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THE IMPACT OF ORGANIZATIONAL CULTURE ON HEALTHCARE EMPLOYEE  
WORKPLACE PERCEPTIONS

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## ABSTRACT

Organizational culture reflects how an organization conducts business, treats employees and consumers, and reinforces company goals (Sanders-Reio, 2011). A positive organizational culture generally leads to higher performance and productivity, greater product quality, and sets an expectation to deliver superior customer care, service and safety (Krause & Hidley, 2009). Promoting a positive organizational culture is especially pertinent in healthcare because of the stressful, fast-paced work environment that challenges individuals with various educations and backgrounds to work together as a cohesive team (Arnetz,1999).

The study's hypothesis is that a supportive organizational culture will positively impact employee workplace perceptions. This study surveyed 1,362 hospital employees working in environmental services (EVS), food and nutrition (F&N), and transportation at four different hospital systems. Participants used a Likert scale to evaluate their relationships with leaders, co-workers, and their perceptions of their department's commitment to safety. A hierarchal linear regression model showed that the variables supervisor support ( $\beta=.298$ ,  $\beta=.106$ ,  $\beta=.234$ ; respectively), workplace environment ( $\beta=.231$ ,  $\beta=.119$ ,  $\beta=.197$ ; respectively), and unit safety ( $\beta=.086$ ,  $\beta=.226$ ,  $\beta=.182$ ; respectively) were significantly related to increased job satisfaction ( $R^2=.318$ ), quality of work life ( $R^2=.305$ ), and quality of care esteem ( $R^2=.171$ ).

The results confirm the hypothesis that positive organizational culture leads to better employee perceptions of their workplace. Supervisor support and encouragement, a workplace environment with cohesive teamwork, and units that emphasize safety practices are associated with higher employee job satisfaction, quality of work life, and quality of care esteem. When employees have better perceptions of their workplace, they are likely to be more engaged in their job, loyal to their employer, and perform better in their profession (Krause & Hidley, 2009).

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## CHAPTER 1: INTRODUCTION

On March 23, 2010 President Obama enacted the Patient Protection and Affordable Care Act (PPACA) law which significantly increased regulation in healthcare (Orszag & Emanuel, 2010). Hospitals and Healthcare systems are under enormous pressure to reduce costs and improve performance (Orszag & Emanuel, 2010). To help achieve PPACA's goals, a possible solution for hospitals is creating a positive organizational culture to improve employee job satisfaction, quality of work life, and employee esteem in the quality of care.

Organizational culture is the collective behaviors and values that influence the social and psychological environment of an organization (Linden, et al., 1997). Organizational culture is expressed by how an organization conducts business, treats employees and customers, allows staff to make their own decisions and develop new ideas, how efficiently information is communicated through the hierarchy, and finally by how committed employees are in achieving collective objectives (Krause & Hidley, 2009). Simply put, organizational culture is "the way things are done around here." (Sanders-Reio, 2011). The slippery nature of organizational culture leads some to believe the concept is too vague to be helpful. However, many behavioral patterns can be categorized and linked to specific outcomes, such as ethical and safe employee performance (Sanders-Reio, 2011). By identifying prevalent employee behaviors and perceptions, a company can gain insight into their organizational culture (Krause & Hidley, 2009). Companies with a positive organizational culture generally benefit from higher

performance and productivity because employees feel connected to their employer and are engaged in their profession (McGinnis, 2008).

### **Literature Review**

In addition to Obama's healthcare reform, hospital systems are also under immense pressure to keep improving because of the looming retirement of hundreds of thousands of baby boomers (Orszag & Emanuel, 2010). There is an ever-increasing demand for healthcare workers to aid the chronic conditions of an aging population. However, healthcare is a high-stress, fast-paced environment, and there are challenges to recruit and retain the labor supply. The extreme occupational pressure can negatively impact employees' work-life balance, job satisfaction, organizational commitment, and organizational citizenship which hinders organizational outcomes (Sanders-Reio, 2011).

Understanding and controlling these occupational pressure triggers is especially important in a "human service field" like healthcare (Krause & Hidley, 2009). A "human service field" is a profession that promotes improving the overall quality of life for patients as well as improving the delivery of service by offering greater accessibility, accountability and coordination (McGinnis, 2008). Hospitals and healthcare systems face unique administrative challenges such as high turnover from burnout. Burnout results from prolonged exposure to high-pressure situations that reduces and employee's ability to adapt and cope with the stressors of the job (Sanders-Reio, 2011). According to employee interviews by Ericson-Lidman and Strandberg, the four common behaviors associated with burnout are managing problems alone, routinely demonstrating self-



sacrifice, setting unattainable goals, and feeling distanced or isolated from the team (Linden, et al., 1997). Human services employees such as nurses, patient care assistants, transportation, hospitality and food and nutrition servers are more susceptible to burnout because of long work hours, poor pay, status differences, heavy patient workloads, physically demanding work, challenging cases requiring difficult and swift decision-making, and the propensity to want to “help others” (Linden, et al., 1997). With a poor organizational culture, employees may struggle to manage conflict appropriately and maintain professionalism in high-stress situations (McGinnis, 2008). Employees are also at increased risk for developing psychological problems such as anxiety and depression because of the extreme physical, psychological, and emotional conditions of their job (McGinnis, 2008). Yet industries in human service fields can overcome these risks by emphasizing a positive organizational culture that provides necessary supervisor support, a reassuring workplace environment, and proper unit safety.

According to employee interviews by Ericson-Lidman and Strandberg, the four common behaviors associated with burnout and workplace distress is managing problems alone, demonstrating self-sacrifice, setting unattainable goals, and feeling distanced or isolated (Linden, et al., 1997). These behaviors can be mitigated with proper supervisor and co-worker support. Another cause for burnout is injury on the job. According to the Bureau of Labor Statistics, in 2003 approximately 3.3 million serious injuries and 4,300 fatalities occurred while on the job (Harter, Schmidt & Keyes, 2003). Healthcare is a particularly vulnerable field because of the physical demands required to take care of patients (Sanders-Reio, 2011). Employee safety is equally as important as patient safety for a hospital to run effectively.

By creating a strong, positive organizational culture, leaders can reduce the risk of burnout by keeping employees safe and happy (Arnetz, 1999). There are nine crucial dimensions of organizational culture that influence employee behavior are Procedural Justice, Leader-Member Exchange, Leadership Credibility, Perceived Organizational Support, Treatment Team Relations, Teamwork, Safety Climate, Upward Communication, and Approaching Others (Krause & Hidley, 2009). By improving these key components, administrators can achieve the desired organizational culture throughout the industry.

An important realization for managers about organizational culture is they may have an inaccurate idea about how their employees perceive the company (Linden, et al., 1997). Leaders often feel more positive about organizational culture when compared to those working at lower, more hands-on levels in the company (Linden, et al., 1997). Leaders are sometimes unaware of problems afflicting the working interface, and as frustrating as these problems are, many frontline employees never vocalize the issue, or when they do vocalize the issue they never see an effective change (Harter, Schmidt & Keyes, 2003). Frontline employees then become resigned, and either accept a problem “is just the way it is” or they eventually quit (Arnetz, 1999). An example of this behavior is when an administrator is satisfied with the allotment of hospital beds for a wing, but are unaware there are too few pediatric beds on the children’s sections of the hospital. Yet when new transportation employees complain, more seasoned employees tell her to just accept the situation as “the way things are done around here.” Another example is transportation may be irritated by communication problems regarding when patients should be moved for X-rays, however there is so much coordination between departments

the fix the problem that they do not know which administrator to discuss their concerns with.

The greatest challenge for administration is to understand organizational culture at the level of those directly involved in the working interface. This awareness is crucial because organizational culture at the frontline is one of the largest determinants of employee satisfaction and safety (Linden, et al., 1997). Adverse events can be avoided when there is constructive communication and conduct between team members, where employees encourage each other to avoid risky behavior and take proper precautions against workplace hazards (Harter, Schmidt & Keyes, 2003). Two useful strategies to enhance understanding of employee perspectives is sending informational surveys as well as comparing policies and procedures of similar organizations to each other (Harter, 2003). Both methods highlight frontline employee perspectives and allow leaders to pinpoint low scoring areas and design improvements. Organizational culture can be adjusted to improve employee workplace perceptions in terms of job satisfaction, quality of work life, and quality of care esteem (Sanders-Reio, 2011).

### **Variables**

To analyze the relationship between organizational culture and employee workplace perceptions, this study examines the effect that supervisor support, workplace environment, a unit safety has on dependent variables job satisfaction, quality of work life, and quality of care esteem. Organizational culture is the expectations, philosophy, experiences, and customs that determine the way a corporation operates, and workplace

perceptions are the gratification, achievement, and level of performance an employee achieves on the job. This study also considers personal demographic information such as gender, employment status, ethnicity, marital status, level of education, health status, length of time working at the hospital in addition to organizational demographic information such as employer, healthcare system and department. These covariates were factored into the analysis because they might also influence employee workplace perceptions.

## **Organizational Culture**

### *Supervisor Support*

The first component of organizational culture is supervisor support. Supervisor support is a critical component of organization culture because according to the book “Taking the Lead in Patient Safety”, there are nine key dimensions when describing organizational culture (Krause & Hidley, 2009). Supervisor support involves the first three organizational behavior theories which are Procedural Justice, Leader-Member Exchange and Leadership Credibility (Krause & Hidley, 2009). Procedural Justice is the perception of fairness in the interactions and decision-making processes between a supervisor and their employees (Walumbwa, Mayer, Wang, Wang, Workman, & Christensen, 2011). Fair interactions are consistent, lack bias, accurate, correctable, representative, and ethical. The next part of supervisor support is Leader-Member Exchange (LMX) which is based on social exchange theory. This theory contends that

employees participate in specific activities, obligations and favors when they expect future return (Walumbwa et al., 2011). Relationships evolve when “each party offers something the other party sees as valuable, and each party sees the exchange as equitable and fair” (Graen & Scandura, 1987: 182). LMX relationships are strongest when there is a high value in the exchange and trust between a supervisor and employee (Walumbwa et al., 2011). For example, a food and nutrition employee will meticulously follow all of the sanitation guidelines if they know their supervisor does routine checks and praises employees for their outstanding work. The final facet of supervisor support is Leadership Credibility, which is the consistency between what leadership says and what is done. Leaders initiate trust when they are competent, reduce uncertainty, act with integrity, share control, communicate openly, and demonstrate benevolence (Walumbwa et al., 2011). A supportive supervisor leads to positive outcomes such as increased employee cooperation and dedication.

### ***Workplace Environment***

The next component of organizational culture is workplace environment. Workplace environment consists of Perceived Organizational Support (POS), Treatment Team Relations, and Teamwork, which are the next three key aspects of organizational behavior theories (Krause & Hidley, 2009). Similar to LMX, POS is also a dimension of social exchange theory. A positive POS relationship is when an individual feels their organization appreciates, values and supports their work (Linden, et al., 1997). When individuals feel supported by an organization, they are more likely to volunteer and

extend themselves for the organization (Landsbergis, 1988). The next part of workplace environment is Treatment Team Relations, which is the perception of how well a team works together, solves problems, respects each other, listen to ideas, and honor commitments (Krause & Hidley, 2009). Built on trust, employees feel unified and supported enough to share their opinions (Sanders-Reio, 2011). When employees identify with their team and have confidence in their leader, they are more likely to comply with safety policies and procedures. The final part of workplace environment is teamwork. Teamwork is the ability to effectively work together to achieve occupational goals (Linden, et al., 1997). Employees feel a greater sense of purpose when their work benefits an entire group instead of only their individual accomplishments (Landsbergis, 1988). A positive workplace environment with organizational and coworker support leads to positive outcomes such as employee volunteerism and commitment to their job.

### *Unit Safety*

The final component of organizational culture is unit safety. Unit safety consists of Safety Climate, Upward Communication, and Approaching Others, which are the final key aspects of organizational behavior theories (Krause & Hidley, 2009). Safety Climate is the first dimension of unit safety, and is the extent which employees perceive that their organization values safety improvement and performance (Sanders-Reio, 2011). Management proves that safety is important when they protect patients and employees from psychological, physical, and occupational danger (Sanders-Reio, 2011). The next dimension of unit safety is Upward Communication. Upward communication is how

freely communication flows between a hospital's hierarchy and the different departments. In healthcare there is a tendency to "shoot the messenger" rather than understand the reason behind the problem (Linden, et al., 1997). Employees are more likely to vocalize safety concerns when there is positive upward communication. The final dimension of unit safety is Approaching Others, which is when employees feel comfortable enough to express to safety concerns to each other (Krause & Hidley, 2009). When leadership values safety, employees are more likely to follow safety procedures which will protect them from occupational harm, anxiety and distress.

## **Workplace Perceptions**

### *Job Satisfaction*

The first element of workplace perceptions is job satisfaction. Job satisfaction is an effective response (positive/negative) to specific aspects of a working condition such as pay, work schedules, and physical working conditions, support among co-workers, participation in work decisions, and promotions (Linden, et al., 1997). High job satisfaction leads to less long term occupational stress, reduces the likelihood of burnout and can be correlated to higher quality care (Krause & Hidley, 2009).

### *Quality of Work Life*

The second proponent of workplace perceptions is quality of work life (QoWL). Walton's (1975) eight requirements for achieving desirable QoWL are adequate compensation, continued learning opportunities, job security, positive social interaction,

fairness, an uplifting work space, social relevance of their work, and maintaining a safe, healthy working environment (Sanders-Reio, 2011). While job satisfaction pertains to employee attitudes about the workplace, QoWL incorporates aspects of employee's entire well-being (Frye & Breugh, 2004). High QoWL improves productivity, reduces absenteeism, and lowers turnover rates (Frye & Breugh, 2004).

### *Quality of Care Esteem*

The final aspect of workplace perceptions is quality of care esteem, which is the confidence employees have that their hospital system is delivering high quality care. Employee quality of care esteem is linked to patient outcomes, the number of myocardial infections, CAUTI/CLABSI infections, surgical site infections, and number of 30-day readmissions (Aiken, Clarke & Sloane, 2002). These factors help determine the quality of care in a hospital, and can influence how highly healthcare employees regard their employer (Aiken, 2002). When employees feel a connection with colleagues as well as the organization, the feeling of partnership generally improves their performance (Harter, Schmidt & Keyes, 2003). Employees that are engaged in their work and trust each other for help tend to work more effectively, and therefore have higher esteem in the quality of care delivered at their healthcare system (Harter, 2003).

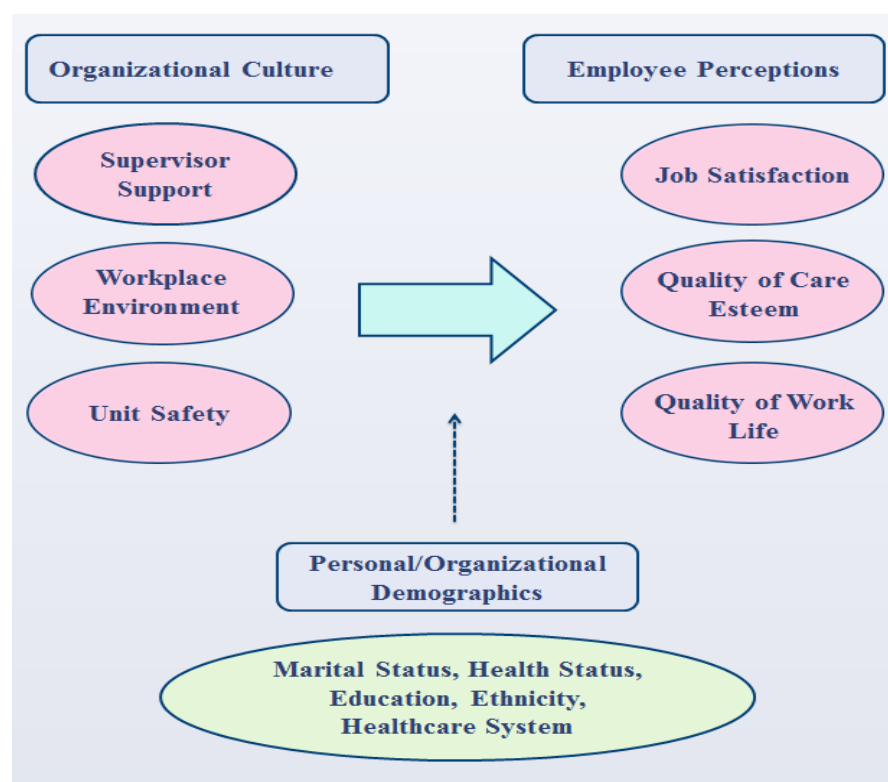
### **The Current Study**

This study examines how specific aspects of organizational culture will impact healthcare employee workplace perceptions. The hypothesis is that supervisor support



will be positively associated with job satisfaction, quality of work life, and quality of care esteem. The second hypothesis is that workplace environment will be positively associated with job satisfaction, quality of work life, and quality of care esteem. The final hypothesis is that unit safety will be positively associated with job satisfaction, quality of work life, and quality of care esteem. This study is relevant because administration can learn what influences employee opinions, how large the effect is, and then strategize ways to improve workplace perceptions. When employees are satisfied with their job, work life, and level of care, they tend to perform better. See Figure 1 below for a visual representation.

Figure 1. *Conceptual Framework of Study Design: Organizational Culture and Employee Workplace Perceptions*



## CHAPTER 2: METHODS

### Participants

The 2007 Pennsylvania State University Study on Healthcare Employee Safety surveyed 1,362 men and women working in environmental services (EVS), food and nutrition (F&N), and transportation at four different hospital systems (McCaughey, 2007). The participating hospital systems are located in Illinois, Texas, Maryland, and Pennsylvania. The hospital size ranged from approximately 150-1,000 beds, with 1 of the 10 hospitals being unionized, half of the hospitals being teaching hospitals with the other half being community hospitals, 6 hospitals were in a suburban location, 3 were in an urban location, and 1 was in a rural location (McCaughey, 2007). This mixture of size, type and location of hospital allows for a more representative sample. See Table 1a and 1b for further demographic information on survey participants.

Table 1a. *Personal Demographic Frequencies*

<b>Gender</b>	Male		Female		
<i>Frequency</i>	32.7%		58.4%		
<b>Employment Status</b>	Full-time	Part-time	Temporary		
<i>Frequency</i>	71.4%	15.1%	2%		
<b>Ethnicity</b>	Caucasian	African American	Hispanic or Latino	Other	
<i>Frequency</i>	23.3%	40.8%	17.4%	18.4%	
<b>Marital Status</b>	Single	Living with Partner	Married	Widowed/ Divorced/ Separated	
<i>Frequency</i>	38%	4%	39.8%	10.1%	
<b>Level of Education</b>	<High School	High School	Some College/ Technical Education	College, Technical, or Secondary Degree	
<i>Frequency</i>	12.6%	45.7%	22%	10.1%	
<b>Health Status</b>	Excellent	Very Good	Fair	Poor	
<i>Frequency</i>	29.7%	23.6%	4.6%	.5%	
<b>Length of Time Working at Hospital</b>	<1 year	1-5 years	6-10 years	11-20 years	>20 years
<i>Frequency</i>	17.4%	41%	14%	11.6%	6.3%

Table 1b. *Organizational Demographic Frequencies*

<b>Employer</b>	ARAMARK		Hospital		Missing
<i>Frequency</i>	39.1%		37.3%		23.6%

<b>Healthcare System</b>	Illinois	Texas	Maryland	Pennsylvania	Missing
<i>Frequency</i>	21.7%	33.8%	8.1%	32.4%	4%

<b>Department</b>	EVS	F&N	CTS&Lift	Mail Room	Transport	Missing
<i>Frequency</i>	52.6%	40.7%	.8%	.2%	1.3%	4%

### **Procedure**

Dr. Deirdre McCaughey, Assistant Professor in Health Care Management & Strategy at the Pennsylvania State University organized a research team and ran a study examining the relationship between employee attitudes, employee well-being, patient safety, clinical outcomes, and financial performance (McCaughey, 2007). Dr. McCaughey partnered with Aramark Healthcare, a company specialized in contracting environmental and food service employees, to gather data from four state and ten hospitals this project. The survey was administered manually (paper and pen) to employees at the various research sites in 2007. The survey consists of 56 questions based on existing valid and reliable scales such as the AHRQ Patient Safety Culture Survey and the U.S. National Health Care Surveys. The survey was divided into sections, and using a Likert scale asked employees to evaluate their relationships with leadership,

their relationships with co-workers, and their perception of safety procedures. There was approximately a 94% response rate.

## **Measures**

### ***Supervisor Support***

From the 56 questions survey, the variable supervisor support was generated by the 4 questions: 1) My supervisor is supportive of progress in my career, such as further training, 2) My supervisor tells me when I am doing a good job, 3) My supervisor provides clear instructions when assigning work, and 4) My supervisor values or appreciates the work that I do. Each question was answered on a Likert scale with 1) Strongly Disagree, 2) Disagree, 3) Neither agree or disagree, 4) Agree, and 5) Strongly Agree. To ensure internal consistency between the questions, a Cronbach's alpha scale of reliability test was run and is further explained in Appendix A Table 3. The Cronbach  $\alpha=.900$  which is a high score and means there is high internal consistency or average correlation. The questions are reasonably related and attempt to measure the same underlying construct. N= 1303 with a nonresponse rate of 4.3%.

### ***Workplace Environment***

The variable workplace environment was generated by the 4 questions 1) We have enough staff to handle the workload, 2) When a lot of work needs to be done quickly, we work together as a team to get the work done, 3) In this unit, people treat each other with respect, and 4) People support one another in this unit. Each question was answered on the Likert scale with 1) Strongly Disagree, 2) Disagree, 3) Neither agree or disagree, 4) Agree, and 5) Strongly Agree . The Cronbach  $\alpha=.807$  which is a high score for internal consistency. N=1304 with a nonresponse rate of 4.2%.

### *Unit Safety*

This variable was generated from the 10 questions, 1) We are actively doing things to improve worker safety, 2) Worker safety is never sacrificed to get more work done, 3) We have worker safety problems in this unit\*, 4) Our procedures and systems are good at preventing injuries from happening, 5) My supervisor overlooks worker safety problems that happen over and over\*, 6) My supervisor says a good word when he/she sees a job done according to established worker safety procedures, 7) My supervisor seriously considers staff suggestions for improving worker safety, 8) Hospital management provides a work climate that promotes worker safety, 9) The actions of hospital management show that worker safety is a top priority and 10) Hospital management seems interested in worker safety only after a worker injury event happens.\* All questions were answered based on the Likert scale 1) Strongly Disagree, 2) Disagree, 3) Neither agree or disagree, 4) Agree, and 5) Strongly Agree . The questions with a (\*) symbol were reverse coded because a lower score connotes higher unit safety. The Cronbach  $\alpha$  = .723 which is a fair score for compatibility. The lower score could be explained because of the reverse questioning. N=1292 with a nonresponse rate of 5.1%.

### *Job Satisfaction*

This variable was generated from the question “Overall, how satisfied are you with your current job?” with participants responding as 1) not at all satisfied, 2) somewhat dissatisfied, 3) neutral, 4) somewhat satisfied, or 5) very satisfied. N=1247 with an 8.4% nonresponse rate.

### *Quality of Work Life*

This variable was generated from the question “If a family member or friend asked my advice about taking a job at this hospital, I would recommend my hospital as a place to work” with participants responding on the Likert scale with 1) Strongly Disagree, 2) Disagree, 3) Neither agree or disagree, 4) Agree, and 5) Strongly Agree. N=1280 with a 5.8% nonresponse rate.

### *Quality of Care Esteem*

This variable was generated from the question “If a family member or friend needed care and asked my advice about receiving health care at my hospital, I would recommend my hospital as a place to seek care.” with participants responding on the Likert scale 1) Strongly Disagree, 2) Disagree, 3) Neither agree or disagree, 4) Agree, and 5) Strongly Agree. N=1282 with a 6.02% nonresponse rate.

### **Analytic Plan**

For the analytic plan, an ANOVA test was used to determine which demographic variables influence the scores of outcome variables job satisfaction, quality of work life and quality of care esteem. A Post-Hoc analysis was run on significant demographic variables. Based on the Levine Statistic either a Dunnett C or Least Significant Difference test was used to evaluate where responses significantly differed. Categories were then recoded with binary values so that a hierarchical linear regression test that accounted for demographic variables could be run. The linear regression determined whether organizational culture significantly impacted workplace perceptions.

## CHAPTER 3: RESULTS

### Job Satisfaction

#### *Demographics*

The first statistical test run was a one-way ANOVA to determine which demographic variables were significantly associated with job satisfaction. According to Table 3 marital status and level of education were significant at the  $p < .05$  level and health status was significant at the  $p < .001$  level.

Table 3. *One-Way Analysis of Association between Job Satisfaction and Demographic Variables*

		<i>Df</i>	<i>F</i>	<i>p</i>
<b>Personal</b>	Gender	1203	1.569	.211
	Employment Status	1175	.794	.452
	Ethnicity	1246	.355	.785
	Marital Status	1212	4.456	.004*
	Level of Education	1198	3.560	.014*
	Health Status	1185	7.286	<.001**
	Length of Time Working at Hospital	1194	2.245	.062
	<b>Organizational</b>	Employer	1013	6.080
Healthcare System		1246	1.406	.239
Department		1246	1.861	.098

\* $p$ -value significant at the .05 level, \*\*significant at the <.001 level

The first Post-Hoc Analysis was conducted for marital status as shown in Table 4 below. The Levine statistic was 1.133 which is not significant therefore equal variance is assumed, and a Least Significant Difference test was conducted. Individuals who are



married score job satisfaction .196 higher than those who are single and .437 higher than those living with partner. Widowed/Divorced individuals rate Job Satisfaction .433 higher than those living with partner. A possible explanation is that those who are married or divorced may have children which is shown to increase job satisfaction. This suggests that individuals who are married or widowed and divorced show significantly higher job satisfaction than those who are single or living with a partner.

Table 4. Post-Hoc Analysis of Marital Status and Job Satisfaction

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
Marital Status	1.133	(3,12309)

<b>Marital Status (I)</b>	<b>Marital Status (J)</b>	<b>Mean Difference (I-J)</b>
<i>Single</i>	Living with Partner	.241
	Married	-.196*
	Widowed/Divorced	-.193
<i>Living with Partner</i>	Single	-.241
	Married	-.437*
	Widowed/Divorced	-.433*
<i>Married</i>	Single	.196*
	Living with Partner	.437*
	Widowed/Divorced	.004
<i>Widowed/Divorced</i>	Single	.193
	Living with Partner	.433*
	Married	-.004

\*Mean difference P-value significant at .05 level

The second Post-Hoc Analysis was conducted for level of education, shown below in Table 5. The Levine statistic was 1.839 which is not significant therefore equal variance is assumed, and an Least Significant Difference test was conducted. Individuals with less than a high school education rate Job Satisfaction .213 higher than those with high school diploma and .361 higher than some college/technical education. Individuals with less than a high school education show significantly higher job satisfaction than

those with a high school diploma and those some college or technical education. This could be explained because individuals with all three levels of education might be working the same maintenance and food services position, however those with higher education have higher expectations about their job such as less manual work, higher pay, and more vacation time.

Table 5. *Post-Hoc Analysis of Level of Education and Job Satisfaction*

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
Level of Education	1.839	(3,1195)

<b>Health System (I)</b>	<b>Health System (J)</b>	<b>Mean Difference (I-J)</b>
<i>&lt; High School</i>	High School Diploma	.213*
	Some College or Technical	.361*
	College or Technical Degree	.212
<i>High School Diploma</i>	<i>&lt; High School</i>	-.213*
	Some College or Technical	.148
	College or Technical Degree	-.001
<i>Some College or Technical</i>	<i>&lt; High School</i>	-.361*
	High School Diploma	-.148
	College or Technical Degree	-.149
<i>College or Technical Degree</i>	<i>&lt; High School</i>	-.212
	High School Diploma	.001
	Some College or Technical	.149

\*Mean difference P-value significant at .05 level

The third Post-Hoc Analysis test was run for overall health status shown in Table 6. The Levine statistic was 2.616 which is significant and therefore equal variance is not assumed, and a Dunnett C test was conducted. Those in excellent health rate Job Satisfaction .326 higher than those in good health, .523 higher than those in fair health, and 1.402 higher than those in poor health. Individuals in very good health rank Job

Satisfaction .175 higher than those in good health, and .373 higher than those in fair health, and 1.252 higher than those in poor health. Those in good health rank Job Satisfaction 1.076 higher than those in poor health. This suggests those in better health have significantly higher job satisfaction than those in poor health.

Table 6. *Post-Hoc Analysis of Overall Health Status and Job Satisfaction.*

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
Overall Health Status	2.616**	(4,1181)

<b>Overall Health (I)</b>	<b>Overall Health (J)</b>	<b>Mean Difference (I-J)</b>
<i>Poor</i>	Fair	-.879
	Good	-1.076*
	Very Good	-1.252*
	Excellent	-1.402*
<i>Fair</i>	Poor	.879
	Good	-.197
	Very Good	-.373*
	Excellent	-.523*
<i>Good</i>	Poor	1.076*
	Fair	.197
	Very Good	-.175*
	Excellent	-.326*
<i>Very Good</i>	Poor	1.252*
	Fair	.373*
	Good	.175*
	Excellent	-.151
<i>Excellent</i>	Poor	1.402*
	Fair	.523*
	Good	.326*
	Very Good	.151

\*Mean difference P-value significant at .05 level

\*\*Significant Levene Statistic

### ***Regression Analysis***

The three demographic variables were recoded with binary values based on the Post-Hoc Analysis. Marital status was recoded with ‘married’ and ‘widowed’ =1 because these categories had a more positive effect on job satisfaction while ‘single’ and ‘living

with partner'=0 because these categories had a more negative association with job satisfaction. Similarly, level of education was recoded where categories '< than a high school education' =1 and '> than a high school education=0'. Overall health status was recoded where 'excellent' and 'very good'=1 and 'good,' 'fair,' and 'poor'=0. These categorical variables were entered first into the linear regression, followed by the independent variables supervisor support, workplace environment and unit safety.

The linear regression for job satisfaction was  $R^2=.318$  and was significant at the  $<.001$  level. This means about 32% of the variation in job satisfaction can be explained by supervisor support ( $\beta=.298$ ), workplace environment ( $\beta=.231$ ) and unit safety ( $\beta=.086$ ). Of the three variables, supervisor support was the biggest predictor in job satisfaction. The change in  $R^2=.287$ , which means demographic variables only contribute .031 (3%) of the variance in job satisfaction.

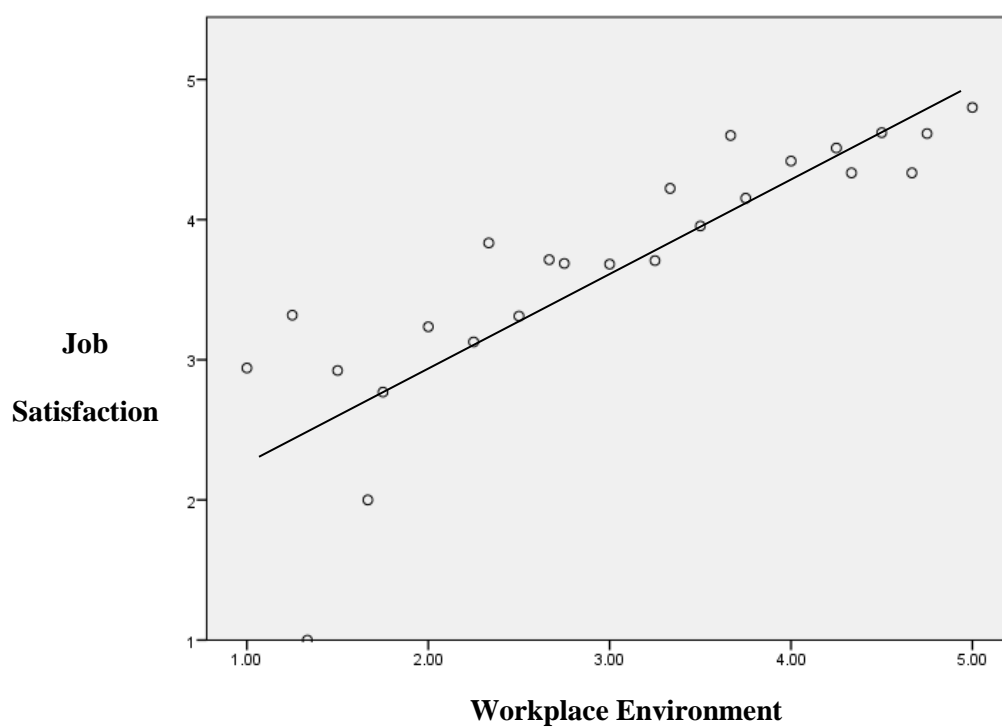
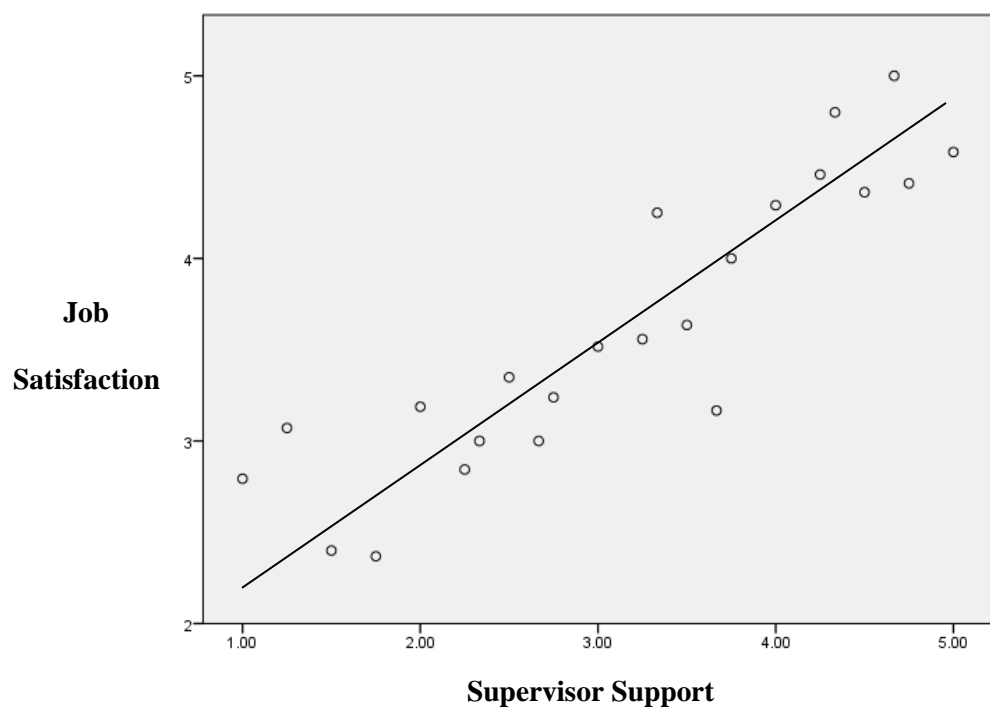
Table 7. *Linear Regression for Job Satisfaction Compared to Independent Variables*

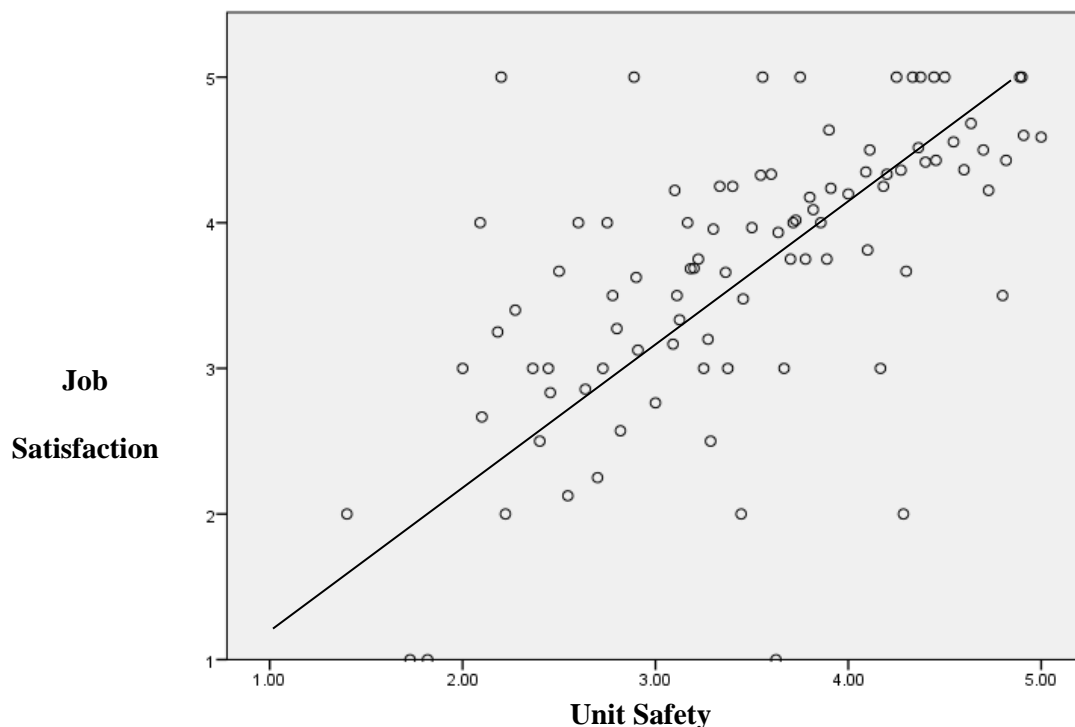
<b>Dependent Variables</b>	<b>Std. <math>\beta</math> coeff.</b>
<i>Marital status</i>	.076*
<i>Level of education</i>	.037
<i>Health Status</i>	-.064*
<i>Supervisor Support</i>	.298**
<i>Workplace Environment</i>	.231**
<i>Unit safety</i>	.086
<i>F-Value</i>	88.28
<i>Df</i>	6,1134

\* $p$ -value significant at the .05 level, \*\*significant at the  $<.001$  level

See Figure 2 below for a scatter plot and best-fit line for Job Satisfaction.

Figure 2. Scatterplot Showing the Influence of Supervisor Satisfaction, Workplace Environment, and Unit Safety on Job Satisfaction





\*Best-fit line shows positive association between Supervisor Support, Workplace Environment, and Unit Safety and Job Satisfaction

## Quality of Work Life

### *Demographics*

A one-way ANOVA was to determine which personal and organizational demographic variables were significantly associated with quality of work life. According to Table 8 ethnicity and marital status were significant at the  $p < .05$  level, and health status and healthcare system were significant at the  $p < .001$  level.

Table 8. *One-Way Analysis of Association between Demographic Variables Quality of Work Life*

		<i>Df</i>	<i>F</i>	<i>p</i>
<b>Personal</b>	Gender	1223	.632	.409
	Employment Status	1188	.424	.655
	Ethnicity	1279	3.408	.0017*
	Marital Status	1233	3.349	.018*
	Level of Education	1215	.981	.401
	Health Status	1207	6.35	<.001**
	Length of Time Working at Hospital	1215	.905	.460
	<b>Organizational</b>	Employer	1024	4.692
Healthcare System		1279	8.747	<.001**
Department		1279	1.453	.202

\**p*-value significant at the .05 level, \*\*significant at the <.001 level

The first Post-Hoc Analysis was conducted for ethnicity as shown in Table 9. The Levine statistic was 1.745 which is not significant therefore equal variance is assumed, and a Least Significant Difference test was conducted. Caucasian individuals score quality of work life .195 higher than people who are African American, .219 higher than people who are Hispanic, and .107 higher than other ethnicities. Caucasian individuals show significantly higher quality of work life than all other ethnicities.

Table 9. *Post-Hoc Analysis of Ethnicity and Quality of Work Life*

<b>Variable</b>	<b>Levene Statistic</b>	<b><i>Df</i></b>
Ethnicity	1.745	(3,1276)

<b>Ethnicity (I)</b>	<b>Ethnicity (J)</b>	<b>Mean Difference (I-J)</b>
<i>Caucasian</i>	African American	.195*
	Hispanic	.219*

	Other	.197*
<i>African American</i>	Caucasian	-.195*
	Hispanic	.024
	Other	.002
<i>Hispanic</i>	Caucasian	-.219*
	African American	-.024
	Other	-.022
<i>Other</i>	Caucasian	-.197*
	African American	-.002
	Hispanic	.022

\*Mean difference P-value significant at .05 level

The second Post-Hoc Analysis was conducted for marital status seen in Table 10. The Levine statistic was 1.626 which is not significant therefore equal variance is assumed, and a Least Significant Difference test was conducted. Individuals who are married score quality of work life .153 higher than those who are single and .324 higher than those living with partner. This suggests that individuals who are married show significantly higher quality of work life than those who are single or living with a partner.

Table 10. *Post-Hoc Analysis of Marital Status and Quality of Work Life*

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
<b>Marital Status</b>	1.626	(3,1230)
<b>Marital Status (I)</b>	<b>Marital Status (J)</b>	<b>Mean Difference (I-J)</b>
<i>Single</i>	Living with Partner	.171
	Married	-.153*
	Widowed/Divorced	-.084
<i>Living with Partner</i>	Single	-.171
	Married	-.324*
	Widowed/Divorced	-.256
<i>Married</i>	Single	.153*
	Living with Partner	.324*
	Widowed/Divorced	.069
<i>Widowed/Divorced</i>	Single	.084
	Living with Partner	.256
	Married	-.069

\*Mean difference P-value significant at .05 level



The next Post-Hoc Analysis was conducted for overall health status as seen in Table 11. The Levine statistic was 4.84 which is significant therefore equal variance is not assumed, and a Dunnett C test was conducted. Individuals in excellent health rate Quality of Work Life .299 higher than those in good health, and .412 higher than those in fair health. Those in very good health rank Quality of Work Life .200 higher than those in good health, and .312 higher than those in fair health. Those in better health show significantly higher quality of work life than those in worse health.

Table 11. *Post-Hoc Analysis for Overall Health Status and Quality of Work Life*

<b>Variable</b>	<b>Levene Statistic</b>	<b>DF</b>
Overall Health Status	4.84**	(4,1203)

<b>Overall Health (I)</b>	<b>Overall Health (J)</b>	<b>Mean Difference (I-J)</b>
<i>Poor</i>	Fair	-.293
	Good	-.405
	Very Good	-.605
	Excellent	-.704
<i>Fair</i>	Poor	.293
	Good	-.112
	Very Good	-.312*
	Excellent	-.412*
<i>Good</i>	Poor	.405
	Fair	.112
	Very Good	-.200*
	Excellent	-.299*
<i>Very Good</i>	Poor	.605
	Fair	.312*
	Good	.200*
	Excellent	-.100
<i>Excellent</i>	Poor	.704
	Fair	.412*
	Good	.299*
	Very Good	.100

\*Mean difference P-value significant at .05 level

\*\*Significant Levene Statistic

The final Post-Hoc Analysis was conducted for health systems shown in Table 12. The Levine statistic was .886 which is not significant therefore equal variance is assumed, and a Least Significant Difference test was conducted. Illinois employees rate Quality of Work Life .359 higher than Texas employees and .232 higher than Pennsylvania employees. Maryland employees rank Quality of Work Life .273 higher than Texas Employees. Individuals working at Illinois or Maryland have significantly higher QoWL than those working at Texas or Pennsylvania.

Table 12. *Post-Hoc Analysis of Health Systems and Quality of Work Life*

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
Health Systems	.886	(3,1276)

<b>Health System (I)</b>	<b>Health System (J)</b>	<b>Mean Difference (I-J)</b>
<i>Illinois</i>	Texas	.359*
	Maryland	.086
	Pennsylvania	.232*
<i>Texas</i>	Illinois	-.359*
	Maryland	-.273*
	Pennsylvania	-.126
<i>Maryland</i>	Illinois	-.086
	Texas	.273*
	Pennsylvania	.147
<i>Pennsylvania</i>	Illinois	-.232*
	Texas	.126
	Maryland	-.147

\*Mean difference P-value significant at .05 level

### ***Regression Analysis***

Based on the Post-Hoc tests, demographic categorical variables were again dummy coded with binary values. Marital status and overall health status used the same dummy coding as explained above. Ethnicity was recoded where 'Caucasian'=1 because this ethnic group consistently scored their overall quality of work life high, and all other

ethnicities =0 because African Americans, Hispanics, and other ethnicities were associated with lower quality of work life scores. Healthcare system was dummy coded where ‘Illinois,’ ‘Pennsylvania,’ and ‘Maryland’ =1 and ‘Texas’ =0.

The linear regression for quality of work life was  $R^2=.305$  and was significant at the  $<.001$  level. This means 31% of the variation in job satisfaction can be explained by supervisor support ( $\beta=.234$ ), workplace environment ( $\beta=.197$ ) and unit safety ( $\beta=.182$ ). Of the three variables, supervisor support again was the biggest predictor in job satisfaction. The change in  $R^2=.273$ , which means demographic variables only contribute .032 (3%) of the variance in quality of work life.

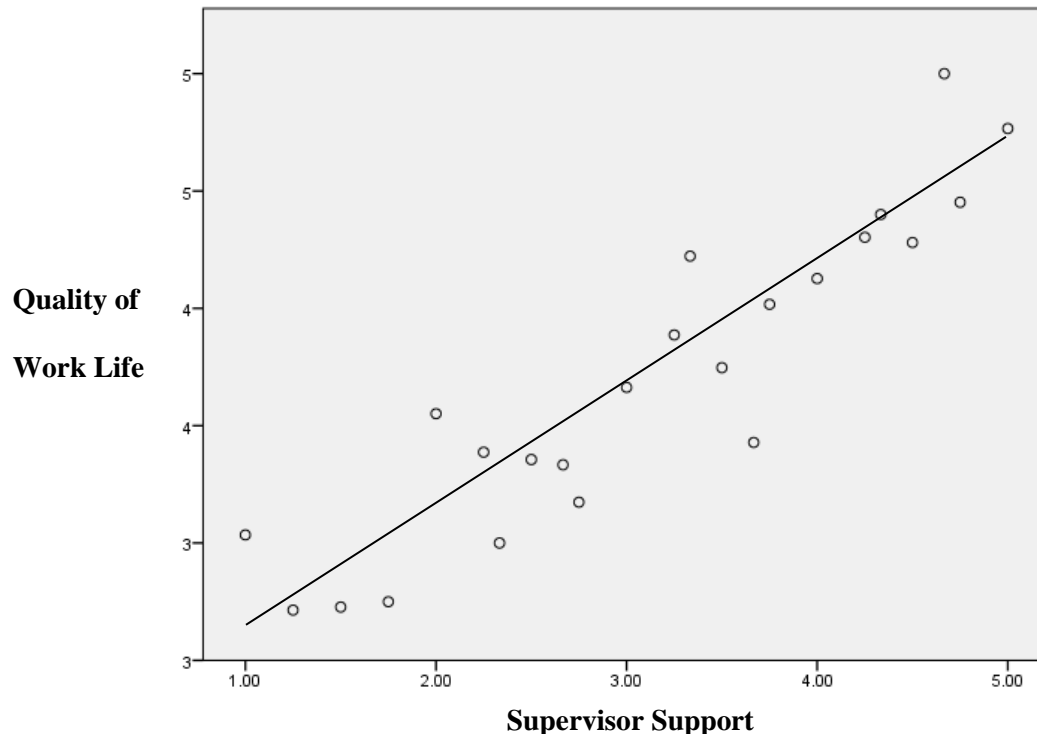
Table 13. *Linear Regression for Quality of Work Life Compared to Independent Variables*

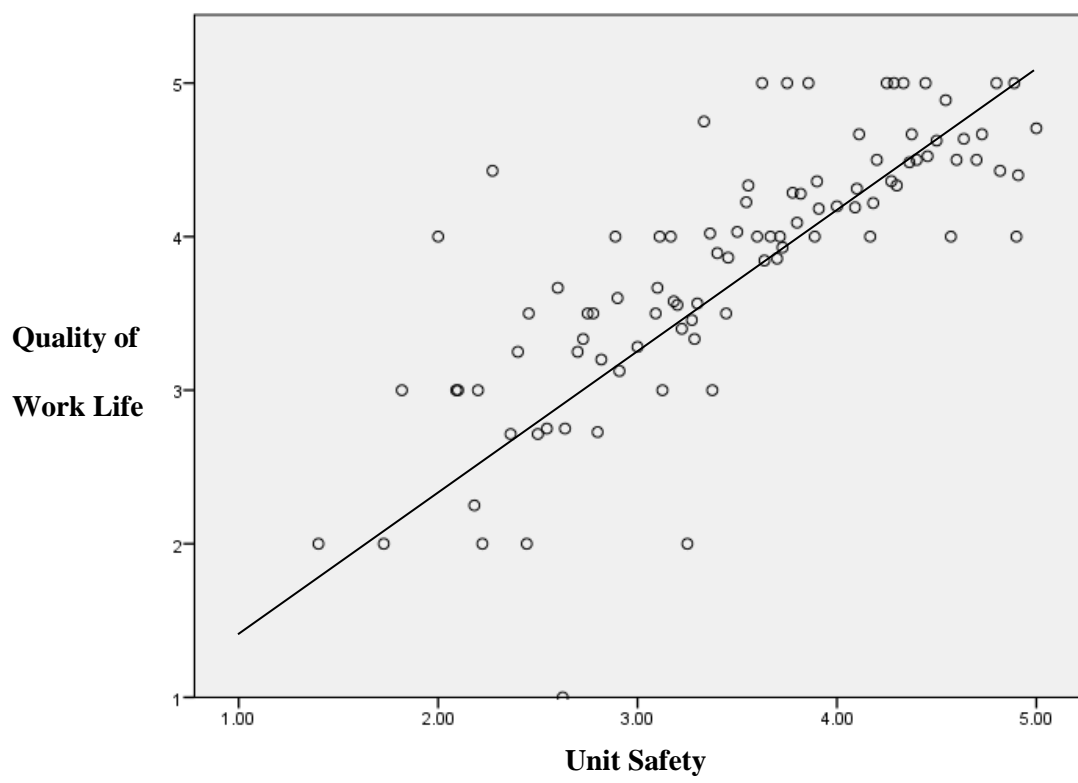
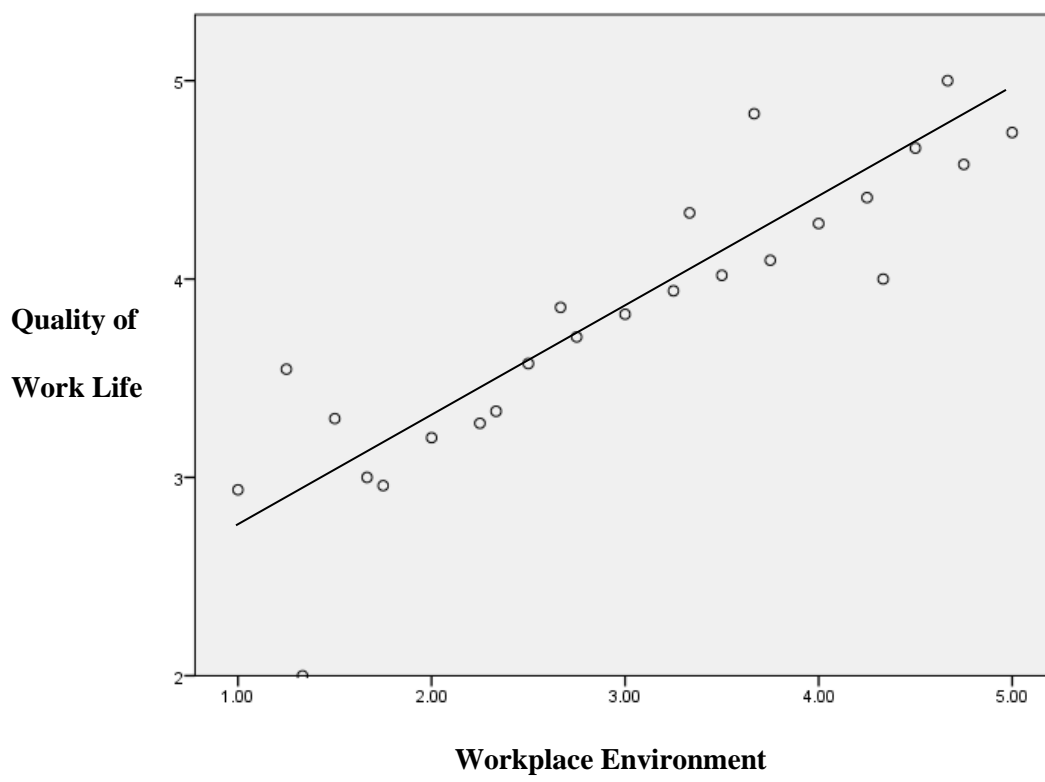
<b>Dependent Variables</b>	<b>Std. <math>\beta</math> coeff.</b>
<i>Marital Status</i>	.052
<i>Ethnicity</i>	.077
<i>Health Status</i>	-.037*
<i>Health System</i>	-.120
<i>Supervisor Support</i>	.234**
<i>Workplace Environment</i>	.197**
<i>Unit safety</i>	.182**
<i>F-Value</i>	73.390
<i>Df</i>	7,1172

\**p*-value significant at the .05 level, \*\*significant at the  $<.001$  level

See Figure 3 below for a scatter plot and best-fit line for Quality of Work Life.

Figure 3. *Scatterplot Showing the Influence of Supervisor Support, Workplace Environment, and Unit Safety on Quality of Work Life*





\*Best-fit line shows positive association between Supervisor Support, Workplace Environment, And Unit Safety between Quality of Work Life

### *Quality of Care Esteem*

The final one-way ANOVA test determined which demographic variables were significantly associated with quality of care esteem. According to Table 14 marital status was significant at the  $p < .05$  level, and ethnicity, health status and healthcare system were significant at the  $p < .001$  level.

Table 14. *One-Way Analysis of Quality of Care Esteem and Demographic Variables*

		<i>Df</i>	<i>F</i>	<i>p</i>
<b>Personal</b>	Gender	1225	.541	.462
	Employment Status	1190	1.279	.279
	Ethnicity	1281	5.008	.002**
	Marital Status	1235	3.001	.030*
	Level of Education	1217	.644	.587
	Health Status	1206	5.316	<.001**
	Length of Time Working at Hospital	1218	1.324	.259
	<b>Organizational</b>	Employer	1027	.001
Healthcare System		1281	10.246	<.001**
Department		1281	1.79	.112

\* $p$ -value significant at .05 level, \*\*significant at the <.001 level

The first Post-Hoc Analysis was conducted for marital status as shown in Table 15. The Levine statistic was .359 which is not significant therefore equal variance is assumed, and a Least Significant Difference test was conducted. Individuals who are married rank quality of care .128 higher than individuals who are single and .295 higher than individuals living with partner. Those who are widowed rank quality of care .304 higher than individuals living with a partner. Married and widowed individuals have

significantly higher perceptions on quality of care than those who are single or living with a partner.

Table 15. *Post Hoc Analysis on the Association between Marital Status and Quality of Care Esteem*

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
Marital Status	.359	(3,1232)

<b>Marital Status (I)</b>	<b>Marital Status(J)</b>	<b>Mean Difference (I-J)</b>
<i>Single</i>	Living with Partner	.167
	Married	.128*
	Widowed/Divorced	.136
<i>Living with Partner</i>	Single	-.167
	Married	-.295*
	Widowed/Divorced	-.304*
<i>Married</i>	Single	-.128*
	Living with Partner	.295*
	Widowed/Divorced	-.008
<i>Widowed/Divorced</i>	Single	.136
	Living with Partner	.304*
	Married	.008

\*Mean difference P-value significant at .05 level

A second Post-Hoc Analysis was conducted for ethnicity as shown in Table 16. The Levine statistic was 4.621 which is significant therefore equal variance is not assumed, and a Dunnett C test was conducted. Caucasian individuals rank their hospital's quality of care .195 higher than African American individuals and .316 higher than other ethnicities. Hispanic individuals also rank their hospital's quality of care .218 higher than other ethnicities. Individuals who are Caucasian or Hispanic significantly show higher quality of care perceptions than African American or other ethnicities.

Table 16. *Post-Hoc Analysis on the Association between Ethnicity and Quality of Care Esteem*

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
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Ethnicity	4.621**	(3,1278)
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Ethnicity (I)	Ethnicity (J)	Mean Difference (I-J)
<i>White</i>	Black	.195*
	Hispanic	.099
	Other	.316*
<i>Black</i>	White	-.195*
	Hispanic	-.097
	Latino	.121
<i>Hispanic</i>	White	-.099
	Black	.097
	Other	.218*
<i>Other</i>	White	-.315*
	Black	-.121
	Hispanic	-.218*

\*Mean difference P-value significant at .05 level

\*\*Significant Levene Statistic

A third Post-Hoc Analysis was conducted for health status shown in Table 17.

The Levine statistic was 1.601 which is not significant therefore equal variance is assumed and a Least Significant Difference test was conducted. Those in excellent health rate quality of care .140 higher than those in very good health and .308 higher than those in good health. Those in very good health rank quality of care .169 higher than those in good health. Individuals in better health show significantly higher quality of care perceptions than those in fair health.

Table 17. *Post-Hoc Analysis on the Association between Overall Health Status and Quality of Care Esteem*

Variable	Levene Statistic	Df
Overall Health Status	1.601	(4,1202)



<b>Overall Health (I)</b>	<b>Overall Health (J)</b>	<b>Mean Difference (I-J)</b>
<i>Poor</i>	Fair	.521
	Good	.590
	Very Good	.422
	Excellent	.282
<i>Fair</i>	Poor	-.521
	Good	.069
	Very Good	-.100
	Excellent	-.239
<i>Good</i>	Poor	-.590
	Fair	-.069
	Very Good	-.169*
	Excellent	-.140*
<i>Very Good</i>	Poor	-.422
	Fair	.100
	Good	.169*
	Excellent	-.140*
<i>Excellent</i>	Poor	-.282
	Fair	.239
	Good	.308*
	Very Good	.140*

\*Mean difference P-value significant at .05 level

The final Post-Hoc Analysis was conducted for health systems as shown in Table 18. The Levine statistic was 5.674 which is significant therefore equal variance is not assumed so a Dunnett C test was conducted. Illinois employees rate quality care .23 higher than Texas employees and .495 higher than Maryland employees. Texas employees rank Quality of Care .265 higher than Maryland Employees. Pennsylvania employees rank Quality of Care .200 higher than Texas employees and .465 higher than Maryland employees. Individuals working at Illinois Healthcare or Mail Line Healthcare have significantly higher quality of care perceptions than individuals working at Texas and Maryland.

Table 18. *Post-Hoc Analysis on the Association between Health Systems and Quality of Care Esteem*

<b>Variable</b>	<b>Levene Statistic</b>	<b>Df</b>
Health Systems	5.674	(3,1278)

<b>Health System (I)</b>	<b>Health System (J)</b>	<b>Mean Difference (I-J)</b>
<i>Illinois</i>	Texas	.230*
	Maryland	.495*
	Pennsylvania	.030
<i>Texas</i>	Illinois	-.230*
	Maryland	.265*
	Pennsylvania	-.200*
<i>Maryland</i>	Illinois	-.495*
	Pennsylvania	-.265*
	Texas	-.465*
<i>Pennsylvania</i>	Illinois	-.030
	Maryland	.200*
	Texas	.465*

\*Mean difference P-value significant at .05 level

### ***Regression Analysis***

The same dummy coding was used to account for the demographic variables marital status, ethnicity, health status and healthcare system in the regression analysis. The linear regression for quality of work life was  $R^2=.171$  and was significant at the  $<.001$  level. This means 17% of the variation in quality of care esteem can be explained by supervisor support ( $\beta=.106$ ), workplace environment ( $\beta=.119$ ) and unit safety ( $\beta=.226$ ). Of the three variables, unite safety was the biggest predictor in quality of care esteem. The change in  $R^2=.148$ , which means demographic variables only account for .023 (2%) of the variance in quality of work life.

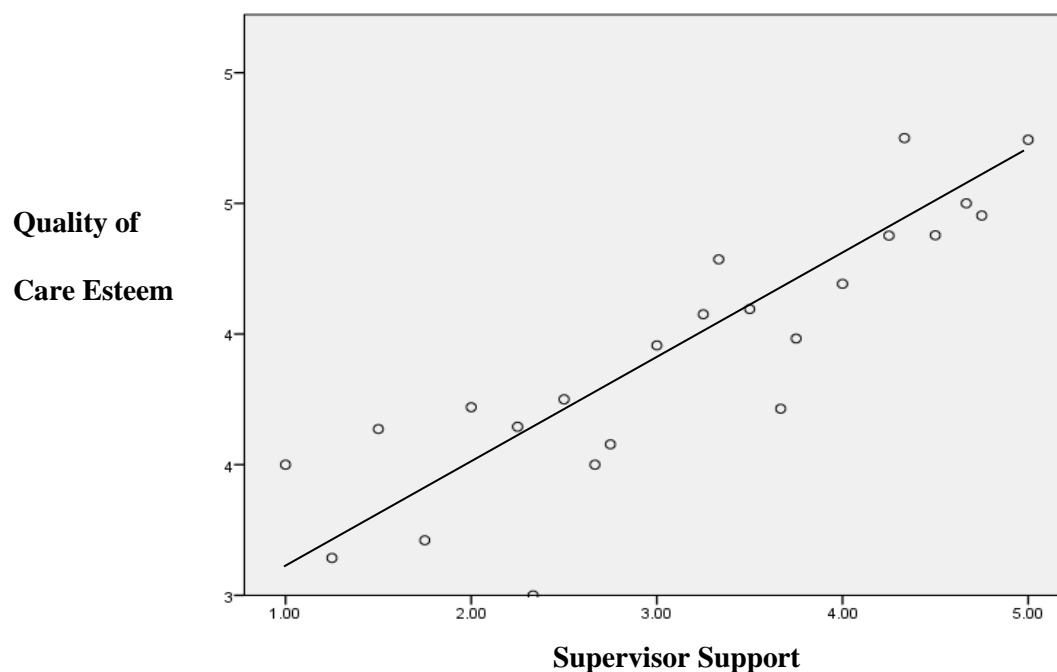
Table 19. *Linear Regression for Quality of Care Esteem Compared to Independent Variables*

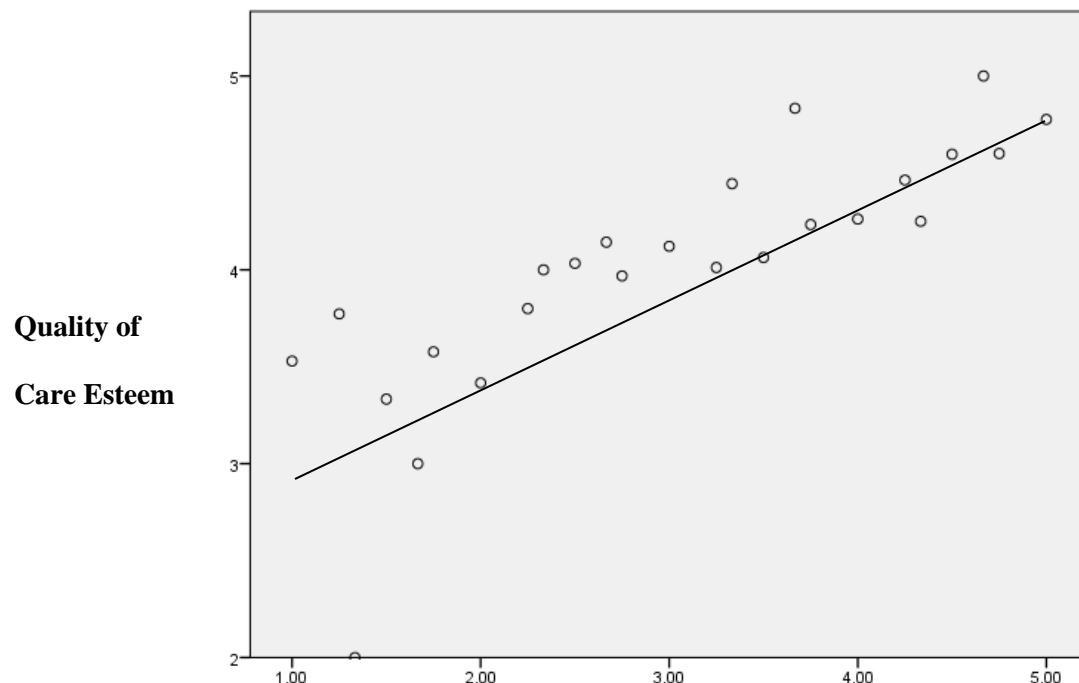
<b>Dependent Variables</b>	<b>Std. <math>\beta</math> coeff.</b>
<i>Marital Status</i>	.063*
<i>Ethnicity</i>	.027
<i>Health Status</i>	-.04
<i>Health System</i>	-.076*
<i>Supervisor Support</i>	.106*
<i>Workplace Environment</i>	.119**
<i>Unit safety</i>	.226**
<i>F-Value</i>	73.390
<i>Df</i>	7,1172

\**p*-value significant at the .05 level, \*\*significant at the <.001 level

See Figure 4 below to see a scatter plot and best-fit line for Quality of Care Esteem.

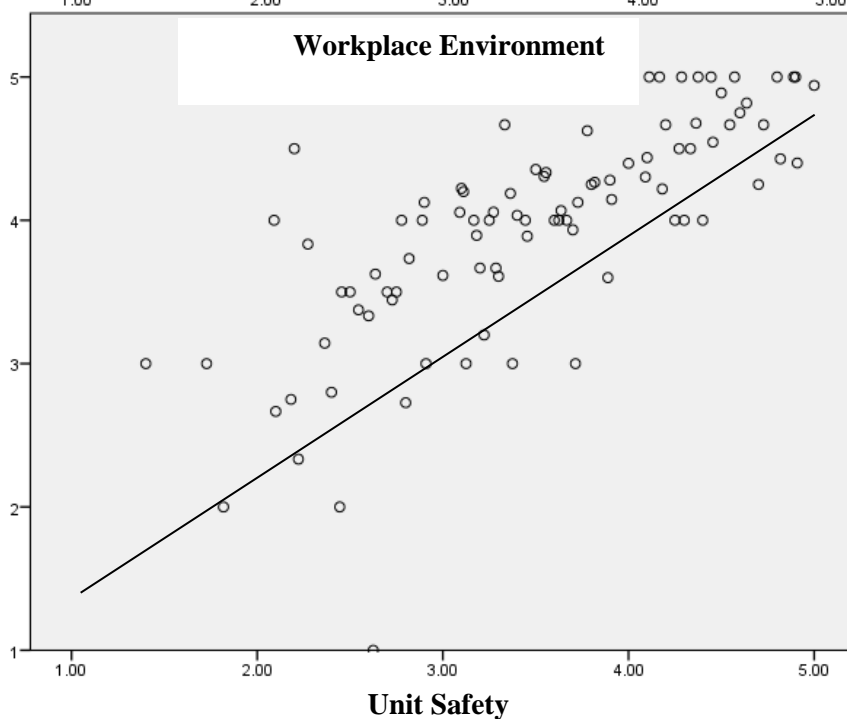
Figure 4. *Scatterplot Showing the Influence of Supervisor Support, Workplace Environment, and Unit Safety on Quality of Care Esteem*





**Quality of  
Care Esteem**

**Quality of  
Care Esteem**



**Unit Safety**

\*Best-fit line shows positive association between Supervisor Support, Workplace Environment, And Unit Safety between Quality of Care Esteem

## CHAPTER 4: DISCUSSION

The results from the dataset support all three hypothesis. Independent variables supervisor support, workplace environment, and unit safety all positively impacted employee workplace perceptions in terms of job satisfaction, quality of work life, and quality of care esteem. The finding is consistent with previous research asserting that when an organization meets employee's emotional, physical and psychological needs, employees tend to be happier, more engaged in their profession and committed to the success of their organization (Harter, Schmidt, & Keyes, 2003).

An interesting finding in the results is that certain aspects of organizational culture have a larger impact on different workplace perceptions. Supervisor support had the largest impact on job satisfaction and quality of work life, followed by workplace environment and then finally unit safety. This finding is explained because when managers are responsive and give individualized attention to their employees, there is a higher frequency of joy, interest, and caring in employees, which helps them bond to each other, their work, and the organization (Harter, 2003). Both job satisfaction and quality of work life are related to the employee's experience at work, so it makes sense that supervisor support, followed by workplace environment which is related to co-worker support influence these dependent variables the most. When leaders show procedural justice by acting fairly, clearly outline job tasks, recognize their employees, and show credibility through consistency and competence, job satisfaction and quality of work life improve (Hoffman & Ingram, 1992).

Unlike job satisfaction and quality of work life, quality of care esteem was influenced the most by unit safety as opposed to supervisor support or workplace

environment. Quality of care esteem is unique from job satisfaction and quality of work life because it involves employees' perceptions on the experience of their patient, rather than their own. When an organization values safety improvement and encourages receptive communication between departments, staff members, and manager about safety concerns, employees are likely to have higher esteem in the quality of care their organization delivers (Rafferty, Ball & Aiken, 2001). Reinforcing safety protocols, such as requiring at least two transfer team members to lift a patient, not only enhances the work environment for employees but also leads to improved patient outcomes, such as reducing the risk that a patient will be dropped (Rafferty, 2001). By increasing unit safety, hospitals can effectively reduce hazardous risks to both employee and patient, which leads employees to have greater confidence in the level of care their hospital delivers.

### **Limitations**

The first limitation in this study was using only one survey question to determine the dependent variables job satisfaction, quality of work life, and quality of care. The independent variables supervisor support, workplace environment, and unit safety might be more accurate because those variables were generated by combining scores from 4-7 different yet related questions. Another limitation is the occupation held by the healthcare survey participants. Much of the previous research considers highly specialized positions such as physicians and nurses, while the participants in the Aramark study are from environmental services, food and nutrition, and transportation. These results are not generalizable to healthcare as a whole. A final limitation is the potential for error using

dummy coding to enter categorical demographic variables into a linear regression model. With binary coding some of the categorical values were oversimplified.

### **Future Research**

The ARAMARK study administered an initial survey to evaluate employee perspectives on managers, teams, and safety. A follow-up study was conducted in 2011 that included a safety intervention to see how opinions could be improved regarding unit safety. Future research suggestions include offering additional intervention strategies such as a more rigorous orientation for managers to improve supervisor support, or more team bonding and effective communication exercises to improve workplace environment. Another idea for future research would be comparing employee workplace perception scores to their hospital and unit's HCHAPS scores. This would show the difference in how patients perceive a hospital versus the way employees perceive a hospital.

### **Conclusion**

Understanding the benefits of a positive organizational culture is advantageous because healthcare organizations can improve employee workplace perceptions in terms of job satisfaction, quality of work life, and quality of care esteem. Improved workplace perceptions can in turn lead to improved customer loyalty, higher profitability, higher productivity and lower rates of turnover (McGinnis, 2008). When the overall well-being of an employee is enhanced, they are more engaged in their work which positively affects their efficiency, retention, memorization, cognitive abilities, creativity, problem-solving skills, volunteerism and ultimately business outcomes (Arnetz, 1999). According to a 1989 study at University of Columbia, participants with a depressed mood state showed interference with memory that resulted in poorer recall when compared to participants of

neutral mood (Colquitt, Scott & LePine, 2007). Depression can hinder cognition, which is especially dangerous in the high-stress fast-paced environments of healthcare (Colquitt, 2007).

This idea about organizational psychology was expanded in 1998 by Dr. Barbara Fredrickson when she proposed a “broaden and build” model suggesting that positive emotions and well-being “broaden people’s momentary thought action repertoires” and “build their enduring personal resources.” (Plant & Devine, 2000) Evolutionary roots suggest that while negative emotions may narrow cognitive ability and lead to fight or flight instincts, positive emotions broaden the scope of attention while enhancing physical, intellectual and social resources (Plant & Devine, 2000). Positive organizational culture supports emotional well-being for employees, and allows them to reach their full potential.

In addition to enhancing employee’s thought process and resources, another social psychologist William Kahn conceptualized that engagement is a basic human need (Kahn, 1990). Engagement is the determining intermediate dictating how environment will affect performance. In other words, employees perform better when they are in an engaging environment (Kahn, 1990). An engaging workplace environment has career growth opportunities, meaningful job designs, recognition for accomplishments, supportive teamwork, and safe working conditions (Kahn, 1990).

A positive organizational culture with high supervisor support, an engaging workplace environment, and proper unit safety can help healthcare organizations increase their employee’s job satisfaction, quality of work life, and quality of care esteem. Employee well-being benefits both the employee by enhancing their thought-process,



resource utilization and engagement, but also the employer with improved productivity and efficiency.

## CHAPTER 5: APPENDIX A

Table 2. *Scales of Reliability for Organizational Culture Variables.*

<b>Supervisor Support</b>	
Questions	Cronbach's $\alpha$
My supervisor is supportive of progress in my career, such as further training.	.900
My supervisor tells me when I am doing a good job.	
My supervisor provides clear instructions when assigning work.	
My supervisor values or appreciates the work that I do.	
<b>Workplace Environment</b>	
Questions	Cronbach's $\alpha$
We have enough staff to handle the workload.	.807
When a lot of work needs to be done quickly, we work together as a team to get the work done.	
In this unit, people treat each other with respect.	
People support one another in this unit.	
<b>Unit Safety</b>	
Questions	Cronbach's $\alpha$
We are actively doing things to improve worker safety.	.723
Worker safety is never sacrificed to get more work done.	
**We have worker safety problems in this unit.	
Our procedures and systems are good at preventing injuries from happening.	
**My supervisor overlooks worker safety problems that happen over and over.	
My supervisor says a good word when he/she sees a job done according to established worker safety procedures.	
My supervisor seriously considers staff suggestions for improving worker safety.	
Hospital management provides a work climate that promotes worker safety.	
The actions of hospital management show that worker safety is a top priority.	

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\*\*Hospital management seems interested in worker safety only after a worker injury event happens.

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\* All Questions scored on Likert Scale with 1='Strongly Disagree' to 5='Strongly Agree'

\*\*Reverse Coded where 1='Strongly Agree' and 5='Strongly Disagree'

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**The Pennsylvania State University, Schreyer Honors College  
State College, PA**

Bachelor of Science in Health Policy Administration

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Dean's List, HHD Honor Society, Fasola Scholarship Recipient, Distinguished Alumni Protégée

#### EXPERIENCE

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**Penn State Hershey Medical Center**

**Hershey, PA**

*Administrative Intern*

2013

- Helped implement new electronic staff scheduling tool SmartSquare
- Led Relational Coordination Project to analyze strength of communication across management teams
- Piloted interaction guideline AIDET to acute care nurses to improve patient satisfaction
- Evaluated hospital-wide quality control initiatives, budget forecasting, and LEAN process improvement

**Johnson and Johnson**

**Piscataway, NJ**

*Customer Contracting Solutions Co-Op*

2012-2013

- Navigated through several data systems to find, update, and relay contract information
- Responsible for five distributor accounts
- Corresponded with multiple J&J branches to obtain information for data cleanses
- Volunteered for the United Way, Safety Fair, and TEDx Talks
- Elected Secretary and Social Chair for the Intern Co-Op Association
- Extended to work part-time throughout the spring semester

**Vector Marketing**

**Blue Bell, PA**

*Inside Sales Representative*

2011

- Persuaded job candidates to interview for a direct sales position over phone lines
- Mentored fellow receptionists on marketing and communication strategies
- Recognized as a Top Northeastern District Representative

#### LEADERSHIP POSITIONS

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**Morale THON Committee**

**State College, PA**

*THON Weekend Development Leader*

2011-2012

- Managed a nine person committee to design decorations for THON, a 46-hour dance marathon raising \$12.37 million for children suffering from pediatric cancer
- Delegated tasks to keep everyone involved and focused

**Lifelink PSU**

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*Special Education Mentor*

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- Attended class and tutored a student with special needs