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The Effects of Personal and Organizational Resources on Work and Well-Being Outcomes among Turkish Nurses¹

Abstract:

This exploratory research examined the relationship of a personal and an organizational resource, optimism and levels of hospital support respectively, on a variety of work

1. We acknowledge the cooperation of our respondents in making this study possible.

and well-being outcomes in a sample of nurses in Turkey. Data were collected from 212 nurses using anonymously completed questionnaires. Feelings of psychological empowerment was positioned as a mediator between resources and work and well-being outcomes which included job satisfaction, work engagement, affective hospital commitment, work-family conflict, family-work conflict, and intent to quit. The sample scored at moderate levels on the measures of resources and work outcomes, though scoring higher of feelings of psychological empowerment. These data indicate potential room for improvement in the work experiences of our nursing respondents. Hierarchical regression analyses controlling for personal demographics indicated that levels of hospital support were significantly and positively associated with most work and well-being outcomes, with levels of optimism significantly and positively associated with fewer of these outcomes. Practical implications of the findings are offered. Hospital efforts to increase levels of optimism and hospital support are described.

Key words:

personal and an organizational resource, hospital support, nurses, work and well-being

Introduction

Nursing staff have an important role in the delivery of health care in all countries. However studies of nursing staff satisfaction in various countries indicated that levels of job satisfaction of nurses are modest, with several intending to leave the profession (Aiken, Clarke, Sloane & Sochalski, 2001). Young women and men are now less interested in the nursing profession, with many countries reporting a shortage of nurses (Shields & Watson, 2008).

In addition, health care systems have undergone significant changes over the past two decades. These include efforts by governments to control health care costs, increasing the use of new technologies, an aging population requiring more care, advances in medical knowledge, the increasing role of nursing associations and unions, and more critical users of the health care system.

More effort has then been undertaken to understand the work experiences of nurses. This has involved issues such as workload (Aiken,

Clarke, Sloan, Sochalski & Silber, 2002), overtime work, patient abuse of nurses, lack of adequate resources, hospital restructurings and how these experiences influence nurse satisfaction, burnout (Greenglass, Burke & Fiksenbaum, 2001; Leiter & Maslach, 2001), absenteeism, intent to leave the profession (Lowe, 2012; Collins, Collins McKinnies & Jensen, 2008; Mannion, Davies, & Marshall, 2005) and quality of patient care (Aiken, 2002; Vahey, Aiken, Sloane, Clarke & Vargas, 2004).

Hospital environments associated with higher levels of patient care have been shown to embrace a philosophy of care that runs throughout all levels of employees, leaders that encourage staff participation, facilities supportive of quality patient care, staff autonomy, and high levels of staff development (Aiken, Sloane & Clarke, 2002; Aiken, Smith, & Lake, 1994; Kramer, 1990). Hospitals that report high levels of nursing staff satisfaction and high levels of patient care provide high levels of support to nursing staff and hold high patient care quality expectations (Eisenberg, Bowman & Foster, 2001).

Nursing research in Turkey

Turkey is obviously facing the same changes in health and health care as most other countries; an aging population, need to constraining costs, develop and retain a capable nursing workforce, learning and improving care practices, and using the latest knowledge and practice evidence.

Orzoy (2007) reviewed the development and status of nursing research in Turkey as well as in some European countries. He concluded that the development of nursing research in Turkey was limited compared to its European neighbors but growing, a conclusion also reached by Cinar and Altun (2010). Ustun and Gigliotti (2009) note the absence of Turkish-based theory in nursing research and the absence of an organized nursing research agenda. Can (2015) found relatively little research interest in the implementation, advancement and nursing experience in pal-

liative care nursing. Tan, Sahin and Ozdemir (2012) found a major barrier to use latest research evidence by nurses was a lack of time. There has also been relatively little attention paid to changing the work environment of nursing staff to increase levels of satisfaction, well-being and performance. We conclude that there has been relatively little research on the work experiences and the work and well-being of nurses in Turkey.

The good news is that there are signs growing interest in nursing research. More academics are now undertaking and publishing research on the nursing experiences. Thus Tuna and Baykal (2014) studied the relationship of job stress and burnout levels among oncology nurses. Partlak-Gunusen, Ustun and Giglietti (2009). Gunusen and Ustun (2010, 2009) have undertaken research on burnout among nursing staff and the value of an intervention designed to address these levels.

In a series of analyses from a large scale study of 224 nurses working in 15 research hospitals in Ankara, Burke and his colleagues (Burke & Koyuncu, 2010; Burke, Koyuncu, Tekinkus, Bektas & Fiksenbaum, 2012; Burke, Koyuncu & Fiksenbaum, 2011; Burke, Koyuncu & Fiksenbaum, 2010; Burke Koyuncu, Durna, Cicek & Fiksenbaum, 2010) reported the following results.

- Levels of psychological burnout (emotional exhaustion, cynicism, low personal efficacy) were related to lower levels of both job satisfaction and work engagement and higher quit intentions.
- Workload, particularly frequency of working more than 12 hour shifts, was significantly related to higher levels of emotional exhaustion.
- Nurses reporting higher levels of flow at work also indicated more work engagement, higher self-rated job performance, more personal efficacy and more positive affect at work. However flow was unrelated to job satisfaction, burnout, intent to quit, life satisfaction, psychosomatic symptoms or medication use.
- Nurses scoring higher on virtues, assessed by levels of optimism and proactive behavior, were more job satisfied, reported lower levels of burnout, more personal efficacy, lower quit intentions, and better

psychological well-being, more positive affect, less negative affect and greater life satisfaction.

- Nurses reporting higher levels of hospital support indicated re job satisfaction, more work engagement, lower quit intentions, less absenteeism, lower levels of burnout, fewer psychosomatic symptoms, more life satisfaction, and a higher quality of patient care being provided.
- Finally, nurses reporting higher levels of work engagement also indicated more job satisfaction, less burnout, more life satisfaction, higher levels of positive affect, fewer psychosomatic symptoms and greater satisfaction in being a nurse.

These findings are consistent with recent benefits associated with the application of positive psychological concepts in organizations (Cameron, Dutton & Quinn, 2003; Cameron & Spreitzer, 2012; Lopez & Snyder, 2016).

Personal and Organizational resources

This research considers the role of two resources, one personal and one organizational, and nursing staff satisfaction. The former involves the individual characteristic of optimism, the latter, the organizational characteristic of hospital support.

Optimism

Optimism is a stable individual difference characteristic defined as “the tendency to believe that one will generally experience good versus bad outcomes in life” (Scheier & Carver, 1985). Scheier and Carver developed a measure of optimism which has been used in countless research studies. This evidence, reviewed by Scheier and Carver (1992,) showed that optimism was usually associated with higher levels of psychological and physical well-being. For example, optimists have been found to cope more effectively with stress. Optimists also reported a higher quality of

life and engaged in healthier life styles. Optimists had access to more social resources, had better social relationships, worked harder on their social relationships or worked more effectively on them (Carver, Scheier & Segerstrom, 2010; Segerstrom, 2007). Levels of individual optimism can also be increased through education and training.

Yousseff and Luthans (2007) include optimism as a central element in positive organizational behavior at work, along with hope and resilience. These measures form their operationalization of Psychological Capital which has been found to be associated with a range of desired work and well-being outcomes, and amenable to development in short training program, associated with later improvements in attitudes, behaviors and performance.

In the workplace, optimists were more likely to believe that good things would happen if they applied their strengths and skills to tasks that made a difference. Optimism has also related to self-efficacy, which has been found to predict a number of important work outcomes (Maddux, 2002). Optimism was selected as an important personal resource in explain important nurse work and well-being outcomes.

Hospital support

Eisenberger, Huntington, Huthcheson and Sowa (1986) created a measure of perceived organizational support that has also been widely used, including in hospital settings Rhoades and Eisenberger (2002) reviewed over 70 studies of perceived organizational support, undertaking meta-analysis of them. Antecedents of perceived organizational support included fairness, supervisor support, the quality of the relationship between supervisors and their employees, formal and informal recognition, providing training and other investments in employees. Organizational rewards and job conditions (e.g., job security, low levels of job stress, pay, promotions). Higher levels of perceived organizational support were asso-

ciated with higher levels of employee organizational commitment, job satisfaction and performance and less intent to quit.

In a study of Iranian emergency room nurses working in general hospitals, Gorji, Etemadi and Hoseini (2014) found a positive relationship of perceived organizational support with nursing staff job involvement.

Eisenberger, Stinglehaber, Vandenberghe, Sucharski and Rhoades (2002), in three studies, found the perception of positive supervisor support lead to higher perceived organizational support. Eisenberger, Huntington, Huthcheson and Sowa (1986) believe that perceived organizational support exists when the organization values staff contributions and cares about their well-being. They write that more favorable work outcomes follow from perceived organizational support particularly among employees having a stronger exchange ideology. That is, these employees are more committed to their organizations when they believe their organizations are committed to them and a belief that greater effort towards meeting organizational goals will be rewarded.

In a hospital setting, Burke (2005) reported, in a 3 year longitudinal study of the effects of hospital downsizing and restructuring in Ontario, Canada, that nursing staff indicating higher levels of restructuring stress and lower levels of hospital support in 1996 indicated more negative views of nursing unit and overall hospital functioning in 1999. In a study of nursing staff in Turkey, Burke, Koyuncu and Fiksenbaum (2011) observed that hospital support was associated with higher levels of job satisfaction and work engagement and lower levels of burnout, absenteeism and quit intentions.

Method

Procedure

Data were collected from hospital-based nursing employees in Antalya Turkey between September and December 2015. Two hundred and fifty nurses were randomly selected to take part, 212 completed questionnaires were received, an 84% response rate. Nurses completed questionnaires during training seminars, nurses were employed in different hospitals, and questionnaires were translated from English to Turkish and back again to English using the back-translation approach. Translation was undertaken by Turkish experts fluent in both languages.

Respondents

Nursing respondents were primarily female (95%), had a mean age of 36.6 years, s.d.=10.02 years, ages ranging from 21 to 52; currently worked an average of 45.8 hours per week, s. d.=5.46 hours; had worked in the nursing profession 15.3 years, s.d.=8.12; had worked in their present jobs/work units an average of 11.7 years, s.d.=8.54; and had been working in their present hospitals for an average of 6.6 years, s.d.=6.37.

Measures

Personal demographics

Personal demographic information was collected using single items and included age, gender, tenure in present hospital, and hours worked per week.

Personal and organizational resources

Optimism, a personal resource, was measured by an eight-item scale ($\alpha=.88$) developed by Scheier and Carver (1985, 1992). One item was "In uncertain times, I usually expect the best". Respondents indicated their agreement with each item on a five-point Likert scale.

Hospital support, an organizational-level variable, was assessed by eight items ($\alpha=.85$) developed by Eisenberger, Huntington, Hutchison and Sowa (1986). An item was "This hospital is willing to help me when I need a special favor." Respondents indicated their agreement with each item on a seven-point Likert scale (1=Strongly disagree, 4=Neither agree nor disagree, 7=strongly agree).

Psychological or personal feelings of empowerment were measured by a twelve item scale developed and validated by Spreitzer (1995). This measure tapped four dimensions, each addressed by three items. Meaning ($\alpha=.74$) "The work that I do is meaningful to me". Competence ($\alpha=.84$) "I am confident about my ability to do my job". Self-determination ($\alpha=.65$) "I have significant autonomy in determining how I do my job". And Impact ($\alpha=.85$) "My impact on what happens in my unit is large". Nurses indicated their agreement with each item on a seven-point Likert scale (1=Very strongly disagree, 4 = Neutral, 7=Very strongly agree). A composite measure of feelings of psychological empowerment was created as the four dimensions were all significantly and positively inter-correlated, the mean inter-correlation being .62, $p<.001$.

Work and well-being outcomes

Six work and well-being outcomes, one having several dimensions, were included.

Job satisfaction was assessed by a seven item scale ($\alpha=.84$) developed and validated by Taylor and Bowers (1972). Nurses indicated their agree-

ment with each item on a five-point Likert scale (1=very dissatisfied, 3=Neither satisfied nor dissatisfied, 5=Very satisfied). One item was "All in all, how satisfied are you with the persons in your work group?".

Work engagement. Three aspects of work engagement were measured using scales developed by Schaufeli, et. al. (2002). Nurses indicated their agree agreement with each item on a five-point Likert scale (1=Strongly disagree, 3=Neither agree or disagree, 5=Strongly agree). Vigor was measured by six items ($\alpha=.82$) "At my work I feel bursting with energy", Dedication was measured by five items ($\alpha=.81$) "I am proud of the work that I do", Absorption was measured by six items ($\alpha=.77$) "I am immersed in my work". A composite measure of work engagement was created by combining the three dimensions since they were all significantly and positively inter-correlated, the mean inter-correlation being .58, $p<.001$.

Affective commitment was measured by a six item scale ($\alpha=.79$) developed and validated by Meyer and Allen (1997). Nurses indicated their agreement with each item on a five-point Likert scale (1=Strongly disagree, 3- Neither agree nor disagree, 5=Strongly agree). One item was "I am proud to tell others I work at my hospital".

Intent to quit was measured by two items ($\alpha=.82$) used previously by Burke (1991). Are you currently looking for a different job in a different organization? Yes/No.

Work-family and Family-work conflict were each measured by five item scales developed by Carlson, Kacmar and Williams (2000). One item for the Work-family scale ($\alpha=.93$) was "The demands of my work interfere with my home and family life"; an item on the Family-work conflict scale ($\alpha=.70$) was "I have to put off doing things at work because of demands on my time at home". Responses were made on a five-point Likert scale of agreement.

Results

Descriptive statistics

An important question becomes the relative standings of the sample on the two measures of resources and the various work and well-being outcomes. Does the sample as a whole score high, average or low on these. Table 1 presents, for each of these measures, the minimum and maximum possible, the mean of the nursing respondents, the standard deviations around these means, and the sample size. On all measures in this table, the sample generally scored at a moderate level, but did score higher on feelings of psychological empowerment. These data suggest potential room for improvement in the work experiences of our respondents. Nurses indicated significantly higher levels of family-work conflict than work-family conflict. This likely reflects the preponderance of women in the sample, women generally having higher levels of responsibility for home and family functioning.

Table 1. Descriptive Statistics

| <u>Measures</u> | <u>minimum</u> | <u>maksimum</u> | <u>mean</u> | <u>SD</u> | <u>N</u> |
|----------------------|----------------|-----------------|-------------|-----------|----------|
| <u>Resources</u> | | | | | |
| Optimism | 8 | 40 | 30.1 | 5.98 | 212 |
| Hospital support | 8 | 56 | 36.6 | 14.67 | 212 |
| <u>Work outcomes</u> | | | | | |
| Empowerment | 12 | 60 | 49.7 | 6.61 | 212 |
| Job satisfaction | 7 | 35 | 20.2 | 5.71 | 212 |
| Commitment | 6 | 30 | 17.1 | 6.68 | 212 |
| Engagement | 17 | 85 | 50.6 | 13.0 | 212 |
| Intent to quit | 2 | 4 | 3.0 | .90 | 211 |
| Work-family conflict | 5 | 25 | 12.0 | 8.94 | 212 |
| Family-work conflict | 5 | 25 | 16.1 | 6.35 | 212 |

Source: own study.

Analysis Plan

Hierarchical regression analyses were undertaken in which various work and well-being outcomes were regressed on three blocks of predictors entered in a specified order. The first block of predictors ($n=4$) consisted of personal demographics (e.g., age, nursing tenure, present hospital tenure, hours worked per week); the second block of predictors included the two measures of resources – optimism and hospital support ($n=2$); the third and final block of predictors ($n=1$) consisted of the composite measure of psychological empowerment. When a block of predictors accounted for a significant amount or increment in explained variance ($p<.05$), individual variables within these blocks having significant and independent relationships with the criterion variable ($p<.05$) were identified. These variables are indicated in the table that following along with their respective B s.

Table 2 presents the results of these analyses. The following comments are offered in summary. First, two of the three blocks of predictors accounted for significant increments in explained variance on Job Satisfaction. Nursing staff indicated higher levels of hospital support, and nursing staff reporting greater feelings of psychological empowerment reported higher levels of job satisfaction (B s=.26 and .40, respectively). Second, all three blocks of predictors accounted for a significant amount or increment in explained variances on the composite measure of work engagement. Older nursing staff, nursing staff having less tenure with their present hospitals, those indicating higher levels of optimism, those indicating higher levels of hospital support, and those reporting more psychological empowerment indicated higher levels of work engagement (B s=.12, -.15, .35, .26 and .39, respectively). Third, all three blocks of predictors accounted for significant increment in explained variance on hospital commitment; nursing staff having longer tenures with their present hospital, nursing staff indicating higher levels of both optimism and hospital support and feelings of psychological empowerment reported more hospital commit-

ment (B s= .16, .17, .23 and .25, respectively). Fourth, two blocks of predictors accounted for a significant amount or increment in explained variance on Intent to quit. Female nursing staff and those indicating more hospital support indicated lower quit intentions (B s=.19 and .20, respectively) Fifth, one block of predictors accounted for a significant increment in explained variance on Work-Family conflict; nursing staff indicating more optimism and higher levels of hospital support reported more work-family conflict (B s=.17 and .20, respectively). Finally two blocks of predictors accounted for significant increments in explained variance on family-work conflict; nurses indicating higher levels of psychological empowerment also indicated more Family-work conflict (B = .24).

Table 2. Personal characteristics, resources and work outcomes

| | <u>R</u> | <u>R²</u> | <u>ΔR²</u> | <u>P</u> |
|--|----------|----------------------|-----------------------|----------|
| <u>Work Outcomes</u> | | | | |
| <u>Job satisfaction (n= 209)</u> | | | | |
| <u>Personal demographics</u> | .13 | .02 | .02 | NS |
| <u>Resources</u> | .43 | .18 | .16 | .001 |
| Hospital support (.26) | | | | |
| <u>Psychological empowerment (.40)</u> | .54 | .29 | .11 | .001 |
| <u>Work engagement (n=209)</u> | | | | |
| <u>Personal demographics</u> | .23 | .06 | .06 | .05 |
| Age (.11) | | | | |
| Years present hospital (-.15) | | | | |
| <u>Resources</u> | .68 | .46 | .40 | .001 |
| Optimism (.35) | | | | |
| Hospital support (.26) | | | | |
| <u>Psychological empowerment (.39)</u> | .75 | .56 | .10 | .001 |
| <u>Hospital commitment (n=210)</u> | | | | |
| <u>Personal demographics</u> | .24 | .06 | .06 | .05 |
| Years present hospital (.16) | | | | |
| <u>Resources</u> | .36 | .12 | .06 | .001 |
| Hospital support (.23) | | | | |
| Optimism (.17) | | | | |
| <u>Psychological empowerment (.25)</u> | .46 | .19 | .07 | .001 |
| <u>Work-family conflict (n=209)</u> | | | | |
| <u>Personal demographics</u> | .10 | .01 | .01 | NS |
| <u>Resources</u> | .35 | .12 | .11 | .001 |
| Optimism (.17) | | | | |
| Hospital support (.20) | | | | |
| <u>Psychological empowerment</u> | .37 | .13 | .01 | NS |
| <u>Family-work Conflict (n=209)</u> | | | | |
| <u>Personal demographics</u> | .13 | .02 | .02 | NS |
| <u>Resources</u> | .28 | .08 | .06 | .01 |
| <u>Psychological empowerment (.24)</u> | .34 | .12 | .04 | .01 |
| <u>Intent to quit (n=208)</u> | | | | |
| <u>Personal demographics</u> | .23 | .05 | .05 | .05 |
| Gender (.19) | | | | |
| <u>Resources</u> | .32 | .10 | .05 | .001 |
| Hospital support (-.20) | | | | |
| <u>Psychological empowerment</u> | .33 | .11 | .01 | NS |

Source: own study.

Four more general observations are worth noting. First, personal demographics included in the study had relatively few significant relationships with the work and well-being outcomes. Second, both optimism and hospital support, but particularly levels of hospital support, had significant and positive relationships with valued work outcomes. Third, levels of psychological empowerment also tended to have significant and positive relationships with valued outcomes. Fourth, there might be a problematic aspect to hospital support and feelings of psychological empowerment as far as levels of family work conflict are concerned.

Discussion

Our findings (see Table 2) were consistent with our general hypotheses and previous research results. Hospital based nursing staff reporting higher levels of hospital support as well as higher levels of optimism indicated more favorable work and well-being outcomes. Personal demographics had inconsistent and small relationships with these outcomes.

The benefits of hospital support should not be surprising. Hospitals that care for and invest in their nursing staffs develop nursing staffs that reciprocate feelings of care and investment, and express positive feelings of attachment to their hospitals. In addition, more optimistic nursing staff create and experience more satisfying work environments and outcomes.

We believe these limited and preliminary findings on the importance of positive attitudes and work experiences in the working lives of nursing staff support not only further research in this general area but efforts to initiate workplace change in these directions. There is also a need to bring these views to nursing and hospital leadership.

Practical implications

We will address practical implications involving both optimism and perceived hospital support. Let us begin with optimism. Optimism is an emotional competence related to employee morale, better interpersonal relationships at work, and employee productivity. Optimism is an important element in a leader's effectiveness; optimistic leaders are more likely to foster optimistic workplace cultures. Optimists are more likely to be creative and innovative as they are more open to potentially useful new ideas. Optimists more likely view setbacks as temporary, specific to a particular issue, as external not internal, and not their fault and not their fault.

Optimism is an attitude that can be learned, practiced and strengthened. Increasing levels of optimism might involve spending more *time with* positive colleagues. Focusing on one's strengths, ignoring what cannot be changed, looking for a positive in a negative situation, using positive words, creating a culture of optimism at work by expecting staff to be successful, encouraging staff if they fall short. Balci (2008), using a treatment group of nurses that received training, and a control group (10 nurses in each, in a Turkish study, reported that a 10 week Emotional Strengths Training Program increased levels of optimism.

To foster an optimistic workplace environment, managers need to be clear on expected goals, priorities, and organizational objectives, offer feedback on contributions, create and support positive relationships at work, and help staff develop positive identities.

Efforts to increase optimism have typically addressed self-defeating beliefs (e.g., negative thoughts) as well as increasing positive habits and thoughts such as cognitive priming, positive visualizations, and use of homework assignments (Riskand, Sarapote & Mercier, 1996; Goldwunn, Mielli, Corsale & Machi, 2006).

Since feelings of psychological empowerment were found to have favorable consequences, nursing leadership should also consider increasing

nursing staff feelings here as well. Leadership behaviors that have been found to increase levels of staff empowerment include leading by example, using participative decision making, informing staff about priorities, changes and unit developments, coaching staff, and showing concern for staff and interacting with the work team (Arnold, Arad, Rhoades & Drasgow, 2000).

In a study of 322 staff nurses in Canada, Greco, Laschinger and Wong (2004) found that leader empowerment behaviors had an indirect effect on emotional exhaustion, a key burnout element, through structural empowerment. In an Italian study of 273 nurses, empowering leadership increased trust in the leader, with trust in leaders and trust in the hospital organization reducing burnout. In an Italian study of 273 nurses, empowering leadership increased trust in the leader, with trust in leaders and trust in the hospital organization (a byproduct of hospital support,) reducing burnout (Bobbio, Mellan & Manganelli, 2012).

Applying theory and research findings to organizational practice

Quinn (2015), building on emerging theory and research in the application of positive psychology concepts in workplaces, writes that managers need to change their negative and constraining attitudes and mental maps and lead their workplaces to more positive places. Quinn provides 100 real life examples of positive initiatives being undertaken by managers in their organizations.

Murphy (2015), similar to Quinn (2015) emphasizes a positive attitude believing that organizations can be more humane, optimistic and sources of joy. Leaders play a central role in creating optimistic workplaces. Murphy identifies seven leadership characteristics: humility, honesty, reflection, grit, resilience, sense making, and vulnerability, and the express these values in behavior on a daily basis.

Chapman and Sisodia (2015), using real-life organizational examples, provide evidence that cultures of caring and commitment can be successful and profitable.

Limitations of the study

Most research has limitations and this study is no exception. First, all data were collected using self-report questionnaires raising the possibility of response set tendencies. Second, the sample was a convenience sample raising the issue of how generalizable our findings would be to other nursing samples. Third, as these data were collected at one point in time, issues of causality could not be adequately addressed. Finally all data were collected from a small number of hospitals in the same region of Turkey, again raising the issues of the generalizability of our conclusions for other nursing regions.

Future research directions

We believe there is a need for increased research attention to the work experiences of nursing staff in Turkey in order to increase the quality of patient care. It would be important to include other individual difference measures (e.g., self-efficacy) and other personal demographic and family characteristics (whether respondents had children, and if so, how many, and their ages, marital status). In addition, longitudinal research would make it possible to examine issues of causality and implications of possible changes in resource antecedents and outcomes consequences with the passage of time. Finally, efforts to evaluate the effects of initiatives that attempt to improve levels of hospital support and increase staff optimism, would add much to our understanding of these resources.

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