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Perceived Workplace Autonomy Scale (PWAS): A Preliminary Psychometric Evaluation Among Moroccan Nurses

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Abstract

Background: A complex profession such as nursing requires technical expertise as well as transversal skills. Nurses face multiple daily decisions, including task prioritization, time management, and maintaining constructive relationships. In this context, autonomy competency is an essential component of job performance, satisfaction, and care quality.

Aim: This study aims to examine the factor structure and internal consistency of a self-administered scale to assess nurses' perceived autonomy competence; their belief in their own capacity to act autonomously, as distinct from structural job autonomy; as well as to identify its underlying dimensions.

Methods: A cross- sectional questionnaire was conducted with 286 nurses from three hospitals in Morocco. The scale comprised 14 items grouped into four theoretical dimensions. A clarity pre-test with five nurses was conducted to ensure comprehension and refine item wording before full administration. Exploratory factor analysis (EFA) was used to

examine construct validity. In addition, internal consistency was assessed with Cronbach's alpha.

Results: Exploratory factor analysis using Principal Axis Factoring, combined with parallel analysis, revealed a single underlying factor accounting for 50.1% of the total variance. The scale demonstrated excellent internal consistency (Cronbach's $\alpha = 0.931$).

Conclusion: The study provides preliminary evidence of the scale's internal consistency and unidimensional structure. This tool can help healthcare managers identify areas for improvement and implement continuing training to strengthen autonomy, thereby enhancing nursing practice and patient care outcomes.

Key words: Autonomy, Workplace Autonomy, competency, scale development.

1. Introduction

Autonomy is a multidimensional concept that has been defined and approached in various ways. According to [1, p. 33] it rests on three interrelated foundations “a knowledge base (independence, rights, and responsibility in decision-making), an action base (independence, rights, and responsibility in practice), and a value base (independence, rights, and responsibility in professional and ethical values)”. These dimensions overlap with other definitions that emphasize capacity, independence, control, responsibility, accountability, authority, and self-directed practice.

Blanchfield and Biordi [2, p. 43] define autonomy as “an individual’s ability to independently carry out the responsibilities of the position without close supervision.” This definition highlights the ability to set daily workload objectives, establish priorities, and make well-considered decisions in critical moments. Similarly, [3] associates professional autonomy with authority and the freedom to act in accordance with one’s knowledge base. On a broader level, [4, p. 83] conceptualizes autonomy as “the ability of the subject to decide for himself the rules he obeys, and to act accordingly”, which includes setting objectives, organizing actions, overcoming obstacles, and critically evaluating outcomes. This perspective suggests both reflective capacity and individual responsibility for choices made.

Modeling autonomy into the realm of competence, eight essential skills were identified by [5] for building and sustaining autonomy, including identifying and asserting one’s resources and needs; starting and leading projects; analyzing situations systemically; collaborating and sharing leadership; managing actions done collectively; resolving disagreements; adapting or developing rules; and negotiating across differences, whether cultural or general. Chatzis [6, p. 29] has also defined Professional autonomy as “the ability to freely determine the rules of action to which one submits and to set the modalities of one’s activity, independently of the norms imposed by the organization”. This includes initiative, discernment, self-organization, and freedom at work. De Ruyt [7] similarly describes the autonomous professional as one who generates their own behavior and strategies of action in response to environmental demands and constraints. Importantly, a distinction can be drawn between implementing autonomy, which is limited to executing directives, and higher autonomy, which includes determining goals.

Taken together, these perspectives converge on a working definition of autonomy as the capacity and legitimated freedom to set goals, choose methods, and exercise judgment within one’s scope of practice, without close supervision,

while remaining accountable for outcomes. This study operationalizes that definition through four dimensions; autonomy in work planning, work methods and procedures, relational autonomy, and learning and development autonomy; that draw in particular on [5] competency framework for autonomy, which similarly spans self-directed goal-setting and resource management (reflected in the planning dimension), systemic problem analysis and rule adaptation (methods), cooperation and shared leadership (relational autonomy), and the ongoing development of one’s own resources and capacities (learning and development autonomy).

1.1 Structural Autonomy Versus Perceived Autonomy Competence

A further distinction is important for situating the present instrument within the broader autonomy literature. Much of the organizational-psychology literature on work autonomy, including the JDS, JCI, GWA, and WDQ reviewed below, conceptualizes and measures autonomy as a structural, job-referent characteristic: the degree to which the job itself, as designed, affords discretion (e.g., “the job allows me to plan how I do my work”). This tradition treats autonomy as a property of the role rather than a property of the individual. The present study, by contrast, is concerned with nurses’ perceived autonomy competence: their self-referent belief in their own capacity to exercise autonomy (e.g., “I am able to set my own working hours”), independent of how the job itself is objectively structured. This self-referent framing aligns the present construct more closely with self-efficacy theory [8], which defines self-efficacy as an individual’s belief in their capability to execute the courses of action required to manage prospective situations, and with the competence dimension of Spreitzer’s [9] psychological empowerment framework, which explicitly treats perceived competence; the belief that one is capable of performing work activities skillfully; as conceptually equivalent to self-efficacy in a work context. Notably, general self-efficacy measures constructed on this same self-referent logic, such as the New General Self-Efficacy Scale [10], have consistently and robustly demonstrated unidimensional structure across contexts, in contrast to the multidimensional structure typically reported for structural, job-referent autonomy measures such as the WDQ.

1.2 Importance of Autonomy for Nurses

In healthcare practice, autonomy competency is deemed fundamental, supporting professional competence, job satisfaction, and organizational efficiency. Despite its recognized importance, autonomy is not experienced enough across healthcare systems and cultural contexts. S. Varjus et

al. [11] have shown that professional autonomy enhances nurses' confidence in practice and promotes accountability. Conceptually, it includes the knowledge, skills, and attitudes required to act independently within one's scope of practice, contributing simultaneously to professional development and to the broader elements in which patient care takes place. The literature emphasizes that autonomy strengthens responsibility and accountability while reinforcing nurses' roles as integral members of the healthcare team. Higher job satisfaction and improved retention have also been associated with increased autonomy, particularly in high-pressure environments such as critical care [12]. Conversely, limited autonomy has been associated with dissatisfaction, demotivation, burnout, and reduced commitment [13], [14], [15].

The autonomy competency is also important to professional socialization and identity development, supporting independent judgment, decision-making, and professional responsibility. Thompson [16, p. 164] underlines that "autonomy, the freedom to practice independently and to exercise judgment in practice activities, is a central element for professional practice and an important dimension of professions." Likewise [11, p. 205] affirm that "autonomy is an essential element of professional status. All over the world the nursing profession desires autonomy." MacDonald [17] further notes that professional autonomy entails control over practice through independent judgment, allowing nurses to establish self-regulated principles derived from established technical and ethical standards.

Empirical studies confirm that greater professional autonomy is associated with higher levels of motivation, innovation, professional development, and overall quality of professional life [18], [19], [20].

A distinction made explicit here is relevant to the scope of this study: the nursing autonomy literature commonly separates clinical autonomy; discretion in patient-care decision-making; from professional or general workplace autonomy; control over one's own working conditions, methods, and practice environment, independent of specific clinical content [21]. The present study, and the instrument it describes, is concerned with the latter: nurses' perceived competence in exercising general workplace autonomy, not their autonomy in clinical decision-making specifically.

1.3 Existing Tools for Measuring Work Autonomy

Several validated instruments have been developed to measure autonomy in general occupational contexts. A smaller number of nursing-specific instruments, such as the Dempster Practice Behaviors Scale [22], the Pankratz Nursing Attitude Scale [23], and [24] Nursing Activity Scale, have also

been developed and used internationally to assess professional autonomy specifically within nursing practice. However, no tool currently adapts general workplace-autonomy dimensions to nursing practice in a Francophone or Moroccan context, which is the gap this study addresses; the rationale for drawing on general instruments rather than an existing nursing-specific tool is discussed further in the Limitations.

Among the general instruments, several embed autonomy within a broader, multidimensional model of job characteristics rather than treating it as a standalone construct. The Job Diagnostic Survey (JDS), developed by Hackman and Oldham [25] to support their job characteristics theory, assesses objective job characteristics, employees' affective responses, growth needs, and motivating potential across dimensions that include skill variety, task identity, task significance, autonomy, feedback, and interpersonal relationships; despite its wide use, the JDS has been criticized for low internal consistency and an unclear factor structure. Likewise, the Job Characteristics Inventory (JCI), developed by [26] measures six aspects of work: variety, autonomy, task identity, feedback, interaction with others, and interpersonal relationships; using 30 items rated on a five-point Likert scale.

Other instruments treat autonomy itself as the central construct. Breugh's [27] Global Work Autonomy Scale (GWA) captures three forms of autonomy; method autonomy (discretion over procedures), scheduling autonomy (control over timing and sequencing of tasks), and criteria autonomy (ability to influence performance evaluation standards); across nine items rated on a seven-point Likert scale, with strong reported reliability (Cronbach's $\alpha = .90$; test-retest $r = .83$). A more qualitative approach is taken by Everaere [28] whose Work Autonomy Measurement Scale assesses autonomy as both capacity and willingness to act, distinguishing four levels; incompetence=0, asking relevant questions=1, adapting rules intelligently=2, and questioning and improving practices=3; each associated with typical behaviors reflecting both objective ability and subjective motivation.

Of these instruments, the autonomy-relevant subdimensions of the Work Design Questionnaire (WDQ; [29]) 'work scheduling autonomy, decision-making autonomy, and work methods autonomy' were selected as the basis for most of the present tool's items. The WDQ is among the most comprehensive and psychometrically well-established instruments reviewed, assessing task, knowledge, social, and contextual characteristics of work within a single integrated framework, with internal consistency reliabilities ranging from .64 to .95 across its subscales. As the WDQ measures autonomy as a structural, job-referent characteristic rather than a self-referent belief in one's own capability, its items were substantially reworded for the present study rather than

adopted as-is; this distinction, and its rationale, is discussed in the preceding section on structural autonomy versus perceived autonomy competence.

None of the instruments reviewed above, all developed between 1974 and 2006, address autonomy in relation to digital tools and technologies, a facet of contemporary work that has become increasingly central to nursing practice with the accelerating digitalization of healthcare. Digital competence is now recognized as a core professional requirement, with the World Health Organization recommending its integration into healthcare curricula [30], and scoping reviews documenting its growing role across documentation, clinical decision-support, and telehealth contexts in nursing practice [31]. This gap could not be filled by adapting existing items and instead required writing new items specific to this facet of autonomy, described in the Instrument section below.

2. Methods

2.1 Research Design

This study adopted a psychometric (methodological) design, relying on a structured self-administered questionnaire. The study aimed not only to assess nurses' perceptions of work autonomy but also to explore its underlying factor structure through item adaptation, clarity pre-testing, and reliability testing.

2.2 Participants

The study was conducted among nurses working at Ibn Sina University Hospital in Rabat, Morocco, across three facilities: the Children's Hospital, Souissi Maternity Hospital, and the National Institute of Oncology "Sidi Mohamed Ben Abdellah." A total of 286 nurses participated.

2.3 Instruments

The Work Design Questionnaire by Morgeson & Humphrey (2006), accounting for its autonomy-relevant subdimensions (scheduling, decision-making, and work-methods autonomy), was the basis for developing this study's instrument. Where seven of the fourteen items were adapted from the of the WDQ but with a thoughtful and consistent shift in framing rather than simple rewording: WDQ items are job-referent, asking whether the job itself offers discretion (e.g., "The job allows me to plan how I do my work"), while the present items are self-referent, asking about the respondent's own perceived capability (e.g., "I am able to set my own working hours"). This shift was intended to align item content with the study's aim of measuring perceived autonomy competence. A self-efficacy-based construct [8], [10] rather than the structural job characteristics the WDQ was originally designed to assess.

Three further items addressing relational autonomy (communication with supervisors, collegial relationships, and participation in team decision-making) were newly developed for this study using the same self-referent framing. At the same time, conceptually related to the WDQ's broader social-characteristics dimension, their content differs substantially from the WDQ's original items, and they are not considered direct adaptations. The remaining four items were also newly developed, using the same self-referent framing, to capture perceived competence in relation to digital tools and technologies, a facet of contemporary nursing practice not addressed by the WDQ or by any of the other instruments reviewed above, given the accelerating digitalization of healthcare since these instruments were developed [30], [31]. Items were adapted and reformulated, and new items written, to reflect the specific context of autonomy competency in a nursing practice, drawing also on theoretical descriptions of autonomy as encompassing knowledge, action, and value bases[1], self-directed rule-setting [4], and core autonomy-related competencies [5]. This process resulted in an initial pool of 14 items grouped into four theoretical dimensions, each rated on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree):

- **Autonomy in Work Planning (4 items):** measures control over planning, including goal setting, working hours, breaks, and participation in decisions about the work environment.
- **Autonomy in Work Methods and Procedures (4 items):** measures participation in developing rules and procedures, problem-solving, selecting methods, and effective use of tools.
- **Relational Autonomy (3 items):** measures autonomy in communicating with hierarchy, collaborating with coworkers, and participating in group decision-making.
- **Learning and Development Autonomy (3 items):** measures commitment to skill development, application of new knowledge, and confidence in using required tools.

2.4 Validity and Reliability

A clarity pre-test was conducted with five nurses before final scale administration to assess the clarity, comprehensibility, and phrasing of each item. Nurses were given a grid and asked to grade each item on a scale from 1 to 5 to identify any items that were vague, difficult to understand, or unclear in meaning. All items were judged clear and comprehensible except one: "I am able to solve the problems encountered in my work" (Work Methods dimension), which two nurses

found unclear. It was reformulated as: "I am able to solve problems encountered at work independently."

2.5 Data Collection and Analysis

The quantitative data were processed using SPSS version 25.0; descriptive statistics were calculated, including means, standard deviations, and demographic distributions. Reliability was assessed using Cronbach's α , and exploratory factor analysis (EFA) was conducted to identify the underlying dimensions of work autonomy competency. Sample adequacy was verified using the Kaiser–Meyer–Olkin (KMO) measure, and Bartlett's test of sphericity was used to confirm the suitability of the data for factor analysis [32]. To extract factors, three indicators were considered. The first was eigenvalues greater than 1, the second was the scree plot, and the third was parallel analysis [33], comparing observed eigenvalues against randomly generated datasets of equivalent size repeated 1,000 times using Monte Carlo PCA software [34]. Given the number of items in the questionnaire, an overall autonomy score was computed as the mean of all 14 items.

3. Findings

3.1 Sample Characteristics

The study sample consisted of 286 participants, the majority of whom were female (76.6%), while males represented 23.4%. 32.9% of participants worked at the Children's Hospital, 31.8% at Souissi Maternity Hospital, and 35.3% were nurses at the National Institute of Oncology. Years of professional experience varied considerably: 22.7% had between 1 and 5 years of experience, 17.8% between 5 and 10 years, and 9.8% less than 1 year. Among more experienced nurses, 30.8% reported between 10 and 15 years of experience, 7.0% between 15 and 20 years, and 11.9% more than 20 years.

3.2 Item Analysis

Participants rated their perceptions of their autonomy competency on the 14-item scale using a 5-point Likert format. Descriptive statistics, including means, standard deviations, skewness, and kurtosis, were computed for each item (see Table 3). Item means varied from $M = 4.03$ to $M = 4.37$, reflecting generally high levels of perceived autonomy across the four theorized dimensions. Standard deviations varied from $SD = 0.64$ to $SD = 0.80$, indicating adequate variability in responses. Skewness values were slightly negative, suggesting a tendency toward higher scores, which is common in perception-based measures. Kurtosis values were within acceptable limits (± 2), supporting the assumption of approximate normality.

Table 1. Descriptive Statistics for the 14 Autonomy Scale Items (N = 286)

Descriptive Statistics						
	Mean	Std. Deviation	Skewness		Kurtosis	
				Std. Error		Std. Error
Item_01	4.31	.668	-.526	.144	-.415	.287
Item_02	4.08	.795	-.602	.144	.173	.287
Item_03	4.06	.801	-.609	.144	.188	.287
Item_04	4.13	.719	-.534	.144	.478	.287
Item_05	4.23	.681	-.520	.144	.024	.287
Item_06	4.20	.752	-.738	.144	.605	.287
Item_07	4.21	.762	-.997	.144	1.675	.287
Item_08	4.23	.736	-.812	.144	.928	.287
Item_09	4.24	.720	-.845	.144	1.202	.287
Item_10	4.03	.796	-.602	.144	.272	.287
Item_11	4.16	.704	-.424	.144	-.269	.287
Item_12	4.19	.728	-.740	.144	.909	.287
Item_13	4.27	.682	-.605	.144	.083	.287
Item_14	4.37	.645	-.522	.144	-.663	.287

3.3 Factor Analysis

To detect the underlying structure of the scale, an exploratory factor analysis (EFA) using Principal Axis Factoring (PAF) was conducted. This extraction method was deemed appropriate to satisfy the purpose of this study based on shared variance rather than total variance. A ratio of at least 5 respondents to 1 item is widely accepted in theory as a minimum and 20 respondents to 1 item as a maximum [35], [36], [37]. In this study, a ratio of 20 respondents to 1 item was used, as it's the recommended method for determining the sample size for EFA. To examine if the data were suitable for factor analysis, the Kaiser–Meyer–Olkin (KMO) indicator was measured along with Bartlett's Test of Sphericity; these two measures were both satisfactory ($KMO = .921$), which exceeds the recommended threshold, and a Bartlett's test of $\chi^2(91) = 2554.37$, $p < .001$ which reflects excellent adequacy of the data for a EFA [38].

Three methods were used to extract factors: first, the Kaiser criterion (eigenvalues > 1), second the scree plot and for greater accuracy parallel analysis. Initially, the Kaiser criterion suggested two factors, along with the scree plot

(Figure 1), with multiple items loading on the two factors; a parallel analysis was conducted to determine the robustness of these two factors [33]. The eigenvalues were compared with those from 1,000 random datasets generated from equivalent data of 286 respondents and 14 items. The results showed that only the first factor with an eigenvalue of 7.497 surpassed its corresponding random criterion value of 1.3894. The second factor's eigenvalue, which equaled 1.207, fell below its random measure of 1.294, signifying that it did not represent meaningful shared variance and should not be retained. One factor was therefore extracted, which accounted for 50.09% of the total variance.

In another run of EFA with the number of factors fixed at 1, all 14 items loaded strongly onto this factor, ranging from .607 to .790 (Table 2). Moreover, communalities ranged from .369 to .625, indicating that most items were above 0.4, except for the second item (Table 3).

Consequently, instead of the 4 theoretical dimensions stated above, the one factor extracted was therefore labeled “**Perceived workplace Autonomy**”, reflecting an overall unified construct encompassing the ability to:

- Organize and plan one’s work;
- Contribute in workplace decisions;
- Communicate and collaborate freely;
- Choose methods and solve problems autonomously;
- Use tools, develop skills, and apply new knowledge autonomously.

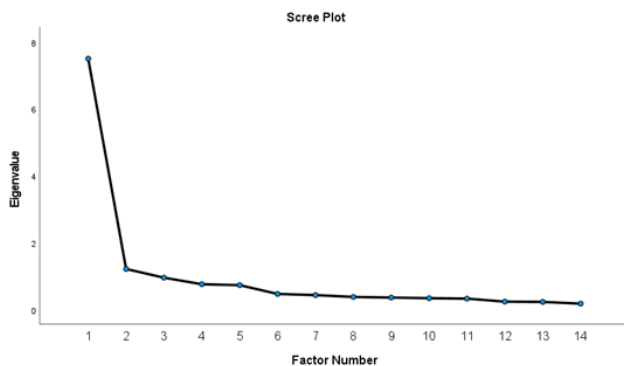


Figure 1. Scree plot of factor analysis

Table 2. Factor loadings

Factor Matrix a	
	Factor
	1
Item _01	.700
Item _02	.607
Item _03	.645
Item _04	.751
Item _05	.790
Item _06	.738
Item _07	.652
Item _08	.770
Item _09	.758
Item _10	.634
Item _11	.790
Item _12	.750
Item _13	.633
Item _14	.650
Extraction Method: Principal Axis Factoring.	
a. 1 factors extracted. 4 iterations required.	

Table 3. Communalities

Communalities		
	Initial	Extraction
Item _01	.554	.490
Item _02	.534	.369
Item _03	.526	.416
Item _04	.652	.563
Item _05	.738	.625
Item _06	.635	.544
Item _07	.578	.425
Item _08	.683	.593
Item _09	.590	.575
Item _10	.471	.402
Item _11	.688	.625
Item _12	.631	.563

Item _13	.498	.400
Item _14	.511	.423
<i>Extraction Method: Principal Axis Factoring.</i>		

4. Discussion

This study's objective was to test the psychometric properties of a preliminary scale measuring **Perceived workplace Autonomy (PWAS)**. The initial scale was designed, based on theoretical frameworks and prior literature, to identify the multiple dimensions of autonomy in the workplace: Autonomy in Work Planning, Autonomy in Work Methods and Procedures, Relational Autonomy, and Learning and Development Autonomy. Exploratory factor analysis using Principal Axis Factoring, combined with parallel analysis for factor retention within a population of nurses in a workplace setting. The latter revealed that a single underlying factor best represented the data, accounting for 50.1% of the variance. Internal consistency, as measured with Cronbach's alpha, was excellent (0.901), along with sample adequacy, as represented by KMO and Bartlett's test of sphericity.

These results suggest that, within this sample of Moroccan hospital nurses, perceived workplace autonomy is conceptualized as a unified, global construct rather than as a set of separable sub- dimensions. All items whether originally conceived as reflecting planning, methods, relational, or developmental autonomy loaded strongly and consistently onto a single factor, with loadings ranging from .61 to .79. This indicates that nurses who report high autonomy in one domain (e.g., setting work objectives) tend also to report high autonomy across all other domains (e.g., communicating with hierarchy, applying new skills), rather than showing the differentiated patterns that would be expected if these were truly distinct constructs.

This result diverges from theoretical models that decompose autonomy into multiple discrete facets, such as [29] own multi-faceted treatment of autonomy within the Work Design Questionnaire, from which seven of the fourteen items were derived. As outlined in the Background, however, this divergence is arguably expected rather than anomalous: the present items were deliberately reframed from the WDQ's job-referent stems (assessing the structural discretion afforded by the workplace) to self-referent stems assessing perceived personal abilities, aligning the construct with self-efficacy theory [8] rather than with structural job-design theory.

This construct-level shift offers the most parsimonious explanation for the present unidimensional finding. Self-efficacy and perceived-competence constructs are consistently and robustly found to be unidimensional across

domains. For example, the New General Self-Efficacy Scale [10] reliably yields a single factor despite drawing on multiple behavioral contexts, and the competence dimension of Spreitzer's [9] psychological empowerment framework is similarly treated as a coherent, generalized self-belief rather than a set of separable task-specific beliefs. If the present scale is better understood as measuring perceived workplace autonomy competence, a self-referent belief in one's own capability, rather than structural job autonomy, then its unidimensional structure is consistent with, rather than surprising relative to, the broader self-efficacy literature.

A further notable finding concerns the seven newly written or substantially reworded items, suggest that, within this sample, nurses do not experience relational autonomy or autonomy over digital tools and ongoing skill development as functionally distinct from more traditional forms of task, scheduling, and decision-making autonomy rather, all of these appear to be integrated into a single, generalized sense of perceived autonomy competence, consistent with the self-efficacy-based interpretation offered above. This is a preliminary finding, given that these items were newly developed and not previously validated, but it is consistent with the broader unidimensional pattern observed across the scale.

A further, complementary explanation is that, in the specific organizational and cultural context of Moroccan public hospitals, autonomy may also be granted or withheld holistically at the structural level; that is, a nurse who is trusted with independent decision-making in one respect (e.g., scheduling) may also be trusted in others (e.g., relational or developmental respects), which could reinforce a generalized rather than domain-specific self-perception of competence. The latter is consistent with findings that autonomy is often shaped by wider institutional and hierarchical structures rather than by task-specific delegation alone [11]. However, this justification was not directly tested here and remains hypothetical.

5. Limitations

As with all studies, the present one presents several limitations. We note that an expert panel did not formally measure content validity, so no Content Validity Index was calculated; we recommend that future work include a structured expert panel evaluation of item relevance and representativeness to guarantee item validity. In addition, when item means were calculated, values ranging from 4.03 to 4.37 were found, indicating a possible ceiling effect that may limit the scale's ability to discriminate between nurses with varying levels of autonomy and raise the possibility of social desirability bias given the self-administered format. At

last, for more robust results, a confirmatory factor analysis is required on an independent sample to verify this structure before the scale can be considered fully validated for broader use.

As noted in the Background, the items comprising this scale reflect general dimensions of workplace autonomy (e.g., planning, methods, relationships, development) rather than nursing-specific clinical autonomy. Indeed, the study was conducted in a healthcare setting within a nursing sample. Still, its content is not exclusive to nursing practice, making it applicable to other workplace settings and, consequently, other professional groups.

6. Conclusion

The study offers preliminary indication for a psychometrically promising, unidimensional, and reliable scale measuring perceived workplace Autonomy, demonstrating excellent internal consistency and a statistically supported single-factor structure. Rather than touching on multiple dimensions, autonomy appears to be experienced by nurses in this sample as an integrated, overall construct. Further psychometric testing, including confirmatory factor analysis in independent samples, is recommended before the Perceived Workplace Autonomy Scale (PWAS) can be considered a validated scale for wider use. In the meantime, this tool may help healthcare managers gain an overall picture of perceived workplace autonomy and identify opportunities for targeted continuous training to strengthen autonomous practice.

APPENDIX 1:

Table 4. Perceived workplace autonomy scale (PWAS) original scale

Items
Je peux réussir les actions suivantes dans la mesure où il me serait accordé de les faire :
Fixer des objectifs de travail.
Fixer des heures de travail.
Planifier des moments de pauses, de congés et d'absences en cas de besoin.
Participer à la définition des règles et des procédures qui régissent mon travail.
Participer à la prise de décision concernant la gestion de mon espace de travail.
Prendre l'initiative de participer à la prise de décision au sein de mon équipe de travail.
Je suis en mesure de :
Communiquer librement avec ma hiérarchie.

Etablir des relations de travail positives avec ma hiérarchie.
Mettre en pratique mes nouvelles compétences au travail.
Résoudre les problèmes rencontrés au travail de manière autonome.
Sélectionner les méthodes et techniques que j'estime les plus appropriées pour accomplir mes tâches.
Utiliser les outils et technologies nécessaires disponibles pour effectuer mon travail efficacement.
J'estime que je suis:
Engagé à apprendre et à développer de nouvelles compétences et apprendre de mes erreurs.
Confiant dans mes capacités à maîtriser les outils et les technologies nécessaires à mon travail.

APPENDIX 2:

Table 5. Perceived workplace autonomy scale (PWAS) English translation

Items
I am able to set work objectives.
I am able to set my own working hours.
I am able to plan breaks, leave, and absences when needed
I am able to participate in defining the rules and procedures that govern my work.
I am able to participate in decision-making regarding my work environment
I am able to take the initiative to participate in decision-making within my work team.
I am able to communicate freely with my supervisors.
I am able to establish positive working relationships with my colleagues.
I am able to apply newly acquired skills in my work.
I am able to solve problems encountered at work independently
I am able to select the methods and techniques I consider most appropriate to accomplish my tasks.
I am able to use the available tools and technologies necessary to perform my work effectively.
I am committed to learning and developing new skills, and to learning from my mistakes.
I am confident in my ability to master the tools and technologies necessary for my work.

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