et al. 2006). When there is a high level of environmental uncertainty, nurses perceive that their contributions to both patient care and organisational outcomes are under-recognised. This can result in negative psychological consequences such as burnout (Jonaton R B et al. 2004, Darlene K Garrett and Anna M McDaniel, 2001).

Employee Health and Wellness

Nurses serve other individuals who are in need of care, physical and emotional health. It is necessary that every employee possesses sound health while providing health care to others. Here, the physical and emotional health of staff is critical. A healthy employee can respond to the needs of colleagues, patients and others.

Absenteeism and Presenteeism

Absenteeism is a commonly used as workplace indicator (Thomas Lund et al.). Lower absenteeism rates are assumed to indicate a healthy employee population and work environment. Absenteeism is also a major cost, in the form of lost productivity associated with unhealthy work environments. Some of the main issues for management arising from nurse absence are provision of counseling/occupational health, quality of care; impact on continuity of care; productivity; organisational costs; effect on remaining staff; times spent organizing cover; time spent by remaining staff monitoring temporary staff; attendance control policies and practice; measuring and monitoring absence; and building in absence rates in
staffing level. A study reports that the absenteeism rate reduces while the length of services increases. At the same time, there is a growing recognition that low absenteeism can mask another problem: presenteeism. This refers to employees coming to work when they are ill or injured instead of taking time off to care for themselves. This behaviour could be due to heavy workloads, or it could be an unintended consequence of attendance management programs or the fear of loss of pay.

**Work Stress**

Over the past two decades, there has been a growing belief that the experience of stress at work has undesirable effects, both on the health and safety of workers and on the health and effectiveness of their organizations (Tom Cox, Sue Cox and Dr. Amanda Griffiths). Dewe (1987) found that the nursing staff have enclosed atmosphere, time pressures, excessive noise or undue quiet, sudden swings from intense to mundane tasks, no second chance, unpleasant sights and sounds, and standing for long hours” which contribute to nurse work stress. He concluded that nursing is, by its very nature, a “stressful” profession (Tom Cox, Sue Cox and Dr. Amanda Griffiths). Job-related stress is one of the commonly cited symptoms of poor quality work. Today a fast life style is the norm (Wet-Hwang and Ann E Rogers, 2006). People expect quick results and want to accomplish things very quickly. Employees in the organisation have to meet many challenges, and demands of modern customers which lead to high levels of tension. Also, many other organisational factors such as shortage staff, lack of resources, poor policies, lack relationship etc., add to the stressed of the employees (Janne Dunham-Taylor and Joseph Z.Pinczuk, 2004).

Nursing is acknowledged to be stressful work, and there is a need to understand the nature of that problem and to better manage it. Both, anxiety on tangible hazards of nursing, and exposure to the psycho-social hazards associated with that work can give rise to the experience of stress. In turn, that experience can detrimentally influence job satisfaction, psychological well-being and physical health (Tom Cox, Sue Cox and Dr. Amanda Griffiths).
EMPLOYEES’ WORK EXPERIENCES AND PLANS

Job Satisfaction

Job satisfaction relates to how nurses feel about their work life (My-Tien N.Ton and Jo-Ida C Hansen, 2001). A study by (Weisman and Nathanson, 1985) reported that the job satisfaction level of nursing staff was the strongest determinant of the aggregate satisfaction level of clients. However, it is difficult to measure because it is closely related to economic and social issues associated with the provision of adequate work environments. The absence of adequate remuneration is a major reason for migration of nurses to many parts of the world. However, studies have shown that in developed nations money becomes a major issue only in the absence of other sources of satisfaction (Weisman & Nathanson 1985). Nurse satisfaction is also affected by overall factors such as government support, physical infrastructure support, and employer commitment to nursing services. Job satisfaction has a number of facets, such as satisfaction with: work, pay, supervision, quality of work life, participation, organisational commitment, and organisational climate (Lum et al, 1998 cited in Joe Kavanaugh, Jo Ann Duffy and Juliana Lilly, 2006). Also the factors like age, education, job tenure, salary, job characteristics, have some influence on the job satisfaction of the employee. (Katherin H Shavar and Linda M Lacey) indicates that there are many factors that contribute to nursing staff satisfaction, but the most consistent finding involves nurses’ perceptions of how often short staffing affects their ability to meet the their patient’s needs. When the nursing staff feel that shortage of staff affects the level of care, the nursing staff are less satisfied with both their job and career (Katherine H Shaver and Linda M Lacey, 2003, Ellen Strachota, Pamela Normandin, Nancy O’Brien, Mary Clary and Belva Krukow 2003, Chen Chung Ma, Michael E Samuels and Judith W Alexander, 2003).

NURSING STAFF WORK PERFORMANCE

Work performance is defined as behaviour associated with the accomplishment of expected, specified, or formal role requirements on the part of individual organisational members (Campbell, 1990). There is an increasing concern regarding nursing staff performance which influence patient safety and healthcare outcomes, and nurses’ work environment (e.g. equipment failure, documentation burden, non-
availability of resources) that has led to an increased interest in measuring and reporting nursing performance. Furthermore, developing nursing performance helps the organisation to achieve benchmarking and best practices, enhance the clinical practice to improve quality, improve the accountability, identify the staffing standards, and identifying the gaps in quality which will inform research, education, and training, needed in measuring nursing sensitive care. Since nursing staff are an integral part of the healthcare delivery system they contribute to the quality healthcare delivery Michael (Pfeil 2003). In most situations the nursing staff’s contribution is part of the whole process of patient care and it (the patient’s recovery) cannot be claimed as sole outcome of the nursing staff’s efforts. It becomes difficult in measuring the nursing staff performance (Jack Needleman et.el 2007) because there are several variables associated with nursing staff performance.

The table presented below summarises the various quality work environment factors which are discussed in the above passages:

According to the table (work environment and organisational outcomes) presented below, the whole organisational environment is influenced by certain characteristics such external pressures, organisational pressures, department or unit characteristics and individual characteristics. These characteristics are pressurizing the organisation to develop or maintain appropriate organisational culture and climate. The organisation dedicates to practice the quality culture within the organisation, and maintain quality oriented work processes and support practices. These practices leads to quality work environment for the organisation whereby the organisation provides quality products / services, improved methods, innovative techniques and satisfied employees.
Work environment and the organisational outcomes

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Unit work environments</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences on the unit work environment</td>
<td>Culture: quality oriented culture and philosophy</td>
<td>Impact of quality oriented work environment</td>
</tr>
<tr>
<td>Pressures external to the organization</td>
<td>• Quality philosophy</td>
<td>Products and services</td>
</tr>
<tr>
<td>Institutional pressures and characteristics</td>
<td>• Quality improvement culture</td>
<td>Quality</td>
</tr>
<tr>
<td>Unit characteristics</td>
<td>• Organizational culture</td>
<td>Quantity</td>
</tr>
<tr>
<td>- Job function</td>
<td></td>
<td>Speed and timeliness</td>
</tr>
<tr>
<td>- Admn unit/division etc.</td>
<td></td>
<td>Costs</td>
</tr>
<tr>
<td>Individual characteristics</td>
<td>Climate: quality oriented work processes and support practices</td>
<td>Unit performance</td>
</tr>
<tr>
<td>- Gender</td>
<td>• Unit climate</td>
<td>Employee satisfaction</td>
</tr>
<tr>
<td>- Ethnicity</td>
<td>• Planning for improvement</td>
<td>customer satisfaction</td>
</tr>
<tr>
<td>- Years at institution</td>
<td>• Satisfying those served</td>
<td>comparative results</td>
</tr>
<tr>
<td>- Highest level of education</td>
<td>• Work processes</td>
<td>Unit structure and design</td>
</tr>
<tr>
<td>- Quality training experience</td>
<td>• Collecting and using information</td>
<td>innovation &amp; implementation</td>
</tr>
<tr>
<td></td>
<td>• Unit efficiency</td>
<td>institutional benefits</td>
</tr>
<tr>
<td></td>
<td>• Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unit staff members</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improving performance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unit performance indicators</td>
<td></td>
</tr>
</tbody>
</table>

Source: Camearon and others, “Assessing the culture and climate for Quality improvement in the work environment, AIR 1994 Annual Forum Paper

3. CONCEPTS, THEORIES AND CONCEPTUAL FRAME WORK

Definitions

According to the American Nurses Association (ANA) monograph: “Nursing is the diagnosis and treatment of human responses to actual or potential health problems (Janne Dunham-Taylor and Joseph Z.Pinczuk, 2004)”.

To Virginia Henderson, nursing is “the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. The nurse is temporarily the consciousness of the unconscious, the love of life for the suicidal, the leg of the amputee, the eyes of newly blind, a means of locomotion for the infant, knowledge and confidence for the young mother, the (voice) for those too weak or withdrawn to speak” (Patricia Potter, Stuart Boxerman, Laurie Wolf and Jessica Marshall November 2004).
Overview of Organisational Theories related to Task and Working Conditions

Overall, the quality of health care is affected by interactions between the factors explained earlier, and therefore it is necessary to begin to explore the connections between motivational issues in professional nursing, task characteristics and conditions at work by which quality work environment and organisational performance can be achieved.

Task Characteristics

Task is that which the nursing staff are expected to carry out in day-to-day functions. This work involves routine and non-routine functions. The nursing work will vary depending on the specialization and volume. It is well accepted that most people look for variety and challenge in a work place. Frank Greer acknowledges that a) Jobs are different and b) Some are more interesting and challenging than others. Task characteristic theories identify the task characteristics of jobs, how these characteristics are combined to form different jobs, and the relationship of these task characteristics to employee motivation, satisfaction, and performance. There is a significant amount of overlap among task characteristic theories for example Herzberg’s Two-Factor Theory and McClelland’s Needs Theory. Both stress that opportunities for achievement, recognition, responsibility, and the like would increase employee satisfaction. McClelland demonstrated that high achievers performed best in jobs that offered personal responsibility, feedback, and moderate risks. Two important theories of task characteristics are requisite task attributes theory, and the job characteristics model for the purpose of theoretical understanding.

Requisite Task Attributes Theory

Developed by Turner and Lawrence (1960) the theory states that the employees would prefer jobs that were complex and challenging; that is, such jobs would increase satisfaction and result in lower absence rates. The theory defined job complexity in terms of six task characteristics: variety; autonomy; responsibility; knowledge and skill; required social interaction; and optional social interaction. According to this theory, employees in high complexity tasks had better attendance records, but no general correlation between task complexity and satisfaction was
found. Turner and Lawrence concluded that workers in larger communities had a variety of non-work interests and thus were less involved and motivated by their work. In contrast, workers from smaller towns had fewer non-work interests and were more receptive to the complex tasks of their jobs. The nursing staff usually have a variety of opportunities to work at different task complexity levels, particularly in general wards, specialty wards and intensive care units. They would require autonomy, well defined responsibility, knowledge and skill to accomplish their tasks. Nursing staff frequently encounter various groups of people in the work settings. This theory would contribute to this study on how task characteristics affect the nursing performance in a complex work environment.

**The Job Characteristics Model**

This theory is an extension of the requisite task attributes theory. The theory was developed by Hackman and Oldham. According to the job characteristics model, any job can be described in terms of five core job dimensions, namely, skill variety; task identity; task significance; autonomy; and feedback. The job activities can be rated high and low for each characteristic. According to this theory, skill variety, task identity, and task significance combined would create meaningful work where the nursing job has these characteristics the incumbent will view the job as being important, valuable, and worthwhile. Job autonomy results in personal responsibility for the results where the nurse receives feedback; she would know how effectively she is performing. From a motivational standpoint, the internal rewards are obtained by individuals when they learn (knowledge of results) that they personally (experienced responsibility) have performed well on a task that they care about (experienced meaningfulness). These psychological states bring greater motivation, performance and job satisfaction to the staff. The chart below shows that the links between the job dimensions and the outcomes are moderated or adjusted by the strength of the individual’s growth need. The core dimensions can be combined into a single predictive index, called the motivating potential score (MPS). According to this theory people who work on jobs with high-core job dimensions are generally more motivated, satisfied, and productive than are those who do not; job dimensions operate through the psychological states in influencing personal and work outcome variables rather than influencing them directly.
CONDITIONS AT WORK

a. Physical Conditions at work place:
Employees prefer to work in appropriate conditions. In Government hospitals there is an acute shortage of resources. Different resources required for achieving the tasks such as adequate staff; material - medicines, drugs, linen, ward furniture, nursing stations, stationeries, tools, equipments; infrastructure; other facilities like provision of safe drinking water, basic sanitation facilities, communication/intercom, place for dining, dress changing room and security and safety of staff during the work as well rest time are all in short supply. Often equipments are extensively in use and do not function effectively. Effective servicing, repairing and maintenance of equipments shall make the staff work effectively and efficiently. However, most people do not give working conditions a great deal of thought unless they are extremely bad. Poor working conditions are negatively associated with job satisfaction and performance of the staff.
b. Psychological conditions

The psychosocial work conditions has been defined as psychological work demands, influence and control over work, good contact with and support from supervisor and fellow workers, stimulation from work and opportunities for development (Källestål 2004, Theorell 2003). The major psychological conditions which affect the work environment are stress and emotional strain, physical strain, competence, work satisfaction, quality of care etc. The current work load, work distribution, duty scheduling shall create more or less physical strains for the staff. To address all these issues classic and contemporary theories of work motivation, can be taken as support. From social psychological, social cognitive, organisational behaviour and nursing literatures, a meta-theoretical model of nurses work motivation can be developed. Various theories which support motivation and performance in the context of multiple work environments are explained below.

1. Hawthorne Studies (Elton Mayo)

The **Hawthorne effect** refers to a phenomenon that observing workers' behaviour in different context and compare their performance by changing the situation temporarily. Employees’ behaviour and performance change when there is increased attention. Mayo and his associates discovered that the answer to this phenomenon was not in the production conditions aspect, but in the human aspect. As a result of the attention lavished upon them by experimenters, the employees were made to feel they were an important part of the company. They no longer viewed themselves as isolated individuals but had become members of a congenial, cohesive work group. This led to the conclusion that the most significant factor affecting organizational productivity is the interpersonal relationships that develop on the job, not just pay and working conditions. This theory provides insight in healthcare organisation interpersonal relationship is most important which will ultimately result in employee relationship and improved patient experiences.

2. Maslow's hierarchy of needs (Abraham Maslow)

Maslow's Hierarchy of Needs is a theory in psychology that Abraham Maslow proposed in his 1943 paper *A Theory of Human Motivation*, which he subsequently extended to include his observations of man's innate curiosity. His theory contends...
that as humans meet 'basic needs', they seek to satisfy successively 'higher needs' that occupy a set hierarchy. According to Maslow's hierarchy of needs theory the human needs are classified into five levels: the four lower levels are grouped together as deficiency needs associated with physiological needs, while the top level is termed growth needs associated with psychological needs. While deficiency needs must be met, growth needs are the need for personal growth. The basic concept is that the higher needs in this hierarchy only come into focus once all the needs that are lower down in the pyramid are mainly or entirely satisfied. Once an individual has moved past a level, those needs will no longer be prioritized. However, if a lower set of needs is continually unmet for an extended period of time, the individual will temporarily re-prioritize those needs - dropping down to that level until those lower needs are reasonably satisfied again. Innate growth forces constantly create upward movement in the hierarchy unless basic needs remain unmet indefinitely. The nursing staff have different needs according to their age and experiences. It is assumed that the senior nurses have satisfied with deficiency needs and they look for satisfying the top level needs that is growth needs. The young nurses are yet to satisfy the deficiency needs in terms of working conditions, basic facilities, infrastructure, and job related needs. This theory would support efforts to find out to what extent the unmet needs affect the nurses performance and identifying the order of needs satisfaction whether it leads to individual performance and developing quality work environment

3. Theory X and Theory Y (Douglas Mc Gregor):

Douglas Mc Gregor (1960) felt that management needed practices based on a more accurate understanding of human nature and motivation. The basic assumptions about both the theories are: Theory X - the workers dislike work; have no ambitions; possess little capacity to solve the organisational problems; motivation occurs only at the physiological and safety levels; and often workers have to be coerced to achieve organizational objectives, and Theory Y - work is as natural as play, if the conditions are favourable; self-control is often indispensable in achieving organizational goals; capacity to solve the problems; and self-directed and creative people.
McGregor's work was based on Maslow's hierarchy of needs. He grouped Maslow's hierarchy into "lower order" (Theory X) needs and "higher order" (Theory Y) needs. He suggested that management could use either set of needs to motivate employees. Today, the theories are seldom used explicitly, largely because the insights they provided have influenced and been incorporated by further generations of management theorists and practitioners. More commonly, workplaces are described as "hard" versus "soft." Taken too literally any such dichotomy including Theory X and Y seem to represent unrealistic extremes. Most employees (and managers) fall somewhere in between these poles. Naturally, McGregor was well aware of the heuristic as opposed to literal way in which such distinctions are useful. Theory X and Theory Y are still important terms in the field of management and motivation. Recent studies have questioned the rigidity of the model, but McGregor's X-Y Theory remains a guiding principle of positive approaches to management, to organizational development, and to improving organizational culture. It can be noted the unmet basic needs lead to more X-type in nature and hence the organisation will suffer. The more Y type persons in the organisation indicates that their needs are satisfied and the quality environment is ensured. The Y type persons are considered better performers. So it is required to find out the extent to which the factors contribute or improve the satisfaction of nursing personal.

4. Motivation – Hygiene Theory (Fredrick Herzberg)
Frederick Irving Herzberg (1923 - 2000) introduced the Two-Factor Theory. The two factors are Motivational factors and Hygiene factors. The motivation factors are the job itself, achievement, recognition for accomplishment, challenging work, increased responsibility, growth and development. The Hygiene factors are policies and administration, supervision, working conditions, interpersonal relations, money, status, and security.

Hygiene factors focus on the context in which the job is done, the conditions that surround the doing of the job. When hygiene factors deteriorate to a level below that which the employee considers acceptable, then job dissatisfaction ensues. Hygiene factors directly affect job attitudes, primarily satisfaction and
dissatisfaction. When these factors have been satisfied or provided to a level which the employee considers acceptable, there will be no dissatisfaction, but neither will there be a significant increase in a positive attitude. People are made dissatisfied by a bad environment, but they are seldom made satisfied by a good environment. The prevention of dissatisfaction is just as important as encouragement of motivator satisfaction. Hygiene factors operate independently of motivation factors. An individual can be highly motivated in his work and be dissatisfied with his work environment. Dealing with hygiene factors helps to manage the work environment effectively. Hygiene needs are cyclical in nature and come back to a starting point. This leads to the "What have you done for me lately?" syndrome.

Hygiene factors, when satisfied, tend to eliminate dissatisfaction and work restriction, but they do little to motivate a nurse to superior performance or increased capacity. Satisfaction of the motivational factors, however, will permit a nurse to grow, develop in a mature way, and increase her ability. Thus, hygiene factors affect the nurse’s willingness and motivational factors impact the nurse’s ability. Basically, hospitals effort shall be directed to concentrate on improving the hygiene factors in the first instance. Subsequently, the focus should be directed to improve the motivational factors.

5. The Theory of Work Adjustment (René V. Dawis and Lloyd H. Lofquist)

René V. Dawis and Lloyd H. Lofquist describe the relationship of the individual to his or her work environment. According to work adjustment theory the work is conceptualized as an interaction between an individual and his/her work environment. The work environment requires that certain tasks be performed, and the individual brings skills to perform the tasks. In exchange, the individual requires compensation for work performance and certain preferred conditions, such as a safe and comfortable place to work. The environment and the individual must continue to meet each other's requirements for the interaction to be maintained. The degree to which the requirements of both are met may be called correspondence. Work adjustment is the process of achieving and maintaining correspondence. Work adjustment is indicated by the satisfaction of the individual with the work environment, and by the satisfaction of the work environment with the individual--
by the individual's satisfactoriness. Satisfaction and satisfactoriness result in tenure, the principal indicator of work adjustment. Tenure can be predicted from the correspondence of an individual's work personality with the work environment. Work personalities and work environments can be described in terms of structure and style variables that are measured on the same dimensions.

<table>
<thead>
<tr>
<th>Self Motivation</th>
<th>High Motivation</th>
<th>Low Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Performance</td>
<td>Moderate Performance</td>
</tr>
<tr>
<td></td>
<td>Moderate Performance</td>
<td>Low Performance</td>
</tr>
<tr>
<td>Conducive</td>
<td>Non-conducive</td>
<td>Work Environment</td>
</tr>
</tbody>
</table>

The employees who are highly self motivated are able to pay attention to an increase in performance in a conducive environment, similarly, the low self motivated person in a non-conducive environment will produce low performance. The above table explains this.
### Highlights of the Task characteristics and Motivation theories

The below table attempts to present in a tabular form the seven theories discussed above.

<table>
<thead>
<tr>
<th>Author</th>
<th>Theory</th>
<th>Significant Postulate</th>
<th>Application to the study</th>
</tr>
</thead>
</table>
| (Turner and Lawrence 1960) | Requisite Task Attributes Theory | - Complex and challenging jobs would increase satisfaction and result in lower absence rates  
- Job complexity- six task characteristics: Variety; autonomy; responsibility; knowledge and skill; required social interaction; and optional social interaction.  
- High complexity tasks had better attendance records  
- Workers in larger communities had a variety of non-work interests and thus were less involved and motivated by their work | - The nursing staff usually have variety of opportunities to work in different task complexity particularly general wards, specialty wards and intensive care units.  
- This theory would contribute for the study “how task characteristics affect the performance in a complex work environment”. |
| (Hackman and Oldham)        | The Job Characteristics Model  | Core job dimensions: Skill variety, Task identity, Task significance – create meaningfulness of work, Autonomy- brings responsibility for outcome of the work, Feedback- provide Knowledge of the actual results of the work activities accordingly the individual achieve the work motivation, work performance, work satisfaction and lower absenteeism of work thereby their growth need strengthened. | Nurses perform multiple tasks  
Need to identify the variety of activities  
The theory would identify the end results of work which provides autonomy, feedback as result the nurse achieve strength to perform, get motivated, learn and grow |
| (Elton Mayo 1924 to 1932)   | Hawthorne Studies             | As this theory the most significant factor affecting organizational productivity is the interpersonal relationships that develop on the job, not just pay and working conditions | This theory provides insight in healthcare organisation interpersonal relationship is most important which will ultimately result in employee relationship and improved patient experiences. |

Contd....
<table>
<thead>
<tr>
<th>Author</th>
<th>Theory</th>
<th>Significant Postulate</th>
<th>Application to the study</th>
</tr>
</thead>
</table>
| (Abraham Maslow 1943)      | Maslow's Hierarchy of Needs                 | • Individuals’ needs to be recognized  
• Each individual’s needs vary at different level  
• The basic four needs are satisfied and then final level of needs emerges  
• The employers should focus on currently unmet needs |
|                            |                                             | **This theory would support the study in terms of identifying the order of needs satisfaction whether it leads to individual performance and establishing quality work environment as per expectation of nursing staff** |
| (Douglas Mc Gregor 1960)   | Theory X and Theory Y                       | People more active towards negative way of thinking and work described as – Theory X  
People more active towards positive way of thinking and work described as – Theory Y  
People can be basically self-directed and creative at work if properly motivated.  
It can be attributed "lower order" (Theory X) needs and "higher order" (Theory Y) needs |
|                            |                                             | **Based on this theory it can be noted the unmet basic needs lead to more X- type persons, hence the organisation will suffer.  
The more Y type persons in the organisation their needs are satisfied, that is the quality environment ensured. The Y type persons are considered better performers. So it is required to find out the extent which the factors contribute or improve the satisfaction of nursing personal**  
**What type of needs is considered as lower order and higher order needs according to nurses?  
Which type of needs satisfaction is more favorable to quality work environment and performance of nurses?** |
| (Frederick Irving Herzberg | Motivational – Hygiene Theory               | The two factor theory emphasis -The motivation factors which allow the employees to grow and develop in a mature way  
The hygiene factors - when these factors are satisfied or provided to a level which the employee considers acceptable, there will be no dissatisfaction, but neither will there be significant positive attitude. |
| 1923 - 2000)              |                                             | **Hygiene factors, when satisfied, tend to eliminate dissatisfaction and work restriction, but they do little to motivate nurse to superior performance or increased capacity. Satisfaction of the motivational factors, however, will permit nurse to grow, develop in a mature way, and increase ability. Thus, hygiene factors affect nurse’s willingness and motivational factors impact nurse’s ability.** |
|                            |                                             | **Contd.….**                                                                           |
Author | Theory | Significant Postulate | Application to the study
---|---|---|---
(René V. Dawis and Lloyd H. Lofquist) | The Theory of Work Adjustment (TWA) | People have required skills to perform the task in the work environment. Work environment is work performance = compensation and preferred conditions. The degree to which the requirements of both are met may be called correspondence. Work adjustment is the process of achieving and maintaining correspondence. Work adjustment is indicated by the satisfaction of the individual with the work environment, and by the satisfaction of the work environment with the individual--by the individual's satisfactoriness. Satisfaction and satisfactoriness result in tenure, the principal indicator of work adjustment. | According to theory:

The employees who are high self motivated are able to pay attention to higher level of performance in a conducive environment; similarly, the low self motivated person in a non-conducive environment will produce low performance. The management ability to create quality environment is the key factor which leads to work performance.

The conceptual frame work derived from the literature review is presented below.

### 4.6 CONCEPTUAL FRAMEWORK

According to the framework presented a variety of factors affect nursing work performance, patient satisfaction and organisational objectives. The organizational variables interact with the intermediate factors. The intermediate factors are quality work environment which in turn are affected by job characteristics and conditions at work. The final outcome is the benefit achieved by the organisation, staff and patients.

The study frame work is presented below:
According to the literature there are several factors that have a strong influence on the nursing staff work life. Basically, the various individual factors and the job...
characteristics make an impact on the quality of work life of nurses. The quality of work life is determined by seven dependent variables like Nursing Staff Work Life Balance, Nursing Satisfaction, Absenteeism, Work Stress, Communication, Organisational Culture and Climate and Self Perception on won performance. At the initial stage it could be possible to understand the role of work environment factors in improving or detoriating the QWL of nurses. Furthermore, it has become necessary to explore the potential scope for changes in the work environment as well look at the opportunity to improve the quality of work life of nursing staff. The solid arrows in the model indicate relationships that are relatively well-established in the literature. The researcher suggests that factors like quality of work environment lead to an improved QWL of nurses. Thus, individual factors, job characteristics and work environment characteristics reinforce each other in the workplace and further determine the QWL.

In conclusion, it may be said that, nurses are integrally involved with developing, and maintaining an organisational culture, high level of patient care and medical ethics. They have to function in multiple environments that influence their behaviour. In light of the ongoing shortages of nurses and other health personnel, several studies have examined the quality of the work environment in hospitals and explored those factors that hinder or foster job satisfaction. In general, these studies have confirmed the need to improve the working conditions of staff nurses and have drawn attention to the importance of such factors as nurse-patient ratio, support services, involvement in decision making, level of compensation (William A Nelson 2005), amount of paperwork, opportunity for professional development, and respect received from hospital management and physicians (Joanne McCloshey and Helen K.Grace 1994). However, in the Indian scenario there are fewer studies in this area. This study attempts to cover key factors of work environment factors such as physical conditions, strengths and weaknesses of the nursing profession, opportunities to develop professionally, regulating and limiting factors with regard to the positive work environment.