



Perceived autonomy and job satisfaction among rural home care nurses  
by Mary Louise Iverson

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing  
Montana State University

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**Abstract:**

The purpose of this study was to determine perceived autonomy and its relationship to job satisfaction and selected demographic variables among rural home care nurses in the state of Montana. Autonomy among the convenience sample was determined using the Dempster Practice Behavior Scale (DPBS). Pearson correlation was used to correlate scores of the DPBS and Job Satisfaction Survey (JSS). The analysis of demographic data, autonomy, and job satisfaction was completed using the Pearson correlation, t-tests, and ANOVA. Results of the study indicated that this sample's nurses consider themselves to be autonomous practitioners with a high level of job satisfaction. The findings of the study can provide employers with insights into the recruitment and retention of home care nurses. Considering the paucity of research findings about rural nurses and autonomy, this study is an elementary contribution to the research literature about autonomy and job satisfaction in rural nursing.

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AMONG RURAL HOME CARE NURSES

by

Mary Louise Iverson

A thesis submitted in partial fulfillment  
of the requirements for the degree

of

Master of Nursing

MONTANA STATE UNIVERSITY-BOZEMAN  
Bozeman, Montana

December 1998

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This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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## VITA

Mary Louise Thomas Iverson was born in Billings, Montana, on January 8, 1955, the daughter of Albert Nordyke Thomas and Ruth Swenson Thomas. She was educated in one-room country schools south of Miles City, Montana, during her elementary grades. After graduating from Custer County High School in 1973, she attended Montana State University receiving a Bachelor of Science Degree in 1977.

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## ACKNOWLEDGMENTS

I would like to take this opportunity to thank the following people for their support and guidance in this endeavor:

To my committee members: Dr. Kay Chafey, Dr. Vonna Koehler, Professor Carolyn Wenger, for the challenge, guidance, and continuous encouragement.

To my husband, Al, for his endless love and support.

To my children, Greg and Jody, who shared their mother with a computer for several years and compared GPA's.

To my Mother and Dad, who instilled in me the drive to be my own person.

To the rest of my family, my friends at work, and in the community who have listened to my trials and encouraged me.

Thanks to all of you for helping me meet this goal.

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## ABSTRACT

The purpose of this study was to determine perceived autonomy and its relationship to job satisfaction and selected demographic variables among rural home care nurses in the state of Montana. Autonomy among the convenience sample was determined using the Dempster Practice Behavior Scale (DPBS). Pearson correlation was used to correlate scores of the DPBS and Job Satisfaction Survey (JSS). The analysis of demographic data, autonomy, and job satisfaction was completed using the Pearson correlation, *t*-tests, and ANOVA. Results of the study indicated that this sample's nurses consider themselves to be autonomous practitioners with a high level of job satisfaction. The findings of the study can provide employers with insights into the recruitment and retention of home care nurses. Considering the paucity of research findings about rural nurses and autonomy, this study is an elementary contribution to the research literature about autonomy and job satisfaction in rural nursing.

## CHAPTER 1

### INTRODUCTION

As nursing has matured into a professional practice discipline, autonomy or independence in nursing practice has become increasingly important to professional nurses. Nurses have confirmed that autonomy is an important aspect of practice by seeking employment and positions in which autonomous or independent practice is encouraged and supported. Indeed, professional nurses value autonomy in practice and often relate the level of perceived autonomy to job satisfaction. Recent literature lends support to the idea that professional autonomy influences job satisfaction among nurses. (Chubon, 1991; Lynch, 1994; Pierce, Hazel, & Mion, 1996). With the changing focus to provision of nursing care outside of institutions and into the patient's place of residence, the opportunity for home care nurses to experience autonomous practice and increasing job satisfaction is growing.

According to the National Association for Home Care (NAHC, 1996), the home care industry is projected to grow 8% annually through the year 2000. In keeping with national trends, it is also reasonable to anticipate a growing demand for home care nurses in Montana. Recruitment and retention of nurses in the home care arena is necessary to support this anticipated level of growth. The limited number of nurses in rural Montana, along with the difficulty in recruiting nurses to isolated areas, makes the recruitment and retention of rural home care nurses even more challenging for rural home care agencies. If rural Montana is to have sufficient numbers of home care nurses to provide care to the growing number of rural patients, every effort must be made to retain the nurses that are now in home care and to recruit new nurses as needed to meet this growing need. An understanding of perceived autonomy as it relates to job satisfaction will provide valuable insight into the attraction and retention of home health nurses for rural areas.

### Purpose

The purpose of this study was to determine the level of the perceived autonomy and how it relates to job satisfaction and demographic variables among rural home care nurses in Montana. Data from this study is useful for rural home care agencies in recruitment and retention of nurses in home care.

### Background and Significance of Study

Autonomous nursing practice is essential in the provision of home care. Nurses in home care practice the profession of nursing in a climate without the traditional barriers associated with institutional settings; therefore, the home care arena requires an independent and innovative level of nursing practice. Often the home care nurse is the only professional to evaluate a patient. Furthermore, the report of the home care nurse to the physician is usually the only link that a physician has to a homebound patient. The role of the nurse is pivotal in guiding the multi-disciplinary team in treatment of the patient.

The nurse who is uncomfortable with autonomous practice may be easily overwhelmed with the demands and amorphous boundaries of home care nursing. For example, it is common for the home care nurse to encounter complex clinical situations, difficulty in accessing physicians, and lack of immediate access to needed supplies and equipment. These factors all require flexibility and creativity on the part of the home care nurse implementing the nursing process. A high comfort level with autonomous practice will clearly increase the nurse's ability to deal with the demands and lack of boundaries found in home care settings.

Autonomous nursing practice is even more critical to rural home care nursing because of the unique circumstances that challenge nurses practicing in rural areas. Unlike their urban counterparts, rural home care nurses face unique problems: accessibility to the patient, poor roads, bad weather, increased travel times, and minimal staffing. Yet, reimbursement for services remains the same as in an urban area, and services are difficult to provide due to unavailability of staff such as physical therapy, medical social services, home health aides, and lab services (Berke, 1992). These unique circumstances further

emphasize the importance for the rural home care nurse to be comfortable with autonomous practice.

Autonomy in nursing is usually related positively to job satisfaction. The perception of autonomy can be the reason nurses either remain in home care or seek another area of nursing practice. For example, McCloskey (1990) identified autonomy as the most important indicator of job satisfaction for nurses. Hanson, Jenkins, and Ryan (1990) found, that for rural nurses, the most important indicator of job satisfaction was their perceived level of autonomy. Home care nurses also identified one of the most satisfying elements of home care to be the high level of autonomy associated with the job (Chubon, 1991; Lynch, 1994).

Based on the studies cited above, it seems evident that the freedom to practice autonomously, that is, to determine the plan of treatment with a patient and then intervene as needed to meet nursing goals, leaves a nurse with a sense of professional satisfaction. As the provision of health care shifts to the community, recruitment and retention of nurses to home care is necessary to meet the growing needs of the home care industry. The perception of autonomy can be the key in maintaining and increasing the number of nurses in this work force.

#### Problem Statement and Research Questions

While the perceived level of autonomy and the relationship of perceived autonomy and job satisfaction have been studied in other practice areas, the relationship has not been explored among rural home care nurses. Research in this area will provide data which will increase understanding of the relationship between autonomy and job satisfaction for home care agencies. The questions which will be answered by this research are as follows:

1. What is the level of perceived professional autonomy among rural home care nurses in Montana?
2. What is the relationship of perceived level of autonomy to job satisfaction among rural home care nurses in Montana?

3. What is the relationship of perceived level of autonomy to selected demographic variables among rural home care nurses in Montana?

### Conceptual Framework

The concept of autonomy provides the foundation for the conceptual framework of this study. The word autonomy originated from the Greek terms *autos*, meaning self, and *nomos*, meaning rule. Independence, freedom, self-governance, self-control, and self-sufficiency are frequently used to define autonomy. The basis of the term is related to the balance of the amount of self-rule against the amount of external control. Autonomy is influenced by both the individual person and outside control; therefore, autonomy may be viewed as a balance between the two influencing sources. Dempster (1994) recognized the need for the balance when she described autonomy in nursing practice as a dynamic process influenced by varying amounts of independent and self-governed behaviors.

In the past, social, economic, and role oppression of women have provided barriers to autonomous practice in nursing. Traditionally, nurses have been viewed as dependent practitioners and, in many cases, were under the control and supervision of both physicians and the organizational structure in which they practiced. However, as nursing has evolved as a profession, autonomy has become a valued and essential component of professional nursing practice. The credibility and autonomy of nursing within the health care disciplines has also been positively influenced through building nursing knowledge based on research findings. Although some barriers still exist, nurses are gaining in recognition as autonomous practitioners (Dempster, 1994).

Dempster (1990) placed the responsibility for nursing autonomy in the arena of nursing practice. After extensive research, Dempster defined autonomy in nursing practice as follows:

Autonomy in practice is theoretically defined from a self, other, or joint locus as a dynamic process that demonstrates varying amounts of independent, self-governed, not controlled, or subordinate behaviors, actions, or conduct related to the readiness for, empowerment for, actualization of, and valuation of autonomous performance and exercise of one's profession. (p. 194)

Dempster's definition of autonomy identifies that the locus of autonomy may be within the

nurse, outside the nurse (such as organizational or legal powers) or a combination of the two. According to Dempster, autonomy in nursing practice is an energetic, fluid process comprised of the dimensions of readiness, actualization, valuation and empowerment. Nursing conduct is comprised of attitudes and behaviors which direct autonomous practice.

The first dimension of autonomy that Dempster (1990) described is readiness. Readiness of the individual nurse for autonomy "is behavior and action involving transitioning, opportunity, evolution, growth, development, movement, and/or progression from one level or degree to another related to autonomy in practice" (p. 194). Dempster identified competence, skill, and mastery as components of readiness. Autonomy is associated with the development of expertise required for a particular practice area. For example, a nurse who has recently graduated and has not yet had nursing experience is a nurse who is not ready for autonomous practice. An example of readiness in home care can be demonstrated by the development of a home care nurse into a specialized practitioner with advanced assessment skills, highly technical procedural skills, an understanding of community nursing, and a high degree of confidence in his/her knowledge of the scope of nursing practice. Home care nursing is now recognized as a specialty area by the National League of Nursing, has stimulated nursing research, and is the focus of several nursing journals.

The second dimension of autonomy described by Dempster (1990) is actualization. In other words, autonomy can only exist through the actions of the nurse as opposed to mere readiness for action. Actualization is the existence, the exercise, or the application of autonomy in practice that involves action to accomplish. The components that Dempster associated with actualization are "determination, decision-making, directing, taking action, controlling, accountability, and responsibility" (p. 194). Home care nurses have responded to the shift in health care delivery into the community by updating assessment and procedural skills and by becoming the pivotal force in the management of patient treatment plans. Continuing education is needed not only in technical areas but also in areas related to home care such as reimbursement, current legislation, communication skills, and other professional issues to maintain current home nursing skills.

The next dimension of autonomy is valuation, which is viewed as an outcome of autonomy in nursing (Dempster, 1990). The element of valuation identifies that nursing practice must have "value, worth, merit, and usefulness" (p. 194) for autonomy to matter to the individual nurse. Dempster cited the components for valuation to be "self-respect, self-achievement, and satisfaction" (p. 194). Home care nurses value autonomy and often seek home care jobs because of the perception that autonomy in home care practice is greater than autonomy in most institutional nursing roles. Nurses who have reached a level of autonomous practice often find more satisfaction in their jobs and advocate for autonomous practice by expanding nursing roles to demonstrate the significant impact that nursing can have in the delivery of health care.

Lastly, Dempster (1990) identified the dimension of empowerment. For a nurse to practice in an autonomous capacity, the nurse must first be empowered through legal sanctions and organizational structures. Given a choice, home care agencies often will not hire a nurse unless he/she has at least a baccalaureate degree in nursing. Home care agencies promote autonomous practice by assigning nurses to be primary case managers for patients and by encouraging the nurse to advocate for the patient's needs with physicians and community agencies. Autonomous nursing practice can only reach its highest level when the organization allows the nurse to practice to the fullest extent of educational preparation. Nurses are able to empower themselves to have autonomy in practice by continuing education and seeking advanced practice degrees. Dempster recognized the components of "legitimacy, having rights, having privileges" (p. 194) to be components of the dimension of empowerment.

#### Autonomy and Job Satisfaction

The concept of autonomy has been related to the complex phenomenon of job satisfaction in that the perception of autonomy which a nurse has about his/her position has been found to influence job satisfaction. A strong relationship between job satisfaction and nursing autonomy suggests that nurses who feel as though they have control over work decisions are more likely to remain in that job (Hanson et al., 1990). Nurses value the

ability to be independent in practice and seek opportunities to exert themselves as professional practitioners. For home care nurses, job satisfaction means having autonomous practice, the ability to interact with patients and families, the challenge of problem-solving, and the responsibility to develop plans of treatments along with the patient (Chubon, 1991).

Nurses are educated to be professionals and expect autonomous practice. If a nurse is not empowered by the organization to practice autonomously, the perception of job satisfaction is negatively influenced (Hanson et al., 1990). Therefore, nurses who are empowered by the work structure to have control over their practice are more likely to be satisfied with their jobs and feel more committed to the employer. Hospitals which have not created structures to allow for independent nursing practice have lost nurses to practice settings which allow the nurse to function more autonomously (McCloskey, 1990). Many nurses previously employed by hospitals have turned to the home care setting to find a more autonomous level of practice. Lynch (1994) found nursing autonomy to be an indicator of job satisfaction in home care nurses and by capitalizing on indicators of job satisfaction, staff can be retained in the job. Retention of nurses in rural areas is even more critical because of the lack of nurses in rural areas (Stratton et al., 1995).

It is apparent that the perception of autonomy in nursing is closely linked to the phenomena of job satisfaction. If a rural home care nurse perceives that he/she has autonomy in nursing practice, it is logical to predict that the nurse may also have a higher level of job satisfaction and remain in that job more often than the nurse who perceives his/her level of practice to be less than autonomous. The importance of the relationship of autonomy as it relates to job satisfaction in rural home care nurses provides the foundation for this research.

#### Definitions

For the purposes of this study, the following definitions are provided:

Autonomy: "...the freedom to make choices, decisions, or to select a course of action without external control" (Dempster, 1994, p. 227).

Rural Home Care Nurse: A registered nurse who provides intermittent skilled nursing care in the patient's place of residence, which is in a community with a population no greater than 20,000.

Perception of Autonomy: The level of consciousness that a nurse has about the phenomena of autonomy as measured by the elements of readiness, empowerment, actualization, and valuation for autonomous performance (Dempster, 1994).

Job Satisfaction: The amount of contentment that a person feels about his/her position of employment.

## CHAPTER 2

### REVIEW OF THE LITERATURE

#### Home Care

Home care has grown rapidly in the United States. In 1963, there were only 1,100 home care agencies in the nation. Medicare accelerated the growth of home care by making services available to the elderly in 1965. By 1973, services were also available to some younger disabled Americans. Twenty-two years later, the National Association for Home Care (NAHC) certified 18,874 agencies. In 1996, it was estimated approximately 3.9 million Medicare enrollees would receive home care services. This was twice the number of people that had received services in 1990 (NAHC, 1996).

Rural patients need home care services as much or more than urban patients (Dansky, 1995). While the number of enrollees in home care from either rural or urban areas was not identified by the NAHC (1996), published sources indicate a difference in the use of home care by rural and urban residents. In 1987, the number of skilled nursing visits to rural residents was slightly greater than the number of skilled nursing visits in urban areas. The number of home health aide visits were also slightly higher to rural residents than to their urban counterparts. However, the number of visits to rural residents by physical, occupational, and speech therapists was significantly decreased compared to urban residents. Furthermore, social worker visits in rural areas were less than half the number of visits in urban areas. It seemed that the lower number of total visits to rural home care patients was probably lower due to the lack of available therapists and social workers in rural areas (Dansky, 1995).

Davis et al. (1992) identified the need to recognize the rural elder's self-reliance and autonomy when providing health care. While the rural elderly in this study described themselves as being self-reliant, they also identified a need for assistive services. As family

structure has changed, the number of elderly who live alone in rural areas has increased to 42% (Davis et al.). Besides having the risk factor of living alone, rural residents are more likely to have more functional limitations than their urban counterparts (Dansky, 1995), thus also indicating an increased need for home care services.

A principle goal of home care is cost-effective quality health care in a restorative setting where the patient is comfortable. In home care, patients are allowed to take an active role in their care. Home care allows patients to remain in control of their own lives and still be as self-reliant as possible. Family and friends provide a great deal of the patient's care. Home care services support patients and their caregivers to maintain the patient's optimal level of independence (NAHC, 1996; Rice, 1996).

To provide home care services, dedicated providers are needed and have grown in number rapidly the last few years. Employment in home care agencies has more than doubled since 1988. It is estimated that home care employment grew from 344,000 employees in 1991 to 610,000 employees in 1995 with Registered Nurses (RN) having the largest number of positions. RN's comprised approximately one third of all home care employees (NAHC, 1996). It is predicted that with the rapid increase in the rate of growth in home care, the number of skilled nursing positions needed will continue to increase dramatically.

#### Autonomy and Nursing

Management of nursing practice by nurses is crucial for the growth of the nursing profession. Autonomy in practice is limited to the area of practice in which the nurse has authority. Authority is derived from expert knowledge. Autonomy is not independent decision-making alone but the responsibility to take a specific course of action or to not take any action at all. Therefore, a consequence of autonomy is accountability, which means being accountable for one's actions and behaviors. Additionally, it is the professional duty of nurses to pursue the knowledge that is needed to maintain accountability and autonomous practice (Nazarey, 1985).

Autonomy in professional nursing has frequently been defined using the relationship of the individual nurse to the organizational or legal structure. For example, Nazarey (1985) defined autonomy as a condition in which "practitioners are self-regulating and have control over their functions in the work situation" (p. 45) and have the authority to practice independently within the organizational structure. Lewis and Batey (1982) identified professional autonomy as the individual's ability to function freely but within the organization's structure. Furthermore, organizational structure may impede the nurse's ability to act autonomously by not allowing the nurse to fully function within the extent of the law (Hylka & Shugrue, 1991). Another influence on nursing autonomy was the environment; for example, home care agencies traditionally tend to empower staff nurses to act more autonomously than staff nurses in institutions because of the independent nature of the home care job.

Empowerment of the nurse by the organization is the key to promoting autonomous nursing behaviors (Hylka & Shugrue, 1991; Marion et al., 1995; Sabiston & Laschinger, 1995). While empowerment of the nurse by the organization is essential for autonomous practice, so is the need for the individual nurse to empower herself by exploring and pursuing Dempster's (1990) dimensions of readiness, actualization, valuation, and empowerment. Autonomy in nursing practice can only reach the highest level when the organizational structure and the individual nurse work together.

Autonomy and the Home Care Nurse. Autonomy in nursing practice is fundamental in home care because the home care nurse is the center of the home care team and responsible to not only the patient but to the rest of the health care team. The Health Care Financing Administration (HCFA) described the duties of the registered nurse (as cited in Rice, 1996) as follows:

The registered nurse makes the initial evaluation visit, regularly reevaluates the patient's need, initiates the plan of care and necessary revisions, provides those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting

nursing and related needs, participates in inservice programs, and supervises and teaches other personnel. (p. 9)

It is apparent that the role of the registered nurse in home care is vital to the provision of quality home care. The expanded role of the home care nurse is associated with increased power and autonomy of practice compared to the traditional institutional settings. The role expectations for the nurse requires that the nurse be a case manager who assumes a leadership role involving autonomous nursing practice to direct the multi-disciplinary team. The qualifications of the nurse who can function successfully in home care include advanced assessment and communication skills, sound judgment, efficient documentation skills, flexibility and creative problem solving, and self-direction. Home care nurses are also required to be expert clinicians, managers, and leaders in health care (Rice, 1996).

Autonomy in Rural Nursing. Recent literature identified that autonomy in practice is also essential for the nurse who works in a rural area. The role of the nurse who practices in a rural area has unique characteristics; one of which is that of being an autonomous practitioner. Davis and Drees (1993) identified that the role of the rural community health nurse is broad in focus and that an understanding of the rural population is necessary for practice in rural areas. Bigbee (1993) asserted specific characteristics of rural nursing: (a) close community ties and relationships, (b) a generalist focus and multiplicity of roles, (c) increased independence and self-direction, (d) cohesiveness among staff, and (e) high degree of visibility in the community. Bigbee stressed that a strong sense of autonomy is essential for rural nurses to remain in practice.

An example of the need for rural nurses to have a high level of professional autonomy is demonstrated by research in the area of rural hospital nursing. For instance, critical care nurses in rural areas have unique challenges which mandate that nurses have to practice autonomously in order to manage the critical needs of patients in rural hospitals. Nurses in rural hospitals are often called on to manage medical/surgical, pediatric, obstetric, and emergency room patients all in one shift and often without the highly

technical equipment or assistance of support staff or a physician (Thompson & Chambers, 1993). It appears that if a rural critical care nurse is empowered by the hospital to practice autonomously, the nurse has a greater chance of job satisfaction.

Autonomy among rural hospital nurses was found to be positively related to a higher level of nursing education in a study by Swenseid (1994). Swenseid used Pankratz and Pankratz's (1974) instrument to describe the level of autonomy in 219 hospital nurses in Montana. Results of the Swenseid study indicated that the rural nurses scored higher on the nursing autonomy/advocacy subscale than did the nurses in the original study. However, many areas of professional nursing have had significant growth between the time of the original study and Swenseid's work, one of the areas being autonomy in nursing practice. One of the influences of the growth related to increased autonomy is the greater emphasis placed on autonomy in professional nursing programs. Another influence is the amount of time the profession of nursing has had to grow in autonomous practice between the studies. Because of the growth of nursing in the last twenty years, it was expected that the score for the subscale of autonomy/advocacy will be higher than the original study in at least some areas of professional practice.

Using a sample of 167 rural hospital nurses in the state of Georgia, Hanson et al. (1990) studied the variables affecting job satisfaction using the Job Descriptive Index. The psychometric properties of this 72 item checklist were evaluated by Robinson and Shaver (as cited in Hanson et al.). Each respondent completed a 13 page questionnaire. The length of the instrument was identified as having a negative influence on response rates. The most significant relationships found were between job satisfaction and autonomy in practice, and the intent to remain in the job and autonomy in practice. In all of these previous studies, there was a strong positive correlation between autonomy and job satisfaction, thus underscoring the need for continued research into the relationship of autonomy and rural nursing practice.

Research on Autonomy in Nursing. One of the first instruments used to measure autonomy in nursing was developed by Pankratz and Pankratz (1974). The Pankratz and

Pankratz tool measures three subscales: nursing autonomy and advocacy, patient's rights, and rejection of the traditional role limitations. The autonomy and advocacy subscale was designed to explore the perception of independence in nurses. It was assumed that a nurse can be a better patient advocate if he/she is able to practice autonomously. The instrument has been used frequently to study the concept of autonomy in nursing. As the profession of nursing has developed and matured, the concept of autonomy in nursing has expanded, and more insight is needed into nursing autonomy than can be provided by an instrument developed twenty five years ago. However, one of the major findings of the Pankratz and Pankratz study which is still valid was the strong positive correlation of higher education with levels of autonomy in nursing. This finding has been validated in several more recent studies such as Swendseid (1994) and others cited below.

In 1987, Schutzenhofer (as cited in Schutzenhofer & Musser, 1994) developed and used the Nursing Activity Scale (NAS) to describe clinical nursing situations that involved autonomy. The most noteworthy result of the Schutzenhofer study in relationship to autonomy was that public health nurses perceived themselves to be even more autonomous than hospital nurses. Then in 1994, Shutzenhofer and Musser used the NAS and the Personal Attribute Questionnaire (PAQ) tool developed by Spence, Helmreich, and Stapp in 1974 (as cited in Shutzenhofer & Musser) to again study autonomy in nursing. Data analysis substantiated a positive correlation between levels of education and perceived autonomy and that public health nurses were found to have a significantly higher autonomy score than hospital nurses.

Dempster (1990) found that although there were many instruments to study autonomy, there was not an instrument to assess the extent of autonomous behaviors and actions associated with nursing practice. By using a process of retroduction and triangulation, the Dempster Practice Behaviors Scale (DPBS) was developed. Through deduction and induction, Dempster found the concept of autonomy to have four dimensions (readiness, actualization, valuation, and empowerment). The tool was developed using the four dimensions to measure autonomous behavior. Dempster stated that the DPBS is generalizable to all areas of nursing and even outside of nursing. The DPBS was used to

measure autonomy in rural home care nurses in the present study because of the emphasis it places on behaviors and actions in practice.

### Autonomy Related to Job Satisfaction of Home Care Nurses

No studies were found that related autonomy among rural home care nurses and job satisfaction. Research on autonomy and job satisfaction has been studied most often with urban hospital nurses. Autonomy has been found to be positively related to job satisfaction and an indicator of intent to remain in the job in several studies (Blegan et al., 1993; Hylka & Shugre, 1991; Kramer & Schmalenberg, 1991; Pierce et al., 1996; Roedel & Nystrom, 1988; Seybolt, Pavett, & Walker, 1978).

Although the research for rural home care nurses is limited, two studies indicated that autonomy is a critical indicator for job satisfaction in the population of home care nurses. In an ethnographic study, Chubon (1991) used a sample of 25 home care nurses and 7 homemaker-home health aides in 2 home care agencies in a southeastern state. When describing job satisfaction, most nurses indicated that autonomy in practice and especially the freedom to carry out treatment plans that the nurse and patient had selected were the reasons that home care jobs were desirable.

The importance of the relationship of job satisfaction to autonomy was supported by a quantitative study of 66 home care nurses from three home care agencies using the McCloskey/Mueller satisfaction scale (Lynch 1994). The instrument used was a 31 item Likert scale questionnaire divided into 8 subscales designed to measure autonomy. The nurses surveyed indicated that autonomy in practice was an important aspect of job satisfaction.

Even though most studies exploring autonomy and job satisfaction have focused on hospital nurses, the importance of the relationship of autonomy and job satisfaction in nursing has been substantiated. There is a dearth of literature which examines the relationship of rural home care, autonomy, and job satisfaction. Research analyzing the relationship provides insight into the problem of meeting the demand for an increased number of home care nurses in rural areas.

## CHAPTER 3

### METHOD

#### Population and Sample

A convenience sample of nurses for the study was drawn from the population of nurses who work in the area of rural home care in the state of Montana. The term *rural* has been defined in several different ways in nursing research. By some definitions the entire state of Montana could be considered rural because the total population density is 5.5 people per square mile (Lee, 1991). For the purposes of this study, home care nurses who practice exclusively in rural communities with a population of 20,000 or less were asked to participate. By limiting the sample to one state, the differences in state Nurse Practice Acts did not influence the nurse's level of autonomous practice and, therefore, did not become another variable in the study.

#### Design

A descriptive correlational survey design was used in this research to measure the level of perceived autonomy among rural home care nurses in Montana, examine the relationship between job satisfaction and perceived level of autonomy, and examine the relationship of demographic variables among the sample with the perceived level of autonomy.

#### Procedures for Data Collection

After approval of the study by the Human Subjects Committee of Montana State University College of Nursing, a list of home care agencies in the state of Montana which provide skilled intermittent nursing services was obtained from the Montana Association of Home Health Agencies (MAHHA). A telephone call was made by the investigator to the director of each agency using a written script to introduce the investigator and the research

project protocol (Appendix A). Following the discussion of the research project with the agency directors, the investigator sent a written letter of introduction to each consenting director along with packets for each nurse who fit the inclusion criteria (Appendix B). The packet for the nurse included a letter of introduction (Appendix C), the survey (Appendix D), a self-addressed postcard, and a stamped, self-addressed envelope. The nurse was asked to complete the survey outside of work hours and return the survey within two weeks. After two weeks, reminders (Appendix E) to complete the surveys were sent to the agency directors for distribution to participating nurses. A returned survey indicated consent to participate. The forms were not coded, and participants were asked not to include their name. Anonymity was thus protected. The investigator wrote the letters and paid printing and postage costs. The data were locked in the investigator's personal files during analysis and then forwarded to the College of Nursing for storage in locked files for five years.

#### Discussion of Human Subjects Consent Procedures

Risks to the nurses in this study were minimal as participation was informed and completely voluntary, and anonymity assured. Directors did not know who completed the survey. The investigator did not know who received the surveys or who returned them. Surveys were returned to the investigator without the use of names or codes, and data were reported only as group data. Individual anonymity was thereby protected. After reading the letter of introduction which summarized the risks and benefits, the nurse indicated informed consent and willingness to participate by completing the survey.

Although the survey was completed outside of the work setting, the nurse may have felt pressure to complete the survey as part of a work assignment since the directors distributed the surveys and the reminders to complete the surveys. The element of coercion by the employer was avoided by requesting the nurse to complete the survey outside of the work setting so the employer did not know who did and who did not complete the survey. At the end of the survey the nurse was asked to contact the researcher if he/she was not comfortable in completing the survey. Individuals who identified adverse effects associated

with the research or who objected in any way to the request for participation or the nature of the research questions were referred to the investigator's thesis chair and given her phone number. Because there is limited research on rural home care nurses and rural nursing practice, benefits of participation were said to include the satisfaction of knowing that the respondent participated in research which was directly related to their field of practice.

The proposal was submitted to the Human Subjects Review Committee of Montana State University-Bozeman College of Nursing for approval. The data was analyzed only by the investigator and was locked in the investigator's personal files during the analysis process. Following the completion of the research project, the data were forwarded to the project advisor at the College of Nursing Montana State University-Bozeman for locked storage for five years after which they will be destroyed.

#### Data Producing Instruments

The instrument which was used to measure the perceived level of autonomy was the Dempster Practice Behavior Scale (DPBS). Dempster's (1990) instrument enabled the concept of autonomy in nursing to be measured by identifying the extent of autonomous nursing behaviors. Using the process of retroduction and triangulation, Dempster developed the DPBS and subsequently tested the instrument using 569 RN subjects. The DPBS is a 30 item tool with a 5-point Likert scale which focuses on behaviors, actions, and conduct which reflect the nurse's level of autonomy in practice.

The DPBS has been proven to have strong psychometric properties. Reliability for the DPBS was established using internal consistency testing. The tool had a Cronbach's alpha of .95. Dempster reports that the DPBS has been used in several studies in the United States and foreign countries. The Cronbach's alphas have ranged from .89 to .95. The content validity, using the Content Validity Index, was calculated to be 1.00 from the ratings of seven content experts (Dempster, 1990).

Construct validity had been demonstrated using several methods. Convergent and discriminant validity for the instrument was determined by using the initial 40-item DPBS

along with three other instruments among 1000 nurses. Factor analysis determined the factorial validity of the instrument and reduced the tool to 30 items (Dempster, 1990).

To measure job satisfaction, Spector's (1997) Job Satisfaction Survey (JSS) was used. The JSS is a thirty-six item scale which measures nine subscales of job satisfaction along with overall satisfaction. Each of the nine subscales is assessed by four items. Ten scores can be generated from the results. A total score of all the items and a separate score for each of the subscales can be elicited.

The JSS also has strong psychometric properties. Reliability for the JSS was determined using internal consistencies or coefficient alphas, for 3,067 responses. The coefficient alpha for the tool is .91. Test-retest reliability for the tool was .71. Construct validity for the JSS was established using convergent validity testing methods with a number of scales and variables that indicate job satisfaction. While content validity is not directly addressed in the instrument explanation, norms have been established from 8,113 subjects from 52 sample groups (Spector, 1997).

The JSS instrument includes the subscales of pay (satisfaction with pay and pay raises), promotion (satisfaction with promotion opportunities), supervision (satisfaction with immediate supervisor), fringe benefits (satisfaction with fringe benefits), contingent rewards (satisfaction with rewards given for good performance), operating conditions (satisfaction with rules and procedures), coworkers (satisfaction with coworkers), nature of work (satisfaction with the type of work done), communication (satisfaction with the communication within the organization) (Spector, 1997, p. 8). The item numbers which measured each subscale are as follows: Pay: 1, 10, 19, 28; Promotion: 2, 11, 20, 33; Supervision: 3, 12, 21, 30; Fringe benefits: 4, 13, 22, 29; Contingent rewards: 5, 14, 23, 32; Operating conditions: 6, 15, 24, 31; Coworkers: 7, 16, 25, 34; Nature of work: 8, 17, 27, 35; and Communication: 9, 18, 26, 36. Items number 10, 19, 2, 12, 21, 4, 29, 14, 23, 32, 6, 24, 31, 34, 8, 18, 26, and 36 were reverse scored. A high score for each question indicated a more positive feeling.

Demographic data and work-related questions were added for further examination. These data included, age, marital status, gender, years in home care, level of education, hours worked per week, role of the nurse in the agency, and income level.

#### Planned Statistical Analysis

Data were analyzed using the SPSS-PC statistical package. Guidelines developed by Dempster (1990) were used to score the level of autonomy for each participant. The scoring of the JSS was completed as indicated by Spector (1997). Descriptive statistics summarized the analysis of the demographic data. Correlational methods described the relationship between the autonomy score and job satisfaction score. The demographic variables, autonomy, autonomy subscales, job satisfaction, and job satisfaction subscales were analyzed using Pearson's  $r$ ,  $t$ -tests, and ANOVA.

## CHAPTER 4

### RESULTS

#### Introduction

The results of the research project are presented in three sections. In the first section, the descriptive data are presented. The characteristics of the sample are described using the variables of gender, marital status, age, financial security, years in home care, hours worked per week, basic nursing education, highest nursing education, and work role. Also reported in this section is the discussion of the first research question: What is the level of perceived professional autonomy among rural home care nurses in Montana?

The second section provides a detailed description of the instruments used in the study. The Dempster's Practice Behavior Scale (DPBS) was used to analyze the overall level of autonomy. For analysis of the job satisfaction, the Job Satisfaction Survey (JSS) was used. The reliabilities of both instruments and their respective subscales are reported in this section.

The last section discusses the relationship among the variables and answers the following research questions: (a) What is the relationship of perceived level of autonomy to job satisfaction among rural home care nurses in Montana, and (b) What is the relationship of perceived level of autonomy to selected demographic variables among rural home care nurses in Montana?

Pearson's  $r$  was used to analyze the relationship between autonomy, job satisfaction, instrument subscales, and demographic variables of age, years in home care, hours per week worked, basic nursing education, and highest nursing education. Analysis of group mean differences between autonomy, job satisfaction, the respective instrument subscales, and demographic data of gender, marital status, financial security, and work

assignment was completed using *t*-tests and ANOVA. The alpha level for all study results was set at  $p \leq .05$  using a 2-tailed test for significance. Refer to Table 1 for a listing of the tables that report the study results.

Table 1: Table of Tables

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- Table 2: Demographic Characteristics of the Rural Home Care Nurse in Montana
- Table 3: Means and Standard Deviations for Autonomy and Job Satisfaction
- Table 4: Total Autonomy Score and Autonomy Subscales Correlations--Pearson's *r*
- Table 5: Correlations between Autonomy Subscales
- Table 6: Correlations between Job Satisfaction and Job Satisfaction Subscales
- Table 7: Autonomy and Job Satisfaction Correlation--Pearson's *r*
- Table 8: Correlation among Autonomy, Age, Years in Home Care, Hours/week Worked, Basic Nursing Education, and Highest Nursing Education--  
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- Table 9: *t*-tests for Autonomy, Gender, Marital Status, and Financial Security
- Table 10: ANOVA of Autonomy and Work Assignment
- Table 11: Correlation of Autonomy Subscales, Age, Years in Home Care, Hours/week Worked, Basic Nursing Education, and Highest Nursing Education--  
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- Table 13: ANOVA of Autonomy Subscales and Work Assignments
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- Table 15: *t*-tests for Job Satisfaction, Gender, Marital Status, and Financial Security
- Table 16: ANOVA of Job Satisfaction and Work Assignment
- Table 17: Correlation of Job Satisfaction Subscales, Age, Years in Home Care, Hours/week Worked, Basic Nursing Education and Highest Nursing Education--Pearson's *r*
- Table 18: *t*-tests for Job Satisfaction Subscales, Gender, Marital Status, and Financial Security
- Table 19: ANOVA of Job Satisfaction Subscales and Work Assignment
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## Descriptive Analysis

### Characteristics of the Sample

Surveys were mailed to 122 rural home care nurses in Montana who practiced in communities with populations less than 20,000. Fifty-nine nurses responded, which was a 48.3% return rate of completed surveys. Please see Table 2 for a summary of the demographic data.

Of the 59 participants, 56 (94.9%) were female, and 3 (5.0%) were male; 43 (72.8%) were married, 3 (5.0%) were single, 9 (15.2%) were divorced, and 4 (6.7%) were widowed; 7 (11.8%) were between the ages of 20-30, 17 (28.9%) were between the ages of 31-40, 26 (44.0%) were between 41- 50 years of age, and 9 (15.2%) were between the ages of 51-60. Forty-seven participants (79.0%) felt that it was necessary to work for the financial security of their families while 12 (20.4%) participants did not feel the need to work for financial security of their families.

Forty-one of the participants had practiced home care nursing for 5 years or less (69.4%), 14 for 6-12 years (23.7%), 3 for 12-20 years (5.0%), and 1 for over 21 years (1.6%). Eight (13.5%) participants worked in home care nursing 8-20 hours per week; 13 (22.0%) worked 21-30 hours per week; 28 (47.4%) worked 31-40 hours per week; 10 (16.9%) worked over 41 hours per week. Thirty-two of the respondents (54.2%) functioned both in the role of patient care provision and management while 25 (42.3%) functioned only in patient care provision, and two (3.3%) functioned exclusively in management. The modal level of basic education for the participants was the BSN (n=34 or 55.9%); 13 participants (22.0%) had an associate degree in nursing while 12 (20.3%) had a diploma in nursing. The highest level of nursing education achieved by the participants is summarized as follows: associate degree in nursing (n=12 or 20.3%), diploma in nursing (n=11 or 18.6%), BSN (n=33 or 55.9%), and 3 (5.0%) of the respondents had completed a master's degree in nursing.

Table 2: Demographic Characteristics of the Rural Home Care Nurse in Montana (N=59)

		n	%
Gender	Females	56	94.9
	Males	3	5.0
Marital Status	Married	43	72.8
	Single	3	5.0
	Divorced	9	15.2
	Widowed	4	6.7
Age	20-30	7	11.8
	31-40	17	28.8
	41-50	26	44.0
	51-60	9	15.2
	61 and over	0	0.0
Financial Security	Needed to work	47	79.0
	Did not need to work	12	20.3
Years in Home Care	0-5	41	69.4
	6-12	14	23.7
	12-20	3	5.0
	21-30	1	1.6
	31 and over	0	0.0
Hours/week Worked	8-20	8	13.5
	21-30	13	22.0
	31-40	28	47.4
	41 and over	10	16.9
Basic Education	Associate Degree	13	22.0
	Diploma	12	20.3
	BSN	34	57.6
Highest Education	Associate Degree	12	20.3
	Diploma	11	18.6
	BSN	33	55.9
	Master's Degree	3	5.0
	PhD.	0	0.0
Work Role	Patient Care	25	42.3
	Patient Care/Management	32	54.2
	Management	2	3.3

### Level of Professional Autonomy

The mean autonomy score for all (N = 59) participants was 123.2 on a scale with a possible range of 30 to 150. The standard deviation was 13.25. Scores ranged from 84 to 146. The results are presented in Table 3.

### Level of Job Satisfaction

The mean score of job satisfaction of the 59 participants was 153.2 on a scale with a possible range of 36 to 216. The standard deviation was 24.39. The scores ranged from 103 to 204. The results are presented in Table 3.

Table 3: Means and Standard Deviations of the Variables Autonomy and Job Satisfaction

<u>Variable</u>	<u>Mean</u>	<u>Standard Deviation</u>
Autonomy	123.2	13.25
Job Satisfaction	153.2	24.39

## Description of Instruments

### Instrument Reliability

To determine the internal consistency reliability for the Dempster's Practice Behavior Scale (DPBS) and Job Satisfaction Survey (JSS) tools, Cronbach's alpha was used to complete an intercorrelation of all items in the scales and the subscales. According to Woods and Catanzaro (1988), the reliability coefficient typically should exceed .70 for new scales and .80 for mature scales. Both instruments used in the study demonstrated a high level of reliability. For this study sample, the Cronbach's alpha for both the DPBS scale and JSS scale was 0.91.

### Subscale Reliabilities

Reliability coefficients were also determined for the subscales of both instruments. The Cronbach's Alpha for the four subscales in the DPBS are readiness, .89; empowerment, .50; actualization, .83; and valuation, .67. The subscales of the DPBS (Table 4) showed a high positive correlation between the total autonomy score and subscales, thereby, substantiating the internal consistency of the instrument.

Table 4: Total Autonomy Score and Autonomy Subscales Correlations--Pearson's  $r^*$   
(N=59)

Subscales	Actualization	Empowerment	Readiness	Valuation
Autonomy (Total Score)	.852**	.593**	.914**	.530**

\*\* $p \leq 0.01$  (2-tailed)

Table 5 reflects the correlations among the subscales of actualization, empowerment, readiness, and valuation. Intercorrelations between the subscales were strongly positive except for the moderate correlation between the empowerment and valuation.

Table 5: Correlation Between Autonomy Subscales

	Actualization	Empowerment	Readiness	Valuation
Actualization	1.00			
Empowerment	.407**	1.00		
Readiness	.736**	.458**	1.00	
Valuation	.542**	.212	.451**	1.00

\*\* $p \leq 0.01$  (2-tailed)

In the JSS, the Cronbach's Alpha for the subscales were as follows: pay, .85; promotion, .78; supervision, .69; fringe benefits, .82; contingent rewards, .72; operating conditions, .57; coworkers, .57; nature of work, .73; and communication, .67. Table 6 reflects a strong correlation between the job satisfaction score and the nine subscales. The correlations among the nine subscales varied in significance as reflected in Table 6.

Table 6: Correlations Between Job Satisfaction and Job Satisfaction Subscales

	JSS Total	1	2	3	4	5	6	7	8	9
JSS Total	1.00									
1	.838**	1.00								
2	.625**	.585**	1.00							
3	.509**	.277*	.155	1.00						
4	.735**	.683**	.472**	.056	1.00					
5	.798**	.648**	.435**	.404**	.632**	1.00				
6	.660**	.571**	.395**	.122	.547**	.341**	1.00			
7	.437**	.147	-.005	.353**	.177	.385**	.133	1.00		
8	.601**	.394**	.317*	.426**	.228	.516**	.154	.453**	1.00	
9	.592**	.377**	.256	.361**	.292*	.422**	.393**	.310*	.271*	1.00

\*  $p \leq 0.05$  level (2-tailed).

\*\*  $p \leq 0.01$  level (2-tailed).

Subscales: 1 = Pay; 2 = Promotion; 3 = Supervision; 4 = Fringe Benefits; 5 = Contingent Rewards; 6 = Operating Conditions; 7 = Coworkers; 8 = Nature of Work; 9 = Communication

### Inferential Analysis

#### Correlation of Autonomy and Job Satisfaction

Since the sample data closely approximated a normal distribution and used ordinal and interval level of measurement, Pearson's  $r$ , a parametric statistic, was used for data analysis. The data analysis yielded a moderate but significant correlation ( $r = .306$  or  $p = .018$ ) between the autonomy scores and the job satisfaction scores as reported in Table 7.

Although the distribution of the data did not indicate serious violation of the assumptions of Pearson's correlation, Kendall's Tau, a non-parametric, test was used to demonstrate correlation of autonomy and job satisfaction and to substantiate the Pearson correlation. The analysis using Kendall's Tau did, indeed, substantiate the Pearson

correlation by demonstrating a moderate but significant correlation (.183 or  $p = .044$ ) between the level of autonomy and level of job satisfaction. In view of the fact that significance was found with both parametric and non-parametric analysis, confidence in the study results was enhanced.

Table 7: Autonomy and Job Satisfaction Correlation--Pearson's  $r$  (N=59)

	Autonomy	Job Satisfaction
Autonomy	1.000	.306*
Job Satisfaction	.309	1.000

\*  $p \leq 0.05$  level (2-tailed)

Relationships among Autonomy, Autonomy Subscales and Demographic Variables

Using the Pearson's  $r$ , the relationships between the total autonomy score, the autonomy subscales, and the demographic variables of age, years in home care, hours per week worked, basic nursing education level, and highest level of nursing education were determined. The correlations of autonomy and these demographic variables are presented in Table 8. The correlations were not statistically significant at the 0.05 level. The negative correlation between age and autonomy indicates that the older the participant, the lower the level of perceived autonomy.

Table 8: Correlation among Autonomy, Age, Years in Home Care, Hours/week Worked, Basic Nursing Education, and Highest Nursing Education--Pearson's  $r$

	Autonomy
Age	-.045
Years in Home Care	.098
Hours/week Worked	.222
Basic Education	.187
Highest Education	.222

\*  $p \leq 0.05$  level (2-tailed)

To compare the group means of autonomy and the variables of gender, marital status, and financial security, *t*-tests were used. No statistical significance in the group means was found. The results are presented in Table 9.

Table 9: *t*- tests for Autonomy, Gender, Marital Status, and Financial Security

Autonomy	<i>t</i>	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Gender	-.640	57	.525	-5.0536	7.8935
Marital Status	.710	57	.481	2.7660	3.8974
Financial Security	-1.366	57	.177	-5.8121	-4.2545

To analyze for difference in group means between autonomy and the demographic variables of work assignment (patient care provision, patient care provision/management, and management), an ANOVA was used (Table 10). No statistically significant difference was found between the group means.

Table 10: ANOVA of Autonomy and Work Assignment

	ss	df	MS	F	Sig
Between Groups	473.299	2	236.650	1.365	.264
Within Groups	9712.260	56	173.433		
Total	10185.559	58			

Table 11 shows the Pearson Correlation between the autonomy subscales and the demographic variables of age, years in home care, hours worked per week, basic education, and highest education. There is a significant positive relationship between both the basic and highest level of nursing education and the autonomy subscale of empowerment indicating that with a higher level of education, the nurse perceives a higher level of empowerment. Highest level of education was positively related to the autonomy subscale of actualization. The subscale of readiness and hours per week worked were also significantly correlated. The negative correlations were not statistically significant and demonstrate a weak correlation.

Table 11: Correlation of Autonomy Subscales, Age, Years in Home Care, Hours/week Worked, Basic Nursing Education, and Highest Nursing Education--Pearson's *r*

	1	2	3	4
Age	.010	-.188	.007	.118
Years in Home Care	.215	-.006	.071	.180
Hours/week Worked	.199	-.048	.326*	.221
Basic Education	.207	.395**	.153	.053
Highest Education	.282*	.346**	.190	.107

\* $p \leq 0.05$  level (2-tailed).\*\* $p \leq 0.01$  level (2-tailed).

1 = Actualization; 2 = Empowerment; 3 = Readiness; 4 = Valuation

Table 12 displays the results of difference in means between the demographic variables of gender, marital status, and financial security and the subscales of autonomy. There are no statistically significant findings in the *t*-tests.

Table 12: *t*-tests for Autonomy Subscales, Gender, Marital Status, and Financial Security

Autonomy Subscales	<i>t</i>	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Actualization					
Gender	.587	57	.560	-1.429	2.434
Marital Status	1.247	57	.218	1.484	1.190
Financial Security	-.971	57	.336	-1.284	1.322
Empowerment					
Gender	-1.596	57	.116	-2.946	1.846
Marital Status	.763	57	.448	.708	.927
Financial Security	-1.947	57	.056	-1.942	.997
Readiness					
Gender	-.302	57	.764	-1.256	4.160
Marital Status	-.059	57	.953	-.121	2.057
Financial Security	-1.468	57	.147	-3.275	2.230
Valuation					
Gender	-.035	57	.972	-2.976	.855
Marital Status	.179	57	.859	7.558	.422
Financial Security	-.76	57	.940	-3.546	.480

To analyze the difference in group means between the variable of work assignment (patient care provision, patient care provision/management and management) and four autonomy subscales, an ANOVA was used. Table 13 demonstrates that no statistically significant differences were found between and within groups.

Table 13: ANOVA of Autonomy Subscales and Work Assignment

Autonomy Subscales	ss	df	MS	F	Sig.
<b>Actualization</b>					
Between Groups	34.665	2	17.333	1.040	.360
Within Groups	932.860	56	16.658		
Total	967.525	58			
<b>Empowerment</b>					
Between Groups	23.944	2	11.972	1.211	.306
Within Groups	553.615	56	9.886		
Total	577.559	58			
<b>Readiness</b>					
Between Groups	226.083	2	113.042	2.447	.096
Within Groups	2586.629	56	46.190		
Total	2812.712	58			
<b>Valuation</b>					
Between Groups	4.348	2	2.174	1.067	.351
Within Groups	114.160	56	2.039		
Total	118.508	58			

Relationships among Job Satisfaction, Job Satisfaction Subscales, and Demographic Variables

Using the Pearson's  $r$ , the relationships between the total job satisfaction score, the job satisfaction subscales, and the demographic variables of age, years in home care, hours per week worked, basic nursing education level, and highest level of nursing education were determined. The correlations of job satisfaction and the latter variables are presented in Table 14. The correlations were not statistically significant at the 0.05 level. The negative correlation between hours per week worked and job satisfaction indicates that the more hours worked per week, the lower the level of job satisfaction.

Table 14: Correlation of Job Satisfaction, Age, Years in Home Care, Hours/week Worked, Basic Nursing Education, and Highest Nursing Education--Pearson's *r*

	Job Satisfaction
Age	.085
Years in Home Care	.039
Hours/week Worked	-.015
Basic Education	.133
Highest Education	.078

\*  $p \leq 0.05$  (2-tailed)

Comparison of the group means of job satisfaction and the variables of gender, marital status, and financial security was accomplished using *t*-tests. No statistically significance differences in the group means were found. The results are presented in Table 15.

Table 15: *t*- tests for Job Satisfaction, Gender, Marital Status, and Financial Security

Job Satisfaction	<i>t</i>	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Gender	-.230	57	.819	-3.3512	14.571
Marital Status	.820	57	.416	5.869	7.161
Financial Security	.221	57	.826	1.761	7.953

To analyze for difference in group means between job satisfaction and the demographic variable of work assignment (patient care provision, patient care provision/management, and management), an ANOVA was used (Table 16). No statistical significance in the findings were found.

Table 16: ANOVA of Job Satisfaction and Work Assignment

	ss	df	MS	F	Sig
Between Groups	626.212	2	313.106	.518	.599
Within Groups	33863.415	56	604.704		
Total	34489.627	58			

Pearson's  $r$  was used to correlate the job satisfaction subscales and the demographic variables of age, years in home care, hours worked per week, basic education, and highest level of education. These results are reflected Table 17. There were no statistically significant correlations between the variables. The negative correlations indicate that the level of the job satisfaction subscale decreased as the level of age, years in home care, hours worked per week, basic education, and highest level of education increased.

Table 17: Correlation of Job Satisfaction Subscales, Age, Years in Home Care, Hours/week Worked, Basic Nursing Education, and Highest Nursing Education--  
Pearson's  $r$

	1	2	3	4	5	6	7	8	9
Age	.147	.099	.066	.069	.090	.024	.015	.048	-.058
Years in Home Care	-.035	.067	.222	.012	.015	.014	.063	.119	-.103
Hours/week Worked	-.011	.088	-.107	.008	-.060	-.058	.134	.036	-.152
Basic Education	-.012	.111	.180	-.010	.013	.122	.101	.149	.161
Highest Education	-.060	.068	.201	-.074	-.016	.115	.127	.084	.089

\* $p \leq 0.05$  (2-tailed)

1=Pay; 2=Promotion; 3=Supervision; 4=Benefits; 5=Contingent Rewards; 6=Operating Procedures; 7=Coworkers; 8=Nature of Work; 9=Communication

Table 18 displays the results of the difference in means between the demographic variables of gender, marital status and financial security and the job satisfaction subscales. There were no statistically significant findings in the  $t$ -tests, except between supervision and marital status.

Table 18: *t*-tests for Job Satisfaction Subscales, Gender, Marital Status, and Financial Security

Job Satisfaction Subscales	<i>t</i>	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
<b>Pay</b>					
Gender	.291	57	.772	-.946	3.254
Marital Status	.730	57	.469	1.169	1.602
Financial Security	.367	57	.715	.651	1.775
<b>Promotion</b>					
Gender	.224	57	.824	.619	2.769
Marital Status	-.247	57	.809	-.337	1.368
Financial Security	.350	57	.728	.528	1.510
<b>Supervision</b>					
Gender	-1.526	57	.133	-3.310	2.169
Marital Status	2.242	57	.029*	2.350	1.048
Financial Security	-1.291	57	.202	-1.537	1.190
<b>Benefits</b>					
Gender	.248	57	.805	.774	3.126
Marital Status	.899	57	.373	1.380	1.535
Financial Security	.852	57	.398	1.445	1.696
<b>Contingent Rewards</b>					
Gender	.199	57	.843	.476	2.398
Marital Status	.573	57	.569	.677	1.182
Financial Security	-.366	57	.716	-.479	1.308
<b>Operating Procedures</b>					
Gender	-.382	57	.704	-.875	2.291
Marital Status	-1.170	57	.247	-1.311	1.120
Financial Security	1.361	57	.179	1.677	1.232
<b>Coworkers</b>					
Gender	.472	57	.639	.863	1.830
Marital Status	.803	57	.425	.724	.901
Financial Security	.191	57	.849	.192	1.000
<b>Nature of Work</b>					
Gender	.746	57	.459	1.220	1.636
Marital Status	1.492	57	.141	1.189	.797
Financial Security	-.715	57	.478	-.638	.893
<b>Communication</b>					
Gender	-1.147	57	.256	-2.691	2.346
Marital Status	-.405	57	.687	-.474	1.171
Financial Security	-.538	57	.593	-.695	1.292

\* $p \leq 0.05$  (2-tailed)

To analyze the difference in the group means between the variable of work assignment (patient care provision, patient care provision/management, and management) and the job satisfaction subscales, an ANOVA was used. No statistical significance was found between and within groups. These results are presented in Table 19.

Table 19: ANOVA of Job Satisfaction Subscales and Work Assignment

Job Satisfaction Subscales	ss	df	MS	F	Sig.
<b>Pay</b>					
Between Groups	57.031	2	28.516	.959	.389
Within Groups	1664.359	56	29.721		
Total	1721.390				
<b>Promotion</b>					
Between Groups	46.726	2	23.393	1.092	.343
Within Groups	1198.460	56	21.401		
Total	1245.186	58			
<b>Supervision</b>					
Between Groups	43.433	2	21.717	1.619	.207
Within Groups	751.279	56	13.416		
Total	794.712	58			
<b>Benefits</b>					
Between Groups	2.389	2	1.194	.042	.959
Within Groups	1585.340	56	28.310		
Total	1587.729	58			
<b>Contingent Rewards</b>					
Between Groups	9.411	2	4.705	2.85	.753
Within Groups	924.759	56	16.514		
Total	934.169	58			
<b>Operating Procedures</b>					
Between Groups	4.430	2	2.215	.146	.865
Within Groups	849.875	56	15.176		
Total	854.305	58			
<b>Coworkers</b>					
Between Groups	4.252	2	2.126	.220	.803
Within Groups	541.375	56	9.667		
Total	545.627	58			
<b>Nature of Work</b>					
Between Groups	8.506	2	4.253	.554	.578
Within Groups	430.240	56	7.683		
Total	438.746	58			
<b>Communication</b>					
Between Groups	54.97	2	27.488	1.792	.176
Within Groups	859.159	56	15.342		
Total	914.136	58			

### Summary

The statistical analysis of the data for the study demonstrated that the level of perceived autonomy in this sample of rural home care nurses in Montana was high. Also, the levels of autonomy and job satisfaction were positively correlated using Pearson's  $r$  and was further substantiated using Kendall's Tau. Pearson's  $r$  was used to analyze the

relationship between autonomy, job satisfaction, instrument subscales, and demographic variables of age, years in home care, hours per week worked, basic nursing education, and highest nursing education. To analyze the group mean difference between autonomy, job satisfaction, respective instrument subscales, and demographic data of gender, marital status, financial security, and work assignment, *t*-tests and ANOVA were used. The analysis of the demographic variables to autonomy and job satisfaction showed few significant correlations and no significance using *t*-tests and ANOVA.

## CHAPTER 5

## SUMMARY AND DISCUSSION

Summary

The purpose of this study was to determine the level of perceived autonomy and how it related to job satisfaction and selected demographic variables among rural home care nurses in the state of Montana. Specifically, the level of perceived autonomy among the convenience sample was determined using Dempster's (1990) definition of autonomy and the Dempster Practice Behavior Scale (DPBS). Dempster's definition of autonomy includes dimensions of actualization, empowerment, readiness, and valuation. The level of autonomy was then related to the level of job satisfaction by using Pearson's correlation to correlate scores of the DPBS and Job Satisfaction Survey (JSS) for each participant. The analysis of the demographic data, autonomy, and job satisfaction was completed using Pearson correlation, *t*-tests, and ANOVA.

Three research questions were addressed: (a) What is the level of perceived autonomy among rural home care nurses in Montana, (b) What is the relationship of perceived level of autonomy to job satisfaction among rural home care nurses in Montana, and (c) What is the relationship of perceived level of autonomy to certain demographic variables among rural home care nurses in Montana? The literature review suggested a strong relationship between autonomy and job satisfaction among nurses (Blegan et al., 1993; Hylka & Shugre, 1991; Kramer & Schmalenberg, 1991; Pierce et al., 1996; Roedel & Nystrom, 1988, Seybolt et al., 1978). However, no research was found that explored the relationship of autonomy and job satisfaction among rural home care nurses.

## Discussion

### Autonomy and Job Satisfaction Levels

While the levels of perceived autonomy and job satisfaction have been positively related in past research for nurses in hospitals, nurses in rural hospitals, and nurses in home care, this research demonstrated that autonomy in practice and job satisfaction are also positively related in the arena of rural home care. Home care nurses practice in a setting with amorphous boundaries and unique demands which mandate that the home care nurse be able to function autonomously. Nurses in rural settings have even a greater need for autonomous practice because of the extraordinary challenges of rural home care. The results of the study indicated that rural home care nurses in this sample consider themselves to be highly autonomous practitioners with a high level of job satisfaction.

### Characteristics of the Sample

The demographic data of the sample provided some insight into the characteristics of nurses who work in rural home care in Montana. Most survey participants had worked in home care nursing for less than 5 years, which is indicative of the rapid growth that home care has exhibited in the last few years. Most of the rural home care nurses in this sample were working at least full-time. The majority of the nurses were female and married and felt the need to work for the financial security of their family. Outlier scores in both the autonomy and job satisfaction results came from women who were 51-60 years of age, who indicated the need to work for financial security of their families and scored lowest on the autonomy and job satisfaction instruments.

Further analysis of the characteristics of the sample revealed that rural home care nurses in this sample generally functioned both in the role of patient care provision and management. This finding supported the premise of Long and Weinert's (1992) rural nursing theory that rural nurses often functioned in multiple roles. Most of the nurses surveyed had a bachelor of science degree in nursing for their basic level of education.

### Analysis of Autonomy and the Demographic Variables

In the analysis of the total autonomy score and the demographic variables, no statistically significant results were found. While the correlation between autonomy and age was not statistically significant, it was a negative correlation indicating that, in this sample, the older nurses had lower perceived levels of autonomy. Possibly, this result could be related to the fact that the characteristic of autonomy was not emphasized in either the educational or early working experience of these older nurses. In fact, both the educational and practice traditions associated with the "ideal" nurse may have rewarded compliance and cooperation. This education and role socialization may continue to be manifested in the older nurses in this study and be reflected in the negative correlation of age and autonomy.

The subscales of autonomy and some demographic variables showed statistically significant relationships. The subscale of empowerment was significantly correlated with the variables of basic nursing education and highest level of nursing education, indicating that nurses in the sample with a higher level of education perceived an increased sense of empowerment in their nursing practice. The highest level of education was also significantly related to the subscale of actualization. For this sample, the conclusion can be drawn that the nurses with higher levels of education perceived a high level of accountability, responsibility, and ability to take action in the job setting. These findings support the standard of many home care agencies that the minimal level of education for nurses is a BSN. The subscale of readiness and hours per week worked were also significantly correlated, indicating that the home care nurse in this sample who work full-time have developed the competence and mastery needed to practice in the specialized field of home care nursing.

### Analysis of Job Satisfaction and Demographic Variables

The analysis of the relationship between the demographic variables and either job satisfaction or its subscales was not significant. A negative correlation, although not significant, was noted between job satisfaction and hours per week worked. In this sample,

the more hours per week worked by the study participants, the lower the perception of job satisfaction. This result could possibly indicate that nurses who work more hours have a greater discontent with the system or could be indicating symptoms of burn-out. It has been previously identified by Berke (1992) that rural home care nurses function under challenging circumstances and face unique problems. Consequently, facing the unique challenges of rural home care nursing on a daily basis impacts the job-related stress that is felt by these nurses. The amount of job-related stress for the nurses in this sample who work more hours may have impacted the perception of job satisfaction.

In the correlations of the job satisfaction subscales and the demographic variables of age, years in home care, hours per week worked, basic nursing education, and highest level of education, there were also some negative correlations. None of the correlations were significant but are interesting to note. For example, the older the participant had a lower rate of satisfaction with the communication within the organization. For the study sample, it also appears that the more years worked in home care, the lower the satisfaction with pay and communication. The subscale of pay was negatively correlated to not only the subscale of years in home care but also to hours per week worked, basic nursing education, and highest level of nursing education. The demographic variables of basic and highest nursing education were also negatively correlated to the fringe benefits subscale. From these results, the conclusion could be made that the study sample of home care nurses in rural Montana, regardless of educational preparation, were not satisfied with their salaries or their benefit packages.

The demographic variable of hours per week worked was negatively, although not significantly, correlated with the job satisfaction subscales of supervision, contingent rewards, operating procedures, and communication. These results suggest that the full-time nurses in the sample have a decreased level of satisfaction with the supervision provided by their immediate supervisor. In addition, the data analysis suggested that many nurses are not satisfied with contingent rewards, operating procedures, or the communication within the organization, which could indicate a dissatisfaction of nurses with the system of home health care provision. These findings may also indicate a trend that full-time nurses are not

as satisfied with their job as the nurses who work part-time. The study findings revealed that younger nurses who work part-time have a higher level of job satisfaction.

The subscale of supervision and the demographic variable of marital status were positively correlated for this sample. The subscale of supervision was measured in the JSS by questions: (a) My supervisor is quite competent in doing his/her job, (b) My supervisor is unfair to me, (c) My supervisor shows too little interest in the feelings of the subordinates, and (d) I like my supervisor. It seems that for this sample the participants who were married were more comfortable with immediate supervision in the work setting.

### Nursing Implications

#### Nursing Practice Implications

The recognition of the importance of professional autonomy and its relationship to job satisfaction among rural home care nurses in this sample can provide employers with insights into the recruitment and retention of nurses in the arena of home care. The results of this study substantiate previous research of McCloskey (1990), Hanson et al. (1990), Lynch (1994), and Chubon (1991). These researchers found that the perception of autonomy is a critical indicator of job satisfaction for nurses in other areas of nursing practice. These study findings reinforce the importance of providing a working atmosphere which enhances autonomy and consequently job satisfaction.

From the results of the study, it can be concluded that the level of autonomy in practice is enhanced by the level of the nurse's education. From the study's results, it seems that, the higher the level of education of the rural home care nurse in Montana, the higher the nurse's level of empowerment, accountability, and responsibility. This suggests to employers that a higher education is advantageous when hiring home care nurses. Also from the results of this study, it seems that flexibility and ability to function in dual roles are a important attributes of the rural home care nurse.

From the findings of this study, nurses were not satisfied with the rewards of the job or the functioning of the system. Consequently, a suggestion to increase job

satisfaction would be for employers to increase pay, increase benefits, increase contingent rewards, streamline operating procedures, and improve communication within the organization.

Another implication of the study is for a nurse who is considering entering the arena of rural home care nursing. By comparing individual characteristics of self with the characteristics of the rural home care nurse in this study, the nurse could better evaluate readiness for entry into the arena of rural home care. The nurse who plans to practice rural home care nursing needs to consider the uniqueness of the role and the demand for autonomous practice to assure job satisfaction.

#### Implications for Nursing Research

Considering the paucity of research findings about rural nurses and autonomy, this study is an initial contribution to the scarce database in research literature about autonomy and job satisfaction in rural home care nursing. In order to generalize the findings of professional autonomy and its relationship to job satisfaction, future research could include replication of this study with a random sample of rural home care nurses in the geographical region. Randomization of the sample would strengthen the study findings and allow for generalization to a population. The study could also be replicated in rural hospital nurses in Montana to determine if the study results are unique to rural nurses or only apply to rural home care nurses. By replicating the study with different samples, the knowledge base of home care and autonomy would be expanded.

Considering the negative and non-significant correlations among autonomy, job satisfaction, and some demographic variables, a qualitative research study would permit an exploration of nurse's thinking, feeling, and perception about autonomy and job satisfaction. For example, how could supervision change to increase job satisfaction? Why do older nurses perceive less autonomy in practice? How could communication processes change to enhance job satisfaction? What would be an acceptable level of pay and benefits? Do part-time nurses have greater job satisfaction?

### Limitations and Recommendations

This study was limited by the self-selected convenience sample. The small number of participants limited the statistical analysis of the data and limited the generalizability of the results of the study to a larger population. With a larger random sample, the study results may have been more representative of the population. Also limiting the analysis of the data was the level of measurement of the demographic data of age, years in home care, and hours per week worked. Recommendations for future study would be to use a random sample and interval measurement of data for the demographic variables of age, years in home care, and hours per week worked.

Another limitation of the study is the decreased reliability of some of the autonomy subscales and job satisfaction subscales. However, while the alpha coefficients of some of the subscales were low, the overall alpha for both instruments was high.

### Conclusion

This study concluded that the perception of professional autonomy was high in this sample of rural home care nurses. Additionally, the perception of autonomy was positively related to job satisfaction for the sample. The recognition of the importance of the relationship between autonomy and job satisfaction provides employers with insights into recruitment and retention of nurses in rural home care. Suggestions for future research include a replication of the study using a random sample of rural home care nurses or nurses in other rural nursing practice areas to allow for generalization of the the findings.

The results of this study confirm the importance of professional autonomy for this sample of rural home care nurses. The study results also substantiate previous research findings of the positive correlation between the perception of professional autonomy and job satisfaction.

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APPENDICES

APPENDIX A  
TELEPHONE SCRIPT

Script for telephone call:

My name is Mary Lou Iverson. I am a graduate student in the College of Nursing at Montana State University-Bozeman. Is this a good time to talk for a few minutes? I am conducting research on the relationship between professional autonomy and job satisfaction in rural home care nurses in the state of Montana. I'd like to visit with you and ask for your help in identifying possible nurses to participate in the study. Is this a good time to talk with you?

Your role in this project would be to identify how many nurses that are in your agency who practice exclusively in communities of 20,000 or less and work more than eight hours per week. I will send you the correct number of surveys for the nurses you identify as eligible to participate in the study and would ask that you distribute the surveys to the identified nurses in your agency. A self addressed stamped envelope will be provided for the return of the materials. The nurses may decline participation by not returning the survey. About two weeks after the surveys have been distributed to the eligible nurses, I will send a brief follow-up reminder to the nurses who are eligible to complete the survey. I would like to ask you to distribute the reminders to the nurses. Would you be willing to assist me with the research project in these ways?

The nurses choosing to participate in the study will remain anonymous since I will not know to whom you will distribute the surveys. I do ask that you include all the nurses who meet the criteria so that the data will be as reliable as possible. The research has been approved by the Human Subjects Committee of the Montana State University-Bozeman College of Nursing.

Do you have any questions about the research? The communities for your area include \_\_\_\_\_. How many nurses does your agency employ that practice exclusively in these communities?

You will be receiving the information in the mail within the next few days. Thanks for your help.

APPENDIX B  
LETTER OF INTRODUCTION  
TO HOME CARE DIRECTORS

January 19, 1998

Ms. Jane Doe  
Montana Home Health Care Agency  
123 4th Street  
Billings, Mt. 59101

Dear Ms. Doe,

Thank you for your assistance with my research study which examines the relationship of professional autonomy and job satisfaction in rural home care nurses in Montana. Enclosed are the surveys to be distributed to the eligible nurses who practice home care in communities of 20,000 or less and work at least 8 hours a week. Distribution of the packets to each nurse who fits the criteria is essential for complete data. Please do not encourage or discourage nurses to participate in this study.

Participation in the study is entirely voluntary and the nurse choosing not to participate will not be penalized in any way. Each nurse you identify as eligible to participate in the study will be given a packet, containing the survey, a letter of explanation about the research project, and a self-addressed stamped envelope in which to return the completed survey. Study participants will be asked to complete the survey outside of work hours. There are no identifiable risks to the study participants but possible benefits include the satisfaction of assisting in building the knowledge base about rural home care nurses since research about rural home care nurses is very minimal at this time. The study has been approved by the Human Subjects Committee of Montana State University-Bozeman, College of Nursing.

Two weeks after distribution of the survey to the eligible nurses, I will send a brief follow-up reminder to the eligible nurses to complete the survey. I am asking that you distribute the reminders to the nurses identified as potential study participants. If any nurse has question about the research study, he/she may contact me at or my advisor, Dr. Kay Chafey, at the addresses and numbers listed in the next paragraph.

Please be assured that I am very grateful for your help in conducting this research study. I will be preparing a summary of the study findings and if you are interested in receiving this report, please write your name and address, and return the enclosed stamped self-addressed post card to me. If you have any questions or concerns, please call me at (406) 259-9629 or my advisor, Dr. Kay Chafey, Montana State University-Bozeman, College of Nursing, Bozeman, MT 59717, (406) 994-4493.

Sincerely,

Mary Lou Iverson, RN, BSN  
643 Summit Ridge Road  
Billings, MT 59101

APPENDIX C  
LETTER OF INTRODUCTION  
TO PARTICIPANTS

**To Study Participant:**

I am a graduate student at Montana State University-Bozeman, College of Nursing, who is conducting a study on the relationship of professional autonomy and job satisfaction among rural home care nurses in the state of Montana.

If you are an RN who provides skilled intermittent home care exclusively to patients who live in communities of 20,000 or less and works 8 hours or more a week, please complete the attached survey outside of work hours and return it to me in the enclosed self-addressed stamped envelope within two weeks. It is anticipated that it will take you approximately 30 minutes to complete the survey. This research has been approved by the Human Subjects Committee, Montana State University-Bozeman, College of Nursing.

Your participation in the research study is essential to the success of the project. Completion and return of the survey to the investigator implies your consent to participate in the study. Your participation in the study is entirely voluntary and a decision to not participate will in no way jeopardize your job or your relationship with Montana State University-Bozeman, College of Nursing. As a study participant, your anonymity is guaranteed for the following reasons: Your name will not be on the returned survey so there will be no way to associate your identity with the returned survey, since you will complete the survey outside of work hours, employers will not know who completed and returned surveys, and all data will be reported as group data so there will be no way to associate individual responses with the survey results.

There are no known risks to you for participating in the study and benefits to you are that you will have the satisfaction of adding to the knowledge base of rural nurses. If you have concerns or questions, you may contact my thesis advisor, Dr. Kay Chafey, Montana State University-Bozeman, College of Nursing, Bozeman, Mt., 59717 or call (406) 994-4493.

Thank you for your participation. I am offering a summary of the research to all participants and home care agencies. If you would like a summary, please write your name and address on the stamped self-addressed postcard and return it.

Sincerely,

Mary Lou Iverson, RN, BSN  
Graduate Student  
College of Nursing  
Montana State University-Bozeman

APPENDIX D  
SURVEY

## DPBS

Please CAREFULLY read and think about EACH statement below.

Then, for each statement, mark the response that BEST indicates how TRUE that statement is for you in YOUR PRACTICE.

IN MY PRACTICE I...	NOT AT ALL TRUE	SLIGHTLY TRUE	MODERATELY TRUE	VERY TRUE	EXTREMELY TRUE
	1	2	3	4	5
1... take responsibility and am accountable for my actions.					
2... have developed the image of myself as an independent professional.					
3... base my actions on the full scope of my knowledge and ability.					
4... self-determine my role and activities.					
5... derive satisfaction from what I do.					
6... take control over my environment and situations I confront.					
7... am valued for my independent actions.					
8... am constrained by bureaucratic limitations.					
9... provide quality services through my actions.					
10... am confident in my abilities to perform my role independently.					
11... have been professionally socialized to take independent action.					
12... function with the authority to do what I know should be done.					
13... have too many routine tasks to exercise independent action.					
14... have a sense of professionalism.					
15... have the rights and privileges I deserve.					
16... have the professional experience needed for independent action.					

DPBS-A

Please continue →

IN MY PRACTICE I . . .	NOT AT ALL TRUE	SLIGHTLY TRUE	MODERATELY TRUE	VERY TRUE	EXTREMELY TRUE
	1	2	3	4	5
17 . . . am restrained in what I can do because I am powerless.					
18 . . . collaborate with others outside my field when I feel there is a need.					
19 . . . derive feelings of self-respect and esteem from what I do.					
20 . . . make my own decisions related to what I do.					
21 . . . possess ownership of my practice; that is, my role belongs to me.					
22 . . . have the power to influence decisions and actions of others.					
23 . . . have a sense of self-achievement.					
24 . . . am provided with a legal basis for independent functioning.					
25 . . . demonstrate mastery of skills essential for freedom of action.					
26 . . . have my activities and actions programmed by others.					
27 . . . have the respect of those in other disciplines.					
28 . . . cannot optimally function because I do not have legal status.					
29 . . . establish the parameters and limits of my practice activities.					
30 . . . accept the consequences for the choices I make.					

DPBS-A

<b>JOB SATISFACTION SURVEY</b> Paul E. Spector Department of Psychology University of South Florida <small>Copyright Paul E. Spector 1994. All rights reserved.</small>													
PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT.		Disagree	Very Much	Disagree	Moderately	Disagree	Slightly	Agree	Slightly	Agree	Moderately	Agree	Very Much
1	I feel I am being paid a fair amount for the work I do.	1	2	3	4	5	6						
2	There is really too little chance for promotion on my job.	1	2	3	4	5	6						
3	My supervisor is quite competent in doing his/her job.	1	2	3	4	5	6						
4	I am not satisfied with the benefits I receive.	1	2	3	4	5	6						
5	When I do a good job, I receive the recognition for it that I should receive.	1	2	3	4	5	6						
6	Many of our rules and procedures make doing a good job difficult.	1	2	3	4	5	6						
7	I like the people I work with.	1	2	3	4	5	6						
8	I sometimes feel my job is meaningless.	1	2	3	4	5	6						
9	Communications seem good within this organization.	1	2	3	4	5	6						
10	Raises are too few and far between.	1	2	3	4	5	6						
11	Those who do well on the job stand a fair chance of being promoted.	1	2	3	4	5	6						
12	My supervisor is unfair to me.	1	2	3	4	5	6						
13	The benefits we receive are as good as most other organizations offer.	1	2	3	4	5	6						
14	I do not feel that the work I do is appreciated.	1	2	3	4	5	6						
15	My efforts to do a good job are seldom blocked by red tape.	1	2	3	4	5	6						
16	I find I have to work harder at my job because of the incompetence of people I work with.	1	2	3	4	5	6						
17	I like doing the things I do at work.	1	2	3	4	5	6						
18	The goals of this organization are not clear to me.	1	2	3	4	5	6						

(continued)

PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT.		Disagree Very Much	Disagree Moderately	Disagree Slightly	Agree Slightly	Agree Moderately	Agree Very Much
19	I feel unappreciated by the organization when I think about what they pay me.	1	2	3	4	5	6
20	People get ahead as fast here as they do in other places.	1	2	3	4	5	6
21	My supervisor shows too little interest in the feelings of subordinates.	1	2	3	4	5	6
22	The benefit package we have is equitable.	1	2	3	4	5	6
23	There are few rewards for those who work here.	1	2	3	4	5	6
24	I have too much to do at work.	1	2	3	4	5	6
25	I enjoy my coworkers.	1	2	3	4	5	6
26	I often feel that I do not know what is going on with the organization.	1	2	3	4	5	6
27	I feel a sense of pride in doing my job.	1	2	3	4	5	6
28	I feel satisfied with my chances for salary increases.	1	2	3	4	5	6
29	There are benefits we do not have which we should have.	1	2	3	4	5	6
30	I like my supervisor.	1	2	3	4	5	6
31	I have too much paperwork.	1	2	3	4	5	6
32	I don't feel my efforts are rewarded the way they should be.	1	2	3	4	5	6
33	I am satisfied with my chances for promotion.	1	2	3	4	5	6
34	There is too much bickering and fighting at work.	1	2	3	4	5	6
35	My job is enjoyable.	1	2	3	4	5	6
36	Work assignments are not fully explained.	1	2	3	4	5	6

Demographic Survey

Please complete the following questions by circling the appropriate response:

1. What is your age?
  1. 20-30
  2. 31-40
  3. 41-50
  4. 51-60
  5. 61 and over
2. What is your marital status?
  1. Married
  2. Single
  3. Divorced
  4. Widowed
3. Indicate gender
  1. Female
  2. Male
4. How many years have you practiced home care nursing?
  1. 0-5 years
  2. 6-12 years
  3. 12-20 years
  4. 21-30 years
  5. 31 years and over
5. What is the average number of hours/week that you work:
  1. 8-20
  2. 21-30
  3. 31-40
  4. 41 and over
6. What is your basic level of nursing education?
  1. Associate Degree
  2. Diploma
  3. BSN
7. What is your highest level of education?
 

<ol style="list-style-type: none"> <li>1. Associate Degree</li> <li>2. Diploma</li> <li>3. BSN</li> </ol>	<ol style="list-style-type: none"> <li>4. Masters Degree in _____</li> <li>5. PhD. in _____</li> <li>6. Other _____</li> </ol>
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8. What is your primary work assignment in your agency?
  1. Patient Care Provision
  2. Patient Care Provision and Management Activities
  3. Management Activities only
9. Do you feel that it is necessary for you to work in this job for the financial security of your family?
  1. Yes
  2. No

APPENDIX E  
REMINDER TO RETURN SURVEY

Reminder to return survey:

Dear Participant,

Thank you for taking time from your busy schedule to complete the survey about nursing autonomy and job satisfaction that you received about two weeks ago. If you have not yet completed the survey, I ask that you do so within the next two days and return it in the self-addressed stamped envelope. I will start to analyze data soon and would like to include your data from the survey also. The more surveys that I receive, the more accurately the data will reflect the perception of nursing autonomy and job satisfaction among rural home care nurses in Montana. I would like to remind you that the returned surveys are anonymous and the research has been approved by the Human Subjects Committee, Montana State University-Bozeman, College of Nursing. If you have concerns or questions about this research, please call me at (406) 259-9629 or my advisor Dr. Kay Chafey, at (406) 994-4493.

Thanks again for your help.

Mary Lou Iverson, BSN

APPENDIX F  
CONSENT LETTERS TO USE INSTRUMENTS

February 17, 1997

Mary Lou Iverson  
643 Summit Ridge Road  
Billings, Montana 59101

Dear Mary Lou:


Your Fax message has been forwarded to me - it looks like it went first to the University of Arizona. I have recently changed positions and am no longer with the University. I have started a new position as Executive Director of the American Academy of Nurse Practitioners. Consequently, please excuse the delay in my response as I am in transition and have been traveling extensively the past few weeks.

Enclosed for your use is a copy of the DPBS, information on the psychometric properties, scoring, and items that correspond to each of the theoretical dimensions. The tool is being used in several studies here in the US and in several foreign countries. The original dissertation remains the best resource for overall information related to the development of the conceptual framework and testing of the tool. I know that the DPBS had Chronbach's alphas of between .89 to about .95 in preliminary reports of its use in some recent studies. The .89 was the alpha in a study where the DPBS had been translated into Chinese.

Please contact me if you need further assistance. My home phone is 602-545-8228 and Fax is 602-545-2810. My home e-mail address is 102252.3157@compuserve.com. The address is 1820 East Cascade Drive, Gilbert, AZ 85234.

Best wishes in your research efforts. I look forward to learning about your results.

Most sincerely,



Judith S. Dempster, DNSc, FNP-C

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## *Appendix: The Job Satisfaction Survey*

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**N**ote: The purchaser of this book is given license to use and modify the Job Satisfaction Survey (JSS) for noncommercial academic and research purposes. This license does not allow the purchaser to sell the JSS alone or as part of a consulting package.

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