

## RESEARCH ARTICLE

# Effects of nursing power and organizational trust on nurse's responsiveness and orientation to patient needs

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**Abstract**

**Aim:** To assess the relationship among perceived nursing group power, organizational trust and patient orientation and identify patient orientation predictors.

**Background:** Nurses and nursing organizations should use all resources to give care.

**Methods:** Survey data were collected from 193 nurses at six acute care hospitals in South Korea. Characteristics of hospitals and nurses were analysed using *t* tests, one-way ANOVAs and regression models.

**Results:** The means for perceived nursing group power, organizational trust and patient orientation were 3.71 ( $SD \pm 0.58$ ), 3.22 ( $SD \pm 0.83$ ) and 3.94 ( $SD \pm 0.53$ ), respectively. Multiple regression analysis revealed that 40% of the variance in patient orientation was explained by perceived nursing group power, organizational trust and work experience.

**Conclusion:** Hospitals should increase nursing group power and improve organizational trust to enhance patient orientation. Hospital executives and nurse managers should work to enhance nursing group power and positive perceptions of organizational trust, which could contribute to patient orientation.

**KEYWORDS**

Korea, nursing power, organizational trust, patient orientation

## 1 | INTRODUCTION

Nurses comprise the largest group of professionals in hospitals, and their knowledge, skills and experiences are an important asset. At hospitals, nursing departments have greater decision-making power than other departments due to their greater workforce (Sung, Lee, Jeong, Park, & Kim, 2014). The status and responsibility of the nursing department are important because nurses play a direct role in the provision of medical services and an important role in improving the performance of hospitals (Sung, Jeong, Park, & Lee, 2017). Additionally, in relation to power, a leader of a nursing group can make a statistically significant difference in the group's ability to actualize their power capacity (Sieloff, 2004). As such, the influence

of individual nurses could change depending on the power of the nursing department. A survey of the status of hospital nursing staff placement in 2014 reported that among 201 hospitals nationwide, 20 (10.0%) used job titles such as *nursing vice president*, *nursing executive director*, *chief of nursing*, *director for nursing operations* and *director of nursing bureau*; 159 (79.1%) used the title *head of nursing department* ("bujang"); and 22 (10.9%) used the title *deputy head of nursing* ("chajang"), indicating that the titles of chief nursing officers vary across hospitals (Hospital Nurses Association, 2014). In addition, the position and affiliation of nursing departments in the hospital organizational chart also differ across hospitals. Therefore, it is necessary to evaluate the current status of the power of nursing departments.

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Nurses and nursing organizations are obliged to use all resources of a healthcare environment to give quality care. The group power of a nursing department is an important resource (Sieloff, 2004) and is worth studying. Previous studies (Bogue, Joseph, & Sieloff, 2009; Matthews, Laschinger, & Johnstone, 2006; Sung et al., 2017) have reported a correlation between nursing group power and organizational effectiveness; however, in-depth studies of this correlation in local environments are needed.

According to Colquitt, LePine, and Wesson (2015), organizational structure is an important factor affecting individual job performance and organizational commitment. However, recent South Korean studies have mainly focused on nurses' empowerment and its effects on organizational commitment and job satisfaction (Lee & Lee, 2011; Oh & Chung, 2011) to identify the influence of socio-psychological variables. Studies investigating the correlation between nursing organizational power/nursing group power and other relevant variables in hospitals are scarce.

As the power of nursing organizations increases, so does trust; members can share knowledge and information without any risk or suspicion (Kramer, 1999). Organizational trust is defined as a general perception of a trusting relationship within a group (horizontally and vertically) in relation to the value that it places on its members' contributions and its interest in their welfare (Cho, 2011). Therefore, this study intended to examine the effects of organizational trust on performance. Higher trust tends to motivate members to create patient values by prioritizing their needs and interests. This concept is linked to patient orientation, which is defined as the degree to which service workers' behaviours satisfy patient needs in personal interactions through their actions when they are faithful to current and future patients' needs and desires (Donavan & Hocutt, 2001). It is also important to know whether nurses are in a stable working environment. In other words, it is necessary to check whether nurses with many clinical backgrounds are working stably without resignation and whether organizational performance differs depending on the characteristics of the organization, such as the wage level of a career nurse or nursing manager. Patient orientation may enhance patient satisfaction by improving relationships and may lead to long-term positive relationships. Thus, patient orientation is the most important characteristic of a nurse and an essential factor in enhancing a hospital's competitiveness. Therefore, it is important to identify the factors influencing patient orientation.

## 1.1 | Objectives

This study aimed to examine the effect of nursing power and organizational trust on patient orientation as an indicator of organizational performance in Korean nurses. This was achieved by (a) identifying the level of nursing group power, organizational trust and patient orientation in Korean nurses; (b) identifying differences in patient orientation according to their general characteristics; and (c)

studying correlations among their perceived nursing group power, organizational trust and patient orientation.

## 2 | METHODS

### 2.1 | Design and sample

This descriptive correlation study aimed to investigate the effects of nurse-perceived nursing group power and organizational trust on patient orientation using a secondary analysis. A survey of chief nursing officers and nursing leaders (or leaders of nursing administration teams) was conducted at six tertiary general and general hospitals selected according to their location and size and whether they were national or public hospitals. Only advanced general hospitals and general hospitals were included in the study. The reason for excluding different classes of hospitals was to avoid the possibility of outliers deviating from the average of the variables suggested in the study. A survey was also administered to nurses at two or more nursing work units selected by the nursing department staff members at the respective hospitals.

The survey was conducted with nurses who understood the purpose of this study and agreed to participate. Using Cohen's sampling formula with the G-power 3.1.9 program, an appropriate sample size of 184 individuals was determined for conducting a multiple regression analysis with a moderate effect size of 0.10, a power of 80%, significance level of 0.05 and 12 predictors.

The raw data consisted of 254 copies of questionnaires, excluding the questionnaires with missing responses, out of which 193 copies were used in this study. The second analysis criterion included only the nurses working at tertiary general hospitals and general hospitals. In hospitals, there is a problem that group power is underestimated. Therefore, the present secondary analysis was conducted with the exception of the hospital.

### 2.2 | Ethical considerations

The first study (Ko, Jeong, & Yu, 2018) was approved by the Institutional Review Board (IRB) at C hospital (IRB No: CHAMC 2016-07-063). In the present study, the secondary analysis was performed under a research and service agreement with the Hospital Nurses Association, using the raw data collected in the first study by using the 3 core variables to empirically investigate the effects of nursing power and organizational trust on patient orientation. This secondary analysis was performed after obtaining separate IRB approval at W University (IRB No: WKIRB-201703SB004).

The data for the previous study were collected from 1 July – 30 August 2016. The researchers explained the purpose of the present study to the nurses by visiting the respective nursing departments or over the telephone. The nurses were given informed consent forms describing the purpose and methods of the present study.

Questionnaires were then distributed to those who agreed to participate voluntarily and signed the consent form.

## 2.3 | Variables

### 2.3.1 | Korean nursing group power

Nursing group power is the ability of nursing departments to achieve their goals (Sieloff, 1996). In this study, it was measured using the Korean-Sieloff-King Assessment of Group Outcome Attainment in Organizations (K-SKAGOAO), comprising 36 items under eight sub-domains: nursing supervisor's power competency, communication competency, controlling the effects of environmental forces, goals/outcomes competency, position, power perspective, resources and role. It was developed by Sieloff (1999) and validated by Sieloff and Bularzik (2011) and locally adapted by Sung et al. (2014). On a five-point Likert scale, responses range from 1 = *strongly disagree* to 5 = *strongly agree*. Higher scores represent greater nursing group power. Cronbach's  $\alpha$  of 0.97 indicated the reliability of this instrument.

### 2.3.2 | Organizational trust

Organizational trust implies that members believe that their organization/CEO is competent and that its/their intentions and actions correspond to the members' common sense and expectations. It was measured with the instrument used by Yun (2004), which comprises seven items and uses a five-point Likert scale with responses ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Higher scores indicate higher organizational trust. Cronbach's  $\alpha$  of 0.95 indicated the reliability of this instrument.

### 2.3.3 | Patient orientation

Patient orientation refers to the hospital focuses its activities on patient demands and was measured using the instrument used by Kim

(2011), which comprises six items. On a five-point Likert scale, responses range from 1 = *strongly disagree* to 5 = *strongly agree*. Higher scores indicate higher patient orientation. Cronbach's  $\alpha$  of 0.92 indicated the reliability of this instrument.

## 2.4 | Data analysis

Statistical analyses were performed using SPSS, version 21.0 (IBM SPSS Statistics for Windows, Armonk, NY: IBM Corporation). Nursing group power, organizational trust, patient orientation, socio-demographic characteristics and organization-related characteristics were analysed using descriptive statistics. To identify the differences in the major variables according to socio-demographic characteristics, an independent *t* test, a one-way ANOVA and a Scheffé test were used. A stepwise multiple regression analysis was performed to identify factors affecting patient orientation. Socio-demographic characteristics, organization-related characteristics, nursing power and organizational trust that showed statistically significant differences or that correlated with patient orientation were included as covariates in the regression analysis. Multicollinearity issues were considered using the variance inflation factor (VIF) and condition index (CI). The contribution of each independent variable was defined as a change in the  $R^2$  of the regression equation. The level of statistical significance was set at  $p < .05$ .

## 3 | RESULTS

### 3.1 | Power-related variables and perceived nursing organizational trust

The mean scores out of 5 for perceived nursing group power, organizational trust and patient orientation were 3.71 ( $SD \pm 0.58$ ), 3.22 ( $SD \pm 0.83$ ) and 3.94 ( $SD \pm 0.53$ ), respectively. The mean scores out of 5 on the power subscales of nursing supervisor's power competency, communication competency, controlling the effects of environmental forces, goals/outcomes competency, position, power perspective,

**TABLE 1** Nurses' perception of the level of nursing group power, organizational trust and patient orientation ( $N = 193$ )

Variables	Mean	SD
Nursing group power	3.71	0.58
Nursing supervisor's power competency	3.88	0.64
Communication competency	3.51	0.69
Controlling the effects of environmental forces	3.71	0.61
Goals/outcomes competency	3.59	0.69
Position	3.62	0.64
Power perspective	3.80	0.58
Resources	3.76	0.65
Role	3.75	0.74
Organizational trust	3.22	0.83
Patient orientation	3.94	0.53

resources and role were 3.88 ( $SD\pm 0.64$ ), 3.51 ( $SD\pm 0.69$ ), 3.71 ( $SD\pm 0.61$ ), 3.59 ( $SD\pm 0.69$ ), 3.62 ( $SD\pm 0.64$ ), 3.80 ( $SD\pm 0.58$ ), 3.76 ( $SD\pm 0.65$ ) and 3.75 ( $SD\pm 0.74$ ), respectively (Table 1).

### 3.2 | General characteristics

Participants' mean age was 33.29 years, with those aged 30–39 years comprising the largest proportion (38.9%). Of all participants, 75.6% were staff nurses, 96.9% were female, 53.9% were unmarried, 61.7% had a bachelor's degree, 67.9% were working in Seoul and Gyeonggi-do and 57.0% were working in general wards. They had an average of 10.8 years of nursing experience and 9.3 working hours per day. Further, 15.5% of the participants had an annual income of less than USD 24,000, while 34.7% earned more than USD 40,000.

Three tertiary general and three general hospitals were selected for this study. Tertiary general and general hospitals accounted for 51.8% and 48.2%, respectively. Hospitals with more than 1,000 beds accounted for 52%, and nursing grade 1 hospitals accounted for 51.3%.

About organizational status, the nursing departments of 50% of the hospitals surveyed were directly under the president of the hospital in the organizational chart, with an average of 1,353.2 nurses, ranging from a minimum of 547 in a general hospital to a maximum of 3,000 in a tertiary general hospital. The average numbers of managerial-level nurses, head nurses, nursing managers with a master's degree or higher and team manager-level nurses in other departments were 6.81, 50.45, 37.01 and 4.33, respectively. The average 3-year turnover of nurses in these hospitals was 11.85%, and new nurses whose annual income was less than USD 16,000–24,000 accounted for 33.3%. *Chief nursing officer* was the most commonly used highest nursing managerial job title (66.7%).

### 3.3 | Differences in patient orientation

There were statistically significant differences in patient orientation according to age, marital status, education level, work experience, position, annual income, hospital location, type of establishment and nursing grade. The post hoc analysis revealed that those who perceived higher patient orientation were in their 30s and 40s, had more than 10 years of working experience, belonged to the nurse group in charge, had an annual income of more than KRW 50 million and worked in Seoul/Gyeonggi-do. Additionally, private institutions/special corporations and nursing grade 1 hospitals perceived higher patient orientation than did educational corporations and nursing grade 2 hospitals (Table 2).

Statistically significant differences were found in patient orientation according to the new nurse annual income and highest academic degree of the chief nursing supervisor. Post hoc analysis revealed higher patient orientation among new nurses with an annual income of USD 32,000 or more than among those with an annual income of less than USD 24,000. Similarly, higher patient orientation was

observed in chief nursing supervisors with a bachelor's or master's degree than in those with a diploma (Table 2).

### 3.4 | Factors affecting patient orientation

To examine the effects of the various variables on patient orientation, assumptions of the regression analysis on independent variables were verified. There was no problem of autocorrelation because the Durbin-Watson statistics were close to 2 in the test for the autocorrelation of errors. In the multicollinearity check, the tolerance limit was more than 0.1 and the VIF did not exceed 10, confirming that the predictive variables were independent. The assumptions of linearity, normality and homoscedasticity to meet the residual assumptions were also satisfied. No value of Cook's distance for examining singular values exceeded 1.0, confirming that there was no singular value (Table 3).

The variables showing differences in patient orientation included age, marital status, education level, work experience, position, annual income, location of hospital, type of establishment, nursing grade, new nurse annual income and highest academic degree of the chief nursing supervisor. They were treated as dummy variables and were entered in the regression model with power-related variables. Nursing group power, autonomy and work experience were subsequently identified as variables that had statistically significant effects on patient orientation and explained about 40.7% of the variance in patient orientation (Table 3).

## 4 | DISCUSSION

Nursing group power was most highly perceived in relation to the nursing supervisor's power. Chief nursing supervisors perform their duties in collaboration with executives and professionals in other departments (Viinikainen, Kvist, & Suominen, 2010). They have the power to make decisions on issues related to nursing, such as those related to human resources and budget management (Fradd, 2004; Viinikainen et al., 2010). This explains why nursing group power was most highly perceived by nurses in relation to the supervisor's power.

Nursing group power was lowest in relation to communication competency, with a mean score of 3.51 points. This is similar to the results of a study by Peltomaa et al. (2013), which showed a low level of nursing group power in relation to this subscale. The nursing organizational culture in South Korea uses mainly downward communication to convey instructions or commands in accordance with the organizational hierarchy or chain of command. Therefore, it seems that the decision authority and communication satisfaction items were perceived as relatively low by the nurses.

The mean score for organizational trust was 3.22 points. Most previous studies examined trust in the context of the relationship between nurses and patients (Johns, 1996). We found that nursing group power, organizational trust and work experience had statistically significant effects on patient orientation. As age and education level increase,

**TABLE 2** Differences in patient orientation according to general characteristics (N = 193)

Variables	Categories	n (%)	Mean ± SD	t or F	p	Scheffé test
Gender	Female	185 (95.9)				
	Male	8 (4.1)				
Age (years)			(33.29 ± 7.52)			
	20–29 <sup>a</sup>	73 (37.8)	3.75 ± 0.55	10.464	<.001	b,c > a
	30–39 <sup>b</sup>	75 (38.9)	3.97 ± 0.45			
	≥40 <sup>c</sup>	45 (23.3)	4.19 ± 0.52			
Marital status	Single	104 (53.9)	3.81 ± 0.52	-3.888	<.001	
	Married	89 (46.1)	4.10 ± 0.50			
Education	Diploma	30 (15.5)	3.80 ± 0.64	3.322	.038	
	Bachelor	119 (61.7)	3.91 ± 0.50			
	≥Master	44 (22.8)	4.10 ± 0.50			
Clinical department	General ward	110 (57.0)	3.97 ± 0.52	1.378	.255	
	ICU/OR	62 (32.1)	3.85 ± 0.54			
	OPD	21 (10.9)	4.03 ± 0.54			
Years of nursing experience			(10.82 ± 7.15)			
	<3 <sup>a</sup>	26 (13.5)	3.62 ± 0.65	10.318	<.001	d > a,b,c
	3≤–<5 <sup>b</sup>	27 (14.0)	3.70 ± 0.44			
	5≤–<10 <sup>c</sup>	51 (26.4)	3.89 ± 0.43			
	≥10 <sup>d</sup>	89 (46.1)	4.14 ± 0.49			
Position	Staff Nurse	146 (75.6)	3.87 ± 0.051	-3.070	.002	
	Charge Nurse	47 (24.4)	4.14 ± 0.53			
Annual income (USD)	<24,000 <sup>a</sup>	30 (15.5)	3.63 ± 0.49	7.410	<.001	d > a,b
	24,000–<32,000 <sup>b</sup>	42 (21.8)	3.84 ± 0.58			
	32,000–<40,000 <sup>c</sup>	54 (28.0)	3.95 ± 0.46			
	≥40,000 <sup>d</sup>	67 (34.7)	4.13 ± 0.50			
Location	Metropolitan area	131 (67.9)	4.09 ± 0.47	6.340	<.001	
	Provincial town	62 (32.1)	3.62 ± 0.52			
Hospital type	Tertiary general hospital	100 (51.8)	3.89 ± 0.53	-1.386	.167	
	General hospital	93 (48.2)	4.00 ± 0.53			
Type of establishment	National public <sup>a</sup>	63 (32.6)	3.97 ± 0.59	5.778	.001	a,c,d > b
	School corporation <sup>b</sup>	30 (15.5)	3.59 ± 0.50			
	Private institutions <sup>c</sup>	68 (35.2)	4.00 ± 0.49			
	Special corporation <sup>d</sup>	32 (16.6)	4.08 ± 0.39			
Number of beds			(1,372.80 ± 775.47)			
	<1,000	93 (48.0)	4.00 ± 0.53	1.386	.167	
	≥1,000	100 (52.0)	3.89 ± 0.53			
Nursing grade	1	99 (51.3)	4.10 ± 0.49	4.401	<.001	
	2	94 (48.7)	3.77 ± 0.52			
Working hours			(9.37 ± 1.05)			
	<10	106 (55.0)	3.99 ± 0.51	1.543	.125	
	≥10	87 (45.0)	3.87 ± 0.55			
Turnover rate			(11.85 ± 5.41)			
	<10	132 (68.0)	3.93 ± 0.50	-0.203	.839	
	≥10	61 (32.0)	3.95 ± 0.59			

(Continues)

TABLE 2 (Continued)

Variables	Categories	n (%)	Mean ± SD	t or F	p	Scheffé test
Organizational membership	A hospital's immediate	93 (48.2)	3.88 ± 0.53	-1.643	.102	
	Medical care department	100 (51.8)	4.00 ± 0.53			
Number of nurses	<1,000	93 (48.2)	4.00 ± 0.53	1.386	.167	
	≥1,000	100 (51.8)	3.89 ± 0.53			
Number of nursing team manager-level nurses/managers	<7	93 (48.2)	3.90 ± 0.55	-1.247	.214	
	≥7	100 (51.8)	4.00 ± 0.49			
Number of head nurses	<30	61 (31.6)	3.95 ± 0.59	1.236	.293	
	30 ≤ - <50	64 (33.2)	3.86 ± 0.51			
	≥50	68 (35.2)	4.00 ± 0.49			
Number of nurses with an MS or PhD degree	<40	125 (64.8)	3.90 ± 0.55	-1.247	.214	
	≥40	68 (35.2)	4.00 ± 0.49			
Number of head nurses in different departments	<10	95 (49.2)	4.00 ± 0.53	1.643	.102	
	≥10	98 (50.8)	3.88 ± 0.53			
Annual salary of new nurses (million KRW)	2000 ≤ - <3,000 <sup>a</sup>	62 (32.1)	3.62 ± 0.52	22.837	.001	b, c > a
	3,000 ≤ - <4,000 <sup>b</sup>	63 (32.6)	4.19 ± 0.42			
	≥4,000 <sup>c</sup>	68 (35.2)	4.00 ± 0.49			
Tenure security	Guaranteed	93 (48.2)	4.00 ± 0.53	1.386	.167	
	Not guaranteed	100 (51.8)	3.89 ± 0.53			
Highest degree of the nursing supervisor	Diploma <sup>a</sup>	32 (16.6)	3.64 ± 0.54	11.217	<.001	c > b > a
	Bachelor's <sup>b</sup>	63 (32.6)	4.15 ± 0.51			
	≥Master's <sup>c</sup>	98 (50.8)	3.90 ± 0.49			
Number of nurses in nurse offices	<7	93 (48.2)	4.00 ± 0.53	1.386	.167	
	≥7	100 (51.8)	3.89 ± 0.53			

Note: Number of nurses with an MS or PhD degree = The number of nurses holding a master's degree or higher among nursing managers.

TABLE 3 Factors affecting patient orientation using the stepwise method (N = 193)

Variables	B	SE	β	t	p
(Constant)	2.025	0.197		10.272	<.001
Nursing group power	0.365	0.074	0.397	4.967	<.001
Organizational trust	0.138	0.051	0.214	2.697	.008
Work experience	0.011	0.005	0.145	2.340	.020
F-value		44.930			
p		<.001			
R <sup>2</sup>		0.416			
Adj R <sup>2</sup>		0.407			

work experience accumulates and the ability to solve patients' problems improves through expertise acquisition and skill improvement, thus explaining why patient orientation was high (Lee & Lee, 2012). Nurses in charge had higher patient orientation than did staff nurses because they make efforts to identify and deal with patients' needs due

to their position (Kim, 2011). Married participants had higher patient orientation than did unmarried participants, possibly because they are socio-psychologically more stable and can immerse themselves in nursing work (Lee & Lee, 2012; Yoo et al., 2006).

Positive correlations were found between nursing group power, organizational trust and patient orientation. It is difficult to compare these results with previous studies because there has been little research examining the correlation between nursing group power and patient orientation or between organizational trust and patient orientation. However, Yeo, Lee and Jin's study (2014) of nurses showed a statistically significant positive correlation between organizational commitment and patient orientation, similar to the findings of Kim, Seo, Kim, and Min (2015), showing a positive correlation between positive psychological capital and patient orientation.

Variables that had statistically significant effects on patient orientation included nursing group power, organizational trust and work experience, with an explanatory power of 40.7%. These results also correspond to the findings of Byun and Ko (2013), who reported that organizational trust influenced patient orientation.

Sung et al.'s study (2014) on the validity and reliability of the K-SKAGOAO and the relationship between nursing group power and

position, job satisfaction, organizational commitment and organizational performance reported that the higher the position, the higher the perceived nursing group power and that there were positive correlations between nursing group power, job satisfaction, organizational commitment and organizational performance.

With reference to patient orientation, we draw conclusions similar to the results of a previous study by Lee, Park, and Cho (2015), which revealed that when nurses perceived their organization as community-oriented and when their sense of fellowship increased, positive effects were observed on their patient orientation. To strengthen patient orientation, it is necessary to build a working environment where members can experience positive organizational trust and perceive their organization as community-oriented. This study's results suggest that to enhance the nurses' patient orientation, measures and programmes to increase nursing group power and improve organizational trust in hospitals should be introduced. Additionally, it is important to improve the physical environment of hospitals and ensure that medical institutions channel their interest and investment into human resources that give medical services. Only then can exceptional personnel be recruited and employees with more work experience be retained to give technically competent nursing care, thereby eventually increasing organizational performance.

Specifically, patient orientation was low in the nurses in their 20s; the higher the age, the more clinical experience they have, the higher their patient orientation. Hong's (2011) research also showed that married women were more patient-oriented than unmarried women, supporting the results of this study. Patient orientation was the lowest in the professional academic group with the lowest academic qualification. General nurses were found to be less patient-oriented than nurses in charge. Clinical experience, marriage and wage levels can be interpreted in the same context as age. As the nurse's career progresses, the experience of acquiring expertise, improving technical procedures, the ability to solve customers' problems and the resulting responsibilities are believed to increase the nurse's patient orientation. Therefore, the nursing management department needs a strategy to enhance the patient orientation of nurses by employing highly skilled and experienced nurses (Hong, 2011). Nurses working at provincial-based medical institutions showed lower patient orientation than nurses working in the cities. This could be because the number of medical institutions and nurses in Korea is concentrated in urban areas and the overall support system, such as salary, welfare and working environment, is relatively poor in the provinces compared with large hospitals in the cities. In this study, differences in patient orientation were observed depending on the general ward nursing grade additives; the lower the level of nursing staff, the lower the patient orientation. This again highlights the importance of securing nursing personnel, which could be used as a strategy to enhance the nurse's patient orientation by creating a safer nursing work environment by securing nursing personnel.

To enhance the nurses' perceived nursing group power, nursing department members should participate in decision-making related

to the operations of the department and hospital and hospital policies should reflect the importance of the nursing department, which accounts for the largest proportion of hospital staff, so that it can be recognized internally and externally. Simultaneously, the job title of chief nursing supervisors should be improved to maximize the autonomy of nursing departments. Additionally, because there was a difference in patient orientation according to nurses' annual income level, an in-depth evaluation of the adequacy of nurses' income should be conducted to enhance the quality of nursing services. This study is statistically significant as it empirically demonstrates that though an individual-level approach is important, various strategies for improving nursing group power need to be implemented to improve nursing performance.

Hospital nursing departments are composed of the largest number of personnel among diverse organizational members employed by hospitals, and the knowledge, skills and experience of nurses are a very important asset in that they are the basis of the overall capacity of the organization. However, it is difficult to conclude that the actualized power of nursing departments or nursing group power in hospitals is higher compared with the other departments in hospitals. Therefore, the present study was conducted to examine the correlations between nursing group power as a variable related to power, organizational trust and patient orientation as a nursing organizational performance variable; and to give basic data on the importance of nursing department power and the need for enhancing nursing group power.

The present study indicated the direction where hospitals and nursing departments need improvements to increase the power of nursing departments in hospitals and suggested that although individual nurses' efforts and their capacity development are needed to enhance the power of nursing departments, a variety of active and sustainable efforts at the hospital and nursing organization levels are needed. However, as this study was conducted with nurses working in six tertiary general hospitals and general hospitals in Korea and there is a limit to the generalizability of these results to other hospitals.

## 5 | CONCLUSIONS

This study offers recommendations to improve the power of nursing departments in hospitals. Further, it suggests that although individual nurses' efforts are necessary, a variety of active and sustainable efforts at the hospital and nursing organization levels are needed. This study proposes that standardized instruments to measure the power of nursing departments in hospitals and to lay the foundation for its enhancement should be developed and further studies need to be conducted to highlight the importance of nursing department power in hospitals internally and externally.

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## CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

## AUTHOR CONTRIBUTIONS

SY, YK, SHJ: Study design. SY, YK, SHJ: Data collection. YK: Data analysis. SY: Study supervision. SY, YK, SHJ: Manuscript writing. SY, YK, SHJ: Critical revisions for important intellectual content.

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