

**PERCEPTIONS OF EXPERIENCED NURSES TO WHAT INFLUENCED THEIR  
DECISION TO LEAVE CLINICAL PRACTICE**

by

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## **Abstract**

Nursing turnover (the loss of experienced nurses from a clinical setting) remains a pressing problem for healthcare delivery in acute care inpatient settings. Turnover contributes to increased recruitment and orientation cost, reduced quality patient care, and the loss of mentorship for new nurses. The purpose of this research was to critically examine the factors that contribute to turnover of experienced nurses' including their decision to leave clinical practice settings and seek new employment in another nursing position. The study objectives were to explore experienced nurses' decision-making processes in leaving current clinical practice settings and to examine the personal and environmental factors experienced nurses' perceive that influenced their decision to leave.

An interpretive descriptive approach was used to guide the study. Interviews were conducted with 12 nurses, averaging 16 years in clinical practice. Participants were equally represented from clinical units, which included critical care and medical-surgical areas. The sample drew on perspectives from point-of-care nurses and nurses in leadership roles, primarily charge nurses and clinical nurse educators.

The findings indicated that nurses' decisions to leave clinical practice were influenced by several interrelated environmental and personal factors such as higher patient acuity, increased workload demands, ineffective working relationships among nurses and with physicians, gaps in leadership support, and significant impact to nurses' health and personal well-being. When participants experienced ineffective working relationships with other nurses and a lack of leadership support, they described being ill equipped to perform their job and reported a loss of job satisfaction. The impact of high stress was

evident on the health and emotional well-being for those who stayed, and family relationships and lifestyles were adversely affected.

It is vital that healthcare organizations learn to minimize turnover and retain the wealth of experienced nurses in acute care settings to maintain quality patient care and contain costs. The study highlights the need of healthcare leaders to reexamine how they promote collaborative practice, enhance supportive leadership behaviours, and reduce nurses' workplace stressors in order to retain the wealth of skills and knowledge offered by experienced clinical practice nurses.

## **Preface**

With guidance from my supervisor, Dr. Vicky Bungay, as well as advice from my committee members, Dr. Angela Wolff and Valerie MacDonald, I designed this research project, conducted all interviews, and wrote this entire manuscript. I hired an independent transcriptionist to transcribe verbatim all digital recordings. I also worked with an editor to assist with thesis formatting.

This research project was subjected to approval from two research ethics boards: The University of British Columbia Behavioural Research Ethics Board approved the project, rating it as minimal risk, and provided a Certificate of Approval (Certificate No. H12-01266). The Fraser Health Research Ethics Board approved the project and provided a Letter of Authorization to Conducted Research (File No. 2013-002).

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## Glossary

*Burnout* is described as a “prolonged response to chronic job-related stressors manifested by both psychological-emotional and physical stress leading to decreased job satisfaction and turnover” (O’Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010, p. 1075).

*Clinical practice*, referred to in the literature as *clinical nursing*, refers to nurses “providing direct patient care in the hospital setting” (MacKusick & Minick, 2010, p. 335).

*Decision making* or “clinical decision making is the ability to sift and synthesize information, make decisions and appropriately implement these decisions in clinical environments. Nurses are expected to be able to correctly define and solve problems which are unique to nursing” (Pritchard, 2006, p. 128). In addition, “clinical judgment and decision-making in experienced nurses are related to complex knowledge and the ability to respond to rapidly changing cues in an uncertain environment” (Rew, 2000, p. 97).

*Experienced nurses* are those who have “acquired knowledge and expertise” (Lerer, Donnelly, & Domm, 2007, p. 308) over the course of 10 years or more (Lerer et al., 2007, p. 310). For the purpose of this study, the experienced nurse is referred to a registered nurse with 3 or more years of experience in clinical practice.

*Healthy work environment* is “a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes and organizational and system performance, including healthier communities” (Registered Nurses’ Association of Ontario, 2013, p. 7).

*Intent to leave* is defined as the nurse’s “anticipation of vacating job in the foreseeable future” (Larrabee et al., 2003, p. 272).

*Moral distress* is described as “an experience associated with feelings of anger, frustration, guilt and powerlessness. . . . Moral distress has become characterized as the result of an incoherence between values and action and possibly also outcome . . . and also as a result of nurses internalizing external constraints such that their own moral identities may shift, sometime to coercive and/or harmful nursing practice” (Rodney et al., 2013, p. 169).

*Personal factors* or personal resources are those that “support effective leadership, including professional identity, emotional intelligence, coping skills, resilience and flexibility; leadership expertise, including knowledge, years of experience and formal, advance education; and social supports which include mentors, supportive colleagues, friends and family” (Registered Nurses’ Association of Ontario, 2013, p. 58).



*Psychoneuroimmunology* is the field of study between “the state of mind and emotions of an individual and the health and well-being of that individual. . . . Stress, particularly prolonged stress, can be detrimental to physical and mental health” (Grafton, Gillespie, & Henderson, 2010, p. 698).

*Replacement costs* have “direct and indirect costs of separating the departing employee, the replacement costs of finding a new employee, and the training costs of getting the new employee completely up to speed. A few costs are represented by direct outlays, for example, employment advertisements, supplies, salary while orienting. A great many more costs—interviewing, coaching, teaching, record-keeping and such are not seen directly but they are fully as real in that staff must exist to perform these functions” (McConnell, 2007, p. 88).

*Retention* is described as a “culture of retention is, in fact, to create a culture of engagement and contribution. . . . It means people enjoy their work and the people they work with so much that they want to stick around and get involved” (Manion, 2004, p. 30). For the purpose of this study, I chose to focus on retention of the experienced nurse.

*Turnover* is defined as the “process by which nursing staff members leave or transfer within the employee’s organization” (Hayes et al., 2011, p. 888). In conducting this study, I was concerned with nurses leaving their previous workplaces and moving to another position in nursing.

*Workplace environment* is the “the tone of any workplace . . . influenced by a variety of factors, including the role of management, peer relations, patient acuity, availability of equipment and the physical environment” (Duffield, Roche, Blay, & Stasa, 2010, p. 24).

## **Acknowledgements**

I would like to thank all of those people who journeyed with me as I conducted this thesis work. To those exceptional nurses who shared their personal stories, my respect for your strength and integrity is immense. Your stories illustrated how you have all strived to be the best nurses you could be, and I am grateful to you all for sharing your experiences. My hope is that this study will enable others to hear your voice.

In particular, my sincerest gratitude to my supervisor, Dr. Vicky Bungay, who gave me endless guidance and support throughout this whole process. Your grounding perspective and insight helped make this learning experience enjoyable and enlightening. I could not have endured the challenges along the way without your kindness. I would also thank my committee members, Dr. Angela Wolff and Valerie MacDonald, not only for your valuable time but willingness to provide expertise on this topic.

To my dear family and friends, your patience and encouragement inspired me to carry on with this work. My husband, Peter, and my dear children, Jordan and Aimee, without you I would have not accomplished my vision. Finally, I'd like to acknowledge my parents who saw no obstacle as impossible to overcome and instilled in me a spirit of perseverance. To my late father, Bill, and mother Elma, thank you for teaching me never to give up and to always live your dreams.

## **Dedication**

For Jordan and Aimee and my parents, Bill and Elma.

*Optimism is the faith that leads to achievement; nothing can be done without*

*hope and confidence ~ Helen Keller*

And for Peter,

for your unrelenting support from day one.

## Chapter One: Defining the Issue

The turnover of experienced nurses—that is, nurses leaving their clinical practice settings and moving to another position in nursing—remains a substantial human resource and nursing workforce issue within the Canadian healthcare system (Blakeley & Ribeiro, 2008; Hayes et al., 2011; Jourdain & Chênevert, 2010; O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010; Thai & Marcus, 2013). Experienced nurses, defined as those with greater than three years of clinical experience, are reportedly changing their clinical practice settings frequently or leaving the profession altogether (Leurer, Donnelly, & Domm, 2007). The impact of turnover has been well documented, including rising costs associated with orientation of new staff and reduced quality of patient care (Elpern, Covert, & Kleinpell, 2005; O'Brien-Pallas et al., 2010). Furthermore, as experienced nurses opt to change their clinical environments, new graduates experience a loss of mentorships and guidance, all of which ultimately affects the quality and safety of patient care (Elpern et al., 2005; Leurer et al., 2007; Roberge, 2009; Varcoe & Rodney, 2009).

Researchers, internationally, have demonstrated that fewer students are enrolling into nursing schools and alarming numbers of nurses are leaving the profession (Duffield, Roche, Blay, & Stasa, 2011). Researchers have also noted that turnover is not isolated to specific generations in nursing, but rather occurs among both those nearing retirement as well as newly graduated nurses, compounding the strain to find sufficient replacement for retiring nurses (Alameddine et al., 2006; Blakeley & Ribeiro, 2008; Duffield et al., 2011; Jourdain & Chênevert, 2010). The data on Canadian specific turnover are inconsistent. One study reported, for instance, that the mean overall turnover rates for nursing within

acute care settings to be 19.9% (O'Brien-Pallas et al., 2010). Conversely, others have cited that reported turnover occurs mainly through retirement in older nurses, accounting for 2% average annual loss of nurses, compared to nurses choosing to leave for other reasons (Thai & Marcus, 2013). An overall turnover rate of 3.9% over a 5-year period from 2007 to 2011 has also been reported, and researchers estimated that within the health authority where the data were obtained, 700 new registered nurses need to be hired to replace those who have left (Thai & Marcus, 2013). Although the reason for the discrepancy remains unclear, it is apparent that turnover remains a pressing issue in healthcare. Researchers have reported many factors associated with nursing turnover, including increased workloads, higher patient acuity, moral distress, burnout, lack of leadership support, and poor interprofessional communication (Duffield et al., 2011; Erenstein & McCaffrey, 2007; Laschinger, Finegan, Shamian, & Wilk, 2001; Leurer et al., 2007; Lu, Barriball, Zhang, & While, 2012; MacKusick & Minick, 2010; Roberge, 2009). These factors have been shown to negatively influence job satisfaction, trust in leadership, capacity to meet job demands for patient care, and the ability to cope with workplace stressors (Elpern et al., 2005; Laschinger, Finegan, et al., 2001; Roberge, 2009; Varcoe & Rodney, 2009). The factors influencing turnover and their effects for nurses are explored further in the literature review presented in Chapter 2.

The fiscal effects of turnover have been well documented. In 2003, for example, Canadian costs associated with replacing one medical-surgical nurse were an estimated \$42,000 with increased costs of \$64,000 for nurses who require speciality training for the practice setting such as critical care (O'Brien-Pallas et al., 2010). In the United States, researchers estimated that costs to manage the increased turnover rates in nurses leaving

current places of practice could be as high as 5% of a hospital's annual operating budget (El-Jardali, Merhi, Jamal, Dumit, & Mouro, 2009). The implications of experienced nurses leaving are substantial to workplace environments, as well as for patient care and outcomes. Turnover contributes to remaining nurses losing the valuable expertise, knowledge, and leadership of these nurses (Laschinger, Finegan, et al., 2001; Varcoe & Rodney, 2009). Experienced nurses are a resource, help newer, inexperienced nurses and peers to navigate complex work environments, and provide clinical leadership in healthcare systems that are struggling to meet patients' needs (Roberge, 2009; Varcoe & Rodney, 2009). In their absence, there is a delay in timely assessments to recognize early signs or deterioration in patients' status and nursing interventions to address concerns; this gap contributes to poorer patient outcomes (Griffiths, 2009; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

Turnover has also been associated with negative consequences for quality patient care and related health outcomes. For example, Roberge (2009) and Varcoe and Rodney (2009) found strong evidence illustrating the negative correlation between nursing shortages and quality of patient care and patient satisfaction. With less direct nursing care, as evident in periods of high turnover and nursing shortages, a higher incidence of nurse-sensitive adverse events, such as pneumonia, urinary tract infections, and falls, have been reported (Griffiths, 2009). Other researchers have demonstrated that many of these complications were likely preventable (Armstrong, Laschinger, & Wong, 2009). More recently, researchers have identified that acute care units that had more experienced registered nurses reported lower incidences of patient falls (Choi & Boyle, 2013), further demonstrating that nursing turnover has direct negative consequences for patient care.

To date, research regarding turnover has focused on identifying which nurses are leaving current workplaces and why this is important to healthcare organizations. Implications of the loss of experienced nurses was examined in the literature and found significant impact to healthcare organizations' replacement costs, quality patient care and outcomes, reduction of mentorship, and to those nurses remaining in acute care settings. Knowledge of experienced nurses' decision-making processes in deciding to leave their current practice settings and go to another area of their health agency has been understudied. The gap in the literature highlighted the need to qualitatively examine the perspectives of experienced nurses who have chosen to leave one clinical practice setting to work in another. This information is essential to shape retention strategies, reduce escalating workforce costs associated with turnover, and retain the clinical support necessary for quality patient care. As such, the overarching purpose of this research was to examine the personal and environmental factors that influenced experienced nurses' decision to leave their clinical practice settings in an acute care setting and seek new employment in another nursing position. A glossary of terms is provided in the prefatory pages of the thesis to help give clarity to the many terms used throughout this study. By identifying these factors, healthcare organizations can evaluate how their retention strategies reflect the needs of these experienced nurses, retain their wealth of knowledge in clinical practice, as well as sustain and optimize patient outcomes.

### **Research Question**

The research question for this study was: What are the personal and environmental contextual factors that influence experienced nurses in their decision to

leave clinical practice and seek new employment in another nursing position? The study objectives were as follows:

1. To explore experienced nurses' decision-making processes in leaving current clinical practice settings.
2. To examine the personal and environmental factors experienced nurses' perceive that influenced their decision to leave current place of employment and seek new employment in another nursing position.

### **Thesis Overview**

In this introductory chapter I identified the challenges within current clinical practice settings and how these factors impact nurses leaving, as well as the impact of their loss to remaining nurses and the workplace environment. This chapter also identified gaps in the research regarding how experienced nurses make the decision to leave previous clinical practice settings and move into another setting. This chapter provided a brief synopsis of contributing factors of turnover, workplace environments, leadership, and patient care. Chapter 2 provides an in-depth literature review that focuses on the impact of work place stressors and how changes in patient populations create complex clinical workplaces for experienced and newer nurses. A glossary of key terms is provided for reference throughout the study. Chapter 2 also examines theoretical concepts for decision-making processes to understand experienced nurses' decision-making behaviours when engaging in workplace and patient care issues. Chapter 3 discusses the methodology to conduct this qualitative study. Chapter 4 presents the data analysis, a discussion of the findings, and provides an overview of how experienced nurses reacted to workplace factors and how healthcare organizations must respond to



counter this outcome. Comparison of the findings to the literature is discussed in Chapter 5 in an effort to highlight key insights of the processes inherent in turnover or retention.

## Chapter Two: Literature Review

As briefly identified in the previous chapter, experienced nurses are leaving clinical practice settings, and this has been shown to be a problem to healthcare delivery, patients, and those staff who remain (Elpern et al., 2005; O'Brien-Pallas et al., 2010). This chapter begins with a description of the methodology used to obtain a literature review on topics related to factors influential in turnover. The chapter explores the research literature on the nursing workforce to identify the knowledge concerned with which nurses (e.g., age, years of experience) are leaving and what is known about the factors contributing to turnover. The factors contributing to nurses leaving their current positions are discussed with the focus on workplace environment, which is defined as “the tone of [a] workplace (Christmas 2008, p. 316) [and] is influenced by a wide variety of . . . factors, including the role of management, peer relations, patient acuity, availability of equipment and the physical environment” (Duffield et al., 2011, p. 24). In addition, the influences of leadership on nurses leaving with a variety of subthemes are embedded in the discussion. As personal and emotional well-being were identified as factors influencing turnover, I then review literature concerned with (a) stress, (b) moral distress, (c) burnout, (d) physical and psychological health, and (e) coping with stress. Lastly, I explore theoretical decision-making processes related to nurses working in acute care settings. It is important to note that I could locate no published literature regarding nurses’ decision-making processes when leaving their positions in general or in relation to the issue of nursing turnover. The chapter concludes with a summary of the factors that were found in the literature to be influential in nurses’ decision to leave current workplaces.

## **Literature Review Methods**

To understand the current state of research in factors that may contribute to experienced nurses leaving their clinical practice setting for employment elsewhere in their healthcare agency and their related decision-making processes, I conducted a literature review using the following academic databases: CINAHL, MedLine, and PubMed. No Cochrane systematic reviews could be found. Years for the search were limited from 2000 to 2014. Research that emphasized factors relating to the role of experienced nurses in acute care hospitals and factors impacting turnover and retention were the focus. A combination of the following keywords were used to search the literature: acute care settings, burnout, decision-making processes, empowerment, experienced nurses, factors influencing nurses, intent to leave, job satisfaction, nursing shortages, patient care, perspective, retention, turnover, and workload.

Research through qualitative and quantitative approaches examined factors that pertained to nursing workforce and shortages, turnover, retention, with further examination of the current state of knowledge through literature reviews and meta-analysis research. Other seminal pieces of work prior to 2000 were also included in the research as these findings contributed invaluable knowledge to this topic of inquiry.

My primary concern in conducting this research was turnover in acute care inpatient settings, otherwise defined as hospitals, as the majority of the nursing workforce are situated in hospitals and have direct point-of-care contact with patients (Canadian Institute for Health Information [CIHI], 2012). In the literature, turnover is used in the broad sense to incorporate many terms, such as attrition; however, in this inquiry, the term turnover describes nurses who have left a position in a clinical practice setting to

move to another nursing position (Hayes et al., 2011). A glossary of the terms used in my research is provided in the prefatory pages.

### **Nursing Workforce**

For the purpose of this study, experienced nurses are defined as registered nurses who have worked in clinical practice settings for 3 years or more. In such roles, nurses provide direct patient care and act as a resource for other nurses caring for patients. In a study concerned with turnover, it was important that I first understand the scope of the nursing workforce in order to situate my work within the broader arena of nursing and healthcare.

The Canadian Institute for Health Information (2012) identified, overall, registered nurses' places of employment remained consistent over a 5-year trend between 2008 and 2012, with 61.6% working in hospitals. Canadian statistics illustrated the supply of eligible practicing registered nurses (RNs) grew proportionately with the general population between 2008 and 2012, with a total number of 271,807 RNs in 2012 (CIHI, 2012). However, the Canadian Institute for Health Information (2012) report also identified that the growth rate of RNs per 100,000 of the population has slightly declined between 2008 and 2012 (from 786 to 779), and does not match the 1990 data of eligible RNs (824 RNs per 100,000 population).

Research conducted more than 6 years ago demonstrated that nurses working in clinical practice settings were an aging workforce; the median age of a nurse was 47 in Canada and the United States (Lavoie-Tremblay, O'Brien-Pallas, Viens, Brabant, & Gélinas, 2006; Leurer et al., 2007). More recent data from the Canadian Institute for Health Information (2012) reported the median age of the nursing workforce to be

slightly younger at 45.2 in 2012. Current western Canadian statistics collected from Canada's largest urban health authority reported an even younger nursing workforce with the median age at 43.9 years of age, attributing this slight decrease in average age due to recruitment and employment of younger student nurses and new graduates (Thai & Marcus, 2013).

The median age and place of employment is important to consider, as this largest group of nurses is in their mid to late 40s and are close to retirement, and the literature demonstrated these nurses are leaving due to personal, financial, and organizational factors (Blakeley & Ribeiro, 2008; Jourdain & Chênevert, 2010). In addition to older and more experienced nurses leaving the workforce, turnover of newer graduates within 2 years were reported, compounding the strain to find adequate replacements for retiring nurses (Alameddine et al., 2006; Blakeley & Ribeiro, 2008; Duffield et al., 2011; Jourdain & Chênevert, 2010). By identifying trends in turnover for specific groups of nurses leaving clinical practice settings, healthcare leadership may be able to address the personal and environmental workplace factors that influence their decision to leave.

Nursing turnover continues to be a challenge in Canada where there are insufficient replacements of nurses to match workforce requirements in healthcare (Hayes et al., 2011; O'Brien-Pallas et al., 2010; Thai & Marcus, 2013). Although statistics for British Columbia showed the nursing workforce to be 41,406 for regulated nurses, this number did not specify RNs only and instead included all regulated nurses in this group, such as RNs, nurse practitioners, licensed practical nurses (LPNs), and registered psychiatric nurses (CIHI, 2012). British Columbia's largest urban health authority reported there remains a consistent need to replace RNs due to retirement at almost a 2%

rate, which they project to increase with aging RNs over the next 5 years (Thai & Marcus, 2013). These concerns remain congruent with earlier international findings regarding a global shortage of RNs (Alameddine et al., 2006; Blakeley & Ribeiro, 2008; Duffield et al., 2011; Jourdain & Chênevert, 2010; Thai & Marcus, 2013).

### **Turnover**

Nursing turnover continues to occur in Canada and internationally, with reported rates as high as 20% in Canada (O'Brien-Pallas et al., 2010). The knowledge regarding 'who' is leaving their employment has demonstrated that both older, more experienced nurses and newer graduates (within 2 years of practice) constitute the subgroups of nurses leaving their practice areas (Alameddine et al., 2006; Blakeley & Ribeiro, 2008; Duffield et al., 2011; Jourdain & Chênevert, 2010). Unfortunately, statistics for turnover of experienced nurses outside of retirement data could not be found (CIHI, 2012; Thai & Marcus, 2013). Rates as high as 30–50% of newly graduated nurses who either left their current workplace or left nursing altogether within 3 years of entering clinical practice have been reported in the United States (MacKusick & Minick, 2010). Further exploration into the turnover of new graduates uncovered similar findings in both Canadian and other American clinical practice settings (Duffield et al., 2011; Zeytinoglu et al., 2007). British Columbia's largest health authority shows overall turnover rates to be 3.9% (Thai & Marcus, 2013). Although it is evident that both new and experienced nurses are leaving, there has been little investigation into the turnover of experienced nurses, thereby supporting the need to further develop knowledge in this area.

## **Contributing Factors**

The literature concerned with factors that influence nursing turnover has been growing steadily over the past two decades and has demonstrated diverse personal and environmental factors that ultimately influence nurses' leaving. To aid in discussing this literature in a coherent manner I have organized my discussion of the environmental factors literature into three broad and interrelated topics: (a) workplace environment, (b) leadership, and (c) personal and emotional well-being. Embedded within these core topics are subtopics that highlight specific findings within the literature. I have also organized the literature pertaining to personal contextual factors according to the overarching category of health and well-being, which is further discussed in the following subcategories: (a) stress, (b) moral distress, (c) burnout, (d) physical and psychological health, and (e) coping with stress (Erenstein & McCaffrey, 2007; O'Brien-Pallas, Duffield, & Hayes, 2006; Weberg, 2010). I recognize that there are many intersections and interrelationships within and between the factors influencing nursing turnover and their decision making to leave. What I present here reflects a coherent approach to reporting on this research.

### **Workplace environment.**

As was defined in the opening paragraph of this chapter, workplace environment, which includes a variety of factors that "set the tone of [the] workplace (Christmas 2008, p. 316)" (Duffield et al., 2011, p. 24), was often reported to influence nursing turnover in the research literature. Of particular importance were factors associated with the patients the nurses cared for, including patient acuity, workload, and the nature of their working relationships with other nurses. In the following discussion, I highlight the state of

knowledge in each of these areas and illustrate that, despite the current evidence of these factors influencing turnover, there remains a relative dearth of information about how these factors are actually experienced by nurses or their role in the decision-making processes of nurses who leave their clinical practice areas.

In attempt to understand the impact that workplace environment has on nurses leaving, it is important to understand nurses' perspectives and attitudes toward their workplace environment and how it may impact decisions to leave. Erenstein and McCaffrey (2007) conducted a literature review examining the impact of the workplace environment on nurses; their findings concluded workplace environment directly influenced nurses' work behaviour and engagement in their work environment. The manner in which nurses respond to their workplace was influenced by their unit culture and organizational climate, leading to turnover (Erenstein & McCaffrey, 2007). These findings were supported by Gormley's (2010) subsequent research, a cross-sectional nonexperimental quantitative study from sample size of 336 nurses. Additional studies identified nurses' quality of the work environment was affected by interpersonal relationships, primarily support from nursing management and physicians; the presence or lack of support influenced nurses' sense of well-being (Stordeur, D'Hoore, & the NEXT-Study Group, 2006). Nurses' perceptions of these vital components in their work were found to shape their sense of autonomy and job structure (Gormley, 2010; Stordeur et al., 2006). Of particular importance, the impact of this organizational climate has been linked to nurses' job satisfaction and patient outcomes and was found to be a predictor of nurses' intent to leave their current workplaces (Erenstein & McCaffrey, 2007; Gormley, 2010; Sherman & Pross, 2010; Stordeur et al., 2006).



Extensive literature identified that a core principle to retain and recruit nurses for clinical practice is cultivating a healthy work environment (Erenstein & McCaffrey, 2007; Larrabee et al., 2003; Nedd, 2006; O'Brien-Pallas et al., 2006). It is well documented that a main strategy to promote retention is addressing job satisfaction in clinical practice (Erenstein & McCaffrey, 2007; Larrabee et al., 2003; Nedd, 2006; O'Brien-Pallas et al., 2006). Shiry (as cited in Erenstein & McCaffrey, 2007) described healthy work environments as “supportive of the whole human being, are patient-focused and are joyful workplaces” (p. 258), all of which promote a culture of collaboration, communication, trust, fairness, and respect in the workplace (Erenstein & McCaffrey, 2007, p. 304). Subsequently, promoting healthy work environments enhance employee job satisfaction, which nurses reported require manageable workloads, autonomy within the scope of their practice, nursing leadership, organizational support, recognition, and professional development (College of Registered Nurses of British Columbia [CRNBC], 2005; El-Jardali et al., 2009; Erenstein & McCaffrey, 2007; Larrabee et al., 2003; Laschinger, Finegan, et al., 2001; Upenieks, 2003).

The American and Canadian healthcare regulatory bodies endorse these healthy work environments in their guiding principles to build respectful and safe workplaces in clinical practice (CRNBC, 2005; Erenstein & McCaffrey, 2007). The American Association of Critical-Care Nurses (as cited in Erenstein & McCaffrey, 2007) outlined six overarching criteria to ensure healthy work environments; these components include communication, leadership, appropriate staffing, decision making, recognition, and collaboration. Study findings indicated nurses found these characteristics were lacking in current clinical practice settings to varying degrees (Erenstein & McCaffrey, 2007).

Although it is well documented that a healthy work environment is optimal to decrease job-related stress, Erenstein and McCaffrey (2007) concluded, due to absence of frontline leadership in clinical practice settings, gaps in communication existed that hindered nurses' ability to collaboratively address excessive demands affecting workloads, poor staffing levels, and limited peer and leadership support. The outcome was expressed as job-related stress and loss of trust for nurses (Erenstein & McCaffrey, 2007). Interesting to note, the findings demonstrated that less experienced nurses expressed a greater sense of autonomy than their more experienced counterparts—defined by Erenstein and McCaffrey (2007) as nurses with greater than 5 years of work experience. Nurses identified a vitally important component to fostering a positive perspective of the workplace environment was to ensure leadership was available to build effective communication, which nurses expressed was lacking in current practice (Erenstein & McCaffrey, 2007).

In summary, quality of work environments has been shown to impact nurses' capacity to have the tools, time, resources, and support to address patient care and challenges within the workplace. When nurses lack these components, the outcome is frustration with perceptions of being ill equipped to manage higher patient acuity levels, subsequent increased workloads and work-related stresses. Over extended periods of time, the literature has shown nurses report loss of job satisfaction and disengagement with their workplace, at which point initial thoughts of leaving arise. To alleviate nurses' frustrations and to address their concerns, healthcare leaders must recognize the importance of the workplace environment and the impact these factors have on declining job satisfaction and subsequent turnover. The role higher patient acuity levels while

juggling higher work demands and less peer support has been noted to contribute to nurses' frustration, stress and decisions to leave.

**Patient acuity.**

Shorter hospital stays and more outpatient procedures have been reported to increase acuity for inpatients (Alameddine et al., 2006; CIHI, 2012). Patients in acute care hospital are sicker, with more complex with serious illnesses and frailty, and require more invasive procedures (Laschinger, Shamian, & Thomson, 2001; Roberge, 2009). Patients who are healthier and younger are most commonly managed in outpatient settings, and when they are admitted to an inpatient bed their stays are usually short (Alameddine et al., 2006; CIHI, 2012). Patients now leave the hospital as soon as they are stable.

This increasing patient acuity has been found to influence turnover. With an aging population living longer with chronic diseases, inpatients experience more acute care needs (Roberge, 2009). This, in turn, requires nursing staff to be highly skilled with in-depth nursing knowledge, resourcefulness, and flexibility to adapt to ever-changing patient needs in the clinical environment (Griffiths, 2009). Nurses must demonstrate critical thinking for effective problem solving, identify deteriorating patient conditions, and activate timely and appropriate interventions to address diverse and complex needs of patients (Griffiths, 2009; Laschinger, Finegan, et al., 2001; Needleman et al., 2002). Research has shown that higher patient acuity levels are indirectly associated with nursing turnover (Erenstein & McCaffrey, 2007).

Experienced nurses with their clinical exposure, applicable knowledge, and mentorship have developed the nursing competencies to provide safe care to acutely ill

patients and are a vital resource to newer staff in clinical practice (Elpern et al., 2005; Griffiths, 2009; Needleman et al., 2002). Experienced nurses significantly impact patient outcomes by implementing clinical expertise for direct patient care in critical situations. These nurses guide their less experienced counterparts, including new graduates, and teach to identify early signs of deterioration with assessments of their patients, to critically think to make nursing diagnosis of patients' symptoms, and to collaborate with resources for most appropriate interventions to address patient concerns (Griffiths, 2009; Needleman et al., 2002). Through role modelling or direct guidance, these experienced nurses enable the new nurses to develop applicable nursing knowledge and clinical reasoning to identify warning signs in patients' changing conditions and better manage complex patient needs, prevent adverse events, and enhance safe and quality patient care and patient outcomes (Griffiths, 2009; Needleman et al., 2002).

Recent literature by Canadian researchers supported Griffiths' (2009) findings, elaborating that not only was the experiential knowledge and competency of the nurses important, but also adequate staffing mix was associated with improved patient outcomes (Armstrong et al., 2009). These findings validate the contribution experienced nurses bring to patient safety and outcomes and introduce the topic that staff mix is another factor that may directly impact patient outcomes. This topic will be discussed later.

Staying current with evidence-informed practice and mentoring newer, less-experienced nurses to manage the higher acuity levels of patients all increase role demands on experienced nurses in acute care settings. Managing increased patient acuity and complexity while mentoring new staff in the context of higher workloads due to nursing shortages creates role strain and frustration. The literature described earlier found

that frustration leads to job dissatisfaction and thoughts of leaving current practice (Erenstein & McCaffrey, 2007). Although healthcare leaders cannot alter the growing demands of patient populations and increasing workloads, they can address staffing and education concerns by providing ongoing information to promote nurses' capacity to recognize deteriorating signs in changing patient conditions and evidence-based practice for optimal interventions to address changing needs of patients. To date, the research illustrated the growing complexity of patients and alluded to the intersections between patient acuity and nursing turnover. However, understanding how patient acuity impacts nurses' decisions to leave current practice may provide insight to nurses' frustration, stress, and decision-making processes in leaving and offer up an area for attention to improve nurses' working conditions.

### **Workload.**

Given the higher acuity levels of patients and expanded workload demands of nurses, the ability to meet more complex patient care standards has proven to be a daily challenge in clinical practice (Numata et al., 2006). These demands have led to increased workloads in workplace environments and have been shown to decrease nurses' job satisfaction and to be contributory factors in nursing turnover, particularly their intent to leave current positions (Erenstein & McCaffrey, 2007; Lu et al., 2012; Zeytinoglu et al., 2006, 2007). To understand how workload may be a contributing factor to turnover, it is important to explore the extent this issue may have on influencing decisions to leave.

In their meta-analysis of nine studies, Numata et al. (2006) investigated the association in critical care between RNs and patient mortality and found that higher patient-to-nurse ratios along with reports of staffing shortages occur on a regular basis;

nurses are struggling to meet the healthcare demands of their patients. Nurses who had less time with their patients were less able to provide direct care and as a result less able to prevent negative consequences for patients (Gardam, Lemieux, Reason, van Dijk, & Goel, 2009). A decrease in direct patient care limits nurses' time with patients, reducing their ability to recognize early signs of deterioration in the patient, which is associated with an increase in preventable adverse events such as nosocomial infections or hospital-acquired complications (Gardam et al., 2009; Griffiths, 2009; Needleman et al., 2002). Poorer patient outcomes resulted in increased morbidity or mortality rates (Estabrooks et al., 2002; Griffiths, 2009; Numata et al., 2006). It is safe to say that retaining experienced nurses in clinical practice positively impacts patient outcomes (Griffiths, 2009). Therefore, developing an understanding of how increased workload impacts nurses and turnover may provide insight into how nurses perceive this issue and the role this may have on influencing decisions to leave.

Associations between levels of staffing and patient outcomes were examined in Griffiths' (2009) meta-analysis of 96 studies. Building on original research by Aitken (2003) and Needleman et al. (2002), Griffiths' (2009) systematic review illustrated the benefits of having an adequate staffing mix, qualified nursing personnel, sufficient staffing levels, and greater nurse-to-patient ratios to improve and optimize patient outcomes. For instance, adequate staffing levels and mix contributed to decreases in failure-to-rescue events, patient length of stay, hospital-acquired pneumonia, and mortality rates. However, the findings were inconclusive in the relationship between staffing levels and hospital-acquired complications, such as pressure ulcers, urinary tract infections, and falls (Griffiths, 2009). Furthermore, the majority of the data were not

current (e.g., greater than 10 years old) and, therefore, potentially do not reflect the current trend in clinical practice settings for healthcare initiatives such as the *Safer Healthcare Now!*, which promotes prevention of common hospital-acquired complications (Canadian Patient Safety Institute, 2012). However, Griffiths' (2009) study did highlight the importance of experienced nurses in using their clinical expertise to guide decision-making interventions to optimize patient outcomes and navigate challenging clinical situations. Recent studies by Canadian researchers found more than a third of reported adverse events for patients were highly preventable (Armstrong et al., 2009), which was congruent with Griffiths' (2009) research. Therefore, the loss of clinical expertise with nursing turnover negatively impacts patient outcomes. Providing safe and quality patient care is a universal standard for any healthcare organization (Canadian Health Act, 1985; Canadian Nurses Association, 2008; CRNBC, 2005). Increased workloads have been noted to add to nurses' frustration and job dissatisfaction and may, therefore, be associated with nursing turnover. By gaining insight into nurses' perspectives on the role that workload has in their decision to leave their positions, we may learn important information that may inform healthcare organizations' strategies to address their concerns.

### **Working relationships among nurses.**

With increased workloads and higher patient acuity, nurses rely on a supportive workplace environment among nursing peers to manage increased job demands (Erenstein & McCaffrey, 2010). However, when workplace environments exhibit poor cohesiveness as a team, researchers (Erenstein & McCaffrey, 2007; MacKusick & Minick, 2010) reported that poor working relationships were associated with nursing

turnover. Findings demonstrated that stress is exacerbated when nurses experience lack of collegiality in working relationships within the work environment, which results in nurses perceiving the unit culture to be unsupportive and compounding their frustration with increased workloads (Erenstein & McCaffrey, 2007). Erenstein and McCaffrey (2007) concluded in their literature review that when nurses do not feel supported by their peers in daily practice, they experience stress with managing job demands, which leads to decreased job performance, absenteeism, decreased quality of patient care, and turnover (Erenstein & McCaffrey, 2007).

MacKusick and Minick (2010), for instance, explored nurses' perceptions through a qualitative in-depth inquiry on how lack of support from peers impacted nurses leaving clinical practice. Ten experienced nurses (with median years of practice of 5 years), identified lack of peer support, compounded with what has been defined in the literature as "horizontal hostility" (MacKusick & Minick, 2010, p. 338) and "bullying" (p. 338) among peers, as a primary factor for nursing turnover. In this descriptive study, nurses noted lack of support from team members exacerbated by "bullying" and lack of leadership support resulted in moral distress, job dissatisfaction, burnout, and consequent turnover (MacKusick & Minick, 2010). The predominant response among these nurses was their belief that they had to leave the unsupportive workplace environment, and they saw this as their only viable option "in basically untenable situations" (MacKusick & Minick, 2010, p. 339) in clinical practice. Although the sample size was small, and the researchers identified need for more research on influential factors, these are powerful statements from nurses referring to stressors from ineffective working relationships, which they had described as workplace "bullying" (MacKusick & Minick, 2010, p. 338)



that was prominent enough to prompt turnover in this population. Workplaces that lack collaboration and engagement among nurses' working relationships and are found to be magnified with "bullying" (MacKusick & Minick, 2010, p. 338) have been shown to lead to decisions to leave.

## **Leadership**

In addition to the workplace environment factors discussed above, leadership was a predominant environmental factor reported in the literature. Leadership and, more specifically, leaders who support nurses in their practice were found to be key in minimizing the turnover of nurses in the workplace in several studies. For instance, researchers explored the role of leadership on nurses' practice and found that leaders influenced nurses' capacities to meet job demands, their job satisfaction, and consequently nurses' intent to stay or leave their current practice (O'Brien-Pallas et al., 2006; Weberg, 2010). Findings demonstrated that healthy work environments along with leaders who promote a culture of openness in communication, group cohesion, acknowledgement and support for nurses all contribute to reports of satisfying and fulfilling nursing practices, which positively impacted nurse retention (Erenstein & McCaffrey, 2007; Sherman & Pross, 2010; Upenieks, 2003).

Canadian researchers Leurer et al. (2007) explored experienced nurses' perceptions on the significance of clinical expertise and suggested seven strategies to retain these nurses in practice settings. Leurer et al. (2007) identified a dominant theme in their data was the need to have managers that are supportive. In their qualitative study, Leurer et al. (2007) elaborated that nurses reported job dissatisfaction when they experienced lack of support from nurse managers who disregarded their ideas, minimized

their input in decision making, or did not acknowledge their contributions; job dissatisfaction resulting from lack of support has been linked to turnover. Although limitations in generalization of findings are evident due to the small sample size and the large variability in work environments and retention policies, the Leurer et al.'s (2007) research offered insights, attitudes, and perceptions from the very target population at which retention strategies are aimed. Their study did not explore decision-making processes for nurses leaving workplaces in attempt to retain them, which could offer further insight into how to hold on to this valuable resource in the workplace (Leurer et al., 2007). There is the need to conduct further qualitative research to explore experienced nurses' perspectives on the leadership behaviours they believe impact nurses' decisions to leave their current practice and how they processed these issues during decision making.

### **Personal and Emotional Well-Being**

Research that demonstrated the link between health and well-being and turnover was a predominant area of knowledge I explored within the context of the literature review (see the Glossary for definitions). Of particular relevance was research pertaining to nurses' frustration, stress, moral distress, and burnout, particularly as factors influenced by leadership and interpersonal working relationships (Blakeley & Ribeiro, 2008; Jourdain & Chênevert, 2010). I explore the state of knowledge in these areas in the subsequent paragraphs.

#### **Stress.**

Stress has been identified as a personal factor contributing to nurses' intent to leave clinical practice settings (Erenstein & McCaffrey, 2007; Lu et al., 2012). Stress

arose as a common theme in the literature due to workplace challenges and the very nature of the profession itself (Dunn, Wilson, & Esterman, 2005; Zeytinoglu et al., 2006, 2007). For instance, Dunn et al. (2005) conducted a mixed-method study to analyze nurses' perceptions of their work and identify factors that contributed to job satisfaction or lack of. The findings demonstrated high levels of stress were associated with insufficient time to provide quality care, increased workload, inadequate staffing mix, and to a lesser degree ineffective working relationships among peers (Dunn et al., 2005). Dunn et al. (2005) reported workplace stress impacts absenteeism, staff conflict, and increased turnover. In attempt to understand the impact of stress and turnover, it is imperative to explore how the role of nursing may in itself lead to stress and decisions to leave. Cullen (as cited in Erenstein & McCaffrey, 2007) appropriately acknowledged that the role of nurses is demanding: "Few professions other than nursing are routinely responsible for another person's life and well-being on a daily basis" (p. 303). In the nursing literature, the discussion about stress includes concepts such as distress, compassion fatigue, moral distress, burnout, and psychological well-being, each of which is discussed separately in the following subsections with the conceptual understanding that they fall under the umbrella term of stress.

### ***Moral distress.***

The literature demonstrated that moral distress, defined as "an experience associated with feelings of anger, frustration, guilt and powerlessness" (Rodney et al., 2013, p. 169), is evident when stress is ongoing, particularly when conflicts arise between nurses' practice and their personal and professional standards. In their qualitative study, Elpern et al. (2005) explored levels of moral distress in intensive care nurses' retention;

the nurse participants in the study reported workplace environments contributed to their stress levels. Nurses expressed frustration with their practice due to deteriorating work environments, intensity of patients' illnesses, and conflicting demands (Elpern et al., 2005). Nurses attributed heavy workloads, high patient-to-nurse ratios, and unmanageable physical demands to their high levels of stress and impacted personal health and emotional well-being and (Elpern et al., 2005). These authors speculated that the more experienced the nurse, the greater the degree of moral distress, which they believe is due to nurses' cumulative experiences with distressing situations; more research is needed in this area (Elpern et al., 2005). Other researchers found similar outcomes with nursing staff who experienced moral distress and apathy, and research identified these factors contribute to increased turnover in clinical practice (Dunn et al., 2005; Elpern et al., 2005; Jourdain & Chênevert, 2010). Although not specifically examined in the study, it is reasonable to assume, in light of evidence provided by Elpern et al. (2005), these experiences of moral distress that affected participants' personal health and emotional well-being may be a contributing factor to turnover.

### ***Burnout.***

Literature linked prolonged stress to burnout, defined as "prolonged response to chronic job-related stressors manifested by both psychological-emotional and physical stress" (O'Brien-Pallas et al., 2010, p. 1075). The examination of chronic stress in intensive care nurses was conducted through a Canadian literature review to understand the prevalence of the pervasive issue of burnout (Epp, 2012). Epp (2012) described the nature of the job responsibilities as intensive care nurses require them to function with an advanced level of knowledge, with specialized technological skills, and managing

distressing situations simultaneously with family's grief; the literature found these nurses experience high emotional exhaustion and high levels of separating their emotional self from the emotional challenges within their work or depersonalization. Subsequent research identified increased demands on experienced nurses leading to burnout for those who are asked to provide clinical leadership and work overtime to cover vacancies (Duffield et al., 2011; El-Jardali et al., 2009; Larrabee et al., 2003; Zeytinoglu et al., 2006). Along with other researchers, Epp (2012) concluded these increased workload factors precipitated unhealthy work environments and were demonstrated to contribute to frustration, burnout, and turnover (Erenstein & McCaffrey, 2007; Stordeur et al., 2006).

Similarly, Stordeur et al. (2006) found burnout was exacerbated when nurses' perceived they were incapable of maintaining their professional nursing standards because of conflicting workload demands required within their critical care role. For example, they struggled to balance workload demands within time restrictions, trying to maintain technological equipment, while coordinating critically ill patients' complex needs with fewer resources. Storlie (as cited in Epp, 2012) described the complexity of burnout as a "process so insidious that an exact etiology is difficult to trace" (p. 25). These key components of burnout trigger an occupational-induced psychological syndrome described a "collapse of the human spirit" (Leiter & Maslach; Storlie, as cited in Epp, 2012, p. 25). As recognized earlier, burnout is an attributing factor to job turnover and nurses leaving the profession (Epp, 2012). More in-depth examination of the complex issues that lead to burnout may disclose how these personal factors influence decision-making processes in leaving current workplaces.

### ***Physical and psychological health.***

Stress, burnout, and extended and rotating shifts impact the personal and emotional well-being of nurses and their physical ability to stay in current clinical practice settings. Examining the effect of prolonged stress and associated conditions is necessary to understand how stress and shift work influence nursing turnover. Psychoneuroimmunologists claim there is a physiological link between the mind, emotions, and physical well-being of humans (Grafton, Gillespie, & Henderson, 2010). In order to understand nurses' work, it is important to take into consideration the extended hours and shift work, including night shifts, nurses experience to provide 24-hour direct patient care in acute care settings. It is imperative to recognize the impact these extended hours have on nurses' performance at work and lifestyle if we are to recognize the significance this component has in turnover. Researchers noted that working nightshifts generates psychological effects in the short and long term as well as physiological impacts, including disturbances to sleep cycles and circadian rhythms, changes in core rhythms of temperature, hormonal levels and immune functioning, with up to 50% experiencing severe sleep disturbances and lower levels of alertness (Berger & Hobbs, 2005).

Nurses with sleep disturbances are impacted in their ability to provide safe and quality patient care and increase risk of making errors (Berger & Hobbs, 2005; Nasrabadi, Seif, Latifi, Rasoolzadeh, & Emami, 2009). Evidence has shown that those who work night shifts experience a decrease in levels of alertness, job performance, and safety, as individuals' circadian rhythms are out of sync with longer wake periods (Berger & Hobbs, 2005). When sleep is brief or interrupted, fatigue is increased and

circadian rhythm cycles become unbalanced, which results in impaired cognitive functioning with delayed recall, attention, response time, impaired agility, with poorer psychomotor skills and coordination (Berger & Hobbs, 2005; Nasrabadi et al., 2009). For those who work nightshifts, the struggle to stay awake has been observed to be most difficult between 4 to 6 a.m.; this time period corresponded with a decrease in body temperature, and research demonstrated the worst performance during these periods (Berger & Hobbs, 2005). Within the context of the workplace, the increased risk of medication or needle stick injury doubles in comparison to those working regular dayshifts (Berger & Hobbs, 2005). Consideration of how these risks to patient outcomes influence nurses' emotional well-being should be explored, not only for quality and safe patient care, but also for potential distress nurses may experience in response to these incidences. The research clearly associated stress and turnover (Grafton et al., 2010); therefore, managing factors that improve nurses' ability to handle stress is essential for retaining nursing staff.

The psychological effects of working night shifts is thought to be more a social disruption and isolation experience, with greater stress, substance abuse, difficulty in maintaining regular lifestyles, and divorce rates (Berger & Hobbs, 2005; Nasrabadi et al., 2009; Ulas et al., 2012). Emotional effects in changes to moods and anxiety with extended sleep deprivation attributed to increased burnout and depression (Nasrabadi et al., 2009), which leads to nursing turnover. Given these findings, it is imperative that we further explore stress in the context of the nurses within my health agency to understand their decision to leave.

### **Coping with stress.**

Researchers identified stress in the workplace environment as a contributing factor to nursing turnover (Grafton et al., 2010). The ability to cope, identified through hardiness, self-efficacy, optimism, and a sense of humour are characteristics experienced nurses likely possess if they are able to manage the adversity and unpredictability of years with work-induced stress (Grafton et al., 2010). In order to maintain work, personal and family responsibilities, these nurses have learned how to adapt to adversity and complex work challenges by recognizing what they can do and what their limitations are, seeking resources, and maintaining a degree of self-reflection and self-care (Grafton et al., 2010).

The ability to manage challenges and responsibilities and to recover from stress is described as resilience (Grafton et al., 2010). Personality and individual coping techniques to work-related stress account for each nurse's degree of innate resilience, and this is observed in nurses' ability to "turn a disastrous day into a growth experience and then move forward in practice rather than leave and seek a new career" (Grafton et al., 2010, p. 699). Grafton et al. (2010) equated depletion in nurses' levels of resilience to a decline in self-preservation when caring for others, which occur to a point at which the nurses lose a positive stress response; subsequently, these nurses experience a loss of empathy for others, of self, and of meaning, purpose, and compassion, which is described as compassion fatigue (Grafton et al., 2010, p. 702). Grafton et al. (2010) found a negative relationship between degree of stress, compassion fatigue, and burnout with a loss of personal well-being. Experienced nurses in the clinical workplace run a high risk of losing resiliency with the inevitable job demands and workplace stress, with the



workplace environment, and gaps in support, ultimately leading to turnover. Although nurses coping behaviours were beyond the scope of this study, it is important to consider how coping may influence nurses' decision making as relevant for turnover.

### **Theoretical Decision Making**

Workplace environmental factors, type of leadership support, working relationships with nurses, and perceived workplace stress influence how experienced nurses determine if clinical practice is an appropriate fit for them. How these elements of the clinical setting operationalize for these individual nurses will affect their perceived control over workplace challenges, influencing their responses to workplace issues and ultimately their intentions to leave the profession. In an attempt to understand how experienced nurses may make decisions, Ajzen (2002) explored the theory of planned behaviour, based on the study of human action. This theory provided the framework with foundational concepts of how beliefs impact human behaviour in response to situations (Ajzen, 2002). Ajzen (2002) developed the concept of perceived behavioural control based upon Bandura's (as cited in Ajzen, 2002) concept of perceived self-efficacy, which is based upon "people's beliefs about their capabilities to exercise control over their own level of functioning and over events that affect their lives" (p. 665). Expanding from Bandura's (as cited in Ajzen, 2002) earlier work, Ajzen's concept of perceived behavioural control incorporates external factors in one's perceived ability to control by the inevitable and unpredictable stressors an individual may encounter. Ajzen (2002) found the degree of perceived behavioural control is influenced by the availability of resources individuals feel they have to equip them to address challenges, and subsequently influences their responding behaviours. Therefore, in relation to planned

behaviour theory, it is safe to say the beliefs experienced nurses hold regarding their perceived support from team members, frontline leadership, and adequate resources all directly impact their sense of control over situational events and their behaviour to these events (Ajzen, 2002). The degree of confidence and sense of ability to manage factors that arise in the workplace will affect job performance, facilitated or impeded by nurses' perceived supports and resources within the workplace (Ajzen, 2002).

According to perceived behavioural control, when nurses perceive lack of support or resources, they will feel less control to address workplace challenges, which may attribute to nurses' feelings of helplessness and apathy in workplaces. Feng and Wu (2005) acknowledged the influence nurses' perceived support and resources have on their beliefs and behaviour and affirmed, "The more favorable the attitude and subjective norms, and the greater the perceived control, the stronger should be the person's intention to perform the behavior in question" (p. 338). Keeping current clinical climates in mind, nurses may respond to loss of perceived control in clinical situations with frustration, burnout, and turnover, as cited earlier in the literature (Ajzen, 2002). This degree of perceived behavioural control and self-efficacy, which impacts experienced nurses' "perceived control over performance of a behavior" (Ajzen, 2002, p. 668), may influence how they make decisions to leave clinical practice settings when encountering workplace stressors with lack support or resources.

Aitken (2003) conducted a small qualitative study to gain understanding into the decision-making process of intensive care unit nurses in management of direct patient care. Within this study, Aitken developed a concept attainment framework, based on Bruner's (as cited in Aitken, 2003) work, to explain that nurses develop a hypothesis of

current situations and simultaneously collect data to negate or validate the existing hypothesis. The data illustrated nurses used a variety of strategies in decision-making processes, with “focus gambling” (Aitken, 2003, p. 481) being the most commonly utilized strategy during the decision-making processes. In this approach, when deciding how to manage a clinical situation, nurses took a “gamble” (Aitken, 2003, p. 482) in their decision of intervention based upon their hypothesis. A hypothesis was formulated from the data collection or attributes found in the situation, changing focus as dictated by the situation, observations, knowledge, and resources. Although Aitken’s (2003) study was limited to a small sample size and one clinical setting, this study demonstrated credibility in its methodology and offered interesting insight in decision-making processes utilized by experienced nurses. Furthermore, this study contributed detailed information of study participants’ decision-making processes through a “think aloud” (Aitken, 2003, p. 483) data-collection method. Aitken (2003) identified this approach of continuously cognitively going back and forth between using intuition and scientific reasoning to make decisions was uncomplicated but abstract. However, the advantages of having a realistic clinical setting to collect data and learn detailed thoughts shared from the experienced nurses may reflect the true nature of decision-making processes experienced nurses utilize in clinical practice. Further research is needed to determine if how nurses utilize clinical decision practices in clinical settings differs when making personal decisions.

Pritchard (2006) conducted further work on clinical decision making and defined it as the “ability to sift and synthesize information, make decisions and appropriately implement these decisions in the clinical environment” (p. 128). After observing how nurses make decisions using logical thought processes, incorporating analysis and

intuitive approaches, Pritchard provided a conceptual framework for the decision-making process.

In clinical practice settings, the healthcare systems relies on experienced nurses' ability to adeptly assess a critical situation using critical thinking, clinical reasoning, and judgement to propose the most likely nursing diagnosis and choose the most appropriate interventions to manage a serious situation. This is the basis for complex problem solving skills in addressing clinical problems. Experienced nurses utilize intuition in clinical practice, which Rew (2000) described as "deliberate application of knowledge or understanding" (p. 94) that incorporates a "component of complex judgement, the act of deciding what to do in a perplexing, often ambiguous and uncertain circumstances" (p. 95). Brenner (as cited in Rew, 2000) referred to this expertise and competence as a differentiating component between the novice and experienced nurse, emphasizing the significance of the "intuitive grasp of the expert" (p. 104) in nurses' decision-making processes. Rew (2000) found the use of intuition was a valued cognitive tool used by nurses. Although findings were preliminary and more research needed, the data illustrated the complexity of decisions made in situations of ambiguity and uncertainty (Rew, 2000). These relevant findings are significant to current clinical practice, as the literature demonstrated the environment in which nurses' practice is often chaotic and the strength in critical reasoning and judgement used by experienced nurses is essential to manage unpredictable clinical challenges. Aitken's (2003) and Rew's (2000) findings provided knowledge that may be useful to understand how experienced nurses may theoretically structure their decision-making processes and decide to leave their previous clinical practice settings.

## Summary

This chapter reviewed research examining the nursing workforce, turnover, as well as factors that contribute to nurses leaving clinical practice. Three major themes were found in the literature to have the greatest influence in nurses leaving.

Environmental factors demonstrated to influence turnover were discussed in components of workplace environments and leadership supportive behaviours. Workplace environments were explored in relation to nurses' capacity to manage job demands with higher patient acuity levels, increased workloads, and poor working relationships among nurses. The second theme examined the impact supportive and unsupportive behaviours of leadership had on nurses' ability to manage workplace challenges, and the role this support had on nurses' decision to leave clinical practice. Personal factors influencing nurses leaving included personal health and emotional well-being challenges, providing the final overarching theme in the literature. Personal health and emotional well-being affected nurses' ability to cope with stress and subsequent personal challenges.

Implications of these outcomes were explored on nurses' personal and emotional health and their ability to provide safe and quality care and meet professional and personal standards. Research on how experienced nurses make decisions in clinical practice was examined to understand how nurses process decisions. A gap in the research was found in what process experienced nurses employed in their decision-making to leave clinical practice settings. Further research in this area may help leadership and administrators to understand the most influential factors triggering nurses' initial thoughts to leave, and which factors are substantial enough to result in departure. The next chapter discusses the research design and approach employed in conducting this inquiry.

### **Chapter Three: Research Design and Approach**

The research question for this study was: What are the personal and environmental contextual factors that influence experienced nurses in their decision to leave clinical practice and seek new employment in another nursing position? The study included the following objectives:

1. To explore experienced nurses' decision-making processes in leaving current clinical practice settings.
2. To examine the personal and environmental factors that experienced nurses' perceive that influenced their decision to leave current place of employment and seek new employment in another nursing position.

In this chapter, I present the theoretical perspectives informing this research and outline the research approach. I begin with an overview of the methodology interpretive inquiry and then detail the methods used to undertake this research. I conclude with a detailed description of the ethical considerations for this project and strategies I employed to ensure scientific quality.

#### **Methodology**

To address the research question and objectives, I selected a methodology that I believed would inspire nurses to respond and generate nurses' willingness to share their stories during the inquiry. The research design was intended to uncover the environmental and personal factors influencing nurses' decision to leave their clinical position. Furthermore, the method of inquiry I used enabled me to uncover the cognitive processes utilized by experienced nurses in their decision-making processes to leave a clinical practice setting. To uncover experienced nurses' insights and gain a

comprehensive understanding of the issues unique to this discipline of healthcare, I selected an interpretive descriptive approach, as this permitted me to more deeply explore how nurses thought and responded to factors within their unique experiences (Thorne, 2008). Conceptual linkages were made by using this methodology, discovering associations, relationships, and patterns in the experienced nurses' stories (Thorne, 2008). These findings illuminated underlying meanings of what occurred in clinical practice settings and provided new information to better understand what influences nurses' decision making, which may ultimately be helpful in generating recommendations for retention planning (Thorne, 2008).

My qualitative approach was grounded in Thorne's (2008) interpretive description design. This approach provided the groundwork for data collection and analysis to explore everyday nursing practice within the context of social, personal, and organizational constructs exposed what decision-making processes were operating, all of which a questionnaire may not capture. Knowledge of the nursing profession and standards of nursing practice were utilized to generate how the interview questions were asked and what was observed, listened to, and interpreted (Thorne, 2008). In keeping with interpretive description, I recruited 12 experienced nurses and utilized individual interviews as the primary data collection method. I sought to find patterns of participants' human experiences and better understand the phenomenon unique to their social and personal context within their clinical practice setting (Thorne, 2008).

Exploring the nurses' decision-making processes and related personal and environmental factors provided important insights into their decisions to leave clinical practice. Findings illustrated how participants perceived their workplaces, the stressors

they experienced, and how these factors impacted them personally and had bearing on their decision-making processes to stay or leave. Only in discovering gestalts or intertwined and overlapping themes and patterns in the data did this study find differences from the existing literature.

## **Research Methods**

This section discusses how the sample of nurses was selected, the data collection method, and how data were analyzed. This section closes with a discussion of rigour within the research.

### **Sample.**

Guided by the research approaches congruent with an interpretive descriptive design, I employed purposeful sampling to recruit 12 nurses with 3 or more years of clinical practice experience who had left a clinical practice setting to move to another nursing position. Drawing upon Thorne's (2008) recommendations for purposeful sampling, I sought to choose appropriate participants who were familiar with the workplace culture in clinical practice and able to share their insights into their intent to leave and decision-making processes therein. The ideal key informant exhibited a willingness to engage and share insights about everyday nursing experiences (Thorne, 2008).

The research sample was obtained from one urban and one rural acute care facilities where nurse managers had approved the research. The clinical practice settings included medical, surgical, older adult, emergency, and intensive care units. To recruit research participants, I attended staff meetings at the approved sites to introduce the topic of inquiry, purpose, objectives, and methodology, and I requested any interested nurses



contact me through email or telephone. Letters of request (Appendix A) and posters (Appendix B) were provided to the nurse managers outlining my research topic and detailed contact information. These were distributed by the nurse manager to potential eligible participants (Appendix C). Recruitment of eligible nurses was based on the inclusion criteria: nurses who had 3 or more years experience in clinical practice, fluency in English, worked in a previous workplace for a minimum of 2 years, and left that workplace for another nursing position within the last 2 years. Upon request, I agreed to send participants a summary of the research findings upon completion of the study.

### **Data collection.**

I utilized an interview guide (Appendix D) to stimulate thoughtful and reflective responses from the experienced nurses about their decision-making processes to leave clinical practice. Individual interviews were conducted at a place of participant's choice and convenience. My intent in questioning participants was to gather insights of how nurses' viewed their work environments, including challenges or strengths in these settings, and their experiences in previous workplaces. The form of questioning was designed to optimize the opportunity to hear the voice of the nurse and promote freedom of expression for unbiased opinions.

Each interview began with a general statement of the research purpose, and I used a conversationally oriented interview guide to conduct the interview (Appendix D). All participants signed an informed consent form prior to taking part in the interview (Appendix E). Sessions ranged from 30 to 60 minutes with ample opportunities for participants to respond to questions and to allow me to probe further delve into nurses' experiences and insights during the dialogue. I sought to examine the context of their

everyday practice, their experiences within the culture of nursing, as well as strengths and challenges experienced in their previous clinical practice (Thorne, 2008).

All interviews were digitally recorded. After each interview, I recorded my observations as well as the participant's expressions and inflections during the interview session. I utilized reflexivity and ongoing journaling to control for any possible biases during data collection, data transcription, and analysis. For instance, when I wrote in the journal, I commented on how my personal experiences may be biased, and how this may impact my observations; I strove to be objective in my observations of the verbal and nonverbal data I noted. I hired an independent transcriptionist to transcribe verbatim all digital recordings, and I checked the transcripts by comparing them against the audio-recordings to ensure accuracy of the nurses' responses.

#### **Data analysis.**

The next stage in the analytical process occurred while reflecting on findings and continuing with ongoing data collection. This approach provided a means to check for consistency in questioning while simultaneously revising questioning to extract deeper meanings in experiences. Miles and Huberman (1994) noted humans try to "understand phenomenon better by grouping and then conceptualizing objects with similar patterns or characteristics" (p. 249). By utilizing sensitivity to nurses' responses and identifying similarities in experiences, I could strengthen the data on pertinent factors influencing decisions to leave previous clinical practice. This inductive approach helped to recognize patterns and themes in the nurses' stories.

According to Miles and Huberman (1994), human beings naturally create ways to interpret random events around them in an attempt to understand what is occurring. These

authors hypothesized that people intuitively group similarities of data in their world to find themes, gestalts, or patterns. This process provides people with the means to make stories of their world and to guide how they will respond (Miles & Huberman, 1994). Interpretative description clusters the qualitative data into themes for pattern coding. Miles and Huberman (1994) described this process as a pattern-making device, as people develop metaphors from these patterns and use the outcomes to find interpretive meaning from the experiences. Glaser (as cited in Miles & Huberman, 1994) argued that researchers “struggle to make sense of social phenomena to attach metaphorical gerunds” (p. 252); through understanding the processes responsible for the phenomena, researchers can make inferences to what may be occurring.

During the interviews, I paid careful attention and listened to the nurses’ narratives to ensure sensitivity to their experiences, as well as the participants’ verbal and nonverbal behaviours, expressions, and how they may have avoided saying what they really meant, such as gestures they made, stopping midsentence, and avoiding responses by changing topics (Polit & Beck, 2008). Individual stories were compared and contrasted to transcripts to verify if identified patterns or associations matched the data collected from prior interviews and transcripts. I incorporated ongoing data analysis to watch for emerging themes, patterns, and inferential data, dependent on the subject’s responses (Thorne, Kirkham, & O’Flynn-Magee, 2004). In the next stage of critical analysis, I compared and contrasted the patterns in the data to test if they actually reflected what might be occurring within the nurses’ experiences, or if they discredited my hypothesis of what may be occurring, expressed in data analysis. This was an important step to validate findings emerging in the data (Thorne et al., 2004). I then

compared the findings to the literature to substantiate the evidence or find undiscovered knowledge influencing the decision-making processes for experienced nurses in their leaving clinical practice. The clinical significance of any novel insights from the findings were found in newly disclosed phenomena in nurses' experiences with leaving, which may contribute to understanding factors influencing turnover.

**Rigour.**

This research involved two associated healthcare authorities, both sharing comparable patient care guidelines and standards for nursing care, to minimize organizational variability with similar expectations for nursing competency and patient care standards. Inclusion criteria, which required participants had been employed in their previous position for a minimum of 2 years, were based on the likelihood that this time allowance enabled familiarity with unit culture and organizational structure.

In attempt to establish rigour in the study, I checked for consistencies in the data by comparing findings with audio-taped interviews, journal notes, and transcriptions to verify authenticity of the data, line of questioning at beginning of interviews, and unbiased recording by the primary investigator (Sandelowski, 1995). These measures provided reliability and validity in results to ensure "trustworthiness, meaning in context [in which knowledge is sought], recurrent patterning, and saturation" (Sandelowski, 1995, p. 4).

To build credibility in the interpretive description research findings, I enhanced objectivity and confirmability through comparison of data to the literature, applying my knowledge of the nursing discipline and experienced practicing nurses, and critically

evaluating if findings made sense (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Thorne, 2008).

### **Ethical Considerations**

The University of British Columbia's Behavioural Research Ethics Board approved the research proposal for this inquiry (see Preface). Ethical approval was obtained prior to contacting agencies or potential participants. A letter of approval was obtained from nurse managers from the facility's clinical practice settings.

I ensured participants were provided with clear explanations of the purpose and process of the study at the beginning of the interview, and I clearly explained participants' right to refuse to answer questions and withdraw from the research at any time. I obtained written informed consent from all participants (Appendix E). I explained how I would ensure confidentiality of their identities including the use of participant codes as identifiers when coding data and reporting results in the final report. Participants received a \$20 coffee card in appreciation for volunteering their time. All handwritten data have been locked in a secure cupboard in an office. Each participant's transcripts and the handwritten interview notes are identified with numerical signifier; this information will be discarded after 5 years, as specified by ethics requirements. Research findings will be shared with participants and the facilities after the completion of the thesis.

As it was possible for participants to discuss potentially sensitive information or to reveal an experienced ethical dilemma or unethical practice during the interviews, I was prepared to seek ethical advice if such an issue arose. I was aware of my obligation

to report confidential information to the applicable facility if necessary. No ethical issues arose during the interview process.

### **Strengths and Limitations**

The strength of this research is that it provides a clinical nursing perspective of what experienced nurses identified as influential factors in their decision to leave current workplaces. Exploratory descriptive analysis facilitates a better understanding of the processes inherent in retention that may be useful to consider in planning organizational retention programs. The data findings may lead to future research. Limitations of this study were evident in that data collection from one urban and one rural health authority, which included a small sample size and engaged only female participants. As such, the findings did not capture all experienced nurses' viewpoints; in particular, male perspectives were not obtained on this topic of inquiry.

### **Usefulness to the Research**

As stated earlier, the research findings will be shared with participants and the facilities at the time of completion of this thesis. Findings will be shared with management and the site leadership teams that focus on reasons for nursing turnover, which may be helpful for retention strategies. The study findings will also be made available to nurse managers, as well as professional practice and integration and human resources professionals who are primary organizers for mentorship and retention strategies.

This research is significant to nursing knowledge, as the findings surfaced new aspects of knowledge from experienced nurses' perspectives on current decision-making processes when leaving clinical practice settings. Healthcare planners could use this

research to compare and contrast how current retention strategies align with experienced nurses' insights. The outcome of this evaluation could reveal the elements of current strategies address experienced nurses' concerns and the impact of nurses' choices in leaving. Based on this evaluation, healthcare leaders could incorporate the greatest elements that impact nurses' decisions, as depicted in the research findings and conclusions in Chapter 4, to revise retention strategies for the greatest impact on reducing turnover and promoting retention of experienced nurses in acute care settings.

## **Chapter Four: Study Findings**

In this study I examined nurses' decision making and the interrelated personal and environmental factors that influenced their decisions to leave their clinical practice settings to work in another nursing position. Through my analysis of the interview data, I identified three interrelated and overarching analytic categories that represent the participants' description of their decision-making processes and the related contributory factors. The analytic categories are as follows: (a) environmental factors, (b) personal factors, and (c) the decision-making process. Within each of these categories I organized the findings into a series of themes and subthemes that represent the core elements of the participants' experiences in a coherent and organization fashion. Participants' quotes are embedded throughout the presentation of the findings to illustrate their experiences and strengthen the analysis. To protect participants' identity, I use the numeric codes P1 through to P12 to cite these sources. In order to contextualize the findings, I begin this chapter with an overview of the nurses who participated in this project. The remainder of this chapter is devoted to presenting the findings.

### **The Participants**

The study included 12 participants, all whom shared a wealth of experience and perspectives of contributing factors in their decision to leave their previous clinical practice settings to work in another nursing position. As shown in Table 1, six of the participants held point-of-care positions in clinical practice settings and the remaining participants were in frontline leadership roles as clinical nurse educators and patient care coordinators. Six participants worked in a variety of medical-surgical units and the other half in critical care, such as emergency or intensive care units (see Table 2). The



participants' predominant workplaces were community-based acute care hospitals, although some worked in tertiary care hospitals. Participants worked in both full- and part-time, regular (e.g., salaried employees, non-casual) positions (see Table 3). The average number of years of nursing practice was 16, with a range of 5 to 26 years. All participants were female. The age range was equally distributed between the two age groups of 35–40 and 45–50 years of age; 17% of participants were between 50–55 years of age, and the mean age of participants was 44.2 years. Educational preparation varied, with some participants being diploma prepared, others either having earned or in the process of earning a bachelor's degree, and some pursuing or having completed a master's degree (see Table 4). Most of the participants working in critical care had specialty certification; one had a specialty certification in gerontology. All participants had been in their previous workplaces for a minimum of 2 years and a maximum of 11 years.

Table 1 *Participants' Positions*

Position	No. of Participants	Percentage of Participants
Point-of-Care	6	50%
Patient Care Coordinator	2	17%
Clinical Nurse Educator	4	33%

*Note.*  $N = 12$ .

Table 2 *Participants' Clinical Practice*

Clinical Practice	No. of Participants	Percentage of Participants
Medical/Surgical	6	50%
Critical Care	6	50%

*Note.*  $N = 12$ .

Table 3 *Participants' Work Status*

Work Status	No. of Participants	Percentage of Participants
Part Time	4	33%
Full Time	8	67%

*Note.*  $N = 12$ .

Table 4 *Participants' Qualifications*

Qualification	No. of Participants	Percentage of Participants
Nursing Diploma	3	24%
Baccalaureate	6	50%
Bachelors Degree – in Progress	1	8%
Masters Degree	3	24%
Masters Degree – in Progress	1	8%
Speciality Certification	5	42%

*Note.*  $N = 12$ . Participants were asked to select all qualifications that applied; therefore, the total of the No. of Participants column exceeds the number of total participants who took part in this study.

### **Category I: Environmental Factors**

There was substantial variation and similarities among the participants in the extent that environmental factors influenced their decisions to leave. To best illustrate these varied and similar experiences, I organized the findings of environmental factors into two broad yet interrelated categories: (a) workplace environments and (b) leadership. I chose to use the term workplace environment to encompass specific elements in their clinical practice settings that are influenced operational features such as the role of management, working relationships with peers and patient acuity, and combined with operational features such as equipment availability and physical layout (Duffield et al., 2011). Drawing upon the participants' interviews, I employed the theme leadership to

capture their descriptions of the practices and responsibilities of those in formal leadership positions, including nurse managers, patient care coordinators, clinical nurse leaders (or charge nurses), and to a lesser extent clinical nurse educators. In the following discussion I present my analysis within these themes, illustrating the complexity of the work environments that the nurses practiced within as well as the impact of these environments on their decisions to leave.

### **Workplace environment.**

Workplace environment was a substantial factor in the participants' decisions to leave their previous workplace. High patient acuity, increased workloads, and ineffective working relationship were the most predominant subthemes of the workplace environment. In the paragraph that follows, I detail each of these interrelated subthemes to illustrate the nurses' experiences in their workplaces as decisions-making determinants.

### ***High patient acuity.***

Participants unanimously expressed that changes in patient demographics over their years of practice show sicker patients in their clinical practice settings. They identified the acuity of patients had increased substantially and that patients' complex needs contributed to increased demands for nursing care. These participants identified the associated stress to these increased work demands were key aspects influencing workplace environment and ultimately their decision to leave. Participants described patients' acuity in relation to complex health challenges and greater medical needs than they had all observed at the onset of their nursing careers. In providing care to these patients, many participants described the need to work faster, more efficiently, acquire

more knowledge, and expand their nursing assessment skills for earlier recognition of signs of patient deterioration. All participants reported that higher patient acuity levels resulted in nurses feeling overwhelmed due to the number of significantly ill patients requiring nursing care simultaneously, resulting in conflicting patient and clinical demands that participants struggled to address. All but one of the participants reported that, over time, these compounding demands to address patients' needs became a burden. They identified the need to be more skilled in frequently changing priorities in patient status and health challenges as well patient demands in the clinical setting. Summed together, these circumstances place a greater demand on nurses, often leading to dissatisfaction in their roles. Participants described that the increased number of acutely ill patients led them to believe they could not keep up, which contributed to experiences of stress, mental fatigue, and burnout. One participant expressed how managing patient populations became increasingly too stressful and draining, contributing to her beginning to consider leaving her workplace:

A typical day . . . I'm a bedside nurse, so it just starts right away coming in getting report. The hospital is a very busy hospital, and we also have a step down unit there on the floor. Getting report, doing assessments, vitals, medications, dealing with doctors, families—I found it more like you're always on the go. The acuity . . . how that impacted me. . . . I guess because I've been doing it for so long, I'm quite comfortable, but with that comes the burnout because, I guess, being experienced nurse knowing [too] much or being able to recognize things earlier like if patients are going downhill, when you recognize that and acting on right away, you're always on the go, but you get burnt out quicker, and you just

deal with it. I look back on it, I was burnt out, because you know your patient assignment stays the same, but like I said, patients are sicker, they require more interventions, more tests, not doing so well, but you still . . . have to provide safe care. (P9)

Another participant identified that her role became harder to manage due to patient acuity, and she surmised she was unable to address and manage medical needs of patients despite her years of experience. This participant expressed feeling defeated and incapable of remaining in her position, which she ultimately left:

[It was] more and more stressful, more and more intense. It just got harder and harder and harder physically and mentally and emotionally. I think that the beginning it was good. I enjoyed it, but it's just, you can just last so long with that adrenaline always at its peak. It just got tiring, and I really felt the last year I wasn't keeping up physically and mentally. I think it was increased intensity of the illnesses of patients in the critical illnesses, and there were some that came in that were shocking and very hard, because they were so sick. One in particular didn't make it, and she was only [a teenager], and it was really hard. I was in charge. And it felt like we weren't a little hospital anymore . . . that's about the time I started looking [for another job]. (P8)

Many participants reported that their workload increased in conjunction with growing number of acutely ill patients, as experienced nurses were assigned more acute patients than their less experienced counterparts. They were also called upon to be the resource in the unit for their problem-solving expertise in addressing complex situations in the clinical setting or in critical patient events such as deteriorating patient status. The

following excerpt highlights how participants experienced demanding workloads associated with patient acuity:

One of my last days in charge, we had a code come in and that patient was intubated. And then we had another patient come in and before we could transfer out the first one, the second patient was intubated and the department [was] full and there were no beds upstairs, and the patients weren't moving. And the high acuity, like all of a sudden you have people that, you know, really need a bed now, we need care and/or place to go to, don't have a monitored bed for them or they're vomiting their guts out, don't have a place to lay them down and start an IV [intravenous]. I mean that's kind of an average day . . . it can be at any time.  
(P3)

While this excerpt is reflective of many of the experiences of the participants, this particular participant also identified that keeping a constant accelerated pace to address the complex care required of the multiple patients on her unit directly contributed to her becoming ill and her decision to leave her workplace, as she was unable to continue in her job demands.

Those who experienced the negative impact of high patient acuity within the workplace environment expressed a sense of defeat when they acknowledged they were ill equipped to meet the overwhelming needs of the patient population they served, and this issue was an influential factor in their decision to leave. Almost all admitted to burnout, identifying that the growing complexity in their patients' needs led to increased workload demands, which they believed they could no longer manage, despite the resourcefulness they had developed through years of nursing experience.

### ***Workload demands.***

In addition to the increased workload demands associated with patient complexity and high acuity, the participants described many other workload factors that influenced their decisions to leave and move to another practice area. For many participants, these increased workload demands were associated with operational features of their work settings, including being chronically understaffed, high patient-to-nurse ratios, overpopulated units that required caring for patients in hallways and other nonprivate spaces, and conflicting and competing demands on their time and work activities.

The participants who shared this common theme of increased and conflicting workload demands in their nursing practice expressed deep regret when they believed patients did not receive the care they deserved and when the nursing care they could provide was incongruent with personal and professional standards. Participants explained that there were too many tasks and demands for nurses to keep up with patients' needs. Some expressed remorse and guilt for being unable to provide patients privacy when providing direct nursing care or patients dying in hallway beds; participants identified that these circumstances lacked the provision of dignity in vulnerable and significant life altering events. One participant illustrated this point and described how this experience of compromised nursing care led to guilt, anxiety, and difficulty of getting out of bed, eventually influencing her decision to leave. Her lingering guilt haunted her when she would leave work, and she would feel anxious returning to work, ruminating on the workload. At night, she reported waking with anxiety when contemplating on missed tasks due to the conflicting and increased demands. Reflecting upon her nursing practice, she expressed she found her experience disheartening and in direct conflict with her

professional and ethical professional standards when she could not provide the care she knew patients deserved due to time limits:

I'm the type of person, I'll go home . . . probably a lot of nurses do this, you go home, when you think about your day, and you just like, I just hope I did my best, and at the same time maybe feeling a bit sorry or guilty that you could have given better care but . . . it's not myself as a person, it's more like the whole picture, the environment of what's going on. . . . I get this feeling, not being able to give the care that I wish my patients could have. . . . I find that I end up being hard on myself because I'm human, and I can do so much. . . . I felt a little weighted about that. . . . They [patients] are really sick, and you can't do everything, you can only do your best, right? (P9)

Many of the participants expressed what they described as “an inability to keep up” over time, which resulted in feeling exhausted and burnt out. Many participants shared they learned to approach their workplace with an attitude of “suck it up” and to exhibit strength in the face of the ongoing stress. They described that gradually, over time, however, they could not manage the stress, experienced guilt at being unable to “keep up,” and that in retrospect, they were very burned out and were unable to cope with the increased workload. One participant reflected on her work experience and what she experienced upon returning to her previous workplace after a brief sabbatical working elsewhere:

I'd have to force myself to roll out of bed to come to work just because I knew what I was walking into. . . . I've always wanted to be a nurse; both my parents are nurses. This is me; it's not just a career and what I wanted to do, but there



have been many, many times, especially just lately within the past year, I struggled to get out of bed to come to work. . . . When I did come back, I had it in me, coming back to my original workplace where I'd worked forever, it was in my head that I can't do this for the rest of my life, because to come into work with anxiety and stress, to do that for a lifetime, like no. . . . I'm like, this is my home work site; I'm comfortable with everything, but to do this a lifetime, no. (P9)

Attempts to manage increased workload were not isolated to participants who work at the point-of-care. For example, those in frontline leadership roles expressed dissatisfaction at juggling multiple demands and conflicting priorities between patient clinical issues, staff issues, and responsibilities to attend meetings both on and off site. Although many participants in leadership roles enjoyed the diversity and the greater responsibilities added to their work, they reported that over time they found their roles to be draining and were unable to maintain the pace and demands in the long term. One participant shared that the constant increased workplace demands became too stressful, which resulted in her leaving her workplace:

There was an awful lot of what I felt pulled in between time spent on the floor and time spent doing other types of duty, and I found it difficult . . . there was not the time to do both. I have expressed my manager some, but I have some dissatisfaction with that, that I felt unless I could clone myself I could do both, and it was either one or the other for me. . . . I found it difficult when I was asked to attend to many meetings, and I couldn't be attending to things I felt I should be doing on the unit when I was off-site. . . . It was increasing, as time went on the more, the more and more it happened. (P2)

An additional workload demand described by point-of-care and leadership participants was the mentoring of others. Although all participants acknowledged the need for them to provide more mentorship to novice nurses and that they enjoyed this supportive role, mentoring was described as adding substantially to their already heavy workload demands. Of particular significance was mentorship to support less experienced nurses navigate complex situations and patients, including learning to recognize warning signs or severity of patients' signs and symptoms and when and how to contact physicians and allied health resources in a timely manner in order to escalate the level of care to address patients' needs. This additional work responsibility compounded participants' stress in the workplace, increased their responsibilities for patient care, and led to exhaustion when trying to balance their workplace demands. One participant explained this issue in detail:

You have to be very on your toes, and while you're managing your assignment you have to be kind of keeping a picture or keeping an image of the whole department [in mind] because . . . a patient . . . may just walk by someone and [think], "Wow, they aren't doing very well and that nurse hasn't picked up on it yet," so you have to be observant [about] what's going on. You have to know the skills of the nurses around you and what's with the patients because you may be intervening elsewhere. I don't think . . . [it's] necessarily part of my assignment, but it's part of my duty. I do think younger nurses don't always have the full picture. And so they miss a lot of signs of somebody, [someone] else will pick up. . . . I think, just as an experienced nurse, we kind of have that sense of, "Well, that

person doesn't look well," and you follow up on it because you just want to know.

(P3)

Some participants reported that they began to question how long they could continue with the increased workload coupled with the changing patient population, which ultimately contributed to their decision to leave. As one participant explained, in addition to managing a high patient acuity level with overseeing inexperienced nurses, these compounding increased workload demands made her role more challenging, increasing her stress and anxiety. She identified these factors led to her burnout and subsequent thoughts of leaving:

You have a whole bunch of new grads come on, and if you're an experienced nurse and you have new grads there, you are here doing a lot of teachings still or helping them out. . . . Which is fine, but with the issues you talked about, it's more added, you know, responsibility to an experienced nurse. . . . At the same time, [when] someone is new and they're missing something, not getting something done properly, you're coming on and you're finding mistakes and correcting, and again that's more work for you. [This was] like an everyday thing.

(P9)

***Working relationships.***

Working relationships were an important and integral aspect of the environmental factors influencing participants' decisions to leave. Participants defined their working relationships by the manner in which nurses helped one another to give patient care, aid in the flow of patient care, and address unit issues in a timely manner. The degree of collaboration and cohesiveness among team members was identified as teamwork and

was a significant determinant for a positive workplace environment and job satisfaction. Those who experienced a strong sense of teamwork reported feeling supported and valued by peers. Others who experienced poor support in their working relationships perceived this lack of teamwork as one of the contributory factors in their decisions to leave their clinical practice setting. Participants reported beliefs that the nature of working relationships was influenced by attitudes and behaviours among team members, a mixed staffing model with RNs and LPNs, and the support provided by team members in the mentoring and integration of new graduates and new nurses into the workplace. How these attitudes and practices were operationalized were identified as either enhancing or being detrimental to their working relationships and sense of teamwork.

It is important to note that there were considerable differences in working relationships experienced by participants. Some participants described working with supportive and collegial peers and including those who were willing to help with daily tasks or able to respond to requests for support respectfully and in a timely manner. These participants attributed healthy morale on the unit to the strong sense of teamwork and a supportive environment and also reported enhanced job satisfaction, citing they could turn to their peers at any given time and they would receive a positive response. Most participants with this experience found this quality to be a strong indicator of retention and identified collegiality in teamwork as what kept them for longer periods of time in their previous unit, despite the increased workload demands and high patient acuity, compared to those who lacked teamwork in their clinical practice settings.

Others who experienced less cohesive working relationships in their previous workplace identified that this gap had a negative impact on their workplace environment,

regardless of their roles as either point-of-care nurses or frontline leaders. Participants who experienced less cohesive working relationships encountered variations in degrees of support and described that periods of less support were heightened when there was higher patient acuity and increased workload demands on the unit. Some participants expressed that the degree of supportive or unsupportive working relationships was dependant on individual nurses who were on shift at any point in time, and described relationships to be cliquy, with support given only to nurses who were part of their group. This lack of working together and exclusionary environment was reported as a significant experience that contributed to participants initial considerations of leaving their practice area.

There were other examples provided by the participants in how ineffective working relationships played out for patient care and contributed to discontent with their work and thoughts of leaving, as reflected in the following excerpt:

It depended on who you worked with, and it depended, for some people, if they liked you. It depends because I know there's people that I work with that [are] great to me and they help me, and I can ask them questions and they just . . . support me in my practice as a bedside nurse. But I see those same individuals sort of not offering that same support to others, which is sad because we should support each other equally. (P6)

The lack of supportive working relationships played out in diverse ways for practice and patient care. Some participants reported, for instance, that their peers refused or made excuses when requested to help transfer physically heavy patients or to assist with competing patient care demands. Other participants noted a lack of help mobilizing resources to address patient care issues or critical events. Some participants reported

patients' call lights going unanswered by some nurses if these patients were assigned to other nurses and that they later discovered those same peers engaged in non-work-related activities at computers. Those who exhibited incohesive working relationships were described as demonstrating poor teamwork. Participants expressed that this resulted in substandard nursing practice and oversights in accountability or responsibility for care. These experiences were described as "distressing" and "frustrating," as demonstrated in the following excerpt:

It was very frustrating. And then the staff morale also over the years was so poor, like everyone was like so unhappy. No one seem[ed] to really want to help anyone else, and so to have that type of mentality, it's very challenging. Like when, you know, someone rings a call bell, "Oh, sorry, I'm not your nurse, . . . you have to wait," and then that person needs to get over the bathroom. You had to search for people, and then people weren't overly willingly sometimes to help you, so you're doing unsafe manoeuvres. And you put your body at risk, your back at risk. And you didn't really feel like there [were] . . . people [who you] could ask for [help], so you're on your own. (P4)

These experiences contributed to feelings of being undervalued as a team member, a situation that led some to experience isolation and to disconnect from their peers in their final months before leaving. Ultimately, these isolating and disrespectful working relationships either were the deciding factor or a contributing factor for nurses' decisions to leave and move to another area of practice.

Undefined roles and scope of practice were also identified to lead to disparity in the working relationships among the team of RN and LPN staffing models. A few

participants described ineffective collaboration between these two scopes of nursing practice, with inflexibility to match assignments to evolving and fluctuating patients' status, and they described this lack of team approach with more complex patient assignments. Unclear communication to outline responsibilities for the different scopes of practice in the mix model raised tension among team members, as was described in the following participant quote:

The collaborative practice comes into it as an issue because you've got two different kinds of nurses with different skills, and I think sometimes that misunderstanding can happen, and so RNs may just want to take over and just do the job instead of trying to really articulate what it is they need and how the LPN can help them. (P11)

Although most participants had similar mixed-staffing models, one participant found this to have substantial impact to her sense of the working relationships in the practice setting:

There's also a staff-mix issue in the unit where they have the RNs so they gave critical care, they have Med-Surg [medical and surgical nurses], and then they have LPNs, so there's lots of tensions around working in that kind of model, especially in this type critical care where it's really acute, and then people being pushed outside their scope. But not just LPNs, . . . RNs too [I] think, [are] pushed outside their scope. There's some LPNs that would say, "No, not working. I can't take those patients because they're too sick," so they have one patient and the RN has eight patients. . . . Instead of saying well, "We can work together, and how can I support you to care for those patients because they're too sick to my scope?"

So they're under my scope, you take care of them, I'll take care of my one patient, [and] will work together.” (P6)

A lack of working collaboratively as a team was reported to be challenging for effective working relationships and identified to affect the cohesiveness of a unit. Unsupportive working relationships impacted unit morale, observed as negativity in attitudes and behaviours among staff members. Furthermore, participants who directly experienced or witnessed peers or leaders undermining the practice or character of a nurse described these behaviours as harassment, which they found to be detrimental to the workplace environment. Participants in both point-of-care and frontline leadership roles reported harassment (i.e., nurses bullying peers at work) in their previous workplaces. Whether observed or personally experienced, harassment had a notable impact to participants' practice by distracting their focus and redirecting their energies to diffusing or trying to manage this negative behaviour, which was reported to impact their ability to attend to other required duties of their job. Those who witnessed or experienced harassment also reported the destructive impact it had to them personally and noted the harmful effects this behaviour had to workplace environment, resulting in poor working relationships, and reduced unit morale. Ultimately, clinical environments with poor working relationships as exhibited as lack of teamwork often experienced greater turnover among new staff and student groups not wanting to come to the unit. One participant shared that her experience with poor working relationships was demoralizing for her, even heartbreaking, and it influenced her decisions to leave and look for other positions in nursing:



I worked for I don't know how many years as a nurse, 25, 26 years, and I've never had an experience that I did here. . . . And it didn't really help that the one [nurse] was, rather than being supportive, she seemed threatened by anything that anybody did or said and all of us as a group . . . used to warn each other, "Oh, better keep your head down or you're going to be in trouble," and [that] was well known. I mean we used to kind of joke that if you were being picked on that meant she [thought you were] really good at your job I guess. . . . It was pretty common, and we would support each other, those of us that were . . . being picked on and bullied. (P1)

This participant expressed how this experience aggravated other challenges she was experiencing in the clinical practice setting and was one of the contributing factors to thoughts of leaving.

Another participant also described workplace challenges with bullying and attributed this factor as to the management overhaul of her clinical practice setting. The participant recalled that bullying created a "negative preexisting culture" (P11) and the complacency of addressing this issue was the reason for firing the leadership. She commented bullying negatively affected working relationships in her clinical practice setting and became a deterrent to new staff and student groups coming to the unit. This situation created a very low morale and fear of being bullied if they reported, and she observed new graduates leaving due to this negative workplace environment, as they were unable to cope with it.

Ineffective working relationships were also a result of poor communication, evident in the power struggles reported among younger, less experienced nurses and

senior nurses. Some participants admitted being hesitant to voice concerns with charge nurses, or point-of-care nurses in charge roles, who were unapproachable, which impeded addressing patient concerns or clinical challenges. One participant explained personally experiencing hesitation in voicing concerns with the varying personalities of leadership members, as well as observing less experienced nurses being frightened to approach charge nurses due to anticipated negative responses. A few participants reported the lack of communication was associated with job dissatisfaction, lack of patient care, and decreased patient outcomes. Participants attributed barriers to develop effective and respectful working relationships were impeded by power struggles preventing nurses from openly communicating patient concerns to their colleagues:

There's intimidation; you don't want to voice your opinion. You don't want to step on anybody's toes, and you don't want to anger anybody or hurt somebody's feelings, so I think that inhibits some of the communication . . . both laterally and up and down. . . . It leaves some gaps . . . so you just have to learn to either assert yourself or figure a way to communicate, you know. There's a chain of command, and you have to learn to do that, and if you're not being listened to, then you've got to learn where to go to be listened to appropriately. (P3)

Some participants discussed the value in the wisdom of experience in managing workplace relationships. This participant articulated that using open communication during power struggles helped her to express concerns with more senior nurses. Those who experienced challenging power dynamics identified communication style and techniques to be key in addressing clinical issues or reporting concerns to resistant more intimidating senior staff. One participant summarized this by stating,

You have to be able to voice your opinion or deliver your information in a way that makes them notice or makes them understand that you feel this is grave or this is important, so sometimes you just have to learn that part. And that's communication skills, and it's a maturity thing as well. It's an experience thing as well. (P3)

Overall, the nature of nurses' working relationships greatly impacted the support participants experienced in clinical practice settings. The nature of their working relationships either empowered them to face the clinical practice setting and patient challenges or alternately was attributed to promoting a sense of powerlessness to manage the workplace environment. In the event of poor working relationships, identified by participants to be the nature of teamwork experienced on the unit, this factor in combination with higher patient acuity and increased workload influenced some to decide to leave and seek other positions in nursing.

#### ***Working relationships with physicians.***

One other area of working relationships that warrants discussion are the relationships that participants described having with their physician colleagues. Physicians were identified as an integral aspect of the interprofessional team required for patient care; they provide leadership for the medical management of patients and collaborate with nurses for the overall plan of care. Challenging working relationships were varied and complex and often were reported to negatively affect patient care. For instance, when physicians did not participate in rounds, then decisions around optimizing care were not made. Furthermore, participants reported oversights in physicians' presence in the face of rapidly deteriorating patients. These participants reported that a lack of

physician direction led to the nurses being pushed to practice out of their scope of practice. Participants admitted to experiencing moral distress when they did everything they could for critically or seriously ill patients, but they could not provide medical interventions without physician direction. One participant attributed an ongoing issue in a serious patient event to be a major factor in her decision to leave:

I don't think it's fair to the family, I don't get think it's fair to the patient, and I don't think it's fair to my nursing license. I think that it impacted, I mean the patient was actually dying . . . it was such a mess. There is no direction given, there were no orders, and the patient was bleeding out and he had esophageal varices, and they weren't going to band it and they weren't going to go back for surgery to band it. So he kept on bleeding out and there was no cold blue, DNR [do not resuscitate] orders written. So we just kept, filling him up with blood and, just kind of running our own kind of situation. It was such a mess that I just, I thought, "You know, it's time for me to leave, because it's just not the way I want to practice nursing." . . . It makes for a stressful environment where you don't want to stay anymore because you just, it's too unpredictable, and in an environment where it needs to be relatively predictable. . . . That's one of the determining factors . . . I left because . . . I was more [often] than not put in a situation where . . . I was performing at a doctor level, not a nursing level. (P7)

Nurses also reported experiencing verbal abuse perpetrated by physicians.

Participants reported poor communication and lack of respect in their working relationships. One participant explained these poor working relationships with physicians

contributed to reduced unit morale, which was a contributing factor in her decision to leave:

I think, for both the nurses and the doctors, roles and responsibilities were very unclear, they seemed to make it up as they go along and fit it into their schedules. . . . Everyone was kind of spinning their wheels in their own direction; they weren't really working, leadership . . . weren't working collaboratively together, and [it] was really evident that the PCC [patient care coordinator] and the CNE [clinical nurse educator] were not getting along. . . . They weren't cohesive and that was clearly evident. . . . They [bedside nurses] clearly understood that they could get away with certain behaviours and challenging the leaders and the doctors. It just, that's the way it is. Nobody talked about it. Nobody really questioned them either. . . . They're authoritative [doctors], and they've got a role. They're very clearly the leaders on the unit, . . . and . . . they appear to us to be conducting themselves in a way they feel is suitable for them, not really about the patients, not collaboratively working with us. That always has a trickle-down effect I think, on the way, because it's like parents and children: If mom and dad don't do it, why should I, you know? And so I think that it becomes part of the culture unit, and then the expectations become lower and lower. (P7)

### **Leadership.**

The second overarching theme to best illustrate the environmental factors influencing nurses' decisions to leave a clinical practice setting was leadership. As noted previously, leaders were described by participants as individuals who held leadership positions at the point-of-care (e.g., frontline leadership), primarily as the nurse manager,

patient care coordinator, or clinical nurse leader (e.g., charge nurse). To a lesser extent, clinical nurse educators were mentioned by some participants, but they were not considered as influential in impacting perceived support as much as the aforementioned roles in this study. Leadership was further described as the practices and attitudes of these leaders that impacted the participants' capacities to do their work as well as leaders mentoring of new staff including new graduates. In some instances, the participants also identified leadership in the context of the interprofessional team, particularly concerning the practices and attitudes of physicians. To a lesser degree, participants identified other interprofessional team members who impacted patient support such as social workers, physiotherapists, occupational therapists, and clinical nurse specialists, all of whom provided leadership to some extent to participants' work. Their discussion of leadership did not include those point-of-care nurses who temporarily took charge nurse positions in their rotating shifts. To help illustrate the analysis of leadership as an influential environmental factor for nurses leaving, I created three subthemes that address the inherent complexity and diversity of the nurses' experiences. The first two themes speak directly to nursing leadership and the third highlights the challenges they experienced when physicians were deemed to avoid assuming leadership for patient care.

***Supportive nursing leadership.***

Some participants reported similarities in the degree of support exhibited in specific behaviours from frontline leaders, namely the nurse managers, charge nurses, physicians, and clinical nurse specialists. Some participants identified leadership qualities that illustrated supportive behaviours to help nurses manage work demands or expand their nursing practice. The description of such leaders were those who provided guidance

and direction for autonomous decision making, acknowledged nurses' contributions in the workplace, provided employees with the sense of being heard, used open and transparent communication to explain the rationale for denied requests, were present on the clinical unit during challenging situations, employed collaborative problem solving through difficult clinical or patient decisions, and encouraged professional development for expanded nursing practice. These supportive leadership behaviours enabled participants to speak up or step up to new opportunities, expand their nursing practice, look beyond immediate tasks at the bigger picture, develop professional goals, seek higher education, and experience greater job satisfaction. In reference to previous workplaces, a few participants acknowledged the presence of mentorship from a leader guided their professional development and provided confidence to take new opportunities. Support from a unit manager empowered one participant to leave her clinical practice setting to accept a new challenge in an expanded nursing role:

It was my manager . . . she wasn't my formal mentor . . . it was her leadership style that I was really impressed with because I knew it was a difficult position to be in. I felt like because she managed to always keep sort of neutral and just do things fairly, like, the right way. I was really impressed. I watched what she did. . . . She would always tell me about opportunities, and she would always encourage me. (P12)

A few participants identified leaders' supportive behaviours to be conditional in some situations. These participants were able to seek guidance from a manager for unit-specific issues, but lacked the freedom to openly discuss negative feedback from staff or conflicts on the unit. This experience left participants with a sense of inhibition and an

inability to be honest and transparent in voicing concerns and struggles to address unit challenges. Some participants expressed performance expectations were high, and attempts to maintain these could be draining, especially when leaders discouraged team members from sharing concerns or struggles. One participant explained, “My manager was quite supportive, somebody that you go to talk about just about anything. Very positive individual but on the downside to that didn’t like to hear anything negative, so you have to be positive” (P2).

***Leadership gaps and oversights.***

In addition to the conditional nature of some leadership practices described previously, the participants also described situations in which leaders’ practices were deemed unsupportive or in some cases absent altogether. These gaps in leadership practice were described as being physically absent in the clinical setting, not listening to nurses’, and contributing to nurses’ feeling undervalued and under acknowledged for their contributions to patient care and unit functioning. Nurses described these behaviours as being “unsupportive” and often associated such behaviours with those in nurse manager and charge nurse leadership roles. The participants described these leaders’ behaviours as hurtful and demoralizing and expressed that these feelings were exacerbated by the fact that participants provided dedicated and committed patient care in everyday practice and through often difficult and challenging situations. These experiences are illustrated in the following excerpt:

Sometimes you just want people to say that you did the best you could do with the circumstances and not be told, “You could have done this, [and] you should have done this,” because you’re already beating yourself up, feeling you failed



anyways. But then you have someone in management tell you that you still didn't do it good enough, and criticism and questioning. That's a big thing, is always been questioned, and knowing I'm pretty 100% in there . . . because that's my work ethic, I do 100%. I don't slack off. I don't. I always do the most I can, and that's hard . . . so a long time coming, I was thinking of leaving, but really feeling like I didn't want to leave them [peers] behind, abandon them. (P8)

Participants were perplexed as to why their leaders' behaviours were unsupportive and questioned how their own behaviours may have contributed to this situation. These nurses expressed losing self-confidence and self-esteem in their roles as a nurse. As demonstrated in the following excerpt, the nurses often reflected on these experiences and spoke of regret for not leaving sooner.

Very much feeling that there was no support, feeling that we weren't working as a team. I rarely met with my manager. She had no idea what I did, and feeling that the PCC [patient care coordinator] didn't work with me. So there was, it was a very unsupported position, and feeling incredibly undervalued. . . . I couldn't figure out . . . how I could've changed, because of my previous positions, I always was valued. . . . I used to go home and wonder what I was doing wrong and what I could do differently, and I just, nothing that I did made any difference. . . . I felt bad in myself, and I didn't feel [supported], even though staff told me I was doing a good job . . . but it was demoralizing, so I wish I'd just have left earlier and that I hadn't gone through that for the length of time because you do tend to internalize things and think it's you as opposed to the environment. . . . Definitely losing self-confidence and self-esteem. (P1)

## **Category II: Personal Factors**

As illustrated in the preceding discussion of the environmental factors associated with their workplaces, the participants experienced substantial feelings of stress, fatigue, burnout, and loss of self-worth. These experiences contributed to what they identified as very personal factors affecting their health and well-being and ultimately their decision to leave a particular practice setting to take another nursing position. The most substantial finding in relation to what I coded as personal factors concerned the nurses' experiences of health problems, some of which were life threatening. The nurses attributed these health concerns to the stress of their workplaces, the details of which are described below to illustrate how ongoing stress associated with their work impacted their personal health and mental well-being, with varying influence on their capacity to remain in their previous workplace.

Mental fatigue and burnout were the phrases nurses used most frequently to describe how they were feeling during the time just before they had decided to leave their clinical practice setting. Participants often attributed these feelings as being a direct result of their attempts to persevere in their job and to ignore the daily stress and challenges they experienced, which resulted in varying degrees of emotional or physical health issues. In addition to mental fatigue and burnout, nurses described experiencing anxiety attacks, insomnia, gastrointestinal disorders, skin inflammation, and cardiovascular symptoms; these health concerns were significant enough to force these nurses to stop and consider the impact their jobs were having on their personal health and well-being. Some participants' responses reflected a tone of defeat at finally admitting the demands in their previous workplace were too much for them.

In some instances, working nightshifts were identified as contributing to health issues for several of the participants. The participants described that over their years of experience they had developed strategies to manage nightshifts; however, working nightshifts over extended periods caused physical fatigue, exhaustion, sleeping disorders, and digestive problems. Some participants reported they started to take prescription medication to manage their symptoms so they could continue with their personal and work demands. Some of the nurses further identified that the stress of night shift work was compounded by the workload demands that were ever increasing in their work environments. When asked how their shifts affected personal health, one participant explained how the compounding stress with the effects of night shift work on her health influenced her decision to leave:

It's long, it's very long and exhausting when you're running like for the 11 hours and 45 minutes; there's no down time. Everything is so rushed in that situation. Nights, there was a time where one of my coworkers preferred nights, so I would do the three days and one night . . . so we would trade and that was fine. When she left and we didn't have our little deal going, I had to go back on medication for my indigestion that I got every day from the shift work and medication for sleeping after my night shift. (P8)

It is important to note that these health issues were not isolated to those working nightshifts, as participants who primarily worked day shifts also experienced health complications. For many who experienced these health issues, their health challenges persisted over time, and these participants could no longer ignore their symptoms. For some, their psychological well-being deteriorated, as they experienced anxiety, mood

swings, feelings of self-doubt, loss of self-esteem or self-confidence, depression, and moral distress. Other participants, both those in point-of-care and frontline leadership roles, expressed that they could no longer cope when physical health problems impacted their ability to function.

Participants' means of coming to the final decision that their personal and mental well-being was significantly impacted varied for those affected. For a few participants, their burnout impacted their well-being enough that they recognized they could not carry on in their previous nursing role, and this influenced their final decision to look for alternate work in nursing. Those who experienced personal health challenges reflected how frightening it was to reach the point where they could not "suck it up" any longer, and their loss in mental and physical well-being triggered their decision to leave. Many participants found this especially challenging given their sense of pride in their years of nursing experience. One participant shared how her health challenges affected her, thereby leading her to leave her clinical practice:

I eat well, I exercise, not as much as I could, but it was a real shocker, I wasn't expecting that. And at that point, I decided to jettison all the stress in my life and do an about-face and decided I needed to get off shift work. (P3)

When asked if her personal health led to her decision to leave, this participant went on to say,

I think really it was the stress of the job and the night shifts that was really the deciding factor. And part of the health . . . and stress is how the nightshifts and shift work affects my home life and my kids most importantly. . . . That's when I decided I had to make a change and do something different . . . and just

cumulatively all the stresses at work, there wasn't any one particular thing, but my health was sort of a trigger for it all. (P3)

All participants admitted to high levels of stress in their previous nursing positions, which resulted in health issues for many, significant enough to impact some participants' decision to leave previous clinical practice settings. Psychological and physical symptoms were significant enough for many participants who experienced health issues that they required prescription medication to cope and manage work responsibilities. For those with health issues, their symptoms escalated to a stage that they were incapable of performing their job duties any longer. Some participants reported a sense of defeat with succumbing to the end of their job in their previous clinical practice setting due to health issues.

### **Category III: Decision-Making Processes**

In addition to describing the environmental and personal factors that influenced their decisions to leave one clinical practice setting and take another nursing position, the participants recounted what their decision-making processes entailed. They described when they began to consider leaving, how long it took to make this decision, and the processes they went through in making their final decision. The length of time of the entire process, from initial thoughts of leaving to the actual decision, varied between 6 months to 2 years with the exception of one participant who described a 4-year process. The nurses varied in the steps they undertook in this process. However, they all described that their initial thoughts of leaving began with their frustration of trying to juggle multiple, conflicting, and increased work demands; unsupportive leadership practices; poor collegial relationships; and the ultimate effects these had for their sense of self-

esteem in job performance. Participants admitted they began to consider that, in light of these factors, they were unable to perform their role to their professional and personal standards.

Participants shared that their initial decision-making processes began with actively considering the benefits and positive aspects of their work and comparing what they valued in their work to their negative experiences. Many participants reflected on aspects of their jobs that gave them substantial satisfaction and a positive view, such as supportive working relationships, friends they had made at work who they described as their family, a sense of belonging, the nature of the job in nursing, having regular work or hours suitable to their lifestyle, the stimulating environment in which they felt challenged, and a sense of purpose or contribution to patient outcomes. However, most participants found the compounding stress and demands ultimately impacted their mental or physical well-being, and they gradually decided that they could not continue in their jobs. All but one participant suggested the varying degrees of stress outweighed the positive and satisfying components of the job, and they began thinking of the next stage in their careers.

At this stage of moving forward in their decision-making process to leave, many participants discussed talking to trusted family members, spouses, or friends, which helped them to determine a course of action. A few participants indicated that significant support persons had recognized their state of unhappiness and how it was affecting their personal lives, including, for some, their role as a parent. All participants described how they began to inquire about other job opportunities in nursing that they would find more suitable and would align more with their areas of strengths, passions, professional

standards, and desire for a healthier lifestyle. For some participants, the prospect of moving to another job in which they could become enthusiastic about potential professional prospects incited their processes to seek professional development through education. Word of mouth for promotional opportunities kindled interest for a few participants, and they considered leaving their previous job, stating the unknown territory of a new position was more attractive than staying. Job displacements occurred for a few participants who were already thinking of leaving, and the resulting loss of hours and job security was the final push to proceed with professional development including continuing education or a job promotion. The process of reflection of weighing the security of their workplace with the unfamiliar future of a new job was challenging for many participants, and these factors kept these nurses in their clinical positions through this stage of decision making. One participant shared what it was like for her:

That was challenging. I wasn't really talking to ton of people about it. I was mostly just talking to my husband at home. . . . It's really, "What do you think is going to work for you?" And, you know, weighing what you have against what might be out there, and it's hard. It's hard to go to a different site and a different job. . . . It's hard to give up everything [and] to start from scratch, so it's a lot of weighing the pros and cons. Yeah a lot of weighing. (P2)

When asked what prompted their decision to leave, most participants expressed that "there came a point at which it was a time to leave" (P3). For a few participants, significant events either with family, work-related situations, or personal health crises occurred, which materialized as the triggering events that finalized their decision to leave. Some participants reported that they had "ignored the warning signs from mental fatigue

and burnout, and they experienced significant physical symptoms” (P8), which prevented them from working or resulted in participants taking sick time or leaves from work. It was at this point, when they were physically unable to persevere in their role, that these participants accepted they could no longer continue in their previous workplace, and they finally made the decision to leave.

Participants’ interviews were interjected with statements of sadness and grief when sharing their stories and experiences in their decision-making processes to leave. All participants experienced a sense of loss in their purpose professionally in contemplating leaving their previous clinical practice position. It was not easy for anyone to leave their positions, as demonstrated in their need for time (6 months or more) to deliberate what would be best for them. Participants who experienced significant impact to personal, physical, and mental well-being had varying degrees of sadness at succumbing to health challenges, but also experienced a sense of relief to leave stress behind and possibility to regain personal well-being. Participants who believed they were leaving good friends in their previous workplaces expressed guilt and lingering sadness that they were betraying loyalties in leaving. Participants who experienced triggering events, such as physical or mental health challenges directly related to their previous job, expressed a tone of sadness for their loss in their role, and to some degree, a sense of defeat in deciding to leave.

### **Summary**

A total of 12 participants shared stories in their previous workplaces, offering varying perspectives of their previous setting and their experiences in nursing practice, frequently highlighting their role as a resource to new nurses, support to the unit during



clinical challenges to varying degrees, and an advocate for patient care. Participants all experienced stress in their previous clinical practice settings from environmental factors within their workplace environment, oversights in effective leadership practices particularly by nurse managers, and unsupportive working relationship among nurses and physicians. Participants identified these stress factors affected their sense of security, ability to do their jobs, and levels of confidence and self-assurance. Personal factors were identified to influence health issues for participants. Some experienced health challenges as a direct result of trying to manage stress from the environmental factors and working to balance health and mental well-being, which participants identified as significant reasons in their decisions to leave. Other participants, while struggling with burnout due to prolonged psychological stressors, experienced a triggering event that was a momentous final contributor in their decision to leave. All participants expressed some degree of guilt and sadness embedded with the various factors, which was greater for those who left friends behind or had physical limitations that prevented them from returning to work. The decision to leave previous clinical practice settings was not easy for these resilient and determined experienced participants.

## **Chapter Five: Discussion and Recommendations**

In this chapter, I discuss the contributions of this study in developing an understanding of why experienced nurses choose to leave their current clinical practice setting to go to another nursing position, and I offer empirically informed recommendations for retention. As noted in Chapter 1, the objectives of the study were to explore environmental and personal factors that influenced experienced nurses to leave clinical practice settings for another nursing position and to understand their decision-making processes. The experienced nurses who participated shared their experiences within clinical practice settings, what they found challenging, and how these issues influenced their initial thoughts about leaving and their final decisions. The participants described undergoing experiences of contemplation and uncertainty in their final 6 months at their workplaces, at which point they compared and contrasted the factors they valued and found satisfying in their previous workplace with their negative experiences. There has been minimal research that has examined experienced nurses' decision-making processes concerning leaving their workplaces, and my hope in conducting this study was to discover the factors that influenced thoughts of leaving, and subsequently their final decisions to leave. These new insights may help to inform healthcare organizations' strategies to address experienced nurses' concerns as a means to retain their expertise in clinical practice. I close this chapter with recommendations for strategies to retain the vital resources of experienced nurses in clinical practice.

### **Discussion**

In this section I discuss the study findings within the context of current knowledge about the topic area, highlighting new and similar findings from previous

research. To aid in presenting this information, I organized the material into three interrelated subtopics that mirror the key aspects of the analysis: (a) nurses' experiences of the workplace environment, (b) leadership, (c) and impact of the environmental context of work for nurses' health and personal well-being.

### **Workplace environment.**

Similar to the findings in this study, other research concerned with nurses' experiences in practice found workplace environmental factors involved higher patient acuity, increasing workload demands, poor professional working relationships, and unsupportive leadership practices (Chiarella & McInnes, 2008; Duffield et al., 2011; El-Jardali et al., 2009; Griffiths, 2009; Larrabee et al., 2003; Leurer et al., 2007; Needleman et al., 2002; Roberge, 2009; Zeytinoglu et al., 2007). This study illustrated that those nurses with years of experience, as demonstrated in the literature, managed conflicting workplace environmental challenges and adopted leadership roles when they observed patient care to be at risk, offering their support and guidance to novice nurses in their care for sicker and more unstable patients (Griffiths, 2009; Needleman et al., 2002; Zeytinoglu et al., 2007). Although nurses enjoyed supporting newer nurses and taking on these leadership roles, over the long term these compounding demands left nurses drained and exhausted, as was also reported in the literature (Griffiths, 2009; Needleman et al., 2002; Zeytinoglu et al., 2007). Additionally, most participants in this study reported feeling overwhelmed and overextended in their daily workload and expressed dissatisfaction with the quality of work either directly to patients or in their leadership roles, which again paralleled other research findings (Chiarella & McInnes, 2008; Duffield et al., 2011; Dunn et al., 2005; Erenstein & McCaffrey, 2007; Estabrooks et al., 2002; O'Brien-Pallas

et al., 2006; Sherman & Pross, 2010). Although my findings were congruent with the literature, I have expanded the scope of our understanding of how these factors were described by the participants as challenges in the workplace, and influenced their decisions to leave.

Similar to the literature, working relationships were greatly impacted by the degree of peer support experienced; the extent to which peer support was present or absent was a crucial element in empowerment to meet job demands, job satisfaction, and the decision to leave previous workplaces (Erenstein & McCaffrey, 2007; Sherman & Pross, 2010). One of the main contributions of this study was the discovery of how influential working relationships were in nurses' decisions to leave clinical practice setting when ongoing disengaged working relationships existed among peers on the unit; poor working relationships aggravated nurses' discontent and provoked thoughts of leaving, especially with increased work demands and greater critical events in patient care.

Participants who experienced positive working relationships in their previous clinical practice settings or leadership teams attributed collaborative practice as a factor that influenced them to remain in their positions, as they were confident their peer support would equip them to manage the inevitable workplace stress and job demands, which was similar to findings from the literature (Erenstein & McCaffrey, 2007; Grafton et al., 2010; Larrabee et al., 2003; Laschinger, Finegan, et al., 2001; O'Brien-Pallas et al., 2006; Parry, 2008; Sherman & Pross, 2010; Stordeur et al., 2006; Zeytinoglu et al., 2007). When poor working relationships were experienced, nurses reacted with thoughts of leaving and subsequently left due to poor collegiality among team members. As was

found in the literature (e.g., Chiarella & McInnes, 2008; Duffield et al., 2011; Dunn et al., 2005; Erenstein & McCaffrey, 2007), the study demonstrated that when incohesive working relationships were experienced, especially with high patient acuity, increased job demands, and clinical expectations, participants reported declining unit morale and a disconnect among team members including situations in which peers refused to help one another. In this study, for those who experienced this situation, regardless of their role as point-of-care nurse or frontline leader, the participants expressed a sense of helplessness and defeat that they were powerless to impact change or improve the situation to address concerns regarding collaborative practice, which increased their frustration and job dissatisfaction and resulted in apathy and their eventual decision to leave.

The perspectives of the experienced nurse participants in this study provided a more in-depth insight of the significance that the state of the working relationship has on nurses' workloads, unit morale, and group cohesion, which were all contributing factors shown to lead to turnover. Acknowledging the impact that poor collegiality among individuals from ineffective working relationships has on nurses' empowerment and examining how this situation has triggered nurses to leave clinical practice settings is crucial if we wish to retain these valuable resources. Addressing the type of working relationships operating in clinical practice settings may be a key point for nurse managers to intervene to enhance nurses' empowerment to manage increased work demands during highly critical periods. In gaining the experienced nurses' perspectives on this factor, nurse managers could address reasons for lack of teamwork, identify obstacles to collaborative working relationships, and improve team-building strategies at the unit

level to enhance retention. Greater support for managers on creating effective teams would also support nurse retention.

### **Leadership.**

As has been reported in other research (e.g., Duffield et al., 2011; El-Jardali et al., 2009; Larrabee et al., 2003), perceived oversights in leadership support for nursing practice and patient care influenced nurses' decision making and turnover. Absence in daily practice, lack of acknowledgement for nursing staff, being dismissive, poor communication, or lack of collaboration with direct patient care were commonly noted oversights in leadership. These factors contributed to nurses' increased stress, job dissatisfaction, reduced capacity for work, and ultimately decisions to leave clinical practice settings, findings that are congruent with other research concerned with nursing turnover (Duffield et al., 2011; El-Jardali et al., 2009; Larrabee et al., 2003). Nurses expressed that when any of these behaviours were experienced from their leaders, especially in highly critical situations, nurses construed these as a lack of valuing their contributions to the workplace.

In alignment with the literature, nurses expressed frustration when inhibited in relaying clinical concerns to frontline leadership or physicians, and when they were not acknowledged, they described this as demoralizing (El-Jardali et al., 2009; Leurer et al., 2007; O'Brien-Pallas et al., 2006). Discontent in the quality of interactions occurred when leadership discouraged transparency or open communication, which participants reported as obstacles to sharing their concerns and further contributed to nurses' beliefs they were not acknowledged.

In addition to corroborating current evidence concerning leadership and turnover, this study contributed to a furthered understanding of leadership and turnover in two distinct ways. Unlike other studies, leadership was explored less as a dichotomy of present or absent, but as a series of practices that varied depending on the context of the issue and the people involved. Participants simultaneously acknowledged that leaders could have both strengths and weaknesses, and it was the degree of oversight that was experienced as a lack of support for excellence in patient care that ultimately affected nurses' decisions to leave.

### **Impact for health and well-being.**

One of the most critical findings of the study was the impact that personal factors had for the participants' health and mental well-being, with many reporting health issues in their final period at their previous clinical practice settings. All nurses experienced stress, which directly impacted many who developed health issues from ongoing stress, with some requiring prescription medications to cope with the stress, health challenges, and demands of the clinical practice setting. The significance this had for nurses was illustrated in their susceptibility and inability to balance long-term stress and nightshifts, observed with struggles in physical, psychological, and personal well-being, which was also well documented in the literature (Berger & Hobbs, 2005; Elpern et al., 2005; Epp, 2012; Lo et al., 2009; Nasrabadi et al., 2009; Ulas et al., 2012).

These findings were similar to what has been reported in the literature, that challenges to physical health impede nurses' capacity to manage workload demands and patient care. Nurses who experience deteriorating health may require increased sick time and be absent from work, thereby contributing to short staffing. These nurses will

ultimately have a reduced ability to carry out work duties over the long term. In a small qualitative study, 18 RNs who worked a minimum of 5 years of night shifts reported fatigue, changes to skin, changes to physical appearance, nervousness, diet imbalances with gastrointestinal problems, and a higher prevalence of being unhealthy (Nasrabadi et al., 2009). In addition to these physiological effects, a Taiwanese quantitative study found extended periods of night shifts to be associated with cardiovascular-related events and complications leading to morbidity and mortality (Lo et al., 2009). Findings from Lo et al.'s (2009) 3-month study demonstrated that the 18 participants (median age 27 years) who worked nightshifts had significantly higher systolic blood pressure (9.7 mm Hg) than those working dayshifts. A delayed recovery of vascular stress after a night shift was seen to be associated with increased fluctuation in autonomic modulation in the short term, with greater incidences of cardiovascular events and disease over the long term (Lo et al., 2009). Examining the extent of the issues for nurses who have worked extended hours and nightshifts may provide an explanation for their decisions to leave their previous clinical workplaces.

Consistent to the literature, participants reported shift work had a negative effect on their physiological health (Berger & Hobbs, 2005; Nasrabadi et al., 2009). To cope with the lack of sleep, function during daytime activities, and meet workload demands, studies found nurses show poorer eating habits such as drinking more coffee, increased cola intake, altered eating patterns, and taking nonprescription gastrointestinal and bowel medications (Berger & Hobbs, 2005). Although the caffeine can aid in feelings of alertness, it can have the side effect of delayed sleep onset and can induce sleep disturbances (Berger & Hobbs, 2005). Further studies also found that for those who did



shift work, their alcohol and sleeping medication intake increased as a means of adapting to alternating sleep hours (Berger & Hobbs, 2005). For individuals working shift work, night-time eating was associated with higher triglyceride and glucose levels, which may negatively impact carbohydrate tolerance (Berger & Hobbs, 2005). Nurses with unhealthy coping habits, such as aforementioned habits to stay awake and fall asleep, who work rotating shifts of 3 nights per month for 15 years have higher risks of other serious health issues such as colorectal cancer (Berger & Hobbs, 2005). Data confirmed adaptation to the aforementioned physical effects of night shift work occurs, particularly if shift workers adopt longer sleeping periods after night shifts and maintain a healthy diet (Berger & Hobbs, 2005). Further exploration on how personal factors impact nurses who work shift work and their decision to leave clinical practice may offer insight into the extent shift work effects nurses and their decisions to leave in order to restore personal health and emotional well-being.

However, unlike the research conducted thus far, the findings from this study illustrated that these stressors were not limited to night shifts. Nurse participants also reported long-term stress in their day jobs that contributed deterioration in their personal health to the point at which they could no longer ignore health symptoms, with some reporting that they could not function without prescription medications to manage regular stress. Declines in personal health and mental well-being from ongoing stress and lack of support resulted in reports of moral distress, burnout, and exhaustion for many in the study; these findings were also noted in the literature (Blakeley & Ribeiro, 2008; Jourdain & Chênevert, 2010; MacKusick & Minick, 2010; Stordeur et al., 2006). Although the results of this study must be interpreted cautiously due to the small sample

size, the descriptive study design, and the nature of the interview questions, there was an apparent positive relationship between the length of time in clinical practice and the reported intensity of personal and mental health deterioration, which is a concern that has gained increasing attention in the nursing literature (Berger & Hobbs, 2005; Elpern et al., 2005; Epp, 2012; Lo et al., 2009; Nasrabadi et al., 2009; Ulas et al., 2012). In the current study, it was apparent that nurses' health was severely impacted, illustrating an urgent need for further study to limit the devastating health effects of negative or stressful workplace environments.

The study identified nurses' decision-making processes when leaving previous clinical practice settings. This component of decision making in turnover was not yet explored in the literature, so a new perspective of what experienced nurses encountered in this journey was brought to light. Nurses expressed thoughts of leaving were generated by environmental or personal factors within their previous workplace, which they found stressful or dissatisfying in their nursing practice. Factors such as high patient acuity, increased workload, ineffective working relationships, and gaps in supportive leadership behaviours contributed to nurses' thoughts of leaving; nurses' decisions could be influenced by a significant stressor alone or in response to these accumulative factors. For many, stress contributed to health issues that imposed restrictions, incapacitating them and deeming them incapable of meeting work responsibilities. For some participants, triggering events occurred that, when combined with other environmental or personal factors, became the final contributor to nurses making the decision to leave. Their decision to leave was not spontaneous; rather, all participants required an extended time frame to make the final decision, spanning 6 months to 2 years. This extended time frame

suggests possible points of intervention to address nurses' concerns and potentially alter their final decision to leave. During this period of contemplation, this may be an opportune time for experienced nurses to expand current coping strategies to equip them in challenging situations, as highlighted in the study. Furthermore, nursing leadership may also intervene at this pivotal point in experienced nurses' contemplation of leaving, to provide supportive leadership behaviours to acknowledge nurses' value and strive to retain their expertise in clinical practice settings. Further research is needed to explore if how nurses make personal decisions differs from how they make clinical decisions, which was explored by the literature (Aitken, 2003; Ajzen, 2002; Pritchard, 2006; Rew, 2000).

### **Recommendations**

Although healthcare organizations have identified the need to recruit and retain nurses, the strategies employed have not been sufficient to sustain adequate nurses to meet staffing replacements needs for current healthcare demands (Zeytinoglu et al., 2007). Justifiably, international healthcare forums such as Economic Cooperation and Development and World Health Organization have prioritized addressing the reasons for nursing shortages and identifying how to manage this alarming situation (Duffield et al., 2011; El-Jardali et al., 2009; Roberge, 2009; Zeytinoglu et al., 2007). In an attempt to produce more RNs, the Government of British Columbia has increased seats in nursing schools; however, it will take time before these new graduates transition from novice to competent nurses in the workplace to address the complex needs of higher acuity levels in patient populations (Thai & Marcus, 2013). Furthermore, earlier research by Blakeley and Ribeiro (2008) found that increasing the enrolment into nursing education was used

as a main approach to recruit nurses; however, there was no guarantee that the younger nurses will stay within the current employment or the profession. The current trend suggests that these novice nurses will leave clinical practice to clinical specialities or leave the country in which they received their education (Blakeley & Ribeiro, 2008). The accumulations of stressors already identified are known to make the nursing profession a less attractive career choice and to significantly increase turnover rates (Lu et al., 2012; Zeytinoglu et al., 2006, 2007). Currently, no experimental studies exist that test retention interventions to determine best practices in this area.

Drawing from the study findings and related empirical literature, I derived three recommendations to regain the vital resources of experienced nurses in clinical practice settings. These recommendations are to (a) promote interprofessional collaborative practice, (b) enhance leadership capacity for supportive behaviours, and (c) address nurses' stressors to promote health and mental well-being.

**Promote interprofessional collaborative practice.**

Ineffective working relationships within healthcare teams are a significant issue that must be addressed, as noted by its impact to experienced nurses' decisions to leave their workplace. Researchers have reported that collaborative practice and effective working relationships promote healthy workplace environments (Sherman & Pross, 2010). Collaborative working relationships are important to creating work environments that foster teamwork to support the retention of nurses and other team members in clinical practice settings. A web-based questionnaire conducted with 303 middle-aged nurses (median age 42.4 years old) demonstrated that when nurses experienced social supports from coworkers, they experienced decreased stress in the workplace, increased

job performance, and greater job satisfaction, all of which promote retention (Erenstein & McCaffrey, 2007). Promoting strong working relationships, in which staff members openly communicate and support each other in day-to-day work demands, is viewed as a key component to building and sustaining a healthy workplace (Sherman & Pross, 2010). Striving for collaborative working relationships requires trust among team members; as the infamous baseball coach Casey Stengel (as cited in Sherman & Pross, 2010) stated, “Finding good players is easy. Getting them to play as team is another story” (p. 7). In summary, effective working relationships among nurses is an important factor in the retention of nurses.

My first recommendation is to alert health organizations to the potential opportunity to intervene and address issues with poor collaborative practice at the unit level by sharing these research findings and literature on impact of poor working relationships on turnover with professional practice and human resource departments. I recommend health organizations access resources such as the *Developing and Sustaining Nursing Leadership Best Practice Guideline* (Registered Nurses’ Association of Ontario, 2013), which offers recommendations to improve interprofessional collaborative practice. Emphasizing and prioritizing collaborative working relationships and collegial teamwork for respectful workplaces with team-building strategies at the unit level may improve team morale, unit culture, and retention. Thai and Marcus (2013) discussed beneficial refreshers on effective and applicable team-building strategies; these approaches need to be reevaluated with these findings and revised to match current workplace demands. Current retention strategies need to be evaluated to ensure they target the unique and

growing complexity of the experienced nurse in the clinical practice settings and address daily practice issues.

For interprofessional support, the executive leadership is advised to build capacity to promote daily presence of unit managers and physicians to increase key leadership members' visibility at the unit level, address concerns, and alleviate feelings of helplessness in influencing improvement. The unit manager's immediate attention to problems and the daily presence on the unit could provide management and leadership opportunities to coach others through challenging situations, mentor or model collaborative practice with frontline leadership teams, and address daily issues to improve workplaces. Daily expectations for collaborative practice at all levels of staff could create a shared unit responsibility so that all staff are accountable to contribute to a cohesive and collaborative team, influence workplace culture, and move toward a healthy workplace.

Nurses can seek professional support through resources within their health authority to develop coping techniques in stressful situations. Further education on communication and conflict resolution skills may empower nurses to have difficult conversations and cope with challenging situations. Furthermore, nurses may need support and coaching in addressing conflict in the clinical practice setting in a respectful and productive manner.

Physicians should be accountable for their lack of patient input. Nurses should be encouraged to utilize existing patient reporting systems to report lack of physician response in critical or deteriorating patient situations to encourage follow up to address these gaps in timely patient care. These processes are a means to address potential or actual errors, learn from mistakes, and correct and prevent future mistakes.

### **Enhance leadership capacity for supportive behaviours.**

The second recommendation is to address gaps in supportive leadership behaviours, as highlighted in this study. Recognizing the significance of these gaps in supportive behaviours from leadership, either through their absence physically or emotionally, in daily practice on experienced nurses was demonstrated to substantially impact nurses and their decisions to leave clinical practice. I recommend a review of leadership development strategies, which was supported by Thai and Marcus' (2013) report titled *Looking Forward: Our People Demographics and Forecast for Future Needs*. In their report, Thai and Marcus analyzed turnover projections among healthcare members and subsequent recruitment needs to match delivery of healthcare services. They also examined challenges and accomplishments in retaining staff in an attempt to support the healthcare needs of the population they serve (Thai & Marcus, 2013). The authors identified that the greatest challenge in nursing, or the most “difficult to fill positions” (Thai & Marcus, 2013, p. 19), are in speciality nursing, such as critical care—a role that requires more advanced nursing skills and applicable knowledge to manage more complex patient populations. To evaluate how to revise current strategies to reflect experienced nurses' insights and address what may be missing in these strategies to retain experienced nurses, I suggest healthcare leadership review this document, or ones such as this, to take into account the perspectives of experienced nurses and what these nurses have identified as most influential in contributing to leaving their previous workplaces. Editing and updating leadership development programs with new information about supportive behaviours and actions of staff may also provide an opportunity to apply new

retention strategies that target the concerns expressed by experienced nurses in what was most influential in their leaving.

Promoting a supportive culture and acknowledging the voice of the nurse is another important element of effective leadership to promote job satisfaction and subsequently minimize turnover (El-Jardali et al., 2009). Supportive strategies aimed at enhancing empowerment by providing opportunities for active participation in decision-making processes, job autonomy, empowerment strategies, collaboration with physicians, and promoting a sense of hardiness would contribute to greater degrees of job satisfaction (Larrabee et al., 2003; Laschinger, Finegan, et al., 2001; O'Brien-Pallas et al., 2006). Currently, these could be enhanced by the manager orientation provided and the interprofessional collaborative practice workshop facilitated by the Professional Practice department. As well, managers embracing the practice council network philosophy would further facilitate improvements in the workplace environment.

A systematic review of the literature illustrated that incorporating transformational leadership styles contributes to a supportive and healthy environment in hospitals and is associated with enhanced nurse retention (O'Brien-Pallas et al., 2006; Weberg, 2010). Such leadership styles have been recognized in American's Magnet designated hospitals, widely studied for their healthy work environments. These hospitals have adopted transformational styles as their gold standard for leadership in their administrative and operations structure (Erenstein & McCaffrey, 2007; O'Brien-Pallas et al., 2006; Sherman & Pross, 2010; Upenieks, 2003). Although these hospitals are structured differently from those within the Canadian health system, the benefits of transformational leadership apply to nursing leadership in Canada. Approaches involving



empowerment strategies, supporting a shared vision, self-governance, and promoting professional development for improvement of the team provide the guiding principles, which may address the unsupportive behaviours of leadership experienced by nurses in this study (Sherman & Pross, 2010; Upenieks, 2003; Weberg, 2010). Overall, the research illustrated that transformational leadership is related to the retention of nurses (Laschinger, Finegan, et al., 2001; Sherman & Pross, 2010; Weberg, 2010). If healthcare organizations could take some of these lessons and incorporate those that enhance supportive leadership capacity through current leadership development programs, leaders may be able to reemphasize key behaviours identified to be missing in the study.

I also recommend that healthcare leaders review leadership development programs (such as Leading for Engagement and Clear Leadership, currently employed by the western Canadian urban health authority) to assess alignment in demonstrating leadership behaviours that support retention. Increasing nurse managers' time to be present in daily clinical practice, acknowledgement of nurses' contributions, collaborative practice, and the coaching of nurses through heightened periods of stress or clinical crisis may help to address some of the gaps of supportive leadership behaviours found in this study. Epp (2012) identified the nurse manager as having an important role in ensuring support is experienced during clinical practice and periods of high stress, which was found to be key in prevention and management of burnout among nurses, a factor found to lead to turnover. Another key area for senior executives to examine would be the clinical program management structure, which requires managers to lead multiple clinical practice settings in different locations, minimizing managers' presence.

This study illustrated the need to emphasize and prioritize the importance of supportive leadership behaviours in promoting healthy workplaces and retention of experienced nurses. Healthcare organizations currently promote leadership development (Thai & Marcus, 2013); in addition to this, evaluating the effectiveness of this training in practice and the ability for managers to be present may expand capacity for those in influential leadership roles, primarily nurse managers and physicians. Furthermore, healthcare organizations may wish to establish nonnegotiable daily rounds for frontline and physician leadership to be present on clinical units, use open communication to address patient and clinical concerns of point-of-care and charge nurses, and recognize efforts and contributions of experienced participants to the workplace. The literature noted the significance of transformational leadership qualities (O'Brien-Pallas et al., 2006; Weberg, 2010); similarly, this study demonstrated the impact its absence had on nurses' decision-making processes to leave. Increasing supportive leadership behaviours, identified as valuable to experienced nurses, may be one small but significant strategy, to directly influence nurses' capacity to provide safe and ethical patient care and manage increased work demands and stress, thereby increasing retention in the workplace. Reviewing and integrating effective behaviours of transformational leadership is valuable, as it could have a transformative power in the workplace to foster a healthy workplace and empower experienced nurses. To achieve this, managers need to work with their frontline leaders to support a team-based care model to focus on the patient needs.

### **Address nurses' stressors to promote well-being.**

The final recommendation is to address the impact that personal factors have on experienced nurses' health. One must question what nursing, as a profession, is doing to the health of nurses over the long term. Further research is needed to address the long-term impact of working in clinical practice settings on nurses' personal health, and healthcare leaders must take notice and address how the profession of nursing is impacting experienced nurses in the current healthcare climate. The study found that long-term stress impacted personal health detrimentally and poor work-life balance, not only those working night shifts, but also to those who worked primarily day shifts; these are new findings to current literature. The current literature did not speak to the impact of stress and adverse health outcomes for experienced nurses who work only day shifts (Berger & Hobbs, 2005; Lo et al., 2009; Nasrabadi et al., 2009).

Promoting wellness through education on self-care and programs to enhance healthy lifestyles and stress management to improve and sustain the personal well-being of experienced nurses are crucial to honour these nurses after years of committed practice. Possible endorsements for stress relief programs include encouraging nurses to utilize the existing health benefits within the organization such as massage, counselling, the facility's gym or partner with community gyms for reduced monthly rates, and offering one free dietary consult or exercise training with new gym passes. Expanding existing leadership competencies in point-of-care nurses and frontline leadership development (Thai & Marcus, 2013) with incorporation of stress management, resiliency training, and coaching sessions to integrate new or modify ineffective skills would help to support and empower experienced nurses' to manage increased job demands and stress.

These practical skills may help nurses use self-reflection with feasible coping strategies to deal with daily demands and recognized organizational stressors, develop healthy boundaries to preserve their own well-being, and enable them to work to their fullest capacity.

Strengthening the role of workplace health in nursing practice may be beneficial as a resource to manage stress and promote coping strategies. Exploring how current workplace health could have more input to daily nursing practice for experienced nurses may alleviate stress and its effects on the experienced nurses. This resource may be overlooked in the current climate of clinical practice, which presents an opportunity to maximize this resource within clinical practice in order to retain experienced nurses.

Promoting professional opportunities in these experienced nurses for transference of knowledge would help to share this wealth of applicable knowledge and mentor newer generations of nurses. Expanding on current mentorship programs, such as Employed Student Nurse and New Graduate Programs, by embedding recognition practices for experienced nurses for their contributions to support the newer generation of nurses may also help to retain experienced nurses. Leaders are encouraged to reward nurses' efforts with possible continuing leadership development, stress management, resiliency education, supporting individual learning needs, professional development, and by giving back to them (Thai & Marcus, 2013). One example of this is the employee recognition program that is underway in the western Canadian urban health authority. Conducting a survey for what experienced nurses would want to feel valued and acknowledged for their contributions may help align current retention strategies to address experienced nurses' concerns.

## **Limitations**

Significant findings were uncovered in this inquiry, but further research is needed to examine the extent of these findings in experienced nurses' perspectives. Although the sample was taken from one urban and one rural acute care facility, the sample size was small, which limited the perspectives to those in these regions. Only female nurses took part in this study, which limited the perspectives gathered in this study. The study's underrepresentation of male participants needs to be addressed; however, at the same, the study population was representative of the current nursing population, which has a female majority. Sample recruitment was obtained through snowballing; the interplay of obstacles resulting in the lack of male respondents who were willing to share their story is unknown. It needs to be considered if the lack of male participation may have shown different perspectives in identifying factors influential to nurses' decisions to leave previous workplaces.

## **Conclusion**

This study explored the contributing factors experienced nurses credited as influencing their decisions to leave their previous workplaces. Key findings indicated the effectiveness of working relationships among nurses and the degree of leadership supportive behaviours directly impact nurses' ability to manage workplace stressors such as high patient acuity, increased workload, and greater role expectations. With gaps in supportive leadership behaviours, nurses also experienced a high degree of stress that contributed to them leaving their previous jobs. For some participants, professional opportunities arose that enabled the nurses to leave their clinical practice settings. Other nurses strove to remain, but internalized the stress of their previous clinical practice

setting, and found this detrimental to their physical, emotional, and psychological well-being. For these nurses, recognition of the cost to their health or experiencing an unexpected health event and acknowledging their unhappiness triggered their eventual decision to leave their clinical practice settings. These nurses subsequently found more suitable nursing positions either in similar roles or expanded nursing roles.

I conducted this research to determine the environmental and personal contextual factors that influence experienced nurses in their decision to leave clinical practice settings and seek new employment in another nursing position. It is my hope that the findings and recommendations from this study enable healthcare leaders to promote collaborative practice, foster supportive leadership behaviours, and reduce nurses' workplace stressors in order to retain the wealth of skills and knowledge offered by experienced clinical practice nurses.

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## Appendix A: Letter of Request and Approval for Nurse Managers from Health

### Facility



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THE UNIVERSITY OF BRITISH COLUMBIA

The University of British Columbia  
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Vancouver, BC Canada V6T 2B5  
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Fax [fax number]

November 16, 2012

Project Title: Perceptions of the Experienced Nurse to What Influenced Their Decision to Leave Clinical Practice

Dear Nurse Manager,

Retention of the experienced, expert clinical nurse is significant as the evidence shows experienced nurses contribute to improving patient outcomes and guide newer nurses in managing complex work demands and higher acuity levels. As well they provide leadership within clinical practice which is particularly important when the healthcare system they work in is already stretched to the limits. With an older nursing workforce, experienced nurses opt for early retirement or leave clinical practice due to burnout. This leaves the remaining nurses with the loss of this valuable resource of expertise, knowledge and leadership that the experienced nurse gives.

We are conducting interviews with experienced nurses to address which factors influence their decision to leave acute care settings. The primary aim of the study is to gain understanding into (a) experienced nurses' perspectives about the factors that influenced their decision to leave their clinical practice (b) elements in their social, environmental and ideological constructs that influenced their decision to leave previous acute care workplaces. A gap in the literature exists in exploring the experienced nurse's perspective in Western Canadian acute care settings. Conducting this study would help to gain understanding of which factors influenced experienced nurses' decision to leave clinical practice. These findings may reveal undiscovered insights from their viewpoint. The data may be compared to current retention strategies to identify if these nurses' concerns are addressed and expose where the gaps may exist. Once gaps are identified, the data may assist in evaluating current retention strategies for future retention planning and provide an opportunity to revise strategies to target these issues.

As a part of the study, we are inviting experienced nurses with greater than four years experience in acute care hospitals to participate. Departure from their previous clinical practice within the last three years, and a minimal of two years experience in the previous setting is required to have familiarity of the nursing role and culture in which left. The study will be conducted in BC, and participants' involvement is voluntary and confidential.

This research study is part of Dana Hayward's Master of Science in Nursing thesis project. Face-to-face interviews will be lead by Dana and her supervisor Dr. Vicky



Bungay, a professor at the UBC School of Nursing. Ten to twelve interviews will be scheduled on nurse's days off and will take up to 45 minutes to conduct at a time of mutual convenience. A total of 10-12 interviews will be conducted at a convenient location. The focus of questions will be the areas of work that provided job satisfaction, attitude toward their role and previous workplace, discussion of what stressors they experienced and how these impacted their practice. Questioning will explore how they view on management in supporting nursing practice and explore how any impact this may have had in their decision to leave. Once the interviews are completed, and all the findings are analysed, a summary of the research findings will be made available to each participant and managers of participating units.

Participants are able to refuse any questions they wish at any time, or withdraw from the study as they feel necessary. If a participant chooses to withdraw, none of the responses will be used in the study. None of the personal information, including demographics details, will be used to connect to any statements. Confidentiality will be discussed with all participants, and although we encourage all participants not to discuss responses in the interview outside the session, we cannot guarantee complete confidentiality.

If you would allow your unit to participate, please respond by phone or email to Dana Hayward. **By agreeing to allow your unit nurses participate in the study, you are providing consent to participate in the study.** Formal consent forms will be provided, discussed and obtained with each nurse willing to participate.

**Study Contact**

Dana Hayward RN, BsN  
Clinical Nurse Educator  
Surgical Program-excluding OR &  
PAR  
PAH  
Work: [telephone number]  
Cell: [cell number]  
Fax: [fax number]  
Email: [email address]

**Principal Investigator:**

Dr. Vicky Bungay  
Assistant Professor  
University of British Columbia  
School of Nursing  
T201-2211 Westbrook Mall  
Vancouver, BC, Canada V6T 2B5  
Phone: [telephone number]  
Fax: [fax number]  
Email: [email address]

If you have any concerns about the participants' treatment or rights a research subjects, you may phone the Research Subject Information Line in the UBC Office of Research Services at the University of British Columbia at [telephone number].

Thank you for taking the time to learn about this project. We appreciate your input. If you have any further questions, please do not hesitate to contact me.

Respectfully,

Dr. Vicky Bungay PhD, RN

## Appendix B: Poster Invitation for Participants

### Identifying the Contextual Factors that Influenced Experienced Nurses in their Decision to Leave Clinical Practice



For more info or to participate,  
contact Dana Hayward at:

[Email address]

Principal Investigator:

Dr. Victoria Bungay,  
UBC School of Nursing, at:

[Email address]

Are you are an experienced nurse  
with an interest in participating in a  
nursing research study?

We are exploring your nursing  
perspective as to what influenced  
your decision to leave your  
previous acute care workplace.

## Appendix C: Letter to Potential Participants



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Phone [telephone number]  
Fax [fax number]

November 16, 2012

Project Title: Perceptions of the Experienced Nurse to What Influenced Their Decision to Leave Clinical Practice

Dear Nurse [Name],

Retention of the experienced, expert clinical nurse is significant as the evidence shows experienced nurses contribute to improving patient outcomes and guide newer nurses in managing complex work demands and higher acuity levels. As well they provide leadership within clinical practice which is particularly important when the healthcare system they work in is already stretched to the limits. With an older nursing workforce, experienced nurses opt for early retirement or leave clinical practice due to burnout. This leaves the remaining nurses with the loss of this valuable resource of expertise, knowledge and leadership that the experienced nurse gives.

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This research study is part of Dana Hayward's Master of Science in Nursing thesis project. Face-to-face interviews will be lead by Dana and her supervisor Dr. Vicky

Bungay, a professor at the UBC School of Nursing. Ten to twelve interviews will be scheduled on nurse's days off and will take up to 45 minutes to conduct at a time of mutual convenience. A total of 10-12 interviews will be conducted at a convenient location. The focus of questions will be the areas of work that provided job satisfaction, attitude toward their role and previous workplace, discussion of what stressors they experienced and how these impacted their practice. Questioning will explore how they view on management in supporting nursing practice and explore how any impact this may have had in their decision to leave. Once the interviews are completed, and all the findings are analysed, a summary of the research findings will be made available to each participant and managers of participating units.

Participants are able to refuse any questions they wish at any time, or withdraw from the study as they feel necessary. If a participant chooses to withdraw, none of the responses will be used in the study. None of the personal information, including demographics details, will be used to connect to any statements. Confidentiality will be discussed with all participants, and although we encourage all participants not to discuss responses in the interview outside the session, we cannot guarantee complete confidentiality.

If you would allow your unit to participate, please respond by phone or email to Dana Hayward. **By your nurse manager agreeing to allow your unit nurses to participate in the study, they are providing consent to participate in the study.** Formal consent forms will be provided to, discussed and obtained with each nurse willing to participate.

**Study Contact:**

**Co-Investigator**

Dana Hayward RN, BsN  
Clinical Nurse Educator  
Surgical Program-excluding OR &  
PAR  
PAH  
Work: [telephone number]  
Cell: [cell number]  
Fax: [fax number]  
Email: [email address]

**Principal Investigator:**

Dr. Vicky Bungay  
Assistant Professor  
University of British Columbia  
School of Nursing  
T201-2211 Westbrook Mall  
Vancouver, BC, Canada V6T 2B5  
Phone: [telephone number]  
Fax: [fax number]  
Email: [email address]

Please contact office of Research Services if any questions arise about the research process. If you have any concerns about the participants' treatment or rights of a research subject, you may phone the Research Subject Information Line in the UBC Office of Research Services at the University of British Columbia at [telephone number].

Thank you for taking the time to learn about this project. We appreciate your input. If you have any further questions, please do not hesitate to contact me.

Respectfully,

Dr. Vicky Bungay PhD, RN

## **Appendix D: Interview Guide**

### **Proposed Question Guide for Interviews**

#### **Perceptions of Experienced Nurses to What influenced their Decision to Leave Clinical Practice**

1. Thank you for agreeing to participate. To begin with, I would really appreciate it if you could take us back in time and describe for me you last job. Describe for example, where you worked, what your role  
Probe: What was a typical day like for you?  
What was the setting like (describe it to me)
2. Can you tell me what it was like working on this unit? What did you see that was great about your work? What was your team like to work with?  
Probe: Can you describe what the culture of your workplace was like to you? Can you give me examples.
3. What was the leadership like to work with? How would you describe the communication among staff, from leadership?
4. What did you find challenging in your previous job? How did this affect you? What do you do when you experienced these workplace challenges?  
Probe: Challenges such as short staffing, higher patient ratios and acuity levels and nurse's leaving the workplace. How often did these issues occur? What were the most challenging issues you had to deal with; how often did these issues come up? How did this affect you?
5. What kind of things did your feel your management or nursing leadership in your previous job do to help you feel supported? How did you see the unit staff work through workplace challenges  
Probe: Can you recall how your manager or leadership supported you in a normal working day? With challenging situations? How did you feel to the presence or lack of support? What was the unit culture in challenging situations?
6. If it is okay with you, would you describe for me how you decided to leave you last job? For example, when did you start thinking about leaving your last job and what was occurring in your unit when you first started thinking about leaving?  
Probe: Would you say the challenges you described earlier impacted your decision to leave? How do you think the leadership's response to your workplace challenges impacted your decision to leave? Can you tell me about the process you went through when you decided to leave.
7. Is there anything else you would like to tell me related to what contributes to you staying in your current workplace or leaving?

## Appendix E: Informed Consent Form



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Phone [telephone number]  
Fax [fax number]

[Date]

**Name of Study:** Perceptions of Experienced Nurses to What Influences their Decision-Making Processes in Intent to Stay or Leave Clinical Practice

**Sponsors:** University of British Columbia

**Purpose of Study:** The purpose of this research is to critically examine the factors that contribute to retention among more experienced nurses.

**Role of Participant in Study:** The participant, you, in the study will be asked to attend an interview for thirty minutes to forty- five in a non-work environment. You will be asked questions related to your current workplace as a nurse in an acute care setting. The direction of questions will include what you think contributes to you staying in your current job, what challenges you experience, and what supports you have experienced or not received in your current workplace. Written notes and audio taping will be taken by primary investigator during interview.

**Risks and Harm:** There is not foreseeable risk or harm to you as a participant in the research study. Questions may be asked that you may find personal, and you are in no way obligated to answer any questions you are uncomfortable with.

**Confidentiality:** All information you share during the interview is confidential. Any information you share will be done so anonymously, unless you choose to give approval to use your identification. All information of the interview will be stored in a locked and secure cupboard. UBC Behavioural Research Ethics Board has been consulted and remains aware of conduct of research to protect your human rights and anonymity.

**Voluntary Participation:** Your role in the study is completely voluntary and in no way obligated to participate. You may choose to stop your participation at any time. This choice to withdraw or stop participation will have no influence with your relationship with the primary investigator or the University of British Columbia now or in future.

**Questions Regarding the Study:** If you have any questions at any point during this study, please feel free to ask primary investigator or contact Dr. Vicky Bungay, Principal Investigator at University of British Columbia at [telephone number] or email: [email address]. The content of this study has been reviewed and approved following the Tri-Council Ethics Research Guidelines and UBC Ethics Board. If you have any questions

about this process, please contact Dr. Vicky Bungay by phone at [telephone number] or email at [email address].

**Legal Rights and Signatures:**

I, \_\_\_\_\_ ( fill in your name ), fully give consent to participate in this study *Perceptions of Experienced Nurses to What Influenced their Decision to Leave Clinical Practice* conducted by Dana Hayward. I understand the nature of the study and agree to participate of my own free will. I am not waiving my legal rights by signing this consent as indicated by signature below.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Participant**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Primary Investigator**