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Nurses' perceptions of the role of health organisations in building professional commitment: Insights from an israeli cross-sectional study during the COVID-19 pandemic

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Abstract

Aims: To reveal the factors associated with nurses' professional commitment during the COVID-19 pandemic.

Background: During the first wave of the COVID-19 pandemic, the Nursing Division at the Israeli Ministry of Health and partners conducted a study to examine the nurses' perceptions towards a set of personal and professional circumstances that may affect their performance.

Method: A cross-sectional Web-based study was conducted in Israel. Study' participants included 817 community and hospital nurses. The Occupational Commitment Scale for Health Professionals during pandemic (PanHP-OCS) was used to gather data. Univariate and multivariate analyses explored associations between the PanHP-OCS score and demographic and professional variables.

Results: About 40% of 817 respondents reported having managerial roles ($n = 320$). Those who received specific pandemic-focused training had significantly better PanHP-OCS scores ($p < .001$). Most respondents expected their organisation to provide them emotional support. Linear regression explored the organisational commitment factor as the greatest contributor to nurses' professional commitment ($\beta = 0.284$, $p < .001$).

Conclusion: To enhance the nurses' professional commitment during the COVID-19 pandemic, training and emotional support must be emphasized in all types of nurses' workplaces.

Implications for nursing management: In a pandemic, health organisations must provide dedicated pandemic training, including proactive emotional support for nurses. Special attention should be given to community care.

1 | INTRODUCTION

Working during a pandemic is a unique situation, and it is imperative to be aware of its special characteristics. Studies conducted during the COVID-19 pandemic reiterate those of earlier pandemics—nurses are concerned with their health and personal safety, their families' health and the need to communicate with team members and family (Yin & Zeng, 2020).

During a pandemic, the work of health care professionals (HCPs) accompanied by significant concerns about the risk of infection (Corley et al., 2010; Lam & Hung, 2013; Wong et al., 2010). Connor (2014) found that readiness to come to work during a terror attack was greater than during a pandemic, due to the lower health risk in the former. Fear for oneself is accompanied by the fear of infecting one's family, which caused HCP to quarantine themselves voluntarily during pandemics (Corley et al., 2010; Lam & Hung, 2013; Martin, 2011). Among community nurses, these concerns were significantly stronger and were usually related to lack of guidance (Wong et al., 2010). To reduce absenteeism due to such concerns, organisations could provide HCP with living quarters (Martinese et al., 2009). However, having a parent away from home, while helping ensure the health of HCP, exacerbates the problem of caring for family; in particular, when schools are closed—in emergencies of all types—parents worry about their children when they themselves must show up (Melnikov et al., 2014; O'Sullivan et al., 2009).

Longer hours and heavy workload during a pandemic lead to significant mental effects, even suicide (Davidson et al., 2020) both during the crisis and long after it (Jun et al., 2020). Work overload and the close contact with infected patients caused HCP to make mistakes, leading to stress that nurses experienced as feelings of frustration and a lack of control (Lam & Hung, 2013; Ornell et al., 2020), and these feelings were intensified by the type of information and the way it is disseminated. The high volume of guidelines delivered to medical teams often generates anxiety and confusion, requiring a careful filtering of unnecessary information (Adams & Walls, 2020). This combination of increased workload, stress and the stream of endless and changing information takes their toll on HCP, and it is incumbent upon organisations to establish a mechanism for providing mental health support for their staff during a pandemic and afterwards (Jun et al., 2020; Gee and Skovdal, 2017; O'Sullivan et al., 2009). Health organisations should focus on supportive conversations, efforts to reduce anxiety, clear instructions rather than recommendations and strive to minimize disinformation (Adams & Walls, 2020).

Nurses who had worked through a previous pandemic were less concerned about being infected than their peers who lacked such experience, attesting to the fact that experience can reduce concerns (Lam & Hung, 2013). Similarly, nurses who work daily with contagious patients were less concerned (Martinese et al., 2009), and nurses who had experience working during emergencies reported a higher level of ability to deal with similar events in the future (Melnikov et al., 2014).

During a pandemic, nurses have a sense of responsibility and mission, alongside their concerns and challenges. Nurses who did not come to work felt that they were not meeting their obligations (Lam & Hung, 2013), and a strong connection was found between the sense of mission and willingness to come to work (Shapira et al., 2019).

Nurses' sense of obligation stems from their loyalty to patients, obligation towards co-workers, professionalism and the status of being an essential worker (Ives et al., 2009). Members of volunteer medical teams in Africa during the Ebola outbreak reported that they were happy to go to disaster-stricken countries and help, despite evidence that their chances of infection were higher than those of the general population (Gee & Skovdal, 2017). The sense of mission is intensified among nurses with greater seniority, those with a specialization and those in administrative positions (Lam & Hung, 2013), and by the gratitude of patients and their families, as well as their employer's recognition of their work (Lam & Hung, 2013).

Ruiz-Fernández et al. (2020) found that the organisation's obligation towards its workers was of utmost importance and that employees felt the lack of such commitment (Billings et al., 2020). One characteristic of work during a pandemic is frequently issued procedures that change rapidly, due to the spread of the disease and they ever-accumulated new information. Vague guidelines lead to poorer compliance, increasing the risk of iatrogenic infection in hospitals for the staff (Elliott, 2009). Therefore, HCP must be provided with clear and concise information (Gee & Skovdal, 2017), efficiently disseminated (Lam & Hung, 2013). The method and frequency of guideline delivery affect HCP's mental state (Adams & Walls, 2020).

Work during a pandemic involves using personal protective equipment (PPE) that is not part of everyday practice. Lack of PPE raises nurses' concern about coming to work (Corley et al., 2010; Lam & Hung, 2013; Martin, 2011) and decreases their willingness to work (Martin, 2011). However, the gear is cumbersome and uncomfortable, and staff members are reluctant to use it (Corley et al., 2010)—although it reduces their worries (Yin & Zeng, 2020). Ives et al. (2009) found that HCP had no confidence in their employers, expecting neither gratitude nor reward for their work, and regarded PPE issued as being of the lowest quality. A study conducted among volunteers in Uganda revealed that more senior workers had more faith than younger ones that the organisation would protect and help them (Gee & Skovdal, 2017).

Organisational obligation also affects resilience in health organisations, especially in extreme situations (Chandra et al., 2011). Resilience is developed during both emergency and routine times, by creating optimal internal communication, which contributes to trust and a sense of control (Maunder et al., 2008). Ensuring that workers have time off, listening to their personal needs and supporting workers as professionals and individuals will help maintain team performance over time, enhancing the resiliency of the organisation (Adams & Walls, 2020).

Social cohesion and good teamwork have been found to be a significant factor in strengthening HCP (Jun et al., 2020). Teamwork, essential sharing information and preventing mistakes, is even more critical in times of crisis and helps deal with complex challenges, the support reducing anxiety levels and increasing team members' sense of self-efficacy (Xiao et al., 2020). However, social cohesion in crisis can also lead to fatigue and team weakness, as people realize that facing the pandemic as a medical team is time-limited (Corley et al., 2010).As the COVID-19 pandemic spreads, and experience gained, it is becoming clear that a new, holistic approach is needed to examine nurses' commitment and find ways to maximize this commitment, and with it, professional performance. Based on the literature, the aim of this study was to reveal factors associating with nurses' professional commitment during the COVID-19 pandemic.

2 | MATERIALS AND METHODS

This cross-sectional study was conducted in Israel during the first wave of the COVID-19 pandemic, with data collected from 1 April 2020 to 5 May 2020.

2.1 | Participants, data collection and ethical aspects

The inclusion criterion for this study was nurses from all types of care: hospitals, community care and geriatric settings. Questionnaires that were returned with less than 80% of the answers were excluded from the study. Based on Martin's measures of nurses' willingness to work during a pandemic, with $\alpha = 0.05$ and power $\beta = 0.85$, the minimum sample size required for this study was 196 participants.

The study was distributed using a Web-based survey software (www.qualtrics.com). A link to the questionnaire was published on the Israeli Nursing Division website, the questionnaire was distributed in relevant social network groups and to Israeli nursing managers for distribution to their teams.

Ethical approval was obtained from the Institutional Review Board (IRB), Faculty of Health Sciences at Ben-Gurion University of the Negev (No. 11–2020), and exemptions from a Helsinki Commission were granted by two academics medical centres. The questionnaire was preceded by an explanation of study objectives, and a statement that participation was voluntary, withdrawal optional at any point and anonymity guaranteed. Filling in the questionnaire signified informed consent.

Nurses' occupational commitment was assessed with a new tool designed specifically for this study—the Occupational Commitment Scale of Health Professionals during Pandemics (PanHP-OCS). In this self-report questionnaire, participants are asked to rate, on a 5-point Likert scale, the degree to which they agree with each of 20 statements (1 = *strongly disagree*, 5 = *strongly agree*). Nineteen statements relate to five factors: professional commitment, organisational commitment, teamwork cohesion, compliance and personal concerns. Based on exploratory factor analysis (KMO = 0.854, $\chi^2 = 6,533$, $df = 171$, $p < .001$), the statement: 'My employer should provide emotional support for staff caring for people with COVID-19' was not loaded to the factors described above. Because of its important content, while this statement was excluded from the final model of the total score, it still appears in the questionnaire. Participants were asked to provide professional and demographic information and to indicate whether they had treated a patient with COVID-19 and whether they themselves had been quarantined. The PanHP-OCS was developed in a mixed-methods research, including literature review and existing relevant research tools, interdisciplinary experts' interviews, content validity, a pilot study, and exploratory and partial confirmatory factor analysis techniques, which presents high reliability of $\alpha = 0.869$.

2.2 | Data analysis

Descriptive statistics described study population and PanHP-OCS scores. Cronbach's alpha was used to examine PanHP-OCS reliability. Univariate analyses explored associations between the PanHP-OCS score and demographic and professional variables based on the type of variable (Pearson and Spearman correlation coefficients, an independent *t* test and ANOVA, followed by post hoc tests).

2.3 | Multivariate analyses

A linear regression model was used to find associations between the dependent variable of professional commitment, as defined in the factor analysis process. The independent variables were entered into the regression equation in three steps: (a) demographic: gender, family status and age (years); daily care of children, parents and relatives with special needs; and health limitations that could impact working during the COVID-19 pandemic; (b) professional characteristics: role (staff/management), training, education and seniority (years); and (c) the four additional factors of the PanHP-OCS score added to the regression equation: organisational commitment, personal concerns, teamwork cohesion and compliance. The results present the regression coefficients of independent variables, along with 95% confidence intervals (CI). IBM SPSS® version 25.0 (IBM Corp, Armonk, NY, USA), the statistical package for the social sciences, was used for data analysis.

Variable		n (%)
Gender	Female	722 (90%)
Age		Mean 33.1, SD = 7.12, range, 21–53 years
Family status	In a permanent relationship	689 (87.5%)
Dependents for daily care	Responders caring for children	404 (49%)
	Responders caring for older parents	355 (43.5%)
	Responders caring for a relative with special needs	70 (8.6%)
Health limitations	No	665 (84%)
	Yes, a few	99 (12.5%)
	Yes, several	26 (3%)
Professional characteristics		
Employment	Full time	566 (72%)
Management role	Yes	320 (40%)
Education	Registered nurse (RN)	76 (10%)
	RN with BA	391 (50%)
	RN with MA	310 (39%)
	RN with Ph.D.	6 (0.8%)
Graduate of specialty courses	Yes	522 (68%)
Seniority	Years as a nurse	Mean 20.8, SD = 11.54, range, 1–48 years
	Years at current place of work	Mean 12.9, SD = 10.43, range, 1–47 years

3 | RESULTS

The study was conducted in Israel in 2020, from 1 April to 5 May.

3.1 | Demographic profile

The participants ($N = 817$), registered nurses from all over Israel, were mostly women ($n = 722$, 90%), in a permanent relationship ($n = 689$, 87.5%), whose mean age was 33.1 ($SD = 7.12$, range, 21–53 years). Most participants noted they did not have health limitations that could prevent them from working during the COVID-19 pandemic ($n = 665$, 84%). The professional characteristics showed that most participants worked full time ($n = 566$, 72%), and 40% were in a management role ($n = 320$). The mean seniority year was 20.8 ($SD = 11.54$, range, 1–48 years). The full demographic and professional profiles are presented in Table 1 and Figure 1.

The distribution of participants in terms of workplace and geographical region are presented in Figure 1.

Approximately 50% ($n = 403$) of the participants had cared for patients with coronavirus ($n = 403$), and 13% ($n = 107$) had been quarantined. About 50% of those quarantined stated that the isolation resulted from their work ($n = 53$). Around 40% ($n = 329$) mentioned that they had received dedicated training for the coronavirus pandemic, with significant differences ($p < .001$) in training found by type of workplace: about 50% ($n = 205$) of the hospital nurses reported that they had received dedicated training, while only 26% ($n = 74$) of community nurses had received such training. However, about 56% ($n = 48$) of the geriatric care nurses indicated that they had received dedicated training for COVID-19.

3.2 | The occupational commitment scale of health professionals (PanHP-OCS)

Based on an exploratory factor analysis, five factors were identified to understand the occupational commitment of nurses during the initial COVID-19 pandemic: professional commitment, organisational commitment, teamwork cohesion, compliance and personal concerns. The PanHP-OCS factors, along with their scores and reliability, are presented in Table 2. The PanHP-OCS items with their scores are listed in Table A1.

No significant differences were found in PanHP-OCS scores between various geographical areas and between nurses' workplaces. However, respondents with a management role had higher scores PanHP-OCS than others, $t(813) = -7.07$, $p < .001$, and age was found to have a weak positive correlation with PanHP-OCS

FIGURE 1 Distribution of nurses' workplace and geographical region
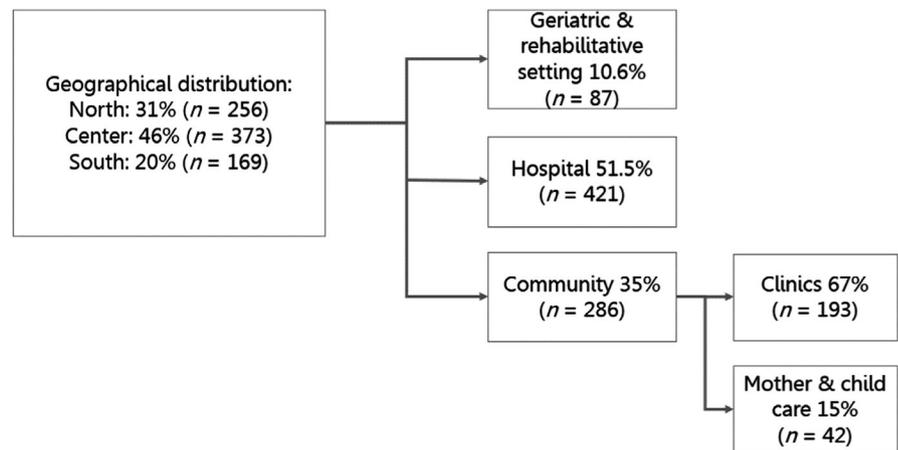
TABLE 2 Scores and reliability of the PanHP-OCS

Factor	No. of Items	Mean	SD	Minimum	Maximum	α
Professional commitment	6	3.8	0.82	1	5	0.79
Organisational commitment	4	3.7	0.94	1	5	0.836
Teamwork cohesion	3	2.9	1.15	1	5	0.758
Compliance	3	4.4	0.66	1	5	0.783
Personal concerns	3	4. 3	0.65	1	5	0.739
Total score	19	3.83	0.59	1.58	5	0.869

scores, $r(817) = 0.126$, $p < .001$. Additionally, a lower score was found among responders with children at home, those who have a relative with special needs ($p > .05$) and those with health limitations ($p < .001$).

Training: 52% of nurses who serve in a management role received dedicated training, compared with 33.6% in a clinical nursing role. In both groups, those who received training obtained higher scores on the PanHP-OCS and all of its factors ($p < .001$). The greatest gap between those who received training and those who did not was in the organisational commitment factor.

3.3 | Emotional support during the COVID-19 pandemic

Most participants largely agreed with the statement: 'My organization should provide emotional support for staff who care for people with COVID-19' (Mean = 4.27, Med = 5, SD = 0.961, range, 1–5). Only 1.3% of participants strongly disagreed ($n = 11$). Examining their PanHP-OCS scores through an ANOVA test, these respondents were found to have significantly lower scores for organisational commitment, teamwork cohesion and compliance factors ($p < .05$).

3.4 | Linear regression

Linear regression was conducted using three steps to model the factor of professional commitment: personal variables (R-square change = 7.7%, $p < .001$), professional characteristics (R-square change = 6.1%, $p < .001$) and PanHP-OCS factors (R-square change = 15.6%, $p < .001$). The final model presented an R-square of 29.4%. The regression results revealed eight statistically significant predictors of professional commitment, of which three are personal: children who are dependent on the participants for daily care, parents who are dependent on the participants for daily care and severe health limitations that could impact working during the COVID-19 pandemic. Two professional predictors identified were management role and seniority. Of the PanHP-OCS factors, organisational commitment, personal concerns and teamwork cohesion were found to be significant. The results of the final model are presented in Table 3 (the different shades present the three steps of the regression model).

4 | DISCUSSION

Using the PanHP-OCS, this study was an examination of nurses' commitment during the first wave of the COVID-19 pandemic in Israel, seeking the key to maximizing occupational performance during pandemics. The study was conducted in collaboration with the Nursing Division at the Israeli Ministry of Health. According to the Israeli Ministry of Health (2020), in 2019, there were 43,000 nurses, about 86% of whom are women, a third work in community care, and about 61% are graduates of specialty courses. In the present study, 90% of the participants were women, 35% were community nurses, and 68% had specialized training.

TABLE 3 Variables associated with the professional commitment factor: final model of linear regression

Variables		Beta	t	p	95.0% confidence interval for *B*	
					Lower bound	Upper bound
Gender	Male	0.050	1.538	.124	−0.037	0.304
Family status	Not in a permanent relationship	0.034	1.011	.313	−0.079	0.246
Age (years)		−0.005	−0.116	.908	−0.011	0.010
Dependents for daily care	Children	−0.093	−2.438	**.015**	−0.271	−0.029
	Parents	0.083	2.557	**.011**	0.031	0.237
	A relative with special needs	−0.033	−1.010	.313	−0.276	0.088
Health limitations	Yes, a few	−0.043	−1.332	.183	−0.268	0.051
	Yes, severe	−0.149	−4.659	**.000**	−1.002	−0.408
Full-time job	No	−0.049	−1.431	.153	−0.208	0.033
Management role	Yes	0.094	2.506	**.012**	0.034	0.276
Education		0.059	1.701	.089	−0.011	0.158
Training	Yes	0.020	0.596	.551	−0.075	0.141
Seniority (years)		−0.095	−0.239	**.042**	−0.013	0.000
PanHP-OCS factors	Organisational commitment	0.284	6.592	**.000**	0.171	0.316
	Personal concerns	0.166	4.797	**.000**	0.069	0.166
	Teamwork cohesion	0.088	2.205	**.028**	0.012	0.207
	Compliance	0.045	1.205	.229	−0.035	0.147

Note: Reference groups for gender, family status, health limitations, full-time job, management role and training are indicated in parentheses (female, in a permanent relationship, with no health limitations, working a full-time job and did not participate in dedicated training, respectively); *p* values in bold indicate statistical significance ($p < .05$).

The importance of developing, strengthening and encouraging of HCP transcends improvement in health outcomes. According to the WHO, they also provide a unique opportunity for the sustainable development of society as a whole in terms of the reduction in poverty, the quality of education, decent work conditions, inclusive economic growth and gender equality (WHO, 2016, 2020). Health policymakers seek to identify modifiable factors that increase HCP efficiency and health outcomes, and decrease morbidity and mortality (Olds et al., 2017). A larger nursing staff is associated with better outcomes for patients during routine times (Aiken et al., 2017) and for the development of the health systems' surge capacity in a time of emergency (Veenema et al., 2016). Although the role of nurses is critical during emergencies, and although a supportive work environment was clearly identified as a significant factor in achieving high levels of safety and quality in hospitals (Olds et al., 2017), research supporting this approach in emergency preparedness and response is lacking.

4.1 | Ratio of hospital care to community care

COVID-19 offers unique opportunities for community health care to handle both direct and indirect health impacts of the pandemic (Sood & Walker, 2020), adding weight to calls to strengthen community care and anchor the health system in primary care to better meet patients' needs (ECCO, 2020). However, emergencies also highlight the organisational structural differences between hospitals and the more fluid community care. Even in Israel, where community care is organised by the Ministry of Health and subordinate to it, we found significant differences between the levels of training provided to hospital and community HCP. Decision-makers should consider ways to enhance the field of community care and maximize its potential. The current study highlights two main issues with policy implications for enhancing the performance of nurses during a pandemic outbreak—training and emotional support.

4.2 | Training

In line with Martin (2011), the present findings revealed the significance of training for nurses' commitment and willingness of nurses to work during a pandemic, and as a mediator variable that was inversely associated with stress (Tian et al., 2020). Based on the current study, we suggest that the essence of training is more than providing information and guidelines. The positive associations between training and PanHP-OCS scores indicate that nurses perceived training as an organisation's act of commitment

to their employees, a commitment was found to be the most important predictor for increasing the participants' professional (Table 3). This corresponds to the findings of Aiello et al. (2011), who identified training as a platform on which to build organisational resilience for pandemic situations.

The results of our study showed that both nurses in management roles and staff nurses perceived training not only as receiving information. As the COVID-19 pandemic progressed, the Nursing Division published a circular, which instructed all health organisations to train their nurses for COVID-19, with the Division inspecting the training. In addition to the local training, a specialty intensive care course was conducted in July for 100 participants, with another course for 400 nurses scheduled for November 2020. These courses are approximately 600 educational hours long and spread over nine months.

4.3 | Emotional support

Beyond providing a safe environment, providing emotional support for HCP working during epidemic/pandemic situations is significant (Dewey et al., 2020; Schroeder et al., 2020) in reducing burnout (Matsuo et al., 2020). Based on our findings regarding the importance that nurses attach to emotional support, it is essential that organisations actively cooperate with teams to provide this support. The low PanHP-OCS scores associated with participants who did not think that their organisation should provide emotional support for them indicate the significance that nurses attach to this support. Following the pandemic's progress, the Nursing Division outlined a policy resilience building for nurses including emotional support aspects. A hackathon was conducted to identify the most effective and applicable resilience-building model. At the time of this writing, the Division is prioritizing the possibilities, and this will be outlining the implementation of the selected model among health organisations. Beyond our study's results, the questionnaire did not include a question that examines the provision of emotional support for nurses during the pandemic. Based on these results, an appropriate item was added to the current version of the PanHP-OCS.

4.4 | Study limitations and recommendations for further research

This study has several limitations. The cross-sectional design reveals associations without causalities. Also, as we did not know the survey's exact scope, we could not calculate response rates. The study reflects the Israeli situation in the first wave of the pandemic, and future research is essential to assess nurses' commitment after more extensive experience with COVID-19 and regulations implemented since the study was conducted. The current sample is younger than the mean age of nurses in Israel. This bias could affect the results; we hope that similar characteristics reinforce the study's sampling.

5 | CONCLUSION

The PanHP-OCS has five factors of occupational commitment: professional commitment, organisational commitment, teamwork cohesion, compliance and personal concerns. These factors engage two content worlds: occupational commitment and the unique attributes of working during pandemics. The perception of nurses regarding their organisation's commitment was found to be the greatest contributing factor to their professional commitment. This study revealed that training and organisations' emotional support significantly enhance nurses' occupational commitment. We also suggest paying attention to differences between community and hospital care. Generalizability of studies among HCP could highlight factors that maximize the performance of different sectors of the health system.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

The role of organisation in building professional commitment should be taken into consideration in managing nurses during pandemics. Assimilation into the work plan of periodical training and promoting active emotional support for nurses should enhance health capacity and prevent nurses' burnout.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICAL APPROVAL

It was obtained from the Institutional Review Board (IRB), Faculty of Health Sciences at Ben-Gurion University of the Negev (No. 11–2020), and exemptions from a Helsinki Commission were granted by two academics medical centres. The questionnaire was preceded by an explanation of study objectives, and a statement that participation was voluntary, withdrawal optional at any point and anonymity guaranteed. Filling in the questionnaire signified informed consent.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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APPENDIX A

TABLE A1 Scores of PanHP-OCS items

	Factor	Item	Mean	SD	Min	Max
1.	Compliance	I am appropriately familiar with the guidelines and procedures regarding managing a pandemic	4.15	0.895	1	5
2.	Compliance	I implement the guidelines for managing an epidemic breakout in the best possible way	4.50	0.694	1	5
3.	Compliance	The team in my department/clinic implements the guidelines for managing an epidemic breakout in the best possible way	4.23	0.814	1	5
4.	Personal concerns	I'm concerned that my family members will contract COVID-19 because I am exposed to it with my patients	2.74	1.359	1	5
5.	Personal concerns	I am anticipating that it will be a problem for me to go home and be with my family after caring for patients with COVID-19	3.04	1.408	1	5
6.	Professional commitment	I feel obligated to care for people with COVID-19	4.11	1.038	1	5
7.	Professional commitment	I feel that it is a calling to care for people with COIVD-19	3.95	1.138	1	5
8.	Professional commitment	I know what my role is in caring for people with COVID-19	4.14	1.032	1	5
9.	Professional commitment	I receive support from my family for caring for people with COVID-19	3.42	1.281	1	5
10.	Professional commitment	I am willing to work on a ward where all patients have COVID-19	2.97	1.417	1	5
11.	Professional commitment	If requested, I will come to work to care for people with COVID-19	4.17	1.034	1	5
12.	Organizational commitment	I believe that the organization I work for is doing all it can to protect me as an employee	3.75	1.175	1	5
13.	Organizational commitment	I receive responses from my organization to questions regarding treatment and care of patients with COVID-19	3.99	1.033	1	5
14.	Organizational commitment	I'm concerned about caring for people with COVID-19	3.20	1.402	1	5
15.	Organizational commitment	The organization provides me with all necessary equipment for caring for people with COVID-19	3.47	1.271	1	5
16.	Organizational commitment	I trust the decision-makers at my workplace	3.74	1.101	1	5
17.	Teamwork cohesion	At my workplace there is mutual assistance and people care for one another	4.14	0.960	1	5
18.	Teamwork cohesion	Good relationships exist between colleagues at my workplace	4.53	0.691	1	5
19.	Teamwork cohesion	I feel a sense of belonging to my workplace	4.57	0.681	1	5
20.		My organization should provide emotional support for staff caring for people with COVID-19	4.27	0.961	1	5