American nurses' work autonomy on patient care and unit operations

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Abstract

Work autonomy is an essential aspect of nurses' professional lives. The aim of this research was to study American nurses' work autonomy and, in particular, autonomy over patient care and unit operations decisions. Data were collected electronically during July of 2004. A total of 300 American nurses were recruited from two clinical listserves in which nurses communicate electronically as a group. Nurses were more autonomous about decisions relating to patient care than unit operations, and their total work autonomy was moderate. Correlations and stepwise regression analyses revealed that nurses' experience, education, and time commitments influenced their work autonomy. Findings suggest that nurses' work autonomy should be enhanced to reach its full potential and that nurse administrators should promote their nurses' work autonomy.

Key words: Autonomy: nurse • Research methods • Management: theory

In the current American healthcare system, there are many challenges that influence nurses' autonomy. Nurses feel that the rules and regulations of hospitals and healthcare organizations affect their work autonomy, especially in the light of the dramatically changing American healthcare environment (Fletcher, 2001; Twaddle, 2002). Nurses feel they do not have freedom to practice because of numerous policies set by hospital administrators, who are usually physicians (Carmel et al, 1988; Budge et al, 2003). Such policies include, but are not limited to, promotion, educational advancement, scheduling and autonomy over nursing practice. Nurses' limited autonomy is related to hiring nurses without considering their varied levels of education. Nurses' employment positions should be differentiated according to nurses' educational levels (Bellack and Loquist, 1999).

Theories of autonomy

There are many theories that explain the concept of autonomy, such as Kanter's theory, which states that, in our daily lives, autonomy is the freedom to act. Kanter (1977, 1993) developed the theory of structural power in organizations and argued that work behaviours and attitudes are shaped in response to an individual's position and personal characteristics. Kanter considers power as a structural determinant that influences organizational behaviours and attitudes.

Power is linked to one's position in the organization and Kanter assumed that there are two types of power:

- Formal power: evolves from having a job that affords flexibility, visibility and is relevant to key organizational processes
- Informal power: is determined by the extent of an individual's networks and alliances within and outside of the organization.

Nurse executives have been striving for the means to equalize the power bases in healthcare settings (Keenan, 1999). Nurse managers should empower their nurses to promote nurses' autonomy, and nurses themselves need both the formal and informal power to be autonomous.

The theory of self-efficacy was used to clarify the concept of nurses' autonomy. In healthcare systems, self-efficacy can be defined as 'the belief that one can carry out a decision to achieve a desired goal' (Clark and Dodge, 1999, p72). In the author's study, self-efficacy is a function of education and experience that could contribute positively to nurses' autonomous decisions about patient care and unit operations.

Significance and purpose of the study

Nurses' work autonomy in acute care settings has been associated with job satisfaction (Carmel et al, 1988; Fletcher, 2001). Therefore, further investigation of nurses' perceptions of work autonomy is useful in identifying aspects of daily practice for which nurses have limited autonomy. Variables that limit nurses' autonomy, and influence nurses' outcomes, such as job satisfaction, require modification. Increased job satisfaction of nurses may lead to reduced burnout and improved retention, thereby contributing to lower nursing shortages (Nursing World, 2001).

In the literature, there are a limited number of studies that link nurses' work autonomy to nurse demographics (Williams and McGowan, 1995; Facteau and Nelson, 2000; Hooi et al, 2000; Shaver, 2000; Halpern et al, 2001). In this study, the effects of the following variables on nurses' work autonomy were assessed: gender, marital status, shift worked, time commitment, education, age, years of experience in nursing, and years of experience in the current area of work.

This research aimed to answer the following questions:

- What decisions do nurses perceive they have over patient care?
- What decisions do nurses perceive they have over unit operations?
- What are the relationships between nurses' work autonomy and their autonomy over patient care decisions and unit operation decisions?
- What are the relationships between nurses' demographics and nurses' work autonomy?
- What are the predictors of nurses' work autonomy?

Literature review

Autonomy is a complex mental formulation of experience (Chinn and Kramer, 1995). The concept of autonomy ranges from a measurable concept to an abstract; thus it is complex to define and measure. As a result, a working definition of the concept of autonomy is elusive and the concept is poorly understood (Keenan, 1999).
In nursing, work autonomy consists of making unconstrained decisions and being able to act on these decisions. However, little is known about the attributes of nurses’ autonomy at work (Wade, 2004). Also, at present, autonomy is not clearly identified in the nursing profession (McParland et al, 2000).

Concept of autonomy
The definition of autonomy is the freedom to determine one’s own actions. Moreover, autonomy is the freedom and capacity to make choices (Keenan, 1999). In the medical profession, autonomy is viewed as the professionals’ directions of their own work, which is not subject to direction and evaluation by other health professionals (Kenny and Adamson, 1992). Self-determination of a professional group is viewed as professional autonomy, and for an occupational group is organizational autonomy. In this study, the term ‘work autonomy’ was defined as the freedom of nurses to decide about patient care and unit operations decisions (Blegen et al, 1993).

Measurement of autonomy
Measurement of autonomy provides the researchers and clinicians with clear phenomena, such as the quality of patient care (Walker and Avant, 1988). In this regard, structural autonomy was outlined in job descriptions that outline the job requirements and duties of employees, which set boundaries or limits to discretionary decision-making (Johns, 1995). The definitions of autonomy are subjective, therefore, only observable attributes of autonomy were measured, i.e. aspects of behaviour which indicated the existence of autonomy (Keenan, 1999). For example, Bouhain (1995) revised an instrument for measuring autonomy-related attitudes and behaviours. However, because the characteristics of autonomy were atidimensional, autonomy was difficult to measure. Researchers should measure autonomy related to autonomy through true empirical evidence (Keenan, 1999). Instruments designed to measure nurses’ autonomy included Pankratz and Pankratz’s (1974) Nursing Attitude Scale (PNS), the Nursing Activity Scale (NAS) (Schatzenhofer, 1987), and Autonomy, the Caring Perspective (ACP) instrument (Boughin, 1995).

In the literature review, various studies reported that nurses desired better working conditions that promoted their job satisfaction, and supportive work environments that enhanced their autonomy (Ballou, 1998; Nietsche and Backes, 2000; Chaboyer et al, 2001; Varjus et al, 2003).

The essential components of professional nursing are accountability, autonomy, communication and authority (Alexander et al, 1998; Kopp, 2001). Ballou (1998) reported two themes to explain the concept of autonomy: the ability to make decisions, and the capacity for self-control while making those decisions. However, people who are autonomous may not like to be accountable, or ‘authoritarian’, a term used to describe a form of authority in which the ruling powers are not accountable to anyone else. Such a trend in the nursing profession is harmful since lack of accountability may negatively affect nurses’ outcomes.

Global autonomy: Worldwide, nursing is striving to be an occupation that deserves the title of ‘profession’ (Wade, 2004). This will not happen until nurses achieve their autonomy at work (Smith and Friedland, 1998; Wade, 1999). Nursing is facing various challenges that include: the nursing shortage, decline in the enrolment of students into the nursing programmes, an ageing workforce (American Association of Colleges of Nursing, 2001), and changes in healthcare systems such as downsizing and restructuring (Twaddle, 2002). These changes have been driven by an ideology of efficiency, focus on competition, reduction in benefits and a focus on cost containment (Twaddle, 2002). All of these factors may limit nurses’ ability to decide autonomously on patient care and unit operations.

Evidence of autonomous, empowered behaviour among nursing personnel at all levels, is one of the main factors in the current healthcare arena (Kramer and Schmalenberg, 1993). Empowering nurses may increase their job satisfaction and improve patient care (Morrison et al, 1997). Empowerment was defined as the interpersonal process of providing the proper resources and environment to develop and increase the ability and effectiveness of others to set and reach their individual and social goals (Hawks, 1992).

In the US: Autonomy, control and nurse–physician relations have been linked to staff retention, level of staff burnout, needlestick injuries and patients’ outcomes (McClure et al, 1983; Fagin, 2001; Budge et al, 2003). It is expected that when nurses have autonomy, they may have control over their practice environments (Wade, 1999), and may have better relations with physicians (McParland et al, 2000; Snelgrove and Hughes, 2000), which may result in higher nurses’ job satisfaction (Fletcher, 2001) and improved patients’ outcomes (Wade, 1999), as evidenced by increased satisfaction and decreased mortality (Weisman and Nathanson, 1985; Aiken et al, 1998; Aiken and Patrician, 2000; American Nurses Credentialing Center, 2003). Aiken et al (2001) reported that nurses’ job dissatisfaction and intent to leave are escalating. In light of the current nursing shortage, decision makers have to provide incentives for hospitals to be mechanisms, hospitals well known for their positive nurses and patients’ outcomes (Nursing World, 2001).

In the UK: There are rapid changes in many aspects of the nursing profession and changing boundaries of work between doctors (with paternalism behaviour) and nurses (nurturing feminized profession), as well as restrictive governmental rules (hiring ‘authoritarian’ matrons) (Buchan and Edwards, 2000). Fulton (1997) reported that British nurses showed signs of being oppressed and striving for liberation, thus empowerment is warranted. Although it is not indicative to all matrons, that position is seen to limit nurses’ autonomy (Hewison, 2001).

British nurses were dissatisfied with many aspects of their work environment and with their professional status (Adamson et al, 1998). The researchers reported that British nurses perceived the medical profession to be more authoritarian, which resulted in low nurses’ autonomy. In exit interviews, nurses verbalized their workplace dissatisfaction resulting from doctors’ domination in healthcare delivery. To overcome the view of nurses as nurturers, the status of the nursing profession will not increase unless nurses are trained and their educational levels advanced. Beyond these, nurses have to move fast to establish and maintain their autonomous status (Bousfield, 1997). Nurses feel they do not have enough authority to change patient procedures (Parahoo, 2000), which may apply for decisions related to units or wards where nurses work. However, the priority of the current nursing workforce is to improve clinical effectiveness. This is a major challenge facing nurses working in the UK, and requires a coordinated approach to promote the autonomy of nurses (Gerrish and Clayton, 1998). This means that policy makers, administrators and nurses need to work as a team while making decisions.

In the UK, Snelgrove and Hughes (2000) reported that nurses were generally reluctant to challenge doctors’ authority. However, some nurses used the notion of patients’ advocacy to justify their questioning of particular
nurses and saw these nurses as the grotip who decisions. British doctors valued experienced nurses and saw advanced nursing qualifications as the most important requirement for the expansion of their roles.

Influence over autonomy
Nurses who are educated and enrolled in professional development programmes have better attitudes toward professional autonomy than nurses who did not enroll (Kikuchi and Harada, 1997). Nurses who had university-based undergraduate courses express professional autonomy better than nurses who had hospital-based training (Williams and McGowan, 1995). It was reported that university education and training have been associated with high autonomy (Facteau and Nelson, 2000; Shaver, 2000; Halpern et al, 2001). Nurses' autonomy is increased in accordance with nurses' position and years of experience (Papathanassoglou et al, 2005). Moreover, experienced nurses have stronger attitudes toward professionalism (Hooi et al, 2000; Papathanassoglou et al, 2005). Further, experienced nurses act more with professionalism and authority, and in turn are expected to be more autonomous in their work (Blanchfield, 1992).

The literature review confirms the importance of autonomy in nursing. However, the literature about nurses’ work autonomy was scarce. In general, work autonomy of nurses leads to positive outcomes for nurses, patients and healthcare organizations.

Method
Sample and data collection
An electronic survey method was used to collect the data over 1 week during July 2004. The electronic questionnaire was sent to American nurses via their e-mails which were collected from listserves to which the researcher herself subscribed, after getting permission from the listserves' directors to participate in the list. However, the sample of the current study was recruited from two clinical listserves, which were selected based on the large number of nurses who were subscribed to those lists.

The author assumes that autonomy increases with experience, thus the eligibility criterion was set as ‘the nurse had worked in a hospital for at least 1 year within the last 3 years’. The total number of possible participants was 950; however, only 300 nurses answered the questionnaire. The response rate was 32%, which is acceptable for electronic data collection method (Sheehan and McMillan, 1999).

In the invitation letter, the following statement was directed to the nurses: ‘answering and returning the electronic questionnaire is your consent to participate in the study.

Ethical approval
The invitation letter sent to each participant included the purpose and the benefits of the study after getting the Institute Review Board approval to conduct the study. Participation in the study was voluntary. The researcher only dealt with the data file, thus confidentiality was maintained. Anonymity was ensured so that participants’ responses to the electronic questionnaire were returned without an e-mail address and the data were imported directly into a database file that was created using Microsoft Access software.

Instrument
The original scale of Blegen et al (1993) was used to in this study to measure nurses’ work autonomy. The scale is a Likert scale with responses ranging from 1 to 5 as follows:
1. Nurses have no authority nor accountability
2. Nurses assume authority and accountability when asked
3. Nurses share authority and accountability with others
4. Nurses consult with others and participate in group decisions
5. Nurses have full independent authority and accountability.

The questionnaire is a self-reported tool that consisted of 42 items; 21 items related to patient care and 21 items related to unit operations. Examples of decisions that promoted nurses’ autonomy about patient care include: define patient care provision; enhance staff collaboration; encourage staff nurses to handle patient and physician complaints; and allow nurses to decide on diagnosis and discharge-related issues. Decisions about unit operations include: encourage staff nurses’ arrangement of their work; foster staff nurse planning to deliver high quality care; encourage staff nurses to develop and revise patient care procedures; and allow staff nurses to manage unit resources.

In a study by Blegen et al (1993), the tool was reported to have good psychometric properties. In Blegen et al’s study, a Cronbach’s alpha of 0.78 for the patient care decisions subscale and 0.92 for the unit operations subscale were obtained. The content validity of the entire scale was determined through the expert panel. In the current study, a Cronbach’s alpha of 0.88 for the patient care decisions subscale and 0.94 for the unit operations subscale were obtained.

Part two of the questionnaire addressed the demographic variables of nurses including gender, marital status, shift worked, time commitment, education, age, years of experience in nursing, and years of experience in the current area of work.

Data analysis
Data were analyzed at alpha 0.05 using the Statistical Package for the Social Sciences (SPSS, 2001). A number of data analysis procedures were used including means, standard deviations, correlations and stepwise regression analyses (Burns and Grove, 2001). Stepwise regression was used to isolate predictor variables to estimate the relationship between the dependent and the independent variables (Burns and Grove, 2001). In the stepwise regression model, the independent variables were nurses’ demographics, while the dependent variable was nurses total work autonomy.

Findings
Sample profile
Almost 86% of nurses were female, married (70.1%), employed on a full-time basis (78.5%), and worked the day shift (50.2%). The average age of nurses was 42.5 years old. A baccalaureate degree was the highest degree held (42.7%). Nurses had 10 years or more experience in nursing (79.2%), and had 10 years or more experience in their current area of work (55.2%). About 21% of nurses worked in intensive care units, 15% in operating rooms and 20% in emergency rooms. The remaining 44% of nurses were working in medical and surgical wards.

American nurses’ work autonomy
An average score for each subscale (patient care and unit operations) was established by adding the scores on all items in the subscales and then dividing by the total number of items in that subscale. The whole sample mean of total autonomy was 3.76; 3.87 for patient care decisions autonomy and 2.65 for unit operations decisions. These results indicated that nurses perceived their total work autonomy as moderate and nurses reported that they have more autonomy over patient care decisions than over unit operations decisions.

To answer the first research question, the reported means of patient care decisions were
arranged in descending order. Nurses reported that they were autonomous in serving as patient advocates, questioning physician orders, teaching patients about medications, consulting with MDs and other professionals, and preventing skin breakdown. On the other hand, nurses had low autonomy in informing patients of surgery risks, ordering diagnostic tests, and determining the day of discharge (Table 1).

To answer the second research question, the reported means of unit operation decisions were arranged in descending order. Nurses were autonomous in arranging for trading hours, deciding their own break and lunch times, making patient assignments, serving on department committees and presenting the unit in-service. Nurses had low autonomy in interviewing and selecting new staff, identifying causes for unit budget variance and planning the yearly unit budget (Table 2).

To answer the third and fourth research questions, correlations were performed. There were significant and positive correlations between nurses' work autonomy and autonomy in patient care decisions ($r=0.62$); and autonomy in unit operation decisions ($r=0.45$). Correlation of nurses' demographics (gender, marital status, shift worked, time commitment, education, age, years of experience in nursing and years of experience in the current area of work) with the total score of nurses' work autonomy yielded that education ($r=0.54$) and experience ($r=0.48$) tended to influence nurses' work autonomy.

To answer the fifth research question, stepwise regression analyses were performed for all variables of nurses' demographics on nurses' work autonomy. The total amount of variance of total autonomy that was explained was $26\%$ which was related to the effect of nurses' experience in nursing and area of work, nursing education, and time commitment (Table 3).

**Discussion**

In the current sample, American nurses' work autonomy was moderate. The moderate autonomy of nurses in the present study could be explained by the presence of frequent escalating changes in healthcare arena which limit nurses' autonomy over patient care and unit operations.

Nurses reported that they have more autonomy in making patient care decisions than unit operation decisions. This finding is consistent with the results of other studies (Cook et al, 2001; Kairirlsh and Anthony, 2001; Varjus et al, 2003). Nurses reported that their total work autonomy was moderate and that they were autonomous, with limits, in many patient care decisions and some unit operation decisions. Nurses who lack control over their own work may feel frustrated and dissatisfied (Nietsche and Backes, 2000; Chaboyer et al, 2001; Varjus et al, 2003).

Nurses reported to have low autonomy about some patient care decisions. Taking into consideration the legal scope of nursing practice, nurses should be given more autonomy on patient discharge-related issues, as early discharge is costly and could result in

| Table 1. Means and standard deviations of autonomous patient care decisions subscale |
|-----------------------------------------------|-------|-------|
| Patient care decisions                        | Mean  | Standard deviation |
| Serve as patient advocate                     | 4.65  | 1.02  |
| Question physician orders                     | 4.48  | 1.08  |
| Teach patient about medications               | 4.42  | 1.10  |
| Consult with physician and other professionals| 4.38  | 1.09  |
| Prevent skin breakdown                        | 4.35  | 1.06  |
| Teach self-care activities                    | 4.31  | 1.15  |
| Discuss alternatives with physician           | 4.28  | 1.14  |
| Prevent patient falls                         | 4.24  | 1.10  |
| Teach healthcare promotion activities         | 4.20  | 1.15  |
| Refuse to carry out physician's orders        | 4.13  | 1.08  |
| Decide time to administer care                | 4.12  | 1.22  |
| Plan care with patient                        | 4.05  | 1.29  |
| Advance RN (as needed) drug orders            | 3.95  | 1.32  |
| Refer to other healthcare professionals       | 3.78  | 1.21  |
| Make decision for pain management             | 3.75  | 1.25  |
| Handle individual patient complaints          | 3.50  | 1.19  |
| Develop patient education material            | 3.22  | 1.25  |
| Handle physician complaints                   | 3.18  | 1.34  |
| Inform patient of surgery risks               | 2.95  | 1.52  |
| Order diagnostic tests                        | 2.82  | 1.39  |
| Determine day of discharge                    | 2.52  | 1.25  |

| Table 2. Means and standard deviations of autonomous unit operations decisions subscale |
|-----------------------------------------------|-------|-------|
| Unit operations decisions                     | Mean  | Standard deviation |
| Arrange for trading hours                     | 3.59  | 1.35  |
| Decide own break and lunch time               | 3.51  | 1.39  |
| Make patient assignments                      | 3.53  | 1.25  |
| Serve on department committee                 | 3.32  | 1.53  |
| Present unit in-service                       | 3.21  | 1.35  |
| Determine delivery of care method             | 3.09  | 1.25  |
| Implement new ideas                           | 3.01  | 1.36  |
| Schedule own hours                            | 2.95  | 1.34  |
| Develop unit goals                            | 2.75  | 1.22  |
| Develop and revise unit procedures            | 2.62  | 1.11  |
| Develop and revise standards of care          | 2.52  | 1.09  |
| Develop and revise unit policies              | 2.49  | 1.32  |
| Initiate research activities                  | 2.45  | 1.39  |
| Determine quality assurance indicators         | 2.38  | 1.52  |
| Choose new equipment and supplies             | 2.35  | 1.24  |
| Determine staff meeting agendas               | 2.32  | 1.32  |
| Develop peer review evaluation                | 2.15  | 1.29  |
| Staff nurse job description                   | 2.11  | 1.26  |
| Interview and select new staff                | 1.85  | 1.11  |
| Identify causes for unit budget variance      | 1.82  | 1.11  |
| Plan yearly unit budget                       | 1.75  | 1.06  |
more complications (Aiken et al., 2001). Of unit operations, nurses should be more involved in planning the capital expenditures as people tend to be committed to the decisions that they take part in.

Experience and education were found to correlate positively with nurses' work autonomy. Research has shown that education is a significant personal factor that influences nurses' perceived autonomy (Ferguson-Pare, 1996; Papathanassoglou et al., 2005). Experience that is gained over time is directly related to nurses' work autonomy (Smith and Friedland, 1998). Nurse administrators should build on their nurses' education and experience as these nurses are expected to have more professionalism than their counterparts (Blanchfield, 1992; Kikuchi and Harada, 1997; Hooi et al., 2000). Administrations must retain and reward their experienced employees as their levels of autonomy expand with experience. In the current study, full-time nurses were reported to be more autonomous as nurses with more full-time work encourages nurses to have more continuity of care with their patients and they have more up-to-date information about their patients' conditions. Time commitment is used as a predictor of professional autonomy (Painter and Akroyd, 1998).

Organizations could implement shared governance and a participative management style to enhance nurses' work autonomy and expand the roles and responsibilities of nurses (Hess, 1993; Specht, 1996; Porter-O'Grady, 2004). Further studies are needed to research the influence of organizational characteristics on nurses' work autonomy. Also, work environment should be linked to nurses' autonomy in further research.

Empowerment promotes nurses' autonomy (Fulton, 1997). The applications of empowerment are wide; it is applied to philosophy, learning, and instruction. Thus, nurses' empowerment should start at the undergraduate level. Students' empowerment means that the student is active in the learning process and will consider learning as lifelong (Hawks, 1992). The professional development of nursing students could foster their autonomy when they become nurses.

Rather than focusing on the limited autonomy when planning capital expenditure and deciding on patient diagnosis and discharge-related issues, nurses must focus on the roles they can have in patients' education about medications, self-care activities, health promotion activities, prevention of skin breakdown, and falls. These roles are reflective of the unique contributions of nurses.

Conclusions

The nursing literature included fragmented and even contradictory studies about nurses' autonomy at work. Given the frequently changing healthcare environment, it is challenging to encourage and maintain nurses' work autonomy. In this study, nurses were more autonomous in patient care decisions than unit operations decisions, and their total autonomy at work was moderate. Nurses' experience, education and time commitment are very important to promote nurses' autonomy in general and nurses' work autonomy over patient care and unit operations in particular.

Table 3. Stepwise multiple regressions (R) of nurses' demographics on total work autonomy of nurses

<table>
<thead>
<tr>
<th>Variable</th>
<th>Multiple R</th>
<th>Squared R</th>
<th>Squared R Change</th>
<th>F-Value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses' experience in nursing</td>
<td>0.372</td>
<td>0.150</td>
<td>0.150</td>
<td>1.789</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nurses' experience in this area of work</td>
<td>0.419</td>
<td>0.182</td>
<td>0.032</td>
<td>23.72</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nursing education</td>
<td>0.455</td>
<td>0.259</td>
<td>0.077</td>
<td>19.29</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Time commitment</td>
<td>0.475</td>
<td>0.255</td>
<td>0.004</td>
<td>16.08</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>


Ferguson-Pare ML (1996) Registered nurses' perception of their autonomy and factors that influence their autonomy in rehabilitation and long-term care settings. Can J Nurs Leadersh 10(4): 67-71


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Key Points
- Nurses were more autonomous in patient care decisions than unit operations decisions, and their total autonomy at work was moderate.
- Nurses' experience, education, and time commitment are important to promote nurses' work autonomy.
- Promoting nurses' work autonomy, hiring full-time nurses, and investing in nurses' education and experience will result in positive outcomes for nurses and patients, and in turn the survival of the organizations.

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