Running Head: NURSES' PERCEPTION OF UNIT QUALITY AND POLICY INVOLVEMENT IN THREE LOUISIANA HOSPITALS

Nurses' Perception of Unit Quality and Policy Involvement in Three Louisiana Hospitals

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Health care is delivered in the United States hospitals predominantly by nurses, twenty four hours a day, and 365 days per year. Patients come to hospitals for nursing care. Today there are heightened expectations for better patient outcomes delivered by fewer nurses. Staff nurses depend on efficient processes to deliver care and achieve quality results. Nurses also strive to balance all demands placed on them while maintaining their professional fulfillment (Reineck, and Furino, 2004). Health care leaders face increasing costs of health care, greater consumer and employer expectations, and financial pressure placed on hospitals by Medicare to delivery quality patient outcomes. Nursing professionals are in a position to "move toward ensuring the placement of safe patient care (and its evaluation) at the center of the health care vortex, which is exactly how it should be!" (Gallagher and Rowell, 2003, p. 279).

Providing outcome-oriented health care in a fiscally responsible manner is not only a duty but an imperative. Disequilibrium exists in balancing three factors which influence quality care: costs, processes and outcomes of care (Gallagher & Rowell, 2003). Since each factor influences the other, understanding of the interrelationship is important to achieve the balance necessary to improve care. For example, inefficient processes lead to higher costs which may not improve the quality of care. Lower costs may also lead to adverse outcomes due to inadequate nursing staffing.

Since October, 2008, Medicare incentivizes hospitals to reduce hospital acquired conditions, stopping the funding for these conditions. This reimbursement change forces hospitals to work more diligently in quality improvement and patient safety. Meticulous

documentation of conditions present on admission is an essential reimbursement strategy (Centers for Medicare and Medicaid Services, 2008).

While experts point to incremental improvement in patient care quality, improvement is still needed (Buerhaus, 2004; Rutherford, Lee, and Greiner, 2004; The Joint Commission, 2008). Lucien L. Leape, MD, influential in promoting patient safety, remarked that "I do not think we can honestly say that health care is now appreciably safer than it was 10 years ago" (Buerhaus, 2004, p.367).

Scope of Review

Nursing and quality improvement literature was reviewed. In the CINAHL, EBSCOhost and ProQuest data bases, the searches were limited to English, peer reviewed studies reported since 2000 yet and classic quality literature was included from the 1980s and 1990s. Nurse*, role*, perception* and quality* were the key words used in the searches. While much has been studied about patient's perceptions of quality, little was found in the studying of the staff nurse's perception of their role in improving quality indicators.

Review of the Literature

Quality care is difficult to define. Donabedian (1980) developed the elements of quality which include the following: structure, process and outcome. Structure is the physical, organizational and system culture which supports the delivery of quality. Process is what is done in caring for the patients which includes the steps taken to deliver care. Outcome is the end result of the care given, usually the improvement in health, but

also in the patient's approach to the illness and knowledge to take care of oneself. Donabedian (1982) quantified the elements of high quality care as appropriate, efficient, and effective with the ultimate result of the best health outcomes for the patients served.

Centers for Medicare and Medicaid Services (CMS) have tracked the Medicare Quality Monitoring System (MQMS) indicators (CMS, MQMS, 2008) since 1992. This data includes quality monitoring and public reporting of indicators for any agency type which is paid by Medicare to provide care. Some of the many indicators are related to the following conditions: acute myocardial infarction, stroke, diabetes, heart failure, cardiovascular surgical services, pneumonia, and acute dialysis care. Extensive reports are found available to the public from links provided (CMS, MQMS, 2008). The MQMS reports are comprehensive and the data include readmission rates, analysis of morbidity and mortality data per state, age, gender and race of patients among other data elements.

While the MQMS is extensive in its scope of quality monitoring, nurse specific quality indicators quantify the impact that nurses make on in hospital care. Studies have defined nurse sensitive patient outcomes (Idvall, Rooke and Hamrin, 1997; Doran, 2003; Savitz, Jones, and Bernard, n.d.; Haberfelde, Bedecarré, Buffum, 2005). Doran, (2003) classified nurse sensitive outcomes across the continuum of health care settings from acute to home care and long term care and are found in table 1.

Currie, Harvey, West, McKenna and Keeney (2005) found in their review of the literature relating the quality of care with the following: nurse staffing levels, skill mix and nurse autonomy studies. Since quality of care is a complex concept with many facets

that are difficult for researchers to evaluate, Currie, et al. (2005) found that there is conflicting information on how patients and nurses view quality of care.

Studies found untoward patient outcomes were based on nurse staffing levels, fewer RNs, education levels of nurses and staff mix (Aiken, Clarke, Sloane, Sochalski and Silber, 2002; Needleman, Buerhaus, Mattke, Stewart, and Zelevinski, 2002) and that with care given by nurses educated at the baccalaureate or advanced degree level, the risk of patient death by failure to rescue was decreased by 5 percent. The investigation reported shortages of BSN prepared nurses may be affecting health care quality and patient outcomes. (Currie, et al., 2005; AACN Nursing Shortage Fact Sheet, 2005; Doran, 2003). Haberfelde, Bedecarré, and Bufffun (2005) found that the relationship between nurse staffing and patient outcomes was mixed.

Part of the challenge of quantifying the relationships between these variables is the varying definitions of terminology, data collection and patient populations to name a few. The National Database for Nursing Quality Indicators (NDNQI) use standard definitions and compare data among Magnet and non magnet facilities. The current NDNQI quality indicators are listed and the Nursing Quality Forum (NQF) indicators are marked as follows: patient falls (NQF), patient falls with injury (NQF), hospital and unit-acquired pressure ulcers, physical/sexual assault, pain assessment, pain intervention, pain reassessment cycle, peripheral IV infiltration, physical restraints (NQF), nurse turnover (NQF), nosocomial infections: (NQF), catheter-associated UTI, central line-associated blood stream infection, ventilator-associated pneumonia, staff mix : (NQF), Registered Nurses (RNs), Licensed Practical/Vocational Nurses (LPN/LVNs), unlicensed assistive personnel (UAP), nursing care hours provided per patient

day (NQF), RN education/certification, RN Survey of job satisfaction and practice environment scales (NQF) (ANA, NDNQI brochure, n.d., retrieved from website).

Perceptions of Unit Quality Studies

Rathert and May (2007) reported their study of perceptions from nurses of three acute care U. S. hospitals. The results showing that nursing satisfaction was achieved also found consistent themes in work groups where their perception of a patient centered environment exists. One qualitative study in Norway measured nursing recognition of "good work" and identified themes essential in their view of quality work (Christiansen, 2008). Kvist, Vehvilainen-Julkunen and Jokela, (2007) conducted another international study which compared the perceptions of patients, nurses, MDs and managers in the quality of care delivered. They found no relationship between quality and leadership.

DeMarco, Flaherty, Glod, Merrill, Terk, and Plasse (2004) reported the perceptions of unit quality (PUQ) by measuring patient and staff perceptions in a pilot study conducted on a psychiatric nursing unit. Many members of the unit staff were surveyed including RNs, mental health specialists, unit clerks, MDs, case managers, nursing assistants and patients. Cronenwett's PUQ instrument (Cronenwett, 1997) was used to measure staff's opinions and the Perceptions of Care (PoC) instrument, developed by Eisen, was used to measure the patient's perceptions of care. When the results were quantified, the sub grouped categories identified were: clinical care, unit atmosphere, collaboration, basic care. The perceptions of overall unit quality were ranked on a scale of 1 to 10. The results of the study showed no correlation between the staff's perception

of quality and the patients' perception of quality. The applicability and transferability of these results are yet to be tested.

Research done to quantify the impact that nursing environments and leadership have in achieving quality outcomes in their work unit relate: communication styles and collaboration (Coeling, and Cukr, 2000), models of supervision (Uys, Minnaar, Simpson, and Reid, 2005), Magnet status (Ulrich, Buerhaus, Donelan, Norman and Dittus, 2007), among others. Wong and Cummins (2007) summarized the results of fourteen variables reported in seven different studies reported from 1999 to 2004. Most studies showed a positive relationship between transformational nursing leadership and improved patient outcomes of patient satisfaction and reduced patient adverse events and complications. Kvist, Vehvilainen-Julkumen, Jokela (2007) studied the perceptions of patients and staff and found that there was no relationship between leadership and quality. This was an international study along with Christiansen (2008) who studied the nurse's perception of the work environment and of quality assurance. Christiansen (2008) found in Norway, that nurses perception of "good work" included securing the needs of the patients and families, and responding to specific situations.).

Another study conducted by the Health Research Education Trust found that hospital managers were the most likely group to be involved in quality improvement activities and physicians were the least likely involved with staff nurses second from the least (Margolin, Bohr, Cohen, and Restuccia, (n. d.). This study confirms the need to studying the staff nurses' perception of their role in improving quality indicators

Testing of an instrument called the Nurses' Assessment of Quality Scale-Acute Care Version (NAQS-ACV) was reported by Lynn, McMillen and Sidani (2007). According to the published instrument development article, this tool contains questions that when answered by staff nurses give a picture of the nurses' opinions of unit quality. The survey questions are divided into sub categories as follows: interaction, vigilance, individualization, advocate, work environment, unit collaboration, personal characteristics and mood. Future work with this instrument could be used to correlate the relationship between nurses' assessment of the care they provide and the outcomes which are achieved (Lynn, McMillen and Sidani, 2006). Upon detail review of this instrument by this author, its use was not acceptable for this study.

Research Questions

The following research questions were posed at the onset of the study proposal:

- Are staff nurses aware of what quality indicators are being measured in their work unit and hospital wide?
- Are staff nurses engaged in the nursing measures needed to improve the hospital quality indicators?
- How are staff nurses involved in improving the quality indicators at the unit level?
- What implications do these findings have on hospital quality improvement plans?
- How do these findings influence the nurses' involvement in unit policy making?
- Does this study provide implications for nursing education?

Methods

As previously mentioned, survey instruments were reviewed for potential use. That developed by Lynn (2007) was not found suitable for this study. Cronenwett's instrument (1997), the Perception of Unit Quality (PUQ) was reviewed and found to be in keeping with the focus of this study. Permission obtained to modify the existing questions and add policy questions. The entire instrument is included as attachment 1 with the instructions for completion included.

Study design was developed and proposed to the Louisiana State University Health Sciences Investigational Review Board. Their approval was sought and obtained as an expedited study. Explanatory emails were sent to nursing executives in the ten Louisiana State University System Hospitals. Support and approval for staff participation was obtained from three facilities. Additional research committee approval from two facilities was required and obtained. Research link was devised and tested to insure anonymity of results. Emails were then sent to RNs and LPNs in the LSU System Hospitals global email address book by group lists provided or city of residence. The emails invited staff to participate in the study. Respondents were asked to express their opinions of their role in achievement of quality indicators within their work unit on a likert scale and to rate the quality of their unit on a scale of 1 to 10 with 10 representing the highest quality.

Results

Analysis of variance and t tests were used to compare multiple variables and establish all relationships. Surveys with less than 50% of the data completed were not included in the analysis. Data was collected and results tabulated. Statistical significance of each question was calculated and resulted in a Chrombach alpha of >.97. There were a total of 944 emails sent

and 140 responses were returned for a response rate of 14.8%. The participant demographics are contained in figure 1. Facility 10 had the largest response rate while Facility 7 had the largest percentage of participation. The overwhelming gender of respondents were female at 84% with the majority of respondents, 52% held positions as staff nurses, working full time, 95% and 73% of the respondents have been practicing nursing more than 10 years which is typical of the tenure seen in state facilities in our area. A total of 47% of the respondents had a BSN (37%) or a Masters degree (10%) and 23% of the respondents work in a medical/surgical specialty area.

The questions were grouped into five dimensions: Clinical care (CC), collaboration (COL), unit atmosphere (UA), basic care (BC), and policy (P). Clinical care (N=8) measures aspects of the clinical care provided to patients. Collaboration (N=3) measures the collaboration with physicians and other health care professionals, and the quality of teamwork. Unit atmosphere (N=4) measures the extent to which staff nurses are satisfied with their work environment. Basic care (N=4) measured the consistency with which staff approach patients and visitors with warmth, courtesy and personal attention. The overall unit ranking question (N=1) considered all factors which influence perceptions of quality of care and asked the respondents to indicate the overall rating of the quality of care on their unit.

The overall results of all questions compared to the facility results are found in figure 2. Of note is the statistical significance of the values of the policy questions comparing facility 6 to facility 7. This may indicate that nurses in facility 6 feel empowered to participate in efforts to improve unit and hospital quality indicators or that the leaders share quality indicators with their staff to a larger measure in facility 6 than facility 7.

There were statistically significant differences in the results when analyzed by job category comparing the RN and LPN's perceptions. Figure 3 lists the dimensions of unit atmosphere, collaboration and basic care which illustrate the scores which had a significance with a p value of <.05. Because the LPN group was such a small part of the overall results, this may have skewed these results. The responses were analyzed by years of experience, as listed in figure 4, which showed no statistical relationship between the results and the years of nursing experience.

There was statistical significance of the nurses' policy responses comparing the Med/Surg nurses with the ED nurses as shown in Figure 5. Also, the policy responses were statistically different in the unit leader group compared with the staff nurses. This may indicate that the unit leaders are more involved in policy change at the unit level as per question 23 which asked the extent to which you are involved in policy changes on your unit.

Conclusions and recommendations for future nursing inquiry

While not all of the research questions were answered by this preliminary work, this is a beginning of the answers to the questions. "How" staff nurses are involved will require more qualitative analysis of their participation. Clearly, if staff nurses are not aware of the quality indicators measured on their units or in their facilities, they will not be active participants in reaching greater measures of quality. Since the staff nurses of today are the unit leaders of tomorrow, the future of quality improvement lies in their crucial participation.

There are many factors involved in the achievement of nursing care quality as discussed in the beginning of this work. In addition, nursing intellectual capital theory (NICT) as described by Christine L. Covell (2008) relates the influence that nurses' knowledge, skills and

experience have on the patient and organizational outcomes. Nurses participate in continuing professional development activities in order to provide high quality and safe patient care. Now the economic pressures to provide the best of care are continuing to impact the nursing profession and the application of this theory has implications in the care delivery. Seeking to explain the driving forces which will impact quality of nursing care in a positive way, this midrange theory contrasts the human capital, structural capital, relational capital and social capital influences on the practicing nurse. Testing Covell's NICT (2008) is in progress and the work of measuring the nurses' perception of unit quality may be another way to test this theory.

Of interest as well is whether the PUQ results would be different comparing non Magnet ™ and Magnet™ Hospitals. Also, including greater emphasis on achieving quality indicators is important in nursing education. Since the results of this study did not vary statistically with years of experience, this indicates that new nurses are equally involved in all aspects of determining unit quality and working towards its improvement.

Table 1. Nurse Sensitive Indicators (Doran, 2003)

Type	**Description**	**Examples**
Clinical	Symptom control or symptom management	Pain, nausea, itching
Functional	Physical and psychosocial, functioning, self care abilities	Activities of daily living, work, social and family role activities, the functional capacity to be independent
Safety	Adverse incidents, complications, sentinel events	Decubitus/pressure ulcers, failure to rescue, falls, infection due to medical care (urinary tract infection prevalence, central line catheter associated blood stream infection, surgical wound infection, septicemia, hospital acquired pneumonia, ventilator associated pneumonia), patient falls, restraint prevalence.
Perceptual	Satisfaction with care	Patient satisfaction, staff satisfaction

Figure 1. Respondent Demographics

Facility/Unit	**% participation**	**Response rates**	**%**
Facility 6	32	Facility 6	16.8
Facility 7	51	Facility 7	11.7
Facility 10	17	Facility 10	31.6
Unit Specialty	**% participation**	**Educational level**	**% participation**
Med/Surg	23	LPN	6
OR/PACU	15	Diploma RN	16
ICU/CCU	17	Associate Degree	31
Peds/OB/L&D	6	BSN	37
Psyc/SNF/Rehab	9	Masters	10
Other	30		
Gender	**% participation**	**Employment Status**	**% participation**
Male	84	Full time	95
Female	16	Part time	3
Years of Experience	**% participation**	**Job Category**	**% participation**
2 or less	12	Unit Staff RN	52
3 to 5	7	Unit Staff LPN	6
6 to 10	8	RN Unit Leaders	24
>10	73	RN others	18

Figure 2. Overall Responses by Unit Dimension Comparing Facilities

Dimension	**Mean Score**	**Facility 6**	**Facility 7**	**Facility 10**
Clinical care	3.87	4.14	4.00	4.00
Unit Atmosphere	3.34	3.84	3.59	3.67
Collaboration	3.59	4.12	3.75	4.08
Basic Care	3.78	4.08	3.91	4.05
Policy	3.42	3.72*	3.25*	3.44
Total Average	3.65	3.80	3.58	3.64
Unit Quality Ranking Score (1=low, 10=high)	7.50	7.98	7.32	7.57

*Significance of p=.02

Figure 3. Responses by Job Category

Dimension	**Staff RN**	**Staff LPN**	**RN Unit Leaders**	**RN others**
Clinical care	3.93	4.45	4.00	3.82
Unit Atmosphere	3.32*	4.29*	3.53	3.67
Collaboration	3.64*	4.51*	3.80	3.99
Basic Care	3.89*	4.53*	3.87	3.76
Policy	3.12*	3.71	3.57*	3.46
Unit Quality Ranking Score (1=low, 10=high)	7.40	8.45	7.51	7.14
*Significance of p<.05				

Figure 4. Respondents' Results by Years of Experience

Dimension	**2 or less**	**3 to 5**	**6 to 10**	**>10**
Clinical care	4.12	3.84	4.29	3.96
Unit Atmosphere	4.04	3.38	3.83	3.56
Collaboration	4.12	3.62	4.31	3.88
Basic Care	4.25	3.73	4.15	3.93
Policy	3.47	3.18	3.56	3.65
Unit Quality Ranking Score (1=low, 10=high)	7.83	6.92	7.92	7.84
*Significance of p=.02				

Figure 5. Policy Results by Unit Group, Job Category and Facility

Unit Group	**Med/Surg**	**OR/ PACU**	**ICU/CCU**	**ED**	**Peds/OB/ L&D**	**Psyc/SNF Rehab**	**Other**
Policy	3.75*	3.39	3.55	3.11*	3.35	3.57	3.54
*significance p=.02							
Job Category	**Staff RN**	**Staff LPN**	**RN Unit Leaders**	**RN others**	**Facility 6**	**Facility 7**	**Facility 10**
Policy	3.12*	3.71	3.57*	3.46	3.72*	3.25*	3.44
*significance p<.05					*significance p=.02		

Attachment 1. Perceptions of Unit Quality (PUQ) Instrument with Instructions

Instructions:

Respondent-Please indicate by marking the proper job category: Unit staff RN, Unit staff LPN, RN nursing unit leaders.

Please indicate what type of unit you work on: Medical, Surgical, OR, PACU, ICU, ED, Pediatrics, OB, L&D, Other

Facility Name/Location-select one

On the average day, how many patients are you responsible for? ____patients

Current work employment as a nurse: _full time, _part time, __PRN Gender: Male/Female

Years as a nurse: 2 or less, 3-5.6-10.greater than 10 years.

Nursing education: LPN, Diploma RN, AD, BSN, Masters

Your responses will be completely anonymous and your hospital will receive a report of the overall results. By completing this survey, you consent to your participation in this study and agree to all publication and discussion of the results without the ability to identify your responses.

Select the indicator which best represents your opinion about each item. If you have no basis for an opinion about an item, or feel that the item is not applicable (NA) to unit, indicate don't know or NA. Please note: The term "staff" on this survey refers to all personnel who regularly provide patient care on the unit, *except for physicians.*	Poor	Fair	Good	Very Good	Out-standing	Don't Know/ NA
1. Staff reliability in recognizing and reporting danger signs or undesired patient outcomes.	1	2	3	4	5	6
2. Consistency with which staff approach patients and visitors with warmth, courtesy and personal attention.	1	2	3	4	5	6
3. Reliability of staff in delivering patient care that consistently meets or exceeds expected standards of care.	1	2	3	4	5	6
4. Extent to which staff plan and coordinate care so that they are consciously assisting the progress of patients toward desired outcomes.	1	2	3	4	5	6
5. Level of morale (energy, optimism, work satisfaction) of staff.	1	2	3	4	5	6
6. Extent to which the nurses on the unit know their patients' current conditions and goals of care.	1	2	3	4	5	6
7. Sensitivity of staff to managing visitors, noise, and other potential disturbances so that all patients have an environment that promotes rest and healing.	1	2	3	4	5	6
8. Quality of staff's collaboration with physicians.	1	2	3	4	5	6
9. Quality of teamwork, respect, and trust among unit personnel.	1	2	3	4	5	6
10. Extent to which nurses appropriately use and collaborate with health care professionals other than physicians, such as social workers, chaplains, case managers, pharmacists, dietitians, and so forth.	1	2	3	4	5	6
11. Degree to which staff communicates a sense of caring for patients and families in the way they touch, talk to, and respond to patients' physical and emotional needs.	1	2	3	4	5	6
12. Quality of problem-solving, judgment and skill of staff.	1	2	3	4	5	6
13. Accessibility of staff for prompt attention to patient, visitor, or provider requests for help.	1	2	3	4	5	6
14. Consistency with which staff respect and protect the confidentiality and dignity of patients.	1	2	3	4	5	6
15. Consistency with which staff meet the basic needs of patients, such as, cleanliness, hygiene and clear identification of caregivers and their roles.	1	2	3	4	5	6
16. Quality of preparation for discharge of patients from this unit.	1	2	3	4	5	6

17. Attentiveness of staff to activities that relieve patient discomfort, such as, pain, nausea, trouble breathing or trouble sleeping.	1	2	3	4	5	6
18. Quality of patient/family education on this unit.	1	2	3	4	5	6
19. Degree to which unit quality indicators and measurements are shared and reviewed with the unit staff.	1	2	3	4	5	6
20. Extent to which you are satisfied with your work environment.	1	2	3	4	5	6
21. Extent to which the staff nurses work to improve quality indicators and measurements as a team.	1	2	3	4	5	6
22. Extent to which your hospital's administration is committed to establishing or changing policies to improve quality.	1	2	3	4	5	6
23. Extent to which you are involved in changing policies on your unit or hospital wide to improve quality.	1	2	3	4	5	6
24. Consistency with which the charge nurses and nursing unit leaders role model behaviors which influence quality nursing care.	1	2	3	4	5	6
25. Considering all the factors that influence *your* perceptions of quality of care, circle one number that shows your *overall* rating of the quality of care on this unit:	1 2 3 4 5 6 7 8 9 10 Poorest quality Highest quality					

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Attachment 2 Perceptions of Unit Quality with Dimension analysis

Dimension analysis key: CC=Clinical Care UA=Unit Atmosphere C=Collaboration P=Policy questions BC=BASIC CARE	Poor	Fair	Good	Very Good	Out-standing	NA/ Don't Know	Dimension
1. Staff reliability in recognizing and reporting danger signs or undesired patient outcomes.	1	2	3	4	5	6	CC
2. Consistency with which staff approach patients and visitors with warmth, courtesy and personal attention.	1	2	3	4	5	6	BC
3. Reliability of staff in delivering patient care that consistently meets or exceeds expected standards of care.	1	2	3	4	5	6	CC
4. Extent to which staff plan and coordinate care so that they are consciously assisting the progress of patients toward desired outcomes.	1	2	3	4	5	6	CC
5. Level of morale (energy, optimism, work satisfaction) of staff.	1	2	3	4	5	6	UA
6. Extent to which the nurses on the unit know their patients' current conditions and goals of care.	1	2	3	4	5	6	CC
7. Sensitivity of staff to managing visitors, noise, and other potential disturbances so that all patients have an environment that promotes rest and healing.	1	2	3	4	5	6	UA
8. Quality of staff's collaboration with physicians.	1	2	3	4	5	6	C
9. Quality of teamwork, respect, and trust among unit personnel.	1	2	3	4	5	6	C
10. Extent to which nurses appropriately use and collaborate with health care professionals other than physicians, such as social workers, chaplains, case managers, pharmacists, dietitians, and so forth.	1	2	3	4	5	6	C
11. Degree to which staff communicate a sense of caring for patients and families in the way they touch, talk to, and respond to patients' physical and emotional needs.	1	2	3	4	5		BC
12. Quality of problem-solving, judgment and skill of staff.	1	2	3	4	5	6	CC
13. Accessibility of staff for prompt attention to patient, visitor, or provider requests for help.	1	2	3	4	5	6	UA
14. Consistency with which staff respect and protect the confidentiality and dignity of patients.	1	2	3	4	5	6	BC
15. Consistency with which staff meet the basic needs of patients, such as, for cleanliness and hygiene and clear identification of caregivers and their roles.	1	2	3	4	5	6	BC
16. Quality of preparation for discharge of patients from this unit.	1	2	3	4	5	6	CC
17. Attentiveness of staff to activities that relieve patient discomfort, such as, pain, nausea, trouble breathing or trouble sleeping.	1	2	3	4	5	6	CC
18. Quality of patient/family education on this unit.	1	2	3	4	5	6	CC
19. Degree to which unit quality indicators and measurements are shared and reviewed with the unit staff.	1	2	3	4	5	6	P
20. Extent to which you are satisfied with your work environment.	1	2	3	4	5	6	UA
21. Extent to which the staff nurses work to improve quality indicators and measurements as a team.	1	2	3	4	5	6	P
22. Extent to which your hospital's administration is committed to establishing or changing policies to improve quality.	1	2	3	4	5	6	P
23. Extent to which you are involved in changing policies on your unit or hospital wide to improve quality.	1	2	3	4	5	6	P

24. Consistency with which the charge nurses and nursing unit leaders role model behaviors which influence quality nursing care.	1	2	3	4	5	6	P
25. Considering all the factors that influence *your* perceptions of quality of care, circle one number that shows your *overall* rating of the quality of care on this unit:	1 2 3 4 5 6 7 8 9 10 Poorest quality Highest quality						

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