**Nurse Professionalism Scale: Development and Psychometric Evaluation**

**Abstract**

**Background:** Professionalism is a key trait connecting the nurse and patient, and Code of Professional Conduct, a professional legitimacy in considering nursing as a profession and an essential tool that facilitates nurse practice. **Objectives:** This study aims to develop the Nurse Professionalism Scale (NPS) using the Code of Professional Conduct for Nurses in India and test the psychometric properties. **Method:** Data were collected through self report from 749 registered nurses selected using multistage stratified random sampling and through multi-source feedback as supervisors’ reports (687) and colleagues’ reports (747). Reliability estimate for internal consistency of the 38 item NPS\*was .910 (self report), .951 (supervisor feedback) and .952 (colleague feedback). **Results:** Exploratory factor analysis in AMOS version 23 using self reported data yielded extraction of five factors with 22 items at Eigen values greater than 1. Items with communalities ≥.4 and factor loadings above .≥.5 were retained. Five factors explained total cumulative variance extracted at 51 percent and KMO value of .893 indicating sample adequacy. Bartlett Test of Sphericity was significant (χ2 = 3318, df= 231, p<.000). The factors are labelled with reference to the labels in the original code of professional conduct and higher factor loading. Confirmatory factor analysis using data from supervisors feedback (CMIN/DF=2.938; RMR=.044; GFI=.926, AGFI=.903; IFI=.939; TLI=.927; CFI=.939 and RMSEA=.055) and colleagues feedback (CMIN/DF=3.165; RMR=.034; GFI=.921, AGFI=.897; IFI=.923; TLI=.908; CFI=.923 and RMSEA=.058) separately yielded acceptable model fit indices confirming the factors in the Nurse Professionalism Scale **(NPS). Conclusions:** The NPS can be used as a tool to evaluate professionalism among nurses. Testing across different settings, levels and sectors of health care will further strengthen the scale. Multisource feedback from stakeholders can also be considered as an effective method of gathering data on this construct.

**Key Words:** Professionalism, nurses, code of professional conduct.

**Introduction**

Across every health system, health workers determine the provision of the nature and quality of services. Surprisingly, most health systems on a global stage face nursing shortage, which further differs across states and rural-urban settings [1]. India is still a developing country [2]. Nurses structure two-thirds of the country’s health human resource and nursing services amount to an integral fraction of preventive and curative phases which is evident through the provision of care from tertiary level to every doorstep even beyond the availability of doctors. Nurses’ contribution towards the achievement of sustainable development goals (SDG) and UN millennium development goals (MDG) is indispensable; yet deficient in creating significant impact on health outcomes [3].

In recent years, nursing in India has witnessed several transformations, successes and challenges through significant effort and movement. Though, nurses’ scope have widened, their roles and responsibilities have multiplied, concerns continue to impact the development, selection, recruitment, placement based on specialization, pre-service and in-service training and human resource issues related to career development. **[**3]. The national estimates indicate shortage of nurses which is further compounded by the international migration of this valuable resource due to varied professional, social and economic reasons. This adds to the non-availability of skilled, standard and quality health services particularly to the under privileged sections in the country [1]. Inadequate workforce and deficient quality care further escalates the morbidity and mortality rates in the country further resulting in overburdened workforce [4]. Thus the vicious cycle continues and hampers the progress of nursing profession in the country.

Nurses are perceived as a compliment ‘package’ or ‘quick’ trained caregivers fulfilling the health provider shortage. However, they are seldom considered while contributing to ideas and views related to client needs or interventions or any form of health care modalities. Also, this scenario does not synchronize with the fact that nurses are ‘round the clock’, well-educated health care providers and constitute the largest group of professionals in the health care delivery system. Hence, amidst tremendous development, professionalism among nurses is essential to promote a transition in the profession. [5].

Adams, Miller & Beck [6] stated that nursing professionalism necessitates nurses to demonstrate definite behaviours illustrating beliefs of the profession in terms of knowledge, attitudes and skills signifying professional identity and commitment to the profession. These features are consistent with the characteristics sketched in the “Registered Nurses Association of Ontario (RNAO)-Best Practice Guideline (BPG),” ‘Professionalism in Nursing’ [7], and “Miller’s model” the ‘Wheel of Professionalism in Nursing’ [8]

This study aims to develop and evaluate the psychometric properties of Nurse Professionalism Scale (NPS) which is based on the Code of Professional Conduct for Nurses in India, Indian Nursing Council (CPCNI-INC). The instrument can be used to explore professionalism among nurses and gather baseline data through individual nurses’ self-reﬂection of their professional behaviour within varied practice settings in a developing country like India. Stakeholders and administrators also contribute to the sustenance and improvement of professionalism among nurses. [5]. Hence multi-source feedback (MSF) is considered as an important method in this study. It might highlight concerns and stimulate awareness regarding professionalism among nurses amidst the shortage and their overburdened schedule in developing countries.

**Methods**

**Development of the Nurse Professionalism Scale (NPS)**

Several researchers have developed instruments to explore and or evaluate professionalism among nurses. Miller’s Model or the ‘Wheel of Professionalism in Nursing’ was an extension of Hall and Friedson’s works. Miller also used “The Social Policy Statement, Code for Nurses with Interpretative Statements and recommendations and policies from the American Nurses Association (ANA)” as a basis for the behaviors represented in the Wheel of Professionalism in Nursing. This instrument was developed to serve as a guide for every nurse in monitoring their professional behaviors. Subsequently, Miller, Adams & Beck developed an evaluative “Behavioral Inventory Form for Professionalism in Nursing” (BIPN) based on the Model which is widely used to evaluate professionalism among nurses [9-12].

Several other researchers explored professionalism among nurses using RNAO-BPG [7] questionnaire, an adaptation of Registered Nurses Association, Ontario (RNAO) Best Practice Guidelines (BPG) [13-14], and “Hall's Professionalism Inventory” (HPI) scale [15]. “The Professionalism and Environmental Factors in the Workplace Questionnaire, (PEFWQ)”, was developed based on literature, code of ethics and jurisdictional practice standards. This instrument was not designed to measure personal professionalism nor as a diagnostic benchmarking tool but rather was used in identifying areas of alarm to nurses and as an opening point for discussion [16].

Relevant literature review on the construct professionalism across various professions revealed that most researchers have described, adopted, adapted or developed instruments based on the professional code of conduct and ethics. Physician Charter on Medical Professionalism is a product of the collaboration between American Board of Internal Medicine Foundation (ABIM), American College of Physicians Foundation, and European Federation of Internal Medicine. This popular document highlights the essential principles and responsibilities fundamental to professionalism in medicine [17-20]. Some others have used standards from the “Accreditation Council on Graduate Medical Education” (ACGME) [21-22]. The “Code of Ethics for Pharmacists and the American Association of Colleges of Pharmacy” (AACP) and “The American Council on Pharmaceutical Education (ACPE) Accreditation Standards” describing the attitudinal and behavioural components have been considered in the context of providing pharmaceutical care [23]. “The College of Medical Laboratory Technologists of Ontario’s (CMLTO) Code of Ethics and Standards of practice” serve as the foundation of MLT’s professionalism [24]. Pollard [25] explored ethical performance contributing to authority, control and social responsibility which are considered as the hallmark of professionalism among news workers. American Bar association (ABA) and the judicial statements on professionalism serve as the basis for evaluating professionalism in the area of law [26].

In this study, the national “Code of Professional Conduct for Nurses in India”, framed by the national regulatory body, Indian Nursing Council (CPCNI-INC) is used to measure professionalism among nurses in the varied settings and at different levels of health care organisations**.** This crucial document is available for nurses as a regular culturally-adapted guidance in making ethical decisions. Every registered nurse is required to follow the code in his/her routine nursing practice. No formal permission is obtained for using the code.

The Code serves the interests and needs of the profession efficiently, as it illustrates individual nurse’s professional responsibility and accountability, nursing practice, communication and interpersonal relationships, valuing human being, management, professional advancement. The code outlines the elements required for ethical behavior and empowers nurses in making perfect ethical decisions as clinical nurses, administrators, researchers, and policy-makers. It reminds the nurses about the valuable status of nursing profession and their attempts mandatory towards upholding as a nurse while providing direct care to clients, teaching students, conducting research, supervision and management.

The process followed in the development of the scaleis based on the steps enlisted by Boateng et.al [27] and Carpenter [28].

**Phase 1**

**I.1. Item Generation**

Following review of literature, the national Code of Professional Conduct for Nurses in India” (CPCNI-INC) framed by the Indian Nursing Council, consisting of 38 items and six dimensions, was identified as a comprehensive measure to identify professionalism among nurses.

The CPCNI-INC was reviewed by four nursing teaching faculty, two senior clinical nurses and three faculty from management for readability, comprehensiveness and appropriateness of the items. Based on the feedback, majority items were re-worded in simpler vocabulary without changing the meaning. This process was completed in three rounds by resubmitting to and discussing the changes with the same experts. Since it was the national professional code of conduct, no items were deleted at this stage. It was decided to use the CPCNI-INC as a “Nurse Professionalism Scale” (NPS\*) on five point likert scale with ratings from 1=never to 5=always. Provision was made to respond on items which are not applicable as “NA”.

Two versions of the instrument were created: one for registered clinical nurses (to be used as a self-assessment) and the other for the supervisors as well as colleagues (used separately) in order to evaluate nurses’ behaviour as multi-source feedback (MSF). Multi-source feedback (MSF) is a method of data collection through different sources; clinical supervisors, peers, other staff in order to develop a broad gauge of practice patterns. MSF aims to raise self-awareness regarding performance, seek encouragement, improvement through feedback [29].

**I.2. Content Validation**

‘A measure has content validity when its items accurately represent the thing being measured’ [16]. The tool was sent for content validation to the experts from the field of nursing and health care management. Initially the tool was sent to 23 experts: 16 Ph. D. In Nursing and 7 Ph. D in Health care management faculty. The experts were requested to validate the tools on relevance and clarity with a 4-point rating scale. Fifteen experts provided valid response, comments and suggestions and 6 experts gave suggestions and comments only. Score of one and two was considered as zero and score of three and four were considered as one during calculation of item as well as scale content validity indices. The calculated I-CVI and S-CVI were above 0.9. However, some experts suggested reframing a few items. Changes were incorporated and the tool was resent for validation to 15 experts from among the initial pool of experts. Five experts from the field of nursing and three from the field of health care management validated the tool and provided their valuable comments and suggestions. The calculated I-CVI and the S-CVI were found to be above 0.9.

**Ethical considerations**

Approval was obtained from the ethical review committee. Written permission was obtained from the authorities of the private and autonomous settings. Informed consent was obtained from the respondents after explaining the purpose, benefits, risks and anonymity and confidentiality assurance.

**Phase II: Scale Development**

**II. 1. Pre-testing**

“Pre-testing helps to ensure that the items are meaningful to the target population before the survey is actually administered” [27]. The tool was administered on conveniently selected 55 clinical nurses working in primary health centres having less than five registered nurses. The participants did not indicate any difficulty in providing responses on the tool.

**II. 2. Survey Administration and Sample Size**

Registered nurses working in the various areas of work (Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Emergency and Intensive Care Unit, Psychiatry and Community) at different levels of health care (Tertiary, Secondary and Primary) in the private, government and the autonomous sector were selected in the study using stratified random sampling. The inclusion criteria were to include hospitals which gave written permission and had equal to or more than five registered nurses working in the respective hospital setting. Data were collected through self report from registered clinical nurses (main sample) and as multi-source feedback regarding the main sample from their supervisors and colleagues. The tool was administered to 1054 registered nurses personally. To avoid researcher presence bias or compulsion for favourable responses and considering their demanding work schedule, the participants were given a period of one week to complete their responses on the tool. While collecting the tool back it was noticed that many participants had not completed their responses owing to their hectic work schedule. To avoid high attrition, each tool was checked for completeness, and the participants were requested to complete the response within another week, after which the tool was collected.

A total of 830 self reported data sets, 687 supervisor and 747 colleague responses sheets were received. However, following data entry, the data were checked for missing and incomplete responses and outliers. Complete set of self-supervisor-colleague responses contained in 644 data sheets (Table 1) received from respondents working across different work areas, different levels and different sectors was used for overall analysis. Reliability estimate for internal consistency of the 38 item NPS\*using Cronbach αwas .910 (self report), .951 (supervisor report) and .952 (colleague report).

**Results**

**II.3. Extraction of Factors**

Factor analysis is used to demonstrate the basic goal of obtaining groups of highly inter-correlated variables into distinct factors [30]. EFA evaluates the construct validity in the initial phase of an instrument development and after an initial set of items have been identified, it is used to inspect the item set underlying dimensionality and the extracted factors explain the maximum variance in the scale. Thus, a large set of items can be grouped into meaningful subsets which measure different factors [31].

Exploratory Factor Analysis was performed with the aim to reduce and group items together so that each factor would represent a consistent content area. In order to exclude the measurement errors in this study, Maximum Likelihood and Promax rotation was used. The aim was to retain factors extracted with Eigen values greater than 1 and items with communalities above .4 which confirms the common variance shared by each measured item with other items of the construct on which it loads. The Scree test identifies the optimal number of factors which can be extracted in a graphical presentation. The scree test of the data set also indicated five factors above one. (Fig. 1). Factor loadings of ± .5 and greater are measured as practically significant [30]. The factor loadings obtained are between .84 and .5 (Table. 2). Four factors are explained by 4-6 items. A two item factor can also be retained and considered acceptable if the items are strongly correlated (r > .70; or >.60) and reasonably uncorrelated with other variable [31, 33]. Hence the factor with two items (r=.62) was also retained in this study. In social sciences a factor solution accounting for the total variance extracted up to 60 percent [30], or at least 50 percent is acceptable [32]. Five factors measured by a total of 22 items explained the total cumulative variance extracted at 51 percent. Kaiser-Meyer-Oklin measure of sample adequacy (MSA) value of .893 indicates sample adequacy. Bartlett Test of Sphericity (BTS) was significant (χ2 = 3318, df= 231, p<.000) and indicates sufficiently large correlations among items.

**Labelling the factors or the dimensions**

Variables with higher loadings on a particular factor are considered as more significant and more representative of the factor. Hence the factor is labelled with reference to the variable with higher factor loading [30]. In this study also, the factors are labelled considering the higher factor loadings. In Factor I, the variable PA2 with highest loading and PA5 are originally (CPCNI-INC) from the dimension “Professional advancement”. The items MAN9 and MAN8 reflect development of the profession through working with other stake holders and participating in policy decisions. Hence, the factor is labelled as “ProfessionalAdvancement /Development**”.** With reference toFactor II,two variables with higher factor loadings (MAN4 and MAN3)are originally from the dimension **“**Management”,the variableVHB2reflects decision making which can be considered as a management function. Hence the second factor is labelled as **“**Management”**.** Factor III,is majorly a reflection of nursing practice besides having the variable NP6 with the highest loading on that factor, which originally is from the dimension “Nursing Practice”. Factor IV is explained by three main variables (PRA5, PRA3 and PRA1), hence the label “Professional Responsibility and Accountability”,is retained as from the original CPCNI**-**INC. Factor V is explained by two variables from the original dimension “Valuing Human Being”, hence the label is retained as seen in table 3.

**III. Scale Evaluation**

**III. 1. Tests of Dimensionality through Confirmatory Factor Analysis**

“Tests of dimensionality determine whether the measurement of items, their factors, and functions are the same across two independent samples or within the same sample at diﬀerent time points. Such tests can be conducted using independent conﬁrmatory factor analysis” [27]. It is a form of psychometric evaluation that permits for the systematic comparison of alternative a-priori factor structure on the basis of systematic model ﬁt evaluation procedures and assess the relationship between latent constructs [28]. Obtaining a good model fit to the data in a different sample supports the factor structure reliability and validity of the scale [31]. Confirmatory factor analysis using AMOS version 23 was conducted using the data obtained from the supervisor’s and colleague feedback responses separately. Confirmation of factors is based on the fit indices which range from 0 to 1, and values closer to 1 suggest good model fit [33]. SEM researchers advocate .95 as a more desirable level. “Root mean square error of approximation (RMSEA) at or less than .05” indicates secure model fit [31]. In this study the model fit indices obtained (CMIN/DF=2.938; RMR=.044; GFI=.926, AGFI=.903; IFI=.939; TLI=.927; CFI=.939 and RMSEA=.055) using the supervisor data and (CMIN/DF=3.165; RMR=.034; GFI=.921, AGFI=.897; IFI=.923; TLI=.908; CFI=.923 and RMSEA=.058) using colleague data resulted in the confirmation of factors in the Nurse Professionalism Scale (NPS).

**Discussion**

This study aimed at development of the “Nurse Professionalism Scale” using the Code of Professional Conduct for Nurses in India, Indian Nursing Council (CPCNI-INC). Exploratory factor analysis using self reported data resulted in extraction of five factors. Supervisor feedback as well as colleague feedback regarding the professional behaviours of registered nurses confirmed the items and the factors. Solomon et. al [13] adapted from RNAO guideline and used it as a 5 point likert scale which consisted of 34 - item in 8 subscales. The subscales were Knowledge, Ethics, Accountability, Advocacy, Spirit of Inquiry, Collaboration and collegiality, Autonomy and Innovation & visionary. To derive common factors reflecting professionalism, exploratory factor analysis was used. Principal component analysis resulted in the extraction of one latent variables/factor with 6-item. The 6 items extracted and used in subsequent analysis were; “I have been open-minded and having the desire to explore new knowledge”. “I am asking questions that lead to the generation of knowledge and refinement of existing knowledge”. “I am recognizing personal capabilities, knowledge base and areas for development”. “I am showing initiative for new ideas and involved through taking action”. “I am collaborating with colleagues to develop and maintain a practice environment that supports nurses and respects their ethical and professional responsibilities”. “I am engaging in critical thinking about ethical issues in clinical and professional practice”. Professionalism is a multi-faceted concept that offers opportunities for nurses’ personal and professional growth [34]. This key trait is the relationship involving the nurse and the patient. Nursing professionalism mirrors the approach in which nurses analyze their work and serves as a lead in their practice towards ensuring patient safety and quality care [34, 10]. The code serves as a guide for nurses’ behaviour while carrying out responsibilities of prevention of illness, protection, promotion and restoration of health, and alleviation of suffering among individuals, families and communities. It is a vehicle for self and peer-evaluation of the care quality delivered to consumers by nurses. Additionally, it guides and assists nurses at every phase of nursing practice [27]. It provides the ethical framework and standards for practice [7]. Nurses need to be aware of the important professionalism accents, behaviours, attitude and the manner of working which will aid in the formulation of their identity as indispensible health care providers in their workplace. Multi-source feedback can be considered as an important method in exploring these behaviours [29]. Self reported data from the respondentscouldinvolve social desirability bias although multisource feedback was obtained from the supervisor and colleagues. The busy schedule amidst the shortage of nurses and the complexity in the wording of the items could have led to some amount of response error.

**Conclusion**

The five factors extracted using exploratory factor analysis from the data obtained regarding the professionalism among nurses based on the code of professional conduct are further confirmed using supervisor and colleague data as indicated through favourable model fit indices. The NPS as an instrument can be further used in evaluating professional behaviours among nurses in other settings. Professional code of conduct and or ethics is viewed as a professional legitimacy for considering nursing as a profession and an essential tool that facilitates nurse practise while handling ethical challenges. Every practising nurse is expected to share the responsibility of self-regulation and practise in accordance with the professional standards and code of ethics for registered nurses as these define values and beliefs in nursing profession. Further studies comparing nurses working in private and public settings, also comparison among nurses from different areas of work can be conducted using the NPS.

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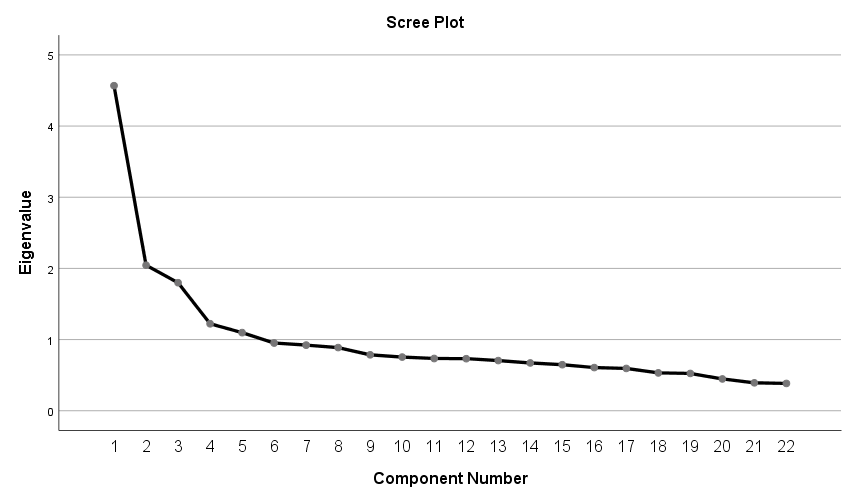
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***Fig 1: Scree*** ***test plot indicating extraction of Factors***



***Table 1. Sample demographics.***

|  |  |  |  |
| --- | --- | --- | --- |
| **I** | **Area of work** | **Frequency** | **Percentage** |
| 1 | Medicine | 130 | 20.2 |
| 2 | Surgery | 136 | 21.1 |
| 3 | Obstetrics and Gynaecology | 42 | 6.5 |
| 4 | Paediatrics | 88 | 13.7 |
| 5 | Emergency and Intensive Care Unit | 144 | 22.4 |
| 6 | Psychiatry | 28 | 4.3 |
| 7 | Community | 76 | 11.8 |
| **Total** | | **644** | **100** |
| **II** | **Levels of Health Care** | | |
| 1 | Tertiary | 400 | 62.1 |
| 2 | Secondary | 195 | 30.3 |
| 3 | Primary | 49 | 7.6 |
| **Total** | | **644** | **100** |
| **III** | **Sector of Health Care** | | |
| 1 | Private | 151 | 23.4 |
| 2 | Government | 479 | 74.4 |
| 3 | Autonomous | 14 | 2.2 |
| **Total** | | **644** | **100** |

***Table 2. Item loadings in Exploratory Factor Analysis***

|  |  |  |  |
| --- | --- | --- | --- |
| **Factors** | **Items** | | **Loadings** |
| **I** | Man9 | Works with patients to identify their needs and sensitizes policy makers and funding agencies for resource allocation. | .771 |
| PA2 | Contributes to the development of nursing practice (by conducting research or trying out new methods of care). | .740 |
| PA5 | Contributes to core of professional knowledge by conducting and participating in research. | .734 |
| MAN8 | Participates in policy decisions related to patient care services. | .687 |
| **II** | MAN 4 | Facilitates conducive work culture in order to achieve patient care objectives. | .853 |
| VHB 2 | Considers relevant facts while taking decisions in the best interest of patients. | .671 |
| PA1 | Takes responsibility for updating my/her/his own knowledge and competencies. | .585 |
| PRA 8 | Provides adequate information to patients and significant others that allows them to make informed choices. | .570 |
| PA 4 | Ensures the protection of the human rights while pursuing the advancement of knowledge (while conducting research or trying out new methods of care). | .560 |
| MAN 3 | Uses judgment in relation to individual competence while delegating responsibility to colleagues, patients, relatives. | .524 |
| **III** | NP 6 | Ensures safe practice of care for self and patients. | .708 |
| PRA 2 | Maintains standards of conduct/practice which adds to the respect/status of the profession. | .641 |
| CIR 1 | Establishes and maintain/maintains effective interpersonal relationships with patients and their significant others. | .613 |
| PRA 7 | Takes responsibility for continuous improvement of current nursing care practices. | .580 |
| NP 2 | Treats patients and their significant others with human dignity while providing holistic nursing care. | .561 |
| PA 3 | Participates in determining and implementing quality care. | .517 |
| **IV** | PRA 5 | Accepts accountability for her/his own decisions and actions. | .709 |
| MAN 1 | Ensures appropriate allocation and utilization of available resources. | .595 |
| PRA3 | Carries out nursing responsibilities within the framework of professional boundaries. | .543 |
| PRA1 | Has a sense of self-worth as a nurse professional and nurtures it. | .516 |
| **V** | VHB 3 | Encourages and supports patients in their right to speak for themselves on issues affecting their health and welfare. | .781 |
| VHB 1 | Takes appropriate action to protect patients from harmful and unethical practice. | .742 |

***Table 3. Label of factors in the Nurse Professionalism Scale (NPS)***

|  |  |
| --- | --- |
| **I** | **Professional Advancement/Development** |
| Man9 | Works with patients to identify their needs and sensitizes policy makers and funding agencies for resource allocation. |
| PA2 | Contributes to the development of nursing practice (by conducting research or trying out new methods of care). |
| PA5 | Contributes to core of professional knowledge by conducting and participating in research. |
| Man88 | Participates in policy decisions related to patient care services. |
| **II** | **Management** |
| Man4 | Facilitates conducive work culture in order to achieve patient care objectives. |
| VHB2 | Considers relevant facts while taking decisions in the best interest of patients. |
| PA1 | Takes responsibility for updating my/her/his own knowledge and competencies. |
| PRA8 | Provides adequate information to patients and significant others that allows them to make informed choices. |
| PA4 | Ensures the protection of the human rights while pursuing the advancement of knowledge (while conducting research or trying out new methods of care). |
| Man3 | Uses judgment in relation to individual competence while delegating responsibility to colleagues, patients, relatives. |
| **III** | **Nursing Practice** |
| NP6 | Ensures safe practice of care for self and patients. |
| PRA2 | Maintains standards of conduct/practice which adds to the respect/status of the profession. |
| CIR1 | Establishes and maintain/maintains effective interpersonal relationships with patients and their significant others. |
| PRA7 | Takes responsibility for continuous improvement of current nursing care practices. |
| NP2 | Treats patients and their significant others with human dignity while providing holistic nursing care. |
| PA3 | Participates in determining and implementing quality care. |
| **IV** | **Professional Responsibility and Accountability** |
| PRA5 | Accepts accountability for her/his own decisions and actions. |
| Man1 | Ensures appropriate allocation and utilization of available resources. |
| PRA3 | Carries out nursing responsibilities within the framework of professional boundaries. |
| PRA1 | Has a sense of self-worth as a nurse professional and nurtures it. |
| **V** | **Valuing Human Being**  .613  .549 |
| VHB3 | Encourages and supports patients in their right to speak for themselves on issues affecting their health and welfare. |
| VHB1 | Takes appropriate action to protect patients from harmful and unethical practice. |