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Development of an Organizational Commitment Model Based on Belief on Nurse Performance

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ABSTRACT

Organizational commitment plays an important role in improving nurse performance and client satisfaction. The research objective was to examine the belief-based organizational commitment model as an effort to improve the performance of nurses in the hospital. A quasi-experimental study with pre-posttest design, with a sample of 80 nurses and 120 clients. The independent variable is the application of belief-based organizational commitment and the dependent variable includes nurse performance and client satisfaction. The research instrument used a modified questionnaire and tested the validity (0.665 - 0.987) and reliability (r = 0.312), the data were analyzed using paired t-test. The results showed that there was an effect of job characteristics on nurse characteristics (T = 4.401), confidence (T = 3.621) and organizational commitment (T = 2.231). There is an effect of nurse characteristics on confidence (T = 3.183) and organizational commitment (T = 2.686). There is an effect of job characteristics on nurse characteristics (T = 3.202) and belief (T = 1.977). There is an effect of work experience on beliefs (T = 2.952) and organizational commitment (T = 2,000). There is an effect of belief on organizational commitment (T = 3.408) and perceived threat (T = 14.563). There is an effect of organizational commitment on nurse performance (T = 7,908). There is an effect of perceived threat on nurse performance (T = 3,920). There is an influence of belief-based organizational commitment on nurse performance (p = 0.000). The new findings of this research are formed a belief-based organizational commitment model that involves organizational characteristics, nurse characteristics, job characteristics and work experience. The belief-based organizational commitment model helps improve nurse performance and client satisfaction.

Keywords: Organizational commitment, confidence, nurse performance, satisfaction

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INTRODUCTION

Client satisfaction in the hospital is often found with poor results and is caused by poor nurse performance. Based on the results of research conducted in the UK at 46 hospitals, it shows that patient satisfaction with services is closely related to nurse performance and poor hospital work environment (Aiken *et al*., 2018). Organizational commitment has a positive effect on employee performance by 0.67 (44.89%) (Narimawati, 2007). Nurses are aware of the responsibility of providing quality services to clients, institutions, ethics, law and professional standards, and how their performance contributes to the assessment of health services and client satisfaction (Regis & Porto, 2011). Organizational commitment needs to be built by the organization, both externally and internally, but until now, many hospitals still see that performance improvement activities are only focused on increasing cost requirements, not adding value to building organizational commitment (Coutts & Herzeberger, 2005). According to Meyer, Becker and Dick (2006) the item of organizational commitment model can be modified by specifically touching the dimensions of moral obligation and obligation of reciprocation. Organizational commitment can only be achieved after there is confidence in the organization (Payne & Huffman, 2005). This belief can be related to prosocial behavior in organizations towards clients, so that it can be adopted and integrated by emphasizing the aspects of belief in health according to the Health Belief Model (Glanz, Rimer & Viswanath, 2008). So far, the model of organizational commitment that integrates prosocial belief values, namely the value of belief in health and its effect on nurse performance and client satisfaction has not been developed. Poor working conditions including inadequate staff and high workloads are a major threat to the quality and performance of nurses, resulting in low client satisfaction (Aiken *et al*., 2018). Organizational commitment can only be achieved after there is confidence in the organization (Payne & Huffman, 2005). This belief can be related to prosocial behavior in organizations towards customers, so that it can be adopted and integrated by emphasizing aspects of belief in health according to the Health Belief Model, namely aspects of vulnerability, seriousness, benefits, barriers, self-efficacy and threat aspects in providing nursing care services with the principle altruism nursing (service by paying attention to the welfare of clients without strings attached). The Health Belief Model theory is used as an attempt to evaluate and explain the failure of broad community participation in disease prevention or detection programs and behavioral responses to treatment of clients with acute and chronic diseases (Conner & Norman, 2005). This model is a form of socio-psychological explanation used to predict a person's behavior in maintaining health and describes the efforts of health workers as health service providers in providing health services to the community (Notoatmodjo, 2012). Meyer, Morin and Vandenberghe (2015) state that the latest trend in commitment research is the use of analytical strategies centered on the homogeneity of individuals with different commitment mindsets. An individual-centered approach requires a holistic perspective, reflecting the complex interactions between thought patterns and / or commitment targets (Meyer, Morin & Vandenberghe, 2015). Research that involves or studies organizational commitment and tries to predict single behaviors such as performance can be modified to include performance-related terms (Jaros, 2007). Organizational commitment is influenced by the existence

of a psychological contract between members and their organization (Farnese *et al*., 2018). The psychological contract in question is the belief of each party that there will be a positive feedback process. Based on the explanation above, the researcher is interested in conducting research on nurse performance related to organizational commitment, based on nurses' beliefs about health (5 dimensions of health belief model) with the principle of prosocial behavior (altruism care) in the organization emphasizing service provision in the form of attention to the welfare of clients. selfless to improve nurse performance. Meyer and Allen (1997) stated that organizational commitment which includes affective, continuous, and normative components is emphasized on aspects of belief in an effort to increase work productivity or performance in organizations. Some of the determinants of labor productivity in organizations include organizational characteristics, individual characteristics (nurses), job characteristics, work behavior and subsequently affect organizational effectiveness, namely client satisfaction and nurse satisfaction (Kopelman, 1986; Nursalam, 2018). The dimensions of employee performance appraisal that are of concern to be identified are work quantity, work quality, work knowledge, cooperation, reliability, initiative, employee attitudes (Bernardin, 2014). Client satisfaction can be identified through the quality of services, namely: reliability, assurance, reality, empathy, responsibility (Mohebifar *et al*., 2016; Nursalam, 2018). This study examines several factors that influence nurse performance and client satisfaction which include: organizational characteristics, nurse characteristics, job characteristics, work experience, with an emphasis on aspects of organizational commitment (affective, continuous, normative) based on nurses' beliefs on health which includes perceptions. : vulnerability and seriousness of health problems, benefits and barriers, self-efficacy and perceived threats faced when providing altruism nursing services. The results of the study was development of a belief-based organizational commitment model on the performance of hospital nurses in South Kalimantan Province.

METHODS

This study used a quasy-experimental design with a pre-posttest control group design to compare the effectiveness of the intervention given to the treatment group with the control group. The number of subjects in this study were 60 nurses for each group with the following criteria: 1) Nurses who have worked at least 1 year; 2) Minimum Diploma III education; 3) has the status of a permanent hospital nurse; and 4) Not sick or on leave. Meanwhile, there were 90 patient respondents for each group with the following criteria: 1) Not experiencing mental disorders / mental retardation; 2) At least 3 days in hospital; 3) Can read and write; and 4) Able to communicate using Indonesian / Banjar language. The nurse performance instrument in this study was based on Bernardin & Russel's (2006) theory of JPE (judgment performance evaluation). The instrument in the form of a questionnaire developed from research variables in the form of closed questions with a Likert scale. The questionnaire used in this study includes: The instrument is equipped with five alternative answers, strongly disagree = 1, disagree = 2, neutral = 3, agree = 4, and strongly agree = 5. The data were analyzed using the non-parametric test, namely the Wilcoxon test and Mann Whitney. This manuscript had passed the ethical clearance from Faculty of Nursing, Universitas Airlangga with the number of ethical clearances was 1761-KEPK.

RESULTS

The Respondent Characteristics of Study

The results of this study indicate that the majority of respondents were female (65%), the age of the respondents is in the range of 21-40 years (96.3%). Most of the marital status was married (90%), diploma level education (65%), employment status as contract employees (73.8%), length of work 1-10 years (73.8%), with most of the income <Rp. 1.5 million (37.5%). The results of the chi square analysis showed that there were no differences in respondent characteristics in gender, age, marital status, latest education, and employment status (p> 0.05), but there were differences in length of work and income (p <0.05). In other words, the characteristics of the respondent in the form of length of work and income have the potential to become confounding variables (Table 1).

Table 1. Nursing respondent characteristics in the hospital

Nursing Characteristics			Group		Total	P value
			Intervention	Control		
Gender	Male	f	12	16	28	0.348
		%	30.0%	40.0%	35.0%	
	Female	f	28	24	52	
		%	70.0%	60.0%	65.0%	
Age	21-40 years	f	38	39	77	0.556
		%	95.0%	97.5%	96.3%	
	40-60 years	f	2	1	3	
		%	5.0%	2.5%	3.8%	
Marital Status	Single	f	2	4	6	0.236
		%	5.0%	10.0%	7.5%	
	Married	f	38	34	72	

Nursing Characteristics			Group		Total	P value
			Intervention	Control		
		%	95.0%	85.0%	90.0%	
	Widow/ widower	f	0	2	2	
		%	0.0%	5.0%	2.5%	
Education Background	Diploma	f	24	28	52	0.348
		%	60.0%	70.0%	65.0%	
	Bachelor	f	16	12	28	
		%	40.0%	30.0%	35.0%	
Employee Status	Civil servant	f	7	12	19	0.419
		%	17.5%	30.0%	23.8%	
	Honorary	f	1	1	2	
		%	2.5%	2.5%	2.5%	
	Contract	f	32	27	59	
		%	80.0%	67.5%	73.8%	
Duration of working	1-10 years	f	35	24	59	0.015
		%	87.5%	60.0%	73.8%	
	11-20 years	f	3	14	17	
		%	7.5%	35.0%	21.3%	
	21-30 years	f	2	1	3	
		%	5.0%	2.5%	3.8%	
	>30 years	f	0	1	1	
		%	0.0%	2.5%	1.3%	
Income*	> 5 million	f	6	2	8	0.000
		%	15.0%	5.0%	10.0%	
	3,5 –5 million	f	3	9	12	
		%	7.5%	22.5%	15.0%	
	> 2,5 – 3,5 million	f	5	6	11	
		%	12.5%	15.0%	13.8%	
	1,5 – 2,5 million	f	3	16	19	
		%	7.5%	40.0%	23.8%	
	< 1,5 million	f	23	7	30	
		%	57.5%	17.5%	37.5%	

* The income of the respondents in IDR

Table 2. Patient Characteristics in the hospital

Patient Characteristics		Group				Total	P Value
		(Pretest)		(Posttest)			
		Intervention	Control	Intervention	Control		
Gender							0.084
Male	f	17	8	15	11	51	
	%	56.7%	26.7%	50.0%	36.7%	42.5%	
Female	f	13	22	15	19	69	
	%	43.3%	73.3%	50.0%	63.3%	57.5%	
Age							0.442
<21 years	f	0	1	1	1	3	
	%	0.0%	3.3%	3.3%	3.3%	2.5%	
21-40 years	f	17	10	9	12	48	
	%	56.7%	33.3%	30.0%	40.0%	40.0%	
40-60 years	f	13	19	20	17	69	
	%	43.3%	63.3%	66.7%	56.7%	57.5%	

Patient Characteristics		Group				Total	P Value
		(Pretest)		(Posttest)			
		Intervention	Control	Intervention	Control		
Marital Status							0.960
Single	f	4	2	2	2	10	
	%	13.3%	6.7%	6.7%	6.7%	8.3%	
Married	f	22	24	24	23	93	
	%	73.3%	80.0%	80.0%	76.7%	77.5%	
Widow/ widower	f	4	4	4	5	17	
	%	13.3%	13.3%	13.3%	16.7%	14.2%	
Educational Background							0.696
No Education	f	0	1	0	0	1	
	%	0.0%	3.3%	0.0%	0.0%	0.8%	
Elementary school	f	4	8	9	10	31	
	%	13.3%	26.7%	30.0%	33.3%	25.8%	
Junior high school	f	9	9	9	7	34	
	%	30.0%	30.0%	30.0%	23.3%	28.3%	
Senior high school	f	12	8	9	6	35	
	%	40.0%	26.7%	30.0%	20.0%	29.2%	
Diploma	f	1	1	2	2	6	
	%	3.3%	3.3%	6.7%	6.7%	5.0%	
Bachelor	f	3	3	1	5	12	
	%	10.0%	10.0%	3.3%	16.7%	10.0%	
master	f	1	0	0	0	1	
	%	3.3%	0.0%	0.0%	0.0%	0.8%	
Occupation							0.111
Civil servant	f	2	8	5	5	20	
	%	6.7%	26.7%	16.7%	16.7%	16.7%	
Privat sector	f	21	10	11	17	59	
	%	70.0%	33.3%	36.7%	56.7%	49.2%	
Entrepreneur	f	1	6	6	3	16	
	%	3.3%	20.0%	20.0%	10.0%	13.3%	
Farmer/ fisher	f	6	6	8	5	25	
	%	20.0%	20.0%	26.7%	16.7%	20.8%	
Source of fund							0.795
Assurance	f	29	29	29	30	117	
	%	96.7%	96.7%	96.7%	100.0%	97.5%	
Independent	f	1	1	1	0	3	
	%	3.3%	3.3%	3.3%	0.0%	2.5%	

Table 3. Distribution of Nurse Performance, Result of Normality Test and Homogeneity of Research Data

Variable		Group	Mean ± SD	Normality test	Homogeneity Test	
					Levene's test	Sig.
Quantity	*Pre*	Intervention	3,175 ± 0,564	0,000	0,197	0,659
		Control	3,000 ± 0,534	0,000		
	Post	Intervention	3,383 ± 0,531	0,000	6,897	0,010
		Control	3,092 ± 0,433	0,000		
Quality	*Pre*	Intervention	3,283 ± 0,509	0,000	0,129	0,720
		Control	3,142 ± 0,511	0,000		
	Post	Intervention	3,499 ± 0,413	0,000	0,115	0,735
		Control	3,191 ± 0,482	0,000		
Knowledge	*Pre*	Intervention	3,417 ± 0,475	0,000	0,557	0,458
		Control	3,300 ± 0,459	0,000		
	Post	Intervention	3,608 ± 0,406	0,000	2,944	0,090
		Control	3,226 ± 0,497	0,000		
Teamwork	*Pre*	Intervention	3,441 ± 0,566	0,000	0,956	0,331
		Control	3,334 ± 0,511	0,005		
	Post	Intervention	3,692 ± 0,380	0,000	0,675	0,414
		Control	3,283 ± 0,396	0,000		
Reliable	*Pre*	Intervention	3,416 ± 0,532	0,000	3,129	0,081
		Control	3,317 ± 0,439	0,000		
	Post	Intervention	3,708 ± 0,371	0,000	3,041	0,085
		Control	3,299 ± 0,500	0,003		
Initiative	*Pre*	Intervention	3,408 ± 0,606	0,000	4,194	0,030
		Control	3,250 ± 0,469	0,019		

Variable		Group	Mean ± SD	Normality test	Homogeneity Test	
					Levene's test	Sig.
	Post	Intervention	3,566 ± 0,435	0,000	0,192	0,663
		Control	3,333 ± 0,477	0,002		
Attitude	*Pre*	Intervention	3,550 ± 0,468	0,000	0,038	0,845
		Control	3,391 ± 0,516	0,000		
	Post	Intervention	3,758 ± 0,377	0,000	17,392	0,000
		Control	3,417 ± 0,526	0,000		
Performance	*Pre*	Intervention	3,384 ± 0,379	0,026	1,838	0,179
		Control	3,248 ±0,328	0,004		
	Post	Intervention	3,602 ± 0,290	0,057	0,590	0,445
		Control	3,263 ± 0,355	0,109		

Table 4 Results of the Nurse Performance Pretest Difference in the Treatment and Control Groups

Parameter	*Before Intervention*		*After Intervention*	
	Test Statistics	*Sig.*	*Test Statistics*	*Sig.*
Quantity	-1,783	0,075	-2,377	0,017
Quality	-1,171	0,242	-2,939	0,003
Knowledge	-1,124	0,261	-3,528	0,000
Team Work	-1,202	0,229	-4,191	0,000
Reliable	-1,089	0,276	-3,708	0,000
Initiative	-1,593	0,111	-2,167	0,030
Attitude	-1,311	0,190	-3,095	0,002
Performance	-1,423	0,155	-4,386	0,000

Table 5: Results of the Pretest and Posttest Differences in Nurse Performance in the Control and Intervention Groups

Parameter	Control		Intervention	
	Test Statistics	*Sig.*	*Test Statistics*	*Sig.*
Quantity	-1,783	0,198	-2,377	0,000
Quality	-1,171	0,871	-2,939	0,012
Knowledge	-1,124	0,478	-3,528	0,001
Team Work	-1,202	0,464	-4,191	0,001
Reliable	-1,089	0,779	-3,708	0,000
Initiative	-1,593	0,460	-2,167	0,007
Attitude	-1,311	0,724	-3,095	0,006
Performance	-1,423	0,883	-4,386	0,000

The results of this study (Table 2) indicate that the majority of respondents were female (57.5%). Most of the respondents were 40-60 years old (57.5%). The majority of respondents' marital status was married (77.5%). Most of the respondents' last education was at the high school level (29.2%) and the majority worked as private employees (49.2%). Almost all respondents used the BPJS health insurance (97.5%). The results of the chi square test show that all variables had a p value> 0.05, indicating that there was no difference in the characteristics of the respondents in gender, age, marital status, latest education, employment status and source of costs. In other words, respondents in both groups had the same initial characteristics, so that the characteristics of respondents in the form of gender, age, marital status, latest education, employment status and source of costs do not have the potential to be confounding variables.

Nursing Performance

The pretest performance of the treatment group was higher than that of the control group, but the difference was not significant. The posttest performance of the treatment group was higher than that of the control group and there was a significant difference. The results of the normality test showed that the pretest data on the performance of nurses in the treatment and control groups were not normally distributed, while the post-test data were normally distributed. The t test analysis can be done for the performance variables at the time of the posttest, while the dimension testing on the performance variables of the treatment group both pretest and posttest uses a nonparametric test (Table 3).

Differences in the performance of nurses before and after intervention in the control group

The table 5 shows that there was no significant difference in the performance of inpatient nurses at the Pembalah Batung Regional Hospital during the pretest and posttest in the control group (p = 0.883). Meanwhile, the treatment group showed a significant difference in the performance of nurses in the Batung Pembalah Hospital before and after being given a training model on organizational commitment based on belief (p = 0.000).

DISCUSSION

The organizational commitment based on belief affects nurse performance. This is supported by previous research which states that belief-based educational interventions (Health Belief Model) improve the performance of nursing staff (Zeigheimat *et al*., 2016). Performance is all behavior related to organizational goals, which can be measured according to individual contributions to organizational goals (LePine *et al*., 2016). Organizational commitment results in increased effort, motivation, job satisfaction, lower levels of absenteeism from work and increased retention in the organization (Shirzad *et al*., 2012; Naghneh *et al*., 2017). Organizational commitment can lead to a sense of satisfaction, ownership, affiliation and employee attachment to the organization, better work performance, and financial success, and can increase organizational effectiveness and efficiency (Bagheri and Tavalaei, 2010). Organizational commitment based on belief has a significant effect on the quantity of work. The quantity of work is the amount of work done in a specified time period (Nursalam, 2018). Working in today's complex health care environment, nurses must provide efficient and effective care. Multitasking is the nature of a nurse's job. To understand multitasking, examining the context of patient care is essential (de Ruiter and Demma, 2011). Measuring multitasking enables health care organizations to increase the efficiency, quality and safety, workflow, and job satisfaction of doctors (Bastian, Munoz and Ventura, 2016). The concept of multitasking is often confused with task shifting, which involves frequent and rapid changes between two tasks (Draheim, Hicks and Engle, 2016). Organizational commitment based on belief affects the quality of work. Quality of work is the quality of work that is achieved based on the requirements for its suitability and achievement (Nursalam, 2018). Many views quality health care as the main umbrella on which patient safety lies. Harteloh (2003) defines quality as the optimal balance between realized possibilities and a framework of norms and values. This conceptual definition reflects the fact that quality is an abstraction and does not exist as a discrete entity. Rather, it is built on the basis of interactions among related actors who agree on standards (norms and values) and components (possibilities). Quality in health is defined as the degree to which health care for individuals and populations increases the likelihood of desired health outcomes and is consistent with current professional knowledge. This leads to a definition of quality which appears to be a list of qualities. indicator, which is an expression of the standard. In nursing, standards can be in the form of implementing Nursing Care Standards (SAK). In providing good nursing care, namely having to meet professional standards that have also been set, this nursing care service is also used appropriately, efficiently, and effectively, also safe for patients and nurses as service providers, satisfying for patients and nursing personnel, social, economic, cultural, religious, ethical and community values are considered and respected to assess the quality of nursing services, a standard nursing practice is required (Nursalam, 2018). Organizational commitment based on belief affects performance in aspects of work knowledge. Job knowledge is the breadth of knowledge about work and skills (Nursalam, 2018). Work knowledge is an important factor for performance. The key to determining the quality of nursing performance is defined as the ability and skills to properly apply domain-specific knowledge in a variety of situations. Job-based competencies can be categorized into three groups: competencies as (i) a list of tasks, (ii) a collection of attributes, and (iii) a holistic or integrated relationship. Work knowledge means "how to apply skills and knowledge in various task situations", and "how to acquire the missing competencies". This competency level assessment is associated with job performance (Guerrero & De los Ríos, 2012). Organizational commitment based on belief affects cooperation. Cooperation is an aspect of contextual performance that indirectly helps in completing tasks (Wu *et al*., 2020). Organizational commitment based on belief affects nurse performance in a reliable aspect. Dependability is awareness and can be trusted in terms of attendance and job adjustments (Nursalam, 2018). Reliability is the ability to provide services as promised, reliable and consistent. Can be relied on to demonstrate responsible behavior related to work. This relates to the extent to which employees can be relied on to complete tasks, time, and high quality. Reliability remains an important aspect of employee performance (Fauth, Bevan & Mills, 2009). Faith-based organizational commitment affects the nurse's initiative. Initiative is a spirit to carry out new tasks and enlarge their responsibilities (Nursalam, 2018). Nurses must have an attitude of initiative, both initiatives in nursing care and initiatives in increasing competence. Faith-based organizational commitment affects attitudes. Attitudes (personal quality) regarding personality, leadership, hospitality and personal integrity (Nursalam, 2018). Attitude is an evaluative tendency to like or dislike, or to act favorably or unfavorably towards someone or something, which may have an impact on the way someone behaves towards that person or object (Greenwald & Krieger, 2006). The attitude that the nurse holds towards the patient and their poor health condition greatly determines the quality and level of emotional, physical and psychological assistance the patient receives from the nurse. Nurses must have a positive character related to the nursing service (nursing care) performed. A positive attitude towards nursing care is related to job satisfaction. Job dissatisfaction causes nurses to have negative attitudes towards their work, which negatively affects the quality of care they provide (Melo, Barbosa & Souza, 2011; Nyirenda & Mukwato, 2016). Nurses' positive attitudes towards nursing care can occur because of the perceived core values inherent in the nursing action profession as a resource that helps nurses achieve moral competence and adherence to the values associated with their intrinsic work, and this can enable nurses to enjoy their jobs and become more satisfied, despite challenges, such as limited resources, high workloads, and low salaries (Ravari *et al*., 2013; Usher *et al*., 2013; Msiska, Smith & Fawcett, 2014). Nurse leaders and senior nurses can take a role and need to be aware of fostering new nurses into the profession to increase positive attitudes (Nyirenda & Mukwato, 2016). Nurse performance will increase if it is influenced by organizational commitment based on belief with the dimension of belief that includes

nurses having the perception that nursing services are provided to overcome vulnerability and seriousness by considering competence, SOP rules, workload, monitoring and evaluation, availability of facilities and infrastructure. Nurses must have the perception that the nursing services provided are beneficial to clients with an orientation to recovery, client safety, treatment effectiveness, and satisfaction. Nurses have perceptions and are able to overcome obstacles in the form of implementing SOPs, workloads, variations in disease and nursing actions. Nurses have good self-efficacy in the aspects of competence, motivation, coordination, and altruism. All of these things contribute to the formation of organizational commitment and support the performance aspects of nurses in providing professional nursing services.

CONCLUSION

The belief-based organizational commitment model affects nurse performance and client satisfaction with the nursing services received. Nurses' performance improved in terms of quantity, quality, work knowledge, cooperation, reliability, initiative and attitude.

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