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VOLUME II

AN APPENDIX TO
VOLUME 1

A STUDY OF INDIVIDUAL AND ORGANIZATIONAL VARIABLES
IN RELATION TO CHARGE NURSE BEHAVIOUR

A Supplement to the thesis presented in partial fulfilment
of the requirements for the degree of Doctor of Philosophy
in Psychology at Massey University

Nancy J. Kinross

1981
In this volume, supplementary information relating to the research study presented in Volume 1, has been collected together in a series of appendices. These have been grouped together under descriptive headings, and follow the sequence of the material presented in the first volume of this research study.
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDIX ONE</td>
<td>A Pilot Study</td>
<td>1</td>
</tr>
<tr>
<td>APPENDIX TWO</td>
<td>Supplement to Section Two (Volume 1)</td>
<td>3</td>
</tr>
<tr>
<td>APPENDIX THREE</td>
<td>Supplement to Section Three (Volume 1)</td>
<td>61</td>
</tr>
<tr>
<td>APPENDIX FOUR</td>
<td>Supplement to Section Four (Volume 1)</td>
<td>79</td>
</tr>
</tbody>
</table>
APPENDIX ONE

A summary of a pilot study
All the inventories devised for the Beta/Delta study were pretested at Alpha Hospital four weeks before they were used in the main research. On the basis of this pretesting, no changes were made in the nursing organization inventory but categories and instructions were clarified and changed in the biographical inventory.

The nursing incidents used in the training programme at Beta Hospital were first experimented with at Alpha Hospital. Some of these were first developed in video feedback sessions with the Alpha charge nurses. Fifteen such incidents were then developed into a nursing problems test. The final ten incidents were selected on the basis of their cognitive idea generativity after three judges had completed a content analysis of the incidents.

The charge nurses from Alpha Hospital also cooperated in allowing the researcher to experiment with the analysis of Kardex items and the treatment sheet score (refer Section Two, Volume 1, p152).
APPENDIX TWO

A Supplement to Section Two

(Volume 1)

This supplement contains information about the initial approaches of the researcher to the organizations; information about the hospitals; and facsimiles of the inventories used for data collection.
List of Contents in Appendix Two

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Letter Requesting Approval</td>
<td>6</td>
</tr>
<tr>
<td>B</td>
<td>Organization and Revision of the Research Project</td>
<td></td>
</tr>
<tr>
<td>B1</td>
<td>Research Proposal</td>
<td>7</td>
</tr>
<tr>
<td>B2</td>
<td>Programme for Research</td>
<td>9</td>
</tr>
<tr>
<td>B3</td>
<td>Amended Programme for Research</td>
<td>11</td>
</tr>
<tr>
<td>B4</td>
<td>Information to Staff (Beta Hospital)</td>
<td>12</td>
</tr>
<tr>
<td>B5</td>
<td>Information to Staff (Delta Hospital)</td>
<td>13</td>
</tr>
<tr>
<td>C</td>
<td>Data Collection Inventories</td>
<td></td>
</tr>
<tr>
<td>C1</td>
<td>Biographical Inventory</td>
<td>14</td>
</tr>
<tr>
<td>C2</td>
<td>Ward Analysis Sheet, Initial Interview</td>
<td>19</td>
</tr>
<tr>
<td>C3</td>
<td>Ward Analysis Sheet, Follow-up</td>
<td>20</td>
</tr>
<tr>
<td>C4</td>
<td>Nursing Organization Opinion Inventory</td>
<td>22</td>
</tr>
<tr>
<td>C5</td>
<td>Analysis of Team Nursing</td>
<td>26</td>
</tr>
<tr>
<td>C6</td>
<td>Scale for Analysis of Treatment Sheet</td>
<td>27</td>
</tr>
<tr>
<td>D</td>
<td>Hospital Information, Beta Hospital</td>
<td></td>
</tr>
<tr>
<td>D1</td>
<td>Staff Establishment, Beta Hospital</td>
<td>28</td>
</tr>
<tr>
<td>D2</td>
<td>Supervisor's Role, Beta Hospital</td>
<td>29</td>
</tr>
<tr>
<td>D3</td>
<td>Job Analysis, Sister in Charge ITU and Acute Post-operative Surgical Ward</td>
<td>32</td>
</tr>
<tr>
<td>D4</td>
<td>Job Description, Block Supervisor</td>
<td>34</td>
</tr>
<tr>
<td>D5</td>
<td>Job Description, Charge Nurse/Male Nurse</td>
<td>36</td>
</tr>
<tr>
<td>D6</td>
<td>Job Description, Hospital Aids</td>
<td>38</td>
</tr>
<tr>
<td>D7</td>
<td>Job Description, Ward Receptionists</td>
<td>39</td>
</tr>
</tbody>
</table>
E  Hospital Information, Delta Hospital
   E1  Nursing Services Committee  40
   E2  Objectives for Nursing Service  41
   E3  Philosophy of Nursing Service  43
   E4  Job Description, Second Assistant Matron  44
   E5  Job Description, Area Supervisor  48
   E6  Staff Establishment  52

F  Team Nursing
   F1  Terms relevant to Team Nursing  53
   F2  Guidelines for Team Nursing  55
   F3  Responsibilities of Ward Sister  56
   F4  Responsibilities of Team Leader  58
   F5  Responsibilities of Team Members  60
APPENDIX A

Department of Psychology

7th September, 1976.

Ms
Chief Nursing Officer,
Hospital Board,

Dear Ms.

Further to our informal discussions, I now wish to make formal application to undertake the research for my PhD thesis requirement at Beta Hospital. I have attached herewith a copy of the outline of my proposal which includes a timetable for my research. As you will see, I hope to pay a planning visit on Wednesday, September 15th. On that occasion it will only be necessary for me to plan the details of the programme with you and the Principal Nurse, should she consent to the study being undertaken. It may also be useful for me to become familiar with the physical layout of the hospital.

As you know, it is important that the details of the project are not known to the participants, or the hospital staff in general. If you agree, it should be sufficient if staff are informed that I am interested in studying the work of nursing staff in a large public hospital and in looking at the relationship between staff training and the work they do.

I hope that it will be possible for me to undertake this project as I believe it could be important not only to Beta Hospital, but to the development of nursing service in New Zealand.

Thank you for your co-operation in this matter.

Yours sincerely,

Nancy J. Kinross,
Senior Lecturer-in-Charge,
Nursing Studies Unit.

Encl.
Objectives: To examine and measure the relationships between the structural and training components of a hospital organisation and specific aspects of the work that charge nurses do.

Researcher: Ms. Nancy Kinross, R.G.N., R.M.N., B.A. (Cantuar) M.S. (Berkeley), Senior Lecturer in Charge, Nursing Studies Unit, Massey University.

Purpose of the Research:

In partial fulfilment of the requirement for the degree of Ph.D. in psychology. In addition, the findings from the research should be useful both to the hospital and to nursing service in general. Nursing is an important and expensive part of the health service in New Zealand. As yet, there is little evidence that variations in structural, training, or individual factors in nursing have a measurable effect on the quantity or quality of practice.

DESIGN OF THE RESEARCH

Introduction

In order to obtain the data required for this project, it will be necessary for the researcher to observe and measure the characteristics of a hospital organisation and of the nurses who work in it.

Location

Beta Hospital has been chosen as a suitable location because of the size of the hospital and the number of staff available within one administration.

Sample

It is proposed that all nurses working in charge positions should be included in the sample.  

\[ N = 45 \]

Outline of Phases in the Programme of Research:

Phase I  Orientation of the researcher. This phase will include a visit to the hospital to discuss planning on Wednesday, September, 15th. At this time visits could
be made to one example of the three basic types of ward areas to be studied.

a) medical
b) surgical
c) obstetric

 Phase II

An examination of the structure and functioning of the organisation.
September 23rd, 24th, 25th and 26th.

 Phase III

Administration of biographical and attitude tests to sample of 45 charge nurses.
Week of October, 11th.

 Phase IV

First staff training programme (20-22 charge nurses). Group A.
October 18th-22nd.

 Phase V

Administration of tests etc. to Group A nurses - October 27th.
Observation of organisation - October 28th and 29th.

 Phase VI

Second staff training programme (20-22 charge nurses) Group B.
November 1st-5th.

 Phase VII

Administration of tests etc. to Group B nurses - November 10th.
Observation of organisation - November 11th and 12th.

 Phase VIII

Observation of organisation December 15th, 16th, 17th and further testing Groups A and B.

 Phase IX

Subsequent visits at 3-4 weekly intervals to observe the organisation for the next 5 months.

Note: It may be necessary to use Delta Hospital as a pilot area to test certain aspects of this design.
## APPENDIX B2

### PROGRAMME FOR RESEARCH

<table>
<thead>
<tr>
<th>Date</th>
<th>Beta Gr. II</th>
<th>Beta Gr. I</th>
<th>Delta</th>
</tr>
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<tbody>
<tr>
<td>Sep 13</td>
<td>1 day</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Orientation of the researcher</td>
<td>Introduction of the project</td>
<td>Weeks 1</td>
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<td>20</td>
<td>1 day</td>
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<td></td>
<td>Introduction and orientation</td>
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<td>2</td>
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<td>27</td>
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<td>Oct 4</td>
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<td>Nursing Audit</td>
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<td>Nov 1</td>
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<td>Testing Nursing Audit</td>
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<td>Testing Nursing Audit</td>
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<td>26</td>
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<td>Nursing Audit</td>
<td>Nursing Audit</td>
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<td>Dec 6</td>
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<td>Nursing Audit</td>
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<td>31</td>
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<td>Nursing Audit</td>
<td>Nursing Audit</td>
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<td>Beta Gr. II</td>
<td>Beta Gr. I</td>
<td>Delta</td>
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<td>May</td>
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</table>
APPENDIX B3

AMENDED PROGRAMME FOR RESEARCH

Phase I:
Wed 15 Sept. Orientation of the researcher. Planning and programming discussions held with the Principal Nurse and Chief Nursing Officer. Project introduced to the charge nurses. Initial discussion with Principal Nurse, Delta Hospital.

23-26 Sept. Beta Hospital - observation nursing administration office. Dates of programme put back two weeks because of prior commitments of hospital. Visits to (1) obstetric (1) paediatric (1) medical and (1) surgical ward.

Phase II:

Phase III:
Mon 1 Nov. Organisational audit and testing Delta Hospital.
Tue 2 Nov. Organisational audit and testing Beta Hospital.

Phase IV:
8-12 Nov. Inservice programme Ward Charges A.

Phase V:
Mon 15 Nov. Organisational audit Delta Hospital.
Tue 16 Nov. Organisational audit Beta Hospital. Ward Charges.

Phase VI:
22-26 Nov. Inservice programme: Ward Charges (B).
Mon 29 Nov. Organisational audit Delta Hospital.
Tue 30 Nov. Organisational audit and testing Beta Hospital.

Phase VII:
Mon 20 Dec. Organisational audit Beta Hospital.
Mon 10 Jan. Audit Beta Hospital.
Tue 11 Jan. Audit Delta Hospital.

and thereafter at three week intervals until May, 1977.
Ms. Nancy Kinross, Nursing Studies Unit, Massey University, is studying the work of nursing staff. She will be visiting Beta Hospital at intervals over the next few months and may come to your ward or department. Two inservice education programmes for Ward Charges will be held while she is here.

Programme:

Wednesday 15 September       Orientation
Thursday 23 September  
R            to  
Sunday 26 September           Beta Hospital.
Monday 11 October  
R            to  
Friday 15 October              Beta Hospital.
Monday 1 November             Beta Hospital.
Tuesday 2 November              3 p.m. meeting, Ward Charges
Monday 8 November  
R            to  
Friday 12 November              Inservice programme: Ward Charges (A)
Monday 15 November             Beta Hospital.
Tuesday 16 November              3 p.m. meeting, Ward Charges
Monday 22 November  
R            to  
Friday 26 November              Inservice Programme: Ward Charges (B)
Monday 29 November             Beta Hospital.
Tuesday 30 November              3 p.m. meeting, Ward Charges
Monday 20 December             Beta Hospital.
Tuesday 21 December              3 p.m. meeting, Ward Charges
Monday 10 January           Beta Hospital.
and thereafter every 3 weeks until May, 1977.

Note: A copy given to all supervisors and Ward Charges, Beta Hospital.
INFORMATION TO STAFF (DELTA HOSPITAL)

Ms Nancy Kinross, Nursing Studies Unit, Massey University, is studying the work of nursing staff. She will be visiting Delta Hospital at intervals over the next few months and may come to your ward or department.

Programme:

14th October 
Brief introduction,
Delta Hospital

4th and 5th November
Delta Hospital

Week of 6th December
(1-2 days)
Delta Hospital

Week of 10th January
(1-2 days)
Delta Hospital

Week of 14th February
(1-2 days)
Delta Hospital

and thereafter every 3 weeks until May, 1977.
In this questionnaire, you are asked to supply personal information which will be treated as confidential and used for statistical purposes only. Please answer questions in the space provided or tick (/) the appropriate box.

1. NAME
   (Surname) ________________ (First name) ________________ (Middle name) ________________

2. DATE OF BIRTH
   (Day) __________ (Month) __________ (Year) __________

3. SEX
   Male __________ Female __________

4. MARITAL STATUS
   Never married __________
   Married __________
   Not now married __________
   Other (state) __________

5. Do you have any persons (other than yourself) dependent on you for financial support?
   YES __________ NO __________

6. Is this job your primary source of income?
   YES __________ NO __________

7. TYPE AND LEVEL OF GENERAL EDUCATION (tick all those you have achieved)
   Up to three years secondary but not school certificate __________
   School certificate __________
   Sixth form certificate __________
   University entrance __________
   Undergraduate diploma __________
   State type, where and when obtained __________
   Undergraduate degree __________
   Postgraduate diploma __________
   Postgraduate degree __________

8. TYPE AND LEVEL OF FORMAL PROFESSIONAL EDUCATION (tick all those you have achieved)
   Three year general (including maternity) __________
   Three year psychiatric/psychopaedic __________
   Three year polytechnic __________
   Midwifery __________
State type, where and when obtained

Post certificate course
(including maternity if not part of basic programme)
Postbasic diploma
University undergraduate diploma
University undergraduate degree
Postgraduate diploma
Postgraduate degree
Other

9. PREVIOUS EMPLOYMENT

Give details of all your work experience as a qualified nurse. Include your present employment but exclude student work experience unless you undertook this as part of a second qualification.

<table>
<thead>
<tr>
<th>Name of Health Agency</th>
<th>Category of Position Held</th>
<th>Area of Nursing (e.g. medical, surgical, obstetric)</th>
<th>Date of Employment From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
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</table>

10. PRESENT EMPLOYMENT

(a) Category of position held
   Supervisor
   Ward Charge
   Staff Nurse

(b) Length of time in present position
   Days  Months  Years

(c) Name and category of the person to whom you are directly responsible
   Name  Category

11. INSERVICE EDUCATION

Give details of all the staff training programmes offered by your hospital that you have attended in the last three years. (please attach additional page if required).
12. INSERVICE EDUCATION

Give details of all the study days and seminars (at least one day in length) that you have attended in the last three years. (Please attach additional page if required).

<table>
<thead>
<tr>
<th>Date</th>
<th>Length of Programme</th>
<th>Type of Programme</th>
</tr>
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</table>

13. Name any health-related organisations to which you belong (outside your working situation).

______________________________

______________________________

14. Name any other organisations to which you belong (outside your working situation).

______________________________

______________________________

15. Some common sources of new information related to nursing practice are listed below.

(a) Place a tick in Column I beside each item that you normally use.

(b) In Column 2, record the frequency of use as

VF (Very frequently, i.e. more than once weekly)
F (Frequently, i.e. more than once monthly but less than once weekly)
O (Occasionally, i.e. less than once monthly)
(c) In Column 3, briefly record the type of information you would normally expect to get from the source.

(d) To complete Column 4, choose the source that you consider the most important to you and rank it 1. Then proceed to rank those others you have ticked in Column 1 as 2, 3, 4, etc.

<table>
<thead>
<tr>
<th>COLUMN 1</th>
<th>COLUMN 2</th>
<th>COLUMN 3</th>
<th>COLUMN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source (other than people)</td>
<td>If normally used</td>
<td>Frequency of use</td>
<td>Type of Information</td>
</tr>
<tr>
<td>Workshops, seminars, study days</td>
<td></td>
<td></td>
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<td>Reference books</td>
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<td>Newspapers</td>
<td></td>
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<tr>
<td>N.Z. Nursing Journal</td>
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<td>American Journal of Nursing</td>
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<td>Overseas Medical Journals</td>
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<td>Nursing Outlook</td>
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<td>Nursing Mirror</td>
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<td>N.Z. Medical Journal</td>
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<tr>
<td>Inservice Education Programme (state)</td>
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<tr>
<td>Postbasic educational institutions</td>
<td></td>
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<tr>
<td>Other (state)</td>
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</table>
16. Categories of people who may act as sources of new information related to nursing practice are listed below.

(a) Place a tick in Column 1 beside each item that you normally use.

(b) In Column 2, record the frequency of use as
   VF (Very frequently, i.e. more than once weekly)
   F (Frequently, i.e. more than once monthly but less than once weekly)
   O (Occasionally, i.e. less than once monthly)

(c) In Column 3, briefly record the type of information you would normally expect to get from the source.

(d) To complete Column 4, choose the source that you consider the most important to you and rank it 1. Then proceed to rank those others you have ticked in Column 1, as 2, 3, 4, etc.

<table>
<thead>
<tr>
<th>Source</th>
<th>COLUMN 1</th>
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<tbody>
<tr>
<td>Chief Nursing Officer</td>
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<tr>
<td>House Surgeon</td>
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<tr>
<td>Assistant Principal Nurses</td>
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<tr>
<td>Supervisor(s)</td>
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<tr>
<td>Charge Nurses (other than yourself)</td>
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<tr>
<td>Staff Nurses</td>
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<tr>
<td>Medical Consultants</td>
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<tr>
<td>Registrars</td>
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<td>Inservice education supervisor</td>
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<tr>
<td>Medical Superintendent</td>
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<tr>
<td>Management Consultants</td>
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<td>Other (state)</td>
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</tbody>
</table>
WARD ANALYSIS SHEET

Ward, Unit or Department No:
Date of Visit:

1. How long have you been in this ward?

2. What changes have occurred in that time?

3. What has stayed pretty much the same?

4. How many staff have you got on duty today?
   Registered:
   Student:
   Other:

5. What dependency are your patients today?
   1 2 3 4

6. How do you organise the work in the wards?

7. Who, mostly, does rounds with the consultant doctors?

8. Do you write in the nurses' notes? If not, who does?

9. If you do not, how do you communicate your ideas to the nurses?

10. Any comments you would like to make.
WARD ANALYSIS SHEET

Ward, Unit or Department No:

Date of Visit:

Comments:

Staffing:

Registered

Student

Other

Dependency:
NURSES' NOTES:

Date:

1.

2.

3.
This questionnaire asks you to state your own opinion on the nursing organisation at your hospital. Your individual answers are confidential, so you should be as candid as possible. Most of the questions can be answered by checking (X) at the point on each scale which best represents your opinion.

For example, if you strongly disagree with the statement, 'All nurses should be female' you would check 7 on the scale below:

Always 1 2 3 4 5 6 7 Never

X

1. A person's rank in the organisation determines his/her relationship to other people.

Always 1 2 3 4 5 6 7 Never

2. In this organisation one is encouraged to think for oneself.

Always 1 2 3 4 5 6 7 Never

3. Team meetings should be a part of the ward nursing routine.

Strongly approve 1 2 3 4 5 6 7 Strongly disapprove

4. New ideas are tried out here.

Always 1 2 3 4 5 6 7 Never

5. The most important part of a supervisor's job is to see that hospital routines are followed.

Under all circumstances 1 2 3 4 5 6 7 Not under any circumstances

6. The most important part of a ward charge's job is to see that doctors' orders are followed.

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

7. I am ahead of most other ward charges in trying out new ideas.

Always 1 2 3 4 5 6 7 Never
8. Formal rules and regulations have a very important place in this organisation.

   Always 1 2 3 4 5 6 7 Never

9. How much does your job give you a chance to do the things you are best at?

   Excellent chance 1 2 3 4 5 6 7 No chance at all

10. Doctors are responsible for the standard of patient care.

    All of the time 1 2 3 4 5 6 7 None of the time

11. A nurse should think of herself as a member of an organisation first, and an individual second.

    Always 1 2 3 4 5 6 7 Never

12. I am slower than most other ward charges in trying out new ideas.

    Always 1 2 3 4 5 6 7 Never

13. Nurses are responsible for the standard of patient care.

    All of the time 1 2 3 4 5 6 7 None of the time

14. To what extent does your work help you to develop more confidence in yourself?

    Very great extent 1 2 3 4 5 6 7 Not at all

15. 'In this organisation it is usual to question well established ways of doing things' - This statement is true -

    Always 1 2 3 4 5 6 7 Never

16. Decisions about nursing are made in the nursing administration office and passed down to the ward charges.

    Always 1 2 3 4 5 6 7 Never
17. The best way of getting along with your supervisors is to try out a new idea.

Strongly agree 1 2 3 4 5 6 7
Strongly disagree

18. Team leaders should not write up the Kardex for their own patients.

Strongly agree 1 2 3 4 5 6 7
Strongly disagree

19. The ward charge is the primary source of nursing information for a ward, unit, or department.

Strongly agree 1 2 3 4 5 6 7
Strongly disagree

20. On the job, do you feel any pressure for better performance over and above what you think is reasonable?

A great deal of pressure 1 2 3 4 5 6 7
No pressure at all

21. Do you feel any pressure at all in your job? YES ☐ NO ☐

22. If you ticked 'Yes', answer this question. (If you ticked 'No', go on to the next question). Twelve possible sources of pressure on you at work are listed below. Write 1 in the box beside the source which you think exerts most pressure. Write 2 in the box beside the next most important source of pressure, and so on down the list to 12. If you think any of them do not apply to you write N.A., in the appropriate box.

Order of Importance

(a) the student nurses
(b) the type of ward, unit or department
(c) my superiors in the nursing department
(d) house surgeons and registrars
(e) people from other departments
(f) patients
(g) patients' relatives and visitors
(h) medical consultant staff
(i) myself
(j) staff nurses
(k) other ward charges
(l) the staff of the school of nursing
(m) other than the above (state)
23. If you ticked 'No', or if you are **not** a ward charge or acting ward charge, answer this question.

Twelve possible sources of pressure for ward charges other than yourself are listed below. Write 1 in the box beside the source which you think is most important to them as a group. Write 2 in the box beside the next most important source and so on down the list to 12. If you think any of them do not apply, write N.A. in the appropriate box.

(a) the student nurses
(b) the type of ward, unit or department
(c) my superiors in the nursing department
(d) house surgeons and registrars
(e) people from other departments
(f) patients
(g) patients' relatives and visitors
(h) medical consultant staff
(i) myself
(j) staff nurses
(k) other ward charges
(l) the staff of the school of nursing
(m) other than the above (state)
APPENDIX C5

ANALYSIS OF TEAM NURSING AS A SPECIFIC ITEM OF INNOVATIVE BEHAVIOUR

1. Implemented and going well.

2. Implemented but continuing with difficulty.

3. Implemented but discarded.

4. Referred to by charge nurse or deputy but never implemented.

5. Not referred to by charge nurse or deputy.

6. Rating not applicable.
APPENDIX C6
SCALE FOR ANALYSIS OF TREATMENT SHEET

No detail for nursing practice except category labels

1. No specific detail other than category labels such as: name, diagnosis, address, hospital number, age, sex, religion, doctor(s), and admission date.

2. Category labels plus information relating to routine delegated medical care, such as: medication, chest x-ray, physiotherapy and laboratory tests.

3. Category labels, delegated medical care, plus information relating to routine nursing care, such as: bathing, bed/ambulation, fluid balance, T.P.R.

4. Category labels, delegated medical care, routine nursing care plus information relating to specific aspects of nursing care such as: play with toddler.

5. Category labels, delegated medical care, routine nursing care, specific aspects of nursing care plus a nursing care plan for the patient.

6. Category labels, delegated medical care, routine nursing care, specific aspects of nursing care, a nursing care plan plus evidence of daily change of at least one item in the nursing care plan.

7. All the above, plus a nursing history included as part of the treatment sheet structure (or vice versa). This type of treatment sheet carries specific information on social history and patient need.
## APPENDIX D1

### STAFF ESTABLISHMENT

**Beta Hospital**

<table>
<thead>
<tr>
<th>Category</th>
<th>Approved</th>
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<th>ACTUAL</th>
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<tr>
<td></td>
<td>Full time</td>
<td>Part time</td>
<td>F.T.E.</td>
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<td>Principal Nursing officer</td>
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<tr>
<td>Matron</td>
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<tr>
<td>Asst. Matron</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Sister-in-Charge/Head Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asst. Sister-in-Charge/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asst. Head Nurse</td>
<td></td>
<td></td>
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<td>11</td>
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<td>Charge/Senior Tutor</td>
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<tr>
<td>Total Tutorial staff</td>
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<td>792</td>
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CONCEPT OF SUPERVISOR'S ROLE AT BETA HOSPITAL

1. Clinical expert: each Supervisor is responsible for wards in which one clinical aspect is predominant and the Supervisor is expected to be able to draw on an extensive background knowledge to offer advice as a clinical nurse/specialist.

2. Manager: within her allocated area the Supervisor has delegated authority to plan, control, enquire, consult, co-ordinate, educate and organise. These activities she performs at the overall group level while encouraging and not detracting from the work of the Ward Sister in these functions.

3. Organiser: she is responsible for deploying units of her section of the work force to meet changing needs on the basis of measured patient dependency ratings, and to ensure the best use of available clinical experience, and to ensure that the individual worker's competence and knowledge is in direct relationship to the volume and nature of work load. By the same token she is a conserver of nursing skills.

4. Educator: works in relationship with Ward Sisters and Department of Nursing to facilitate the teaching of students in the clinical setting, uses all opportunities to teach registered nurses in own area, participates in planning and carrying out of in-service education programmes and encourages staff to attend any relevant education sessions within the hospital and elsewhere in the community.

5. Team member: by meeting daily with her nursing administration associates for exchange of such information as is significant for the effective work of the group as a whole: only a selected portion of such information is further referred to the Matron. In weekly sessions with the Matron an enlarged group of Assistant Matrons and Supervisors meets to review, discuss and plan matters of significance in respect of the total hospital nursing service.

Team leader: by holding monthly meetings of Ward Sisters in Her/His group to ensure maximum benefit from pooled experience and to maintain uniform philosophy and even implementation of change and progress.

7. Counsellor (and comforter): over wide range of hospital personnel, especially nursing, and of patients and relatives where the situation has become too trying for ward staff to handle in the normal way.

8. Learner: the Supervisor him/herself is given opportunity and is encouraged to expand his/her clinical, professional and general education by all available means. Additionally by rotational relief of the 1st and 2nd Assistant Matrons the Supervisor is gaining expanded insight into the overall pattern of the nursing administration.

9. Trouble Shooter: by being readily available for discussion purposes she is often able to forestall complaint and trouble, but if either arises she conducts on the spot investigation of such and of all untoward incidents.

10. Environmental Developer: over and above the work of each Ward Sister within the group the Supervisor generally watches and works to see that all patient occupied and nurse working areas are as suitable, satisfactory, and attractive as possible for their purpose.

11. Area Safety Officer: consults with Hospital Safety Officer and Fire Officer.
To meet these many aspects of her role the Supervisor will be involved in:

1. Ward Rounds: although the term is used for lack of a better - by this is meant that 4-6 hours per day is spent in the clinical scene, usually in relationship to points of heavy nursing dependency ratings, to patients and the nursing staff, medical and other professional patients and their relatives, and to ancillary and supportive lay staff.

2. Liaising with other nursing officers, other departments within the hospital, and health workers in the community.

3. Attending meetings and lectures of varying frequency and duration, both within and without the hospital scene.

4. Interviewing.

5. Fact finding and reporting.
APPENDIX D3

JOB ANALYSIS

Sister-In-Charge

I.T.U. and ACUTE POST-OPERATIVE
SURGICAL WARD

Responsible to: Principal Nursing Officer, for

a) Knowing:
   Nursing employment regulations, Acts and Regulations,
   Hospital Policies.

b) Management:
   Co-ordination of Services affecting Patient care, staff nursing,
   Medical staff, relatives, visitors, maintenance and ancillary staff.
   Overseeing hygiene of Unit
   Overseeing maintenance of sufficient and efficient equipment
   and supplies.
   Ensuring all nursing staff function within their legal bounds.
   Attending staff meetings.
   Delegation of responsibility and authority to the Staff Sister/
   Staff Male Nurse in charge of the Post Operative Ward.
   Receiving daily reports from this nurse and meeting him/her
   weekly to discuss any problems or policies.

c) Education:
   Own: Extra mural studies. Professional knowledge.
   Junior R.N.'s Release for In-service programme
   Encourage in extra mural studies
   Planned clinical teaching session
   On the job education

d) Evaluation:
   Of on going education
   programmes
   Of standard of
   nursing care

 e) Liaison:
    Surgical Supervisor
    Attendants,
    Manager (Administration)
    Stores
    Engineers etc.
    Vacuum Cleaning Company
    Admissions
f) Channels of Communication:
Through Surgical Supervisor to Principal Nursing Officer -
or directly to P.N.O. Directly to Supervisor in Charge
of registered staff.

g) Clerical:
i. Overseeing clerical staff for accuracy in:
   charts
   requisitions
   dependency ratings
   daily bed state

ii. Directly responsible for
    Kardex
    Drug Registers
    Ward reports

iii. Any other matter which is essential to nurse.

h) TO MAKE MEMBERS OF STAFF AVAILABLE IN TIME OF NEED IF UNIT
   IS QUIET.
Title: Supervising Sister - Surgical Wards, Beta Hospital.

Requirements:

(a) Professional: Registered General Nurse and Registered Maternity Nurse or Registered Psychiatric Nurse. Diploma of Nursing (N.Z.) or its equivalent.

(b) Clinical: A minimum of two years recent experience as a Ward Sister in General Surgical Wards together with a sound knowledge of Otolaryngology - Ophthalmology - Plastic Surgery - Cardio-vascular Surgery and Intensive Care Nursing.

Functions:

(i) To ensure the highest possible degree of nursing care to all patients in the above named area of nursing.

(ii) To be fully conversant with all the surgical specialties and to be prepared to give considered and expert specialised advice on nursing care.

(iii) To be fully conversant with all Acts, Regulations, and Hospital Policies related to patient care, nurse education programmes (clinical) scope of nursing responsibilities and limitations.

(iv) To hold weekly group meetings with the Surgical Ward Sisters to discuss and solve problems common to all.

(v) To attend the weekly meeting of Supervisors held by the Matron to discuss problems not resolved at the Ward Sisters' group meeting and any other problem which may be unexpected and un-resolvable.

(vi) To report to the Second Assistant Matron each day on:

(a) The patient-nurse dependency ratings.

(b) The staffing of each ward.

(c) The seriously ill, the number of patients on intravenous therapy.

(d) The number of patients requiring additives to the intravenous infusions.

(e) The number of "Booked Admissions".

(f) The number of patients going to the Operating Rooms and the proposed Surgery involved.

(g) The number of Patients for discharge.

(h) The emergency admission days.
(vii) To assist individual Ward Sisters to solve immediate administrative problems.

(viii) To be sympathetic to, rather than critical of any mismanagement or misjudgement.

AUTHORITY. Every Nurse Supervisor carries the full authority of the Matron and bears the responsibility of accountability for his/her actions to the Matron. The Nurse Supervisor can be assured of the full support of the Matron where any error is made in good faith but not in deliberate defiance or ignorance of legal requirements.
BETA HOSPITAL

JOB DESCRIPTION

Charge Nurse / Male Charge Nurse

Responsible to the Principal Nurse, Beta Hospital through the appointed Supervisor for:

The highest degree of direct nursing care and service to the patients under his/her supervision.

The supervision and direction of all categories of nurse working in the ward.

Determining and being responsible for the quality of nursing care rendered to the patients.

Completing nursing student assessment forms in the presence of the individual nurse concerned together with the relevant clinical tutor.

Ensuring that Staff Nurses are delegated and effect such responsibilities in respect of direct patient care for which they become 'team leaders'.

Ensuring that any principle taught in the Department of Nursing Education is adhered to and that no individual Charge Nurses preference is imposed on the students or graduates from Beta Hospital without consultation and agreement with the Charge Tutor.

Ensuring that each nurse member of the Ward Staff knows his/her place in the team and how to function effectively.

Knowing and enforcing the Nurses legal responsibilities in respect of:

(a) Nurses' Registration Regulation
(b) Nurses' Employment Regulation
(c) Narcotics Act and Regulations
(d) Hospital Act and Regulations
(e) Health Act and Regulations
(f) Hospital Policies related to Nursing Practice

Attending the Charge and Departmental Sisters' Meeting held by the Principal Nurse.

Attending In-Service programmes as arranged.

Furthering own education in professional and general matters.

Ensuring that the allocated nursing staff is distributed evenly on each day of the week when compiling the duty roster.
Ensuring a safe environment for patients and staff.

Co-operating and communicating with the Supervising staff who are the Principal Nurse's delegated nursing officers with full responsibility, authority and accountability.

Knows the Philosophy and Objectives of Nursing Service and formulates goals of nursing service within this framework.

Hours of Duty: 0800 hours - 1630 hours
Hospital Aids (Nursing Administration)

Responsible to Nurse in Charge of the Ward for:

1. Assisting with: Bedmaking, 
   Sponging, bathing or showering of patients. 
   Changing soiled attire, 
   Feeding patients, 
   Giving out morning and afternoon teas when Dietary Assistants not available, 
   Serving of Suppers 
   Giving bedpans/urinals (Measuring and recording contents), 
   Walking patients, 
   Greeting visitors and being helpful 
   Clearing lockers of urinals and any other unhygienic materials, 
   Attending to all flowers, 
   Supervision of general ward tidiness, 
   Admission of patients and close care of their property, 
   Sluice Room duties.

2. Reporting anything that appears to be abnormal.

3. Attending own in-service programme each week.

4. Attending regularly on duty as rostered.

5. Acting as a reliable member of the Nursing Team.
BETA HOSPITAL

JOB DESCRIPTION

Ward Receptionists

Under Clerical Workers Award

Responsible to - Manager (Administration)
Charge Nurse for all duties delegated in the Ward or Department.

These include -
Answering telephone
Writing patient dependency board
Checking Stationery, Stores, Sterile supplies, Linen (Imprest system)
Filing all reports when sighted by Charge Nurse
Assembling Admission and Discharge Charts
Checking with Cleaning Company and reporting unsatisfactory standards.
Collecting and depositing patient's valuables.
Taking messages - Laboratory reports (per phone)
X-Ray reports (per phone)
Writing tidy duty lists (rosters)
Inserting fresh Kardex cards as required.
Organising visits from District Nursing Service
Social Workers
Physiotherapists
Dietitians
Occupational Therapists
Filling in Thermic Charts i.e. putting little dots in the appropriate place.
Ruling up any books requiring same.
Checking to see that the Crash Trolley check book has been signed.
Keeping patient situation board up to date.
Writing bed labels.
Some actually assist with feeding patients but this is voluntary.
APPENDIX E1

DELTA HOSPITAL

Nursing Services Committee

Terms of Reference

Within the framework of Hospital Board and Health Department policies the Nursing Services Committee:

1. Receives information and submissions on matters affecting nursing services.

2. Sets up sub-committees, as it considers necessary, to study and advise on major concerns related to nursing services, e.g.
   - manpower planning and staff allocation;
   - nursing practices and procedures including plans to meet emergency situations;
   - evaluation of patient care;
   - staff appraisal and development;
   - staff welfare.

3. Co-opts such personnel, with special knowledge and skills, as it needs, for the work of its sub-committees.

4. Considers the submissions of its sub-committees, defines and recommends policies for nursing services to the Principal Nurse.

5. Keeps nursing and other personnel informed of matters affecting nursing services.

6. Promotes the undertaking of studies as a basis for improving nursing practice and encourages the publication of the results of such studies.
DELTA HOSPITAL - NURSING SERVICE
OBJECTIVES FOR 1976

Nursing Administration
1. To define duties and areas of responsibility for Assistant Matrons and Day Supervisors.
2. To complete job descriptions for all supervising N/staff, ward and departmental sisters.
3. To evaluate the work load in clinical areas in order to set realistic N/staff establishments for all categories of staff.
4. To develop a workable filing system for N/staff records and directives with the assistance of the clerical staff.

Nursing Service
1. To introduce a system of planned individual care by using the patient assignment method in the general ward areas.
2. To develop a nursing service policy for the storage and admin. of all medicines and drugs kept in clinical areas. This with the assistance of the N/Service/Committee.
3. To introduce an improved kardex system for reporting on patient's progress, including the use of N/care plans.
4. To formulate N/care plans to meet emergency situations in liaison with the Officer-in-Charge of "Disaster Planning".

Nursing Education
1. To encourage supervisors, ward/departmental sisters to undertake some Admin. training by:
   (1) arranging study/visits to Beta Hospital.
   (2) arranging a 2 day workshop Delta Hospital.
2. To increase the Reg. N/Staff establishment in specialised areas e.g. Ob.U., A & E, Intensive Care and C.C.U. in order that students allocated to these areas for clinical experience are
supernumary to the N/staff work force e.g. they are given student status.

Staff Welfare
1. To investigate ways of improving changing room/locker facilities for living out N/staff.
APPENDIX E3

DELTA HOSPITAL

PHILOSOPHY OF NURSING SERVICE

1. The community to which the Nursing Service is ultimately responsible has a right to expect effective nursing care to be provided for those of its members who become patients in this hospital. We recognise the worth of each individual, regardless of his background, and believe that he should receive nursing care designed to meet his specific needs - physical, mental, emotional and spiritual. We also believe that each patient's autonomy should be preserved in illness, insofar as he is able to exercise it.

2. As the member of the health team having the broadest function and most continuous contact with the patient, we believe that the nurse is in a unique position to act as advocate for the patient. This means that, in addition to giving care, the nurse observes and interprets different facets of the patient's condition for other members of the health team, and in turn communicates the objectives of the team to the patient.

3. With the proviso that the safety and welfare of our patients is the first priority, the Nursing Service should co-operate with agencies responsible for the basic education of nurses by providing the necessary clinical experience. We recognise that the quality of basic nursing education is one of the most important factors influencing the quality of nursing care.

4. The Nursing Service also accepts responsibility for the education and welfare of its qualified staff. We believe that to function effectively, nurses need planned orientation to their positions, clear job descriptions, opportunities to develop professionally, assistance with evaluating and improving their performance, and access to such counselling and health services as they may require.

5. We believe that we are responsible for improving the quality of our service to the community by collecting data, trying out and evaluating new methods of planning and giving nursing care, and by freely sharing information which will help others to improve the total health care services.
DELTA HOSPITAL

JOB DESCRIPTION

Title: Second Assistant Matron

Hours: 40 hours per week (over 5 days) and within the hours of 7.30 a.m. and 4.30 p.m.

Salary: Grade 16 in accordance with Hospital Regulations (Nurses').

Responsible to: Matron - Delta Hospital.

Reports to: Matron.

Qualifications: Registered Nurse (General).
Diploma of Nursing or equivalent.
Post basic experience in a teaching hospital, at Ward Sister/Supervisor level.
Personal qualities suitable for good leadership.

Job Summary: The work involves deputising for the Matron or the First Assistant Matron as necessary; the general management of the Wards/Units within her area; acting as consultant; maintaining and developing optimum levels of nursing care within her area through the principles of management.

Special Responsibilities: Allocation and rostering nursing staff (Delta Hospital); liaising with Supervisor (Domestic).

Knowledge of:
1. Nurses' Act (1971) and amendments.
2. Hospital Employment (Nurses') Regulations.
4. Narcotics Act (1975) and Regulations.
5. Hospital Board and local hospital policies.
6. Student Nurses' Curricula -
   (i) General
   (ii) Community.
7. Health Department directives relating to nursing practice.

Functions:
1. Guides Ward Sisters in planning, implementing nursing care by:
   (a) Maintaining planned individual care by the patient assignment method.
   (b) Examining and defining the daily routine of care.
   (c) Evaluating nursing procedures.
(d) Defining and eliminating non-nursing duties.
(e) Ensuring that established communication systems are maintained.

2. Evaluates nursing care by:
   (a) Assessing nursing records.
   (b) Initiating patient interview systems.
   (c) Consulting with allied health groups and community services.

3. Evaluates nursing care plans by:
   (a) Ensuring individual care is planned for patients.
   (b) Assisting in planning care for those patients requiring complex nursing.
   (c) Visiting patients in her area daily.

4. Serves as a resource person by:
   (a) Being available to sisters and other staff to help solve nursing care problems - (holding group meetings of Ward Sisters in her area).
   (b) Co-ordinating nursing care with care given by doctors and other health groups.

5. Plans for the effective utilisation of staff by:
   (a) Recommending desirable staff establishment, using levels of nursing skill appropriate to patient requirements.
   (b) Assessing the adequacy of afternoon staffing in her area.
   (c) Controlling overtime and leave (including annual leave) of the staff.
   (d) Conserving nursing skills for nursing activities.

6. Ensures all staff are evaluated regularly as required.

7. Initiates planned in-service and staff development programmes in liaison with the members of the In-Service Education Committee.
   (a) Recognising staff training needs.
   (b) Assisting in clinical teaching of all nursing staff in her area.
   (c) Ensuring staff participate in other appropriate staff training programmes.

8. Maintaining her own professional education by planning an active programme for herself.

9. Setting and maintaining professional standards of conduct and dress.

10. Recognises staff welfare needs by:
(a) Observing levels of staff health and referring to Health Clinic when appropriate.
(b) Providing support and guidance to individual nurses when necessary.

11. Maintains a co-operative liaison and ensures good relationship with medical staff, nursing staff in other areas, staff in Hospital departments and community services.

12. Creates and maintains a favourable relationship with the public.

13. Checks dangerous drugs in her area weekly with the Ward Sister and investigates errors in drug administration and missing drugs.

14. Undertakes any other duties as delegated by the Matron.

15. Supervisory ward rounds to be conducted by Ward Sister giving information on:
   (a) Seriously ill and/or dying patients.
   (b) Number on intravenous therapy.
   (c) Number in (b) above, requiring additives.
   (d) Any possible legal complications.
   (e) Number for Theatre - major and minor and whether relatives notified or any special request for non-notification of relatives.
   (f) Any lost property.
   (g) Any thefts - if reported to Police.
   (h) Any ward equipment in need of repair and not attended to.
   (i) Any nursing defects noted.
   (j) Any other fact which causes detriment to patient care or hinders efficient nursing management.

   Any complaints from patients, patients' relatives, nursing staff, medical staff or ancillary staff.

   Danger or trouble areas in any ward, i.e. rude or abusive patients or alcohol on premises.

   Where no solution or an unsatisfactory conclusion is reached on any problem, to report either verbally or in writing to the Matron.

Special Responsibilities include:

1. Roster and arranging the clinical experience for nursing students in liaison with the Charge Tutor according to the requirements of the General and Community Nursing curricula.

2. Rostering the Registered Nurses, Registered Community Nurses and Hospital Aids - General Wards and Departments.

3. Arranging annual leave for nursing students as well as other nursing staff in the supervising area.

4. Overall coverage of duties due to sickness or absenteeism.
Authority:

The Second Assistant Matron is delegated the full authority of the Matron and carries the responsibility and accountability for her own decisions.
APPENDIX E5

January 1976

DELTAL HOSPITAL

JOB DESCRIPTION

Title: Area Supervisor - Nursing Service.

Hours: 40 hours per week (over 5 days) and within the hours of 7.30 a.m. and 4.30 p.m.

Salary: Grade 15 in accordance with Hospital Regulations (Nurses).

Responsible to: Matron - Delta Hospital.

Reports to: Matron.

Qualifications: Registered Nurse (General). Diploma of Nursing or equivalent. Post basic experience in a teaching hospital. Personal qualities suitable for good leadership.

Job Summary: The work involves the general management of the Wards/Units within her area; acting as consultant, maintaining and developing optimum levels of nursing care within her area through the principles of management.

Special Responsibilities: Nursing staff health.

Knowledge of:

1. Nurses' Act (1971) and amendments.
3. Hospital Employment (Nurses') Regulations.
4. Narcotic Act (1965) and Regulations.
5. Hospital Board and local hospital policies.
6. Student Nurses' Curricula -
   (i) General
   (ii) Community.
7. Health Department directives relating to nursing practice.

Functions:

1. Guides Ward Sisters in planning, implementing nursing care by:-
   (a) Maintaining planned individual care by the patient assignment method.
   (b) Examining and defining the daily routine of care.
   (c) Evaluating nursing procedures.
   (d) Defining and eliminating non-nursing duties.
   (e) Ensuring that established communication systems are maintained.
2. Evaluates nursing care by:-
   (a) Assessing nursing records.
   (b) Initiating patient interview systems.
   (c) Consulting with allied health groups and community services.

3. Evaluates nursing care plans by:-
   (a) Ensuring individual care is planned for patients.
   (b) Assisting in planning care for those patients requiring complex nursing.
   (c) Visiting patients in her area daily.

4. Serves as a resource person by:-
   (a) Being available to sisters and other staff to help solve nursing care problems - (Holding group meetings of Ward Sisters in her area).
   (b) Co-ordinating nursing care with care given by doctors and other health groups.

5. Plans for the effective utilisation of staff by:-
   (a) Recommending desirable staff establishment, using levels of nursing skill appropriate to patient requirements.
   (b) Assessing the adequacy of afternoon staffing in her area.
   (c) Controlling overtime and leave (including annual leave) of the staff.
   (d) Conserving nursing skills for nursing activities.

6. Ensures all staff are evaluated regularly as required.

7. Initiates planned in-service and staff development programmes in liaison with the members of the In-Service Education Committee.
   (a) Recognising staff training needs.
   (b) Assisting in clinical teaching of all nursing staff in her area.
   (c) Ensuring staff participate in other appropriate staff training programmes.

8. Maintaining her own professional education by planning an active programme for herself.

9. Setting and maintaining professional standards of conduct and dress.

10. Recognises staff welfare needs by:-
    (a) Observing levels of staff health and referring to Health Clinic when appropriate.
    (b) Providing support and guidance to individual nurses when necessary.
11. Maintains a co-operative liaison and ensures good relationship with medical staff, nursing staff in other areas, staff in Hospital departments and community services.
12. Creates and maintains a favourable relationship with the public.
13. Checks dangerous drugs in her area weekly with the Ward Sister and investigates errors in drug administration and missing drugs.
14. Undertakes any other duties as delegated by the Matron.
15. Supervisory ward rounds to be conducted by Ward Sister giving information on:-
   (a) Seriously ill and/or dying patients.
   (b) Number on intravenous therapy.
   (c) Number in (b) above, requiring additives.
   (d) Any possible legal complications.
   (e) Number for Theatre - major and minor and whether relatives notified or any special request for non-notification of relatives.
   (f) Any lost property.
   (g) Any thefts - if reported to Police.
   (h) Any ward equipment in need of repair and not attended to.
   (i) Any nursing defects noted.
   (j) Any other fact which causes detriment to patient care or hinders efficient nursing management.

   Any complaints from patients, patients' relatives, nursing staff, Medical staff or ancillary staff.

   Danger or trouble areas in any ward, i.e. rude or abusive patients or alcohol on premises.

   Where no solution or an unsatisfactory conclusion is reached on any problem, to report either verbally or in writing to the Matron.

Authority:

The Area Supervisor is delegated the full authority of the Matron and carries the responsibility and accountability for her own decisions.

Special Responsibilities include:

(a) Supervising and co-ordinating matters of health, reporting through correct channels, instituting medical instructions and maintenance of relevant records in relation to nursing staff.

(b) Tactful observation of staff who seek treatment, especially nursing students under pressure of examinations and adjustment; counselling and teaching of preventive health.
(c) (i) Health records of nursing staff at the Delta Hospital.
(ii) Reporting and follow-up of accidents, acute illnesses-operations, ailing staff.
(iii) Special situations -
T.B. contacts follow up.
Entitlement to special maternity leave, under the Board's policy.
Workers' Compensation forms.
Accident forms.
(iv) Liaison with Supervisor - Nursing allocation.
List of sick nurses to duty office - in some instances, special items necessary where state of health affects ability to work.
(d) Reporting to Matron, or Deputy, particulars in connection with Nursing Staff, including matters of a private and urgent nature concerning staff members.

Liaison with:
Ward Sisters of hospitalised staff.
Supervisor, Accident and Emergency Department.
Nurses' Duties Supervisor.
Staff Clerk - Delta Hospital Board Office (re salaries sick staff).
Charge Radiographer (re routine x-rays).
Supervisor, Staff Residence (re sick staff in residence).
Hospital Chaplain and other Ministers of Religion.

Preventive Health:
Interview and lecture oncoming nursing students.
Annual routine chest x-rays for nursing staff.
Immunisation Therapy programme.
Routine for staff nursing Tuberculosis patients - positive Tuberculin test or scar check after B.C.G. and clear x-ray report.
## STAFF ESTABLISHMENT

**Delta Hospital**

### STAFF ESTABLISHMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>Approved</th>
<th>ACTUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full time</td>
<td>Part time</td>
</tr>
<tr>
<td>Principal Nurse</td>
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</tr>
<tr>
<td>Assistant Principal Nurse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nurse-In-Charge/Head Nurse</td>
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<td></td>
</tr>
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<td>Assistant Nurse-In-Charge Supervisor</td>
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<td>1</td>
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<tr>
<td>Charge Nurse</td>
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<tr>
<td>Staff Nurse</td>
<td>51</td>
<td>58</td>
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<tr>
<td>Reg. Maternity Nurse</td>
<td>5</td>
<td></td>
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<tr>
<td>Reg. Community Nurse</td>
<td>57</td>
<td>5</td>
</tr>
<tr>
<td>Karitane Nurse</td>
<td></td>
<td></td>
</tr>
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<td>Total qualified staff</td>
<td>138</td>
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<tr>
<td>Srn Assistant Nurse</td>
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<td></td>
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<tr>
<td>Hospital Aid</td>
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<td>8</td>
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<tr>
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<td>Psychiatric student</td>
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<tr>
<td>Community student</td>
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<td></td>
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<tr>
<td>Midwifery student</td>
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<tr>
<td>Maternity student</td>
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<tr>
<td>Charge/senior tutor.</td>
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<tr>
<td>Tutor</td>
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</tr>
<tr>
<td>Total Tutorial staff</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Total All Staff</td>
<td>316</td>
<td>77</td>
</tr>
</tbody>
</table>
Nursing Team: Two or more nursing personnel who plan and work together under the guidance of a nursing leader, to provide patient centred nursing care.

Team Leader: An experienced nurse who assumes responsibility for the nursing care of a group of patients assigned to her team. She plans, directs, co-ordinates, supervises and evaluates the care given by team members to the patients assigned to the team. She is responsible to the Ward Sister for providing optimum nursing care.

Team Conference: An informal discussion by team members which is organised by the team leader. The primary purpose is to provide an opportunity for team members to plan and evaluate the care they have given and to use a problem-solving approach to nursing care. The Conference is group centred and each team member is encouraged to participate and contribute. Secondary purposes of a conference are to consider nursing management in general, new treatments or discuss broader aspects of patient care with other members of the health team.

Team Report: The team meeting at the beginning of the duty when the team leader reads the report and ensures that each team member is familiar with her responsibilities and the care she is to give her patients.

Team Plan: A prepared form which indicates the team members and allocation of patients as well as the non-nursing tasks assigned to team members. It is prepared the previous day and amended if circumstances dictate a change. The team plan is displayed so that it is readily accessible to all staff.

Accountability: When a nurse assumes responsibility for nursing care she becomes accountable for the standard of care that she gives and for her actions.
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Care Plan</td>
<td>A plan for care for the patient which is based on his/her needs. It is flexible and amended to meet his/her changing needs and nursing dependence. The form of nursing care plan varies from a simple to a complex form.</td>
</tr>
<tr>
<td>Patient Centred Care</td>
<td>Nursing care which is planned to meet the individual needs of the patient.</td>
</tr>
<tr>
<td>Comprehensive Patient Care</td>
<td>Care planned for the patient which takes into account his/her individuality and recognises his/her relationship to his/her family and community and the dependence on all members of the health team to provide care which will meet his/her physical, emotional, social and spiritual needs.</td>
</tr>
<tr>
<td>Functional Assignment</td>
<td>A form of nursing care which is centred on tasks rather than the patient.</td>
</tr>
<tr>
<td>Non-Nursing Tasks</td>
<td>To ensure effectiveness in giving nursing care, the environment and facilities must be maintained efficiently. Nurses have a responsibility for supervision and maintenance of working areas and supplies.</td>
</tr>
<tr>
<td>Nursing Care Conference</td>
<td>A conference organised by the Ward Sister or Team Leader at which general aspects of nursing care are discussed. Standards and deficiencies of care can be evaluated and appropriate action planned and effected.</td>
</tr>
</tbody>
</table>
GUIDE LINES FOR TEAM NURSING

Team nursing is a means by which the highest possible standard of patient care is achieved.

The ward personnel are organised into small work groups (teams) with a registered or senior nurse as leader of a group. The Ward Sister delegates to the team leader the responsibility for planning a programme of nursing care for a group of patients and for guiding and directing the members of the team in carrying out their assignment.

The team, as a group, works together, plans together, learns together and confers together.

Team Nursing
- Is individualised, patient-centred care.
- Utilises the abilities of each team member.
- Provides for close guidance and supervision of all nursing care by a registered or senior nurse who is team leader.
- Implements patient-centred care by the daily team conference.

We believe that the patient is the centre and focus of all activity, and it is the responsibility of the nurse to meet his/her nursing needs. The nurse who performs at optimum level is the one who gains satisfaction in her work and is entitled to this reward, therefore every opportunity should be provided for her to enjoy it.

By organising the ward staff in teams, registered nurses and senior student nurses are provided with motivation to leadership roles and to the development of creative ability. The delegation of responsibility to team leaders provides opportunity to plan work to be done to meet the learning needs of student nurses and other members of the team and to give closer supervision and guidance. Opportunity to learn, to develop skills and abilities and to participate in group conferences, should result in satisfaction in one's work.
RESPONSIBILITIES OF WARD SISTER

The Ward Sister

- co-ordinates the Administrative and nursing activities of the Ward
- plans allocation of patients to rooms
- maintains effective communication with team leaders
- is aware of patients' needs, condition and progress
- acts as resource person when problems arise that are unable to be handled by team leader
- reports on patients and nursing care to the Supervising Sister
- plans allocation of staff to teams in consultation with team leaders
- provides for staffing needs over the twenty-four hour period
- evaluates the quality of nursing care provided by each member of the nursing staff
- attends Doctor's round with Team Leader
- attends Team Conference when possible and assists team members with solutions to problems.
- conducts a nursing care conference weekly with the purpose of improving patient care
- encourages the highest standard of nursing care
- plans and implements an orientation programme for all staff assigned to the Ward in consultation with I.E.S.S.
- plans and carries out a teaching programme for nursing students and hospital aides in consultation with Principal Tutor and I.E.S.S.
- encourages registered staff to use every opportunity for teaching
- encourages the development of registered staff both professionally and clinically
- observes and reports the health of nurses and reports accidents or injuries to staff and patients
- is responsible to the Matron and Medical Superintendent for the care of all patients in the Ward
- assists the Ward Sister in evaluating the performance of team members
- recognises and accepts the contribution made by each team member
- is responsible for the Kardex report but encourages team members to write reports of their own patients when appropriate
- ensures that patients have adequate explanation of procedures and processes and that follow-up care is organised
- ensures that non-nursing tasks and responsibilities allocated to team members are efficiently executed.
The Team Leader

- maintains effective communication with the Ward Sister and team members in all matters relating to nursing care
- plans with her team members the care of patients assigned to the team
- assists team members to identify the nursing needs of patients and determine priorities of care
- co-ordinates activities with other team leaders to ensure that team members understand need for interaction with other teams
- assigns patients to team members in consultation with Ward Sister and amends assignment to provide for new admissions, critically ill patients or change in team membership
- directs and supervises the members of the team in carrying out nursing care and ensures that each team member is fully conversant with, and competent to carry out the care of assigned patients
- visits each patient assigned to the team as frequently as necessary
- attends Doctor's round
- is readily available to team members for consultation and assistance
- participates in direct patient care taking into account the need to be available to team members
- conducts a team report to clarify assignments
- plans a team conference
- acts as leader for the conference but encourages team members to participate and contribute
- encourages team members to report individually on care of patients
works with the team to identify and interpret nursing problems and seeks the co-operation of team members in planning to meet the individual needs of patients

- maintains a high standard of nursing care

- plans and designates times for tea and meal breaks and co-operates with other team leader to ensure that the care of patients will not be deficient with absence of staff

- ensures that team members are aware of the team leader's expectations of them

- fosters increased personal satisfaction, professional development and clinical competence of team members

- is accountable to the Ward Sister for the care of patients assigned to her team

- assists the Ward Sister in evaluating the performance of team members

- recognises and accepts the contribution made by each team member

- is responsible for the Kardex report but encourages team members to write reports of their own patients when appropriate

- ensures that patients have adequate explanation of procedures and processes and that follow up care is organised

- ensures that non nursing tasks and responsibilities allocated to team members are efficiently executed.
RESPONSIBILITIES OF TEAM MEMBERS

The Team Member

- develops an awareness of the needs of assigned patients and determines priorities of care
- plans and carries out the nursing care of patient's assigned to her
- seeks help and guidance from the team leader and more senior team members when necessary
- is accountable to the Team Leader for the nursing care of patients assigned to her.
- works with other members of the team to effect improvement in nursing care
- attends conference and participates in discussion
- reports to Team Leader on the care of her patients
- makes use of learning experiences to improve nursing care and her clinical competence
- maintains optimum standard of nursing care
- writes Kardex report of her patients when appropriate.
APPENDIX THREE

A Supplement to Section Three (Volume 1).

This Supplement contains additional information in relation to the processing of data and the results reported in Volume 1.
## List of Contents in Appendix Three

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Code for Content Analysis of Interviews</td>
<td>63</td>
</tr>
<tr>
<td>H</td>
<td>Categories for Kardex Theme Counts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H1 Categories for Kardex Content Analysis</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>H2 Differentiation on Value of Themes</td>
<td>67</td>
</tr>
<tr>
<td>I</td>
<td>Factor Analysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I1 Facsimile of Computer Sheets</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Variable List</td>
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</tr>
<tr>
<td></td>
<td>Correlation Coefficients</td>
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<td>Factors (percentage of variance)</td>
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<td>Factor Pattern</td>
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<td>Factor Structure</td>
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<td>I2</td>
<td>Factor Structure: Summary</td>
<td>78</td>
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## CODE FOR CONTENT ANALYSIS OF RECORD OF OBSERVER'S VISITS TO WARD/UNIT/DEPARTMENT

(Categorization by theme)

<table>
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<tr>
<th>Task (a)</th>
<th>Category Definition</th>
<th>Code</th>
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<tr>
<td>patient dependency, work load score</td>
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<tr>
<td>nursing care plans, patient history</td>
<td>a2</td>
<td></td>
</tr>
<tr>
<td>patient treatments</td>
<td>a3</td>
<td></td>
</tr>
<tr>
<td>philosophy and/or objectives</td>
<td>a4</td>
<td></td>
</tr>
<tr>
<td>administration (hosp/ward/unit/dept)</td>
<td>a5</td>
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</tr>
<tr>
<td>includes assessment of staff, and ward rounds. research, trial, survey, study, development</td>
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<td>ward meeting, staff meeting</td>
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<tr>
<td>record keeping, reporting, kardex/nurses notes</td>
<td>a8</td>
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<tr>
<td>decision making, responsibility</td>
<td>a9</td>
<td></td>
</tr>
<tr>
<td>analysis of work</td>
<td>a10</td>
<td></td>
</tr>
<tr>
<td>reading, theory, as basis for practice</td>
<td>a11</td>
<td></td>
</tr>
<tr>
<td>staff training, teaching, committee, conference</td>
<td>a12</td>
<td></td>
</tr>
<tr>
<td>patient requests, meal service, patient activity, personal service</td>
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<td></td>
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<tr>
<td>communication: staff/staff, staff/patient, patient/patient</td>
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<table>
<thead>
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<th>Structure (b)</th>
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<tbody>
<tr>
<td>ward/unit/dept. medical staffing</td>
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<td>ward/unit non-medical staffing</td>
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<tr>
<td>patient distribution and movement</td>
</tr>
<tr>
<td>charge nurse/ deputy charge nurse duties</td>
</tr>
<tr>
<td>hospital/other units in hospital</td>
</tr>
<tr>
<td>team nursing, patient assignment, primary nursing</td>
</tr>
<tr>
<td>charge nurse: beginning/returning/leaving</td>
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<tr>
<td>ward: closing/opening</td>
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<td>outside hospital</td>
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<table>
<thead>
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<tr>
<td>equipment</td>
</tr>
<tr>
<td>furnishings</td>
</tr>
<tr>
<td>drugs/diet/intravenous</td>
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<tr>
<td>safety</td>
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</table>
Human  (d)

medical
tutor/supervisors/principal nurse/assistant principal
nurse/chief nursing officer
subordinates: nurses/non-nurses
patients: comments about condition and other
  qualifying statements
charge nurse, acting charge nurse and peer groups
hospital and other units
hospital/ward/office: climate, environment
ward task level
relatives/visitors

Time/Date

Negative Change
  same, not improved, no change, worse

Positive Change
  improving, change, innovation, new, new ideas

Researcher Comment

Project Training Course

Researcher Emphasis

No Comment By Ward Charge
CATEGORIES FOR CONTENT ANALYSIS OF KARDEX ITEMS BY THEME.

(Categories adapted from Georgopoulos and Jackson (1970) and applied to scheme (Holsti, 1969), developed for the charge nurse innovation project).

1. **Functional Status**: any statements referring to symptoms or signs (other than vital signs) manifested by the patient, physiological dysfunctions, level of consciousness, level of severity of illness.

2. **Physical Care**: data about the patient's positioning, hygiene, grooming, rest and comfort, prosthetic or dental care, and other physical aspects, references to "same cares".

3. **Psychosocial Care**: references to the patient's emotional response, adjustment, fears or anxiety, self-concern, family or occupational and social relation, concerns with diagnosis, prognosis, therapy, rehabilitation, or post-hospital care, referral to community agencies, and other psychological and social problems.

4. **Patient Progress**: any statements concerning changes over time, whether positive or negative, in the patient's condition or hospitalization stage and status.

5. **Patient Participation**: explicit statements pertaining to patient involvement in the care process or self-care, including self-medication, attendance at classes (e.g. diabetic, antenatal).

6. **Ability/Disabilities**: statements of specific sensory-motor impairments and of special assistance needed by patient in connection with this, special patient skills, and/or abilities and references to deficits secondary to the patient's pathology or main reason for hospitalization.

7. **Patient Preferences/Interests**: individual desires, likes and dislikes, hobbies, personal preferences, and statements regarding patient acceptance or refusal on matters not directly associated with his illness.

8. **Pain**: all explicit and specific references to pain or its characteristics.

9. **Sleep**: any direct references to the patient's sleep.

10. **Medications**: any references to medicines or drugs (type, dose, frequency), and their prescription, supply, administration, effects, and recording (excluding intravenous additives).

11. **Patient Diet**: all statements regarding food or nutrition including therapeutic dietary requirements and the type, amount, and special characteristics of food, required, ordered or consumed.

12. **Patient Activity**: any statements concerning activity privileges or restrictions for the patient including immobilization and locomotion concerns.
13. **Blood Pressure:** any data pertaining to the patient's blood pressure.

14. **Weight:** any data concerning the patient's weight or weighing.

15. **Intake and Output:** specific references to the quantity of fluids taken by the patient and subsequent output, fluid restrictions, fluid balance, and medical orders, regarding fluids and their administration and recording. P.V. loss is included in this section.

16. **T.P.R.:** any statements concerning the patient's temperature, pulse or respiration.

17. **Treatments:** all explicit comments regarding specific therapies such as suctioning, dialysis, wound dressing, physiotherapy, inhalation treatment, soaks, enemas, irrigations, catheterizations, the use of special aids such as heat lamps, Stryker bed, etc.

18. **Specimens:** any themes concerning the collection, management, processing, and character (purpose, type, frequency, findings) of specimens obtained from patients, as well as medical instructions regarding specimens.

19. **Tests and Procedures:** all references to diagnostic tests (blood and urine tests, x-rays, biopsies, scans, liver function tests, etc) and related procedures, or to patient preparation for tests and procedures, whether at the bedside, the patient unit, or other parts of the hospital. Routine and special physical or technological examinations by a doctor are included here.

20. **Precautions:** any themes concerning isolation or other precautionary measures relating to such things as seizures, allergies or infections, antisuicidal measures, and measures against exposure to radiation or other dangers, either on the part of patients or staff.

21. **Artificial Drainage Methods:** all explicit themes about urinary tract drainage devices, their functioning, and their use and care. Functioning of colostomy, ileostomy and attachments. Care and functioning of tracheostomy and thoracic drainage also included.

22. **Artificial Intake Methods:** themes concerning any intravenous or parenteral fluids including fluids with medication additives and their administration and management. Also included are the care and functioning of nasogastric tube, subcutaneous infusion etc.
DIFFERENTIATION OR VALUE OF THEMES

A. Descriptive: a statement of condition not elaborated in any way. Statements such as:

- slept well
- satisfactory
- good night
- comfortable
- sits up in bed
- uncomplaining
- no complaints
- up and about
- cheerful
- no visitors today
- usual self.

B. Prescriptive: any statement which contains order or intent e.g. "same cares".

C. Evaluative: any statement which contains an element of judgement assessment, or decision making which elaborates the statement (may contain action) e.g. "refer to H/S" or statements related to decision making, nursing diagnosis.
APPENDIX II

Factor analysis: Facsimile of Computer Sheets

Variable List
Correlation Coefficients
Factors (percentage of variance)
Factor Pattern
Factor Correlations
Factor Structure
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**Note:** The table above represents the correlation coefficients between various variables. The correlation coefficients range from -1 to 1, where 1 indicates a perfect positive correlation, 0 indicates no correlation, and -1 indicates a perfect negative correlation. The p-values indicate the statistical significance of the correlations.
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**S P A C E **

**S P A C E **
FACTOR STRUCTURE

Nine initial factors were extracted from the unrotated correlation matrix. Oblique rotation, using direct oblimin loadings and Kaiser normalisation yielded nine factors whose structure indicates that they may well be related to organisational personality and nursing functions.

Factor 1 responsible for 21.3% of the variance loads highly on achievement and intellectual efficiency.

Factor 2 responsible for 17.1% of the variance loads highly on POI inner directedness, existentiality and spontaneity. Related to independence, and flexibility.

Factor 3 responsible for 15.1% of variance loads highly on time competence, and self-acceptance and appears to be an organisational factor.

Factor 4 which contributes 12.6% of the variance loads highly on number of patients and average occupied bed rate, a moderating structural factor.

Factor 5 contributes 9.5% of the variance loads highly on POI capacity for intimate contact. This is clearly an interpersonal factor.

Factor 6 is related to innovativeness.

Factor 7 loads highly on doctor-dependent and nurse-dependent Kardex variables. This seems to be a nursing practice factor.

Factor 8 has a high loading on feeling reactivity.

Factor 9 loads highly on socialisation and perceived organisational-self.
APPENDIX FOUR

A Supplement to Section Four (Volume 1)

This Supplement contains additional information about the training programme used as intervention in the experimental extension of the thesis presented in Volume 1. In this Appendix, details of techniques used in the programme, and the outcomes of these techniques have been included for those interested in group work practice.
List of Contents in Appendix Four

<table>
<thead>
<tr>
<th>Appendix</th>
<th>page</th>
</tr>
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<tbody>
<tr>
<td>J</td>
<td></td>
</tr>
<tr>
<td>J Training Programme, Beta Hospital</td>
<td></td>
</tr>
<tr>
<td>J1 Original design</td>
<td>82</td>
</tr>
<tr>
<td>J2 Revised Programme, Groups A and B</td>
<td>84</td>
</tr>
<tr>
<td>J3 Aspects of Work of Ward Charges (Group A)</td>
<td>86</td>
</tr>
<tr>
<td>J4 Aspects of Work of Ward Charges (Group B)</td>
<td>87</td>
</tr>
<tr>
<td>J5 An Introduction to Groups and Group Process</td>
<td>89</td>
</tr>
<tr>
<td>J6 Operation Fishbowl</td>
<td>96</td>
</tr>
<tr>
<td>J6.1 Group Exercise</td>
<td>97</td>
</tr>
<tr>
<td>J6.2 Group Decision-making</td>
<td>98</td>
</tr>
<tr>
<td>J7 Training Programme, Beta Hospital</td>
<td>99</td>
</tr>
<tr>
<td>J8 Nursing Incidents</td>
<td>100</td>
</tr>
<tr>
<td>J9 Methods of Evaluating Nursing Practice</td>
<td>104</td>
</tr>
<tr>
<td>J10 Notes on Methods of Delivering Nursing Care</td>
<td>108</td>
</tr>
<tr>
<td>J11 Exercise Future</td>
<td>110</td>
</tr>
<tr>
<td>J12 Evaluation of the Training Programme</td>
<td>113</td>
</tr>
<tr>
<td>J13 Exercise Self-appraisal</td>
<td>114</td>
</tr>
<tr>
<td>K Before and After Treatment</td>
<td></td>
</tr>
<tr>
<td>K1 Group B (T3-T2)</td>
<td>116</td>
</tr>
<tr>
<td>K2 CPI, POI &amp; NOI Profiles</td>
<td>117</td>
</tr>
<tr>
<td>K3 NOI Profiles A &amp; B</td>
<td>118</td>
</tr>
<tr>
<td>K4 CPI Profiles (T1,T2,T3,T4)</td>
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<td>K4.1 Group A</td>
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Group Programme: November 8th - 12th & November 22nd - 26th

Monday

0900 - 1015
Introduction
- Objectives
- Outline of the course
- The individual
- The group and the organization
- Group exercise

1015 - 1030
Tea

1030 - 1215
"You and your work"
- A group incident approach and discussion (plenary session)

1215 - 1300
Lunch

1300 - 1500
Groups and group process
(Plenary session)

1315 - 1630
Observation of groups
"Operation Fishbowl"

Tuesday

0830 - 1015
Group I discussion, using videotape
Group II discussion

1030 - 1215
Group II discussion using videotape
Group I discussion

1300 - 1330
Plenary session
- to discuss morning programme

1330 - 1500
- leadership
- membership
- roles

1515 - 1630
Group exercise

Wednesday

0830 - 1015
Management - and the ward charge
(plenary session)

1030 - 1215
Group I) discussion
Group II) discussion

1300 - 1500
Aspects of modern management

1515 - 1630
Group I) discussion
Group II) discussion
### Thursday
- **0830 - 1015** Systems of delivery of nursing care
- **1030 - 1215** Group discussion
  Groups I, II, III and IV
- **1300 - 1500** Evaluation of nursing and management practice
- **1515 - 1630** Group discussion
  Groups I, II, III and IV
  and feedback session

### Friday
- **0830 - 1015** Strategies of change and the process of change
- **1030 - 1215** Exercise Future
- **1300 - 1500** Plenary session
- **1515 - 1630** Summary and evaluation of the programme
Monday

0900 - 1015  
Introduction  
- objectives  
- outline of the course  
- introduction of members  
- the group and the organization  
- group exercise

1015 - 1030  
Tea

1030 - 1215  
"You and Your Work"  
- a group incident approach and discussion  
  (plenary session)

1300 - 1400  
Groups and group process  
  (plenary session)

1400 - 1500  
Observation of groups  
  (group exercise)

1515 - 1630  
Observation of groups  
"Operation Fishbowl"

Tuesday

0830 - 1015  
Group discussion  
  (using case incidents)  
  I and II  
  III and IV

1030 - 1215  
Groups and Group Process  
- leadership  
- membership  
- roles

1300 - 1500  
Group discussion  
  (using videotape)  
  I and II  
  III and IV

1515 - 1630  
Counselling in nursing practice
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<td>1515 - 1630</td>
<td>Summary and evaluation of the programme.</td>
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ASPECTS OF THE WORK OF WARD CHARGES
identified by Group A
using incident technique.

1030 - 1230 hours, Monday, November 9th

Clinical:

Giving information to patients or relatives.
Increase in facilities for relatives.
Communication with doctors.
Advising on treatment of patients.
Preparation of patients for surgery.
Giving support to patients.
Patient rehabilitation (especially reducing excess disability).
Standard of clinical care.
Criticism of nurses' work by other professionals (e.g. doctors, dietitians, etc.)
Expectation of staff performance by other professionals and the ward charge.
Side effects of radical (or life saving) patient treatments.
Interference in nursing by doctors.
Loneliness of patients.
Approaches of nursing and medical staff to patients.
Attitudes of patients.
Spending time with patients.
Functioning and ordering of equipment.
The confidence of patients in hospital treatments.
Clinical teaching (of housemen and nurse students).
Crisis intervention.
Decision making by ward charges in relation to patient care.
Communication with patients and relatives.

Management:

Nurses' duty requests.
Communication with supervisor, staff rotation.
Ward environment - ward "climate".
Communication, patients and staff.
Co-operation - with other sections of hospital, especially nursing administration.
The relationships between ward charges and nursing administration.

Teaching:

Making out and giving ward reports to students.
APPENDIX J4

ASPECTS OF THE WORK OF WARD CHARGES

IDENTIFIED BY GROUP B

Using Incident Technique

1030-1220 hours, Monday, November 22nd 1976

Clinical

Patients making their own decisions about their care.
Medical decision making about patient care.
Standard of patient care.
Standard of nursing care.
Comfort of the patient.
The transfer of patients to or from another department.
Communication with patients.
The role of the charge nurse in clinical decision making.
The power of the charge nurse.
The knowledge and expertise of the charge nurse.
Feedback about performance from doctors.
Clinical experience and clinical opportunities for charge nurses.
Obtaining proper clinical care for patients.
Decisions to cease treatments.
Rehabilitation of patients.
Scapegoating in treatment failure.
Patient safety.
Trust by relatives.
Trust by patients.
Feedback from patients and relatives.

Management

Communication among nursing hierarchy - upwards, downwards and horizontally.
Lines of communication in the hospital.
Changes in policy.
Knowledge of the system and the rules of the system.
Responsibility for decision making.
Feedback on performance.
Decision making by other nursing staff.
Organization of the ward or unit.
Staff relationships.
Staffing - numbers, turnover, continuity, etc.
The roles of categories of nursing staff including registered staff returning to nursing.
Attitude change - including one's own.
Power - and the basis for power.
Methods of problem solving.
Job satisfaction - own and other staff.
Communication with other departments.
Ordering of priorities.
Teaching

Working with students.
Teaching students.
Students' experiences with patients.
Preparation of staff for working in particular ward or unit.
AN INTRODUCTION TO GROUPS
AND GROUP PROCESS

A. WHAT IS A GROUP?

Most people spend at least part of their day in the company of others. These others may be members of one's family, friends, strangers on a bus, co-workers or clients, but they are all people with different feelings, reactions and attitudes. When does such a collection of people form a group? Is a crowd at a football game, a group? Does listening to music in the company of three or four friends constitute experience within a group situation?

In order to understand the behaviour of people in groups it is necessary to explore the various definitions of the term "group" and to select for further examination those definitions which describe the situation in operational terms.

Definition:

Miles defines a "group" as "several persons working in a face-to-face setting on a task that requires their co-operation. For example: a study group dealing with reading retardation, a subcommittee of a school staff looking at merit rating; a kindergarten class and teacher planning a trip to the airport; a work group in the office".

Kemp quotes Krech and Crutchfield's definition as follows: "A group refers to two or more people who bear an explicit psychological relationship to one another".

Curran defines a group as "Two or more people who interact".

Characteristics:

On the surface, these definitions appear rather different. However, an examination of them shows that the following characteristics are either stated or implied: ..

- a group is limited in size;
- there is an aspect of choice, or at least freedom to leave the group. This aspect is more obvious in voluntary task centred groups where membership of the group frequently changes according to the inclination and available time of the participants;
a collection of people does not constitute a group unless there is a willingness on the part of each individual to interact with other individuals in the group; a group should be heterogeneous in composition. That is, the variety innate in human nature makes a collection of human people a group (given the other criteria listed above). A bank of computers does not therefore constitute a group.

B.

In every group, there are some members who tend to be task-oriented. They keep the group moving towards the completion of the task and contribute factual knowledge to help with this. There are others, however, who are concerned with ensuring that a pleasant atmosphere is maintained in the group, that conflict is resolved and that quiet members have the chance to talk. They are concerned with the process or way in which the group functions, rather than with the content or task of the group. Next time you are attending a meeting at the office, on the site or at the P.T.A., see if you can distinguish these two types of people.

Some groups are much more task oriented than others. You will be very used to participating in groups with people where the main aim is to get a job done as quickly as possible. Other groups, which are often called T-groups or training groups, are concerned with process, not content, and are designed to allow members to develop and practice new skills in working with other people.

In any study of group process, it is useful to have a model which enables you to examine the process and to make comparisons between individuals and groups. "The Johari Window" was postulated some years ago by Ingham and Luft and is still a useful concept:

<table>
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<th>II</th>
<th>The Johari Window</th>
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<td>IV</td>
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<tr>
<td></td>
<td>Area of free Activity</td>
<td>Blind area</td>
<td>Avoided or hidden area</td>
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</table>
C. COMMUNICATION

- it is a basic group process and involves transmission, perception and feedback
- it may be formal (e.g. drug prescription), or informal (between a group)
- it may be necessary to build formal channels of communication into the structure of a group or organisation
- informal patterns of communication will arise, shift and change as a result or needs within the group at the time
- involves interaction between at least two people and a system of signals (language) which may be verbal or non-verbal
- learning is therefore an important factor (set, and customary patterns of behaviour)
- ability of group members to listen is often interfered with (e.g. selective perception and preoccupation with own feelings and ideas)
- feedback should be accurate, from a trusted source, and should follow closely on the action
- willingness to give and to accept feedback is an important factor in effective communication
- feedback has an important function in checking on distortions in communication
- barriers to effective communication include: no common language; or verbal body language not easily understood; emotional and health factors; previous learning, including defense mechanisms; attitudes; selective perception; selective, wrong or inappropriate feedback; physical factors e.g. distance, method of communication inappropriate e.g. memorandum instead of "face-to-face".

D. LEADERSHIP

Tannenbaum, Weschler and Massarik (1961) define leadership as "interpersonal influence exercised through the process of communication toward the attainment of a specified goal or goals".

Lassley (1971) discusses the dimension of leadership and also identifies two sets of activities:

1. Task functions - initiating activity, information seeking, information giving, opinion giving, elaborating, evaluating and diagnosing.

He also describes typical non-functional behaviour such as aggression, blocking, self-confessing, competing, seeking sympathy, special pleading, horsing around, recognition seeking and withdrawing.

McGregor (1960) defines four major variables:

i characteristics of the leader
ii attitudes, needs, and other personal characteristics of the followers
iii characteristics of the organisation
iv social, economic and political milieu

Authority: the relationship between leader authority and group freedom is illustrated in this diagram (Lassey, 1971).

The model below (Tannenbaum and Schmidt 1961) shows a continuum of leadership behaviour from management-centred leadership to subordinate-centred leadership.
**Blake and Mouton**

**The Managerial Grid**

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1,1 Management  
- minimum effort  
- minimum membership

1,9 Management  
- excellent work relationships

9,9 Management  
- interdependence  
- commitment and trust

9,1 Management  
- efficiency  
- minimum human involvement

5,5 Management  
- balancing people and organisation performance

---

**E. THE TASK AND MAINTENANCE FUNCTIONS OF GROUPS**

Most of the work groups with which you are associated will be task-oriented groups and members will be much more occupied with task rather than maintenance roles. However, in therapy and training groups, as you are well aware, maintenance roles are more important. Benne and Sheats identify group roles as follows:

**Group Task Roles:**

- the *initiator contributor* suggests or proposes to the group new ideas or a changed way of regarding the group problem or goal ...  
- the *information seeker* asks for clarification  
- the *opinion seeker* asks for a clarification of values pertinent to the task the group is undertaking ...  
- the *information giver* offers "authoritative" facts or generalisations.  
- the *elaborator* spells out suggestions in terms of examples.  
- the *co-ordinator* shows or clarifies the relationships among various ideas and suggestions and tries to pull these together ..  
- the *orienter* defines the position of the group with respect to its goals ...
the evaluator-critic subjects the accomplishment of the group to some standard or set of standards on group functioning ...
the energizer prods the group to action or decision, attempts to stimulate or arouse the group to "greater" or "higher quality" activity.
the procedural technician expedites group movement by doing things for the group e.g. re-arranging the seating.
the recorder writes down the product or record of the group - a "group memory" role.

**Group Building and Maintenance Roles:**

Here the analysis of member-functions is oriented to building ---- or the maintenance and perpetuation of such group-centred behaviour.

- the encourager praises, agrees with and accepts the contributions of others.
- the harmonizer mediates differences between other members ...
- the compromiser operates from within a conflict in which his idea or position is involved.
- the gate-keeper and expeditor attempts to keep communication channels open by encouraging or facilitating the participation of others ....
- the standard setter or ego ideal expresses standards for the group to attempt to achieve in its functioning or applies standards in evaluating the quality of group process.
- the group-observer and commentator keeps records of various aspects of group process ....
- the follower goes along with the movement of the group ....

Benne and Sheats (1961) also identify a list of roles which can be linked with the non-functional behaviour described by Lassiey (1971). These roles include the aggressor, the blocker, the recognition-seeker, the self-confessor, the playboy, and dominator, the help-seeker, and the special-interest pleader.

**Decision-Making in Groups**

Kurt Lewin, one of the originators of the training-group, was deeply concerned with the preservation of democratic values. It is important to recognise the mechanisms operating in decision-making within a group and to recognise the extent to which members have reached a free consensus, or have been manipulated in making a particular decision.
In a well-organised 'participative' group, no formal voting should be necessary. Factors such as hostility, lack of available facts, differing perceptions, differences in goals and personal bias, all prevent a group from reaching a 'consensus'. A consensus is defined by Gibb, Platts and Miller (1961) as the agreement by all members on a particular solution to a problem. Decisions, they say, fall into many categories and they have classified these into four groups:

a) the immediate-trivial decision
b) the immediate-vital decision
c) the postponed-vital decision
d) the viewpoint decision

G. REFERENCES


Step 1: Form two groups, one seated facing inward. The members of the other group should place themselves where they can easily observe the "fishbowl" group.

Step 2: Read the incident and make a note of the action you would take.

Step 3: Discussion time, first group 20 minutes. The group must reach a group decision at the end of this time.

Step 4: "Feedback" period 10 minutes.

Step 5: Compare the group decision with your own - was it different?

Step 6: Reading and individual decision time.

Step 7: Discussion time, second group 20 minutes. The members of the first group now become observers.

Step 8: "Feedback" period, 10 minutes.

Step 9: Compare the group decision with your own. Was it different?
III. GROUP EXERCISE III.

Write down, individually, a list of five things in your ward that you would like to change. Rank these from highest (1) to lowest (5). (5 minutes)

Now, decide as a group the one change that you would most like to make (should the administration give you carte blanche) and the one that you would least like to make, as a group. (35 minutes)

How did you arrive at your decisions?
Who gave in?
Who "talked over" whom?
Did the decision(s) just emerge from group discussion?
If not - give reasons ....
GROUP DECISION-MAKING EXERCISE

Observe the group perform the functions necessary for effective decision-making. During the feedback period, help the group assess its progress according to the following guide-lines.

Phase 1 Defining the Problem

(a) Did the group define its task?
(b) Were group members committed to solving the problem as defined?

Phase 2 Collecting Ideas

(a) Did the group give consideration to feelings and opinions as distinct facts?
(b) What means did the group use to gather information?

Phase 3 Testing Ideas and Developing Alternatives

(a) Did group members offer alternative proposals?
(b) Did various members check the effects of the proposals on all concerned?
(c) Did members indicate commitment to the various proposals?

Phase 4 Making the Decision

(a) How did the group make its final decision? (majority vote, consensus, silent consensus?)
(b) Who decided on the method for the final decision?
BETA HOSPITAL

Programme

Tuesday April 12th
and
Wednesday April 13th

Tuesday, April 12th

0900 - 1015  Introduction
            - objectives
            - outline of the course
            - the individual
            - the group
            - the organisation
            - group exercise

1015 - 1030  Tea

1030 - 1215  "You and your work" - a group incident approach and discussion.

1300 - 1500  Systems of delivery of nursing care.

1515 - 1630  Evaluation of nursing practice.

Wednesday, April 13th

0830 - 1015  Groups and group process

1030 - 1215  Observation and discussion of group process (using fishbowl technique and case incidents).

1300 - 1500  Aspects of modern management

1515 - 1630  Future development - Beta Hospital.

Take away - "Exercise Future"
APPENDIX J8

NURSING INCIDENTS

On the following pages, ten incidents are described which could occur in a ward, unit, or department in your hospital. You are asked to list as many problems or difficulties you can think of which arise from or are associated with each incident. Write these down in the space provided at the end of each paragraph. You should try to write down as many problems as possible for each incident, and do not spend your time on just one or two. Include all the problems you think of, even if they seem unlikely to happen.

1. Marcia Robinson is a ward charge at Vogel Hospital. Recently Miss Boyce, the Assistant Principal Nurse, was told to explain about a new system of nursing records to be used in the hospital.

   During the ward charge's staff meeting when Miss Boyce was giving details of the new system, Marcia Robinson stood up in front of the 20 people present and said,

   "I don't even want to hear about it." Then she left the room.

   Later Miss Boyce confronted Marcia Robinson.

   Boyce:  "Why did you refuse to co-operate?"

   Robinson: "Because it's unnecessary. You are too military and act like a dictator. Why can't the charges decide. You'd think this was the army the way we're ordered around".

2. Miss Ashley, having just completed her basic nursing education at the Memorial Hospital School of Nursing, asked for an appointment with Miss Peterson, Principal Nurse. She has just entered the office where - as it happens - Miss Peterson has been looking over the staffing roster for the next week.

   Miss Peterson: Good morning, Miss Ashley, are you enjoying your vacation?

   Miss Ashley: Yes I am - thank you. Miss Peterson, I wanted to talk to you about coming to work next week on Warren Ward; why wasn't I assigned to Ward A?

   Miss Peterson: We need nurses for Warren, so we can reopen that ward.

   Miss Ashley (hesitantly): Well...er...it's just that some of my classmates feel that because you promised - well, they think I should go to Ward A with them.

   Miss Peterson: I suppose I did say I'd honor requests. I was so pleased that your group wanted to help out on Ward A. But now we need help on Warren. And you know I have a responsibility towards patients and physicians....

   Miss Ashley: But I don't like Warren, and I planned on going to Ward A!
3. A delegation of six charge nurses has just entered the office of the Principal Nurse, Tainui Hospital. Irene Smith speaks for the group:

"Miss Albert, you will have to do something about Marie Colbert. If you don't all of us will leave. She has only been here three months, but already she is trying to change the way we do things. She's only a staff nurse, even if she is helping out with the morning supervision. You are in charge and we won't be ordered about by her. Even if she does have overseas experience, she doesn't know enough about this hospital to change anything."

Miss Albert listened to this statement and promised to look into the matter.

4. Barbara Balthene has been a charge nurse at The Narrows Hospital for ten years. She does an adequate job, but the supervisors have recently been looking for ways to get her to improve the method of record keeping on her ward. In the course of investigating the many books in the office, some information came to light which the supervisor felt she had to report to the Principal Nurse.

Supervisor: Miss Allen, it appears that there are anomalies in the method of counting and recording barbiturate drugs in this ward. I have reasons to believe that small amounts of these drugs have been disappearing over the last year.

Principal Nurse: I know that you must be pretty sure about this, or you wouldn't have reported it. But it comes as a real shock, Barbara and I started here on the same day.

5. Mrs. Jensen (Assistant Principal Nurse) is at her desk in the Nursing Office. She is busy checking time slips and gives no sign of noticing that Mrs. Ryan (deputy charge tutor) has entered the room.

Mrs. Ryan (cheerfully): Good morning, Mrs. Jensen. Going to this Christmas party tonight?

Mrs. Jensen (Emphatically): I am not! (in a tone of reproach): "I've been meaning to call you, Mrs. Ryan, to tell you how hurt I am. I wasn't even asked to contribute to Helen's gift!"

Mrs. Ryan: Gee, Mrs. Jensen. I didn't mean to hurt you. I've never been a collector before. I just figured you'd be making your own collection, with your own service group.

Mrs. Jensen: Why should we? We've always been included with the tutors. Now, just because they've separated student rostering from this office - well, I certainly never expected it would carry through socially, too.
Mrs. Ryan: It was never meant to. Why should it? That's why you and Josey were invited to Helen's party. Come on, now. Don't you want to come?

Mrs. Jensen: No - I just couldn't bring myself to do it. You people in the school have cut me right off! I don't think it's nice. I'm as much a member of the school staff as Miss Sweeney is. Don't I teach ward administration to the seniors? And besides - how am I supposed to know what's going on in the school? I tell you, Mrs. Ryan, they ought to put me back on!

Mrs. Ryan: But, Mrs. Jensen .......

Mrs. Jensen (Emphatically): This separation is no good at all. I've had nothing but problems since it happened. I've been hurt so many times.....

6. Miss Wilson, a first year staff nurse, called Mrs. Rooney, day supervisor, in charge of her ward. She is close to tears and says: I've just had a - er - problem with Dr. Johnson over his colostomy patient. And I don't know what kind of appliance to get.

Mrs. Rooney: Could it wait till Mrs. Hardy gets back?

Miss Wilson: Oh no! And he was so angry. Could you come up and....

Mrs. Rooney: Oh heavens! We just got two emergencies in. I don't think I can come up there for quite a while. Use your judgment.

7. A regular meeting of the Ward Charges Committee is in progress. The membership of the committee is being reviewed and the Principal Nurse has asked for recommendations:

Mrs. Little (Ward Charge): I see no reason why Miss O'Brien should continue to be chairman of this committee. She is not in charge of us but she keeps on assuming responsibility.

Miss Peterson: Oh, that just means that she is in charge of planning that particular inservice programme and....

Miss Riley interrupts: We all plan the programme together, why don't we have a rotating chairmanship. If we're all called charge nurses, then I don't see how any one of us can be in charge of others.
8. Miss Gonsalves (staff nurse in charge): I was just going to call you!
Miss Hammond (afternoon supervisor): Is anything wrong?
Miss Gonsalves: What shall I do about moving the coronary patients -
shall I move them in their beds or put them on stretchers?
Mrs. Hammond: Move them where - why?
Miss Gonsalves: Mrs. Jackson just called me and said they were
closing this ward for the weekend. He told me where to transfer the
patients and to start moving them right away - I thought you knew!
Mrs. Hammond: First I've heard about it.
Miss Gonsalves: And another thing - what about supper? Shall I
serve it now?

9. Mr. Packard is a middle aged businessman and has just been moved
from the coronary care unit, to a regular medical ward. He has been
used to discussing his medication with the nurses in the unit, and is
very knowledgeable about anticoagulants, prothrombin times and the
signs and symptoms of overdose. In the ward a student nurse presents
him with a paper cup containing a white pill and a pink pill.
Mr. Packard asked her what the medication was. Her reply was "You'll
have to ask your doctor. I'm not allowed to tell you what they are."

10. A drug and alcohol treatment unit has recently been opened in
Tainui Hospital. One morning, a tall muscular farmer threatens
patients and staff with a baseball bat which he is brandishing. A
variety of methods have been suggested for subduing the man who is
rapidly becoming agitated and suspicious.

The supervisor for the block comes to the door of the ward and
says "Let me try something. You wait here." She slowly walked toward
the patient who was twice her size, and said: "Mr. Y., no one is
going to hurt you. I know you don't want to hurt anyone". He looked
at her, clutching the club in both hands. She continued, "Jim, I
want to help you." His arms seemed to relax. Then extending her hand,
she said, "Give it to me." And he did. She handed it to one of the
staff members, and then walked Mr. Y. back to his bed, reassuring him
that the staff would not allow anyone to hurt him.
GROUP A

Developed out of group discussion the following models for evaluating the standard of clinical nursing practice in a variety of areas:

I. Surgical Ward Evaluation of Nursing Practice

i. Define Nursing Practice.

ii. Establish criteria for setting standards:

   Based on:

   (a) Patients' needs - What the Charge Nurse considers patients need? What does the patient consider is his/her need?

   (b) Nurse's needs - Particularly knowledge and understanding of the assignment she has been given.

   (c) Organisational needs: e.g. is the equipment required for the job readily available.

   (d) Needs of relatives - information and support.

iii. Method of gaining data:

   (a) Select 10 patients.

   (b) Choose 5 aspects of nursing practice pertaining to those patients and analyse. Ideally choose 5 aspects which will require different methods of gaining information.

      e.g. 1. Observation (maybe of state of skin and finger nails)

            2. Direct Questioning (do you feel comfortable)

            3. Analysing records - (has the patient received sufficient fluid)

            4. Measuring equipment - (Does the bed table move easily)

iv. Measuring Nursing Practice

   Comparing information acquired to base line standard. Compile graph/wall chart to plot level of nursing practice on the ward. Display.

v. Evaluate Results -

   What factors might cause decline in nursing practice?
2. Obstetric Ward

Report to Administration on standard of nursing practice in your area.

Summary of Headings:

(1) Profile of area.
(2) Method of measurement of nursing practice.
(3) Evaluation.

(1) Profile of area:-

(a) Type of patient
(b) Number of patients
(c) Type of staff
(d) Number of staff
(e) Facilities
(f) Location

(2) Method of measurement of nursing practice:-

(1) Observation of:-

(a) Environment
(b) Staff
(c) Patients

(2) Feedback from:-

(a) Community
(b) Patients
(c) Colleagues
(d) Auxiliary staff

(3) Morale:-

(a) Interpersonal relationships

(4) Record keeping:-

Kardex
Monthly reports
Charts - i.e. feeding.

How this method of measurement was achieved.

(a) Questionnaires
(b) Interviews
(c) Group discussion

(3) Evaluation:-

(a) Climate
(b) Attitude of discharge
(c) Stability of staff
3. **Medical Ward**

i  State aims and objectives.

ii  State type of Ward, number and type of patients and then evaluate care.

iii  Value of patient feedback?

iv  Ensure efficient communications between all members of group involved: i.e.

(a) Patients
(b) Relations
(c) Nursing
(d) Medical

so that patient will receive optimum care.

v  Note feedback from nursing staff.

vi  Personal observations and eavesdropping.

**Steps in Process**

i  Gather all information available from above.

ii  Evaluate and assess the data provided. (whether relevant)

iii  Compile report.

**Headings of Report**

i  Word type

ii  No. patients

iii  No. staff and category

iv  Aims and objectives

v  Evaluate care given and summarise.

4. **Special Areas**

(Geriatric and Paediatric)

i  Measurement of care - ward situation
   Evaluate goals (standard of care)
   Quality of nursing staff
   Climate of ward
   Environment of ward
   Number of patients - severity of illness and care required.
ii Evaluate work process within ward
Evaluate constraints and facilities
Evaluate supportive bodies
Quality and quantity of staff
Evaluate arising needs and problems

Assessment and planning

iii Type of functional nursing
Use of supportive bodies
Use of equipment
Control of climate and environment of ward
Constant reassessment of ward situation -
take into account the feedback

Implementation

iv Structure
Assessment and planning of situation
Implementation
Measurement of Effects
Whether the planned programme meets the needs of the individual (staff and patient).
NOTES ON METHODS OF DELIVERING NURSING CARE

Over the years nurses have developed a variety of ways of delivering nursing to clients. Basically these can be divided into:

(a) Functional methods which are related to the school of scientific management.
(b) Team methods.
(c) Case assignment methods.

If you look at nursing in New Zealand you will notice that the method of delivering nursing skills is related to the level of experience and education of the nurse, and to the place where nursing takes place.

(a) In community health, public health nurses, plunket nurses and district nurses carry case loads and work usually on a one to one basis with their clients. Grouping of patients occurs naturally in family groupings, or in clinic groupings. Auxiliary workers are not yet common in community health.

(b) In private hospitals patients are often assigned to qualified nurses who may be assisted by auxiliary staff.

(c) In the general wards of public hospitals, patients usually receive care, either by functional or by team assignments of staff.

In recent years there have been some interesting experiments reported in North America, and this year in New Zealand with a new type of nursing care - Primary Nursing.

Logsdon, in an article entitled "Why Primary Nursing", in Nursing Clinics of North America, Vol.8, No.2, June 1973, defines this type of nursing in the following way:

"Primary nursing is the nursing care provided to the patient by one nurse who plans with the patient the care that the patient and the nurse decide is needed - care that results from co-ordination with other disciplines and collaboration with the primary physician."

She states that "primary nursing seems to be the most successful on units of 10 to 15 patients. For example, let us look at the 10 bed medical unit. The staffing for this unit is 4.5 registered nurses, 3.5 licensed practical nurses, and one aide.... This means one registered nurse, one licensed practical nurse and an aide five days of the week on the day shift, one registered nurse and one licensed practical nurse on the evening shift, and one registered nurse on the night shift. Each nurse carries at least two primary patients and acts as co-primary nurse with the licensed practical nurse. When the primary nurse is off duty the other nurses carry out the plan of care developed by the primary nurse".

Logsdon outlines the duties and responsibilities of the primary nurse as follows:
(a) Obtaining data and assessing the patient
- physical care needs
- lifestyle of the patient
- education needs
- attitudes and feelings about hospitalization
- identification by the patient of his short and long term goals.

(b) Developing a nursing care plan from the data obtained
- physical care
- teaching plan
- discharge plan.

(c) Co-ordinating care given to patients

The method has advantages and disadvantages.

Group Exercise:

What are the advantages and disadvantages of:

(a) Functional assignment.

(b) Team assignment.

(c) Case assignment.

Which one does your group favour at this time, and why?
A. Purpose

The purpose of this exercise is to explore individual expectations of changes in work and life environments and to develop specific plans for dealing with change.

B. Procedure

Step 1: Read the statement on attitudes towards change.

Step 2: Working alone, list some of the major changes which have occurred in your job, or field of specialization and in your life space in general during the past five years.

Step 3: Based on your own awareness and any other forecasts you may have read or heard, identify significant changes which you expect in your job and your style of living during the next five years.

Step 4: Meet with your sub-group and share your perceptions as described in Steps 1 and 2. As you share your predictions identify the ones you think you will like the most as well as those that give you the greatest concern.

Step 5: Working alone again, prepare a plan for your personal development during the next five years which you believe will enable you to increase your own effectiveness in light of the changes you anticipate.

Step 6: Meet with two other members of your sub-group and take turns sharing your development plans and helping each other test for clarity of plans and relevance to personal life goals.

Step I: Personal Attitude Towards Change.

People vary across a broad spectrum in their attitudes towards change. Some actively seek it as if there were positive good in any change, regardless of the direction it takes. Others work to avoid it, preferring the security of the known and the familiar rather than risk a change for the worse. Some are frantically pursuing change at any cost while others are resisting change in ways that are sometimes irrational.

It is no wonder that in organizational life the instigators of change view it as positive and frequently have great difficulty seeing the negative side while the masses in the organization who don't participate in choosing the direction for change are quick to see the negative aspects and frequently
can't find any good in change. "Why change a winning game?" "We've done it this way for X years and made money every year; we would be crazy to change now." or "If you're not changing, you're dead or dying." Chances are you've heard many variations on these themes or personal philosophies of change.

It may well be that for most of us the choice is not whether or not we will change but how we'll change and in what direction. If we choose to live in society a certain amount of change seems inevitable. In his book "Future Shock", Alvin Toffler argues that the how (process) of change is just as important - perhaps more so - as the direction of change. He presents a great deal of data to illustrate his central theme that the rate of change which we are experiencing now is qualitatively different from anything man has experienced in the past. It is his belief that the accelerated rate of today's change has become in itself an elemental force in individual lives and society in general.

Step 2: Changes Which You Have Observed During the Past 5 Years

Working alone, briefly describe the changes which you have experienced or observed during the past 5 years. It probably will be more productive for you if you use a "brainstorming" approach and write down every change which occurs to you instead of stopping to evaluate in your head whether it is a significant change or whether others will agree with your perception.

Step 3: Future Expectations

Still working alone, write down a list of the changes you expect to occur during the next 5 years. When you have finished go back and rank them in order of significance.

Step 4: Sub-group Meetings

Form a sub-group with 5 other people from the total group and share your perceptions and expectations as detailed in Steps 2 and 3. As other group members share their ideas you will no doubt be reminded of some things you forgot to include. Feel free to add these to your own list.

Step 5: Personal Development Plans

Working alone, describe the things you want to do in order to better prepare yourself for the future as you see it. You will probably want to include specific kinds of training and learning experiences as well as job and life experiences you feel you need.

Step 6: Work Development Plans

Working alone, describe the things you would want to implement in your work situation in the next five years. Rank these in order of priority and give some indication of time sequence.
Step 7: Consultation

Form a trio with two other members of your sub-group. You should plan on being together for at least 60 minutes. During this time, you should have three meetings each lasting 20 minutes. Each of you will be in three positions, according to the following plan:

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<th>Meeting</th>
<th>Adviser</th>
<th>Observer</th>
<th>Planner</th>
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<tr>
<td>1</td>
<td>Member 1</td>
<td>Member 2</td>
<td>Member 3</td>
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</tr>
<tr>
<td>3</td>
<td>Member 3</td>
<td>Member 1</td>
<td>Member 2</td>
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Adviser's task:

You are to serve as a consultant, helping the planner to clarify and develop her plans.

Observer's task:

You should observe the process of discussion for 10 minutes and then offer comment which will make the consultation process more effective.

Planner's task:

Your job is to settle on a clear series of actions which you will take that will satisfy your needs, as well as those of your organization. You should be concerned with devising ways in which you might measure your progress in achieving in your plans.

After completion, revise and review your own action plans.

Step 8:

A combined list of participants' perceived and expected changes over a five year period will be prepared. Action plans will be examined. Major trends should emerge that will then serve as a basis for discussion by the whole group.
**EVALUATION OF THE TRAINING PROGRAMME**

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**STYLE OF MANAGING**

**Step I.**

This exercise is designed to help you describe and discuss your actual and preferred ways of managing. For each of the statements below, write the number which best describes you in the left hand column (actual). Then, write the number which best expresses what you would prefer to be like in the right hand section of the first column.

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<table>
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<td>Extremely venturesome</td>
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<tr>
<td>Delegation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prefer to solve problems</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Prefer to let others solve problems</td>
</tr>
<tr>
<td>Concern for Welfare of Subordinates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No concern at all</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Complete concern</td>
</tr>
<tr>
<td>Relations to Higher Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always rebel</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Always depend on higher authority</td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Here and now&quot;</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Always consider the long range view</td>
</tr>
<tr>
<td>Decision-Making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prefer group decisions</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Prefer individual decisions</td>
</tr>
<tr>
<td>Concern for Rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disregard whenever they get in the way</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Obey completely at all times</td>
</tr>
<tr>
<td>Political v Participative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rely on political alliances, deals and bluff</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Rely on open communication, involvement and trust</td>
</tr>
</tbody>
</table>
Use of Authority in Getting Work Done

<table>
<thead>
<tr>
<th>Rely on persuasion and/or skill and knowledge</th>
<th>Self appraisal</th>
<th>Other appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Rely on position and power</td>
<td></td>
</tr>
</tbody>
</table>

Task vs. Human Relations

<table>
<thead>
<tr>
<th>Primarily concerned with getting job done</th>
<th>Self appraisal</th>
<th>Other appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
<td>Primarily concerned with maintaining good relations</td>
<td></td>
</tr>
</tbody>
</table>

Step II.

Pair up with the person next door to you and rate him. Write down that rating number in the third column.

Step III.

Discuss with your neighbour the discrepancies in your ratings of each other.

Step IV.

Class discussion of reasons for differences.
Group B (before and after treatment \(T_3 - T_2\))

Distribution of Significant Mean Differences for
Representative Predictor and Moderator \((p < 0.05)\) \(N = 21\)

<table>
<thead>
<tr>
<th>POI Test</th>
<th>Difference (Mean)</th>
<th>Standard deviation</th>
<th>t</th>
<th>df</th>
<th>(P) (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner directed</td>
<td>3.2381</td>
<td>5.787</td>
<td>2.56</td>
<td>20</td>
<td>0.019</td>
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<tr>
<td>Existentiality</td>
<td>1.7619</td>
<td>2.364</td>
<td>3.41</td>
<td>20</td>
<td>0.003</td>
</tr>
</tbody>
</table>

There were no significant differences \((p < 0.05)\) on the remaining CPI and POI measures, nor on the three organizational climate scores. Training effects \((p < 0.05)\) are not noticeable in the POI variables. This table shows some immediate effect after training, on two of the same variables as for Group A. The shift in existentiality is of the same order in both cases \((p < 0.01)\). However, Group B showed differences on both these variables prior to training.
An inspection of the CPI baseline mean scores displayed in Figures K4.1 and K4.2. shows that the two groups have differing profiles over ten variables. The mean scores are similar, for CPI capacity for status, social presence, wellbeing, socialization, tolerance, communality, achievement via independence and psychological mindedness. These are spread throughout the four classes of measures outlined by Gough, 1956. On the other hand, the significant mean differences for variables listed in Table 12.2 for Group B (T2-T1) are largely those listed in Class I and Class II. It could be then that the two groups are different in terms of the CPI variables measuring self-assurance, interpersonal adequacy, maturity, responsibility, and intrapersonal structuring.

A comparison of the baseline mean scores (T1) for Groups A and B for variables from the POI scale shows a different picture, displayed in Figures K5.1 and K5.2. There are some differences between the two sets of scores but the profiles are similar to that described by Shostrom (1966) for male supervisors (N=66). Group B is markedly higher on capacity for intimate contact than either Group A, or the group of male supervisors. Both groups A and B are higher on
existentiality, spontaneity and self-regard, than the male supervisors' group.

Figure K.3 shows the distribution of mean NOI scores for $T_1$ to $T_2$ for both groups and for $T_1$, $T_2$ and $T_3$ for Group B.

![Graph](image-url)

**Figure K.3 Mean Score Profiles, Nursing Opinion Inventory $T_1$, $T_2$ and $T_3$.**
PROFILE SHEET FOR THE California Psychological Inventory: FEMALE

Name: GROUP A, BETA HOSPITAL  
Age:  
Date Tested: NOV. 12/13, DEC. 14

Other Information

Notes:

Figure K4.1. CPI Profiles Group A (T1, T2 and T4)

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PROFILE SHEET FOR THE California Psychological Inventory: FEMALE

Name: GROUP B, BETA HOSPITAL

Other Information

Notes:

Figure K4.2 CPI Profiles Group B (T1, T2, T3 and T4)

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Notes:

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PROFILE SHEET FOR THE California Psychological Inventory: FEMALE

Name GROUP C, DELTA HOSPITAL Age Date Tested NOV, DEC

Other Information

Notes:

Female Norms

Figure K4.3. CPI Profile (T1 and T4) Group C.

Reproduced from Manual for The California Psychological Inventory, by Harrison G. Gough, Ph.D. Copyright by Consulting Psychologists Press, Inc., Palo Alto, California. All rights reserved.
<table>
<thead>
<tr>
<th>Name</th>
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<th>Date Testd</th>
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</table>

Other Information

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**Male Norms**

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<th>Cs</th>
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</tbody>
</table>
Figure K5.1  POI Profile Group A, T₁, T₂ and T₄.
BRIEF DESCRIPTION OF WHAT THE POI MEASURES

Your profile on the Personal Orientation Inventory (POI) shows the degree to which your attitudes and values compare with those of self-actualizing people. A self-actualizing person is one who is more fully functioning and who lives a more enriched life than does the average person. Such a person is developing and utilizing his unique talents to the fullest extent. It is generally agreed that a self-actualizing person might be seen as the desired result of the process of counseling or psychotherapy.

The interpretation of your scores falls into two general categories, the ratio scores and the profile scores. If your ratio scores are close to the scores that self-actualizing persons make, you may consider your values and attitudes, as measured by the POI, to be similar to these people. Your profile scores will further help you to compare yourself with self-actualizing people.

RATIO SCORES

Interpretation of the \( T_I - T_C \) Ratio

In order to understand the Time Incompetent - Time Competent (\( T_I - T_C \)) ratio, it is of help to consider time in its three basic components -- Past, Present, and Future.

The \( T_I \) (Time Incompetent) person is one who lives primarily in the Past, with guilt, regrets, and resentments, and/or in the future, with idealized goals, plans, expectations, predictions, and fears.

In contrast to the \( T_I \) person, the \( T_C \) (Time Competent) person lives primarily in the Present with full awareness, contact, and full feeling reactivity. Because it is known that the self-actualizing person is not perfect, he is understood to be partly \( T_I \) and partly \( T_C \). His \( T_I - T_C \) ratio is, on the average, 1 to 8. His ratio shows that he therefore lives primarily in the Present and only secondarily in the Past or Future.

If your score is significantly lower than 1 to 8, for example 1 to 3, this suggests that you are more time incompetent than the self-actualizing person. If your score is above 1 to 8, for example 1 to 10, this suggests that you are excessively time competent and this may perhaps reflect a need to appear more self-actualized than you really are.

Interpretation of the \( O - I \) Ratio

In order to understand your score on the Support (Other - Inner) ratio, one should first understand that the self-actualizing person is both "other-directed" in that he is dependent upon and supported by other persons' views, and he is also "inner-directed" in that he is independent and self-supportive. The degree to which he is each of these can be expressed in a ratio. The \( O - I \) ratio of a self-actualizing person is, on the average, 1 to 3, which means that he depends primarily on his own feelings and secondarily on the feelings of others in his life decisions.

If your score is significantly higher than 1 to 3, that is 1 to 4 or above, it may be that this indicates an exaggerated independence and reflects a need to appear "too self-actualized" in responding to the POI. On the other hand, if your score is lower than 1 to 3, for example 1 to 1, it would suggest that you are in the dilemma of finding it difficult to trust either your own or others' feelings in making important decisions.

PROFILE SCORES

On the Profile Sheet, short descriptions of each of the sub-scales are shown which describe high and low scores. In general, scores above the average on these scales, that is, above the mid-line shown by a standard score of 50, but below a standard score of 60 are considered to be most characteristic of self-actualizing adults. The closer your scores are to this range, the more similar are your responses to the POI responses given by self-actualizing people. The further below the score 50 your scores are, the more they represent areas in which your responses are not like those of self-actualizing people. If most of your scores on the profile are considerably above 60, you may be presenting a picture of yourself which is "too" healthy or which overemphasizes your freedom and self-actualization. Your counselor can discuss the psychological rationale of each scale in greater detail with you.

The ratings from this inventory should not be viewed as fixed or conclusive. Instead they should be viewed as merely suggestive and to be considered in the light of all other information. The Personal Orientation Inventory is intended to stimulate thought and discussion of your particular attitudes and values. Your profile will provide a starting point for further consideration of how you can achieve greater personal development.
Figure K5.2  POI Profile Group B T₁, T₂, T₃ and T₄.
BRIE DESCRIPTION OF WHAT THE POI MEASURES

Your profile on the **Personal Orientation Inventory (POI)** shows the degree to which your attitudes and values compare with those of self-actualizing people. A self-actualizing person is one who is more fully functioning and who lives a more enriched life than does the average person. Such a person is developing and utilizing his unique talents to the fullest extent. It is generally agreed that a self-actualizing person might be seen as the desired result of the process of counseling or psychotherapy.

The interpretation of your scores falls into two general categories, the ratio scores and the profile scores. If your ratio scores are close to the scores that self-actualizing persons make, you may consider your values and attitudes, as measured by the POI, to be similar to these people. Your profile scores will further help you to compare yourself with self-actualizing people.

**RATIO SCORES**

**Interpretation of the T1 - Tc Ratio**

In order to understand the Time Incompetent - Time Competent (**T1 - Tc**) ratio, it is of help to consider time in its three basic components -- Past, Present, and Future.

The **T1** (Time Incompetent) person is one who lives primarily in the Past, with guilt, regrets, and resentments, and/or in the Future, with idealized goals, plans, expectations, predictions, and fears.

In contrast to the **T1** person, the **Tc** (Time Competent) person lives primarily in the Present with full awareness, contact, and full feeling reactivity. Because it is known that the self-actualizing person is not perfect, he is understood to be partly **T1** and partly **Tc**. His **T1 - Tc** ratio is, on the average, 1 to 8. His ratio shows that he therefore lives primarily in the Present and only secondarily in the Past or Future.

If your score is significantly lower than 1 to 8, for example 1 to 3, this suggests that you are more time incompetent than the self-actualizing person. If your score is above 1 to 8, for example 1 to 10, this suggests that you are excessively time competent and this may perhaps reflect a need to appear more self-actualized than you really are.

**Interpretation of the O - I Ratio**

In order to understand your score on the Support (Other - Inner) ratio, one should first understand that the self-actualizing person is both "other-directed" in that he is dependent upon and supported by other persons' views, and he is also "inner-directed" in that he is independent and self-supportive. The degree to which he is each of these can be expressed in a ratio. The **O - I** ratio of a self-actualizing person is, on the average, 1 to 3, which means that he depends primarily on his own feelings and secondarily on the feelings of others in his life decisions.

If your score is significantly higher than 1 to 3, that is 1 to 4 or above, it may be that this indicates an exaggerated independence and reflects a need to appear "too self-actualized" in responding to the POI. On the other hand, if your score is lower than 1 to 3, for example 1 to 1, it would suggest that you are in the dilemma of finding it difficult to trust either your own or others' feelings in making important decisions.

**PROFILE SCORES**

On the Profile Sheet, short descriptions of each of the sub-scales are shown which describe high and low scores. In general, scores above the average on these scales, that is, above the mid-line shown by a standard score of 50, but below a standard score of 60 are considered to be most characteristic of self-actualizing adults. The closer your scores are to this range, the more similar are your responses to the POI responses given by self-actualizing people. The further below the score 50 your scores are, the more they represent areas in which your responses are not like those of self-actualizing people. If most of your scores on the profile are considerably above 60, you may be presenting a picture of yourself which is "too" healthy or which overemphasizes your freedom and self-actualization. Your counselor can discuss the psychological rationale of each scale in greater detail with you.

The ratings from this inventory should not be viewed as fixed or conclusive. Instead they should be viewed as merely suggestive and to be considered in the light of all other information. The **Personal Orientation Inventory** is intended to stimulate thought and discussion of your particular attitudes and values. Your profile will provide a starting point for further consideration of how you can achieve greater personal development.
Figure K5.3 POI Profile (T₁ and T₄) Group C
BRIEF DESCRIPTION OF WHAT THE POI MEASURES

Your profile on the Personal Orientation Inventory (POI) shows the degree to which your attitudes and values compare with those of self-actualizing people. A self-actualizing person is one who is more fully functioning and who lives a more enriched life than does the average person. Such a person is developing and utilizing his unique talents to the fullest extent. It is generally agreed that a self-actualizing person might be seen as the desired result of the process of counseling or psychotherapy.

The interpretation of your scores falls into two general categories, the ratio scores and the profile scores. If your ratio scores are close to the scores that self-actualizing persons make, you may consider your values and attitudes, as measured by the POI, to be similar to these people. Your profile scores will further help you to compare yourself with self-actualizing people.

RATIO SCORES

Interpretation of the T1 - Tc Ratio

In order to understand the Time Incompetent - Time Competent (T1 - Tc) ratio, it is of help to consider time in its three basic components — Past, Present, and Future.

The T1 (Time Incompetent) person is one who lives primarily in the Past, with guilt, regrets, and resentments, and/or in the future, with idealized goals, plans, expectations, predictions, and fears.

In contrast to the T1 person, the Tc (Time Competent) person lives primarily in the Present with full awareness, contact, and full feeling reactivity. Because it is known that the self-actualizing person is not perfect, he is understood to be partly T1 and partly Tc. His T1 - Tc ratio is, on the average, 1 to 8. His ratio shows that he therefore lives primarily in the Present and only secondarily in the Past or Future.

If your score is significantly lower than 1 to 8, for example 1 to 3, this suggests that you are more time incompetent than the self-actualizing person. If your score is above 1 to 8, for example 1 to 10, this suggests that you are excessively time competent and this may perhaps reflect a need to appear more self-actualized than you really are.

Interpretation of the O - I Ratio

In order to understand your score on the Support (Other - Inner) ratio, one should first understand that the self-actualizing person is both "other-directed" in that he is dependent upon and supported by other persons' views, and he is also "inner-directed" in that he is independent and self-supportive. The degree to which he is each of these can be expressed in a ratio. The O - I ratio of a self-actualizing person is, on the average, 1 to 3, which means that he depends primarily on his own feelings and secondarily on the feelings of others in his life decisions.

If your score is significantly higher than 1 to 3, that is 1 to 4 or above, it may be that this indicates an exaggerated independence and reflects a need to appear "too self-actualized" in responding to the POI. On the other hand, if your score is lower than 1 to 3, for example 1 to 1, it would suggest that you are in the dilemma of finding it difficult to trust either your own or others' feelings in making important decisions.

PROFILE SCORES

On the Profile Sheet, short descriptions of each of the sub-scales are shown which describe high and low scores. In general, scores above the average on these scales, that is, above the mid-line shown by a standard score of 50, but below a standard score of 60 are considered to be most characteristic of self-actualizing adults. The closer your scores are to this range, the more similar are your responses to the POI responses given by self-actualizing people. The further below the score 50 your scores are, the more they represent areas in which your responses are not like those of self-actualizing people. If most of your scores on the profile are considerably above 60, you may be presenting a picture of yourself which is "too" healthy or which overemphasizes your freedom and self-actualization. Your counselor can discuss the psychological rationale of each scale in greater detail with you.

The ratings from this inventory should not be viewed as fixed or conclusive. Instead they should be viewed as merely suggestive and to be considered in the light of all other information. The Personal Orientation Inventory is intended to stimulate thought and discussion of your particular attitudes and values. Your profile will provide a starting point for further consideration of how you can achieve greater personal development.
Table K6  

Group B  

Distribution of Significant Mean Differences  
before and after treatment and time $T_4-T_1$ ($p < 0.05$) N=20

<table>
<thead>
<tr>
<th></th>
<th>Difference (Mean)</th>
<th>Standard deviation</th>
<th>t</th>
<th>df</th>
<th>p (2-tailed)</th>
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<tr>
<td>CPI Social presence</td>
<td>1.8095</td>
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<td>POI Time competent</td>
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<td>0.010**</td>
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<td>Innovative behaviour ward</td>
<td>-3.1905</td>
<td>4.238</td>
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<td>0.003**</td>
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</table>

* Significant at $p < 0.05$
** Significant at $p < 0.01$
*** Significant at $p < 0.001$