HOSPITAL ADMINISTRATORS' PERSPECTIVE OF AND RESPONSE TO NURSING TURNOVER

BY BRENDA GREGORY

A THESIS PRESENTED TO THE UNIVERSITY OF MANITOBA IN FULFILMENT OF THE THESIS REQUIREMENT FOR THE DEGREE OF MASTER OF EDUCATION IN THE DEPARTMENT OF GRADUATE STUDIES

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ABSTRACT

Historically, hospitals in North America have experienced a high turnover rate in their nursing staff. Although the definition and measurement of turnover is difficult to capture, it has been found that the turnover of general duty nurses is more than four times higher than the turnover of members from other professional and technical occupations. Nursing turnover is thought to hinder the efficiency of hospitals and the quality of care delivered to patients. It is the hospital administrators responsibility to supervise and manage employees to ensure that all of the departmental efforts are coordinated towards achieving the organizational goal of providing quality patient care.

The purpose of the study was to obtain the hospital administrators' perspective on the phenomenon of turnover amongst general duty Registered Nurses and to investigate what strategies were in place in their institutions to retain nurses. As well, the study attempted to inquire as to why certain strategies were implemented and how effective they were.

The study design was a survey and the instrument that was devised was a semi-structured open-ended interview schedule. After a pilot study, Eight Executive Directors and one Assistant to an Executive Director (non-nurse) were interviewed.

The findings revealed that none of the participants in

the study viewed nursing turnover as a problem and that only one third of the participants knew the turnover rates for their facilities. Overall, the hospitals were doing a poor job of measuring nursing turnover. Few of the Executive Directors offered deliberate retention strategies aimed at reducing the exodus of general duty nursing employees. The most notable strategy that was being considered by several facilities to retain nurses was futuristic, and involved re-defining the role of the nurse and articulating non-nursing functions. The rationale for this endeavour was attributed as an indirect response to the provincial-wide nurse's strike of January 1991.

The study concluded that nursing turnover was not seen to be an important problem by hospital administrators, and that it was not measured properly by the hospitals in the study. As a consequence, it is unlikely that nursing turnover will be effectively reduced or controlled in hospital organizations.

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Dedicated to all nurses who practice in hospitals

....past....present....future.

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I) INTRODUCTION

Background Information For The Study

Historically, hospitals in North America have experienced a high turnover rate in their nursing staff. In the United States, a study conducted by the American Nurses' Association in 1962, revealed an annual turnover rate in excess of 40% (Cavanagh, 1989). Hospital nursing turnover increased to an alarming degree in the mid 1970s and was reported to be as high as 61% (Marquis, 1988). A 1980 report by the American Nurses' Association, and the National Association of Nurse Recruiters estimated the average turnover rate for Registered Nurses employed in hospitals between 32 and 40% (Wolf, 1981). More recently, the 1987 statistics from a survey conducted by the National Association for Health Care Recruitment, listed the crude nurse employee turnover rate at 20% nationally (Wall, 1988).

Data regarding the velocity of nursing turnover in Canada is obscure, at best. Unpublished information collected by Statistics Canada, and Health and Welfare Canada in an annual survey of health care facilities during the 1977/78 fiscal year reported a 21% turnover rate in full-time nursing staff. This turnover rate fell substantially to 13% in 1984/85. Interestingly, these national figures were considerably lower than those calculated in individual provincial studies. Provincial calculations of turnover during the same year,

revealed varied and dramatic ranges in their results. The Nova Scotia Department of Health, Council of Teaching Hospitals, and Registered Nurses Association reported a 0-80% nurse turnover rate in their province. The Alberta Hospital Association reported nursing turnover in their province as 26-33%, and the New Brunswick Manpower Consultative Committee on Nursing Shortage documented a 0-32% nurse turnover rate in their province (Employment and Immigration Document, May 1988). These findings reflect both tremendous national variation and major methodological differences in the definition and measurement of nursing turnover in Canada.

Although the rates and measurement of turnover vary between wards, institutions and regions, it has been found that the turnover of general duty nurses is more than four times higher than the turnover of members of all professional and technical occupations (Price, 1977). James Price and Charles Mueller in their book; Professional Turnover: The Case of Nurses, report that hospital nurses have more than three times the turnover rate of teachers and one and one-half times the turnover rate of social workers (cited in Munro, 1983).

Impact Of The Problem

The effects of nursing turnover are felt throughout the hospital organization, the nursing profession and society at large. A degree of turnover can be viewed as needed for renewal of the organization, however excessive turnover can specifically affect: the budget of the hospital, the productivity of the staff, organizational effectiveness and the quality of patient care the hospital delivers, the professional image of nursing, the cost of nursing education and finally, the cost of health care in Canada.

The most obvious problem with Registered Nurse turnover in hospitals is its tremendous cost to the organization. The direct cost of replacing a Registered Nurse considers recruitment and orientation of a new nurse and the cost for overtime pay to cover the vacancy. This cost has consistently been estimated from study to study to be between 2,000 to 3,000 American dollars per nurse (Wall, 1988). In addition to these projections, the analysis of replacing critical care nurses has found that the complexities of this type of nursing require an extended education and orientation period. Some organizations have estimated the cost of replacing an intensive care nurse between $7,000 and $8,000 (Hinshaw et.al., 1987). Thus an average urban hospital that contains approximately 300 beds and employs 500 Registered Nurses and has an annual turnover rate of 30%, requires 150 new positions to be filled every year at a cost of approximately $500,000 to

the hospital. Almost a half a million dollars for one institution is a staggering expense, when it is simply required to replace staff.

In addition to expenses incurred for obtaining replacements for resigning nurses, there are other critical factors to be considered when reviewing nursing staff turnover. The first factor to appraise is the effect turnover has on overall employee productivity. As Flamholtz discovered in his research during the early 1970s, staff turnover translates into such things as loss of efficiency on the part of the leaver prior to the separation, the lag time of the new employee to become efficient, and the increased workload left to existing employees who must perform the tasks (Mobley, 1982). In addition to this, Staw's research findings in 1980 indicated that turnover may by itself stimulate additional turnover by highlighting the fact that alternative jobs may be available (Mobley, 1982). Group cohesiveness and morale may understandably decline with high turnover, which in turn could markedly affect overall staff performance.

Another important factor to consider in conjunction with employee productivity is the notion of organizational effectiveness. Organizational effectiveness is the degree to which an organization achieves its goals. The most prominent goal of any hospital is to deliver quality patient care services. This goal is the primary responsibility of the Department of Nursing. If the Department of Nursing makes up

50-70% of the employees of the hospital (Vogt et.al., 1983) and is responsible for providing care to all patients, the most disturbing potential consequence of high nurse turnover rates, is the loss of overall organizational effectiveness of the hospital, in relation to the quality of patient care it provides. Although further research is required to arrive at an assessment of turnover's net impact on organizational effectiveness, James Price, in his book The Study of Turnover, reports "There is certainly an impressive amount of data supporting the idea that successively higher amounts of turnover probably produce successively lower amounts of effectiveness" (1977, p.115). Indeed, there is mounting evidence to suggest that nursing staff turnover disrupts overall staff productivity and can be detrimental to the quality and quantity of patient care (Cavanagh, 1989). This has serious implications for the care itself as well as for the image of the hospital because ultimately, nursing staff turnover compromises the quality of patient care services the organization strives to deliver.

The historic high rate of attrition among nurses in hospitals has damaged the professional image of nursing. Nursing is a unique profession in that it is female dominated, (97 percent of nurses are women according to Statistics Canada 1988) and provides a 24 hour a day, 7 day a week, 365 day per year service to its clients. Although the labour participation rate of Canada's 249,673 Registered Nurses

amounts to 92 percent, 37 percent of those who are employed assume part-time positions (Statistics Canada, 1988). Furthermore, roughly 60 percent of the nurses working in hospitals are under 40 years of age (Green, 1987). These statistics combined with turnover rates in hospitals, invite questions as to whether nurses commit themselves to their profession and career on a lifelong basis.

Nursing education takes place in institutions such as Universities, community colleges and hospitals. The financing for post-secondary education in Canada is heavily subsidized, and funding comes primarily from the provincial governments, and partially from the federal government. Payments are transferred between the health and education sectors of the government such that the nursing student ends up paying only 10 -15% of the total cost of her education. With regard to nursing students and their career patterns following graduation, it would appear that Canadian society is not getting their money's worth out of their nursing workforce. Nurses that opt out of work before retirement age, force more nurses to be trained, which in turn drives up the costs of nursing education, and ultimately drains the public purse.

Finally, nursing turnover can be said to have a tremendous impact on the financing of the Canadian health care system. Universal health care in Canada is funded by governments, which receive their revenue by taxing the citizens in the country. When a quarter of a million

Registered Nurses represent almost half of all Canadian health care workers, and more than 65% of these nurses work in a hospital setting (Statistics Canada, 1988), and 50% of a hospital's budget is for its payroll, and more than 70% of this figure is for nurses' salaries (Vogt et.al., 1983), and approximately 30% of those nurses leave the organization annually, it would appear then that the government is pouring health care dollars into a bucket that has a gaping hole in its bottom.

Statement Of The Problem

A review of the literature and my personal experience as a nurse, indicate that turnover amongst nursing employees in hospitals is problematic and hinders the efficiency of the organization and the quality of care delivered to patients. In the last decade, the phenomenon of nursing turnover in hospitals has been perceived as a disturbing and complex problem by nurses. Nursing research, nursing texts, and nursing journals have recognized it, and have devoted much time and effort to investigate and discuss the phenomenon and its challenging causes and potential solutions. Unfortunately, there is only a small amount of Canadian literature on the topic, and any investigations that have been done (as discussed in the previous section) are replete with irregularities in methodology and reveal inconsistencies in the findings. According to the Manitoba Health Services

Commission, an investigation regarding nursing turnover in hospitals in this province has never been done. Consequently, a general overview and summary of the problem of nursing turnover in provincial hospitals within Canada is extremely difficult to present.

After reviewing the nursing literature on this phenomenon, I felt it was important to review the hospital administration literature, in order to obtain that perspective. After all, it is the staff nurses' general responsibility to provide care for patients in hospitals, but it is the hospital administrator's responsibility to supervise and manage employees to ensure that all of the departmental efforts are coordinated towards achieving the organizational goal of providing quality patient care. A disturbing finding in this literature review was the lack of recognition given to nursing turnover by authors of texts about hospital administration. Three books written in the 1980s regarding the management of health services organizations, the management of health care professionals, and the management of human resources in health services organizations, **did not mention the problem of nursing turnover!** (Fottler, Hernadez & Joiner, 1988; McConnell, 1984; Rakich, Longest & Darr, 1985). In fact, these books devoted fewer than five pages in total, to a discussion of employee turnover in general. This finding was not only disturbing, but bewildering as well. Why was nursing turnover not addressed in these texts? The most

obvious assumption on my part was that if the topic was not addressed by hospital administrators, it was not perceived as a problem. If that is the case, why would there be such divergent interests between nurses and hospital administrators on such a subject? Further literature searches revealed there is a dearth of information that outlines hospital administrators' perspective on any nursing issue, including expanded roles of the nurse, entry to practice, nursing research, and nursing care delivery modes. This discovery was alarming.

Textbooks that outline management theory and speak to hospital management in particular, repeatedly identify and delineate the major activities of managers. These functions include; planning, organizing, directing, controlling, coordinating, staffing, representing, decision making, communicating critical information, allocating scarce resources, managing conflict and change, creating a facilitating climate, and maintaining stability (Charns & Schaefer, 1983; Goldsmith, 1981; and Numerof, 1982). The general definitions of management vary but they basically state a similar premise:

> Management maintains control and supplies direction in the accomplishment of the goals and objectives within an organization (Numerof, 1982, p.242).
>
> Management work is decision making, in the broadest sense, addressed to the achievement of organizational performance (Charns & Schaefer, 1983, p.11).

It goes without saying that hospitals are tremendously diverse organizations and that the role of the manager is an exceedingly complex and difficult one. However most would agree that although the management process entails many interrelated activities and techniques, the ultimate responsibility of a manager is to ensure the organization performs effectively and efficiently. This responsibility involves a tremendous amount of decision making. These two critical functions are repeatedly identified in definitions of management theory: **decision making** that ensures and takes **responsibility for organizational effectiveness.**

With respect to management theory and nursing turnover, I found this particular statement by Numerof rather poignant: "The manager although not necessarily able to perform the work of the specialist, must know enough about the needs and functions of particular specialties to understand how they contribute to the whole (1982, p.236)." A review of the hospital administration literature and my experiences as a general duty nurse lead me to believe that hospital administrators do not address many of the needs or functions of nurses, and do not demonstrate sufficient understanding of how professional nurses contribute to the whole. The extensive review but limited discussion of management theory presented here gives rise to some important questions:

1) If the mandate of a corporate CEO is to manage personnel and resources to deliver a quality service, should not the CEO have a vision of how best to deliver that service?

2) What do hospital administrators know about nursing practice in the total context of patient care services?

3) More specifically, how do hospital administrators view nursing turnover?

Presently, nurses are being held accountable for the quality of care they deliver. Concurrently, nurse researchers are developing and expanding the body of scientific knowledge that forms the foundation for their practice. In order to deliver quality patient care by competent and accountable nursing staffs, it would seem essential that hospital administrators collaborate and support their nursing employees in order to provide this service. Specifically, this means that managers of hospitals should provide an environment that links nursing theory, research, education and practice to policy. A hospital administrator is rarely seen by a staff nurse and therefore nurses' opinions of administrators are largely based on their perception of the CEO's implicit views and decisions that are outlined in hospital policy and procedure manuals. Consequently, most staff nurses view hospital administrators as invisible and silent autocrats who are very unaware as to what goes on "at the bedside".

Sullivan illustrates this perception held by nurses toward hospital administrators most explicitly in the following statement; "Many of them believe that management's goal is the antithesis of nursing's goal: the care of patients" (1988, p.408). Why does there seem to be suppressed animosity held by nurses towards administrators? Could it be as Numerof stated, that nurses feel that hospital administrators do not know about their collective needs and professional functions or understand how they contribute to the "whole" of patient care services that are delivered in hospitals?

It is widely believed that the problem of turnover amongst hospital nurses lies in the nature of hospital nursing jobs and the incentive structures by which their work is rewarded, rather than the characteristics or motivations of individual nurses (Beyers et.al., 1983; Darbyshire, 1988; Hoffman, 1989; Huston & Marquis, 1989; McCloskey, 1974; Munro, 1983; Prestholdt, et.al., 1988; Ruffing et.al., 1984; Vogt et.al., 1983; Wolf, 1981; Weisman, 1982). It is the structure of the organization, design of the tasks that make up the job, allocation of resources, provision of rewards, and the creation of a facilitating climate that fall under the auspices of management. Thus, according to nurses, the problem of turnover does not lie solely with nursing personnel. Indeed, many nurses are of the opinion that much of the problem stems from the ranks of administration and their inability to manage the nursing personnel.

The implications from the turnover research in the past are especially important, because their results direct hospital and nursing administrators' attention to the specific aspects of nurses' jobs and the organizational settings within which they work, that may significantly contribute to the problem of nursing turnover in hospitals. The turnover research results suggest that by changing those conditions that contribute to nursing turnover, hospitals can substantially reduce this pervasive problem.

Purpose Of The Study

The purpose of this study is:

(1) To obtain hospital administrators' perspective on the phenomenon of turnover amongst general duty Registered Nurses;

(2) To investigate what strategies are in place in hospitals to retain nurses;

(3) To investigate why the retention strategies have been implemented;

(4) To investigate how effective the retention strategies are.

General Research Questions

1) How do hospital administrators perceive turnover amongst general duty Registered Nurses

in hospitals?

2) What strategies have been designed to prevent turnover and/or retain nurses?

3) Why have the strategies been implemented?

4) How effective are the strategies?

Significance Of The Study

Nursing turnover has received much attention from different fields of social inquiry, but it has received little attention from hospital administrators. This study focuses on the hospital administrator's perspective of turnover among general duty nurses that work in hospitals.

The study examines the relationship between general management principles and the principles of hospital management, and reveals gaps between what the hospital administration literature professes and how hospital administrators practice.

The study will demonstrate the importance of recognizing and incorporating the nursing perspective into hospital management concepts, theories, and models. In so doing, it urges social scientists to identify and increase the conceptual link between administrative theory, hospital administrative theory, and hospital policies and practice.

The intent of this research is to signal to students, practitioners and authorities of hospital administration that in order to direct activities within hospitals, it would be

appropriate to expect Executive Directors to have knowledge of nursing issues, nursing research and nursing care delivery modes, so that nursing practice- a large "product" and cost of hospital organizations- can be integrated in hospital policy.

Nursing turnover has a serious impact on the hospital organization, the nursing profession and society at large. This study hopes to contribute to the understanding of nursing turnover by: presenting relevant literature; exploring hospital administrator's attitudes regarding the phenomenon; and collecting data about current retention strategies and their effectiveness. It is hoped that the greater understanding of nursing turnover that this study offers, will prompt concerted efforts to alleviate the problem.

Finally, this study can potentially contribute to: improved dialogue between hospital administrators and nursing staff; changes in the organizational structure of hospitals; changes in the job design of general duty nurses; optimization of nursing services; improved retention and increased recruitment of nurses; decreased costs for nursing education; decreased costs for Canadian health care; and ultimately, improved patient care in hospitals.

II) REVIEW OF THE LITERATURE

THE PHENOMENON OF TURNOVER

Overview

People leaving organizations -employee turnover- is a major organizational phenomenon. Employee turnover is both an interesting and important subject because it has potentially critical consequences for the individual, the organization, and the community at large. The data from innumerable sources indicate and illustrate that employee turnover occurs in all organizations, regions and nations. It is for these reasons that turnover has been investigated in a vast number of studies and is likely to remain a key focus of personnel research by social scientists and managers.

The earliest recorded research that investigates employee turnover dates back to the early 1900s, and since then over 1,000 quantitative and qualitative studies on the subject have been carried out (Steers and Mowday, 1981). As the second half of the century evolved, additional research and several proposed conceptual models spurred occasional reviews of the literature. Although several reviews have been done, the most notable general publications include March and Simon, 1958; Porter and Steers, 1973; Price, 1977; Mobley, Griffeth, Hand and Meglino, 1979; Mobley 1982; and Cotton and Tuttle, 1986. All of these reviews recognize the multiple determinants of

turnover and the need for incorporating study variables into conceptual models for future testing. These publications have contributed greatly towards the understanding and development of a comprehensive field concerning employee turnover.

Definition

There are many alternative definitions of turnover presented in the scientific literature. Generally speaking "turnover" refers to individuals who leave organizations. Price defines turnover as "... movement across the membership boundary of a work organization" (1977, p.3-10). Mobley's definition of employee turnover is: "The cessation of membership in an organization by an individual who received monetary compensation from the organization" (1982, p.10).

Given these general definitions of employee turnover, researchers have distinguished amongst various types of cessations. A major distinction in the definition of turnover is whether or not the individual's separation has been voluntary or involuntary. Involuntary turnover is generally classified as death, retirement, dismissal or layoff, whereas voluntary turnover is most commonly classified as quits (Price & Mueller, 1986). The most critical element in the distinction of voluntary and involuntary turnover in organizations is the exercise of choice by the individual (Price, 1977). Voluntary turnover then, as defined by the U.S. Bureau of Labour Statistics is, "...individual movement

across the membership boundary of a social system which is initiated by the individual" (Price, 1977, p.3-10). This definition appears simple, however the distinction between voluntary and involuntary turnover remains deceptive.

Researchers have used varying methodologies to distinguish between voluntary and involuntary turnover but to date, a consensus has not been reached. What category does an individual who quits before they are fired fall into? What category does pregnancy fall into?

Although most research focuses on voluntary turnover, there is still no valid, reliable, or standard procedure to distinguish empirically between voluntary and involuntary employee turnover.

Measuring Turnover

In the literature there exist several methods for calculating employee turnover rates. The most comprehensive description of these methods are found in Price (1977) where he identifies six of the most commonly used methods:

1. Average Length of Service-

   (Stayers): sum of the length of service for each member divided by the number of members.

   (Leavers): sum of the length of service of all members who leave during a period.

2. Crude Turnover Rates-

   (Accession rate): number of new members added

during the period divided by the average number of members during the period;

(Separation rate): number of members who left during the period divided by the average number of members during the period;

3. Stability rate- number of members who remain during the period divided by the number of members at the beginning of the period;
4. Instability rate- number of members who leave during the period divided by the number of members at the beginning of the period;
5. Survival rate- number of new members who remain during the period divided by the number of new members;
6. Wastage rate- number of new members who leave during the period divided by the number of new members.

It would appear that the most prevalent calculation for measuring turnover in organizations is the separation rate. This calculation not only provides the broadest indication of the turnover problem, it also is the most convenient for allowing comparability between and among research findings (Price 1977, Mowday et.al., 1982). Once again however, measuring the rate of turnover is a complex problem. To date there is no valid, reliable, and standard procedure for measuring turnover rates. Many authors are keenly aware, that

the characterization of turnover by statistical means is extremely problematic. Each formula has its shortcomings, and yet each calculation taps a different aspect of turnover. Meaningful analysis of employee turnover requires more than computation of aggregate turnover rates, and this will be discussed in the Retention Strategies section of this Chapter.

Factors Related To Turnover

The literature is replete with studies attempting to identify specific causes or variables which will predict employee turnover in organizations. Unfortunately, no circumscribed interrelated set of variables (in the form of a model) have been identified which cause or predict which employee will leave their job and at what time (Models of Turnover can be found in March & Simon, 1958; Mobley, Griffith, Hand & Meglino, 1979; Price 1977; Steers & Mowday, 1981). When reviewing some of the isolated studies of turnover, one discovers contradictory findings among them, both supporting and rejecting the effects of certain variables. Compounding these difficulties, is the fact that many different research methodologies have been adopted in turnover studies, making comparison of the results difficult.

Several reviews of the turnover literature alleviate the confusion in that they have attempted to assess and categorize studies which investigated factors that had a consistent (strong or weak) relationship with the phenomenon of employee

turnover. These reviews discovered that there are indeed some major factors that strongly correlate with turnover, as well as several sub-factors that have been identified as being consistently significant or non-significant in their relationship with the turnover process as well.

The major factors that have been identified as being consistently related to turnover are: 1) Economic Factors; 2) Organizational Factors; 3) Job Factors; 4) Demographic Factors, and; 5) Individual Factors (Cotton & Tuttle, 1986; Mobley, 1982; Price, 1977).

The sub-factors of turnover, tend to operationalize the major factors they have been assigned to. Some examples of the sub-factors are as follows;

1) Economic Factors- unemployment levels, inflation rate, job market, etc.

2) Organizational Factors- size, centralization, reward system, communication patterns, etc.

3) Job Factors- pay, responsibility, autonomy, role clarity, coworkers, supervisors, etc.

4) Demographic Factors- age, education, gender, family responsibilities, spouse's career, etc.

5) Individual Factors- values, abilities, intentions, work ethic, leisure preferences, etc.

The following summary is the writer's overview of the reviews of the literature. The factors of turnover are listed with their sub-factors in vertical columns one and two in

Table 2.1. The third vertical column in the table is labelled "Relationship", and refers to the strength of the relationship between the factor and sub-factor as delineated by the review works of Price, 1977; Mobley, Griffeth, Hand, & Meglino, 1979; Mobley, 1982; and Cotton & Tuttle, 1986. The relationship category is based upon the writer's subjective review of those authors' evaluation of the quality, quantity and interpretability of published research. It must be said that the review is limited to published studies, therefore the analysis is biased because published studies usually tend to report significant effects.

The column entitled "Relationship" indicates the magnitude of the relationship. All the variables listed in the table are potentially related to turnover, however those sub-factors that are listed as strong and medium appear to provide the strongest generalizations possible on turnover to date. The mark of (-) refers to a negative relationship, that is; the higher the variable the lower the turnover, or the lower the variable the higher the turnover. The mark of (+) refers to a positive relationship. A positive relationship can be interpreted as; a high variable will in all likelihood be related to high turnover, and a low variable will in all likelihood be related low turnover. The variables that are listed as weak, have for the most part, been studied with insufficient frequency to evaluate their relevance. A strength listed as "contradictory" means a number of research

projects have found strong support for the relationship, while other research endeavors have found no support for the relationship at all. The term "inconclusive", means an inadequate number of studies were done for findings to be considered significant, or incomparable methodologies were utilized to obtain significant results.

Table 2.1 An Interpretive Summary of Research on Factors and Sub-Factors Related To Turnover

Factors	Sub-Factors	Relationship
A. Economic Factors	-level of unemployment	strong -
	-union presence	strong -
	-inflation	weak + -
B. Organizational Factors	-pay	strong -
	-centralization	medium +
	-integration	medium -
	-communication	medium -
	-type of industry	weak + -
	-work-unit size	weak + -
	-organizational size	weak + -
	-routinization	contradictory + -
	-reward system	not studied
C. Job Factors	-pay	strong -
	-stress	not studied
	-satisfaction	
	:work itself	medium -
	:role clarity	medium -
	:autonomy & responsibility	medium -
	:supervisory style	medium -
	:promotional opportunities	medium -
	:conditions of work	medium -
	:coworkers	medium -

D.	Demographic Factors	-age	strong -
		-tenure	strong -
		-number of dependents	strong +
		-spouse's career	not studied
		-satisfaction with job content	medium +
		-gender	contradictory + -
		-education	contradictory + -
E.	Individual Factors	-overall satisfaction	strong -
		-intentions to quit	strong +
		-organizational commitment	strong -
		-employment perceptions	medium +
		-professionalism	inconclusive
		-career expectations	inconclusive
		-performance	inconclusive
		-aptitude and ability	inconclusive
		-intelligence	inconclusive
		-personality inventories	inconclusive
		-absenteeism	inconclusive
		-interests	inconclusive

Discussion Of The Turnover Research

Even with the vast amount of turnover research that has been collected to date, relatively few strong generalizations are possible. As can be seen by the table; age, tenure, pay, overall job satisfaction, union presence, level of unemployment, number of dependents, behavioral intentions to quit, and organizational commitment have consistently been found to be stable, reliable sub-factors related to turnover. Thus, the empirical statements made about turnover such as,

"High levels of unemployment are associated with low levels of turnover" and "Older employees are less likely to turnover than younger employees", indicate a correlational but not necessarily a causative relationship. But the strong sub-factors listed in Table 2.1 combined (such as age, tenure, organizational commitment, job satisfaction etc.) **explain less than 20% of the variance in turnover studies** (Mobley, Griffeth, Hand & Meglino, 1979; Price & Mueller, 1986).

Several problems have been identified with the turnover research:

1. Infrequent longitudinal studies- most studies examine turnover on a cross-sectional versus a longitudinal basis;
2. Insufficient multivariate studies- most research examines singular sub-factors of turnover;
3. Failure to integrate Factors- most studies look at turnover in relation to the economy, the organization, the job, or the individual, and rarely are the variables integrated into one "big picture", namely a systems approach.
4. Difficult construct definition- many of the sub-factors associated with turnover are complex constructs to define (for example; job satisfaction, organizational commitment or integration). Although they appear related to turnover, there may be limitations in the research

design that make comparisons between findings difficult. As well some sub-factors may be related to other sub-factors (for example age) and are difficult to isolate.

5. Insufficient testing of sub-factors- recently studied factors such as met-expectations, intentions, stress, organizational rewards, spouse's career and organizational commitment have not been tested extensively and appear to have considerable impact on the turnover process.
6. Insufficient research on the consequences of turnover in relation to the individual, the organization, and the society
7. Contradictory summaries- not all of the reviews of the literature arrive at the same inferences
8. Insufficient development of turnover process models- the concept of turnover has not been developed adequately to guide research design and interpretation. (Price, 1977; Mobley, Griffeth, Hand & Meglino, 1979; Mobley, 1982; Cotton & Tuttle, 1986)

A great deal is known about employee turnover, however as this section has pointed out, there is still much to discover. Those who have studied employee turnover have yet to come up with a satisfactory definition, and experts can not agree as to how it should best be measured. The presented summary of

turnover findings outlines that many factors, that are at times entwined, are involved. To date, there are no models that will explain or predict employee turnover with a high degree of accuracy. Mobley writes;

> The challenges before us are to develop this body of knowledge further, to address the voids in the body of knowledge, and to translate this body of knowledge into more effective management, of employee turnover in particular, and of human resources in general. (1982, p.133)

THE PHENOMENON OF NURSING TURNOVER

Overview

The turnover rate among nurses employed in hospitals has been recognized as a very serious problem in relation to the quality of care provided, and to the cost of delivering nursing services. Currently, the retention of nurses is a vexing problem for hospital and nursing administrators in North America.

The conventional explanation for nursing turnover in hospitals has been based on gender; nurses are predominantly female, they are not committed to long term careers, and quit their jobs to raise families or to pursue other interests. The volumes of turnover research in the past three decades have consistently and reliably provided evidence to refute this explanation (see Table 2.1). Being female is no more related to employee turnover than being male is. While turnover rates remain high among nurses employed in hospitals, these rates have declined considerably since the 1970s. It

has been discovered that only a small portion of those nurses that resign from hospital jobs, actually become inactive in the profession (Grocott, 1989; Prestholdt, Lane & Mathews, 1988; Weisman 1982), and that presently the labour force participation rate of nurses is at the highest level ever (Statistics Canada, 1988, Grocott, 1989). These very important findings when combined, seem to suggest that due to some dramatic changes in our social system- feminism, birth control, changes in family structure, dual-career families, increased labor participation by women, child care, unions, and nursing education in the university setting- nursing is being pursued as a career more than ever, by those who enter the profession.

Concomitant with the development of several models of turnover behaviour in the last few decades (Mobley, 1983; Price, 1977; Steers & Mowday 1981, etc.), there has been growing interest in researching and refining the multivariate linkages among the diverse variables thought to be predictors of voluntary turnover among nurses. Thus various models of turnover behaviour amongst nurses have been developed (Hinshaw, 1987; Parasuraman, 1989; Price & Mueller, 1981; Seybolt, 1986; and Weisman, 1982). The analytical techniques in nursing turnover investigations that have produced nursing turnover models have been innovative in that they utilize multiple variables versus simple bi-variate relationships, and articulate more in-depth concepts, for example; intent to

stay, promotional opportunities and kinship responsibilities, in place of variables such as "job satisfaction".

Interestingly, the five general factors that are implicated in the general turnover research (Economic, Organizational, Job, Demographic and Individual), are also found in the nursing turnover research. Although not all of the models explicitly use those exact factors, each of them are nonetheless implied. A discussion of each of the five major factors and their relationship to nursing turnover in hospitals will be presented.

Nursing Turnover In Relation To Economic Factors

The relationship between the economy and nursing turnover in Canada is a complex topic to discuss. Compounding the difficult nature of the discussion is the fact that the labour market for nursing is unlike that of any other occupation, and this same market is characteristically subject to rapid and constant revision (Employment and Immigration Document, 1988). The Employment and Immigration Department analyzed the supply-demand situation for nursing personnel in Canada in a 1988 publication and concluded that: because of nursing's high female representation, the nature and environment of patient care, and Government regulation of Health Care practice "...traditional methods of labour market analysis do not wholly capture the demand and supply mechanisms relevant to today's Canadian market for nursing services" (p.5). Thus,

the problem of nursing turnover in relation to economic factors is not generally well understood.

Despite the difficulties in analyzing this topic, it is agreed by all who study it, that there is currently a "nursing shortage" in Canada- an imbalance in the demand for, and supply of, Registered Nurses. Presently the labour market for nurses in Canada is extremely dynamic. Although nursing is possibly the most mobile of occupational groups, the percent of nurses employed outside of nursing is low, and the nurse unemployment rates also remain low, in comparison with average unemployment rates for women (Prescott, 1989; Seybolt, 1986; Statistics Canada 1988). Despite the fact that in actual numbers, there are more Registered Nurses now than ever before, the **demand** for nurses is particularly high. A combination of factors is said to have caused this:

1. Unprecedented growth in the health care industry;
2. The aging population;
3. Rapid technological change;
4. More acutely ill patients;
5. Changing expectations regarding the nurse's role in the health care system;
6. Expanding bounds of nursing knowledge.

Those factors which are seen to be contributing to the decreased **supply** of nurses include:

1. Increased educational requirements;
2. Demographic shifts in the profession;

3. Lack of fit between "baby boom generation" values and the values of organizational settings;
4. Turnover of nurses in hospital settings (Cohen, 1989; Employment & Immigration Canada, 1988; Huston & Marquis, 1989; Prescott, 1989; Vogt et.al., 1983).

As many of these variables are inter-related, it is impossible to isolate each variable and discuss it thoroughly. By expanding on the ways in which the factors are thought to contribute to the perceived "nursing shortage", and by illustrating their relationship to one another, this section will attempt to provide a global view of the multi-faceted factors involved between the economy and the phenomenon of nursing turnover.

Between 1950 and 1983 North America not only experienced an increase in health care expenditures per person, but also saw, an increasingly larger share of the nation's total economic output directed towards health care. Canada's unique socialized health care system, super-specialization, health promotion, illness prevention, and changes in delivery of care for patients requiring chronic, rehabilitative, and acute care, has created a high demand for nurses in diverse settings both in and out of the hospital. Indeed, the majority of health professions are still considered growth occupations (McConnell, 1984).

An important variable that has been identified as a contributing factor for nursing services is that of the aging

population in our country. Life expectancy has increased and there is a definite positive relationship between the aging process and disease. As Canada's baby boom population ages, the proportion of the population aged 65 and over will escalate. These demographic advances have, and will place demands on the growth and cost of the Canadian health care system, and particularly on the demand for nursing services.

The technological changes that have coincided with the industry's growth in the past 30 years have been astounding. There have been unprecedented discoveries that have led to changes in research, diagnostic, treatment, and care regimes for patients. Technological innovation has expanded to make methods of disease prevention, health maintenance, illness diagnosis and disease treatment more varied, more complex, and more demanding for all health care personnel.

The combination of our aging population and the rise of technology has resulted in more acutely ill in-hospital patients and more acutely ill out-patients. Thirty years ago a 70 year old patient with cancer of the bowel would have died. Today, that patient is aggressively treated surgically and medically, both in the hospital, and during recovery after discharge from the hospital into the community. Nursing care for the patient includes extensive teaching, physical and hygiene care, drug administration, complex dressing and ostomy changes, monitoring of equipment in relation to the patient's physiological status, and psychological and emotional support

for both the patient and the family.

The bedside nursing care translates into such things as bed baths, physical assessments, oral hygiene, lifting and positioning, range of motion exercises, comfort measures, deep breathing and coughing exercises, ambulation, administration of narcotics, antibiotics, sedation and occasionally chemotherapeutic drugs through parental routes, insertion and monitoring of invasive devices such as nasogastric tubes, foley catheters, and intravenous fluids, use of aseptic technique during frequent complex dressing changes, interpretation of lab results, coordination of diagnostic exams, charting, providing information to other departments via phone, psychological and emotional support of the patient and their significant others via attentive and empathetic listening and communication skills, and follow up care with the arrangement of social and community services upon discharge. Needless to say, the increasingly complex and technical nature of in-patient care has demanded much lower nurse-patient ratios, once again placing greater demands on qualitative and quantitative nursing personal services.

The combination of industry growth, aging population, technological change and more acutely ill patients has changed expectations regarding the nurse's role in the Canadian health care system. Primarily, it has meant that nurses are gradually finding themselves in multidisciplinary settings other than a hospital organization. Nurses are employed in

industry (occupational health); public health (well-baby care); clinics (reproductive centers, nutrition and diet centers); and in the community (home care, schools, day-care, and cardiac rehabilitative centers). Nurses' roles have diversified in the hospital setting as well, and it is not uncommon to see nursing titles such as Ostomy Therapists, Nurse Anaesthetists and Cardiovascular Associates. This phenomenon has been recognized as "the expanded role of the nurse", which in part is contributing to the increased multi-dimensional demands being placed on nursing services.

The previous discussion recognized factors that contributed to the increased demands being placed on nursing services. Those major factors thought to contribute to the dwindling supply of nurses will now be illustrated.

Intimately related to the expanded role of the nurse is the increased educational requirements of the nurse. Nursing practice realities include events surrounding birth to death. Recipients of nursing care include individuals, families and communities, and range from the unborn fetus to the expired donor of organs for transplantation. Nursing care focuses not only on activities that support health maintenance, health promotion, and illness prevention, but also concentrates on activities that provide physical and psychological support for the acutely ill and dying patient. Nurses must be intelligent, sensitive, assertive critical thinkers with leadership qualities and decision making skills and abilities.

As well, they must possess excellent communication skills that allow them to deal effectively with tremendously complex and often times ambiguous work situations in a variety of work settings.

The combination of factors that have been discussed in the previous paragraphs have collectively demanded that nurses have a broad educational base which includes courses in the sciences, social sciences, humanities, and the discipline of nursing. The expanding bounds of nursing knowledge and the increasingly broad roles in which nurses find themselves, has resulted in the Canadian Nurses Association recommending an increase in the educational investment of the nurse, proposing that by the year 2000, all new graduates of nursing possess a baccalaureate degree. This proposal may potentially decrease the supply of nurses by prolonging their preparation time prior to market entry.

Demographic shifts throughout the entire nursing workforce have also proved worrisome and are thought to contribute to a decrease in the nursing supply (Ginzberg, 1987; Powills, 1988). Declining enrolments in nursing schools have been reported throughout North America, and it is thought that two inter-related reasons account for this. First, young women of today have more occupational options and opportunities available to them than have women at any other point in history. It is obvious from the statistics that women in increasing numbers are choosing careers other than

nursing. Related to the increasing options available to women are the degree of attractiveness these other occupations hold in their view. It becomes glaringly apparent that the work of nurses is not held in very high regard - nursing is notorious for being a "hard work/low pay/low prestige" kind of job. In fact in 1986, *Working Women* magazine chose nursing as one of 10 "dead-end" occupations (Wilson, 1987, p.23). In comparison to other types of work, nursing does not appear as an attractive career option, and because of this it may have tremendous difficulty recruiting individuals into the educational system and workforce, thereby threatening the supply aspect of the market system (Huston & Marquis, 1989; Vogt et.al., 1984).

Many authors propose an interesting factor that may have significantly altered the demographics of the nursing workforce as well. They claim that there is a lack of fit between "baby boom" generation values, and the traditional values of organizational settings. This generation's philosophy is characterized by a lack of conformity to rules and regulations, higher expectations for self fufillment in the workplace, and a growing anti-authoritarian attitude in relation to the distribution of governing power in hierarchical bureaucracies (Park,1983; Pascarella, 1984; Peskin, 1973). More and more employees are becoming better educated, and this factor in combination with their attitudes, poses some challenges to the present conditions of working

life. Educated workers expect to have a job, feel entitled to work, and anticipate full participation in decisions affecting their jobs and their work life. In so doing these "*New Achievers*" expect work to provide enjoyment and fulfilment, along with an appropriate balance between leisure and work, and the instrumental and expressive aspects of their life (Munro, 1983; Pascarella, 1984). Nurses in particular have a great desire to maintain normal personal lives while fulfilling reasonable work responsibilities. Therefore, the traditional ideology and labour practices of hospitals: having their full-time nursing employees work within rigid schedules that involve shiftwork, long hours, long stretches, 50% nights, and 50% weekends; rules and regulations governing everything from nurses attire to their practice; and the unequal and unfair distribution of power within the bureaucracy, are not consistent with the ideologies held by the present generation of nurses. Thus the incongruent convictions held by nurses and hospital organizations may be a contributing factor in demographic shifts and, ultimately, may have a major effect on the supply of workers and their turnover.

The phenomenon of turnover in hospitals is thought to exacerbate the supply aspect of the job market. High turnover creates more opportunities, which may possibly create higher turnover; a very vicious cycle. High turnover in hospitals is translating into "job hopping" for nurses, thereby limiting or

decreasing the available supply of nurses. Furthermore, high turnover inescapably reflects poorly on the image of nurses and the hospital, and may ultimately discourage individuals from entering the profession, further reducing the prospective supply of nurses.

In light of the above discussion of nursing turnover and its relationship to the economy, it is clear the phenomenon can not be defined by general unemployment levels, national inflationary rates, or an analysis of job market trends. Although the presence of a union (as a sub-factor of Economic Factors) has shown a strong negative relationship to the process of turnover, a recent review of the literature has shown that manufacturing organizations show more reliable effects for the presence of a union on turnover than do service organizations (Cotton & Tuttle, 1986). Considering the aforementioned, the review of several prominent factors that contribute to demand and supply mechanisms for nursing womanpower, seems to provide a somewhat clearer picture of the linked variables involved in the complex turnover-economy relationship. What is evident, is that most of the sub-factors of the Economic Factors related to general turnover, do not apply to nursing turnover.

Although in the past, nursing shortages have been cyclical, it is genuinely felt that the aforementioned factors make the current nursing shortage unique. In the minds of many, **there is no nursing shortage.** It is felt that there are

enough nurses that have been educated to practice and that the current nursing shortage is not found in the actual numbers of nurses, but instead, is based on the improper use of nurses and their services (Grocott, 1989; Huston & Marquis, 1989; Prescott, 1989; Vogt, 1983). Grocott presents a clever article and claims that by failing to distinguish between; i) pure wastage ii) net wastage iii) re-entry and iv) internal transfers within the field, analysts have failed to assess accurately the available nursing workforce. He postulates that the wastage rates of the total nursing workforce is actually declining (as was discussed in the Overview of Nursing Turnover) thereby refuting the claim that nurses are leaving the profession in droves, or voting with their feet. Accordingly, the present nursing shortage should not be viewed as a high demand/low supply scenario, instead, it should be recognized as a high demand/available supply but **underemployment of available nurses** in the workforce (Ezrati, 1987; Grocott, 1989; Prescott, 1989).

These interpretations of the nursing shortage stand up very well with the Canadian research on the phenomenon. In 1980 the Alberta Hospital Association released their findings of their investigation into the nursing shortage. They discovered that there was not a deficit in the number of Registered Nurses, as much as there was a deficient number of nurses who were willing to participate in the workforce under the set of circumstances in which they were expected to work.

Likewise, the Ontario Nurses Association in June of 1988 also determined in their investigative findings that the shortage of nurses in the province was primarily the result of nurses being unwilling to participate in the workforce as a result of the working conditions in which they were forced to practice (CJNA, October, 1988).

The unique nature of nurses' work and the inconsistent patterns of their work force participation rates, combined with inaccurate measures of their wastage, turnover, re-entry and transfer behaviours have put furrows in the brows of economic analysts. At this point in time, there does not seem to be a consistent or predictable relationship between nursing turnover and Economic Factors. What is needed for a more in-depth understanding of the nature of the problem, is a discussion of nursing turnover in relation to other important variables.

Nursing Turnover In Relation To Job Factors

The nursing turnover models that have been devised do not adequately explain why nurses leave their jobs in hospitals. As with the general turnover models, the nursing models poorly predicted nursing turnover, accounting for less than 17 percent of the variance (Hinshaw, Smelter and Atwood 1987; Parasuraman, 1989; Price & Mueller, 1981; Seybolt, 1986 and Weisman, 1982). Table 2.1 indicates there are moderately strong relationships that can be identified between job

factors and the turnover process. When comparing nursing turnover research with the general turnover research, consistent and inconsistent findings are discovered.

Researchers have consistently reported a strong negative relationship between pay levels and turnover rates, whereby successively higher amounts of pay, tend to produce successively lower amounts of turnover (Cotton & Tuttle, 1986; Mobley, 1982; Mobley, Griffith, Hand & Meglino, 1979; Price, 1977;). For the most part, pay is seen to be an objective variable, while satisfaction with pay is seen to be a subjective variable. This makes the factor of pay somewhat difficult to categorize, into an Organizational, Job or Individual determining factor when applied to the process of turnover. With respect to nursing, pay in itself has not appeared to be a major factor in relation to turnover (Beyers et.al., 1983; McCloskey, 1974; Prestholdt et.al., 1988; Ruffing, 1984). It is felt that one of the more important considerations for nurses is the relationship of pay to the career structure within the hospital, and the need to have salary commensurate with responsibility and educational preparation (Munro, 1983; Weisman, 1982). Recent research with regard to pay and its relationship to turnover has suggested that perceived equity of pay may in fact be a more important determinant of turnover than level of pay (Mowday, et.al., 1982). These findings support the more recent conclusions in a meta-analysis of turnover research, that pay

is less consistently related to turnover in service organizations (Cotton & Tuttle, 1986). This may have to do with the fact that persons who enter the occupation of nursing consider the psychological and emotional rewards as important, or equal to, the economic rewards. Thus, pay is considered to be a very important variable in the general turnover research, while the nursing turnover research has found that pay is important, but not a primary motivator for turnover. This paradox in the nursing/general turnover literature can be detected in the nursing turnover models, as only two of the models include pay as a variable related to turnover (Price & Mueller 1981; Hinshaw, Smeltzer & Atwood, 1987).

Not surprising is the support the general research generates for a medium negative relationship between overall job satisfaction and turnover. This means that job satisfaction decreases the probability of turnover, whereas job dissatisfaction increases the probability of turnover. Although job satisfaction has been a compelling variable to include in the turnover research, it continues to be a difficult construct to define and isolate. "Satisfaction" is a personal and perceptual phenomena, and is strongly related to numerous important variables within the work environment; pay, relationships with colleagues, job content, supervision, rewards, etc. Although people may be satisfied with their pay, dissatisfaction with other variables may compel them to leave an organization. Likewise, an individual may be

dissatisfied with pay, but satisfied with most other variables, and remain committed to an organization. Thus the conceptualization of "job satisfaction" continues to elude researchers. It is the perception of many that nursing turnover is a result of job dissatisfaction. Does this mean that those who stay with an organization are "satisfied"? Hardly! In fact, nurse job satisfaction has been discovered to be a relatively poor predictor of whether they subsequently remain in their positions (Price & Mueller, 1981; Taylor & Covaleski, 1985). The concept of job satisfaction however can not be completely ignored. Nurses have a genuine interest, aptitude, and desire to help and care for individuals who are unable to care for themselves. Giving of self is inherently gratifying, and doing good work is naturally satisfying. Overwhelmingly, staff nurses who are employed in hospitals say that providing excellent patient care is the most satisfying component of their jobs.

As Table 2.1 illustrates, there is a medium negative relationship between satisfaction with the work itself and the turnover process. Once again, this means that if nurses are highly satisfied with the work itself, the likelihood of turnover is low, and vice-versa. For the most part, the most dissatisfying aspect of nurses' jobs seems to be those things which prevent them from providing quality care to their patients. The reasons given for job dissatisfaction by nurses employed in hospitals include: inappropriate and unsafe

staffing levels; difficult hours and schedules; insufficient and/or inadequate equipment; poor supervision, limited opportunities for advancement; insufficient educational and professional development activities; inadequate salary structures that are insensitive to practitioner's education, knowledge, experience, responsibility and performance; non-democratic forums for decision making within the institution; inadequate hospital policy and lack of administrative support; limited consultative activities regarding areas of nursing responsibility; and lack of appreciation and respect shown by other personnel in the workplace (Cronin-Stubbs, 1977; Ginzberg et.al., 1982; Godfrey, 1977; Joiner & Van Servellen, 1984; McClosky, 1974; Ullrich, 1978; Weisman, 1982; Wolf, 1981). The relationship between job satisfaction and turnover is consistent throughout turnover investigations, and interestingly Cotton & Tuttle's review discovered that the relationship between turnover and satisfaction with work is much more reliable in service versus other types of organizations. The fact of the matter remains however; the correlation between job satisfaction and turnover is rarely stronger than -.4 (Mobley, 1982, p.102). This leads one to conclude that job satisfaction is but one of the many complex variables that determine an individual's propensity to leave or commit themselves to an organization.

Discontent among nurses across the nation runs high, and their frustrations have become increasingly apparent in

the past decade as evidenced by the many labour disputes that have occurred throughout the country. The basis for this discontent (when one reviews the listed factors for job dissatisfaction), appears to stem from two deeply rooted problems that plague nursing: an unclear definition of nursing's role on the health care team, and; a lack of autonomy nurses have over their practice and their work environment. Table 2.1 displays a medium negative relationship between role clarity and the decision to terminate employment. If employees are confused or frustrated with the ambiguous nature of their roles in the work place, there is a greater probability of them leaving the organization.

When nurses articulate dissatisfaction with their jobs, they are in part, struggling to clarify and crystallize their role on the health care team. Parallel to this attempt for role definition are nurses' efforts to obtain control over their practice. In so doing, nurses are raising some fundamental questions about their working lives. Questions such as "Who is in control of nursing practice?" and "Who should be in control of nursing practice?", are but two. The answer to the first question is relatively easy and can be traced back through history. Nursing has always been closely allied with medical progress and practice. Nurses and physicians have worked together since the establishment of their professional existence, and their relationship has

generally been seen to be unilateral. In past, physicians were predominantly male, and as a result, the interaction between the groups took place in a society and an organizational milieu (the hospital) that espoused male dominance and female subservience. Nurses were expected to obey unquestionably and carry out physician's orders. Nurses were also expected to devote themselves to patient care and the institution in which they were trained. Power and decision making were the domains of men and these roles were granted to physicians and hospital administrators alike. This unilateral, dependent, subservient and subordinate relationship nurses assumed as employees of hospitals prevails today, as physicians and hospital administrators are still very much responsible for nurses work direction.

The answer to the question of "Who should control nursing practice" evolves from the answer to the previous question. Nurses believe their work direction should come from their patients, and the control of their practice should be authorized predominantly by the Professional Association of Nurses. Because nursing services are an integral part of any hospital, because nurses work closely with many of the other departments in a hospital, and because nurses are essentially the coordinators of all caregiving in hospitals, input for redefining nurses roles should be a collaborative effort between all of the health care professionals. The health care team of today has become a highly interactive and

interdependent group, and nursing services are entwined with, not subordinate to, the departments of physiotherapy, dietary, pharmacy, medicine, respiratory therapy, social work, and occupational therapy.

Table 2.1 also shows a medium negative relationship between turnover and worker autonomy and responsibility. What is especially unique to nurses' work is that the two sub-factors of autonomy and responsibility do not go hand in hand. Over the years, nurses' responsibility for patient care has increased dramatically, but their autonomy to act upon their assessments remains controlled and very limited. Case in point: a critical care nurse is expected to care for a patient in the intensive care unit by utilizing advanced physical assessment skills, monitoring and interpreting readings from very technical equipment and complex machinery (such as cardiac monitoring systems, arterial and Swan Ganz catheters, or ventilators) and administering and evaluating the effect of potent pharmacological agents. Simultaneously, the nurse can not administer an aspirin or provide a hot water bottle for this same patient, until she has contacted a physician for an "order" for that drug or form of treatment. This tremendous responsibility without the requisite authority to make decisions regarding patient care puts all nurses working in hospitals in an untenable position, and accounts for a tremendous amount of frustration within the ranks.

Job satisfaction, the work itself, role clarity,

autonomy, and responsibility, are descriptors of "Job Factors", which have been found to be strongly related to employee turnover (as outlined in Table 2.1). For the most part, nurses are satisfied with the work they do in hospitals, but they are dissatisfied with the way their work is organized for them. Nurses face tremendous challenges with regards to gaining autonomy over their practice, and obtaining control within their working environments. The problems that nurses experience with their work have their origins in the historical development of the profession, and reflect the immense changes that have occurred throughout society. As this discussion illustrates, these important job factors which are identified in the general turnover literature, are especially problematic for nurses, and have the potential to affect significantly the turnover of nurses working in hospitals today. The remaining sub-factors that are related to "Job Factors", but in this author's opinion fall under the category of working conditions (which in large part are controlled by the organization), will be discussed in the next section.

Nursing Turnover in Relation to Organizational Factors

"An organization is a collection of people working together under a division of labour and a hierarchy of authority to achieve a common goal" (Sullivan & Decker, 1988, p.16). This definition emphasizes that an organization exists

for the purpose of achieving a goal or a set of goals. In order for an organization to achieve its goals it must accomplish certain tasks. In order to coordinate tasks, organizations must be built or given structure. It is this structure that gives an organization many of its distinctive characteristics. Structure dictates in large part, patterns of authority and collegiality, which in effect establish the patterns of communication that are basic to information flow, and ultimately decision making. Besides structure, an organization must have technological resources or its own particular "tools of the trade". Finally, an organization must have people. It is the people, in combination with the technology, who must contribute to the task, in order that the organization can achieve its goals. Thus, an organization must be appropriately structured, equipped, and staffed in order to achieve its mission.

The five internal and interdependent organizational factors - *goals, tasks, technology, people, and structure* (commonly referred to as sociotechnical system theory) are said to be highly interactive and are thought to shape and mold one another such that a significant change in one will result in some adaptation on the part of the others. These internal organizational factors are in turn, subject to the larger external environmental factors such as economics, law, culture, demographics, politics, and ecology. (McClure, 1984; Owens, 1981).

Hospitals are unique and complex organizations. A major goal for most hospitals is to provide an effective and efficient health care program to the community it serves. One of the primary and most essential tasks of any hospital is to deliver safe and effective nursing care to its patients. In order to achieve its task, and ultimately its goal, the organization must utilize up-to-date technology and skilled personnel. In order to coordinate the tasks of nursing with other departments in the hospital, the hospital organization has assumed a traditional structure. Although there are many types of organizations, hospitals have historically functioned as bureaucratic structures - mechanical, formal, hierarchical and centralized (Campbell, 1984; Darbyshire, 1988; Sullivan & Decker, 1988). By definition, bureaucracies typically function by subordinating the needs of individuals to the needs of the institution (March & Simon, 1958).

Any organization depends on member behaviour that is consistent with its goals, in order to achieve optimum productivity. This means that people who work within a bureaucratic organization must behave in prescribed ways, sacrificing some of their personal autonomy and freedom. The price that individuals pay in loss of personal freedom, must be weighed against the economic and personal benefits they glean from the system. This position highlights the fact that in order for organizational goals to be achieved, members of the organization must be productive, and the working

relationship between organizations and their memberships must be given constant attention. Indeed, behavioral scientists keenly analyze and interpret that dynamic interplay between the organization's demands and the needs of the human employees who work within them, namely; *organizational behaviour*.

Voluntary employee turnover is an organizational behaviour. Chronic nursing turnover disrupts the tasks of an organization and therefore limits the goal achievement of hospitals. Most hospital administrators view high attrition rates as inevitable (Marquis, 1988) so in effect, nurses are considered to be the weak link in the chain for maintaining an optimally functioning organization.

Theories of organizations and particularly the sociotechnical theory, however, force us to look at the highly interactive and interdependent organizational factors within the larger social context (McClure, 1984; Owens, 1981). These factors are said to shape and mold one another. Traditionally, rigid bureaucratic hospital structures attempted to shape and mold their nursing employees. For the most part however, the response of the nurse employees has been consistent, and their behaviour in the form of turnover can hardly be considered adaptive if it translates into quitting their jobs and leaving the organization. If structure dictates how an organization is staffed and equipped, and if the organization is not adequately staffed or equipped to achieve its mission, it

would seem logical that the structure is inappropriate for the accomplishment of goals. Rather than continue to shape and mold its employees, hospitals must do an about-face and begin to adapt, by allowing employees to shape and mold the organizational structure (Beyers, et.al., 1983; Campbell, 1984; Kidder & Gruending, 1989; Larson, 1984; Prescott, 1989). Sue Hegyvary writes; "Beyond the provision of direct patient care, however, nurses in institutions hold a position of crucial importance: they are the interface between patient care and institutional operations" (cited in Sullivan & Decker, 1988, p.vi). Thus if nurses are inappropriately or under-utilized in hospitals, patient care and institutional operations suffer.

The studies that have investigated nurse employee turnover have incorporated general theories of organizational behaviour in their applications, and their findings have contributed to a clearer understanding of the turnover process. The results of these studies have enhanced our ability to identify and assess organizational factors associated with turnover. Organizations are primarily responsible for policies, practices, and working conditions for employees. If there is congruence between the organization and the employee with regard to policies, practices and working conditions it would seem to follow that there would be more commitment, more productivity and less voluntary turnover on behalf of the employee. When reviewing

the Organizational Factors such as centralization, communication, and integration (Table 2.1), it is noted that they have a medium strong relationship to the turnover process. As was discussed earlier, the structure of an organization dictates many of these related factors. Thus the more notable characteristics of bureaucracies (and hospitals for that matter) are a high degree of centralization, a formal communication process, and a pyramidal shape of authority. These factors are exactly the organizational variables that have been most strongly related to employee turnover in the research investigations.

Nursing turnover research consistently suggests that in large part, hospitals and their organizational structures are not responsive to their nursing employee needs, and that the demands from the institution far outweigh what these employees are willing to sacrifice in terms of personal and professional autonomy, economics and personal benefits (Banning, 1990; Loveridge, 1988; Weisman, 1982; Wolf, 1981). As a result, negative organizational behaviour in the form of excessive and chronic turnover ensues, and a negative organizational climate persists, which is characterized by the reluctance of nurses to invest themselves personally or professionally in the organizations within which they work.

Nursing Turnover In Relation To Demographic Factors

Many demographic factors are linked to employee turnover in organizations. The two sub-factors that are consistently and strongly related to employee turnover in organizations are age and tenure (see Table 2.1). There is a strong negative relationship found between employee age and turnover, and, employee tenure and turnover. Thus, the generalizations that young members of organizations and members with low lengths of service (tenure) have higher turnover rates than older members and members with high lengths of service, receive strong support in the literature (Cotton & Tuttle, 1986; Mobley, et.al., 1979; Price 1977).

Although these two variables have been shown to be good predictors of turnover, many researchers have failed to explain why they are. Many reasons have been put forth, but the predominant theme in most explanations is that both age and tenure covary with many other important variables that influence a person's decision to stay with, or leave an organization. It is thought that younger employees within an organization have more entry-level opportunities for employment, hold inaccurate and unrealistic job expectations, lack experience and expertise in their new positions, have more routinized work, receive less pay and acquire few benefits, have few family obligations and few close friends within the organization, and are not allowed to participate fully in organizational decision making, thus making their

decision to terminate employment with the organization somewhat easier than an older employee (Mobley, 1982; Mowday, et.al., 1982; Price & Mueller, 1981). On the other hand, older employees have more often than not invested more in the organization and concomitantly have more at stake when considering leaving the organization.

Surprisingly, the factor of age has not received much attention in the nursing turnover literature. Four of the five nursing models did not isolate age as a variable. Instead, if it was utilized at all, it was grouped together with other demographic factors. Only one of the five models isolated age as a sub-factor (Parasuraman, 1989), and only one other model lumped this specific factor with other variables in a category classified as "mobility factors" (Hinshaw et.al., 1987). With the exception of Price & Mueller, no explanation was provided in the nursing turnover literature for the deletion of this important variable. In the article *Age Drain* by Esther Green (1987), it was suggested that for whatever reasons, mature nurses tend gradually to opt out of hospital nursing. Indeed, nurses who work at the bedside are often young or have relatively little nursing experience. If this premise is true, the negative relationship found between older employees and turnover may in fact not apply in nursing because older staff nurses in hospital organizations rarely exist. Certainly this implies a unique finding for nursing turnover research because it is contrary to all of the general

turnover research.

Tenure, on the other hand receives much more attention in the nursing turnover research and is included or implied in virtually all of the models. Unfortunately though, tenure is vaguely or not sufficiently conceptualized in the models, so its influence on the turnover process is hardly discernable. The term "tenure" connotes permanence or length of service of an employee. The previous paragraph suggested that most nurses in hospitals are relatively young and therefore inexperienced. This phenomenon in combination with the problematic nature of high turnover amongst nursing employees in hospitals, prompts a serious question; if turnover amongst nursing staff in hospitals is high, and nursing staff in hospitals are predominantly young and inexperienced, is "tenure" a meaningful concept amongst nurses who work in hospitals? Arguably, the concept of "tenure" for staff nurses is non-existent. Once again, this situation is problematic when viewed with the general turnover research, as the negative relationship found between tenured employees and turnover may not apply in nursing.

Finally, the sub-factor of "kinship responsibilities" (or number of dependents) has been shown to have a strong positive relationship with employee turnover in the general turnover literature (See Table 2.1). As with the sub-factor of age, kinship responsibilities in the nursing turnover research are either ignored or lumped together with other variables (Price

& Mueller, 1981; Hinshaw et.al., 1987). An explanation for its absence was not provided by any of the authors. Once again, this sub-factors absence in the nursing turnover models is perplexing. If nurses are predominantly female, and North American women assume the majority of child-care responsibilities (although this society **claims** parenting is a shared endeavour) can the strong positive relationship found between kinship responsibilities and turnover hold true for this particular occupational group? If it does, the relationship has not yet been quantified, and if it doesn't, once again the general findings in turnover research have no parallels with nursing turnover research.

Nursing Turnover In Relation To Individual Factors

The Individual Factors have been very difficult to capture in the turnover research. Many sub-factors in this category have been conceived and tested in turnover models, but their relationship to the turnover process is very unclear. Sub-factors such as values, intelligence, personality, work ethic, job aptitude, ability, and professionalism are extremely difficult constructs to conceptualize and measure. Yet it would appear that these personal attributes may decide whether or not an individual commits to, or exits from, an organization (Hinshaw, Smeltzer & Atwood, 1987; Mobley, Griffith, Hand & Meglino, 1979; Parasuraman, 1989; Price & Mueller, 1981; Seybolt, 1986;

Weisman, 1982). Based on the results of the turnover research, it is apparent that different individuals react to their work in different kinds of ways. Assuming this, it could be said that turnover is ultimately an individual decision.

Two sub-factors have received considerable attention in the past decade, and show some promise for integrating the five major turnover factors. These two are; intentions to quit, and organizational commitment.

Theoretically, an individual's intention to quit should be a good predictor of behaviour. This concept has been supported empirically, and in fact has been shown to be among the best individual-level predictors of turnover in several research endeavors (Mobley, 1982). Indeed, it has been incorporated into the majority of general and nursing turnover models (Hinshaw, Smeltzer & Atwood, 1987; Mobley, Griffith, Hand & Meglino, 1979; Parasuraman, 1989; Price & Mueller, 1981; Seybolt, 1986). Although many factors are correlated with turnover, intention to quit is significantly related. Unfortunately, what is not understood about this sub-factor is what elements lead up to the decision. Intent to leave has been found to be the best predictor of turnover, but to date, no researcher has been able to identify the psychological or behavioral processes that lead up to the actual turnover event.

Organizational commitment has repeatedly been shown to be

an important factor in understanding the psychological processes and behaviours (including turnover behaviour) of employees in organizations (Mowday, et.al., 1982). The developing body of research on commitment suggest that this concept is significantly and negatively related to turnover and is more strongly related to turnover than is satisfaction (Mobley, Griffith, Hand & Meglino, 1979; Price & Mueller 1982; Taylor & Covaleski, 1985). Unfortunately however, no single definition of organizational commitment exists. Most definitions attempt to portray the phenomenon as an attitude or behaviour. Mowday, Porter & Steers define organizational commitment as "...the relative strength of an individual's identification with and involvement in a particular organization" (1982, p.27). These authors characterize organizational commitment by at least three factors: (a) a strong belief in and acceptance of the organization's goals and values; (b) a willingness to exert considerable effort on behalf of the organization; and (c) a strong desire to maintain membership in the organization (1982, p.27). In a general sense, the concept of organizational commitment assists researchers in explaining how people find purpose in their work, and to a certain degree, in their personal life as well.

In the case of nursing turnover, it would appear most beneficial if hospital organizations could distinguish those aspects of the organization their nurses believe, accept and

identify with (commitment), and those aspects of the organization that nurses question, renounce and eventually withdraw from (turnover). It is apparent that the factors of intention to quit and organizational commitment are, in effect, dimensions of one another, but their exact relationship is still not known. Interest in turnover behaviour amongst nurses who work in hospitals and their commitment to the organizations are likely to increase in the future, as concern grows for the relationship between the quality of services delivered by an organization and the quality of work life in that organization.

Discussion Of The Nursing Turnover Research

As the previous sections have outlined, there are consistently low explanatory powers of all the turnover models, nursing and otherwise. As a result, employee turnover in organizations and within hospitals remains poorly understood. Turnover then is not simply one subject, but many. Those factors believed to influence the turnover process have been applied to nursing and have been critically examined. Nursing turnover is thought to be the result of complex linkages among economic, organizational, job, and personal factors which, after analysis by an individual's value system, contribute to that person's decision to remain with, or leave the hospital. Some of the findings from the general turnover research are congruent with the nursing

turnover research, but many contradictory and nonsignificant findings are also present.

The relationship between turnover in general and the variables operationalizing Economic and Demographic Factors are not readily applicable to nursing turnover at all. Those factors which seem to hold more relevance with regards to nursing turnover are found within the categories of Organizational and Job Factors. Although the Individual Factors revealed some applicability to the phenomenon of nursing turnover, the difficulties in conceptualizing the sub-factors and the small amount of research that has been done in the area limit the generalizability of the findings. In this author's opinion, several variables that may possibly be important to this specific occupational group and could be related to turnover were not even mentioned or studied, namely: kinship responsibilities (number of children, ages of children), work values (job or career, full-time or part time, career plans), family values (primary wage earner, spouse career, child care arrangements) and career stage ("Raw Recruit, Young Turk, Sceptic, Burnt Out, or Old Guard" {Seybolt, 1986}).

In summary, a review and a comparison of the vast amount of turnover literature has not allowed a clear understanding of nursing turnover. What is apparent, is that of all the variables studied, **Organizational and Job Factors contribute most significantly to the problem of nursing turnover.** It is

these two factors which will be targeted in the next section, and to which most Retention Strategies will be directed.

STRATEGIES TO DECREASE TURNOVER AND INCREASE RETENTION OF NURSE EMPLOYEES IN HOSPITALS

Introduction

The current nurse shortage/nurse turnover situation in Canada is a threat to our present system of health care. The problem of nurse turnover in hospital based practice is complicated, and its solutions are immensely challenging. The literature review reveals that the responsibility for nursing turnover does not lie solely with individual nurses, or the demographics of this occupational group. Rather, it has been discovered that turnover in large part, represents a failure on the part of the organization in selecting, placing, orientating, supervising, challenging and rewarding their nurse employees (Beyers, Mullner, Byre & Whitehead, 1983; Campbell, 1984; Darbyshire, 1988; Hoffman, 1989; Huston & Marquis, 1989; Larson, 1984; McCloskey, 1974; Munro, 1983; Prestholdt, et.al., 1988; Ruffing et.al., 1984; Vogt, Cox, Velthouse & Thames, 1983; Wall, 1988; Weisman, 1982; Wolf, 1981).

A major premise in the turnover literature was that organizational characteristics could influence people's

attitudes to stay or leave the organization. The complexity, diversity, and importance of staff nurse turnover have underscored the necessity for changes to be made in hospital organizations.

What is required is an in-depth and long range approach to the solution and resolution of the problem. The successful reduction of turnover must be an undertaking that is not assumed lightly, or decided by one particular individual. The participants involved must be multidisciplinary and representative of all hospital employees. The strategies that are initiated must be discussed and planned, recognizing that their discussion and implementation will require tremendous energy, and will involve conflict and stress. The projects that are designed must include short and long term perspectives and must contain elements of ongoing individual, departmental and organizational assessment.

> Retention is planned. It is obvious in an organization's mission statement and in an administrator's philosophy, as well as in the organization's policies and procedures, supervisory job descriptions, performance appraisal mechanisms, conflict resolution tactics, and its methods for self evaluation. (Vogt, Cox, Velthouse & Thames, 1983, p.4)

The focus of the strategies will consider the general and nursing turnover research, and will be tailored to suit the needs of both the organization and its employees, based on a thorough assessment of the problem at the organizational (versus global) level. Finally, the institution must individualize its retention strategies by matching findings

from its ongoing assessment to identified needs (Curran & Minnick, 1989; Huston & Marquis, 1989; Vogt, Cox, Velthouse & Thames, 1983).

An interesting Hospital Nurse Retention Model encompassing all of these principles is presented by Curran & Minnick;

Principle #1- Retention is affected by the interaction of multiple internal and external factors, difficult to predict universally due to the complexity of interrelationships.

Principle #2- Each institution must develop retrievable data gathered during an ongoing organizational assessment

Principle #3- Strategies and tactics to improve retention must be highly individualized by matching findings from the ongoing assessment to identified demands (1989, p.326 & 327).

Kramer and Schmalenberg (1988) conducted an innovative study that analyzed 16 magnet hospitals to ascertain if they possessed characteristics, similar to those identified by Peters and Waterman's (*In Search of Excellence*) best run business firms in the United States. Their summary concluded, quite simply, in the affirmative.

> They [magnet hospitals] are infused with values of quality care, nurse autonomy, informal, nonrigid verbal communication, innovation, bringing out the best in each individual, education, respect and caring for the individual, and striving for excellence. They are led by nurse leaders and managers who are zealots in holding and

promulgating these values.

(1988, p.17)

Thus the essential characteristics of eminent business firms were very similar to hospitals which were deemed "excellent", and had a highly successful record for attracting and retaining qualified nursing staff. The benefits of increased productivity, efficiency, morale, growth and profitability provided by a stable workforce have been demonstrated repeatedly by industry. It can be logically assumed that the existence of a stable nursing workforce can only serve to benefit Canadian hospitals as well.

Changing The Employer-Employee Relationship

If organizations want to improve retention and employee productivity, it is mandatory that they examine how they view their human resources (Huston & Marquis, 1989; Vogt, Cox, Velthouse & Thames, 1983). Close inspection of a hospital's actions towards its patients and employees should in itself allow an investigator to determine the institution's philosophy and mode of human resource management.

Hospitals and their administrators profess to value quality patient care and nursing services, and often declare this value with statements in their organizational philosophies. One of the four characteristics that determine a true value is; that it must be positively affirmed and **acted on** (Huston & Marquis, 1989, p.22). If hospitals and their administrators value quality patient care and nursing services

are required to administer it, why then do these same organizations provide inadequate nursing staff to deliver that care, at the same time allowing for excessive turnover amongst staff? It would appear then that hospital administrators hold a positive attitude with respect to nurses, but do not truly value them.

The most important and fundamental retention strategy that must occur for all others to be successful is for hospitals to rethink completely the traditional employer-employee relationship (Huston & Marquis, 1989; Mallison, 1986; Prescott, 1989; Vogt, Cox, Velthouse & Thames, 1983; Weisman, 1982). One author states that hospitals are abusing nurses' professional commitment, loyalty, and dedication. She candidly writes; "...the system is killing them softly" (Chandler, 1988, p.4). Indeed, nursing is not taken seriously as a long term career and the organization of hospitals reflects this attitude. Hospitals lack long term commitment to their nursing employees as exemplified in their severely compressed salary structure, deficient promotional opportunities, poor working conditions, and general lack of initiative in employee development. Instead of valuing experienced, satisfied careerists, their objectives are short term and are directed by recruitment efforts and bringing in less skilled (new or foreign) practitioners. The editor of The American Journal Of Nursing has aptly coined this style of hospital administration as "Wring 'Em Dry Mismanagement",

because it relies on inexperienced and naive beginners who are wrung dry and tossed aside in a few years because of a perceived infinite supply of nurses.

Rather than work on recruitment efforts to alleviate turnover problems, it is the opinion of many that retention strategies must be designed for nurses who have already acquired their education and experience. If the organization is in fact contributing to the problem of nursing turnover, the focus of the retention strategies must initially concentrate on changing the system in which nurses work.

Measuring Staff Nurse Turnover

In order that effective strategies can be implemented to reduce turnover it is imperative that the problem be thoroughly investigated. If an organization values its employees, it will naturally take stock of their coming and goings. A complacent attitude towards nurse turnover suggests and leads to a diminished value of and investment in those employees, which in turn contributes to the problem. Further, it puts the hospital organization in a passive, dependent and reactive position at a time when health care urgently requires a proactive and deliberate stance. If the problem of nursing turnover can be well defined, it will follow that a goal statement and comprehensive plan of action can then proceed. Several authors pragmatically suggest that the first step towards reducing turnover is to measure it (Duxbury &

Armstrong, 1982; Ezrati, 1984; Hoffman, 1981).

How does the organization begin to measure the problem of nursing turnover? It is felt that preestablished criteria should be outlined for both acceptable and unacceptable turnover prior to measuring turnover rates. Each case of turnover should then be analyzed by an exit interview which is accompanied by a performance rating based on prior evaluations. Finally, based on the interview and collection of data, it can be determined if the turnover is voluntary or involuntary, and functional or dysfunctional. In its rough form, turnover can then be assessed and categorized (Sullivan & Decker, 1988; Vogt, Cox, Velthouse & Thames, 1983). Once turnover is measured, and evaluated in terms of its rate, pattern, location, causes, and consequences, an assessment of all of this information will allow a clearer understanding of the problem.

> The availability of this information is a vital prerequisite to the effective control and reduction of turnover. Unless the calculation of such data is understood, as well as consistently produced and disseminated at appropriate levels of the organization, subjective and frequently erroneous decisions will continue to be made about the management of human resources.
>
> (Hoffmann, 1981, p.37)

As an earlier section outlined, there are problems associated with the measurement of turnover, but this should not deter organizations from collecting an accurate data base. Duxbury's and Armstrong's article entitled *Calculating Nurse Turnover Indices* comprehensively addresses the problems

inherent with measuring turnover. Their recommendations are to calculate Crude Turnover Rate, Median Service of Leavers, and a Survival of Leavers Curve. These calculations provide a measure of turnover volume and a measure of who, by length of service, leaves (1982).

Changing The Organizational Structure Of Hospitals

"The domain of organizational structure is usually in the control of organizational leaders" (Larsen, 1984, p.38). Thus the person in the organization usually responsible for the mediating role between organizational demands and human needs, is the administrator. Administration's mandate is very complex, however their functions can generally be summarized as being two-fold: (1) *Supervision*- defined as the process of getting work done through others; done properly, on time, and within budget, and (2) *Management*- defined as deployment of resources to accomplish organizational ends (Sullivan & Decker, 1988, p.43). Essentially then, an administrator's job is to make the organization's resources productive. It is very apparent throughout this entire discussion, that nursing turnover is counterproductive for the organization, that the organization's structure dictates many factors that are moderately related to the phenomenon of turnover, and that in large part because of their crucial position in the organization, hospital administrators should be held accountable for this situation.

> "Advocating increased attention to structural constraints in nursing means that we must study the organization of nursing as seriously as we study clinical practice "
> (Campbell, 1984, p.28).

A fundamental restructuring of hospitals and their use of nurses has been called for (Campbell, 1984; Larson, 1984; Prescott, 1989). For too long, practising nurses and nurse managers have been excluded from the forums of decision making and policy formation at the institutional level. Nurses' input into major decisions affecting the direction of health care, management of their work units, work schedules, workload, policy development, committee structure, continuing education, research and personnel evaluations, has been limited at best. The hierarchical structure of hospitals that implies authoritative power at the narrow pinnacle shared only by a few, and impotent servility allotted to the masses, has been very distasteful for nurses, and there have been increasing demands by nurses to democratize all decision making in hospitals. A critical change that must occur in the hospital organization to accommodate these demands is the structural renovation known as **decentralization** (Allen, Calkin, & Peterson, 1988; Althaus et.al., 1982; Callahan, 1987).

The main goal of decentralization is to press responsibility and authority downward in the organization so that decision making takes place as close as possible to the point at which the work is actually performed (McClure, 1984).

The innovations that have resulted from this design renewal take the form of participative management or shared governance. "In the last ten years, the concept of participative management has been advocated and honed as the style most conducive to organizational and personal well-being" (Vogt, Cox, Velthouse & Thames, 1983, p.245). It is thought that as decentralization occurs, the traditional hierarchy of authority in the hospital will become less significant, and the opportunity to participate in creating organizational objectives would be more satisfying for nurse employees. Ultimately, this strategy would increase nurse's autonomy and make organizational structure and professional practice more complimentary.

Redesigning Nurses' Work

A job is deemed "enriched" if it allows workers to have significant autonomy in their job actions, variety in task assignments, direct feedback from their clients, colleagues, and supervisors, and extensive identification with the whole or finished product (Joiner & van Servellen, 1984, p.17; Whitsett, 1975). All job enrichment strategies try to enrich the role, thereby increasing overall job satisfaction, and ultimately creating higher quality outcomes for the worker and the organization. In the case of nurses, job enrichment can be interpreted as being more beneficial for patient care, and more beneficial to the organization in the form of decreased

rates of turnover amongst staff. What types of strategies are considered enriching, and how must nurses' work be redesigned to be considered "enriched"? The literature is replete with hundreds of methods that can be implemented by organizations to improve factors within nurses' jobs that will decrease the rate of staff nurse turnover (for example: Registered Nurses Association of British Columbia, 1989).

For the most part, three broad strategies that markedly renovate nurses'job content are thought to encompass most of the retention strategies considered to affect and reduce nursing turnover in hospital organizations. These strategies include primary nursing, clinical ladders, and joint collaborative practice.

Primary Nursing

Historically, four nursing care modalities have dominated the ways in which nursing care delivery is organized: case method, functional method, team nursing and primary nursing (Joiner & van Servellen, 1982, p.18-23). Case method nursing is seen most predominantly in public health and community based nursing practice. This type of nursing puts nurses in a relatively autonomous position as they possess a caseload of patients and full domain of commitment to the patient's wholeness, with few intermediaries. This case method, according to today's view of job enrichment, has much to offer today's nurse.

Functional nursing divides nursing into specific tasks and was very prevalent during the first half of the century. Narrowly defined tasks (administering medications, dressing changes, etc.) turned into job specialization whereby individual nurses assumed a specific job, and the patient was divided into pieces and received care from a multitude of nurses. The nurses' limited knowledge of the "whole" patient had obvious limitations with regard to skill variety, task identity and significance, as well as autonomy and feedback.

Team nursing operates on the premise that a leader will designate assignments to various members of staff, and the team will be responsible for a caseload of patients. In essence, this nursing modality combines attributes of the functional method, but the patient load is considerably decreased. The problems associated with this form of nursing is that autonomy is minimal, identification of the whole patient is limited, feedback is largely indirect and task variety is only moderate.

Primary nursing was first introduced in the early ninety seventies and embodies a distinct philosophy which entails a unique distribution of nurses to patients. The care on a ward is distributed so that the total care of an individual patient and family is the responsibility of one particular nurse. The primary nurse has autonomy and authority in the care of a small group of patients and is accountable for delivering individualized, comprehensive, coordinated and continuous

patient-centered care. Primary nursing not only changes the utilization of professional staff but has also been shown to improve the quality of care to patients (Anderson & Choi, 1980). The in-depth continuous relationship with the patient enables the primary nurse to deliver quality care, identify with a finished product and receive direct feedback from the client and her peers and colleagues. It is felt this enriching environment increases job satisfaction and ultimately improves nurse retention. (Anderson & Choi, 1980; Joiner & van Servaleen, 1984).

Clinical Ladders

The traditional system of organizing nursing service usually rewards clinical excellence by moving the nurse away from the patient into administration. This engagement of administrative activities is perceived more as nursing the system versus the patient, and unfortunately interferes with or extinguishes the nurse's retention for clinical skills that led to the promotion in the first place (Colavecchio, Tescher & Scalzi, 1974). What seems to be lacking in hospital based nursing practice is a method that allows a nurse to achieve stature, status and economic advancement without leaving the bedside. Restructuring the salary system and providing for lateral or horizontal promotion (a clinical ladder versus a career ladder) to fit long term career expectations is seldom discussed. Nursing is one of the few professions that after

10 years of experience sees an increase in salary of only $6,000.

Several plans have been set forth to systematically devise four levels of practice: Clinical Nurse 1 to Clinical Nurse 4. The clinical ladder considers the nurse's knowledge, education, experience and clinical competence. These levels serve as recognition of professional development with each position (Bracken & Christman, 1978; Colavecchio et.al., 1974; Ulsafer-Van Lanen, 1981). The rationale for this concept is twofold; it will provide high quality and efficient nursing care to patients, and theoretically, the status and rewards obtained will reduce job dissatisfaction amongst nurses, thereby improving nurse retention.

Joint-Collaborative Practice

The relationship between nurses and physicians has generally been viewed as a unilateral one. Most of the power and decision making has been granted to the physician, and nurses have been expected to carry out "orders". The past few years has seen a slow shift from previous unilateral-dependent relationships to more interdependent-collaborative ones. The multiple causes that have been attributed to this shift of patient-care control have been; feminism, more liberal education of the nurse, a sense of professional pride that recognizes and values nursing practice, and insistence that medical care is only one part of health and illness care

(Mauksh, 1981). As well, the persistent will of nurses to be more autonomous and accountable has greatly affected their relationship with physicians and the health care organization.

The joint-collaborative practice approach is relatively simple. A doctor and nurse together plan care for a group of patients. This is characterized by joint decision making, a mutually agreed upon division of labour, and unified goal achievement (Mauksh, 1981; Wolf, 1981). This strategy is most prevalent in critical care areas today and is slowly moving into the other departments. The most important key to successful implementation assumes physicians will allow significant roles besides their own to be featured and valued. The end result will be a wider range of services delivered to the health care consumer, delivered by health care providers who express respect for each other's competencies and communicate well with each other. This, along with the joys that accompany colleagueship, will ultimately lead to greater job satisfaction, decreased turnover, improved patient care and enhanced organizational effectiveness.

Human Resources Management

Hospital organizations must change their industrial-era modes of thinking to accommodate the change in nurses and the way they are able to practice.

> It is evident that in recent years, the sciences of management, sociology, and psychology have had a significant impact on organizational philosophy, and subsequently

> on how people are managed at work; but it is also evident that many managers retain a distrust and nonacceptance of subordinates. This belief system leads to human resource management decisions that often result in reduced productivity and increased attrition. If organizations and managers wish to make continued progress toward a more humanistic approach to managing people, they must be willing to examine their personal and organizational values and initiate change where necessary.
> (Huston & Marquis, 1989, p.32)

A contingency approach to administration that would genuinely value and respect nurses must be adopted. Human Resources Management (HRM) is the term used to describe a systematic approach to management (and administration) based upon the application of behavioral science. Human Resources Management is based upon the overlapping theories and concepts of many behavioral scientists including Douglas McGregor, Abraham Maslow, Frederick Herzberg and Rensis Likert. The most distinctive characteristic of HRM is that it does not adhere to hard-and-fast rules; critical situations that occur in organizations are dealt with on a contingency basis, based on the successful application of HRM ideas. The cluster of assumptions that embody an HRM approach include;

1. In order to maximize organizational effectiveness it is mandatory that internal arrangements are created that support a climate that increases human motivation and enhances human growth.

2. Administrators will seek to increase the involvement of all employees at all levels of the organization, recognizing the potential energy and creativity of the human resources in the organization.

3. To facilitate full communication and the productive management of conflict, there must be a climate characterized by high levels of trust and openness,

thereby allowing full constructive participation.

4. In the fast-changing and ambiguous world of today, healthy organizations (personified by being adaptable and problem-solving) are not likely to emphasize authoritarian, hierarchical, bureaucratic structures. They are more apt to emphasize flexible organizations that put a premium on expertise rather than on status in the hierarchy.

5. Apathy, poor performance, alienation, and turnover at work are more closely related to the satisfaction, sense of contribution, achievement and intrinsic value of work that people get from their jobs than to the "kinds of people" that they are.

(Owens, 1984, p.309-310)

As has been discussed, there is a complex network of variables that influence voluntary job termination with nurses. The ability to predict those nurses who will leave their hospital of employment is poor. Of the many multi-faceted reasons that nurses give for leaving their work in hospitals, it is the opinion of many that they include factors within the realm of nursing management and hospital administration (Butler & Parsons, 1989; Ginzberg, Patray, Ostow & Brann, 1982; Hoffman, 1989; Loveridge, 1988; Weisman, 1982).

Much of the research tends to suggest that organizational change can lead to improved staff retention. Two separate research endeavours discovered that 57% and 88% of the nurses in each study stated that appropriate managerial intervention early in their leave-taking decision process would have halted their decision to leave (Landstrom, Biordi, Gillies, 1989; Marquis, 1988). It is felt that perhaps by altering the circumstances in which Registered Nurses work, it may alter

the professional attrition rate, entice more nurses back to work and attract more individuals in to the profession. In the long run, retention strategies can help hospitals rehumanize rather than dehumanize the women that work in them, and the spillover from the changes will be exemplified in lower turnover, greater organizational effectiveness, and ultimately, improved quality of care delivered to patients.

III) METHODOLOGY

Design Of The Study

The research questions that were generated from this study's purpose statement are directed towards hospital administrators, and endeavour to discover: their perspective of the velocity of nursing turnover in their institutions; strategies in place designed to reduce or counteract the phenomenon; rationale for utilizing the retention strategies that are in place; and effectiveness of the strategies for retaining nursing employees. These general questions seek information, and in so doing, require that the researcher ask the hospital administrators to report the data for themselves. "Subjects in a research study often have information that is important to the study and that can be obtained only by asking the subject" (LoBiondo-Wood & Haber, 1986, p.160).

Surveys are exploratory and descriptive in nature and attempt to search for information about the characteristics of particular situations, institutions, groups or subjects. "The purpose of survey research is to obtain information that describes existing phenomena by asking the individuals their perceptions, attitudes, behaviours or values" (Moore, 1986, p.174).

The most frequent mode of data collection for survey research is by means of a questionnaire, or an interview (Moore, 1986; LoBiondo-Wood & Haber, 1986). A survey

investigation appeared most appropriate in this particular study, either in the form of a distributed questionnaire or an interview directed towards hospital administrators. Questionnaires can be distributed to large populations, are usually less costly in time and money, and have the potential to be answered anonymously. In addition, if the questions are clear and specific, there is little possibility of bias by the researcher who administers it. An interview on the other hand, is a strong approach to gathering information for research because it approaches the task directly. An interview is "...a process by which the researcher gathers data by verbal questioning of the study subjects to elicit data on the variables being studied" (Abdellah & Levine, 1986, p.387). It retrieves specific kinds of information such as beliefs and attitudes that would be difficult to obtain without asking the subject directly. An interviewer can clarify questions that are unclear or misunderstood, and can also maintain the order of the questions for the subjects. The refusal rate for interviews is much less than for questionnaires. When open-ended responses are sought, an interview allows for richer and more complex data to be collected (LoBiondo-Wood & Haber, 1986).

The number of subjects required to obtain the data for this investigation was small. As well, no similar studies had been done, therefore reliance on a previously structured research design could not be utilized or incorporated into

this study. In light of this, and the discussion from the previous paragraphs, and the personal belief of the researcher that an interview would obtain better data than a questionnaire, it was felt that the most expedient way to obtain the data for this particular study would be to solicit interviews with hospital administrators. Dexter summarizes when to use interviewing: "....interviewing is the preferred tactic of data collection when in fact it appears likely that it will get *better* data or *more* data or data *at less cost* than other tactics" (1970, p.11).

Validity Of The Design

The limitations of any investigation are usually fixed by the study design. In the case of interviewing, there are three potential threats to validity that can influence the collection and analysis of the data. These generally include the researcher, the behaviour of the subjects, and the environment in which the research is conducted. These potential threats to validity are discussed at length in Dexter 1970, Katzer, Cook & Crouch 1978, LoBiondo-Wood & Haber 1986, Merriam 1988, and Treece & Treece 1986.

The key to conducting quality survey research is the same as that of experimental and quasi-experimental research- minimizing the threat of possible confounding variables that could influence the survey results. For the researcher using an interview format, it is thought that techniques such as:

the courteous maintenance of a non-judgemental and neutral interviewer that listens to the informants' frame of reference and refrains from arguing; a pretest and pilot study of the instrument; a tape recorder and interview summaries that are sent back to respondents for clarification, further comments and editing; the sorting of subjective data (such as opinions, values, attitudes and tendencies to act) from objective data (such as comparison of accounts from one respondent to another, and evidence of written documentation) as a validation technique; and the selection of an optimum time and place for the interview, may minimize those variables that may threaten the validity and reliability of the research findings.

The Instrument

The purpose of any research Instrument is to help gather data to answer the questions raised in the problem statement. Four general questions were raised following the problem statement of this study, therefore the intent with the design of this particular Instrument was to glean the most substantive and comprehensive data that could be systematically analyzed and organized to answer the research questions.

The Instrument for this study attempted to determine four things: hospital administrator's perspective on the phenomenon of general duty Registered Nurse turnover; strategies that had

been designed to retain nurses and prevent turnover; the rationale for implementing the retention strategies that were in place; and, the effectiveness of those strategies.

For purposes of this study, "turnover" will be operationalized as: general duty Registered Nurses who quit their jobs and leave the employing organization.

The overall design of the interview took the form of a *semi-structured open-ended interview schedule (Appendix C).* "The investigator determines the content of an interview or questionnaire from the literature review" (LoBiondo- Wood, 1986, p.160). A similar study had not been done with this topic, therefore an entirely new Instrument had to be developed to obtain the information sought from the research questions. The research questions were to provide the basis for the interview, and the literature review gave the most direction for the construction of the questions that were asked during the interview.

It is said that the most important thing an interviewer/researcher must do at the beginning of an interview is not to ask questions but to establish rapport with the subjects (Treece & Treece, 1986; Dexter, 1970). This was done by introducing myself, briefly explaining the purpose of the study, and providing reassurance to the subjects that their participation would be kept in confidence, and that their names and the name of their institution would not be used in the study. As well the researcher asked each

respondent if they had any questions about the study before the formal interview began (see Appendix C, step 1-5).

The intent of the first question of the interview was twofold. First, the researcher wanted to engage the interviewee and make the first question "easy", therefore it was decided to ask the respondents to talk about themselves (assuming of course that, generally speaking, people find it easy to talk about themselves). Secondly, the researcher wanted to satisfy a personal curiosity about the educational and professional background of the respondents.

Section One of the Instrument proceeded to ask each respondent about their organization's response to nursing turnover. After much deliberation it was felt that the "test" questions should be asked first because the respondents would more than likely refer to their organization's statistics to validate part of their subjective responses to the general questions that were meant to "discover". Therefore, the specific questions in Section One of the Instrument attempted to secure objective data for the study, whereas the questions in Section Two were designed to explore and discover hospital administrator's opinion and attitudes, thereby providing subjective data for the study.

The second question of Section One in the Interview Schedule asks a very important and specific question- "Is turnover amongst general duty Registered Nurses in this institution measured?" If the respondent replied "yes"

questions 3 to 13 were then asked. These questions were designed to determine how accurate and effective the measurements were and what was being done with the turnover data. If the respondent replied "no" questions 14 to 18 were asked. These questions were hypothetical in nature and were meant to explore and discover beliefs and opinions. In order to obtain the administrators' perspective on nursing turnover, general questions were devised in such a way as to obtain their opinions and attitudes regarding the phenomenon. Questions 19 through 27 in Section Two of the Interview Schedule were purposely neutral, ambiguous and open ended in order to obtain more subjective data for the investigation.

Section Three asked the three most critical questions of the study. It attempted to solicit both subjective and objective data and indeed, answers to the three key research questions for the study: what strategies are in place?; why are they in place?; how effective are they?

Section Four of the Interview Schedule used general questions to test, probe and discover if the organizations utilized the major and most significant retention strategies delineated in the literature review. As answers were delivered by the respondents, it was thought that the researcher could take some liberty at this point with further questions to probe the individual responses (hence a semi-structured interview format).

Section Five used specific questions to discover if the

organizations were considering or had adopted, some of the minor retention strategies cited in the literature review. It also asked why the strategies were adopted and how effective they were for retaining nurses.

The final section of the interview allowed the respondent to expand on any topic that had been discussed.

Subjects

The population to be studied for purposes of obtaining data with regard to the research questions, were the administrators of hospitals in a large Canadian urban centre. Specifically, the population was the Executive Directors of the Concordia, Deer Lodge, Grace-Salvation Army, Health Sciences Centre, Misericordia, Seven Oaks, St. Boniface, Victoria, and the Winnipeg Municipals in Winnipeg, Manitoba, Canada. With the exception of Deer Lodge, these hospitals contain no less than 125 beds. The participation of the subjects was voluntary.

Procedure

After approval from the University Ethics Committee, a pilot study was done to test the Instrument. The pilot study took approximately four weeks to arrange and complete. Letters were sent to the Executive Directors of the hospitals in Portage la Prairie and Selkirk, introducing the researcher, outlining the purpose of the study and soliciting their help

for refining the study's tool (Appendix A). A follow up phone call was made to their offices to secure an appointment. One administrator did not participate. The pilot study was subsequently carried out to test the Instrument with one Executive Director and with one Assistant to the Executive Director. Slight revisions to the Instrument were made.

Upon completing the pilot study, a letter was sent to each of the nine hospital Executive Directors requesting their confidential participation in the study. The letter introduced myself as a researcher, outlined the purpose of the study, requested their permission for a tape recorded interview, and specified the time required of them (Appendix B). A follow-up phone call to their office was made five days following the date of letter posting, to inquire about their decision as to whether or not they would participate. In order to secure an appointment I spoke with three of the Executive Directors, and six of their secretaries. One of the Executive Directors declined to participate, however his secretary ensured I interviewed someone in senior management who was not a nurse. I accepted the replacement (after knowing I had secured appointments with the other eight Executive Directors) and found the selected individual to be appropriate for the interview. An appointment was then made for me to meet with these respondents, preferably in their office. The nine interviews occurred four days to four weeks from the time of the initial calls. One of the interviews was

rescheduled three times due to the Executive Director's full and sometimes conflicting appointment schedule.

The structured, open-ended interview schedule (Appendix C) was conducted with each participant, and the researcher took notes and tape-recorded the interviewees' responses. Documents that were provided during the interview were reviewed and recorded. After the interview, the researcher replayed the tape and transcribed it. A copy of the transcript was returned to each respondent within three weeks of the interview along with an accompanying letter that thanked them for participating in the study and encouraged them to add or delete comments from the document, or to contact the researcher if they found any discrepancies in the recording of the conversation (Appendix D). An addressed and stamped envelope was provided for them to send the summary back to the researcher after their review.

All but two of the respondents sent the copy back to the researcher. A follow up telephone call was made to verify that the summary had been received by those particular subjects. One secretary stated there were no revisions to be made and another secretary informed me that the Executive Director required the week-end to review it. That particular transcript was never returned and from that I assumed I could go ahead with the analysis.

Very few changes were made in the transcripts. Ninety percent of the changes were for grammar. Some respondents

filled in the blank spaces that I had purposely left out so as not to identify them! Three of the respondents sent back their best wishes on the documents and bade me luck with the study. Three of the participants edited information they felt was confidential to their hospitals. One of these sent me more information from the hospital, and another photocopied two articles about nursing turnover from a journal of hospital administration. One respondent was interested to see the results of the study and asked for a copy, which I promised I would send.

IV) PRESENTATION OF DATA

Context

When I began working on the research project in May of 1990 I had full intent of keeping the city I studied anonymous. I was going to refer vaguely to the study location as a large Canadian city, thereby protecting the identity of the respondents who participated. However a major event that was related to the investigation and that occurred throughout the province just before my data collection phase, has prevented me from keeping the research location clandestine. As a novice researcher I found myself in an unpleasant quandary and I feared the entire project was doomed.

The event that I am referring to was the largest labour dispute in Manitoba since the 1919 General Strike. It involved 9,500 nurses who went on strike throughout the province. Contract talks between the Manitoba Health Organizations Inc. (the body representing the health facilities) and the Manitoba Nurses Union broke down, and nurses were subsequently on strike from January 1, 1991 to February 1, 1991. The 31 day strike was the longest nurses' strike in Canadian history, and nurses in rural and remote areas within the province were on strike about four weeks longer. The predominant issue that the media focused on was that which embroiled the two opposing sides: wages. Those aspects of nurses' working lives that seemingly were not

addressed in the contract dispute, but were of major concern to nurses on the picket lines were given attention by the media as well. Stories that related low pay, little respect, more responsibility, few opportunities and insufficient mechanisms to allow a stronger voice in decision making within hospitals were covered.

In the third week of April 1991, and ten weeks after the nurses went back to work, I sent my letters to the Executive Directors of the hospitals, requesting their participation in my study. Somehow I was not very optimistic that I would receive favourable replies. I felt that no hospital administrator would want to take part in a study investigating a phenomenon such as Nurse Turnover/Nurse Retention, least of all be interviewed by a nurse. Would they regard me with suspicion? Would they view the nature of the study as threatening or vindictive? Would they simply refuse to participate?, thereby ruining ten months of research preparation and ultimately delaying my graduation for God knows how long?

I was pleasantly surprised by their collective reaction. I was well received by eight of the nine respondents and although one individual did not participate in the study, he allowed me to interview someone within the organization whom he thought would be helpful. The impact of the strike may have affected the research results by altering the attitudes and behaviors of the participants of the study towards nurses

and their work settings.

Another equally important factor that affected the context for the study, was the state of the Manitoba and Canadian economy. For the second time in ten years the country experienced a recession, displayed by a composite leading indicator. From May of 1990 to May of 1991 this leading indicator steadily dropped from 144.2 to 136.5 points (Statistics Canada in the Free Press, August 7, 1991) denoting a nation wide recession. Business, agriculture and the manufacturing sector were all hit hard and subsequently, unemployment levels rose. As outlined in the literature review, the general economy has a significant impact on an individual's resolve to stay with, or quit their job. Undoubtedly, the recession has affected the nature of the results of this study.

Finally, and on a more personal note, at the time of the interviews and data collection stage, my family moved residences. This disruption in my life during a critical stage in the research process had an effect on my interviewing skills and left me somewhat dissatisfied with the incomplete nature of the answers I obtained to some of the questions.

Subjects

Most qualitative studies delight in describing their subjects, however I have refrained from doing that in order to protect my participants' true identities. I have given each

respondent a fictitious name and in so doing, an assigned gender. The descriptions of the subjects for this study therefore are rather general. Occasionally, I have referred to individuals by their fictitious name, and this has been done to illustrate a point or to give the reader a greater understanding of the story that is being presented. The use of the name in the data presentation is not meant to single out or identify any of the respondents who took part in the study.

Eight of the nine respondents I interviewed were male. All of the participants were caucasian, however various ethnic backgrounds were apparent and it was evident that at least three of them were bilingual. Their ages ranged from early forties to late fifties, possibly early sixties. Six of the nine respondents had two or more University degrees, including arts, science, education, nursing, social work and pharmacy. Six of the nine respondents had some hospital administration education and two of the nine respondents had Masters level preparation. The time spent in their position as Executive Director ranged from six months to 15 years. All of the respondents had some experience in hospital administration prior to their present role, although more than half of the participants had been in the Executive Director position in their particular organization for less than two years. The remainder of the Executive Directors had been in the same position for five and a half, to fifteen years.

All nine of the interviews took place in the respondents' offices during normal working hours. Five of the nine had a secretary immediately outside their office while four seemed to have a secretary that was shared among several people. My initial contact immediately before six of the interviews was with the Executive Director's secretary. One of the immediate contacts before an interview was with the respondent's co-worker, and one of the contacts was with a security officer in the building. One Executive Director was working in his office which I entered directly.

Five of the respondents were prompt while four were delayed anywhere from five to twenty minutes. Those that were late apologized and gave an explanation for their hold-up. All of their working attire was suit and tie, although three of the respondents did not wear a suit jacket during the interview, and three of them removed their suit jacket during the interview. Five of the nine respondents offered some sort of refreshment before we got started which I declined. Four of these individuals had a beverage with them although they seldom sipped at it. The offices of the participants were all of a good proportion having at least one large desk, book shelves and another table (all but one of which were round). Five of the nine offices were nicely decorated, one was richly decorated, two were quite plain, and one office was rather austere. Eight of the offices were very modern nonetheless, and all of them were tidy and in good order (not one slob in

the bunch).

Two of the respondents sat at their desks while I sat in a chair across from the desk. The remainder of the respondents chose a sitting area within their office for us to converse. Thus five interviews were at a table, one interview was conducted with us both sitting in chairs opposite one another, and one interview had the respondent in a luxurious wingback chair while I sat on a sofa.

None of the participants were reluctant to be tape recorded and almost all of them felt that a transcript of the conversation for their review would not be necessary. At the outset of the interview I assured confidentiality, however I told them I could not guarantee anonymity because the timing of the strike during my study would probably give away the location of the investigation. None of the participants were concerned about confidentiality- they felt they would probably be recognized by either their comments or a description of their organization.

After our greeting and an explanation of the study I began the Interview Schedule. In my opinion, eight of the nine respondents conducted the interview in a businesslike manner and yet I would describe their attitude towards me as relatively warm. One respondent was neither businesslike or warm and appeared rather disinterested, tired and unsure about many things (Jamie). I felt that seven of the respondents were very comfortable being interviewed and were relaxed

during our verbal exchange. These seven respondents did not appear "pressed" for time and although near the end of the interview I felt I was keeping them from something, they did not attempt to speed up the interview nor did they ask me when it would be over. Two of the respondents (Bruce and Carl) were slightly on guard and appeared somewhat cautious and almost defensive with me at the outset of the interview, and Bruce became very distracted during the end of the interview because of an irate family that wished to speak with him ASAP. I did not feel that any of the participants felt threatened by my presence or my questions. Eight of the nine interviews had at least one interruption, either an in-going or out-going phone call which was usually brief. One phone call was long distance and appeared personal so I left the room to provide for privacy. During each interruption I turned off the tape-recorder, which proved to be somewhat problematic later on during the typing of transcripts because more often than not I neglected to turn it back on again. In fact it was the participants who often reminded be to resume tape-recording.

The interviews lasted from seventy minutes to two and a half hours. Most interviews took one and a half hours. Other than for purposes of clarifying the meaning of a question, at no time during any of the interviews did a respondent ask me a question. At the end of the interviews and after I expressed gratitude for their participation, all respondents walked me out of their offices. Danielle was the only

participant to request to see the findings of the study.

The Interviews in Brief

In order to give a sense of the conversation I had with the respondents I felt it would be important to present at least some of the dialogue in the thesis itself. It is not my intent to simplify or distort the participants answers for this section. Rather my purpose for doing this is threefold: i) to give the reader a sense of the individuals that participated in the study; ii) to strive towards presenting the voluminous data in a comprehensive yet concise form; iii) to provide a framework that will present the participants' answers to the major research questions, thereby focusing on the purpose of the study.

In order to present some of the data, I have attempted to summarize each interview and display the answers the participants gave to the principal questions posed by the study. Thus, the summaries of the interviews will flow from the questions posed in the Interview Schedule (Appendix C). In order to help the reader follow the questions from the Interview Schedule, I have indicated which interview it was by designating a letter from A to I, and which section of the Interview Schedule the questions were taken from. For example A-1**** provides the answers for Interview A/Section 1 of the Interview Schedule, A-2**** provides the answers for Interview A/Section 2 of the Interview Schedule, just as C-1****

provides the answers for Interview C/Section 1 of the interview schedule, and so forth.

Interview A: Danielle Hallas

A-1****

When I asked if Danielle's organization was measuring turnover amongst general duty nurses in the organization she stated:

> If you mean am I getting regular statistics on it? No. But are we keeping track of it? Yes.

Danielle did not know what the level of turnover was in the organization but replied:

> I can tell you we have not been having a whole lot of difficulty in getting people in the general duty ranks at the moment, and unlike what we were hearing in other provinces, we didn't seem to go through that shortage problem....only in the specialty areas are we having the usual problems.

When I asked Danielle how the organization was measuring turnover in these areas she replied:

> In terms of measuring numbers, obviously that is a straight statistical calculation of the number of people that are supposed to be in the positions and the number of people that actually occupy the positions. We calculate the percentage of turnover on the basis of the percentage of staff turnover in an area.

Related to this definition, Danielle felt that maternity leave was classified as turnover, as expressed in this comment:

> That (maternity leave) can be short term turnover, but none the less it is an element of turnover.

Danielle believed that the nursing force was quite stable in the organization. Her perception was based on some general

statistics she had read that were not from her particular organization. She believed there were a lot of long term general duty nurses and many bread-winning mothers on staff. She also stated there were presently too many nurses in the province and new graduates were having to look in the United States for work.

In her facility the Nursing Department collected and synthesized some turnover data and general reports were shared quarterly with the Executive Director and the Board of Directors. Exit interviews were carried out in the organization and were related to the departure of the personal, but Danielle did not indicate what the compliance rate was with this or what form they took (either a survey or an interview). There were no pre-established criteria for acceptable or unacceptable turnover rates in the institution. Although Danielle emphasized that performance was an on-going process throughout the duration of the employee's adherence to the organization, she was unaware if turnover was actually linked to the performance of the employee when they departed.

Danielle thought that hospitals ought to measure turnover amongst staff because it indicated many things within a facility. She felt that turnover measurements allowed the organization to pinpoint problems, and allowed management to look at trends so as to plan and react accordingly.

A-2****

When asked what kind of impact nursing turnover had,

Danielle did not really answer the question but made a point of saying that an element of turnover is healthy because it brings in new people with new ideas. She did not know what the appropriate level would be but felt it would be somewhere between:

> ...achieving the new eyes and inflow of new people ideas, and not being so severe that it inhibits your ability to provide good care and costs you such an awful lot for orientation all the time that it becomes a real problem.

When asked why she felt nurses left their jobs she replied:

> Oh darn there are so many reasons. I honestly think that a whole lot of them are related to family....maternity....husbands transferring....some of it is stress related, there is no question, probably because the work is very difficult....some are adventurous and they want to go somewhere else or travel...in terms of the economy of course, the more difficult the economy the more stable the staff is, because there is no place else to go.

Danielle felt management could increase or decrease nursing turnover in many ways. She spoke generally and gave a few examples to show how management could show concern for them: involve them in the decision-making process; be sensitive to their needs; be prepared to make changes; be flexible and; recognize them by focusing on nursing activities within the hospital and the hospital newspaper. She felt all of these activities fell under the roof of "communications", in an attempt to show the staff that they were appreciated for the work they do and were cared about. Danielle related a humorous story about a new employee who was oriented to the job by an administrator and how the new employee's colleagues

then showed her how to "really" do the job after the administrator left.

> That is why you involve your staff at all levels, and with the "doing".

When I asked Danielle why she managed this way she replied:

> Because they are the ones that will tell you how to do it right! There is no question. I mean that has been proven and proven and proven, and yet some...I'm getting into my soapbox here,..and yet some management think that it is their capability as a manger to come up with the answers to everything, and if they can't come up with it that it reflects badly on them. They think it is a weakness to simply ask, "What is the right way to do this?" When a plumber comes in to your home do you tell him what to do? No! ...The fastest way you can get people to dig their heels in is to tell them what to do and how to do it. That is not good management. ...The idea that we have to know everything is crazy.

Danielle also recognized that:

> I don't think there is any doubt that you (management) could do a better job but one of the things that hinders you- and this is factual as opposed to anti-union. You are really not in a position to give rewards to people who do extra and provide special effort because of the way the union philosophy works. You just can't do that. ....they have certainly not been unsuccessful in terms of nursing negotiations, goodness knows they needed a lot of help in terms of their relative position financially over the past few years...but only part of it is dollars and cents. ....But facilities can play a role in the satisfaction of nurses who practice, there is no doubt about that. I suppose fringe benefits are a biggy, not just the salary but the fringe benefits that go along with it.

Danielle did not feel that any one particular person had the primary responsibility for retaining nurses. She felt that nursing retention was a corporate responsibility "from me down".

A-3****

When asked what qualities or strategies the hospital had for keeping or retaining nurses Danielle replied that it went back to the things she talked about earlier (showing concern, involving them in decision making, being sensitive to their needs, being flexible, recognizing them, and the overall quality of care being provided in the facility). She felt in order to retain nurses you use the same things you try to use to attract them. She stated that the organization also had a fair renumerative package that helped retain nurses. One of the major strategies that the hospital has begun to develop was re-defining the role of the nurse.

> ...one of the big areas of dissatisfaction and it's a legitimate concern- the nurses are doing a whole lot of things on the wards that you don't have to be a nurse to do. So we are going to concentrate over the next few years, it will probably take that long, to really look with them as to what their job ought to be. ...This handmaiden business is gone and let's recognize that and do something about it. What we have now are pilot studies being set up in our own institution, and we have other portfolios involved, particularly Operations. I mean what are the things that should be done by Housekeeping and by Dietary and so on that nurses are expected to do? ...the question we hadn't addressed was: what are the services that a nurse has been doing that are in fact essential for a nurse to do, and what are not. And that has never been brought as forcibly to my attention in the past ...I have never had that kind of thing brought to my attention. In a way that gives us an advantage, because maybe we can break some new ground here and it's going to be contagious right across this country.

When asked if this strategy was implemented because of the strike Danielle replied "I think that was an unintentional portion of the strike."

Generally speaking in terms of the effectiveness of strategies Danielle felt that some of the strategies were effective in some cases, and that other strategies seemed to have little impact. The following comment illustrates her viewpoint:

> But whether or not increasing those types of things (benefits) would have any impact on nurse turnover is difficult to really know. You can guess and guess and guess. ...And even then, you can never be sure of what caused it or if turnover drops and you've done a whole lot of things. You never really know, you can guess but that's it.

A-4****

Danielle felt that her organization had a combination of centralized and decentralized functioning.

> What I've tried to do here, is to say to people, look, there are elements of an organization such as this one that have to be done on a centralized basis. Because we essentially are all under one roof. But there are also elements that are unique to your particular area and I have no quarrel with you maintaining your identity. ...the same rules don't apply to each situation. And I think what you have to do is rely more on the people in the area to call more of the shots... But when it comes to specifics that you need for the special areas you have to consider that in light of their particular requirements, and listen to them. For God's sake listen to the people.

When asked about the effectiveness of that approach she stated:

> It depends entirely on your people. ...You can be as flexible as you want to be in this chair but if you can't get other people to react accordingly down through the ranks, you will be in trouble.

Danielle did not know what primary nursing was and stated she was unable to answer the question.

She was unsure of what a clinical ladder was and asked

what it meant. Her response to the notion of clinical ladders was "One of the things we recognized here is that the long term general duty nurse is not given the recognition she deserves."

Finally, Danielle stated that joint-collaborative practice occurred in some areas of the hospital (specifically I.C.U.) however she felt it would be tremendously difficult to apply to all areas of the hospital. She speculated that if implemented, it would probably translate into a lot better patient care.

A-5***

Danielle's organization had twelve of the nineteen minor retention strategies on the checklist, but many of them were qualified. Danielle felt that things like job sharing, significant shift differentials and financial recognition for advanced preparation should be refined, and that recognition for nurses was difficult to do given the size of the organization and the union philosophy. Once again Danielle felt that some of these strategies helped retain nurses and some of the strategies had no impact.

Interview B: Bruce Zimmerman

B-1****

When I asked Bruce if his organization was measuring turnover amongst the general duty nurses he stated he wondered how helpful he would be for my study.

> Because you seldom see this hospital advertise for nurses, because we seem to have continuously, applications on deck that people have come just voluntarily to apply for work. The only area in which we have had some sporadic difficulty is in Emergency and Intensive Care Units, the specialized acute care centres. ...we have not experienced a shortage of nursing staff during the (X) years I have been here.

I acknowledged this comment but asked Bruce if there was turnover among the employees that filled those positions.

> Well there has always been that turnover but of course it has become much more stable in the last decade I would guess, partially because of the economic conditions for families generally in the province... What I wanted to say though is that we have a long term service recognition, as most hospitals do and the number of people showing 10, 15 and 20 years of employment at the hospital is increasing. ...We have a fairly stable work force here and that includes nursing. ...I just have to re-affirm that we seem to be enjoying a stability in our nursing staff that really doesn't cause anxieties about having to fill vacancies.

In the next question, I began by stating "So in effect your organization is not measuring turnover..." and following this I began my next question declaring "You say that you are not actually measuring turnover so I guess I would like to ask you what your perception of a stable nursing workforce is based on." Bruce replied that he goes on the weekly conversations he has with his Assistant Executive Director of Nursing who is part of the management team. He felt that if

turnover were problematic she would report that to him. He also felt that another good indicator of low turnover is the fact that the hospital does not have to advertise for nurses.

> And I just have to say again that, I think, is a pretty valid observation about this hospital.

I asked Bruce under what circumstances the organization would begin to measure nursing turnover. He replied:

> Well if it got to the point where services had to be curtailed because of lack of staffing, then certainly we would take some more aggressive measures in recruitment, but as long as we can maintain full services and staff seems to be available in the various disciplines they are needed, then I don't perceive that as a problem.

Bruce then spoke to the dynamics that occurred in the facility and the style of management he used. After our discussion about this I asked Bruce in his opinion, what percentage of nursing turnover would be considered unacceptable for the facility. He had a lot of difficulty answering that question so I prompted him by saying that the literature stated that on average, hospitals have a 20-30% turnover rate in their nursing staff. Bruce then asked me if he could phone somebody about that and the question he posed to the person on the other end of the line was what the turnover rate of nurses in the hospital was (I am unsure of who he phoned). She replied that she thought it was in the range of 10% or less. Bruce still had difficulty with deciding on an unacceptable percentage rate for nursing turnover so he reluctantly gave a figure of 17 and one half percent.

The steps he would take if he started to measure turnover

would be:

> Well, first of all you would like to understand the reasons why. Is it friction or work pressure that can be corrected? Or is it that the patient loads are unacceptable. Is it interdisciplinary friction or lack of supportive relationships? Those are the initial things that one would have to look at internally, and then perhaps look around at the external factors. Is the supply of nurses in the community dwindling? Are schools of nursing not attracting students? It goes much broader than your institution.

B-2****

Bruces' response to the question of impact that nursing turnover had was:

> But the impact of nursing turnover is very significant because continuity of care is something that we always want to offer patients. If there are people with varying degrees of expertise and experience that are available for patients and we can't offer that continuity of care, then I think it is very significant. ...turnover also prevents the working relationships within units, therefore one should harvest continuous staffing relationships for better working conditions.

When asked why he thought nurses leave their jobs Bruce answered:

> I think I have no reason to be concerned about why they are leaving. I think the turnover is acceptable. There are transfers of families, and people with career goals that move on.

Bruce thought that management could affect turnover and that the most constructive thing management could do was:

> ...provide an atmosphere in the workplace that is, you know, is productive and gives employees a sense that they matter to the institution.

Bruce thought that for the most part nursing turnover was largely due to personal, career and family reasons, and that the nature of this kind of turnover was not within the control

of management. Bruce also felt that no one particular individual should be held accountable for retaining nurses, that it should be a shared responsibility within the hospital.

B-3****

Bruce thought the qualities or strategies the hospital had for retaining nurses were:

> ...I think we provide a satisfactory work environment. We acknowledge long term service. We encourage communication and positive staff relationships. ...We have the cheapest parking rates per month. But I'm not sure that is exactly what a staff member looks at.

Bruce thought that these qualities were very effective for retaining nurses because of the low turnover within the facility.

B-4****

When asked if his organization was decentralized Bruce replied:

> Well if you are looking at the management style and wanting to consider a more participative management style, I would like to think of us as having that style at all levels. Just for an example, there are targeted reductions for all hospitals to achieve for the next fiscal year. So we are meeting at a workshop next week with head nurses and department heads to brainstorm the ways and means for how we can cut down whatever is possible. Do we need to change sheets everyday? I don't know if that is a question. But reducing 1 kilogram of linen per day saves us so many dollars per day. Whatever question comes up will be discussed. Staff is being invited to respond and participate in those kinds of decisions.

When I asked Bruce why he invited the staff he stated that it was not his style to say "You will now only change linen every Monday" and that he felt it was better to have staff who are working there come up with ideas. When I asked Bruce why that

was his style he stated:

> I happen to believe that is better and is supportive for a more productive workforce.

Bruce understood the concept of primary nursing and replied that his organization did not have it.

Bruce was not familiar with the term of clinical ladders and required an explanation. After I defined it for him he replied:

> I guess that hasn't been refined. ...Recognizing by means of renumeration, I guess we have failed to come up with a way of doing that (because of) budget limitations I guess and also an interesting phenomena, of union mentality where we will send a nurse off to an I.C.U. course which is a nine month course and then you come back, and they have some expertise or additional expertise that you didn't have before why can't we give some form of acknowledgment, and the union says no. Now isn't that odd? I find that odd.

The only area in his organization that utilized joint-collaborative practice was in the I.C.U. and his reason was "...because they depend very much on each other."

B-5****

Bruce's facility had twelve of the nineteen minor retention strategies in the check off-list, most of which were qualified. He felt that some of them were effective and some of them did not have an impact on retention, however for the most part he thought these qualities/strategies were very effective for keeping nurses within the organization because of the low turnover rate in his facility.

Interview C: Carl Bertram

C-1****

Carl's facility was not measuring turnover amongst general duty nursing staff because it was not viewed as a problem. Carl's perception of low turnover was based on his discussions with his Assistant Executive Director of Nursing and his involvement with the restricted budget, staffing and the various programs within the facility.

> And there is no evidence really of a big turnover. ...They tend to stay here quite a long time actually.

When I asked Carl under what circumstances the organization would commence measuring turnover he replied:

> If it were just isolated to one area or one ward, I think I would see that right away. The fact there is a danger signal and that something were wrong. In a central way I think we keep a close hand on the difficulty with recruiting to certain areas. We've had some difficulty in recruiting, we haven't figured it out as yet, although it is not as bad as it was say three years ago.

Carl had difficulty with the question of an unacceptable turnover rate for nurses, but finally declared about 5%. I asked him what steps he would take and how he would go about measuring turnover if he did decide to keep track of it.

> Good question. Well, if it were just one particular area, or one particular ward, we would have a very careful look at it's history to see if there was a slow trend. I think it should be continuous, whereby you monitor something like that over time. If we felt we needed to be serious we would make sure that one of the things we would do would be to take exit-interviews, and the whole exercise would have to take place to diagnose what was wrong.

Carl's facility used exit-interviews to a limited extent but stated the predominant reason that nurses had left the

organization was very obvious: their husbands were transferred.

C-2****

Carl felt that nursing turnover "...can have a poor impact on patient care and the continuity of services." He also stated:

> Well it's always difficult for staff turning over all the time in terms of feeling competent with direct patient care. But also in understanding policy, philosophy, the understanding and implementation of the mission statement of the centre, and these sorts of issues.

Carl felt that nurses leave their jobs;

> ...there are actually a number of reasons. The obvious ones are they get married, some of them. I think they get, understandingly, frustrated. It doesn't so much happen here but I'm thinking in terms of the health care organizations that run strictly on the medical model. I think it is frustrating for the nurses nowadays who are better educated- they are taught much better assessment skills than they were years ago. Some of this is not being utilized in those environments which are medically driven. ...and they think, "Why did I go through all this schooling and why do I have to have a baccalaureate degree when here I am doing things that really, just add to my stress, and consist of non-nursing duties." Although I think the nursing profession has to really sit down seriously with themselves to define what is nursing.

Carl felt that management could increase or decrease nursing turnover an awful lot.

> I think it can show nursing as any other professional group that, and it applies here because we do use it, is a multi-disciplinary environment. Not for just one professional group making decisions in patient care, it is a multidisciplinary approach. And we actually do that here. And I think management always being available, not by just having an open door, and having people come and see you, but by speaking to people who are actually doing the work and by asking, "What can we do better to make your work easier?" That type of approach. ...being visible. Plain and simple. By being visible and

approachable. I think that is very important.

When asked who has the primary responsibility for retaining nurses in the facility Carl felt the department of nursing had a critical role for retaining Registered Nurses.

> How the nursing department views them and how they relate to them plays an important role.

C-3****

When Carl was asked what qualities or strategies his hospital had for keeping or retaining nurses he stated:

> Making sure that they (nurses) really do believe that they are part of the decision making process. I think that is terribly important. Making sure that nursing is seen, and making sure your Associate Director Nursing is in the management team. Making sure that nursing has input in the decision making of every department. I think that helps the nursing staff feel very comfortable with all the other professionals and administration.

When asked why the hospital did that, Carl said because of his own professional background and because he had always believed that was the way it ought to be.

C-4****

Carl requested a definition of decentralization and replied:

> Increasingly (the organizational) structure is becoming flatter, and it's pretty flat now. We are getting away from all the super-managers, assistant managers, sub-managers and the rest of the bureaucratic tree.

When asked why the organization chose to do it that way he answered:

> Because you have a valuable resource directly in the nursing department, well trained with good ideas, and if you have too many managers on top of them they say "What difference does it make what I have to say about this.

> Why should I bother." But if you can see that within the policy structure we have, that everybody has had some input into, it makes a difference. ...Money is important to all of us. You also hear what is perhaps more important to nurses is that they want to be treated like professionals and they want to be involved.

Carl was a little confused between the different types of nursing and needed some clarification with the term primary nursing. He replied that they were using it in a flexible form throughout the hospital. When I asked him why the hospital was using this type of nursing he said this decision was made by the nursing department and that the type of nursing a hospital has can only be a nursing decision. He felt this type of nursing was an effective way to retain nurses.

Carl was unsure of the term clinical ladder and required a definition. Once this was given he replied "That makes a lot of sense doesn't it?" Further to this he stated:

> That makes a lot of sense. Why do you always promote your best people in the facility into administrative positions? They are usually the best patient care givers but many of them don't have the skills for administration.

Carl stated the hospital used joint-collaborative practice throughout the facility. He also mentioned that the practice extended to physiotherapists, and occupational therapists such that it was a multi-disciplinary collaborative practice.

> Each has their own input. We don't have separate Dr.'s comment sheets. It is a multi-disciplinary charting system. ...If care decisions are multi-disciplinary why would we stick with the old fashioned way of having Dr's orders at the top of the chart? To me that was a good

decision.

Carl thought this was an effective retention strategy and mentioned that it had never been suggested to him that it change.

C-5****

This organization had twelve of the twenty minor retention strategies from the check-list and the respondent identified several more that were unique to the organization (the Director of Nursing was on the senior management team, utilizing a multi-disciplinary model versus a medical model in the facility, a state of the art library, and nursing grand rounds). Carl felt that all of them in combination promoted retention.

C-6****

Carl wished to add that he hoped the nursing profession could attract people in the future. As well he stated;

> ...it would be fatal to go back to the days, and allow untrained people to care for patients in hospitals. We have a lot of "aides" working presently, who do have something to offer, but ultimately we need the Registered Nurse with her assessment skills to provide bedside care.

Interview D: Kelly Jenkins

D-1****

Kelly stated that her organization was measuring turnover but unfortunately she had not had time to get the numbers for me. She thought it was "less than 15%" and stated that they have had a lower turnover rate in the last 12 months for

fairly obvious reasons;

> The lack of the number of jobs available, even for nurses. Nurses can't just suddenly drop one job and move to another one tomorrow, even though their quota has been perceived as a shortage. In reality I'm not so sure how severe that shortage is... ...if you look at the general duty side there is probably an excess number of nurses. But the question is why don't they decide to go into Intensive Care, Emergency and even O.R. gets a little dicey I suppose, but primarily Intensive Care and Emergency. I don't know why. ...(the pay) works out to be about 10 cents more an hour (for working in these areas). They are saying to me, "It's not worth it. Why would I bother." Make it more attractive and you will probably get more people. That's what they are saying. That's what I'm hearing. And I guess realistically that probably is a point of view that one should have a little bit of time for.

The facility used exit interviews in those cases where there might be a "potential for information", and the department that collected and synthesized the data was the Human Resources Department in collaboration with the Nursing Department. The reason the organization utilized exit interviews was to ascertain why the individual was leaving and also to obtain insight as to what was happening within the organization (usually the department they worked in, and the management therein). Kelly felt there should be more exit interviews done.

There were no pre-established criteria for acceptable or unacceptable turnover rates and turnover was not linked to performance.

When I asked Kelly why the organization began to measure turnover she stated:

> Oh I don't know why but I would assume that from a good business or any kind of operation you would like to know

> what kind of rate of turnover you have amongst your employees. And you want to be able to compare it with rates of turnover in other organizations. Which to some degree seem to suggest if you are at a norm or whether you seem to be an exception.

When I asked Kelly what was done with the information that human resources have compiled, she replied; "You really want to know? ...I don't think anything."

D-2****

Kelly felt that nursing turnover had an impact on training and orientation costs for new nurses coming into the organization.

> Probably the biggest cost is the patient care impact. Because every time you turn over people on the unit or in the middle of a program, there is a period of adjustment. One wouldn't necessarily say the quality of care goes down but certainly the continuity of care in terms of relationships established between patient and care giver are disrupted, and that's important....And in terms of productivity and efficiency, new personal spend a lot of time trying to find out where supplies are and how the policies are set up, and just the general knowledge of how the unit functions, and I think this translates into a reduction of productivity.

Kelly felt that nurses leave their jobs for a multitude of reasons;

> Some of them are totally offended by the rates of pay. Some of them don't believe there is enough professional respect in terms of their discipline. Some of them leave because they feel they are abused, not only by patients but primarily more by management and by the system. Some of them leave for the obvious but good reasons, like raising families and doing all those positive things which is OK. The other reasons are negative, but there are good reasons to leave in terms of career development or family growth or those kinds of things. I guess they leave because they feel that when we talk about professional respect, (it means) the opportunity for involvement in decision making opportunities. To have a sense of consultation and collaboration with management so they get a feeling that they are able to get their

> input and feel that they are able to state not only what is wrong with the organization but what is right with the organization and to respond to the directional plan that the organization is taking.

When asked how much management can affect turnover amongst nurses Kelly thought:

> I think management can affect turnover tremendously. Everything I have said so far says that if management treats all of the professional groups with respect and values their input, not just says that, but lives it, by providing a process where they can actually see an opportunity for input. That dialogue does occur. It's not verbal in the sense of going out and saying "Yea we think you people are important and we want to hear what you have to say.", and then never providing the forums and facilitating dialogue and conversations to taking place. That's not what I'm talking about. If you are really effective at it, and you get people involved and you give them the forums, and you give them a process whereby there input is there, and show that you do mutually respect them. If you can increase the morale, morale is a significant factor in terms of reducing turnover.

Kelly credited her personal philosophy versus a management philosophy for this kind of outlook. She felt that if you lived this style of collaboration, participation and consultation in your personal life (marriage, friendships, children, etc.) then it would be incorporated into the way you manage.

Kelly felt that the primary responsibility for retaining Registered Nurses lay with the nursing department.

D-3****

When I asked Kelly what strategies the hospital had in place to keep nurses working there she replied:

> Well I guess...I'm not sure that the hospital has any particular strategies.

After speaking about some of the things that had recently been implemented in the hospital Kelly thought that their recent endeavors to match nursing skill to the programs in the hospital could be considered a strategy.

> ...other than that I think the other strategy of improving communication and dialogue and participation of staff in management and the decision making process. That is another strategy that goes beyond nursing. It is for all the staff.

When I asked Kelly why the organization had decided to go the participative management route she stated;

> Well from my point of view there are a number of reasons. Efficiency of the organization, the effectiveness of the organization, the morale of the employees in the sense of how much they are respected, the whole aspect of improving patient care and I guess the other is a reflection of my own individual thoughts of how an organization should run. ...If we can change the attitudes of people and they can see the benefits of behaviour in this way- and there are many benefits- we can augment commitment to the organization, improved patient care, and organizational efficiency.

When I asked Kelly how effective these strategies will be for retaining nurses she said:

> I guess realistically that is a hard one. That's really hard. ...I will be looking for things such as...the turnover rates of the facility,...efficiency factors (in terms of utilization) as well as effectiveness...I would look at whether or not the institution is able to grow clinically as far as programs are concerned...what changes have been made to the image of the organization. I would investigate by continued external information I guess, on my own personal level with other CEO's and other people in the community. I'll talk with staff internally...look at patient complaints. ...It's not a very scientific evaluation, but some of it is good data that will help us to assess. We will actually have to pull together is a sense, what the plan is for evaluating some of the things we have done. We haven't really organized that effectively- those are all things that are in my head, that have not been written down.

D-4****

Kelly thought the organization was moving towards decentralization however she did mention the tremendous problems the organization was having with managers of different departments communicating. I asked Kelly why the organization was decentralizing and she stated:

> Literature is replete with the whole aspect of solving problems at the lowest level in the organization, not letting them linger or carry up several levels so that this person up here is writing memos down to this person over here and this person is speaking with another person over here. That has been proven to be an inefficient way of doing things.

This philosophy was not documented or written within the mission statement.

Kelly was not familiar with the terms primary nursing or clinical ladders and was unsure whether or not the organization utilized these strategies.

Kelly was also unsure of the term joint-collaborative practice however after an explanation she outlined it was only done to some degree in the critical care areas because there is a greater dependence on the nursing staff in the I.C.U. and Emergency areas.

> Seems to me to be from the skewed viewpoint of the physician the critical care nurse is more capable and qualified so they feel more comfort working in that collaborative process. It seems to me that the sense of trust is not there in the general duty wards. I don't know if that is valid or not but that seems...there is greater dependence on the nursing staff in the I.C.U. and Emerg areas.

D-5****

Kelly's organization had approximately twelve of the

eighteen minor retention strategies from the checklist. Generally speaking, Kelly thought that job rotation, flexible scheduling and career counselling were areas that should be reviewed and improved upon. Kelly felt that some of them helped to improve nursing retention and some of them had no impact.

Interview E: Brian Tannor

E-1****

Brian stated his organization was measuring turnover amongst all employees within the facility. Brian had an individual from the Human Resources Department come and speak with me about their Quality Assurance Program and that same individual shared several documents that illustrated their turnover numbers. The reason the organization decided to measure turnover was because "It stresses accountability."

The turnover data was collected by the Human Resources Department and numbers were collected monthly and evaluated semi-annually. Statements were then provided at meetings and evaluated within the framework of a Quality Assurance Program that included a Risk Management Protocol. Exit interviews were to be conducted on all full-time and half-time employees who were terminating, however the compliance rate for these interviews was variable (67% at last count). The rational for conducting exit interviews outlined in the Quality Assurance plan was: "...to assist in determining reasons for turnover by

various Departments. Statistics to be used for Departmental follow-up, long term staffing requirements." The exact definition for "termination" was not provided in this particular document, nor were the calculations for determining turnover percentage rates. The resignations were classified as voluntary and involuntary. The individual from Human Resources stated "The information I get I don't convert into a turnover rate. We look more at the number of monthly leavings and why." Employees were grouped into categories of the various departments in the organization (such as nurses, support staff, lab, physicians, etc.), however the different nursing wards were not evaluated separately. Brian stated that terminations were looked upon globally and felt they should be looked upon more specifically. Turnover was measured between full-time, part-time and casual staff.

There were no pre-established criteria for acceptable and unacceptable turnover rates in the facility and turnover was not linked to performance although Brian felt it should be.

> We are in a bit of a transition. Our benchmark indicators are being re-established.

The general duty Registered Nurse turnover in the facility was approximately 6% for full time staff, 12% for part-time staff, and 14% for casual staff over the past three years based on my rough calculations of the numbers given to me.

The three major reasons for staff leaving the organization as outlined in exit interviews (that may not

necessarily have been nurses) were moving out of city/province, retirement, and better job opportunities.

> The bottom line is you have to look at the area and identify what the problem is, whether it is the people, the facilities, the hours or whatever. You see a lot of statistics and they are all there. But it is not the statistics, it's breaking them down.

E-2****

Brian felt that nursing turnover had an impact on many things. He felt that patient care suffered and the institution incurred substantial costs. He also thought turnover decreased morale for existing staff and increased pharmacy related errors. Finally, he felt that turnover was hard on the management team as well.

Brian thought nurses left their jobs mainly because of their lifestyle; that nurses wanted a quality life outside of work as well as have children and stay at home to care for them. He also felt they left because of poor pay, high stress and little recognition or respect from physicians and other people in general.

Brian thought management was the most important link between high and low employee turnover.

> Providing at least good information and allowing employees to decide for their own what's happening is very important. ...We are very quick to say "You should do this" but we are not very quick to say "What do you think we should do?"

When I asked Brian why he thought it was important for nurses to make decisions about their work he replied:

> Because they know better. The point is, that if you work with something everyday, it just seems to me you should

> know what the hell bothers you. That often we are not the best people to be making those decisions in management, because we are really not in the front lines and we really don't have to work with the issues those people are facing. ...Not only listening to what is being said but doing something about suggestions.

When I pointed out that hospitals never used to think like that he agreed and stated:

> If an idea didn't come from management, it wasn't a good idea. I think now we are realizing, from a funding perspective and a practical perspective, high morale means low absenteeism, means good patient care, means all of these things.

Brian felt the primary responsibility for retaining nurses in hospitals lay with the Assistant Executive Director of Nursing.

E-3****

When I asked Brian what qualities or more importantly what strategies retained nurses within the facility he replied:

> Well one of the things we are doing here is addressing the issues of non-nursing functions seriously. It was a result of the strike but we were looking at these things before even talk of the strike.

He also mentioned moving panelled patients into one area so as to provide proper care for them and to give nurses who wished to work with that kind of patient the opportunity. To this question Brian stated they were looking at a staffing mix, with more nursing assistants to free up the R.N.'s time, and possibly becoming a training centre for these aides. Finally Brian stated that the Assistant Executive Director of Nursing portfolio was increasing, so that individual would now be a

primary member of the Medical Advisory Committee and the Finance Committee. The Assistant Executive Director of Nursing also had the departments of Respiratory, Housekeeping, Rehab, Admitting, Medical Records and the hospital wide Quality Assurance programs. The hospital was doing all of this to make an impression and in the hopes of making a difference to get nurses at the highest level possible of decision making. When I asked why he replied:

> Hopefully it is better quality of care. If you don't provide the bare essentials, how the hell can you do your job? Even though you make an effort- I guess it's one of my frustrations, having been a worker for most of my life and you know that somebody sends you out to do a job, and doesn't give you anything to work with, and then you get hell because you didn't do a good job, it's not a very healthy environment. It's very demoralizing to know you a doing the best you can and nobody cares. But if you are sincere (about quality care) then we should be concerned about our resources and how they are utilized. ...It's a simple statement to talk about "Quality of Care" all the time but if you don't show it through your actions that you mean it, it doesn't amount to a hill of a lot of beans.

E-4****

Brian gave the impression that the organization was moving towards decentralization. He stated that groups were starting to get together. When I asked if the groups were contributing to overall decision making he replied:

> That's the plan. It's more than that. We have been (the separate departments) isolated and I guess we tend to defend our own turf. But when we understand the issues that we are facing and the new health-care model that is evolving, and the funding that we are facing, it's more of a tendency to say, "We better work together on this." And that's a fact. That same message has to be communicated to all staff and at all levels. That message shouldn't change whether you are at the senior level or at the grass roots level. We have to be

> consistent and portray that we all have a share in the problem and we all have a share in the solution. It's not a management problem anymore, it's our problem. And if you don't help us out, we are not going to have a health care system of the future and you are going to be waiting for admission to facilities. We are all potential patients.

Although the hospital had been utilizing primary care nursing for some time Brian stated:

> We are probably going to phase that out eventually or consider some changes. It's problematic to a certain extent too. ...Primary care is OK but we are out of sync right now. We may have to move to a different model. We are going more towards team care and having multi-levels of health care workers and maybe having a person in charge of a group of people, rather than having a primary care nurse. I think we are going to see some changes. ...I'm not convinced that it's the only way to provide quality care. I'm not saying it's not any good, I'm just saying that there are other ways of achieving the same thing.

Brian asked for an explanation of clinical ladders and joint-collaborative practice. He didn't think his organization had clinical ladders and he thought only Emergency and I.C.U. used this form of practice.

> I think it's a great idea. If you are asking me if nursing functions should have more autonomy and more authority to carry out those functions and not always have to go to the physicians, I think protocols could be set in place to accommodate that kind of practice. As a matter of fact, at times I think it could even improve the quality of care. There are many functions right now that are being performed now by physicians that could be effectively performed by nurses. I believe that. This hospital would be looking at all those kinds of things in the future. Why not? And I think that the physicians are ready to consider that. ...

E-5****

Due to time constraints I only asked a few of the minor retention strategies from the checklist. Brian's organization

had three of the seven minor retention strategies and some of them were qualified. He felt that some of the strategies were effective for retaining nurses and others had no impact.

Interview F: Tim Newman

F-1****

Tim's organization was measuring turnover. Tim had last year's statistics of turnover amongst hospital personnel and stated the rate of turnover within the organization was about 10%. The Personnel Department collected the data on a monthly basis whereby the information was assessed informally between Tim and the Director of Personnel. The turnover in the organization was then reviewed more formally on an annual basis.

> ...So that I do have a clear feel for turnover and any problems. Likewise we have bi-weekly senior management meetings, which is a management committee, which is the senior team. And one of the standing items on the agenda is the staff, and how are we doing? Is there a problem, is there not a problem? So we do tend to monitor.

People leaving the organization were categorized into the major categories of resignation, dismissal, disability, retirement layoff, and death. The workers were also classified as permanent or temporary. Turnover was measured throughout the organization however it was done on a global basis and was not divided into professional groups or departments. Tim stated "We informally plot that."

Exit interviews "frequently" accompanied the resignations however compliance rates were not provided. The reason for

leaving was always identified on the document. Tim stated that turnover was not linked to performance, however he stated that the exit interview had a "window" that the immediate supervisor had to complete that indicated if the employee had been satisfactory, unsatisfactory or would you re-hire?

There were no pre-established criteria for acceptable and unacceptable levels of turnover however Tim stated "We get a feel for it."

He considered the turnover in his organization as "...really very, very low. Relatively speaking."

When I asked Tim why turnover was being measured in the facility he stated that is was just a basic management tool and that there was no magic to it. It was just one of the indicators that was done and monitored. When I asked for what purposes, he stated:

> It's an indicator of the morale within the corporation, it's an indicator as far as job satisfaction. It gives you a feel for your recruitment abilities. I mean the market always ebbs and flows in most of the professions, and it is just something as a manager I do instinctively. I don't know whether it's my training, or whether it is just necessity. Necessity has driven it in the past. Here we do not a have particular problem with turnover anywhere.

The annual report was looked at by the senior management group that consisted of the Executive Director, the Assistant Executive Director of Nursing, the Medical Director, the Assistant Executive Director for Support Services, the Director of Finance and the Administrative Coordinator.

> It's one of about eight items on a typical agenda. We don't spend a lot of time on it because it's not a big

> problem. It comes and goes. You look at it and say, "Oh that's nice,...next!"

F-2****

When asked what kind of impact nursing turnover has Tim replied:

> Well it certainly can be very disruptive. The whole process of advertising, your recruitment exercise is a very expensive and time consuming exercise. And it is a very disruptive process. If you have to take a number of senior people out of the line and have them dedicated and concentrating on recruiting on a full time basis, everything else comes to a grinding halt. Your ability to work on projects and move ahead in the industry is really jeopardized. The other thing, as a side effect, if you have high turnover, you are short-staffed. Which means that generates a whole series of problems. The morale of the rest of the staff becomes very low, you're in crisis management all the time. This is particularly true on an acute care ward. ...Because if you are short staffed, it takes time to fill a vacancy. You know someone resigns and it may take a month or six weeks until someone is hired. So it can be disruptive from two sides. One from the patient care side and the other one is the management side.

Tim thought there was "a whole kaleidoscope of reasons" why nurses left their jobs. He felt that one had to look at junior nurses and senior nurses to really get a handle on the reasons. In the case of junior nurses he felt they wanted to obtain experience in different clinical areas and were able to move in and out of jobs more easily because they were mobile and had the flexibility. These junior nurses were also drawn to more education and once they got a feel of what they liked and didn't like, typically specialized.

> Being younger, they get married, and that contributes to turnover. Being the younger group, they start their families and move out of the work force.

Thus Tim felt that the three reasons of obtaining more

experience, increasing their education and raising their families were the major reasons for turnover in the junior nurses. For the senior nurses Tim thought that husbands transferring out of town was a major reason for turnover amongst this group. As well in this group he included burnout and career change as the major reasons for turnover in the senior nurse group. In summary on this topic he concluded:

> I don't think there is any one reason to it. You can go on for longer about a number of things, but I think I touched the major ones.

When asked how much management can do to affect turnover Tim thought "...in some cases, they can do quite a bit, and in other cases they can do very little." We conversed on this topic for a little while and Tim said he found it hard to generalize.

> ...Can management do something? I say yes. If it is a problem, you can do something. If there is not a problem, as you point out, and it's a good point, maybe we are doing something right. If employees are satisfied and the environment is conducive to retention, that's a valid point. I guess I have trouble sitting down and drawing up a list of, you know, items that I hadn't thought about in that context.

Tim felt that the Assistant Executive Director for Nursing was primarily responsible for retaining Registered Nurses in the hospital.

F-3****

Time felt that the qualities or strategies the hospital had in terms of retaining nurses were;

> ...I think listening to them is something we have done here reasonable well. We have tried to open up the communication links. ...We always try to encourage

dialogue with the nurses union.

He also felt that the quality of patient care and the excellent reputation the organization had, contributed to nurse retention.

F-4****

The hospital was becoming more decentralized because of Tim's style of management and his personal philosophy. He had the department of nursing in his senior management team because he recognized that nurses made up the majority of employees in the organization. He worked that way because "...It's much better and decision making is quicker." He stated he managed that way because of his education and previous work experience and not because his colleagues had influenced him. There was no management statement written that ascribed to decentralization in the facility.

Tim did not know what Primary Nursing was and could not answer the question. He was unsure of clinical ladders and his conversation revealed the hospital did not have them. When asked if joint-collaborative practice was used in the facility he answered:

> The official party line here is that we use a team approach to patient care. That works better in some wards than it does in others depending on the physician and the nursing staff. But that is the philosophy. It is a team concept. ...But it tends to be dominated more heavily than perhaps it should by the medical model.

When I asked why this model was incorporated Tim replied:

> I think because of some very innovative thinking by the Assistant Executive Director of Nursing. She was the one that was the spark plug and was the drive behind it. She

> deserves the full credit for that. ...It is also supported by some very strong people in the therapies. You know O.T., P.T. in particular, and respiratory therapy, they have all been players in the formula.

F-5****

Tim's organization had seven of the thirteen minor retention strategies from the checklist, and he mentioned other qualities as well that might help retain employees (a decentralized education/travel budget, having a nurse recognition day, small gifts for staff, and staff appreciation days in the form of barbecues and pancake breakfasts). When I asked why these things were implemented he stated:

> The strength of the hospital and in any corporation, is its people. You can build the most elaborate facilities, or assembly lines or you name it, but unless you have the support, participation and enthusiasm of your people that work there, you really don't have a great deal. History has proven that the best equipped armies in the world can collapse overnight if they are not led properly and are not directed properly. You can have fantastic equipment all of it can go "pop" like a balloon. The Iraqis are a classic example of that. They were rotten from the inside and they had the most sophisticated hardware around. And how long did they last? Six hours in the combat conditions. I mean that is a military example. I think a corporation is the same- its strength is in its people. I don't think you can quantify many of these things. I mean you do a number of activities some in response to staff requests, some at the suggestion of staff, some driven by management, some driven by the Board, and I think the strength of the corporation is a compilation of all of these little things. They go to make up a place where people say they are happy to work, and the turnover in fact is very, very low. And we I think have gone a long way to accomplishing that. I can't put my finger on any one of those, that are the main...that are the red button or the green button. They are all...in combination I think they all contribute to that "mystique" that this is a good place to work.

F-6****

Tim wanted to add that he thought we were in a very

interesting and dynamic time.

> You know I think from what I see in health care, it seems to move in starts and fits. It jerks ahead and then moves in a stable mode, and then it jerks again and goes off in another direction. I think we are in the middle of one of these jerks, and I'm not to sure which direction it is going to go. ...There are two big issues coming up. The system is virtually running out of money. That is a major problem. ...I think the system is living way beyond its means. You look at the deficits. We are spending more money that we can afford to. There is going to have to be a correction in that. I'm no economist, but I am watching it with great interest. ...There are going to be some very hard decisions. All the terms are out there now; rationing, the whole subject of ethics. It is going to affect all disciplines. What should be insured, what should not be insured? These issues have to be hammered out. We can no longer afford the luxury of what we have been running.

Interview G: Jamie Irving

G-1****

Jamie stated that turnover was not measured amongst the general duty Registered Nurse staff at his hospital.

> ...it's not a huge problem for us. We have our own nursing school so we do receive our grads from the nursing school and a lot of them have spent their whole careers here. And other ones who don't have positions, and if they are young and unmarried, will venture forth to other provinces in Canada and the United States. At times they do come back to us.

I asked him what his perception of low turnover was based on.

> Well it's just based on that there has been no real complaints from the (Department of Nursing) but we do have comparable staff according to the money which we receive from the Ministry of Health, that we do keep our staff up to that quota. And we have not had any real problem during that time.

I asked Jamie under what circumstances the organization would start measuring turnover. He replied:

> If it became a real problem that the nursing units didn't have enough staff, and we had the money in the budget, then it would become a real concern to myself and the nursing person. And then we would certainly look at how many we had lost and then try to find out the reasons.

When I asked Jamie what percentage of turnover amongst nurses would he deem unacceptable and/or dysfunctional for the organization he guessed 10 to 15%. When I asked Jamie what steps he would take if the organization did decide to measure turnover he stated:

> Well it would probably be very basic. You would count how many nurses you'ld have lost over the last one, two, three,...maybe going back as far as five years.

When I asked who would collect this data he replied that the Human Resources Department presently do terminal interviews for employees that leave the organization and they itemize the reasons people were leaving. The records were maintained through the Nursing Department but were going to be transferred to the Human Resources department in the near future.

G-2****

Jamie felt that nursing turnover was disruptive for patient care services because continuity is gone, and also it was costly for the organization to orient a new nurse. When asked why nurses leave their jobs he replied:

> They leave because of marriage and their husband or future husband wants to re-locate. They leave because of curiosity, different challenges in different places. And they leave because of discontent. ...Discontent with the system. And that can be an individual hospital or the health care system in the province.

I asked Jamie what management could do to affect turnover

he stated that they could keep as good a relationship in the hospital and possible.

> And you can do that by listening to their complaints and the person in Nursing does that- has meetings with them. I meet with what we call the employee liaison, which has nursing on it, and that meets every four months. ...I know in the nursing group they are more expressive there. ...And we are looking now at the nursing tasks, to see if we can make some changes to take away the things that aren't nursing.

Jamie stated that the reason they were doing these things was as a result of the strike. He added:

> But you can do things to stop nurses from leaving nursing. That's by listening to their concerns and their beefs and by, now as I said, the majority of hospitals are working on the tasks, changing the tasks.

Jamie felt that the primary responsibility for retaining Registered Nurses lay with the Department of Nursing.

G-3****

When I asked Jamie what qualities or strategies the hospital had for keeping nurses working there he answered:

> Well I would say that it is the fellowship that the nurses enjoy among themselves. ...And they do get listened to. ...We hear their concerns. Do something if we can. And then if you live in this district, we are close to people who live in this area.

G-4****

When I asked Jamie if the organization was becoming decentralized he required a definition of the term. He then replied:

> The structure hasn't changed since I've been here. There is no anticipation that it will change in the future months. The nurse at the units once in a while we hear that they like to have more authority, but the head nurses are unionized and do listen to the staff. And there are good Directors of Nursing here. I think they

> are good. Maybe the staff don't, but I do. And it's hard to allow everyone to operate the ship. We do hear them when they are griping and we do try to change things, but it is very difficult to allow everyone to run the unit. And I would vouch that the head nurses do hear what is being said and do make changes appropriately.

When I expressed my opinion to Jamie that hospitals say they are becoming decentralized but their organizational charts remain the same he commented:

> ...Hospitals have operated that way successfully for years. But certainly the strike made people sit up and listen more.

We talked about primary nursing in the hospital. It appeared the hospital was using a modified version of primary nursing, however Jamie stated:

> ...now we are looking at using aides and people to make the patient's beds, and assisting with washing and getting up to the bathroom and things like that. I really think that nurses are getting themselves away from primary nursing as I see it, and are becoming more involved in the technical aspects of medicine.

When I asked Jamie what he thought the nurses wanted to do, he replied:

> That is what I'm trying to figure out too. You can't pay nurses to sit at the desk and watch others work. We have just basically got started at looking at what we can do. This is what nurses don't realize. If you bring in a robot then you don't need as many people to do what the robot is doing.

Clinical ladders were not being utilized in the hospital and joint collaborative practice (as Jamie seemed to understand it) was being utilized on an informal basis.

G-5****

Jamie's hospital had twelve of the nineteen retention strategies. He felt that for the most part, the strategies were effective for keeping nurses within the organization. At the end of the interview he phoned down to the Human Resources Department to inquire about turnover rates among nurses and discovered that the 1990 statistics for the hospital revealed a 17% turnover rate for R.N.'s, R.P.N.'s and L.P.N.'s and about 14% for R.N.'s alone.

Interview H: Andrew Laschuck

H-1****

Andrew stated his organization was not measuring turnover.

> ...Now there may be some rough calculations kept by the various departments, but overall I think it would be very hard for us to come up with a number to say what our turnover is. ...It is not being captured right now in any meaningful way.

Andrew's perception of turnover was that it was not that extremely high. He quickly noted that was his perception and he was unsure how valid his perception was and if it differed significantly from other institutions. His perception was based on his feelings, his involvement with senior management in nursing, and his conversations with the general duty nursing staff.

When I asked Andrew what circumstances would have to exist before the organization considered measuring nursing

turnover he replied:

> Well I think it should be measured now. It is a goal of (individual in senior management) to measure turnover. She has a very strong human resource background and understands the need to do that. Secondly in terms of functioning as an organization, we are a people business. I think people know until you have somebody responsible for running the department and making sure that proper Human Resource type of activities are conducted, then, until you have that type of person, it becomes very difficult to support HR activities. Part of the problem is that it is not seen as a priority. Labour relations is seen as a priority, and negotiations with unions, dealing with grievances, dealing with the normal day to day problems you may have, are seen as a priority. The other things are sort of put on the sidelines and really, nothing is done with them.

Andrew and I spoke at length about unacceptable turnover rates for hospitals and he was very reluctant to give a specific number. He thought it would be important to gather some historical data and have comparative data with other facilities in similar areas in order to calculate what would be acceptable and what would be unacceptable. He felt that the statistics and numbers that an organization collected were not as important as the meaningful description of all the gathered information and what it meant for the organization.

H-2****

Andrew felt that nursing turnover had an impact on the care that was delivered in a hospital. He also stated it was expensive to keep hiring new people and affected the smooth functioning of an organization. Andrew thought that nurses left their jobs for the same reasons that a lot of people in institutional care leave.

...they feel they are really a part of a very large

> bureaucracy and they don't feel they have any control over things. ...they don't feel the organization is meeting their needs for whatever reason. Nurses would feel that way I suspect, number one because the organization isn't putting enough emphasis on a particular area of patient care. They may feel that way because the relationship with the medical staff are not good. And that happens. I think those days are going out the door in a sense because nurses don't put up with that bullshit anymore.

Andrew felt that management could affect turnover. He stated at one point that the new generation of people coming in to hospital administrator positions have a much different perspective of how to work with people. He was of the opinion that they are much more consultative in their dealings with problems.

> ...the whole idea is to talk to the people who are providing patient care because they are your front line people.

He also felt that hospitals should have good statistical information on their nursing population so they could respond to the demographics of the group as a whole.

When asked who was primarily responsible for retaining Registered Nurses in the facility he stated: "From a practical point of view, in our organization it is the nursing director."

H-3****

When I spoke with Andrew on the phone before our interview he stated that there were no specific retention strategies designed to keep nurses working within the hospital. He echoed this statement when I asked the same question during the interview. He did consider that the work

environment was a good one, and that quality may help to retain nurses within the facility. He also felt that decision making was taking on a more informal, versus formal process. Andrew stated that many changes had to be made to the organizational structure to empower employees. He felt that a major difficulty with the organization was the mechanics of communication (a very critical component of any organization in his view) and this was hindered in large part by the size of the facility.

Andrew did not feel the organization was decentralized but thought they were moving towards it.

> ...and I think the last thing you want to do in an organization like this is add levels, because all that does is frustrate people. And I think the one thing you are going to hear over the next decade in this institution is that we are going to talk a lot about issues of empowerment, about decision making and so on, and I think you are going to see a flatter organization, you are going to see less management in a sense, and a lot more front line decision making by people who are providing patient care.

Andrew was unsure of the exact areas that were utilizing primary nursing as a mode of patient care, however he knew that some areas were using it and that it was thought to be a better way to provide nursing care because it addressed the continuity of care issues more comprehensively.

Andrew did not know what clinical ladders were and required a definition of the term. The organization was not utilizing them however he felt the concept needed to be addressed so that the expert bedside nurse could be given recognition and pay.

As far as Andrew knew, the "traditional" form of caring for patients was taking place, whereby the doctors wrote out the "orders" on the chart and the nurses were responsible for executing them (the orders, not the doctors).

H-5****

Andrew's facility had eight of the fourteen minor retention strategies. He felt that some of them were effective and that some of them were not effective for keeping staff. In combination however, he felt that the above strategies helped retain staff to a certain degree.

Interview I: Brock Worthington

I-1****

Brock's organization was measuring turnover and he pulled out statistics when I asked the question. When I asked Brock why the organization had decided to measure turnover, he replied that management wanted to be able to look at staffing trends and discover why people were leaving the facility. The organization also started to measure turnover because of a decreased supply of nurses in certain areas.

> When there is a big supply you don't worry about that. You don't worry about those issues. But when there isn't a big supply....and probably like a lot of other places, we don't seem to have a problem finding people to do general duty med/surg, even OB, stuff like that.

The data that was collected was done by a Human Resources department and the measurements were taken annually. Exit interviews were conducted on all employees who left, however

the compliance rate was not 100%. Brock stated they got a "pretty good response" when doing exit interviews however. The reason they employed exit interviews was;

> To make sure that people weren't leaving for reasons we could control. And if it was a matter of working conditions, or that kind of thing, we want to be a good employer, we want to be pro-active in these areas, and it is important that you do that. If you work for us and you stay with us for six months, and then you leave and are on the cocktail circuit and somebody asks you if you work at the (X) hospital, and they say "No! I left there and it's really a crappy place to work." We don't want that our there. If there are things we can do to improve things,...

Although he did not give an explanation of turnover and how it was calculated in his organization, it was clear from our conversation that casual nurses who became part-time nurses or moved into full time positions within the organization were still considered "turnover".

There were no pre-established criteria for acceptable or unacceptable turnover rates however the organization always compared themselves with other similar organizations and rated themselves accordingly.

> ...But if you're 3% and everybody else is 2.8 or 3.2, and there is the odd one is at 2 and the odd one at 6, you would take a look at that and say, we're okay! It's all relative isn't it? That's basically what we do.

Brock did not exactly answer the question when I asked him if turnover was linked to performance in his organization, however he did state that people usually left the organization for the right reasons, like promotions in larger institutions.

> People have ambition. I think that is great. But no, we don't have good people leaving, just to leave.

In terms of what Brock had learned from the data, he listed several findings. The majority of terminations were due to pregnancy. Those nurses stayed home to raise their children and did not come back. Another large portion of turnover was due to re-location out of province because of their spouse being transferred. Other terminations were a result of nurses wanting more specialized nursing, and a small group left to further their education in nursing.

In a few instances, after reviewing data that had accumulated over the years, Brock recognized that good employees were leaving as a result of poor leadership on the part of their supervisors. In these cases, Brock had to terminate some long term people in leadership roles who weren't fulfilling their job description.

The results for the rates of turnover in Brock's organization were as follows; for the year of 1989, there was a turnover rate of 13.2 percent for full-time R.N.'s, 15.3% for part-time R.N.'s and 40.9% for casual R.N.'s. For the year 1990 the turnover rates were 13.9% for full-time R.N.'s, 19.2% for part-time R.N.'s, and 24.5% for casual R.N.'s.

I-2****

Brock thought that in some ways nursing turnover had a positive impact. He felt that new people brought new ideas and vitality to an organization.

Brock thought that management could do a lot of things to affect turnover. Generally he felt it was important to

"...keep your people happy,..."

> The very best thing you better have is a really good program when they come in at orientation so that they understand a lot of things about the organization, what it's mission is, it's philosophy, aims, objectives, the kind of hospital it is, how they operate, what procedures you use, from the very simple like what kind of IV's are you using, and some training in that regard. What you have to know in the event of a fire, a disaster, and those things, in addition to all the specialty orientation of what happens in a nursing area. I think that is really key. That is really important.
>
> I think you have to recognize people for the job they do and have some method of recognition for them. I don't mean a diploma or...quite often, in fact in our employee satisfaction survey, we ask "What's important to you?", and what's important is that people are told they did a good job and that they are thanked for it. Just a thank you. It has to come from more that the patient, it has to come from the people they work with. People have to feel that they are a part of the institution, that there is good communication, that they feel they are getting the information they need, and that they are getting some input as well. Good communication and input, you know participative management is really important.
>
> ...we make darn sure we have user groups in each area. And the user-groups are not department heads, they are staff nurses. If you are designing a laboratory you don't have the chief pathologist and the head supervisor, you have them of course, but then you have the people who work in the various areas who are at the bench who are on the equipment.

The reasons Brock had everyone's input for decision making was because he felt that the work gets done quicker and better. He worked for a dictator in the past and found the experience distasteful and dysfunctional for the entire organization.

Brock felt that the primary responsibility for retaining Registered Nurses in the hospital lay with the nursing administration department.

I-3****

When I asked Brock what qualities or strategies were in place to keep nurses working within the facility he stated that he had mentioned many of them earlier in the interview. Brock indicated that if patients wrote letters with compliments to specific nurses, the nurses were given the letters to read by their immediate supervisors. Brock also felt that accessible parking helped retain nurses, and thought the hospital was seen as a fair employer. Brock felt the size of the hospital was just right- big enough to offer a variety of programs for staff, yet small enough that people could become familiar with one another. Besides the orientation for new employees, Brock felt that the teaching and in-service programs offered to staff as well as the hospital TV network were important for retaining staff. Providing employment opportunities for staff and allowing for flexibility in schedules and job sharing so staff could attend courses, were other strategies mentioned. The organization also ran Employee Satisfaction Surveys and published a newsletter once a month to enhance communications in the organization. He felt it was very important to recognize staff as well.

> And that is important to us. We deliberately do a couple of events a year just to recognize the staff. We do a lot of little things but the major things are the recognition night. That's a dinner/evening out and the hospital, we pay for it (it's a (X) type of owned hospital),we don't use the government's money. And the other thing we do at Christmas time is we have for everybody on staff- a luncheon. Which is really like a Christmas dinner. And we do it noon and evening. We try and catch all the staff. It's a full Christmas dinner

> with all the trimmings.....So there is that kind of recognition. We try to work on that and that's important. We found out through the survey that it's darn important.

When I asked Brock why these strategies were implemented he replied:

> It's part of quality assurance isn't it? You are always trying to find out outcomes. Like how did that patient do? And the big deal is outcomes. Well, how are our staff doing? How are they, what are the things they value about the place that make them want to work here, that recommend their friends come or don't come to work here, that kind of thing.

He also answered this when I asked him about the rationale for some previous strategies:

> Because our philosophy is that our people are part of the reasons why we do what we do reasonably well. It's not the scanner, it's not the lab equipment, it's the people. It's not the bricks and mortar, if the people aren't doing it... ...They are your most important resource. You can have the greatest whiz-bangs up in the lab or in I.C.U. or anywhere else, but if people don't apply themselves and have a commitment to the place, then we are just another hospital.

I-4****

When I asked Brock if the organization was decentralized he replied:

> It varies from division to division and it is not done to the degree that I would be satisfied. ...We are not decentralized to the point that I would like to see us decentralized. We are to a degree. But not...I'm not satisfied.

Brock was unsure what Primary Nursing was and required an explanation of it. He stated the facility was using that mode of nursing. When I asked why he stated:

> Not being a nurse, quite frankly when we....we go through accreditation process with the Canadian Council of Health Facilities Accreditation, the nurse surveyor said we seem

> to be doing it in some areas and not others, and it appears to be the way to go and we should look harder at that and they essentially bought into it...so yeah we are.

When I asked Brock if he felt Primary Nursing helped to keep nurses working within the facility he stated that from the feedback he received, that in fact it did.

Brock wanted an explanation of clinical ladders for nurses. He stated they were not utilized in the facility and felt that the salary scales that are structured by the union should be reviewed.

Brock said that joint-collaborative practice was utilized in Intensive Care.

> But the general wards, the nature of the majority of physicians, still the majority, although it's shrinking. They want the nurse to come behind with the Kardex and write things down. It's really bizarre. The younger guys and gals are much more open to that kind of thing. Where they actually say "What happened today?" What do you think we ought to do about this?" You know what I mean? There's still a lot of that.

I-5****

Brock's organization had 11 of the thirteen minor retention strategies from the checklist. He felt most of them were effective for retaining nurses.

I-6****

Brock also added that he was slightly uneasy about the transition phase of Baccalaureate nursing education for the future.

> ...I don't know. I'm just a little bit queasy about all of that. More the interim period than the outcome. I think the outcome will be pretty good. Because I think the baccalaureate...the diploma people are fine, but I

think the baccalaureate people are...become...I don't know how to say it...better employees, better nurses. You know, after...there is that early period where perhaps because of, diploma people are more familiar with the practice of nursing. There's a difference though, after six months or so, there is no comparison, by and large. ...

V) RESULTS

The findings of the study will be presented in the order of the four major research questions. A summary will be provided after each section to identify and focus on the key points.

The first section will profile the perception hospital administrators had with regard to turnover among general duty Registered Nurses in hospitals.

The second section has been divided into two parts and describes: a) how nursing turnover was measured in each hospital and; b) what strategies had been designed to prevent turnover and\or retain nurses in the facilities.

The third section outlines why the strategies had been implemented in the various facilities.

The final section portrays how effective hospital administrators believed those strategies were for retaining general duty Registered Nurses.

Hospital Administrators' Perspective Of Nursing Turnover

All nine of the participants claimed that turnover among the general duty Registered Nurses was not a problem in the hospitals they managed, however when I specifically asked the respondents if their organizations were measuring turnover among their general duty Registered Nurses, four of them said "yes", four of them said "no", and one of them said the equivalent of "sort of".

Three of the participants shared their facilities' recent turnover statistics with me. One of the participants knew the organization was measuring turnover but did not have time to collect the data for me. Another participant stated her organization was "keeping track" of turnover but she did not know what the level was. The other four participants stated their facilities were not measuring turnover and that they did not know what the rates were for the general duty Registered Nurses in their organizations.

Five participants were asked what level of nursing turnover would be considered unacceptable for their organizations. All of them felt the question was a difficult one and were reluctant to answer it, but their responses ranged from 5-17%.

When asked what kind of impact they thought nursing turnover had, seven of the nine respondents stated they felt nursing turnover had an effect on the continuity of patient care services, and five of the nine believed it was costly. The cost was stated as either a financial strain to the organization related to orientation costs, or as a cost in terms of reduced productivity of employees within the facility. Four of the respondents stated outright, that in their opinion nursing turnover had a negative impact on the quality of care provided to patients.

All nine of the participants (including the ones that were not measuring turnover) felt they knew the causes of

nursing turnover within their organizations. Eight of the nine participants stated the most frequent reason for nursing turnover was family related: six respondents claimed spouse-job-relocation was a major factor, and; three respondents believed pregnancy was another major factor for turnover in their facilities. Six of the nine subjects were of the opinion that one of the other reasons nurses quit their jobs was generally because they were dissatisfied with their work. This was expressed in comments describing; high stress, poor pay, erratic schedules, low recognition, little respect, abuse by patients, physicians and management, not being asked for input during decision making and not being utilized properly. Finally, five of the nine respondents felt that another major reason nurses left their jobs was to develop their careers by obtaining more education or specializing in a particular area of nursing.

When asked what ward they thought would have the highest nursing turnover, five of the respondents were of the opinion that it would be the Long Term Care wards, and four of them thought it would be the Critical Care areas.

The answers for the question that asked what ward they thought would have the lowest amount of turnover were assorted, but the two areas identified most were Surgery and Maternity.

The qualities that were thought to be attractive or unattractive for nurses considering work in their particular

organizations were so diverse that all of the answers could not be categorized. However, with the exception of two respondents, all of the Executive Directors stated that a quality their organization had in terms of attracting nurses to work in their facilities, was their excellent reputations and/or the quality of care they delivered.

Six of the nine managers felt they could affect turnover a great deal. Indeed, three of the respondents said management could increase or decrease nursing turnover. Only one participant was of the opinion that in some cases management could do a lot, and in other cases management could do very little with respect to affecting nursing turnover.

The most important tool all the managers identified in terms of affecting the rate of nurse turnover within the organization was "good communication". Their many comments expressed that good communication was a matter of:

...showing concern
...listening to their complaints and concerns
...you have to let them know in the best way you can that they are appreciated
...give them a sense that they matter to the organization
...show respect
...provide them with information
...empower them
...value their input
...we have tried to open up the communication links both formally and informally
...get them involved in decision making
...recognize them for the work they do
...show sensitivity and show you care and that you are flexible and prepared to make changes.

Some specific strategies were offered to "communicate" with the nursing staff. One participant felt that an **excellent**

orientation was a critical element of communication with new employees. As well, **employee satisfaction surveys** that asked what was important to them, and **participative management** that allowed employees to have input when decisions were being made, were thought to be vital communication strategies. Two other participants echoed the participative management strategy and one of these organizations utilized an **employee-liaison committee** while the other facility was looking at having general **forums** to involve nurses in the decision making process. Another Executive Director thought that monthly **newsletters** that were distributed throughout the facility displayed recognition and appreciation to nursing employees thereby displaying respect and providing information to them. Another important communication strategy identified by yet another participant was that **management should be extremely visible, available and approachable.** Finally, although it was not explicitly stated in response to this particular question, another communication strategy that was identified throughout many of the interviews was the **social functions** that invited hospital employees to attend, as an extension of gratitude by the facility for the work that was done. These included things like barbecues, Christmas parties, and the distribution of pins, and stickers to the employees. Other than three individuals mentioning "participative management" as a communication strategy, at no other time did any of the respondents mention strategies such as decentralization,

primary nursing, joint-collaborative practice or clinical ladders.

Six of the nine respondents were of the opinion that the primary responsibility for nursing retention lay with the Department of Nursing.

The only concern many of the administrators expressed with regard to nursing "numbers", was in the critical care areas. They referred to a shortage of nurses in those areas, and spoke to the difficulty in recruiting nurses into the critical care specialties.

SUMMARY OF HOSPITAL ADMINISTRATORS' PERSPECTIVE OF NURSING TURNOVER

* *Two thirds of hospital administrators did not know the level of nursing turnover in their organizations.*

* *Nursing turnover was not viewed as a problem by any of the hospital administrators. Although they all cited the negative impact nursing turnover had on hospitals, they all believed that nursing turnover in their facilities was "low" and within acceptable limits.*

* *Hospital administrators felt the major reasons nurses quit their jobs were because of spouse job re-location, pregnancy, job dissatisfaction and career development.*

* *Hospital administrators only concern with staff R.N.'s was with filling vacant staff positions.*

* *The majority of hospital administrators felt they could affect nursing turnover a great deal.*

* *Two thirds of hospital administrators were of the opinion that the primary responsibility*

of nurse retention lay with the Department of Nursing.

How Turnover Was Measured

When I asked the participants how turnover was measured in their facility, none of them provided me with a definition of the term and none of them specified the calculations they used to actually measure it. One Executive Director gave me a calculation for a vacancy rate versus a turnover rate, and she also viewed maternity leave as turnover. Another respondents' organization had a high casual nurse turnover rate, and he felt that this was because these nurses assumed part-time positions within the facility. Thus one organization saw temporary leave as a form of turnover and another organization seemed to define turnover as people simply quitting their position, versus people quitting their job and leaving the organization.

Three organizations were measuring turnover among the full-time, part-time, and casual staff, and were sorting the turnover as voluntary or involuntary, by stating if the quit was due to retirement, death, resignation, dismissal, disability or lay-off. Two facilities were measuring turnover among all personnel in the facility (nursing, dietary, housekeeping, pharmacy, etc.) however they were not dividing the turnover rates into the separate wards of the nursing department.

Exit interviews were employed by all of the organizations

that were measuring turnover however the compliance rates for the interviews varied. All participants unanimously stated the rationale for doing the exit interviews was to identify the reason an employee had for leaving. Two of the respondents stated the interviews were also done to try and improve the general work environment and to ensure that people were not leaving for reasons the organization could control.

One hospital linked employee performance with turnover, and it was the employee's immediate supervisor who conducted this final rating.

None of the facilities had pre-established criteria for acceptable or unacceptable turnover rates.

The organizations that were measuring turnover were taking the measurements annually or quarterly. Most of the respondents stated the Personnel, Human Resources, or Nursing Department collected and synthesized the turnover data. These data were then circulated to the senior management levels for review. However because none of the hospitals viewed nursing turnover as a problem, very little time was spent discussing it at any of the managerial or board meetings.

The turnover rates of nurses for the three facilities that were measuring it, ranged from 6-15% for full time staff, 12-20% for part time staff, and 14-40% for casual staff for the year of 1990.

SUMMARY OF HOW NURSING TURNOVER IS MEASURED IN HOSPITALS

** Fewer than half of the hospital administrators stated their organizations were measuring nursing turnover.*

** Definitions of "turnover" were not provided by any of the participants.*

** Perceptions of the term "turnover" were different between organizations.*

** Calculations for measuring turnover were not provided by any of the participants.*

** Eight of the nine organizations did not link employee performance with turnover.*

** None of the organizations had pre-established criteria for acceptable or unacceptable turnover rates.*

The Retention Strategies

Most respondents gave very brief answers to the critical question of what qualities or strategies were in place in their facilities to retain the nursing staff. All of the administrators gave much more lengthy and detailed answers to the question in the preceding section which inquired as to what management could do to affect turnover.

When I asked the respondents what qualities or strategies were in place to retain the general duty nursing staff who were already working in the hospital, two of the subjects initially stated there were no specific retention strategies in place in their facilities.

Brock was the only participant who appeared to have a prepared statement for this question. He spoke at length

about a **good orientation program** right at the beginning of the employee-organizational introduction, good **in-service programs** for the staff, **flexibility in scheduling and job sharing,** distribution of **employee satisfaction surveys, providing feedback to outstanding staff, recognizing the work of employees via social functions put on by the hospital, providing information to staff via newsletters and a T.V. network in the hospital,** and allowing for the staff's input in the form of **participative management.**

Carl thought the most important way management could decrease nursing turnover was to support a **multi-disciplinary environment versus the traditional medical model environment.**

Carl and Brian felt the retention strategy they had in their facilities was **ensuring the Assistant Executive Director of Nursing was part of the management team** so that nursing was involved in most departmental decision making and at senior management levels.

Danielle thought that the **fair remuneration package** was a strategy her organization had that helped retain nurses.

Bruce suggested that the **good working environment** and the **acknowledgement of long term service** were retention strategies in his facility.

Jamie thought the **fellowship** that the nurses enjoyed among themselves was a retaining quality his organization had.

Tim, Brian and Bruce thought that the **good communication** within their facilities was something that kept nurses working

within their organizations.

In response to nurses expressing their dissatisfaction with their roles in the hospitals during the strike, Jamie, Danielle and Brian stated that their facilities were looking at changing the tasks of nurses so as to identify what responsibilities were under the domain of nursing, thereby **defining non-nursing functions**. In so doing, these managers were looking at ways to re-arrange the staff mix as a potential strategy to increase morale and retain staff. On this same topic, Kelly and Brian thought **matching nursing skills with programs**, such as placing all the panelled patients on one ward with staff who wanted to work with that kind of patient, was a good strategy to retain nurses.

Andrew thought that having a **Human Resources Department** in place to collect and synthesize turnover data, thereby allowing the organization to respond to the demographics and information obtained in the employee profiles and exit-interviews, should be in place in every hospital.

Many of the participants in the study suggested at some time during the interview that good communication (in the form of listening to and providing information for employees) and participative management (allowing nurses to have some decision making powers) were important strategies their organizations had, or were striving towards.

Section Four of the Interview Schedule used general questions to test, probe and discover if the organizations

utilized some of the major and most significant retention strategies delineated in the literature review. None of the Executive Directors offered decentralization, primary nursing, joint-collaborative practice or clinical ladders as a retention strategies utilized in their facility.

When the participants were asked if their organizations were decentralized or moving towards decentralization, six of the participants answered their organizations were.

Six of the participants were unsure of what Primary Nursing was and requested an explanation. After I defined the term, three of the subjects were reluctant to answer because they had no idea of the type of nursing that was being utilized in their facility. Eventually five of the nine participants declared they were using primary nursing in their facility.

All of the respondents required an explanation of the term clinical ladder. None of the organizations had them. Five of the participants stated that presently, the long term general duty nurse is not given the recognition, reward or remuneration she deserved.

When the respondents were asked if their organizations used joint-collaborative practice between nurses and doctors, many of them required an explanation of the term. Six of the managers stated the practice took place in some form within their facility, most notably in the critical care areas. Carl and Tim explained that joint-collaborative practice was the

philosophy of their organizations, in that their hospitals were "team oriented" and multi-disciplinary in nature, versus "physician driven" with respect to patient care.

SUMMARY OF THE RETENTION STRATEGIES IDENTIFIED BY HOSPITAL ADMINISTRATORS

** Two of the nine participants initially stated there were no specific strategies in place to retain nurses.*

** Three of the nine participants felt the low turnover rates may be a result of the recession and the depressed economy.*

** None of the participants listed primary nursing, decentralization, joint-collaborative practice or clinical ladders as strategies to reduce or alleviate nursing turnover.*

** The strategies that were offered by hospital administrators to retain nurses included:*

- a multi-disciplinary environment versus the traditional medical model environment.

- ensuring the Assistant Executive Director of Nursing was part of the management team.

- defining non-nursing functions for the future.

- matching nursing skills with programs.

- participative management.

- fair remuneration packages.

- flexibility in scheduling and job sharing.

- good communication (newsletters, hospital T.V. network program, social functions).

- a good orientation program.

- good in-service programs.

- *employee satisfaction surveys.*
- *feedback to outstanding staff.*
- *acknowledgement of long term service.*

Rationale For The Strategies

Five of the participants were asked why their organizations were measuring nursing turnover. Generally speaking, they all believed it was a good management tool because it indicated many dynamics within the facility. They also felt it was capable of identifying problems in the organization either within a particular area, or with the management presiding in the area.

For the most part, the respondents' answers to the question: "What qualities or strategies are in place in this organization to retain nurses?", did not allow the researcher to ask them why they were implemented (see Bruce and Jamie for example). However the questions in Section Four of the Interview Schedule provided the most specific answers in terms of providing rationale for retention strategies, and those comments will be presented first.

Six of the participants were asked why their organizations were decentralized or were moving towards it. Three of them thought that their nurses were valuable employees and should be recognized and given decision making powers. One respondent stated that the literature he read gave him reason to believe that a decentralized structure was

the most efficient way to run a hospital. One respondent was of the opinion that decentralization made for a more productive workforce. Another respondent's personal and professional experience led him to believe that decentralized organizations were more efficient and effective. Finally, one Executive Director felt that decentralization empowered employees which in turn enhanced morale and lowered absenteeism translating into better patient care being provided.

When I asked five of the participants why their hospitals utilized primary nursing, two participants responses did not answer the question. Two other respondents stated their nursing department made the decision and that primary nursing appeared to be the way to go in terms of providing quality patient care. One participant stated it was used in his facility because it was the best way to provide nursing care and addressed the continuity of care issue most comprehensively.

When I asked two participants why their organizations utilized joint-collaborative practice, one stated his Director of Nursing was primarily responsible for that decision and the other simply stated that the idea made the most sense and since its inception had never been challenged.

As was stated earlier, many of the answers to the question of retention strategies did not allow me to ask why they were implemented. However several times throughout the

interview, I asked the participants why they were doing things the way they were. Their answers were diverse, but after analyzing all the comments I feel I have been able to arrange their statements into five major categories. The five major reasons that were provided for implementing the various retention strategies were: to empower employees and improve their productivity; to improve organizational efficiency and effectiveness; to deliver quality patient care services; because of influence from leaders within the nursing departments of their organizations; and, because of the nurses' strike of 1991.

SUMMARY OF RATIONALE FOR IMPLEMENTING RETENTION STRATEGIES

** the reasons the participants provided as rationale for implementing retention strategies were:*

- *to empower employees and improve their productivity;*
- *to improve organizational efficiency and effectiveness;*
- *to deliver quality patient care services;*
- *because of influence from nursing leaders within the departments of their organizations.*
- *because of the nurses' strike of 1991.*

Effectiveness Of The Strategies

The question of the effectiveness of the strategies that were implemented was not an easy question to ask because of

the answers given to the previous two questions. However I did ask this question several times at specific moments throughout most of the interviews. After reviewing the transcripts I realize that at some points I asked the question "How effective do you think that strategy is?", when I really meant, and should have asked, "How effective do you think that strategy is for retaining nurses within the facility?". In spite of this I believe the answers I obtained, collectively, expose a portion of the whole picture I am trying to present.

Regrettably, in hindsight, I did not ask any of the participants if they thought that decentralizing their facilities was an effective way to retain nurses.

I asked two participants if they felt that primary nursing helped to keep nurses working in their facility and they both replied in the affirmative.

I asked one participant if joint collaborative practice was an effective way to retain nurses and he stated in his opinion it was.

Two Executive Directors thought that their strategies were effective for retaining their nurses because of the low turnover rate in their facilities. Two other Executive Directors thought that some of the strategies were effective for retaining nurses and that some of them were not. Three other Executive Directors thought that in isolation, no single strategy was effective for retaining nurses, but that combined, the strategies were effective for retaining nursing

staff. Finally, one Executive Director was the only participant who felt that measuring the effectiveness of retention strategies was a very difficult thing to do.

SUMMARY OF THE EFFECTIVENESS OF RETENTION STRATEGIES

* *One third of the participants believed that no single strategy was enough to prevent nursing turnover but that combined, the strategies in place were effective for retaining nurses in hospitals.*

VI) DISCUSSION

The purpose of the study was:

(1) To investigate what strategies were in place in hospitals to retain nurses;

(2) To investigate why the retention strategies had been implemented;

(3) To investigate how effective the retention strategies were;

(4) To obtain the hospital administrators' perspective on the phenomenon of turnover amongst general duty Registered Nurses.

The discussion that follows will revolve around the major findings for each of these questions. The order of the questions has been changed and the chapter has been divided into five sections to deal with the four questions.

The first question that asked what strategies had been implemented to retain nurses in hospitals will be divided into two parts. The first section of this chapter discusses how nursing turnover was measured in the various hospitals. The second section discusses what retention strategies were in place to keep nurses working in the organization.

The third section will discuss why the retention strategies were implemented.

The fourth section will discuss how effective the participants felt the retention strategies were.

Finally, the last section will discuss the hospital

administrators' perspective on the phenomenon of nursing turnover.

How Turnover Was Measured

It was noted in the literature review that the first steps towards reducing nursing turnover in hospitals was to measure it (Duxbury & Armstrong, 1982; Ezrati, 1984; Hoffman, 1981). Generally speaking, the hospitals that participated in the study were doing a poor job of measuring nursing turnover.

Fewer than half of the hospital administrators in the study said their organizations were measuring nursing turnover. Definitions of "turnover" and calculations for measuring turnover were not provided by any of the participants, and it became evident during the study that the organizations were not defining nursing turnover in the same way.

These findings prohibit the researcher from comparing turnover rates between each organization, because evidently they define, calculate and measure it differently. How can a 13% turnover rate in one facility be compared with a 5% turnover rate in another facility if the facilities aren't defining or measuring turnover in the same way? Obviously, different measurements result in different outcomes, and it would be incorrect and misleading for this study to compare their data.

The Executive Directors did not provide any type of

turnover calculation for the researcher. Calculations such as average length of service, accession rates, stability rates, instability rates, survival rates or wastage rates were not offered (Price, 1977). It would appear that the most prevalent calculation that was used by all facilities was the separation rate: the number of members who left during the period, divided by the average number of members during the period. As useful as this measurement is, it provides only a glimpse of what the entire turnover picture is (Duxbury & Armstrong, 1982).

What are the average length of service years of the nurses in the hospital? What are the stability and survival rates of the various wards? These are the numbers that might indicate the organization is a good employer and has loyal and tenured employees. What might it say about the quality of care being delivered? Do patients want to be admitted to a hospital that has nurses with 16 months of service or sixteen years of service? Is the care that is provided better on a ward that has a stability rate of ninety five percent or forty one percent? These are tough questions, and it is time hospital administrators began asking them. "Quality Care" seems to be the buzz word of the day, but I have yet to see hospitals tackle the relationship between the quality of patient care and the experience, stability and tenure of nurses working within the organization.

Three of the hospitals studied were attempting

aggressively to measure nursing turnover. The major flaw I discovered with their measurements however, was that none of the facilities could identify the locations of the nursing turnover. For example, one Executive Director was convinced that the highest rate of turnover in his facility occurred in the Intensive Care Unit, however, he was not able to verify that statement with all the turnover statistics that had been gathered from his facility. Thus nursing turnover rates were tallied for the organizations but the managers were unable to decipher where the most (or the least) amount of turnover was occurring. Determining the rates of turnover is an important measurement, however neglecting to determine the location of turnover overlooks critical information that would allow a clearer understanding of the phenomena and the implementation of the most effective management strategies to deal with it.

Exit interviews were employed by all of the organizations that were measuring turnover but only one of the hospitals was linking employee performance with turnover. If exit interviews do not include a performance evaluation of the employee, hospitals are unable to determine if their turnover is functional or dysfunctional (Sullivan & Decker, 1988). Replacing an exiting R.N. with another R.N. intimates that staff nurses are expendable, and gives little consideration to the abilities or liabilities of the leaver or the newcomer. If hospitals do not evaluate the performance of leavers they can not accurately assess the total impact (either beneficial

or detrimental) the exit has on the care that is delivered in the organization. By simply maintaining full staff quotas and replacing R.N.s with R.N.s, hospitals would have us believe that all is well with patient care delivery.

Despite this, all of the Executive Directors felt their institutions delivered excellent patient care. A few of the respondents even told me that the strength of a hospital was not found in its facilities or the type of technology it employed, rather, it was found in its employees. By not linking employee performance with turnover though, the participants fail to demonstrate how they correlate the strength of their employees with the quality of the product they deliver. Furthermore, by neglecting to classify the loss of an employee as detrimental or beneficial to the organization, an overall assessment of organizational effectiveness (or "excellence" for that matter) can not be properly conducted or evaluated.

None of the hospitals had pre-established criteria for functional or dysfunctional turnover (Sullivan & Decker, 1988; Voght, Cox, Velthouse & Thames, 1983). Some of the managers spoke about the positive effects of turnover, however there was tremendous hesitation on their part to state what level of turnover would be dysfunctional for their organizations. Many of the Executive Directors spoke about the tremendous stability of their middle and senior management groups. In fact "off the record" some of them spoke about the stagnation

versus stability of their nursing managers. Indeed, one participant referred to his Assistant Executive Director of Nursing as a dinosaur! I have since wondered what kind of effect this phenomena would have on the corporation. Those who are responsible for delivering the product of the organization don't stay, and those who are responsible for supervising the product of the hospital don't leave. Scary. This unintentional finding that was expressed as a concern by many of the participants would indicate to me that as important as it is to have pre-established criteria for dysfunctional turnover for the general duty Registered Nurse, it is equally important to have pre-established criteria for functional turnover with the Registered Nurses in management.

The Retention Strategies

Two participants stated there were no retention strategies in place in their facilities and three participants proposed that the reason for the low nursing turnover rates in the city could be a result of the nation wide recession and the general state of the Canadian economy. Thus, over half of the hospital administrators implied that the reason for low nursing turnover was due to factors external to the hospital environment versus factors implemented within the hospital environment.

After careful analysis of the interview transcripts, a puzzling finding emerged. Many of the major retention

strategies (decentralization, primary nursing and joint-collaborative practice) were in place in varying degrees throughout the hospitals. This finding was concealed because the Executive Directors did not delineate them as such.

When I asked the Executive Directors what strategies were in place to keep nurses working in their facilities, none of them mentioned primary nursing. However when I asked them if primary nursing was being utilized as a mode of delivering patient care, five participants stated that it was. Only one participant referred to participative management (decentralization) as a retention strategy in his facility. However when I asked the Executive Directors if their organizations were decentralized or moving towards decentralization, six of them replied that they were. Only two of the participants suggested that joint-collaborative practice was a retention strategy in their facilities, however seven of the other Executive Directors admitted their facilities had limited forms of that practice when questioned. The checklist that was done at the end of each interview also pointed out that many minor retention strategies were in place in the hospitals. An example of a conversation I had with one of the participants illustrates this peculiar occurrence.

> Interviewer: But can't you say that you as management are doing something to keep them here? Or is that just an accident?
>
> Subject: No I don't think it is an accident. I'm saying there isn't a problem so maybe we are doing something right. I buy what you are saying. I see where you are coming from. That is quite possible, yes. I mean if

they are happy and satisfied they tend to stay here, that's correct. Being happy and satisfied is once again, a combination of umpteen factors.

Interviewer: That's right. You can have very dissatisfied people continuing to work here if they have no other options or feel thy have no other options. And happy people leave sometimes too.

Subject: And once again, that may be that they have no choice in the matter too. As I say, you have to look at individual cases, I find it difficult to generalize. Can management do something? I say yes. If it is a problem, you can do something. If there is not a problem, as you point out, and it's a good point, maybe we are doing something right. If employees are satisfied and the environment is conducive to retention, that's a valid point. I guess I have trouble sitting down and drawing up a list of, you know, items that I hadn't thought about in that context.

Why weren't the Executive Directors citing these definitive management strategies as measures directed towards retaining nurses?

Very few of the participants understood the terms depicted as major retention strategies in the nursing turnover literature. All of the participants required a definition of primary nursing and three of the participants were still unsure if their hospital utilized that form of nursing care. None of the participants knew what a clinical ladder was and the majority of them required clarification of the term "decentralization" and an explanation of the term "joint-collaborative" practice.

These accumulated findings strengthened the assumptions outlined in the Statement of the Problem; **hospital administrators have a poor understanding of nursing practice.**

The management literature repeatedly states that managers

need to know enough about the needs and functions of particular specialties to understand how they contribute to the whole (Numerof, 1982). This understanding then permits administrators to plan, organize, control, manage, create a fascillitating climate, maintain stability and supply direction in the accomplishment of the goals and objectives within an organization (Charns & Schaefer, 1983; Goldsmith, 1981; Numerof, 1982). Nursing turnover has been identified as a problem in most hospitals, and nurse retention has been targeted as a goal for hospitals. However, if hospital administrators know very little about nursing practice, how can they be expected to plan, organize and supply direction in the accomplishment of this goal? Could this be a factor that has contributed to persistent nurse turnover in hospitals?

Executive Directors are hired and are given the responsibility for ensuring the organization performs effectively and efficiently. Yet the "powers that be" assign people who know very little about the needs and functions of the nursing staff at the general duty level to "manage" nursing staff in hospitals. Many of the Executive Directors in this study complained that their nursing managers had very little education in management. An equally valid complaint by the Nursing Department would be that the Executive Directors have virtually no education in nursing practice. This limitation would appear to affect the Executive Director's ability to structure the hospital organization, design nursing

jobs and manage nurses. How can these individuals be given the authority to deliver a quality service to the community if they do not understand the needs and functions of over 60% of the employees who contribute to the product of the organization? This finding of the study points to the gap between what the management literature professes and how managers in hospitals really perform (Fottler, Hernadez & Joiner, 1988; McConnell, 1984; Rakich, Longest & Darr, 1985).

A review of the interview transcripts revealed that the Executive Directors offered very few deliberate retention strategies that had been established in their organizations directly targeted to control the exodus of nurses. Essentially three groups of retention strategies were proposed by a few of the participants. They included: (1) structural renovations aimed at decentralizing the hospital such as participative management, a multi-disciplinary environment versus the traditional medical model environment, and ensuring the Assistant Executive Director of Nursing was part of the management team; (2) job renovations aimed at defining the role of the nurse and matching nursing skills with programs, and; (3) development of the nurse employee by implementing good orientation and in-service programs, flexibility in scheduling and job sharing, good communication, acknowledgment of long term service and a fair remuneration package.

Many of these retention strategies had either just been implemented, were not fully developed, were not consistent

throughout all of the organizations, or had not been activated yet. Based on these findings and the paucity of retention strategies offered by Executive Directors it is felt that the seemingly low nursing turnover rates in this study were a result of factors external to the organization and the job (see Literature Review, page 21), versus any strategic retention policies implemented inside the organizations for nursing jobs.

Rationale For The Strategies

The answers the Executive Directors gave to the question of why certain strategies had been implemented revealed a wealth of management experience, expertise with general management principles, genuine respect for the work that nursing employees do in the hospital, and an overall concern with running a good hospital that provided a good service.

The question of why they were doing the things they were doing prompted many of the respondents to express openly their personal philosophies of management. My analysis of the data reveals that the participants seemed to provide the rationale for implementing retention strategies under five predominant themes: to empower and enhance the productivity of employees; to improve organizational effectiveness; to deliver a quality service; because of influence from nursing leaders within the departments of their organizations; and because of the nurses' strike of 1991.

In a sense, the Executive Directors based most of their actions on their thoughts, beliefs and attitudes about three critical elements of their work: the organization, the employees of the organization, and the product of the organization. The participants expressed concern about their budgets, about the nurses who worked in their facilities and about the quality of patient care they delivered. Most of the Executive Directors in this study incorporated the nursing employees' contribution to the hospital in the equation of the achievement of organizational effectiveness. Why were these managers concerned about employee productivity, satisfaction and absenteeism among nurses? Where did these participants obtain their thoughts, beliefs and attitudes about managing hospital organizations and nurses? One might think this is a rather elusive question at this point in the study, but in the authors' opinion it is a question worthy of discussion.

Many of the participants related how their academic, work and life experiences had influenced their perspective of hospital management. Indeed a few of them gave full credit to their nursing departments for having initiated policy within their facilities. However one of the most notable reasons that was provided as rationale for changing their current patterns of thinking about hospital organizations was the 1991 labour dispute between the union of nurses and the provincial department of health organizations.

The 1991 nurses' strike, more than anything else they

talked about, was responsible for changing the way they were looking at nurse's work. Why? I believe that the Executive Directors were thrust into a difficult and unfamiliar job position for 31 consecutive days in the first month of 1991. Never before had they come as close to performing the actual work, that prior to the strike, they had only "managed". During the period of the strike, the Executive Directors of hospitals handed out food trays, answered phones, communicated with stressed out family members of patients, changed dressings, and assisted with the physical care of patients. Could it be that this profound experience and the encompassing events of the labour dispute provided them with the strongest reasons for re-evaluating the design of nurse's jobs and the role of nurse's work in the hospital?

What would their rationale have been for implementing nurse retention strategies had I executed this same research project prior to the strike? Would there have been the same amount of energy and motivation to re-evaluate nursing jobs and study the role of the general duty nurse in the hospital prior to the strike?

Effectiveness Of The Strategies

The questions posed by the researcher were not entirely effective for fully answering the inquiry about the effectiveness of retention strategies. Generally speaking, the answers to this question were so diverse that they had to

be arranged into several categories.

The only theme that emerged was that one third of the participants believed that no single strategy was enough to prevent nursing turnover but that combined, the strategies in place were, in their opinion, effective for retaining nurses in hospitals.

If very few retention strategies were offered by the majority of participants, could an evaluation of their effectiveness be accurate? In order to have a clear understanding of nursing turnover, the phenomenon must be measured and evaluated in terms of its rate, pattern, location, causes, and consequences. The availability of this information is a vital prerequisite to the effective control and reduction of nursing turnover (Hoffmann, 1981). Given that the majority of hospitals were not effectively measuring turnover and the Executive Directors were unable to delineate specific retention strategies for nursing employees, it would appear their assessment of the effectiveness of the strategies in place in their hospitals was rather subjective.

Hospital Administrators' Perspective of Nursing Turnover

Two thirds of hospital administrators did not know the level of nursing turnover in their organizations. Only three of the nine participants in the study shared any kind of turnover information from their facility with me. This finding makes me question the amount of preparation some of

the administrators did for the interview, and how seriously they took me as a researcher.

Nursing turnover was not viewed as problematic by hospital administrators. Indeed, nursing turnover was thought to be low and within an acceptable limit. In spite of this finding three things were disturbing throughout the interviews:

1) None of the Executive Directors gave any indication that they knew that nurses have historically had higher turnover rates than other occupations and professions (Munro, 1983);

2) None of the Executive Directors expressed concern about the historical patterns of turnover for hospital nurses (Cavanagh, 1989; Marquis, 1988; Wall, 1988; Wolf, 1981);

3) Only one of the Executive Directors mentioned the amount of recent literature that has been published on the topic.

I was not able to ascertain if the lack of concern and knowledge about nursing turnover that was displayed by all of the administrators was because: they were simply unaware of the historical high rates of turnover among nurses that worked in hospitals; they had never had problems with excessive nursing turnover in their organizations, or; the phenomena had always existed in their organizations and therefore was considered standard employee behaviour.

Whatever the reason, the lack of concern, the collective

inability of the respondents to acknowledge the phenomenon of nursing turnover, and the significant difference between their perception of nursing turnover and my perception of nursing turnover, led me to believe that most of the Executive Directors of hospitals were out of touch with the Registered Nurses who work at the staff level in the organization, and regard general duty nurse turnover as relatively standard behaviour in hospitals.

Hospital administrators felt the major reasons nurses quit their jobs were because of spouse job re-location, pregnancy, job dissatisfaction and career development. With the exception of job dissatisfaction, these reasons point the finger at the employee for quitting their job and erroneously relieve the organization of responsibility for the employee's exit. Could it be that the benign classifications of employee exit forms that list reasons for leaving work as "pregnancy" "spouse transfer" and "obtaining more education" tend to conceal the true motivations of the employee? Perhaps returning to work is not economically or personally beneficial for mothers with young children, or the spouse's career is seen to have more opportunity than the nurse's career, or obtaining more education is considered more challenging and is thought to hold more opportunity for advancement than bedside nursing?

The only concern that was expressed by most administrators with regard to nursing turnover, was with the

supply of general duty nurses in their facilities. Most of them were of the opinion that there were **excessive** numbers of general duty nurses, and a **shortage** of critical care nurses. For the most part, the problems expressed by many of the administrators was with their ability to **fill** vacant staff positions, not with their ability to **keep** experienced nurses. Thus the Executive Directors were more troubled by the recruitment of critical care nurses versus the retention of general duty staff nurses. Very few of the Executive Directors spoke about the tenure of staff nurses and none of them spoke about accession rates, stability rates, or survival rates for these same employees on various wards in the hospitals. Indeed, one of the comments made by a respondent exemplifies the perception held by many of the administrators regarding nursing turnover:

> ...if it got to the point where services had to be curtailed because of lack of staffing, then certainly we would take more aggressive measures in recruitment, but as long as we can maintain full services and staff seems to be available in the various disciplines they are needed, then I don't perceive that as a problem.

The implicit assumption from this statement is that full nursing staff quotas, mean full (sufficient) patient care services. As long as there is someone in the wings that has R.N. behind their name that can fill in the vacant position left by a pregnant, spouse transferred, school-bound or burnt out nursing employee, then hospital administrators determine that the organization is running efficiently.

If human resources determine the strength of hospitals, and if the managers believe that the type of care they deliver relies heavily on their employees, then shouldn't these organizations be concerned with the quality of those resources versus the quantity of those resources? Full staff quotas only indicate a hospital is maintaining adequate patient services. The quality of the staff would be a better indicator of the degree of distinction a hospital has with regard to patient care services and overall organizational effectiveness. How are hospitals evaluating the quality of their nurses? Do they weigh the nurses' educational level, career experience, tenure with the organization, or contributions to the facility? If hospitals do not evaluate the quality of their staff, they can not properly evaluate organizational effectiveness and therefore any claim of "excellence" is unsubstantiated.

The majority of hospital administrators felt they could affect nursing turnover a great deal. The most important tool all the managers identified, in terms of affecting the rate of nurse turnover within the organizations was "good communication". Most of the communication strategies they cited provided information to the nursing employees via orientations, in-services and newsletters. Few of the strategies included listening to the employees. How do hospitals show concern for their nurses, let them know they are appreciated, show respect, and empower their nursing

employees?

Some of the participants stated they were presently looking at implementing general forums to involve staff with management decisions. As one of the participants pointed out, using the Human Resources Department to obtain employee profiles could truly assist hospitals to respond to employees, a rather new phenomenon for these bureaucratic organizations which are renowned for directing their employees instead of responding to them.

There is incongruity between the finding that hospital administrators believe that the two major reasons nurses leave their jobs are not within their control, and the finding that they felt they could affect nursing turnover a great deal. The last major finding of this section points out another incongruity; two thirds of hospital administrators were of the opinion that the primary responsibility of nurse retention lay with the Department of Nursing.

If the mandate of an Executive Director of a hospital is the supervision and management of employees, and if their fundamental responsibility is to ensure that all of the departmental efforts are coordinated towards achieving the organizational goal of providing quality patient care, then shouldn't the primary responsibility of nurse retention lie with the hospital administrator? Is that not the point of having an Executive Director- someone to assume the overall responsibility of patient care? Doesn't the management

literature outline that some of the functions of these leaders are staffing, planning, controlling, creating a facilitating climate and maintaining stability (Charns & Schaefer, 1983; Goldsmith, 1981; Numerof, 1982)? Are these not critical functions for the retention of nurses?

How can Executive Directors believe they can affect the turnover of nurses but not feel responsible for the retention of nurses? Why aren't they being held accountable for the staffing of their organizations? These findings suggest that Executive Directors of hospitals are given a tremendous amount of authority in the corporation but assume very little responsibility when it comes to actually supervising and managing the bulk of hospital employees. The finding of who is primarily responsible for the retention of nursing staff denotes yet another gap in the management literature and the practice of hospital management.

Limitations Of The Study

No investigation is cut and dried and this study was not an exception to that rule. Two situations arose that smudged the findings of the study.

First, upon completing the data collection phase I realized that two respondents had referred to some general statistics on hospital nurse turnover rates that had been collected in the city. These two individuals stated they had used these statistics to compare with their facility's

turnover statistics. These declarations baffled me during the data analysis stage because five of the nine respondents I interviewed had claimed they were not measuring nursing turnover in their organizations. Four important questions arose from this particular finding, namely; where did those two individuals get that information?; who was compiling and publishing that information?; why was that publication not offered to me during any of the interviews I held?; and why would some of the hospital administrators tell me they were not measuring nursing turnover if there was a publication that presented nursing turnover statistics for all of the hospitals?

Second, (and related to the first situation) a very perplexing and eventually frustrating incident occurred during two interviews. At the beginning of Bruce's and Jamie's interviews, they both stated their organizations were not measuring nursing turnover. However at some point in the interview, each of them made a phonecall to another department within the hospital to inquire if there were any statistics on nursing turnover for the facility. Both of them were given a percentage rate for nursing turnover for their respective organizations for the year of 1990! The most absurd moment of the study was with Jamie. Near the beginning of the interview I asked him what percentage of nursing turnover would be considered unacceptable or dysfunctional for the organization and he replied 10 to 15%. At the end of the interview he

phoned a department and learned that the 1990 turnover rate for full time R.N.'s was 15%!

Thus, although fewer than half of the hospital administrators stated they were measuring nursing turnover, it would appear in fact that the majority of hospital organizations were measuring nursing turnover, and that some of the Executive Directors were simply not aware of it.

VII) CONCLUSION

The purpose of the study was to obtain the hospital administrator's perspective on the phenomena of turnover among general duty Registered Nurses and to investigate what strategies were in place in their institutions to retain nurses. As well, the study attempted to inquire as to why these strategies were implemented and how effective they were.

Although the majority of hospital administrators thought that nursing turnover had a negative effect on patient care services and was costly for the organization, none of the participants in this study viewed nursing turnover as a problem either within their facilities or with other facilities throughout the city of the study. All of the Executive Directors felt the turnover of general duty nurses was low and within an acceptable limit. Interestingly only one third of the participants knew the turnover rates for their facilities, even though the investigation discovered that the majority of hospitals were measuring it.

Generally speaking, the hospitals that participated in the study were doing a poor job of measuring nursing turnover. The efforts by the few hospitals that admitted to collecting turnover data were well coordinated, however the measurements that were being used were incomplete for studying the full impact of nursing turnover both within their facilities and for comparison between other facilities. Thus, the turnover data collected from the nine organizations studied could not

be properly synthesized into any form of meaningful comparison.

Few of the Executive Directors offered deliberate retention strategies aimed at reducing the exodus of general duty nursing employees. However, the investigation revealed that several of the major retention strategies identified in the literature were indeed in place (in some form) within most facilities. It was difficult to discern if the perceived low turnover levels were a result of strategic internal factors within the organizations or extraneous factors outside of the organizations. Given the brevity and unsubstantial nature of the majority of their answers to this critical question in the study, there was little reason to believe that the perceived low turnover rates in most of the facilities were a result of strategic internal policies.

The most notable strategy that was being considered by several facilities to retain nurses was futuristic, and involved **re-defining the role of the nurse and articulating non-nursing functions.** The rationale for this endeavour was attributed to be in direct response to the provincial-wide nurse's strike of January 1991.

The effectiveness of the retention strategies was difficult to categorize due to weaknesses in the Interview Schedule and diverse opinions offered by the participants. However because turnover was not effectively measured in the organizations and most Executive Directors were unable to

delineate specific retention strategies, it was felt their assessment of the effectiveness of the retention strategies was highly subjective.

The only problem most participants identified with regard to general duty nursing was with the chronic shortage of critical care nurses. By not speaking about stability rates, accession rates or survival rates of existing nursing employees and expressing more concern about vacancy rates, it was felt the participants focused more attention on the quantity of their nursing resources versus the quality of those particular employees. Consequently, their interests appeared to lean more towards caring about the efficiency of the organization versus caring about the effectiveness of the organization.

In spite of their concerns about the shortage of critical care nurses, all participants believed their organizations delivered excellent patient care. It was subsequently argued by the researcher, that by not considering the quality of their nursing staff with more comprehensive turnover calculations, the effectiveness of the organization and the quality of patient care could not be properly evaluated on their part, and that claims of "excellence" in patient care delivery were unsubstantiated.

The four major reasons the Executive Directors thought nurses left their jobs were; spouse transfer, pregnancy, general job dissatisfaction and to obtain more education. All

of the participants in the study felt that spouse transfer, pregnancy and returning to school, were not within their control and the discussion section of the thesis challenged this notion and encouraged them to re-consider how those reasons for turnover could be managed.

All of the Executive Directors felt they could affect the rate of nurse turnover predominantly by utilizing "good communication". It was felt their comments in this area were sincere but their overall ability to articulate communication strategies were rhetorical, inconsistent and lacked conviction. The overall communication strategies that were offered appeared to expend more energy "talking to" nursing employees (orientations, in-services, newsletters and T.V. networks) and not enough effort in "listening to" or responding to the nursing employees (social functions, employee satisfaction surveys, feedback to outstanding staff, and utilization of Human Resource Departments). Job dissatisfaction was listed as the third most prevalent reason for nursing turnover by hospital administrators, but I was not given any specific information about what the hospitals were doing to counteract this dissatisfaction.

A surprising finding in the study was that six of the nine respondents were of the opinion that the primary responsibility for nurse retention lay with the Department of Nursing. The accountability of the Executive Director (who has authority and responsibility for 100% of all employees)

and the accountability of the Assistant Executive Director of Nursing Services (who has authority and responsibility for at least 60% of all hospital employees) was then illustrated.

The finding that Executive Directors had a limited understanding of nursing practice coupled with the finding that they felt their nursing departments were primarily responsible for nurse retention, called into question their ability to supervise and lead nursing departments in hospitals and their ability to structure the environment to ensure organizational effectiveness. Much of the discussion focused on the disparity between the management literature, and the researcher's perception of management practice.

Throughout the interviews most participants spoke liberally about their styles and philosophies of management. Many of the administrators believed their management style was hindered by the structure and philosophy of the nursing union, and a few of the participants believed that there was inadequate nursing leadership in their facilities. A predominant theme that emerged from the analysis of the data was the submission of several critical elements believed by most Executive Directors, to constitute the formula for organizational effectiveness. Generally speaking, they professed to a belief in productive, empowered employees who provided a service within a decentralized environment, which ultimately affected the organization's efficiency and effectiveness. In as much as it was perceived that the

participants were "out of touch" with the nursing turnover actualities of their organizations, and that their honourable ideologies did not reflect reality, it was encouraging to listen to their overall convictions to work towards their beliefs.

In summary, the study has illustrated how the hospital management literature fails to define accurately hospital management practice, and how hospitals in general, fail to respond to its largest and most valuable resource- the general duty Registered Nurse. Nursing turnover was not seen to be a problem by the administrators of hospitals, and nursing turnover was improperly measured by the majority of hospitals in the study. Given these important findings, it is unlikely that nursing turnover will be effectively reduced or controlled in these organizations.

Study Recommendations

The following recommendations are submitted by the author in response to the findings of this study.

1. All hospitals should collaborate and share a universal definition of the term "nursing turnover". For example: All Registered Nurses who quit their jobs and do not return to the organization within 12 months.

2. Turnover data should be collected and synthesized by a department other than the Nursing Department (for example the Human Resources Department).

3. Pre-established criteria should be established for functional/dysfunctional turnover for each ward in the facility.

4. Exit interviews should be done for all nursing employees and should include Likert Scales to describe job satisfaction, career opportunities within the organization, responsibility, recognition from the organization, etc.

5. Exit interviews should not list "spouse transferred", "pregnancy" or "returning to school" in boxes for resigning employees to check off. Rather, open ended questions such as "What will your next job give you that can't be obtained here?" and "What might this organization have done to have kept you working here?" should be provided.

6. All employee exits should be classified as voluntary or involuntary, and functional or dysfunctional.

6. Minimal turnover measurements for all wards should include:
   a) crude turnover rates;
   b) median service of leavers;
   c) a survival of leavers curve.

7. Hospitals should annually review what they provide for their nursing employees in terms of pay, recognition, job satisfaction/dissatisfaction, responsibility and career opportunities.

8. The concept of clinical ladders is one that should be seriously considered by the provincial Association of Nurses, the provincial Union of Nurses, and the provincial hospital organization.

Suggestions For Further Study

As is often the case, the study raised more questions than it answered. The findings prompted questions that could be transformed into research inquiries for the future.

1. What qualifications should hospital managers possess?

2. Who should manage nurses in hospitals?

3. Who should define nursing practice in hospitals?

4. How do hospitals view their nursing resources?

APPENDIX A

Name
Executive Director
Hospital
Address
City, Province
Postal Code

Brenda Gregory
Address
City, Province
Postal Code

Date

Dear Executive Director,

I am a nurse and a Graduate Student in the Faculty of Education at the University of Manitoba. I am conducting a research project in the form of a Thesis.

I am interested in the phenomenon of nursing turnover, and I am particularly interested in management's (non-nursing) perspective of this behaviour among employees. Specifically, the study's intent is to obtain the Executive Director's viewpoint on this phenomenon, to discover what is being done by the institution to prevent or alleviate nursing turnover, to inquire as to why specific strategies are being utilized, and how effective they are. In order to investigate this phenomenon, I plan to interview several Canadian hospital administrators.

A study like this has never been done, therefore I have had to design my own questionnaire for the interview to collect the data. In order to ensure validity of this research project, it is important to pilot test the instrument on subjects similar to the ones that will be used in the study. This is where you come in!

I wish to solicit your help in assisting me to refine my questionnaire. This would consist of you reviewing and critiquing the questionnaire that I have designed and would take approximately one hour of your time.

I will contact you within a week to receive news of your decision to participate in the study. Should you require additional information regarding the study, you can contact me at my residence, (phone number), or my faculty advisor Dr. Benjamin Levin in the Department of Educational Administration, (phone number).

Thank you for your consideration.

APPENDIX B

Name
Executive Director
Hospital
Address
City, Province
Postal Code

Brenda Gregory
Address
City, Province
Postal Code

Date

Dear Executive Director,

I am a nurse and a Graduate Student in the Faculty of Education at the University of Manitoba. I am conducting a research project in the form of a Thesis, which has been approved by the Faculty of Education Ethics Review Committee.

I am interested in the phenomenon of nursing turnover, and I am particularly interested in management's (**non-nursing**) perspective of this behaviour amongst employees. Specifically, the study's intent is to obtain the Executive Director's viewpoint on this phenomenon, to discover what is being done by the institution to prevent or alleviate nursing turnover, to inquire as to why specific strategies are being utilized, and how effective they are.

In order to investigate this phenomenon, I plan to interview several Canadian hospital administrators. The interview would require 60-90 minutes of your time, and for purposes of data collection I would like to tape-record the interaction. Following this, a transcript summary of the interview would be provided for your review and editorial comments before I proceed with the analysis.

Throughout the study, I will not use your name or the name of your institution. Your wish to discontinue participation in the project would be respected at all times during the conduct of the investigation.

I will contact you within a week to receive news of your decision to participate in the study. Should you require additional information regarding the study, you can contact me at my residence, (phone number), or my faculty advisor Dr. Benjamin Levin in the Department of Educational Administration at the University of Manitoba, (phone number).

Thank you for your consideration.

Sincerely,
Brenda Gregory

APPENDIX C

INTERVIEW SCHEDULE

Step 1. Introduce self.

Step 2. Briefly describe the purpose of the study.

Step 3. Reassure personal and institutional anonymity.

Step 4. Briefly describe the procedures that will be taken during the study (tape-recorded interview, their review of the interview transcript before researcher analysis).

Step 5. Any questions?

==========

Question 1. To begin with, could you tell me about your educational and professional background, and how it is you came to this particular job?

SECTION 1

Question 2. I am interested in your institution's response to nursing turnover. Is turnover amongst general duty Registered Nurses in this institution measured?

If the answer is yes, go to question 3. If the answer is no, go to question 14.

****

Question 3. What is the level of turnover?

Question 4. Can you tell me how it is measured?

Question 5. Can you tell me why this institution decided to measure turnover?

Question 6. Who collects the turnover data?

Question 7. How often are measurements taken?

Question 8. Are there pre-established criteria for acceptable and unacceptable turnover rates in this institution?

How were they derived?

Question 9. Do exit interviews accompany R.N. turnover?

If so why?

Question 10. Is turnover linked to performance? (performance ratings?)

If so why?

Who does the ratings?

Question 11. Who synthesizes this turnover data?

Question 12. What is done with the data?

Question 13. What have you learned from the data?

Causes of turnover...

locations,...

patterns,...

rates,... and

consequences,....

****

Question 14. What is your perception of turnover amongst general duty Registered Nurses who work in this hospital?

Question 15. What is your perception based on?

Question 16. Under what circumstances would you start to measure turnover?

Question 17. What percentage of turnover amongst nurses would you consider to be unacceptable for this institution?

Question 18. If you did decide to measure turnover, what steps would you take, and how would you go about **measuring it?**

****

SECTION 2

Question 19. In your view, what kind of impact does nursing turnover have?

Question 20. In your opinion, why do you think nurses leave their jobs?

Question 21. What can management do to affect turnover?

Question 22. In your opinion, what percentage of turnover with nurses is;

inevitable? _____ avoidable? _____

Question 23. In your view, who has the primary responsibility for retaining Registered Nurses in hospitals?

Question 24. What ward would you expect to have the highest amount of turnover amongst their general duty Registered Nurse staff?

Why would you say the _____ ward?

Question 25. What ward would you expect to have the lowest amount of turnover amongst their general duty Registered Nurse staff?

Why would you say the _____ ward?

Question 26. How have the particular features of this organization affected your views on nursing turnover?

Question 27. What qualities would you say this hospital has for attracting Registered Nurses?

Question 28. What qualities would you say this hospital has that may be considered unattractive by Registered Nurses who are contemplating working here?

****

SECTION THREE

You've spoken to the qualities this hospital has that may be attractive or unattractive to potential Registered Nurses contemplating working here.

Question 29. What qualities or strategies does this hospital have for keeping, or retaining their nurses?

Question 30. Why have those strategies been implemented?

Question 31. In your opinion, how effective are those strategies for retaining nurses?

****

SECTION FOUR

Question 32. Would you say this organization is moving towards decentralization?

If so, why?

Can you provide me with some examples or documentation?

Question 33. Is this organization using Primary Nursing as a mode of patient care?

If so, why?

Can you provide me with some examples or documentation?

Question 34. Does this organization have clinical ladders for its nursing staff?

If so, why?

Can you provide me with some examples or documentation?

Question 35. Does this organization utilize joint-collaborative practice between nurses and physicians?

If so, why?

Can you provide me with some examples or documentation?

SECTION FIVE

Question 36. Would you please respond to a checklist of possible retention measures stating which have been considered or adopted by the organization. I would like to know why you adopted them and how effective you think they are for retaining nursing staff.

RETENTION MEASURES	YES	NO
A. Patient Classification Systems or Workload Measurements.		
B. Unit specific staffing.		
C. Flexible scheduling.		
D. Job sharing.		

E. Cafeteria style benefits package.

F. Bonuses (such as gift certificates, journal subscriptions, educational leave, bursaries, attendance at nursing conferences, etc.)

G. Recognition (nursing newsletters, awards dinners, bonuses, etc.)

H. Promotional opportunities outside of administration.

I. Educational opportunities (seminars, workshops, conferences, in-services, etc.)

J. Child care.

K. Free parking.

L. Job rotation.

M. Resources to decrease non-nursing tasks (24 hour support staff,equipment, supplies, etc.)

N. Committee work/staff designed projects.

O. Significant shift differentials.

P. Financial recognition for advanced preparation.

Q. Meal service for shift workers.

R. Research activities (designing, implementing, publishing).

S. Employee-Management Advisory Committees.

T. CEO opinion surveys.

U. Regular "Coffee with Admin" events.

V. Consultation for career planning and development.

W. Employee Centre (exercise classes, stress management, etc.)

X. Others

Question 37. That completes the interview. Is there anything I have missed or that you would like to expand on?

APPENDIX D

Name
Executive Director
Hospital
City, Province
Postal Code

Brenda Gregory
Address
City, Province
Postal Code

Date

Dear Name,

I have completed collecting the data for my study entitled *Hospital Administrators Perspective Of And Response To Nursing Turnover.* I can now proceed with my analysis of the data. Before I do however I would like you to review the enclosed transcript of the interview I had with you. The purpose of this is to allow you to edit and/or expand on comments you may have made. I believe this exercise will further validate the data and will protect you as a subject.

I have allowed 10 working days for this process. I will phone your clerical staff to ensure you received a copy of the transcript. Certainly if you require more time, you can contact me at my residence (phone) to let me know when I can expect a return. If I do not hear from you within 10 working days of your receipt of this transcript I will assume I may go ahead with the data analysis.

Once again I am very grateful for your participation in the study and for taking the time out to talk with me.

Sincerely,

Brenda Gregory
Graduate Student
Faculty of Education
University of Manitoba

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