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# The Effect of Moral Distress on Nursing Retention in the Acute Care Setting

Cynthia L. Cummings  
*University of North Florida*

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**The Effect of Moral Distress on Nursing Retention in the Acute Care Setting**

by

**Cynthia L. Cummings**

**A dissertation proposal submitted to the Doctoral Program Faculty  
in Educational Leadership in partial fulfillment  
of the requirements for the degree of**

**Doctor of Education**

**UNIVERSITY OF NORTH FLORIDA**

**COLLEGE OF EDUCATION AND HUMAN SERVICES**

**April 2009**

**The dissertation of Cynthia Cummings is approved:**

**Signature Deleted**

\_\_\_\_\_  
Russell O. Mays, Ed.D, Chair

3-3-09  
Date

**Signature Deleted**

\_\_\_\_\_  
Larry G. Daniel, Ph.D.

03/03/2009  
Date

**Signature Deleted**

\_\_\_\_\_  
Steven K. Paulson, Ph. D.

3-3-09  
Date

**Signature Deleted**

\_\_\_\_\_  
M. Catherine Hough, Ph.D.

3-3-09  
Date

**Accepting for the Department:**

**Signature Deleted**

~~John J. Venn, Ph.D., Interim Department Chair~~

4/27/09

**Accepting for the College:**

**Signature Deleted**

Larry G/Daniel, Ph.D., Dean  
College of Education & Human Services

April 27, 2009

**Accepting for the University:**

**Signature Deleted**

\_\_\_\_\_  
David E.W. Fenner, Ph.D.  
Dean, The Graduate School

30 APRIL 2009

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## Abstract

This descriptive study explored the relationship between moral distress, professional stress and intent to stay in the hospital setting. The study involved 234 nursing participants and was conducted via an online survey over a 90 day period. The survey tool consisted of 51 items taken from known moral distress, professional stress and intent to stay tools. The items were divided into frequency and intensity of occurrence. Various statistical measures were utilized to conclude that moral distress and professional stress factors were significant ( $p < .001$ ) in predicting an employee's intent to stay. Factor analyses identified factor groupings related to professional recognition, moral distress, patient care, competence, and lack of confidence. Of these, professional recognition and moral distress were the most strongly correlated groupings.

The results confirmed that there was a correlation between moral distress and professional stress with regard to the employee's intent to stay at the institution. In addition, moral distress alone was identified as a significant factor ( $p < .05$ ) under discriminant analyses. Discriminant analyses also noted certain distinct factors as relevant to those employees working in the critical care area. Those factors were related to the intensity of professional competence, patient care, and moral distress issues. Due to the current climate of a shortage of nurses in the acute care setting, it is imperative that nursing management understand the concept of moral distress, as well as professional stress issues. In addition, members of management should alleviate some of the stressors and provide outlets for expression of these concerns.

## CHAPTER 1

### Introduction

In this study I explored the relationships among moral distress, professional stress, and nursing retention. The focus of this study was on nurses in the acute care hospital setting; more specifically, the effect of moral distress and health care professionals' stress on intent to stay. I attempted to determine if higher levels of stress occur in some areas of nursing more than in others and will present possible strategies to deal with this type of distress.

The possible relationship of moral distress as a concept and its relationship to nursing retention has not been discussed in depth in the literature. The idea of moral distress has been conceptualized for many years and the effects of distress on nurses have been identified as far back as the 1970s (Benner, 1984; Humphrey, 1988; Maslach & Jackson, 1981). Moral distress has been defined as a situation in which the ethically appropriate course of action can not be taken (Corley, 1995). This may often take the form of life-saving interventions and treatments performed on a patient without medical benefit. An example is the terminally ill patient who continues to receive intensive therapy and interventions, such as central line placement or multiple blood draws that do not result in significant improvement. It may be a patient who expresses that they want to die, yet the family continues to ask for full treatment, or it may be the stress of working contrary to the wishes of the patient and family because of the desires of the health care

team. In all, multiple scenarios are possible, and many nurses must deal with these issues on a daily basis.

The type of distress known as moral distress is a serious problem among critical care nurses and can be associated with job dissatisfaction and poor retention (Elpern, Covert, & Kleinpell, 2005). The moral distress scale developed by Corley (1995) is one method to examine the level of moral distress experienced by the nursing staff. The effect of moral distress can take many forms; nurses may feel frustrated, depressed, or anxious (Corley, Minnick, Elswick & Jacobs, 2005). Meltzer and Huckabay (2004) found that moral distress was significantly related to emotional exhaustion. Emotional exhaustion occurs when the person's stressors exceed their ability to cope because of conflict with their value and belief system. This type of stress has been closely linked to burnout.

Nursing burnout has been studied for a number of years and has been related to three main components: depersonalization, diminished personal accomplishment, and emotional exhaustion. These components can lead to apathy and a loss of concern, negative and cynical behaviors, and a feeling that one is unable to effectively carry out one's job (Maslach & Jackson, 1981). These components can also lead to poor job productivity and a desire to leave the health care setting.

Stress in the nursing workplace and its effect on nursing retention has taken many forms. Stress can result from anxiety-provoking events, such as emergency situations, tension from conflict with others, emotional events, such as deaths and pressure from administration and physicians to consistently perform to the highest ability and energy levels. Nurses are frequently under stress from many sides including patients, families, co-workers, physicians, and hospital management personnel. Nurses must deal with life

and death situations every day, and they need to be able to meet these challenges and perform very technical skills with high degrees of accuracy. Nurses reported that trying to cope with events beyond their immediate control and a feeling of increased responsibility with too little time to accomplish the demands placed on them often lead to stress in the workplace (Humphrey, 1988; Wolfgang, 1988). Events such as emotional outbursts by family members or patients, overwork, lack of control, feeling burnt out by events, and the constant pressure of having to make critical decisions were all harmful and lead to stressful feelings among members of the staff.

Constant stress in the workplace can lead to physical and psychological symptoms and can eventually cause the employee to leave the organization and possibly even the field. Several authors have explored the effect of workplace stress (Jex, Cunningham, De La Rosa, & Broadfoot, 2006; Kim, Price, Mueller, & Watson, 1996; Murphy, DuBois, & Hurrell, 1986). When under prolonged stressors, employees had difficulty performing task-related behaviors and concentrating; they tended to be negative and had difficulty interacting with other team members. Stressors were found to lead to anxiety, fatigue, decreased attention, inaccuracy, and ultimately improper use of equipment, risky behaviors, and accidents. All of these effects are very detrimental in the health care setting and should be of great concern to hospital management.

The idea of moral distress and professional stress issues in relation to nursing retention must be investigated among acute care nurses. The nursing profession has found itself in a crisis situation for a number of years (Buerhaus, Auerbach, & Staiger, 2007). The current shortage peaked in 2001 when the average hospital vacancy rate was 13% and there were an estimated 126,000 unfilled positions (AHA, 2001). Buerhaus,

Auerbach, and Staiger estimated the present shortage to be 8.5% to 9 %. However, the trend in hospitals is on a downward spiral again. The shortage appeared to improve in 2002 and 2003, but in 2004 there was a shortage of approximately 7,000 in-hospital nurses and by 2005 that number had risen to a shortage of 51,000. The number leaving health care settings other than hospitals is also increasing, but not nearly at the in-hospital rate.

The reasons provided for the loss of nurses are many and include an aging workforce, insufficient pay and benefits, and a decrease in the number of persons entering the profession (Buerhaus, Auerbach, & Staiger, 2007). The main reasons cited by a group of 1,392 nurses in 2006 were salary and benefits, more career opportunities found elsewhere, faculty shortages, and negativity and unrewarding characteristics of the profession (Buerhaus, Donelan, Ulrich, DesRoches, & Dittus, 2007). These reasons are all cause for concern, but the idea that nursing has a negative image and is perceived as an unrewarding career may be related to the stressors that nurses report dealing with on a daily basis. When nurses in the study by Buerhaus, Donelan, et al.(2007) were questioned about their intent to leave, 18% said they would leave in the next 12 months and 28% indicated that they would leave in the next 3 years. Of those who planned to leave, 48% noted they would take a different position, outside of the hospital setting. These numbers are frightening. Nursing management personnel must do everything in their power to stop this loss of nurses. It is not enough to bring nurses into the profession; managers must work to retain them. This can only be done through recognition of a variety of problems and strategies to help the nursing staff deal with these issues.

### *Statement of the Problem*

The specific research problem investigated in the present study was the relationships among moral distress, health professions stress, and intent to stay among nursing staff. Every day, nurses in the acute care setting are faced with moral and ethical dilemmas. These situations create distress in the nurse and can ultimately lead to a desire to leave their present position or the profession altogether. The present study included nurses from a variety of in-hospital units and investigated the level of moral distress and professional stress that they experience and the relationship of these factors to their intent to stay at the institution. The problem of nursing retention is a critical factor for the profession and it is imperative that nursing research and nursing management focus on exploration of this topic and strategies for alleviation of the problem.

### *Purpose of the Study*

The purpose of the study was to determine whether relationships exist between the concepts of moral distress, professional stress, and nursing retention. The idea is to discover the level of moral distress to which in-hospital nurses are exposed and to determine the relationship between this distress and the nurses' desire to remain in the hospital setting.

### *Theoretical Framework*

A causal model that closely mirrors the conflict seen in the present nursing profession was developed in 1996 by Kim, Price, Mueller, and Watson. The model focused on intent to stay among military health care workers. Physicians, nurses and

allied health professionals were studied to determine possible reasons for retention within the institution. From this information, the researchers developed a model for intent to stay. The model is based on three main variables: environmental, individual, and structural, each of which then contributes to job satisfaction and organizational commitment. These variables, coupled with search behavior, lead to one's intent to stay. Moral distress and professional stress appear to be most closely linked to the individual and structural variables, while some aspects, such as opportunity and family issues come under environmental. The model is explained and presented in Chapter 2.

### *Research Questions*

The following research questions guided this study:

1. Is there a relationship between the amount of moral distress experienced by nurses and their intent to stay in acute care?
2. Is there a relationship between Moral Distress and Health Professions Stress Inventory scores in the nursing setting?
3. Is there a relationship among Moral Distress, Health Professions Stress Inventory scores and intent to stay?
4. Is there a significantly higher level of moral distress in some nursing units as opposed to others?

### *Significance of the Study*

All stakeholders are affected by the nursing shortages and the less than optimum performance by nurses that may result from moral distress. This study explained whether



or not there was a relationship between moral distress, professional stress, and intent to stay. Therefore, the results of this study will be important to staff nurses, nursing faculty, nursing management, and the health care team. It also has relevance to patients, families, physicians, and all health care consumers. In addition, nurses need to be attuned to the fact that they are under tremendous stressors and levels of stress every day. They need to be cognizant of the concept of moral distress and recognize those symptoms that may result from prolonged work-related stressors, especially those that evolve from moral and ethical situations. It is vitally important for nursing management to recognize the stressors that the staff may be under and to investigate provisions that may be needed to deal with these issues, such as counseling, employee assistance programs, and time off when needed. Nursing faculty must be aware of the effect of moral distress on in-hospital staff and incorporate these concepts into their curricula. Zuzelo (2007) emphasized that nursing curricula address the meaning of ethics, ethical practice, and moral sensitivity.

The nursing profession as well as the American Hospital Association and consumers in general are in a critical situation as a result of the nursing shortage. Patients are faced with prolonged wait times and there may be delayed responses to calls and poor communication (Buerhaus, Donelan, et al., 2007). All of these problems are possibly related to a shortage of nursing staff. Patients may not receive the care they need, and hospitals are unable to provide the care and treatments that are expected because they do not employ enough staff to effectively meet patients' needs. The hospital associations are also under criticism for increased patient complaints, reduced number of available beds, and, more importantly, quality and safety concerns (Institute of Medicine, 2000).

In 2000, the Committee on Quality of Health Care in America published a staggering report on the quality of health care in America. The report was entitled, *Crossing the Quality Chasm* (Institute of Medicine ([IOM], 2000). The committee was formed in June 1998 by the Institute of Medicine to examine the quality of care delivered and to develop some fundamental guidelines to improve the American health care delivery system. The committee reported that health care today harms too frequently and routinely fails to deliver its potential benefits (IOM, p.1). This is a significant statement; the idea that our health care system not only fails to provide needed care but also may harm patients is offensive. The nursing shortage only exacerbates this problem. The IOM has called for streamlined practices and consistency with care. The committee recommended that all hospital associations commit themselves to practices that guarantee that all patient care is safe, effective, patient centered, timely, efficient, and equitable. These demands emphasize the need for a highly trained, effective and well-staffed nursing workforce.

In addition to the IOM, a number of nursing initiatives have examined strategies to relieve the nursing shortage, such as those suggested by the Nurse Reinvestment Act (Donley, Flaherty, Sarsfield, Taylor, Maloni, & Flanagan, 2002) The purpose of the act was to assist the nursing community to deal with recruitment and retention issues (Donley et al.). Recruitment efforts were focused on television ads, scholarships, and loan forgiveness programs, all targeting the younger population. Retention efforts focused on all age groups and encouraged clinical ladders, educational and practice area funding, as well as grants for faculty enhancement. Some states have also explored mandatory staffing ratios and anti-mandatory overtime practices (Tounsel & Reising, 2005).

Overall, the nursing profession has been investigating ways to alleviate the nursing shortage, but as discussed earlier, the shortage, especially for nurses in acute care remains. This shortage may only get worse as nurses are required to fulfill demands from administration, physicians, and state and federal organizations. In the past few years the number of federally recommended initiatives has doubled (Strategic Framework Board, 2001). Many of these initiatives developed as a result of the IOM (2000) report, which concluded that hospitals needed to put systems in place to provide for safer patient care. These programs led to computerization of the patient health record, bar-coding for patient medications, strategies for safer surgical preparation, and evidence-based care programs. All of these initiatives take time to perform and have placed added burdens on the nurse (Buerhaus, Donelan, Ulrich, DesRoches, & Dittus, 2007). In addition, the National League for Nursing (NLN) identified the concern that patients are living longer and requiring more intense care. In the past, nurses could adequately care for 8 to 10 patients on a traditional nursing unit; now, however, because of higher patient acuities and federal legislation, nurses are only able to care for 5 to 6 patients. This, therefore, calls for even greater numbers of nursing staff (NLN, 2007).

The present study will provide evidence that addresses the issues of moral distress, professional stress, and the nursing shortage in terms of intent to stay and is, therefore, a much needed and critical study. Nursing researchers should do everything possible to investigate areas of concern and recognize potential problems in the field.

### *Methods and Procedures*

The population for the present study was professional nurses working on inpatient units at an acute care hospital in Northeast Florida. The sample was a convenience sample made up of nurses who could be contacted via email from within the institution. This population enabled me to include nurses throughout the institution. In addition, they were readily accessible via the intranet. Because of the online format, responses could be obtained fairly quickly and the respondents could remain anonymous. The number of in-hospital nurses employed at the institution was approximately 480. As the primary researcher, I gained access to the group through the intranet, the hospital wide computer network. I chose this method because the institution has successfully conducted a number of research projects and survey processes through the system, and it was not unusual for staff to utilize this process.

I controlled for confidentiality by maintaining all employee information through an outside survey system that the employees accessed through a hyperlink rather than using the hospital system to gather data. The survey information was stored outside of the institutional setting and the identities of the responding employees were not known to anyone. The results were stored and collated through this monitored system and were not made available to parties outside of the research project. I also informed the participants that the information was confidential and included a confidentiality statement at the beginning of the survey (Appendix A). I did not ask for the participants' names or any identifying information. The surveys were given a number when they were returned and saved in the system. The participants were told that their assistance with the survey was strictly voluntary, that they were under no obligation to participate, and that they could

withdraw at any time during the process. No individually identifiable data were reported at any time during the study, and there was no way for local hospital superiors or members of hospital administration to access individual response information.

The research design that I used was non-experimental. The sample was a convenience sample of nurses across the hospital campus, and was not random other than the randomness of the individuals choosing to participate. There was not an experimental treatment. Therefore, no control or experimental groups were required. The study was correlational and attempted to predict relationships between subjects' scores on three combined surveys.

The instruments that were utilized were the Moral Distress Scale, Health Professions Stress Inventory, and Intent to Stay Scale. I obtained permission for use of the scales from the authors. (Appendix B). I incorporated the scales into one survey instrument that was mailed electronically to the nurses. The data collection time frame for surveys to be returned was three months because the information could be fairly quickly returned over the intranet.

The data collected were quantitative and made up of survey response data, with demographic information included. Descriptive information included the following: type of clinical setting in which the respondent was employed, years of nursing experience, highest education level, position held, full or part time employment, age, and completion of an applied ethics course. There was also an open-ended comment section at the end of the survey to provide participants the opportunity to contribute specific examples of moral distress situations they have encountered. This information, not identified by source, was included in the discussion section of the study report.

The information obtained was analyzed for relationships between moral distress, intent to stay, and health professions stress scores. I used a variety of statistical analyses to investigate the research questions. I began with multiple regression analyses to determine the degree and direction of relationships. Multiple regression is a commonly used method to analyze the relationship between a single dependent variable and several independent variables (Hair, Black, Babin, Anderson, & Tatham, 2006). The dependent variable was nursing retention as identified by intent to stay scores. The independent variables were scores on the Moral Distress Scale and the Health Professions Stress Inventory. In addition to multiple regression, factor analyses, and discriminant and canonical correlation analyses were also performed utilizing SPSS. Factor analysis was used to determine specific groupings of items and to ascertain correlation coefficient scores. Following that, discriminant and canonical correlation analyses were used to determine the predictability of the grouped items and the degree of prediction for intent to stay scores as well as work units. Descriptive statistics were used to provide a profile of the participants, and Cronbach's alpha was used to determine the internal consistency of the questionnaire.

### *Delimitations and Limitations*

Limitations of the study included the fact that the population was delimited to a convenience sample of nurses from one hospital. Even though this sample provided a fairly good number of participants, results are still only generalizable to the population of nurses from the participating site. As a result, the population may encounter different working conditions than nursing staff members at other hospitals or may have other

advantages, such as better counseling or assistance programs than at other institutions. In general, however, I did not anticipate the scores of the participants to be that dissimilar from those that would be found with nurses at other facilities. Reports in the literature indicated that the issues being addressed by the present study are national in scope. It is likely, therefore, that the nurses who made up the population for the present study experienced the same or very similar stressors as others in the profession experience. In fact, in some areas such as critical care, the nurses may experience greater levels of moral distress than that which affects nurses who work at less acute facilities.

Limitations to the study may come from a variety of areas. One limitation is the use of the intranet. Some nurses may not be as familiar and may not have participated because of the electronic format. Others may have elicited the help of colleagues in completing the survey, and this can lead to false information. Even though the electronic medium is a widely used and preferred format in many areas, the use of web-based survey methods do bring challenges in the form of comprehension of the material, multiple participants on one survey, withdrawal of subjects or mortality because of the time involved in participation, and the feeling that the organization is trying to obtain confidential information (CITI, 2007)

Other issues may be the survey tool itself because of the length and incorporation of three scales into one format. In addition, the survey questions were separated into frequency and intensity responses. This amounted to 102 questionnaire responses. The time to complete the survey was found to be approximately 10 minutes. This may be a potential problem because the participant usually completed the survey in the workplace. Because the tool was sent over the intranet, participants may have felt that they were

being coerced by the organization to complete it or they may have feared that the information would be shared.

The scales have been shown to yield scores with acceptable reliability and validity, which has been reported through previous testing (Erlen & Sereika, 1997; Meltzer & Huckabay, 2004; Nedd, 2006). In all, while there may have been some threats to internal validity with the present study, the electronic format and the strength of the instruments controlled for some of these factors. In addition, I did not interact with the participants, except through the electronic media, which removed some of the researcher bias and interaction as a potential threat.

### *Organization of the Study*

Chapter 1 is a presentation of the major points of this study including my reason for the study and some main concepts further explored in the literature review. A statement of the problem and purpose were included, as well as a brief explanation of the theoretical framework. Research questions were outlined, and the significance of the study from a larger nationwide perspective was presented. The chapter concludes with a summary of the methods and procedures used, as well as delimitations and limitations of the study.

Chapter 2 includes the review of related literature. A thorough explanation of the methodology is presented in Chapter 3. Chapter 4 includes an explanation of the results and discussion, while the conclusions are presented in Chapter 5.



## CHAPTER 2

### Literature Review

The issues of stress, moral distress, and retention in the field of nursing have been addressed by a number of researchers in the past. The purpose of this literature review is to provide a setting, in terms of previous research, that will serve as the context for the present study.

Nursing retention is a major issue in the health care industry. In 2001, the national hospital vacancy rate for registered nurses (RNs) was estimated to be 13%, with nearly one fifth of all hospitals expecting this rate to climb to over 20% by the end of the decade (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005). The American Hospital Association (AHA) reported that there were over 126,000 unfilled RN positions across the United States in 2001, and over one million vacancies are expected by the end of 2010. In addition, one in five nurses will leave the profession within the next 5 years (AHA, 2001). Presently, the AHA has documented an 8.1% vacancy rate and 116,000 unfilled nursing positions (AHA, 2007). What can be done to improve the retention rate for nurses, and what factors are causing them to either not enter or to leave the profession all together? In a study by Bowles and Lori (2005), the authors reported that 57% of new nursing graduates leave nursing within the first 2 years. This is a staggering number. What is causing them to leave the profession so soon, and what can be done by nursing management to improve this situation?

One factor that affects nursing satisfaction is the concept of workplace stress. Meltzer and Huckabay (2004) addressed the idea of moral distress in nurses working in acute care settings. Moral distress has been defined as a stress response experienced by nurses when they deal with stressful situations, such as cardiac arrests, withdrawal of life support, and other ethical dilemmas. Moral distress and other stress related variables have been identified as factors which affect nursing retention (Brooks & Anderson, 2005; Hayhurst, Saylor & Stuenkel, 2005; Meltzer & Huckabay). Numerous authors have also investigated the relationship between workplace stress and retention and developed corresponding frameworks (Beehr & Newman, 1978; Kim, et al., 1996; Locke, 1976; Schuler, 1982). This chapter addresses the issue of nursing retention, factors relevant to nursing retention, the effect of stress on the nursing workplace, the concept of moral distress, a conceptual framework derived from the literature, and possible strategies for relief of distress.

### *Nursing Retention and Intent to Stay*

In 2002 the Health Resources and Services Administration (HRSA) provided validation that the United States was experiencing a nursing shortage in all areas of healthcare delivery. The group identified issues that directly impacted the shortage. Some of the predominant concerns were an aging RN workforce, lack of nursing faculty, declining enrollment in nursing programs, changing work climates, and a negative image of nursing (Strategic Framework Board, 2001). Numerous reports indicated that the shortage could reach critical proportions by 2020, when it is estimated that the nursing shortage will reach over 29% of available positions (Andrews, & Dziegielewski, 2005).

In addition to this labor shortage, the average age of the RN in America is increasing at a dramatic rate. It is anticipated that by 2020, over 40% of the RN workforce will be over 50 years of age (Norman, et al., 2005). An aging workforce means that many nurses will retire and withdraw from the workforce during a potentially short period of time, resulting in even more vacancies. Because of these growing concerns, federal and state agencies, legislators, professional nursing organizations, and the health care industry are responding with recommendations and resources to address this problem (Andrews & Dziegielewski).

An aging RN workforce and the lack of nursing faculty were noted by Goodin (2003) as two major contributors to the current nursing shortage. The largest influx of individuals into the nursing profession occurred during the 1960s and 1970s. These “baby boomers” will become eligible for retirement between 2010 and 2015, potentially resulting in a dramatic loss of staff. The lack of nursing faculty may be the result of poor salaries, unrealistic expectations from the programs, and insufficient funding for advanced degrees. In addition, the number of people entering nursing programs has been negatively affected by the lack of faculty. Since 1995, enrollments in baccalaureate nursing programs have decreased by 21%, and the number of students taking the licensure exam has declined 26% over the past six years (Goodin). Seago, Spetz, Alvarado and Keane (2006) surveyed over 3,000 college students and found that they viewed nursing as still a women’s occupation and a profession which was not as lucrative as other options available to them.

The Nurse Reinvestment Act is one approach to addressing the nursing shortage. The purpose of the act was to assist the nursing community to deal with recruitment and

retention issues (Donley et al., 2002). Recruitment efforts were focused on television ads, scholarships, and loan forgiveness programs, all targeting the younger population.

Retention efforts focused on all age groups and encouraged clinical ladders, educational, and practice area funding, as well as grants for faculty enhancement. Nursing leadership realized that it was not enough merely to bring new nurses into the profession; they also had to retain the current staff. As the nursing population is aging, the leaders must look toward those areas to retain experienced nurses and utilize their knowledge and expertise.

In today's nursing shortage the effects are more broad-based than just a lack of nursing staff. Shortages occur in all health care areas including hospitals, nursing homes, and home health care agencies. The national average for shortages in hospitals was around 8% in 2005 with the greatest shortages seen in medical, surgical, critical care, and emergency care units (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005). The lack of staff in specialty units is especially troubling because of the time that it takes to adequately train this type of personnel. Cline, Reilly and Moore (2003) noted that the real reason nurses leave is not really salary and benefits, but is more often a perceived lack of support from management, poor recognition, difficult workloads, and demands and safety issues with patient care. All of these issues led to stressors that nurses could no longer tolerate.

In a series of surveys conducted by *Harris Interactive for Nurse Week*, the American Organization of Nurse Executives, Johnson and Johnson, and *Nursing Spectrum*, similar results were obtained that led to an insight into reasons for the current nursing shortage. Some of the main issues given for the shortage between 2002 and 2004 were salary and benefits, undesirable hours, more career options for women, stress in the

workplace, and the negative perceptions of health care positions. When asked who was responsible for correcting the shortage, almost all of the nurses (93%) agreed that hospitals, the federal government, and the nursing profession were collectively responsible (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005).

As experienced nurses leave the acute care setting, a greater burden is placed on the newer, more inexperienced staff. Norman et al. (2005) conducted a survey of 1,783 nurses. The results indicated that for the RNs surveyed, 31% were age 50 or older. The experienced RNs were less likely to work in acute care settings, only 38% compared to 62% for the younger group. As experienced nurses are seeking positions in the less acute areas, they are taking their clinical expertise away from the staff members that would probably receive the greatest benefit from them. In addition, as the experienced staff retires from the non-hospital positions, they may pull the younger staff away from the acute care settings where they are most needed. When asked how the current nursing shortage will impact them, over 98% of the nurses surveyed reported that it would lead to increased stress. Additionally, 93% reported that the shortage will lead to a lower quality of care for patients and cause nurses to leave the profession for other jobs (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005). Strategies identified by nurses as making a difference in solving the nursing shortage are improved wages and benefits, improved working conditions, higher status of nurses in the hospital environment, and better working hours.

Bedside nurses, physicians and administrators agree that the nursing shortage has a negative effect on patient care. Erlen (2001) wrote, "the shortage of nurses and the flaws within the structure of the current health care system are compromising the nurse's

ability to provide competent, compassionate care” (p.76). When a survey was conducted with RNs and chief nursing officers (CNOs), the majority indicated that care processing, adequate communication, timely response to pages and telephone calls, delays in patient discharges, and the time patients have to wait for tests and procedures were still negatively affected by nursing shortages (Buerhaus, Donelan, Ulrich, Norman, Williams, & Dittus, 2005). Approximately 81% of physicians questioned reported that the nursing shortage was still impacting their hospitals. Nurses indicated that even with two years of RN growth, the staffing level is still not sufficient to provide the amount and quality of nursing care they believe is needed by patients. While the shortage may be getting better, it still impacts hospitals negatively because of the loss of staffed patient beds, patient wait times for surgery, and increased complaints about nurses (Goodin, 2003).

The nursing profession has recognized that there is an imperative need to recruit and retain staff. There are a number of articles stressing the importance of working with the nursing staff to meet their needs and promote a positive work environment (Bethune, Sherrod & Youngblood, 2005; Cline, Reilly, & Moore, 2003; Goodin, 2003). Izzo and Withers (2002) identified the need for more flexible scheduling and personal balance with work life. They encouraged employers to offer a variety of schedules, child care and various benefit options. They also stressed the need for nurses to recognize that they make a valued contribution to the organization and to the public. Organizations should offer incentive programs and celebrate the involvement of nursing in the healthcare field.

Intent to stay has been defined as the likelihood of continued membership in an organization (Nedd, 2006). Intent to stay is a crucial element in the concept of nursing retention, and it is imperative that nursing leaders recognize some critical contributing

factors. Nedd stressed the importance of workplace empowerment, as well as opportunity, power, support and information access as significant factors related to the intent to stay. Other retention strategies as outlined by Gullatte and Jirasakhiran (2005) are clinical ladders, encouraging praise and support, mentoring and preceptorship programs, and the creation of a culture of support and teamwork.

Magnet hospitals may also prove to be an incentive tool to retaining nursing staff. The American Academy of Nursing conducted a survey to identify those hospitals which were successful at retaining nursing staff and found that those with certain characteristics did better (Stordeur & D'Hoore, 2006; Upenieks, 2005). These characteristics were adapted into a certification process called the Magnet Hospital program. Magnet hospitals incorporate a number of concepts that aid in the retention of staff. Some of these are participatory management, flexible scheduling, career opportunities, continuing education, clinical ladders, and planned orientation. One of the goals is to utilize the older staff as mentors for the new nursing staff.

The experienced workforce may actually be in a position to help younger nurses. In a report entitled "Wisdom at Work: The Importance of Experience and Experienced Nurses," the author noted that retaining experienced staff may help by educating and acclimating new staff to the profession (Ross, 2006). Experienced staff members provide a wealth of wisdom and calm in a potentially chaotic environment. They also provide a strong support system and a method by which new nurses can gauge their own behavior. One of the biggest concerns of hiring new graduates is the idea of "reality shock" (Casey, Finck, Krugman, & Propst, 2004). If new nurses are mentored by more experienced staff, then they are provided a great resource and assistance with alleviating some of the

stressors. The greatest difficulties of new nurses centered on lack of confidence, peer relationships, frustrations with the work environment, and communication with the physicians. Managers need to adequately train the graduate as well as experienced nurse in new technologies, and they also need to offer opportunities for advancement and use of the skills that the experienced nurse has acquired over the years. Stress management and priority setting are two areas in which experienced staff can greatly assist new nurses (Ross). In all, the healthcare industry is a place that needs to encompass all age groups and offer valuable incentives to not only the young, but also the experienced staff member.

In 2007, the National League of Nursing, NLN, issued a policy statement that underscored the problems related to retention in the nursing profession. The authors wrote that the “nursing shortage is very real and very different from any experienced in the past” (NLN, p. 1). The reasons for the declining number of nurses are many and varied. Not as many students are entering the nursing field, the present workforce of nurses is becoming increasing older, and the number of nurses going on to academia has steadily declined. The authors acknowledged that there are multiple reasons for the shift away from the nursing field. The Tri-Council noted that part of the problem stems from the changing healthcare arena. Patients are living longer and requiring more intense care. In the past, nurses could adequately care for 8 to 10 patients on a traditional nursing unit. Now because of higher patient acuities and federal legislation, nurses are only able to care for 5 to 6 patients. This has placed an even greater burden on an already stressed system (NLN).



The value that the public places on safety and longevity has added to these problems. This is not to say that these concerns are not important, only that these values have contributed to changing the face of the American healthcare system. In fact, the Tri-Council noted that in many areas hospitals have closed units and cancelled surgeries because of a lack of nurses. Nursing in its present state is under ever-increasing burdens and the nursing shortage has created a very real crisis.

### *Factors Relevant to Nursing Retention*

As noted above, the nursing shortage is a very real problem. Some of the relevant factors related to nursing retention will be presented in the following section. Aiken, Clarke, Sloane, Sochalski, and Silber (2002) reported a significant finding regarding the nurse-patient ratio and patient mortality, failure to rescue surgical patients, and factors related to nurse retention. The researchers conducted a cross-sectional analysis of linked data obtained from 10,184 nurses and 232,342 surgery patients discharged from 168 general hospitals in Pennsylvania over an 18-month period. Aiken et al. concluded that for each additional patient an RN had to care for, there was a 7% increase in the likelihood of that patient dying within 30 days of admission. The same results were obtained for the failure to rescue a patient who experienced complications following surgery. In addition, an increase of just one extra patient to a nurse's assignment was associated with an increase of 23% burnout factor and a 15% increase in job dissatisfaction. These latter results showed that nurses in hospitals with an 8:1 patient to nurse ratio were 2.29 times as likely as nurses with a 4:1 patient ratio to show high emotional exhaustion. In fact, when the patient to nurse ratio was increased from 4:1 to

just 6:1, the nurses' experienced significant ( $p < .001$ ) emotional exhaustion and job dissatisfaction.

The conclusions presented by Aiken et al. (2002) have been widely discussed in nursing literature and have led to the landmark decision by the California legislature to enact set nurse-to-patient ratios. The study by Aiken et al. was critically important not only because of the findings, but because of the large sample size. It was one of the first studies to demonstrate the correlation between nurse-patient ratios and successful patient outcomes. The researchers were also able to link the data to nursing dissatisfaction and burnout and demonstrated through the size of their study how important nurse-patient ratios are to nursing satisfaction and retention. The American Nurses Association (ANA, 2001a) agreed with Aiken et al.'s findings stating that the three factors associated with the nursing shortage were mandatory overtime, unsafe staffing practices, and high nurse to patient ratios. Even though California has enacted legislation to control for nurse-patient ratios, no other states have followed and, with the nursing shortage, it is unlikely that all states will make this effort unless the federal government steps forth with legislation to this effect. The Aiken et al. study, while vitally important, does need to be replicated in order to see if any changes in outcomes have taken place over the past 5 years.

In a similar study, Bowles and Lori (2005) surveyed 352 RN's who had graduated within the last 5 years. The survey tool was one developed by the authors and had an Alpha reliability coefficient of .89. They noted that initial content validity was developed through extensive literature research on previously used nursing satisfaction tools. Bowles and Lori also subjected the survey items to a factor analysis and determined that

24 of the original 31 items met the loading criteria. The survey results obtained were then tested utilizing ANOVA and t-tests. Of the 352 respondents, over 30% (105) had left bedside nursing within the first year. The authors concluded that the most frequent reason for the subjects leaving their first position related to stress associated with the acuity of patients, unacceptable nurse-patient ratios, and the feeling that patient care was unsafe. Some positive findings were that nurses were more likely to stay in an institution that was not-for-profit, had lower nurse patient ratios, and allowed them to make unit-based decisions, such as self-scheduling.

The Bowles and Lori (2005) study relates closely to Aiken et al.'s (2002) findings of the importance of nurse-patient ratios and acceptable working conditions. The idea that 30% of new graduates will leave nursing within the first year is staggering. One limitation of their study may be that the survey was sent out to over 3,077 nurses and had only an 11% return rate. The respondents who returned the survey may have been those who were disgruntled and did not experience a positive first year, so the sample may not be truly representative of the feelings of a majority of the nurses. Nonetheless, the results do appear to validate the findings of that poor staffing ratios affect nursing satisfaction. One conclusion from their findings points to the fact that just increasing the number of new nursing graduates may not be the answer. Instead, administrators must address issues related to job satisfaction before continuing to loose more staff.

One program that seems to emphasize the need for nursing involvement is the recent concept of Magnet certification. In a press release by the American Nurses Association (ANA, 2001a), they wrote that, "Nursing retention in Magnet facilities is twice as long as that of non-Magnet institutions" (p.2). The association reported that the

major contributing factor to the current nursing shortage is dissatisfaction with the work environment. The dissatisfaction caused experienced nurses to leave the bedside and has drastically hindering recruitment efforts. Magnet certification is a process conducted strictly by nurses, whereby the nurses direct a number of patient care initiatives at their institutions. These initiatives aid in improving patient care, nursing satisfaction, and nursing recruitment. The process focuses on improving the education level of the nursing staff, instituting quality care programs led by nurses and encouraging new staffing processes and community involvement (Nursing Management, 2006).

The use of management development courses to train and stimulate nurses to remain in the field was emphasized by Wilson (2005). Wilson's premise was that all too often nurses leave because they are frustrated with nursing management when they really do not understand the forces impacting the nurse manager. Wilson devised a nursing management education program and provided scholarship monies for staff that agreed to attend. The Anticipated Turnover Scale (ATS) was administered to the program recipients before and after the management program. Her findings revealed that the program did significantly reduce ( $p < .05$ ) the participants' ATS scores. Wilson concluded that the benefits to nursing are not only retention of staff, but creation of future nursing leaders. Leigh, Douglas, Lee, and Douglas (2005) similarly conducted a quality management training program with new nursing staff and found that it significantly improved their retention, decreasing turnover from 24% to only 1%.

The above studies demonstrated that education and advancement opportunities were related to nursing satisfaction and retention. The results for Wilson's (2005) study were significant; however the sample size was small. The program started with 43

participants and ended with 35 completing the program. Twenty six participants received a scholarship for the program, while the others were sponsored by their employers. The researchers discovered that 23% of the scholarship recipients dropped out of the program as compared to only 6% of the employer-sponsored participants. This finding was probably related to the employer contract for completion with the employee. The study by Leigh et al. (2005) seems significant, but statistical results were not provided in the article. The results however, did stress the importance of employer sponsored management and education programs and their related significance on nursing satisfaction.

Work factors centering on emotional issues and the influence of these factors on nursing retention were studied by Hayhurst, et al. (2005). Their correlational design compared four subscales (peer cohesion, supervisor support, autonomy, and work pressure) to the retention factors of changing units or leaving the hospital setting. The subscales were part of the Moos' Work Environment Scales. A total of 272 RNs returned the surveys, and the retention rates for those employees were compared over a 6, 12, and 18 month period. The results were analyzed using the t-test. None of the subscale differences reached significance; however, the two subscales which demonstrated the closest correlation, as noted by the authors, were peer cohesion and autonomy. The autonomy questions related to whether the employee felt self-sufficient and capable of making his or her own decisions. The nurses who stayed in the profession reported higher levels of autonomy. Autonomy is an area that is strongly correlated with decreased stress level and improved retention (Erlen & Sereika, 1997; Naude & McCabe, 2005; Ulrich et al., 2006).

Problems with the Hayhurst et al. (2005) study were that they used a voluntary convenience sample of nurses from one hospital in California. Questionnaires were sent out to 692 nurses and 272 were returned (40%); this represents a fairly good return rate. The nurses who returned the surveys were more likely to be white (43%), over 40 (44%) and a nurse for more than 10 years (60%). This respondent sample may limit the generalizability of the findings. The results are probably very different in other settings, yet I think that it is important for hospital administrators to closely research why their nursing staff is leaving. They need to understand the factors that lead to dissatisfaction and to explore ways to improve their nursing workplace.

It is clear that nurses recognize that autonomy and recognition are major factors for improving job satisfaction, yet hospital administrators may not be truly attuned to correcting these problems. In a 2005 study published by *Nursing Economics* magazine, the authors, Buerhaus, Donelan, Ulrich, Norman, and Dittus, reported that only 12% of hospital administrators offered scheduling options, 19% offered financial incentives for quality improvement ideas, and only 31 % had nursing recognition events. In fact, only 47% of the institutions paid for continuing education classes and mentoring programs for new graduates. Yet hospital administrators play a balancing game between caring for the nursing staff and satisfying stock holders in many areas.

Positive retention strategies have been explored by a number of authors. Bethune, Sherrod and Youngblood (2005) emphasized emotional needs by listing 101 ways to retain a happy staff. They described the importance of realizing that each nurse is an individual and no one health care worker is like another. The authors noted that nurse managers must value each employee and provide for methods by which nurses can assist

in making decisions about unit based operations. They also wrote that management should provide resources by which nurses have more flexibility and can spend more time caring for the patient. This may be accomplished through technology and staffing resources. Another area that Bethune et al. discussed was the concept of fitting the right nurse to the right unit. This sounds somewhat like Collins's (2001) book, *Good to Great*. Collins stressed the need for management to find the right person for the right job and if the employee is not right, then they need to either "get off the bus or find another seat" (p.44). Bethune et al. also wrote that nursing management must act as a role model for creating a work environment that promotes mutual valuing and respect. Empowerment, flexibility, respect and recognition all go hand in hand with Collins's concepts.

Brooks and Anderson (2005) attempted to define the quality of nursing work life through investigation of nursing research articles. They separated their findings into four concepts of quality: job satisfaction, organizational commitment, job tension, and job involvement. The authors developed a conceptual framework of four dimensions related to the quality of nurses' work life. These dimensions are similar to the contextual areas discussed in *The 8<sup>th</sup> Habit* (Covey, 2004). The dimensions are: work life/home life, work design, work context, and work world. Each dimension focuses on a different and important area that affects the satisfaction and retention of nurses. The work life/home life dimension centers on the balance between work and home needs, child care demands, energy levels, and scheduling options. The work design dimension deals with the time available to do the job, workload demands, autonomy of decision making, assistance and resources. The work context dimension explores relationships between superiors and staff, career advancement, teamwork, respect, recognition and support. The final

dimension, work world, deals with the contribution of the job to society and community, security, and compensation for skills.

The relationship between empowerment and the intent to stay in nursing was explored by Nedd (2006). She examined why nurses stay in the profession. She based her survey on the concept of organizational empowerment and the nurse's perception of formal and informal power, as well as access to the empowerment structure. Nedd surveyed 275 RNs across Florida and obtained correlational data comparing empowerment variables with the intent to stay. She found that the highest correlation was obtained for the variables of overall work empowerment and opportunity. She concluded that leadership must include nursing staff in unit based and hospital work groups and task forces. She noted that it is important for them to make decisions that impact the efficiency and quality of patient care. Including nurses in overall decision making allows them to feel a part of the team and to express their concerns. These factors lead to a feeling of empowerment and value within the organization. Budge, Carryer and Wood (2003) also found similar results when they surveyed 225 nurses. Their results demonstrated that there was a relationship between empowerment, autonomy, and the nurses' rating of their own health. They felt that the greater control they had, the less stress they experienced.

Nedd's (2006) study had some definite strengths, including the sample size and sampling procedure. The author randomly sampled 500 RNs out of 147,000 from the state of Florida. Of the 500 surveys sent out, 275 were returned, which resulted in a 55%, very high return rate. The sample was comprised of 93% females with 20.1 mean years of nursing experience. The respondents completed three separate instruments: Job Activities



Scale ( $r=.81$ ), Organizational Relationship Scale ( $r=.92$ ), and Conditions for Work Effectiveness ( $r=.96$ ). All three instruments demonstrated good internal reliability. The researchers computed the associations between the intent to stay and the three empowerment variables by using the Pearson correlation coefficient and each variable was significant ( $p<.01$ ). The results of their survey appear very strong, yet it would still benefit nursing administrators to continue to study these variables using a variety of samples, including those with only associate degrees and new graduates who do not have the advancement and empowerment opportunities that may be afforded more experienced nurses. Also, based on the study by Budge et al. (2003), it is important for managers to be aware of the relationship between autonomy, the work environment, and perceived health. Budge et al. noted that when autonomy and work environment were compared to the employee's perceived level of health, there was a relationship between the factors, although it was not significant. When the nurses indicated that they had greater autonomy and a positive work environment, they were more likely to view their health as positive.

In an article related to leadership and spiritual needs, S. E. Wagner (2006) wrote that research confirms an employee's relationship with his or her immediate supervisor is a primary determinant of their satisfaction level and retention at the institution. Wagner suggested that nursing managers move employees from being satisfied to becoming engaged in the workplace. S. E. Wagner conducted a web-based survey with RNs at 14 hospitals in New York. The survey results divided the respondents into highly engaged, moderately engaged, and disengaged. The disengaged group accounted for 32% of the nurses surveyed, although the total number of respondents was not noted. The common factors that were identified in the highly engaged group included valued by the

organization; inclusion in decision making; respect by the organizational management; and integrity, recognition, and open communication apparent with upper management. S. E. Wagner concluded that it is necessary for effective nursing leaders to demonstrate the skills of team commitment, positive team building, and providing employee recognition and staff involvement in order to develop an engaged and loyal staff. Alspach (2005) concurred with S. E. Wagner's reflection on the importance of good management in nursing retention. In his article, he outlined six standards for a healthy work environment. The standards are skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership.

S. E. Wagner's article was based on research supported by a grant by the Healthcare Association of New York State (HANYS). HANYS contracted with Quality Data Management to develop and survey employees at 14 selected hospitals. The author stated that the instrument was tested by the management corporation for reliability and validity, but no results were reported. The author also wrote that the sample size was very large and was made up of respondents from the 14 area hospitals who answered the survey; however, the exact number was never provided. It would have been better to view the actual results, yet the study did have some excellent findings related to the concept of engaged versus disengaged employees. Also, following the survey, the hospitals were all given a one hour session by the researchers to review the findings and discuss possible plans for engaging the staff. This is a very positive factor for encouraging change within the organization.

Conflict and stress in the healthcare workplace have been identified as also contributing to retention issues. Judith Briles (2003) in her book *Zapping Conflict in the*

*Healthcare Workplace* wrote that all too often women in the healthcare industry are undermined and dissatisfied because of their fellow nurses and managers. She stated that the major problem with nursing retention was the noxious environment within which nurses exist. She outlined a number of factors which influence why nurses leave the profession, but the most prevalent was competition and criticism from other nurses. Nurses criticize and compete with each other for a sense of power and prestige within the nursing workforce. They may try to impress physicians, patients, or other healthcare workers. Briles noted that the healthcare environment is a truly bureaucratic and industrial type of mentality in which the nursing staff is not often valued or included. Those nurses who do make it to the top of the profession often do so by clawing their way over others. It is not a pretty picture of the nursing profession, although it is not totally unrealistic.

Nursing is a competitive and demanding profession, and the impetus of Briles's (2003) book is to make nurses aware of the need to look first to themselves for building up the profession. Too often nurses blame administrators for their unhappiness, when they also need to look at how they impact others in the profession. They need to focus on ways in which they may be turning new nurses away; ways in which they are not encouraging others to come into the profession; and ways in which they are not being more supportive and nurturing of others. In all, the nursing profession has a long way to go to improve the present state of crisis. Nurses and nursing administrators must focus on improving the whole person paradigm. They must look toward multiple factors, such as physical, mental, emotional, and spiritual stressors, and correct these in order to improve the quality of the nurse's work life and in so doing improve nursing retention.

### *Effect of Stress and Burnout in the Acute Care Setting*

Humphrey (1988) defined stress as “any factor acting internally or externally that makes it difficult to adapt and that induces increased effort on the part of the person to maintain a state of equilibrium” (p.18). There are many reactions to stress; some are physiological, such as rapid heart rate, perspiration, and increased blood pressure, while others are behavioral, such as defensive or avoidance behaviors, anger, inability to concentrate, and inappropriate actions. A stressor may not be solely an undesirable event, but may be seen as a motivator or initiator of behavior. Selye referred to stress as the “spice of life” (Sulsky & Smith, 2005, p. 3). The stress response is produced when a stressful or threatening stressor is present. This stressor may be any variety of psychological or anxiety provoking situation. Many events in a hospital setting are seen as “distressful,” where distress refers to an unhealthy type of stress.

Stress in the healthcare setting may take many forms. In a random sample of over 40,000 nurses in Maryland and Virginia, Humphrey (1988) reported some interesting statistics about stress among hospital-based nurses. He found that when nurses were questioned about what constitutes stress, 32% said anxiety-provoking events, 19% said emotional events, 17% said tension, and 16% said pressure in the workplace. When further questioned, the nurses reported that anxiety-provoking events are situations such as trying to cope with events beyond their immediate control, a feeling of increased responsibility and too little time to accomplish the demands. Examples of emotional events included emotional outbursts by family members or patients, reaction to negative or unsettling events, and uncomfortable demands placed on the nurse. Tension and

pressure were related to overwork, lack of control, feeling burnt out by events, and constant pressure from having to make critical decisions. Wolfgang (1988) conducted a stress-related survey involving 3,105 health professionals. He found that physicians, nurses, and pharmacists all reported a significant level of stress within their current position. He postulated that these higher stress levels could produce decreased enthusiasm, impaired problem-solving, and lessened quality of care to their patients.

In a short story, Hiscoe (1976) described what it is like to help a wife decide to let her husband die without any further heroic measures. The nurse stated that she felt overwhelmed and inadequate to make the decision, but she was the only one there and the wife needed her support. So, even though she was anxious and stressed herself, she knew that the wife was under a much greater stress and the burden of this decision rested with her. Hiscoe wrote that this type of decision and family anxiety and grieving happened many times a week in the intensive care unit. Often the nurses did not speak about it, but held their own emotions inside, only to have them resurface at home or with their colleagues.

Nurses experience stress when a bond is formed with the patient. If a patient is repeatedly admitted to the hospital, the nurse often develops a rapport or friendship with the person. This makes it even more difficult for the nurse to deal with life and death situations. While patients ask for the nurse to listen and help them, the nurses also need that same support from others. All too often, nurses are the ones who need another support system to relieve the stress that they have placed upon them (Sontegard, Hansen, Zillman, & Johnston, 1976). The authors noted that it is not only the family but the nurses who go through a grieving process when they lose a patient to whom they have been

close. They may blame the physician or even themselves; they may deny what happened or become depressed. These feelings occur over and over again in critical care settings. Ufema (1976) wrote that seeing so much sorrow and death places nurses at a point of examining their own mortality, and caring makes the nurse give a piece of herself. Davitz and Davitz (1980) noted that society expects nurses to be without feelings, but all too often they are not prepared for the feelings they will experience.

In a study of several hundred caregivers, nurses were asked how they handled their emotions in the workplace. Many stated that it depended on the patient and the circumstance. Those patients who were closer to the nurses' age or who reminded them of someone usually brought up more of an emotional attachment. Some nurses responded to patients who reminded them of a family member. In all, the nurses surveyed said that in most cases there was some emotional involvement and attachment, especially when they cared for patients on multiple occasions. In addition, the majority expressed the view that they were not adequately prepared in school to deal with those feelings. They said that in school it was emphasized to not become involved with patients and to maintain a distance, but in reality when they were officially the caregiver, this idea was difficult to follow (Davitz & Davitz, 1980).

Interestingly, Lazarus proposed a cognitive-phenomenological model of stress in 1978 to explain the relationship between the demands placed on a person and the power to deal with these demands. According to Lazarus, a person views a stressful situation as one of three potential types: irrelevant, benign-positive, or stressful. It is only the stressful area that brings a stress-related response to the person and over time may have a negative effect on the individual (Sulsky & Smith, 2005). The job-related model of stress as cited

in Sulsky and Smith explained the relationship between job demands and job decisions. The model identified a heavy workload and critical decisions along with a lack of control as contributing to employee stress. This model relates closely to the type of situations that nurses are placed in each day. Davitz and Davitz (1980) described the nursing issue of over-involvement with patients. They wrote that nurses developed physical symptoms that paralleled those of the patient. Nurses noted that they frequently take these patient problems home with them and have to “work” at feeling good.

Stress and employee effectiveness were described in an article by Jex, Cunningham, De La Rosa, and Broadfoot (2006). The authors noted that when stress is prolonged and distressful, the employee has difficulty performing task-related behaviors. They may find it difficult to concentrate, may make negative remarks, have difficulty interacting with other team members, and may develop a behavior of learned helplessness. The development of these actions would be very detrimental in the health care setting when staff members are required to work so closely with each other. In a particularly concerning model by Murphy, DuBois and Hurrell (1986), the idea that work related stressors lead to anxiety, fatigue, decreased attention and accuracy, and ultimately improper use of equipment, risky behaviors and accidents was presented. The impact of such behavior on patients is especially frightening.

Nurses have reported that work overload, heavy physical work, shift work, patient concerns, such as death and interpersonal problems are common stressors. In a study of 171 nurses in five hospitals, Motowidlo, Packard, & Manning (1986) found that the above stressors led to depression and decreased work performance. When 900 professionals were surveyed concerning work related stress, the findings demonstrated

that the top five workplace stressors were uncertainty, heavy workload, interpersonal stress, work demands, and lack of control. The authors concluded that these stressors over time could lead to work-related illnesses and poor attendance, although the study was not followed for an extended length of time (Rossi, 2006).

Stress-related disorders may account for a large percentage of absences from work, and this can contribute to the already burdensome nursing workload. Cooper and Payne (1988) wrote that 60% of absences are caused by stress-related disorders. These stress related disorders were defined by Cooper and Payne as cardiovascular heart disease, mental illnesses, and immune disorders, such as asthma and diabetes. A study by Payne and Fletcher (1983), examined the relationship between job demands, job support, and the risk of strain on health. The results showed that the higher the job demand and the lower the support, the greater the risk for health-related problems. The strain also led to behaviors such as smoking, increased alcohol consumption, and higher absentee rates. The rates of diseases were presented for this group of individuals, and it was noted that 48% had developed some form of cardiovascular disease. However, the authors did acknowledge that there may be many contributing factors in these persons, and they were not compared against any other group. In addition to absences, the cost of stress-related illnesses in the United States is \$4.2 to \$6 billion, with an annual cost of \$13,000 per employee regardless of the profession (Shirey, 2004).

Even the fact that nurses work in a “caring service” may produce elements of stress. Clements and Zarkowska (1994) described some key features for working in a caring service. These features are sustained relationships with a variety of people, specialized and complex skills, teamwork, and close contact with others. All of these



factors can lead to distress and inadequate coping in the workplace. Distress in the workplace may take the form of forgetfulness, arriving late or being absent, making mistakes, conflicts with others, and not following through on actions. These behaviors may be signs of personal burnout. According to Simendinger and Moore (1985), personal burnout may take a variety of forms, but generally follows three defined levels. The first level involves complacency and failure to follow through on tasks. The second level may lead to loss of sleep, weight gain, and loss of energy, while the third level can result in physical or psychological disturbances such as heart disease or mental illness. Stress in any form in the workplace can have very detrimental effects on the employee, and over time continued stressors can lead to health-related problems and loss of employees.

The problem of job burnout was first studied in those occupations that are considered “service” oriented. Maslach (2006) wrote extensively on the subject and noted that:

The therapeutic or service relationships that caregivers or providers develop with recipients require an ongoing and intense level of personal, emotional contact. Although such relationships can be rewarding and engaging, they can also be quite stressful. (p. 39)

Maslach (2006) noted that three important dimensions associated with burnout are exhaustion, cynicism, and inefficacy. Employees may call out sick, argue with others, or exhibit detached behaviors and express feelings of inadequacy and negativity to the job itself. The employee essentially becomes “disengaged” with the job. This means that managers must find a way to keep their employees engaged and motivated, similar to the strategies discussed by S.E. Wagner (2006). Nursing managers must recognize that

burnout is a very real problem, especially in acute care settings, and do all they can to eliminate stressors present in the work environment.

The relationship between burnout and stress has been studied by a number of authors (Glasberg, Eriksson, & Norberg, A, 2007; Skinner, Agho, Lee-White, & Harris, 2007). Glasberg et al. specifically looked at burnout and moral strain, which is explained by the experience of a troubled conscience. This troubled conscience develops when employees can not provide the care that they feel it is their duty to give. Using regression analysis, the authors were able to explain 59% of the total variance as emotional exhaustion, or the idea that stress and work demands can lead to a feeling of exhaustion or burnout. Burnout was related to high workloads and time pressures, while emotional exhaustion was related to care of terminally ill patients and blaming self for not being able to meet the patient's needs.

In a similar study, Skinner et al. (2007) used the Maslach Burnout Inventory (Maslach & Jackson, 1981) and a nursing stress scale developed by Stordeur, D'Hoore and Vandenberghe (2001) to explore the relationship between nursing stressors and burnout. Skinner determined that the original Maslach inventory did not sufficiently cover the current stressors that nurses experienced. A new questionnaire was developed based on participant responses, and the resultant format consisted of 38 items and 15 vignettes. The items were based on six main areas: work environment, burnout, control, job satisfaction, stressors, and work. The authors concluded that there was a strong correlation between stress and burnout.

### *Moral Distress in the Workplace*

While nurses are frequently under a variety of stressors, one area to consider is the concept of moral distress that most often affects nurses in the acute care setting. Moral distress has been defined as a situation in which the ethically appropriate course of action can not be taken (Corley, 1995). According to Elpern, Covert and Kleinpell (2005), this type of distress is a serious problem among critical care nurses and can be associated with job dissatisfaction and poor retention. In their study of 28 nurses working in a medical intensive care unit, they reported a moderate level of moral distress. The nurses were administered the moral distress scale and described how they felt about this distress. The study was a descriptive, non-experimental study which was conducted over a 6 week period and the authors had a 72% response rate to this survey. Information about the reliability and validity of the data were not provided, however the results produced scores for the nurses within a moderate range of intensity for moral distress. The nurses were also asked to describe the personal impact of morally distressing situations. The results demonstrated that the nurses were experiencing some feelings of depression and poor job satisfaction. Some nurses stated that they had considered leaving the hospital and even the profession because of these situations.

The impact of moral distress takes many forms. Nurses often feel frustrated and inadequate in their ability to handle these situations. Corley, Minnick, Elswick, and Jacobs (2005) noted similar levels of moral distress in the 106 nurses they surveyed. The respondents viewed working with terminally ill patients and having to make critical decisions as the greatest distress they faced. Omery, Henneman, Billet, Luna-Raines and Brown-Saltzman (1995) identified issues related to ethical decisions, do-not-resuscitate,

and dying with dignity as those causing the highest levels of distress. Elpern, Covert and Kleinpell (2005) also found that a number of nurses expressed an unwillingness to participate in blood and organ donation because of the distress related to keeping transplant patients alive against their wishes. The study was conducted at a large transplant center, and the nurses had a higher than average frequency of caring for these patients. They expressed a feeling of distress at the suffering that the transplant population experienced.

The concept of moral distress was explored in depth by Jameton (1984) in his book entitled *Nursing Practice: The Ethical Issues*. He noted that there were three main types of moral problems in nursing, those that deal with moral uncertainty, moral dilemmas, and moral distress. Moral distress was defined as “knowing the right thing, but constraints make it impossible to pursue the right course” (p.6). The problem stems from the idea that there are four conventional ethical principles of nursing. These principles are:

1. Nurses have an obligation to be competent.
2. Good of the patient is the nurse’s primary concern.
3. Nurses should not use their positions to exploit patients.
4. Nurses should be loyal to each other. (p.73)

Jameton noted that nurses make moral decisions all the time in an effort to meet these principles. In addition, there may be sanctions or rewards by either the institutional representatives or others such as co-workers for attempting to adhere to these principles. Nurses are placed in positions to decide how they can be competent and do the best for the patient in the work environment. In all, nurses must learn how to deal with moral and

ethical decisions and how to work through dilemmas as they arise. The author emphasized that nurses should not make decisions for the patient based on their own personal values and must treat each patient empathetically and equally.

The relationship between moral distress and burnout was explored by Meltzer and Huckabay in 2004. Sixty nurses were given the moral distress scale and the Maslach burnout inventory. The results showed a significant positive correlation between the moral distress scale and the emotional exhaustion scale on the burnout inventory ( $p=.05$ ). Linear regression analysis was also conducted and indicated significance ( $r^2 = 0.10$ ) for moral distress frequency subscale and the Maslach burnout inventory emotional exhaustion subscale. This result indicated that moral distress can be predictive of emotional exhaustion. Emotional exhaustion can lead to a variety of issues such as poor attendance and even loss of staff. These previous studies utilized the moral distress scale as devised by Corley, Elswick, Gorman and Clor (2001). However, an additional scale called the Moral Distress Assessment Questionnaire was developed by Hanna (2004). Hanna's questionnaire was used in a study with 259 health care professionals. The study included not only nurses, but pharmacists and physicians. The results showed the highest level of moral distress to be among nurses (60.8 %), as compared to pharmacists (50.2%) and physicians (52.5%). A significant difference between groups ( $p < .01$ ) was reported.

End of life issues are often seen as very distressing. The death of a patient is emotionally the most devastating (Davitz & Davitz, 1980, p. 116.). It can lead to feelings of helplessness, anger, and despair. Badger (2005) used a descriptive qualitative study to report the findings of 24 nurses in a medical intensive care unit. The nurses described end of life issues as the most distressing that they have to face. They said that dealing with

younger patients in acute life-threatening situations and performing futile care on elderly patients were the most stressful. It was difficult for the nurses to change from a cure model to a comfort care model, and this often caused frustration and anxiety in their decision making process. Badger conducted the study over a six week period and employed focus group interviews, informal conversations, and observations. The questions focused around four key questions related to stress, cure versus comfort care, and the effect that dying patients and grieving families have on the nurses. The nurses acknowledged that dying occurred frequently in the unit and was rarely talked about in great detail among the staff. They felt, however, that suffering of their patients was worse than dying, and futile care evoked ethical questions with the staff. In a study conducted by Erlen and Sereika (1997), 61 critical care nurses were surveyed using the Health Professions Stress Inventory and the nurse's ethical decision making scale. What they found was that when nurse's autonomy increased, perceived anxiety decreased ( $p < 0.01$ ). In addition, when restrictions in the work setting decreased, the level of stress also decreased ( $p < 0.05$ ). Therefore it appears that when nurses have more autonomy and control over the care of the patients, even in stressful situations, their anxiety level decreases.

Erlen (2001) took an even broader stance on moral distress and wrote that moral distress also occurs because nurses cannot take the course of action that they would like because of system constraints. She noted that all too often nurses are placed in situations where by they can not provide the bedside care that they know the patient needs. This dilemma is caused by system requirements, such as mandatory documentation, shortages of caregivers, and hospital policies. Nurses indicated that their complaints and issues fell

on deaf ears, and they lack the autonomy and control to make a difference, placing them in grave moral conflict. Unfortunately, the outcome is for the nurse to either become apathetic or leave the environment. Erlen noted that this type of stress is creating a toll on nurses' personal lives and leads to physical, emotional and social problems. Even when nurses leave, they are faced with similar problems at the next institution.

The American Nurses Association (ANA) issued a statement concerning the effect of working conditions on the nurses' perception of the Code of Ethics (2001b). The Code of Ethics states that nurses are obligated to act in a manner consistent with maintaining patient and personal safety. The code states that the nurse's primary commitment is to the patient, family, and community. The nurse is also responsible and accountable for protecting and maintaining the patient's health and safety. It further delineates that the managers and institution are responsible as well for providing that the nurse has an acceptable work environment. These ethical obligations place a burden on the nurse and, as stated earlier, can lead to feelings of distress when desired patient care cannot be performed.

### *Conceptual framework*

Based on the above information, a number of models for work related stress and its effect on retention have been developed. Locke (1976) described a model related to role conflict and role ambiguity, which in turn leads to problems with job satisfaction, physical symptoms and then turnover intentions.

Locke's (1976) writings focused on the nature and causes of job satisfaction. He wrote that job satisfaction is not just related to the employee and employer, but is also

related to the work itself. Locke defined job satisfaction as “the pleasurable positive emotional state resulting from the appraisal of one’s job or job experiences” (p.1300). This appraisal is what the employee performs for every element in the job. The employees assess if the task is fulfilling their needs and allowing the fulfillment of their important values. Each main element in the employee’s work is evaluated for value and importance. Locke noted that if there is a discrepancy between what the employee values and what the task is requiring, then the employee will not be satisfied. This appears to be what is occurring when a nurse is forced to perform care that is incongruent with the person’s basic values. When this continues to occur over time, dissatisfaction develops.

Kim, Price, Mueller, and Watson (1996) developed a causal model for the intent to stay among military healthcare workers. Their model was based on expectancy theory as explained by Vroom (1964). The idea is that employees enter an organization with certain expectations and values. The assumption is that these criteria will be met; if so, then the employee will remain with the institution. If not, then they will contemplate leaving. This lack of desire or intent to stay is the precursor to turnover. Kim et al. theorized that there were three main variables, which led to job satisfaction and organizational commitment. These variables were environmental, structural, and individual. Job satisfaction and organizational commitment then determined their desire to search for another job and ultimately their intent to stay.

The variables were devised from studying 244 physicians, although previous studies had been conducted utilizing nurses, dental hygienists, and all hospital employees (Agho, Mueller, & Price, 1993; Mueller, Boyer, Price, & Iverson, 1994; Price & Mueller, 1981). The environmental variable consisted of two main factors: kinship and



opportunity. Kinship relates to family and responsibility within the group. Opportunity relates to the job market and the ability of the employee to change positions. The greater the opportunity exists for employees to work elsewhere, the lower the expected intent to stay score.

Individual variables centered on general training, job motivation, met expectations, positive affectivity, and negative affectivity. Affectivity refers to the tendency for individuals to experience pleasant or unpleasant emotional states, essentially how the individual is affected. Met expectations refer to whether the job fulfills the individual's beliefs about the nature of the employment. The final structural variables are autonomy, distributive justice, job hazards, job stress, pay, professional growth, promotional chance, routinization, and social support. These structural variables lay the groundwork for how the individual copes with the situation. Employees desire autonomy, a sense of equity and fairness, and an opportunity for professional growth. They want to be protected from work hazards and from stress, and they want to receive appropriate pay. In addition, employees would prefer the chance for promotion and success within the institution. Routinization refers to the repetitive nature of the job and the desire to experience variety in the workplace for most individuals. Lastly, a strong social support system is important to employees and affects their desire to stay at the institution (Kim et al., 1996). It is clear that the intent to stay within any position is made up of a large variety of factors.

Even though I only experienced a few of these factors in my study, it is important to note the interrelatedness of these components and to explore the strength of factors, such as professional stress and moral distress. Many of the professional stress items

focused on individual and structural factors, such as job motivation, general training, autonomy, pay, and professional growth. The structure of the organization appears to play a role in the development of these items as stressors. Moral distress items, however, focused on individual factors such as met expectations and positive and negative affectivity. These issues are closely tied to an individual's expectations and experiences. The model developed by Kim et al. appears as below.

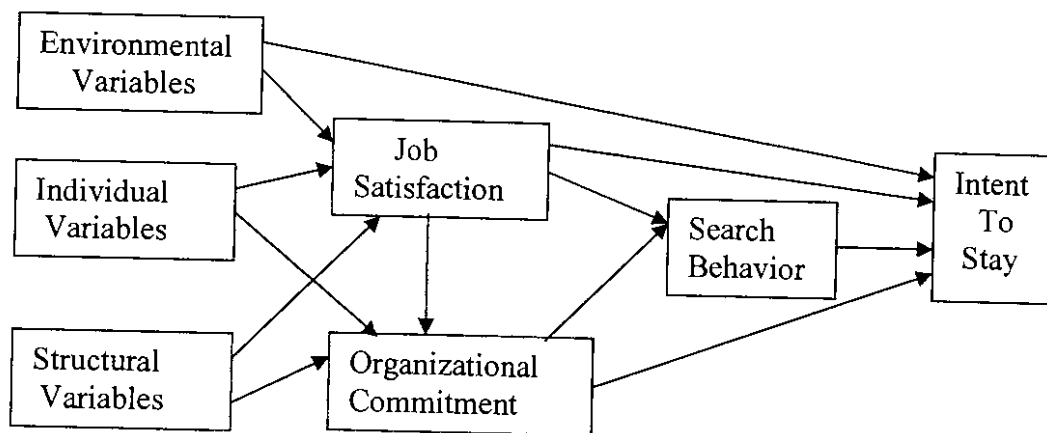


Figure 1: Intent to stay model

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From "The Determinants of Career Intent among Physicians at a U.S. Air Force Hospital," by S. Kim, J. L. Price, C. W. Mueller, and T. W. Watson, 1996, *Human Relations*, 49, p. Reprinted with permission of the author.

### *Possible Strategies for the Relief of Stress*

Nursing leaders must look toward the organization and culture for assistance with alleviating the stress experienced by their nursing staff. Some possible strategies are weekly massages, support staff, mentorship programs, empowerment through Magnet programs, and health promotion opportunities (Bost & Wallis, 2006; Donnelly, 1984; Leners, Wilson, Connor, & Fenton, 2006; Naude & McCabe, 2005; Stordeur & D'Hoore,

2006). Coping strategies for stress may be aimed at three areas: control, escape, and symptom management (Sulsky & Smith, 2005). Sulsky and Smith described the importance of proactive behaviors to remove the stressful situations, escape strategies, such as taking time off and getting away from stress, and symptom management through exercise, yoga, or other positive behaviors. Administrators must also facilitate dialog related to stressful situations and develop a support system through mentoring and counseling (Erlen, 2001). In nursing, managers rarely can remove the stressful situation, so it is important to practice escape and symptom management strategies, such as taking time off and encouraging exercise programs through the organization. In addition, nursing administrators must recognize that these stressors exist and search for ways to help relieve the anxiety that the staff may feel.

Lazarus identified four major methods of coping: information seeking, direct action, inhibition of action, and cognitive coping (as cited in Benner, 1984). As a manager, it is important to provide information on stressors and help employees to understand that their feelings are normal. Managers also need to allow for open discussion and counseling as needed to deal with feelings arising from moral distress. It is necessary to provide opportunities for employees to discuss their feelings and brainstorm coping strategies with others.

Health prevention and healthy lifestyle have been discussed by a number of authors (Clements & Zarkowska, 1994; Cooper & Payne, 1988; Donnelly, 1984; Humphrey, 1988). These authors stress the importance of being aware of one's limitations and also aware of the effect that stress may be having on the body. All of the authors promote the importance of organizational involvement and support for healthy

workplace strategies. Some ideas include company wellness programs and healthy meals in the cafeteria. The authors encourage the use of paid time off, support for child care, and employee assistance programs.

In all, it is imperative that nursing leaders take an active stand in understanding the stressors that nurses in the acute care setting face and do everything in their power to assist the staff to relieve this stress. Simendinger and Moore (1985) noted that the most critical factor in relieving employee stress is the recognition and support given by front-line managers. Therefore, it is necessary for nursing managers to be aware of what factors comprise stress in the nursing workplace and do all in their power to relieve it.

### *Conclusion*

Distress and specifically moral distress can have a very negative impact on the nursing workplace. Stress in itself can have detrimental effects on health care workers and managers need to remain cognizant of the stressors that their employees are under. In the critical care setting, nurses are frequently confronted with life and death situations. The American Association of Critical-Care Nurses issued a position statement on moral distress in 2004 and stated that employers must make every effort to combat the harmful effects of moral distress among workers (AACN, 2004).

The biggest areas of concern in critical care centered on communication, respect, and decision-making issues with other team members and managers. When 4,346 nurses were surveyed in 2006, 20% stated that they planned to leave their current position in the next 12 months and 29% planned to leave within 3 years. The staff felt that they were not adequately recognized for the stress-filled work that they performed every day. They

wanted greater control and autonomy in decision-making and patient care. They wanted to be recognized for the support that they give patients and families (Ulrich et al., 2006). Shirey (2004) described the need for a strong social support among nurses. She noted that social support is critical in helping to alleviate stress in the nursing workplace, as are opportunities for empowerment. Shirey noted that the social support a nurse receives should not only be on the unit but also part of the leadership culture. Spencer (1994) also found in a study of 72 nurses that the most common way for them to deal with grief and stress at work was to talk to other staff members. Therefore, nurses need this outlet for their stress, and the organization needs to allow this type of discussion to occur. If the nurses do not feel that they can express these feelings or if they feel that their opinions are not valued and respected, greater levels of internal stress may result.

What then can be done to assist nurses with these high levels of stress? Harris (2001) wrote that employers need to ensure the safety and health of their employees, and in addition, legislation may need to be enacted to provide for stress relief and stress prevention in the workplace. Harris suggested that the government should develop a 10 year plan to increase retention by decreasing stress related factors, such as poor physical conditions, inappropriate work demands, poor communication, and insufficient support. Occupational health specialists should take an active role in stress management classes, teach health prevention, and survey staff for potential stress related areas. Tounsel and Reising (2005) took the discussion of governmental involvement even further by examining current and potential legislation that centers on inadequate staffing, mandatory overtime, whistleblower protection, nurse recruitment, and retention initiatives. The

authors noted that these types of legislative actions would aid the nursing workforce and so help to alleviate the burnout process.

California was the first state to pass minimum patient to nurse ratios for every hospital unit (Tounsel & Reising, 2005). Enacted in 2004, the rest of the country is still waiting to see the outcome of this legislation before taking drastic stands on these mandates. There is concern about the ability of the government to oversee the enforcement of the staffing models and also the problem of staffing due to the continued nursing shortage. Connecticut was the first state to pass anti-mandatory overtime legislation and others are following suit (Tounsel & Reising). Mandatory overtime was used in hospitals as a way to cover shortages, but it is seen as a huge dissatisfier and places nurses in potentially greater stress-filled situations due to inadequate staffing. Other legislation to help nurses involves whistleblower protection for the reporting of unsafe situations and the use of government funds to attract and educate nurses to the profession (Tounsel & Reising).

Besides legislation and administrative strategies to improve retention, nursing research must continue to explore factors related to why nurses are leaving the acute care setting. Much of the research has centered on tangible options such as nurse-patient ratio (Aiken et al., 2002; Bowles & Lori, 2005), as well as education and recognition (Bethune et al., 2005; Leigh et al., 2005; Nedd, 2006; Wilson, 2005). Yet, nursing researchers must continue to look at psychological reasons such as workplace stress. Researchers have identified workplace stress as a significant factor in retention (Hayhurst et al., 2005; Humphrey, 1988; Rossi, 2006). Yet, moral distress is an area that has been less frequently cited as a cause for decreased nursing retention. While few authors have researched the

effect of moral distress among acute care nurses (Elpern, Covert, & Kleinpell, 2005; Meltzer & Huckabay, 2004), this is critical for nursing researchers as well as nurse managers to understand and additional research is needed.

Just as previous authors have focused on a variety of physical factors to improve nursing retention, we must also continue to look at the psychological aspects and work to decrease this type of variable when possible. Distress, specifically moral distress, is a very real and important phenomenon for nursing researchers to further explore. Therefore, this research centered on the effect of moral distress in the acute care setting and its effect on nursing burnout, anxiety, and ultimately nursing retention. If health administrators can more fully understand moral distress and its affect on the nursing profession, then they can more effectively find ways to alleviate this type of stress, develop strategies to cope in the workplace, and increase the quality of work life for nursing professionals, thereby improving the quality of nursing care.

Chapter 2 included a thorough review of the literature, highlighting those areas of nursing retention, the effect of stress and burnout, moral distress, the conceptual framework, and possible strategies for the relief of stress. Chapter 3 will explain the methodology, including the population, sample, instrument, and data analyses employed.

## CHAPTER 3

### Methodology

#### *Introduction*

This chapter is a presentation of the methods and procedures utilized in the present study. Selection of the population and sample will be discussed as well as the research design, instrumentation and methods of analysis. This study utilized a descriptive correlational design and was guided by the following research questions:

1. Is there a relationship between the amount of moral distress experienced by nurses and their intent to stay in acute care?
2. Is there a relationship between Moral Distress and Health Professions Stress Inventory scores in the nursing setting?
3. Is there a relationship among Moral Distress, Health Professions Stress Inventory scores and intent to stay?
4. Is there a significantly higher amount of moral distress in some nursing units as opposed to others?

#### *Sample Participants*

The participants included 234 nurses employed by a 220-bed hospital in Northeast Florida. The nurses are employed in a variety of settings, from medical-surgical to intensive care units, as well as some in an outpatient setting. The questionnaire was sent



via the institutional intranet to all nurses listed in the hospital system. The instrument was sent to all nurses in the system because it was not possible to select out only those working in certain areas. Therefore, nurses in clinic settings were also invited to respond. The nurses were asked in the questionnaire to list all clinical areas of employment in order to capture those who may have worked in acute care, but who were not presently working in that area. In addition, some nurses worked in both the clinic and hospital settings, so they were not excluded from the study.

This population was selected because it was intranet accessible and covered a variety of nurses employed by the institution. In addition, the nurses were accustomed to completing on-line surveys from the health system and had easy access to computers. These nurses were computer literate because many of the hospital processes involved computer access.

### *Instrumentation*

The instrument was a questionnaire made up of 51 items covering the areas of moral distress and professional stress. Five additional items for intent to stay were listed at the end of the inventory, as well as a section for comments and shared experiences. The instrument is a combination of three scales: the Moral Distress Scale, the Health Professional Stress Inventory, and the Intent to Stay scale.

Each scale was previously tested and was shown to yield scores with acceptable reliability and validity. The original Moral Distress Scale (MDS), as developed by Corley (1995), had a score reliability of .98 utilizing Cronbach's alpha for the MDS intensity scale and .90 for the MDS frequency scale (Corley, Minnick, Elswick, &

Jacobs, 2005). Both of these sections were included in the 32-item scale. In addition to reliability, content validity was determined by three experts in the field of nursing ethics. A shortened version of the scale was utilized for the present study, based on further unpublished research by Corley and Hamric (2007). The shortened version consisted of 21 items, which were administered to 196 registered nurses in the intensive care setting. Cronbach's alpha for internal consistency for scores on the shortened version was found to be .85 (Corley & Hamric).

The Health Professions Stress Inventory consisted of a 30-item questionnaire and was made up of descriptions of general stressful situations experienced in health care settings. The reliability was tested using Cronbach's alpha for internal consistency and found to be .89 (Erlen & Sereika, 1997). Concurrent validity was established at .78 utilizing comparison to a work-related tension measurement (Erlen & Sereika). The alpha coefficient for scores on the five-item Intent to Stay scale was found to be .85 (Kim et al., 1996; Nedd, 2006). Nedd (2006) demonstrated significant concurrent validity for the Intent to Stay scale with relation to organizational commitment and search behavior items ( $p < .01$ ).

In addition to the questionnaire, the respondents were also asked for demographic information. This information consisted of age, gender, years of nursing experience, years on present job, area in which they were employed, highest level of education obtained, and whether participants had taken an applied ethics course. At the conclusion of the questionnaire, a comment section was included for the participants to note any additional information about experiences with moral distress that they may have encountered and would like to include.

Anonymity of the research participants was ensured by the design of the study. The questionnaires were returned via the institutional intranet to an outside the institution survey system. The survey system protected respondent anonymity and allowed all information to be held in secure files. I did not have access to the personal information of the respondents. All information was collated and tallied by the survey company. This allows the respondents to feel more confident that their responses were not shared with supervisors, members of the hospital administration, or any other party. The results were retained until the study was completed and then were archived in a secure location. They were not shared with any outside party. In addition, the respondents voluntarily chose to participate in the study and were informed at the beginning of the questionnaire that their participation acknowledged their willingness to participate. The opening paragraph of the questionnaire noted that anonymity would be maintained. It also acknowledged that none of the data obtained would be shared with their supervisors. Institutional Review Board (IRB) approval was obtained from both the university (Appendix C) and hospital prior to initiation of the study. Only IRB approval from the university is included in appendix C so that the identity of the institution is not disclosed.

### *Data Analysis*

Data were analyzed using multiple statistical procedures and the Statistical Package for the Social Sciences (SPSS). For the first research question concerning the relationship between the amount of moral distress experienced by nurses and their intent to stay, multiple regression, discriminant and canonical correlation analyses were utilized. The third question related to the relationship between moral distress,

professional stress and intent to stay scores also utilized the same methodologies. Factor analyses to identify distinct factor groupings was used to explain the second research question which dealt with the relationship between moral distress and health professions stress inventory scores. The final research question sought to discover if certain nursing units experienced higher levels of moral distress than others. Discriminant analyses were utilized to identify these areas. Explanation of the individual statistical procedures is presented in the following paragraphs.

Multiple regression analysis was used to determine the relationship between moral distress, professional stress inventory scores, and intent to stay scores. The dependent variable was scores obtained on the intent to stay scale determined by responses to the five items identified by Kim et al.(1996). These items were related to the independent variables of moral distress and professional stress, utilizing items from the two previously discussed scales. Multiple regression analysis was used to analyze data because it employs correlational methods and demonstrates the relationship between one dependent variable and several independent variables (Hair et al., 2006). Multiple regression, instead of simple regression, is utilized when two or more independent variables exist. The main purpose of this type of analysis was to predict the outcome of the dependent variable based on the results of the independent variables. Therefore, the scores on the questionnaire were analyzed to determine if they predicted the outcome of intent to stay, which in turn can be said to affect nursing retention.

Regression analysis produces weighted variables and determines the contribution of each variable to the prediction or outcome. This type of analysis can note the degree of relationship and also the direction of relationship. Therefore, the results may be

negatively or positively correlated. In all, multiple regression provides insight into the relationships between the dependent and independent variables. It also can provide information about the relationships between the independent variables. The effect of collinearity can increase the predictive power of the regression equation and must be taken into account. Correlations between independent variables were provided by the regression output.

Factor analysis was also utilized in order to determine the strength of related factors and groupings of factors. Hair et al. (2006) defined the primary purpose of factor analysis as “defining the underlying structure among the variables in the analysis” (p. 104). Factor analysis was run for both the frequency and intensity items identified in the questionnaire. Four factor groupings for each area were extracted and additive subscale scores for each grouping were computed using the SPSS compute function. Factor analysis identified the commonality among questionnaire items and the strength of item variance by correlation coefficients.

The additive subscale scores were then used in discriminant and canonical correlation analyses in order to further understand the relationship among the items. Discriminant analysis was conducted utilizing the factor scores and intent to stay scores in order to determine which factors best discriminate with intent to stay scores. Discriminant analysis was also used with factor scores and work units, in order to determine if factor can discriminate certain work units. Discriminant function and structure coefficients were obtained for each analysis, as well as a territorial map. These aided the researcher in uncovering relationships and predictability of factors.

Canonical correlation analysis was also utilized to compare the frequency factor groupings to the intensity factor groupings. This analysis can be considered an extension of multiple regression. Intensity factors were used as dependent variables and the frequency factors were independent variables. This method identified the relationship between the frequency of occurrence and the intensity of the experience.

The reliability for scores on the instrument was determined by using Cronbach's alpha for internal consistency. This is the most widely used method of reliability testing (Creswell, 2005) and the results were consistent with previous studies.

This chapter included a description of the population and sample in the study. The instrument employed had established reliability and validity data. Issues of participant confidentiality of information and methods of data analysis were also described. The various methods of data analyses were presented with rationale. Chapter 4 includes a presentation of the results as well as discussion of the results.

## CHAPTER 4

### Results and Discussion of Findings

#### *Introduction*

This chapter includes the findings from the statistical analysis of the Moral Distress/Health Professions Stress Inventory and the relevance of these findings to the research questions previously identified. The purpose of the study was to determine whether relationships exist among the concepts of moral distress, professional stress, and nursing retention. Specifically, the study sought to discover the level of moral distress to which in-hospital nurses are exposed and to determine the relationship between this distress and the nurses' desire to remain in the hospital setting.

The inventory consisted of 51 items combined from published moral distress and professional stress questionnaires. Each respondent was asked to reply to both a "frequency" and "intensity" prompt for each of the items. The items were scored in a Likert-format of 1 through 5, with 1 meaning *never* and 5 being *very frequent* for the frequency scores, and 1 representing *none* and 5 representing a *great extent* for intensity scores. In addition to the survey questions, demographics and open-ended responses were included. The questionnaire was presented in an online format and conducted by an outside survey company. It was sent out initially on May 1, 2008, to the general nursing staff at a 220-bed hospital in Northeast Florida. It was resent on June 16, 2008, in order

to ensure that all participants were aware of the survey and had sufficient opportunity for participation. The questionnaire was not available for response after July 30, 2008. Therefore, the participants had a 90-day time frame to complete the survey. This was deemed to be ample time for those who wanted to complete the survey.

This chapter presents the results of the study followed by a discussion of the major findings. The results will be presented in the following order: description of the participants, mode scores for each questionnaire item, responses to the intent to stay variable, reliability and validity estimates for data collected with the questionnaire, multiple variable analyses, and summary of the qualitative responses. Descriptive data included frequencies, means, and standard deviations for the frequency and intensity scores of each item. Statistical analyses included multiple regression, factor analysis, discriminant analysis, and canonical correlation analysis for the questionnaire and the intent to stay variable. Reports of data analysis are followed by a summary of how the data address each research question.

### *Description of the Participants*

Of the 234 potential participants, only 159 (67.9%) completed the entire survey. This was probably related to the length of the survey and the fact that most of the participants would have completed it in the workplace. Even though it was an online survey, most employees would have had access to it only at the institution. This could have interfered with finishing the survey. The work environment of the participants was primarily the acute care setting, with the greatest number, 70 (29.9%), employed in critical care, while 65 (27.8%) were in an acute care specialty area and 59 (25.2%) were



on a medical-surgical unit. The additional 40 respondents were employed in the clinic or outpatient setting, education, or administration (Appendix D).

The largest group of the participants were in the age range between 41 and 50 years (30.3%), while the second largest group included persons between 31 and 40 (28.2%) years. The next largest group (23.5%) consisted of persons between 51 and 60 years. This coincides with what is commonly seen in the health care setting with respect to the average nursing age for the hospital workforce (Norman, et al., 2005). The aging workforce can have a major impact on the stability and performance of the staff. Many older nurses have the background to mentor and educate new nurses but may also require more time off for health and family issues. In addition to the age of the respondents, information about their years of employment was also obtained. The largest group of employment was those who had been employed 11 to 20 years (29.9%) while the next largest group (28.2%) was employed 21 years or greater. This is encouraging for the institution because it notes the longevity and experience of the staff. The rest of the employees (41.8%) had 10 years of experience or less. This reflects a good basis for mentoring of the staff because of the distribution of experience.

Additional information was also obtained concerning educational level, position held, employment status, and previous knowledge of applied ethics. Interestingly, the largest group of respondents held a bachelor's degree (39.3%), while 35.9% held only an associate's degree. Nineteen (8.1%) of the respondents held a master's degree. It is encouraging for this institution that a greater percentage of the nursing staff held a bachelor's degree or higher and that 47% or 108 had taken an applied ethics course. This may be due to the fact that the bachelor's degree nursing programs in the area have this

course as a requirement. The fact that there is a larger percentage of staff taking this course may also mean that some of the associate degree employees are returning for their bachelor's degree.

Other information obtained dealt with the type of position held and the employment status. The majority of the participants were staff nurses, 168 (71.8%), with 26 (11.1%) as charge nurse and another 25 (10.7%) listed as other. In addition, 190 (81.2%) were employed full time. This is an interesting item because many institutions have a large number of part-time or as needed employees. By contrast, at this hospital, the majority of the staff was employed in a full-time position. This institution also had available a modified full-time position, in which the staff member is employed in either a 60-hour or 72-hour per 2 week pay period position, which may be one reason why more nurses appear as full-time. Either way, this also is a benefit for the hospital because the staff would be more consistent and committed to the institution. As expected, the majority of the respondents were staff nurses, although it is interesting that some managers and charge personnel also completed the survey. This should provide a wide base of experiences.

#### *Descriptive Data for the Frequency Items*

The responses to each item were analyzed to ascertain the percentage answered for each possible category (Appendix D). The responses were separated into frequency and intensity answers. For the 51 items, some percentages stood out as high in some expected and not so expected areas. In the frequency category, the following items were deemed to occur *very frequently* by the respondents (Table 1). All of the items involved

professional stress issues and because of the frequency of occurrence should be a major area for the institution to investigate as possible staff dissatisfiers.

Table 1

*Frequency Items Occurring "Very Frequently"*

Item #	Item Content	% Occurrence
24	I am trying to meet society's expectations for high-quality medical care	63.9
12	I find myself caring for the emotional needs of the patient	55.9
39	I have found myself being interrupted by phone calls or people while performing job duties	45.8
45	I feel that I am inadequately paid as a health professional	44.5
35	I have found myself in situations where there was not enough not enough staff to adequately provide necessary services	33.8

In addition to those questions noted as occurring *very frequently*, a number also were classified as *frequent* items. Most of the items were again professional stress questions with one question 47 addressing a moral distress item (Table 2).

Table 2

*Frequency Items Occurring "Frequently"*

Item #	Item Content	% Occurrence
21	I am keeping up with new developments in order to maintain professional competence	46.4
27	I find myself dealing with difficult patients	39.8
47	I have cared for terminally ill patients	36.4
6	I often feel ultimately responsible for patient outcomes	33.5

Finally, those items which were noted to occur *sometimes* included items measuring professional characteristics, as well as some additional moral distress items. Only those items with *sometimes* percentages greater than 40% are included in this discussion (Table 3). Items 10 and 50 dealt with moral distress issues, while others

included topics related to patient care, especially the feeling of not being able to provide the best possible care. Other identified items dealt with conflict at work and some items dealt with competence.

Table 3

*Frequency Items Occurring "Sometimes"*

Item #	Item Content	% Occurrence
13	I have disagreed with other health professionals concerning the treatment of a patient	70.8
10	I have been uncertain about what to tell a patient or family about the patient's condition and/or treatment	55.4
42	I have worked with nurses who are not as competent	53.0
16	I have experienced conflicts with coworkers as the patient care requires	47.0
50	I have followed orders for pain medication even when the medications prescribed do not control the pain	46.7
31	I have found myself lacking adequate information regarding a patient's medical condition	44.8
20	I have assisted a physician who in my opinion is providing incompetent care	44.3
15	At times, I have not had opportunities to share feelings and experiences with colleagues	44.0
51	I have feared that a mistake will be made in the treatment of a patient	43.6
1	I find myself providing less than optimal care due to pressures to reduce costs	43.5
18	I have had work-related duties which conflict with family responsibilities	42.5
2	I have so much work to do that I can not do everything well	42.4

On 10 items, the majority of the respondents chose *never* in frequency occurrence.

These items included those related to nurse-physician relationships and moral distress issues (Table 4). It is encouraging that the majority of nurses have not been involved in those issues which could possibly have a great intensity of moral distress.

Table 4

*Frequency Items Occurring "Never"*

Item #	Item Content	% Occurrence
44	I have ignored situations of suspected patient abuse by caregivers	93.3
37	I have responded to a patient's request for assistance with death when the patient has a poor prognosis	79.3
3	I have asked the patient's family about donating organs when the patient's death is inevitable	70.0
34	I have increased the dose of intravenous morphine in end of life situation what I believe will hasten the patient's death	69.1
40	I have followed the physician's request not to discuss death with a dying patient who asks about dying	62.7
32	I have followed the physician's request not to discuss 'Code Status' with the family when the patient becomes incompetent	62.0
46	I ignore situations in which patients have not been given adequate information to insure informed consent	61.8
48	I have followed the physician's request not to discuss 'Code Status' with the patient	58.3
26	I have let medical students perform painful procedures on patients solely to increase their skill	56.0
17	I follow the physician's order not to tell the patient the truth when he/she asks for it	50.3

*Descriptive Data for the Intensity Items*

When the items were answered in the intensity category, the following items listed in Table 5 were identified as being experienced to a *Great extent*. Many of these items concern the provision of care and the idea that the nurse is unable to provide the best possible care. These items are especially critical for the managers to investigate, as they demonstrate the highest level of intensity for the staff and possibly the greatest stressors (Appendix D).

Table 5

*Intensity Items Occurring to a "Great Extent"*

Item #	Item Content	% Occurrence
35	I have found myself in situations where there was not enough staff to adequately provide necessary services	64.1
51	I have feared that a mistake will be made in the treatment of a patient	52.2
45	I feel that I am inadequately paid as a health professional	47.9
24	I am trying to meet society's expectations for high-quality medical care	41.3
36	I have had non-health professionals determine the way that I must practice my profession	41.0
20	I have assisted a physician who in my opinion is providing incompetent care	38.9
42	I have worked with nurses who are not as competent as the patient care requires	38.2

Under the *Moderate Extent* of intensity, eight items dealt with moral distress issues (Table 6). Even though these items were identified as being of a moderate intensity, none were previously identified as occurring with a high frequency. This is important to note, yet it is also important to be cognizant of the degree of intensity of these moral distress items. The other moderate intensity items deal with professional issues that were identified as occurring with some frequency. These items are ones that managers need to continue to monitor.

Table 6

*Intensity Items Occurring with "Moderate Extent"*

Item #	Item Content	% Occurrence
27	I find myself dealing with difficult patients	44.1
7	I have initiated life-saving actions when I think it only prolongs death	42.2

39	I have found myself being interrupted by phone calls or people while performing job duties	40.5
2	I have so much work to do that I can not do everything well	40.2
13	I have disagreed with other health professionals concerning the treatment of a patient	38.6
11	I carry out the physician's orders for what I consider to be unnecessary tests and treatments for terminally ill patients	38.2
12	I find myself caring for the emotional needs of patients	37.3
50	I have followed orders for pain medication even when the medications prescribed do not control the pain	37.3
6	I often feel ultimately responsible for patient outcomes	36.9
47	I have cared for terminally ill patients	36.0
41	I have found myself not being allowed to participate in making decisions about my job	35.2
14	I have continued to participate in care for a hopelessly injured person who is being sustained on a ventilator, when no one will make a decision to "pull the plug"	33.9
1	I find myself providing less than optimal care due to pressure to reduce costs	33.9
5	I have followed the family's wishes to continue life support even though I did not feel that it was in the best interest of the patient	33.3
4	I have experienced conflicts with supervisors and/or administrators at work	32.1
31	I have found myself lacking adequate information regarding a patient's medical condition	32.1
18	I have had work-related duties which conflict with family responsibilities	31.5
25	I supervise the performance of coworkers	27.8
21	I am keeping up with new developments in order to maintain professional competence	27.5
16	I have experienced conflicts with coworkers	27.3
9	I have followed the family's request not to discuss death with a dying patient who asks about dying	27.0
28	I feel that I have not been recognized or accepted as a true health professional by other health professionals	26.7
23	I have prepared an elderly person for surgery to have a gastrostomy tube put in who is severely demented and a 'No Code'	26.5
38	I have worked in situations where I did not know what type of job performance was expected	25.6

### *Intent to Stay Responses*

Finally, the respondents were asked select which statement most accurately captured their feeling about intent to stay at the institution. Of the five possible answers, three dealt with planning to stay: item 5, "I plan to stay with this organization as long as possible," item 4, "I would be reluctant to leave the organization," and item 3, "Under no circumstances would I voluntarily leave this organization." Based on these items, 111 participants (66.9%) noted their intention as planning to stay. The other options were: item 1, "I plan to leave the organization as soon as possible," and item 2, "I may leave the organization within the next year," These choices were selected by 55 people (33.1%). Even though 33% indicated that they would possibly leave in the next year, the greater percentage preferred to stay.

### *Reliability and Validity Analyses*

The internal consistency of responses to the Moral Distress/Professional Stress questionnaire was estimated by coefficient alpha. Alpha reliability for scores on the 102 items for the present sample ( $N=139$ ) was found to be .958. This coefficient indicates that scores from the instrument are stable and consistent (Creswell, 2005). This is even higher than the separate reliability estimates found for scores from each questionnaire in previous studies. Data from the shortened version of the Moral Distress scale previously yielded a coefficient alpha of .85 (Corley & Hamric, 2007). Scores on the Health Professions Stress Inventory previously yielded a reliability estimate of .89 using Cronbach's alpha (Wolfgang, 1988), and the reliability for scores on the five-item Intent to Stay scale was previously found to be .85 (Kim et al.,1996).



The authors of each of the three scales used in the present study previously established validity estimates for data on the instruments. A panel of nursing experts was used to develop the items on the Moral Distress scale (Corley et al., 2005). This represents content validity. Concurrent validity of scores on the Moral Distress scale was established with the Health Professions Stress inventory (.78) using comparisons to a work-related tension measurement, while the Intent to Stay scale was correlated with an organizational commitment and found to be significant ( $p < .001$ ). (Erlen & Sereika, 1997; Kim et al., 1996).

### *Multiple Variable Analyses*

*Factor analysis for frequency items.* A series of factor analyses were performed separately for frequency and intensity. The initial variance for the 51 frequency items extracted 15 factors, using Eigenvalue  $> 1$  (Table 7). This number of factors was considered too large and later factors were poorly defined, so the analysis was rerun with six factors extracted. Six factors were initially selected based on the scree plot (Appendix E). However, later factors were still ill-defined and some “doublets” were noted. Doublets refer to correlation values which are similar in strength across two or more factors and therefore make it difficult to identify the main factor for that item. Four factors were then extracted and rotated to the varimax criterion (Table 8). These factors accounted for 39% of the variance. Using a factor saliency criterion of  $\pm .40$ , there were no doublets, yet 13 items had correlation coefficients too low to be considered relevant.

Table 7

*Total variance explained*

Component	Initial Eigenvalues		
	Total	% variance	Cumulative %
1	10.075	19.754	19.754
2	3.709	7.272	27.026
3	2.552	5.004	32.030
4	2.222	4.356	36.386
5	2.040	4.000	40.386
6	1.890	3.706	44.093
7	1.581	3.101	47.193
8	1.519	2.978	50.172
9	1.333	2.613	52.785
10	1.326	2.601	55.386
11	1.221	2.395	57.780
12	1.195	2.342	60.123
13	1.153	2.261	62.384
14	1.042	2.043	64.427
15	1.025	2.041	66.437
16	.975	1.912	68.350
17	.944	.850	70.200
18	.924	1.811	72.011
19	.889	1.742	73.753
20	.822	1.611	75.364
21	.765	1.500	76.864
22	.720	1.412	78.276
23	.717	1.406	79.682
24	.676	1.326	81.008
25	.652	1.278	82.286
26	.620	1.217	83.502
27	.610	1.196	84.698
28	.580	1.138	85.836
29	.553	1.084	86.920
30	.509	.998	87.918
31	.495	.970	88.888
32	.447	.877	89.765
33	.422	.827	90.592
34	.410	.804	91.395
35	.396	.777	92.172
36	.375	.735	92.907

37	.357	.700	93.607
38	.340	.666	94.273
39	.329	.645	94.918
40	.310	.607	95.525
41	.298	.584	96.109
42	.283	.554	96.663
43	.263	.516	97.179
44	.239	.468	97.647
45	.226	.443	98.090
46	.201	.395	98.485
47	.180	.353	98.838
48	.172	.337	99.175
49	.159	.311	99.486
50	.143	.280	99.766
51	.120	.234	100.000

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Table 8

Varimax Rotated and Sorted Component Matrix for Frequency items

Item	Component			
	1	2	3	4
45.	<b>.660</b>	.092	-.023	-.004
28.	<b>.639</b>	.166	.202	.043
41.	<b>.606</b>	.184	.182	.038
8.	<b>.605</b>	.153	-.007	.048
42.	<b>.580</b>	.319	.235	.172
22.	<b>.549</b>	.082	.172	.214
36.	<b>.518</b>	.137	.266	-.050
49.	<b>.506</b>	-.126	.143	.301
33.	<b>.506</b>	.206	.119	.180
15.	<b>.497</b>	.033	.123	.277
35.	<b>.490</b>	.209	.441	.040
39.	<b>.470</b>	.049	.332	-.009
43.	<b>.446</b>	-.050	-.349	.239
27.	.359	.188	.207	-.065
12.	.222	.084	.119	-.135
14.	.198	<b>.758</b>	-.069	.160
5.	.143	<b>.758</b>	.001	.153
11.	.100	<b>.679</b>	.280	.225
7.	.294	<b>.645</b>	.089	.133
47.	.319	<b>.605</b>	-.006	.082

13.	.371	<b>.575</b>	.103	-.045
34.	.125	<b>.570</b>	.033	.046
23.	.109	<b>.546</b>	.250	.236
50.	.056	<b>.475</b>	.155	.019
37.	.052	.336	-.147	.244
26.	.312	.326	.022	.321
16.	-.018	.305	.156	-.023
24.	.007	.198	-.032	.096
46.	.023	.180	.020	.102
31.	.149	-.029	<b>.692</b>	-.168
1.	.209	.062	<b>.657</b>	-.043
30.	.088	-.005	<b>.627</b>	.037
2.	.280	.054	<b>.612</b>	-.037
51.	.391	.114	<b>.481</b>	-.101
6.	.001	-.057	<b>.457</b>	.138
38.	.200	.066	<b>.453</b>	-.082
18.	.166	-.086	<b>.421</b>	.192
20.	.229	.244	<b>.418</b>	.119
19.	.243	.180	<b>.407</b>	-.059
29.	-.062	.345	.393	.093
4.	.115	.264	.364	.055
10.	.157	.290	.345	.001
25.	-.122	.146	.220	.031
48.	-.007	.221	.029	<b>.788</b>
40.	.021	.295	-.036	<b>.766</b>
17.	-.064	.181	.163	<b>.686</b>
32.	.173	.213	.009	<b>.632</b>
9.	.104	.253	.127	<b>.560</b>
44.	-.025	-.041	.278	<b>.449</b>
21.	.109	-.004	-.100	.247
3.	.106	.152	.057	.224

*Note.* Bolded values represent items assigned to the four selected factor groupings.

Based on the rotated matrix, items 45, 28, 41, 8, 42, 22, 36, 49, 33, 15, 35, 39, and 43 were selected as one factor named “professional recognition.” The next factor group was made up of items 14, 5, 11, 7, 47, 13, 34, 23, and 50, and was named “terminal illness.” The third factor group included items 31, 1, 30, 2, 51, 6, 38, 18, 20, and 19. These items were identified as “lack of confidence.” The final grouping was called “moral distress” and consisted of items 48, 40, 17, 32, 9, and 44. Only items with correlation coefficients greater than .40 were selected for the group. Therefore, 13 items

(27, 12, 37, 26, 16, 24, 46, 29, 4, 10, 25, 21, and 3) were not identified with any factor.

Utilizing the SPSS compute function, the individual item scores for each factor grouping were added to form a factor subscale score, which could then be used in discriminant and canonical correlation analyses.

*Factor Analysis for Intensity items.* The initial factor analysis for the intensity items using the Eigenvalue >1 criterion produced 11 factor groupings (Table 9). The number of factors was considered too large and therefore the analysis was rerun with six factors extracted and rotated. Six factors were selected because they accounted for 56% of the total variance. However, this process still produced some doublets and unclear items. So, based on the scree plot, four factors were extracted and rotated using the varimax criterion (Appendix E). These factors accounted for 49.5% of the variance (Table 10). It is important to note that all of the intensity items were identified with at least one factor and had a correlation coefficient greater than .40 on the salient factor. The intensity items demonstrated slightly higher correlation coefficients than the frequency items.

Table 9

*Total variance explained*

Component	Initial Eigenvalues		
	Total	% variance	Cumulative %
1	16.229	31.822	31.822
2	4.491	8.806	40.628
3	2.431	4.767	45.395
4	2.137	4.190	49.585
5	1.801	3.532	53.117
6	1.526	2.992	56.109

7	1.356	2.658	58.768
8	1.326	2.600	61.368
9	1.113	2.183	63.551
10	1.087	2.131	65.682
11	1.051	2.061	67.743
12	.976	1.913	69.656
13	.927	1.818	71.474
14	.878	1.721	73.194
15	.823	1.614	74.808
16	.754	1.479	76.287
17	.732	1.435	77.722
18	.710	1.393	79.115
19	.690	1.353	80.468
20	.660	1.294	81.762
21	.627	1.229	82.991
22	.594	1.165	84.156
23	.546	1.070	85.227
24	.523	1.026	86.253
25	.496	.973	87.226
26	.472	.925	88.151
27	.436	.854	89.005
28	.406	.795	89.801
29	.395	.775	90.575
30	.360	.705	91.281
31	.355	.696	91.977
32	.339	.665	92.642
33	.325	.637	93.279
34	.305	.598	93.877
35	.299	.586	94.463
36	.283	.555	95.018
37	.258	.506	95.524
38	.243	.477	96.001
39	.230	.450	96.451
40	.221	.434	96.885
41	.201	.394	97.279
42	.189	.371	97.651
43	.186	.365	98.015
44	.162	.318	98.334
45	.155	.304	98.637
46	.141	.277	98.914
47	.136	.266	99.180
48	.127	.248	99.428
49	.110	.216	99.644
50	.100	.196	99.840
51	.082	.160	100.000

Table 10

*Varimax Rotated and Sorted Component Matrix for Intensity items*

Item	Component			
	1	2	3	4
40.	<b>.811</b>	.116	.006	.070
37.	<b>.802</b>	.121	.066	.157
44.	<b>.781</b>	.263	-.104	.133
46.	<b>.768</b>	.177	-.073	.240
48.	<b>.762</b>	.193	.044	.171
34.	<b>.723</b>	.195	.026	.248
32.	<b>.701</b>	.215	.130	.171
26.	<b>.682</b>	.229	.037	.355
29.	<b>.613</b>	.360	.010	.100
17.	<b>.590</b>	.516	-.001	.064
14.	<b>.578</b>	.393	.240	.010
5.	<b>.478</b>	.399	.292	-.004
50.	<b>.449</b>	.391	.152	.222
3.	<b>.432</b>	.425	.146	-.218
9.	<b>.425</b>	.357	.095	.266
2.	.104	<b>.685</b>	.147	.092
51.	.267	<b>.629</b>	.116	.322
11.	.208	<b>.606</b>	.301	.096
7.	.301	<b>.605</b>	.283	.086
20.	.332	<b>.599</b>	-.059	.221
30.	.448	<b>.583</b>	-.002	.130
4.	.153	<b>.579</b>	-.147	.095
10.	.281	<b>.543</b>	.337	-.013
31.	.387	<b>.530</b>	-.014	.226
38.	.333	<b>.529</b>	-.053	.253
23.	.402	<b>.525</b>	.202	-.008
16.	.184	<b>.513</b>	.107	.108
1.	.228	<b>.509</b>	-.041	.174
42.	.328	<b>.497</b>	.137	.326
35.	.110	<b>.491</b>	.180	.344
19.	.384	<b>.463</b>	.121	.381
6.	.041	<b>.462</b>	.385	.010
18.	.241	<b>.434</b>	.043	.291
12.	-.063	-.090	<b>.759</b>	-.050
24.	-.093	.043	<b>.756</b>	.009
47.	.145	-.034	<b>.681</b>	.151

21.	.074	-.340	<b>.624</b>	.096
27.	.038	.194	<b>.618</b>	.090
39.	-.116	.217	<b>.530</b>	.311
13.	.221	.402	<b>.477</b>	.227
25.	.067	.241	<b>.410</b>	.123
15.	.033	.323	<b>.402</b>	.176
43.	.257	-.027	.019	<b>.668</b>
49.	.277	.050	.072	<b>.613</b>
33.	.216	.171	.184	<b>.586</b>
8.	.114	.137	.438	<b>.546</b>
45.	.035	.184	.371	<b>.539</b>
41.	.140	.443	-.036	<b>.485</b>
28.	.234	.262	.393	<b>.481</b>
36.	.223	.368	.018	<b>.481</b>
22.	.102	.363	.297	<b>.472</b>

*Note.* Bolded values represent items identified with the factor groupings for intensity.

Based on the rotated matrix, the first group of items (40, 37, 44, 46, 48, 34, 32, 26, 29, 17, 14, 5, 50, 3, and 9) was identified as “moral dying.” The next grouping consisted of items 2, 51, 11, 7, 20, 30, 4, 10, 31, 38, 23, 16, 1, 42, 35, 19, 6, and 18. This was identified as “professional patient care” and had the largest number of items. The third group was termed “professional competence” and was made up of items 12, 24, 47, 21, 27, 39, 13, 25, and 15. The last factor group consisted of items 43, 49, 33, 8, 45, 41, 28, 36, and 22 and was named “professional recognition.” The intensity item scores were then added using the compute function and factor subscale scores were obtained for the four intensity groups. As previously noted, each answer was given a 1 to 5 score based on the likert-format. Descriptive statistics for the factor groups are included in Table 11.

*Multiple regression.* Multiple regression analysis was utilized to ascertain the relationship between the questionnaire items and the respondents’ intent to stay, as well as to determine if respondents in certain units had higher stress scores than others. Data were analyzed using the SPSS software. Each item was given a numerical identifier of 1



through 5 based on the respondents answer. Multiple regression analysis was conducted to determine the relationship between questionnaire scores and the respondents' intent to stay score. The dependent variable was the intent to stay and the independent variables were the questionnaire scores for both frequency and intensity. Multiple regression was chosen because the data were interval and there was more than one predictor variable. The results initially produced a large effect size,  $R^2=.797$ ; however, this was not statistically significant ( $p=.161$ ). Therefore, the data were rerun using previously identified factor scores, instead of individual items. The descriptive data obtained are presented in Table 11.

Table 11

*Descriptive Statistics for 8 Predictor Variable Factor Groups Used in Multiple Regression Analysis*

Factor group	Mean	S. D.
Intensity Items		
Moral dying	41.6835	16.080
Professional patient care	63.6619	13.856
Professional competence	33.0144	6.088
Professional recognition	30.3597	7.101
Frequency Items		
Professional recognition	41.8993	8.131
Terminal illness	24.2806	6.738
Lack of confidence	27.9712	5.478
Moral distress	9.9712	3.843

*Note.*  $N=139$

The results demonstrated a medium effect size  $R^2=.182$ , which was statistically significant ( $p<.001$ ; See Table 12). Therefore, the null hypothesis was rejected. However, even though the results were statistically significant when all factor groups were combined, none of the factors individually had statistically significant beta weights. The

highest Beta weights were for factors intensity professional recognition ( $r = -.219$ ), frequency of professional recognition ( $r = -.172$ ) and intensity of moral dying ( $r = .113$  Table 13). Yet, when all factor groups were combined, the variables were predictive of intent to stay. In addition, the largest structure coefficients were for professional factors: frequency of professional recognition ( $r = .384$ ), intensity of professional recognition ( $r = .365$ ), frequency lack of confidence ( $r = .262$ ), intensity of professional competence ( $r = .256$ ), and intensity of patient care ( $r = .241$ ; See Table 13). The moral distress factors had lower correlation coefficients.

Table 12

*Analysis of Variance for 8 Factored Groups*

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	33.280	8	4.160	3.621	.001
Residual	149.368	130	1.149		
Total	182.647	138			

Table 13

*Summary of Regression Analysis for Variables Predicting Intent to Stay*

Variable	B	SE B	Beta	Sig.	rs
Moral dying	.008	.009	<b>.113</b>	.395	-.109
Prof patient care	-.003	.014	-.039	.824	<b>-.241</b>
Prof competence	-.014	.017	-.075	.417	<b>-.256</b>
Prof recognition	-.035	.025	<b>-.219</b>	.156	<b>-.365</b>
Freq prof recognition	-.024	.020	<b>-.172</b>	.235	<b>-.384</b>
Freq terminal illness	.003	.017	.019	.851	-.188
Freq lack of confid	-.018	.026	.087	.489	<b>-.262</b>
Freq moral distress	-.002	.028	.008	.930	-.114

*Note.* Bolded values represent the largest Beta weights and structure coefficients.

*Discriminant analysis for intent to stay.* Utilizing factor subscale scores, discriminant and canonical correlation analyses were conducted based on intent to stay

variables and the eight factored subgroups. These analyses were used to determine whether the subgroups could predict outcomes and the degree of this prediction. Two discriminant analyses were conducted. The first discriminant analysis examined the eight factored subscales' ability to discriminate participants based on their intent to stay. The Box's M value for the intent to stay was found to be statistically significant ( $p < .01$ ), indicating that the homogeneity assumption was not met. This analysis yielded four discriminant functions as shown in Table 14; functions 1 and 2 were of appreciable size (Wilks' Lambdas = .659 and .859, respectively). However, only function 1 was statistically significant ( $p < .01$ ).

Table 14

*Wilks' Lambda for Intent to Stay Discriminant Analysis*

Test of Functions	Wilk's Lambda	Chi-square	df	Sig.
1 through 4	.659	54.449	32	.008
2 through 4	.869	18.281	21	.631
3 through 4	.934	8.949	12	.707
4	.987	1.659	5	.894

Discriminant function and structure coefficients are presented in Table 15. Based on structure coefficients for functions 1 through 2, six of the eight subscale scores served as adequate discriminating variables, namely frequency professional recognition, intensity professional recognition, frequency lack of confidence, frequency terminal illness, intensity professional patient care, and intensity moral dying. Only intensity professional competence and frequency moral were not strongly correlated with the dependent (i.e., grouping) variable. Based on the territorial map, function 1 discriminated participants in groups 2 and 3 from those in groups 4 and 5 (Appendix G). Group 4 and 5

represented those nurses who planned to stay as long as possible and who would be reluctant to leave. Groups 2 and 3 represented those who may leave within the year and those who would not leave under any circumstances.

Table 15

*Structure and Function Coefficients for Intent to Stay Discriminant Analysis*

Structure Matrix for intent to stay discriminant analysis

	Function			
	1	2	3	4
Frequency prof recognition	<b>.874</b>	.334	.049	-.114
Professional recognition	<b>.730</b>	.382	.019	.318
Frequency lack of confiden	<b>.614</b>	-.349	.320	-.007
Frequency terminal illness	<b>.420</b>	.414	.320	.243
Professional patient care	<b>.397</b>	.308	.048	.178
Moral dying	.090	<b>.520</b>	.460	.335
Professional competence	.428	.270	.310	<b>-.473</b>
Frequency moral	.238	.274	.208	<b>.331</b>

Discriminant Function Coefficients

	Function			
	1	2	3	4
Moral dying	-.415	.348	1.365	.042
Professional patient care	-.091	.661	-1.544	-.230
Professional competence	.040	.175	.430	-.791
Professional recognition	.629	-.541	-.061	1.125
Frequency prof recognition	.359	.698	-.288	-.886
Frequency terminal illness	.036	.273	.269	.287
Frequency lack of confiden	.428	-1.169	.859	.273
Frequency moral distress	.028	.079	-.157	.381

*Note.* Bolded values represent the largest structure coefficients for functions 1-4.

*Discriminant analysis for work units.* Discriminant analysis was also conducted using work units as the discriminant function. This analysis examined the eight factored

subscales' ability to discriminate participants (n=138) based on their work unit. The Box's M value for work unit was .125 ( $p > .05$ ). This indicates that the homogeneity assumption was met and there was no difference between the groups. This analysis yielded three discriminant functions. As shown in Table 16, only function 1 was of appreciable size (Wilks' Lambda = .824). However, none of the functions was statistically significant.

Table 16

*Wilks' Lambda for Discriminant Analysis of Work Units*

Test of Function	Wilks' Lambda	Chi-square	df	Sig.
1 through 3	.824	24.930	24	.410
2 through 3	.940	8.028	14	.888
3	.977	3.004	6	.808

Discriminant function and structure coefficients are presented in Table 17. Based on structure coefficients for function 1, four of the eight subscale scores served as adequate discriminating variables, namely intensity professional competence, intensity professional patient care, intensity moral dying, and frequency terminal illness. Based on the territorial map, function 1 discriminated participants in group 3 from the other groups (Appendix G). This group was identified as the critical care area.

Table 17

*Structure and Function Coefficients for Discriminant Analysis of Work Units*

## Structure Matrix for Discriminant analysis of work units

	Function		
	1	2	3
Intensity professional competence	<b>.614</b>	.356	.009
Intensity professional patient care	<b>.565</b>	.562	-.071
Intensity moral dying	<b>.538</b>	.313	-.244
Frequency terminal illness	<b>.442</b>	-.125	.433
Frequency lack of confidence	.213	<b>.553</b>	.282
Frequency moral	.472	<b>-.532</b>	.226
Intensity professional recognition	.239	<b>.456</b>	.270
Frequency professional recognition	.011	<b>.281</b>	.068

## Discriminant Function Coefficients for work units

	Function		
	1	2	3
Intensity moral dying	.119	.205	-.539
Intensity professional patient care	.630	-.116	-.679
Intensity professional competence	.600	.230	-.250
Intensity professional recognition	-.247	.415	1.456
Frequency professional recognition	-.537	-.117	- 1.234
Frequency terminal illness	.335	.210	.561
Frequency lack of confidence	-.195	.657	.844
Frequency moral	.360	-.701	.140

*Note.* Bolded values represent the largest structure coefficients for functions 1 and 2.

*Canonical correlation analysis.* Canonical correlation was conducted utilizing the four intensity variables as dependent variables and the four frequency variables as independent variables. This analysis tested the degree to which participants were consistent in their perceptions of frequency versus intensity of issues rated. The analysis yielded four canonical roots (Table 18). Function and structure coefficients are shown in

Table 19. Three of the four roots were statistically significant ( $p < .05$ ). However, only two of these accounted for a noteworthy amount of shared variance.

Table 18

*Eigenvalues and Canonical Correlations*

Root No.	Eigenvalue	Pct.	Cum. Pct.	Canon Cor.	Sq. Cor.
1	1.19680	57.4840	57.484	.73810	.54479
2	.80367	38.6020	96.086	.66751	.44558
3	.08148	3.9130	99.999	.27448	.07534
4	.00000	.0001	100.000	.00052	.00000

Table 19

*Structure Coefficients for Correlations between Dependent and Canonical Variables*

Variable	Function			
	1	2	3	4
Intensity moral dying	.28430	-.26825	.72186	.57108
Intensity prof patient care	<b>.48278</b>	<b>-.75754</b>	.31355	.30782
Intensity prof competence	<b>.49595</b>	-.21025	.53683	-.64934
Intensity prof recognition	<b>.96388</b>	-.07225	.17571	.18668

*Function Coefficients for Correlations between Covariates and Canonical Variables*

Covariate	Canonical variable			
	1	2	3	4
Frequency prof recognition	<b>.98845</b>	-.12247	.07128	-.05377
Frequency terminal illness	<b>.46887</b>	-.18981	.64241	.57571
Frequency lack of confidence	<b>.40824</b>	<b>-.89659</b>	.10130	-.13860
Frequency moral	.23837	.03820	.89160	-.38309

*Note.* Bolded values represent significant shared variance for functions 1 and 2.

Root 1 ( $R_c = .74$ ;  $R_c^2 = .54$ ;  $p < .001$ ) accounted for approximately 54% of shared variances in the variable sets. Structure coefficients indicated that the dependent set for

this function was most highly defined by professional recognition ( $r_s = .96$ ) followed by competence ( $r_s = .50$ ) and patient care ( $r_s = .48$ ). The independent canonical variate was most defined by professional recognition ( $r_s = .99$ ), followed by terminal illness ( $r_s = .47$ ), and lack of confidence ( $r_s = .41$ ). Hence, participants' perceptions of frequency of issues in the workplace is highly related to their perceptions of the intensity of similar issues.

Root 2 ( $R_c = .67$ ;  $R_c^2 = .45$ ;  $p < .001$ ) accounted for approximately 45% of shared variance in the variable sets. This root focused largely upon the correlation between participants' perception of the relationship between intensity of patient care issues and the frequency of their lack of competence. Structure coefficients indicated that the dependent set for this function is most highly defined by professional patient care ( $r_s = .76$ ). None of the other coefficients accounted for a large correlation coefficient. The independent canonical variate was most defined by lack of confidence ( $r_s = .90$ ). Therefore, participants' perceptions of patient care were highly related to their perception of confidence.

### *Qualitative Responses*

Forty-three participants included individual stories about their stressful experiences. Some addressed moral distress issues such as giving morphine around the clock to a dying patient, performing unnecessary procedures on terminally ill patients, not being able to fully discuss the patient's condition with the family, having staff and physicians give inadequate care to dying patients, and having to deal with difficult family members when their loved one was dying. These concerns were enumerated many times in the responses (Appendix H). Other issues concerned inadequate numbers and training



of staff, physician conflicts, poor pay and recognition, incompetent staff and physicians, being constantly interrupted by phone calls and family members, and not feeling that they had the time and equipment to effectively care for their patient. Many of these stories are especially touching, such as the nurse who had a 38 year old patient tell her that he did not want to be intubated and yet the physician did it anyway and the patient never got to say goodbye to his wife or children, or the nurse who begged the physician to do something to care for a hospice patient who was having trouble breathing. She called the physician numerous times until he finally came and the patient was placed on a respiratory modality that reversed the problem and the patient was able to recover enough to be with his family for a few more days. The intensity of these stories does more to demonstrate the strength of this issue than any statistical finding.

### *Research Questions*

The following research questions guided this study:

1. Is there a relationship between the amount of moral distress experienced by nurses and their intent to stay at the institution?
2. Is there a relationship between Moral Distress and Health Professions Stress Inventory scores in the nursing setting?
3. Is there a relationship among Moral Distress, Health Professions Stress Inventory scores and intent to stay?
4. Is there a significantly higher level of moral distress in some nursing units as opposed to others?

Based on the above analyses, the research questions can be explored and discussed. As for question 1, there is a demonstrated relationship between the amount of moral distress experienced by a nurse and their intent to stay at the institution. Multiple regression analysis yielded a statistically significant result for factored stress groupings and intent to stay at the institution. The most highly correlated factors were intensity of moral dying and professional recognition. Factor analysis correlation coefficients showed that the moral distress items had strong correlation coefficients in both the frequency and intensity categories. Two moral distress factor groups were significant under discriminant analysis: frequency of terminal illness and intensity of moral dying ( $p < .05$ ). Hence, there is a relationship between moral distress and the nurses intent to stay. When the qualitative responses were reviewed, it is noteworthy that many of the stories discussed moral distress issues. It is, therefore, a topic that is very important and relevant in the practice of nursing.

Question 2 addressed the relationship between moral distress and professional stress scores. Understandably, the scores were expected to be distinct because the surveys dealt with different topics. When factor analyses were performed, eight distinct factors were identified. The factors included four for the frequency items and four for the intensity items. A few items crossed factors and so were not included in factor scores. None of the intensity factors had doublets and only 13 of the 51 frequency items had values across factors. Therefore, the moral distress and professional stress items are distinctive and address different topics; there is not a relationship between the scores. However, when combined they both correlated with the intent to stay variable. This is important for question 3.

Question 3 addressed the relationship among both moral distress and professional stress scores and the participants' intent to stay. When these factors are combined, there does appear to be a relationship. Multiple regression analysis indicated a statistically significant relationship ( $p < .001$ ) between the eight factors and the intent to stay variable. Professional recognition and moral dying factors were noted as the most highly correlated based on Beta weights. Discriminant and canonical correlation analyses indicated that the factors were strongly correlated with the intent to stay variable. Under discriminant analysis six factors were identified as noteworthy in size with two being moral distress and four containing professional stress items. The professional stress factors had higher correlation scores under discriminant analysis. However, because the homogeneity assumption was not met, the results can not be considered statistically significant.

As for canonical correlation, there were two statistically significant and noteworthy canonical functions, indicating that the frequency of professional recognition issues is related to the intensity of professional recognition. In addition, the participants' perceptions of professional patient care were related to their perceptions of confidence. The significance of these factor groups is very important and sheds light on the relationship between these factors and the nurses' intent to stay at the institution. With 33% of the participants considering leaving the hospital and the majority of these from the acute care setting, it remains imperative for nursing management to consider the importance of these factors.

Question 4 addressed the relationship between moral distress and the nursing unit in which the respondent worked. This was not statistically significant for any one function. Yet, some variables were highly correlated with function 1. They appeared to

discriminate group 3 or the critical care units from the other units for the factored groups of intensity of professional competence, intensity of patient care, and the intensity and frequency of moral issues. Therefore, though not statistically significant, there may be some discriminating variables with the critical care group.

### *Summary*

In conclusion, there appears to be a strong relationship between moral distress and professional stress scores in relation to a nurse's intent to stay at an institution. This suggests that there is a correlation between the moral distress and stress variables. The factors cannot categorically predict an individual's intent, but they can imply that these items play a role in influencing one's intent to remain in the hospital setting. The results show that certain moral distress and professional stress items have a very strong relationship with a nurse's intent to stay. These items follow distinct groups that relate to terminal illness, care for dying patients, professional competence, professional recognition, and patient care. All of these factors are important to the nursing staff and can influence their actions as well as their beliefs. The qualitative responses of the nurses should not be overlooked. They represent the heart of this study because they highlight the type of situations in which nurses are placed every day. It is imperative that these situations be made known to not only the nursing profession but also to nursing students and the general public. The final chapter includes a discussion of these conclusions and potential solutions in some of these situations.

## CHAPTER 5

### Conclusion

#### *Introduction*

This chapter includes the conclusions discovered from the data analyses, poses some possible strategies, discusses limitations of the study, and proposes future research for lessening the stress experienced by nurses in the hospital setting. It is clear that nurses are under a considerable amount of stress in the workplace. Based on the participants' responses, professional or work-related items play as important a role in one's intent to stay at an institution as do morally distressing events. The data analyses showed that when both professional stress and moral distress items were related to intent to stay, the effect was significant ( $p < .001$ ). Some items were more highly correlated than others, specifically intensity of professional recognition, frequency of professional recognition, and the intensity of moral dying.

#### *Conclusions*

Discriminant analysis indicated that the six factors of frequency professional recognition, intensity professional recognition, frequency lack of confidence, frequency terminal illness, intensity professional patient care, and intensity moral dying were predictors of nurse's intent to stay in the hospital setting. This answers research question 1 that there is indeed a relationship among moral distress, professional stress and one's

intent to stay in the hospital setting. Only intensity of professional competence and frequency of moral dying were not sufficient predictors. This suggests that the frequency of moral dying items may be low or insufficient in number to predict one's intent; however, the intensity of those items demonstrates predictability. Based on discriminant analyses, the frequency of terminal illness and the intensity of moral dying were identified as noteworthy in size and significance ( $p < .05$ ). This answers research question 1, which deals with the relationship between moral distress and the nurses' intent to stay. In addition, the intensity of professional competence is not sufficient, yet the frequency of this occurrence may be predictive. This may mean that when the nurse's competence is at risk over an extended period of time, it may be predictive. This may occur for a number of reasons such as inadequate orientation or working in an area that often requires a high competence level.

The predictability of stress items to work units was explored using discriminant analyses and showed that certain factors were more closely associated with the critical care unit than with other work units. This validated research question 4. The factors were the intensity of professional competence, the intensity of patient care, the intensity of moral distress, and the frequency of moral dying. This correlates with what would be expected in a critical care area, namely that the patient care and required competence would be higher. In addition, moral distress appears to occur with higher intensity and frequency in a critical care unit than in other work units. This is what has previously been speculated (Elpern et al., 2005).

In related canonical correlation analyses, the frequency of professional recognition was strongly related to the intensity of recognition. This factor grouping

appeared to have the strongest correlation in many areas. Professional recognition included items such as “I am inadequately paid” (item 45); “I feel that I am not adequately recognized by other health professionals”(item 28); “I am not allowed to participate in decision-making” (item 41); “I feel that I do not receive the recognition from the public” (item 8); “I feel that opportunities for advancement on the job are poor” (item 22); and “I have not been able to use my abilities to the fullest extent on the job” (item 49).

These factors confirm findings of previous studies on problems in the workplace (Alspach, 2005; Budge et al., 2003; Nedd, 2006; C. M. Wagner, 2006). Employee recognition and empowerment are critical factors influencing stress, burnout, and retention in the nursing workplace. Lack of recognition was identified by employee comments that refer to low pay and lack of respect by physicians and other health professionals, as well as the inability to participate in unit decision-making.

The lack of professional competence and the intensity of patient care were identified through canonical correlation analysis as being closely related. This may suggest that participants perceived the degree of competence needed was related to the intensity of the patient care that was required. Items identified under professional competence included “I have found myself with inadequate information to care for the patient” (item 31); I find myself providing less than optimal care due to pressures to reduce cost” (item1); “I feel that I may be inadequately prepared to meet the needs of patients” (item 30); “I have so much work to do that I can not do everything well” (item 2); “ I have feared that a mistake will be make in the treatment of a patient” (item 51); and “I often feel ultimately responsible for patient outcomes” (item 6). The patient care

items contained the same items, with the inclusion of some moral distress factors, such as “I carry out the physician’s orders for what I consider to be unnecessary tests and treatments for terminally ill patients” (item 11); “ I have initiated extensive life-saving action when I think that it only prolongs death” (item 7); “ I have assisted a physician who in my opinion is providing inadequate care” (item 20); and “I have been uncertain about what to tell a patient or family about the patient’s condition or treatment” (item 10).

Competence and the intensity of patient care are often identified as factors that affect the stress level of nurses. All too often, nurses are placed in situations in which they are forced to make critical decisions related to patient care. The frequency of this occurrence can be influential in causing stress and burnout (Meltzer & Huckabay, 2004). Many of the employee comments related to working conditions and the feeling that they were unable to meet the needs of the patient because of inadequate staffing, high acuties, and insufficient orientation.

Although professional stress issues were noted frequently in the above analyses, the moral distress items were strongly correlated with intent to stay under multiple regression and discriminant analyses. In addition, the nurses’ open-ended responses referred most often to morally distressing issues. This suggests that moral distress is a concept that is strongly related to emotional factors and distinct from professional stress issues. Based on factor analyses, the moral distress items were distinct factors under both frequency and intensity categories. This correlates with research question 2, that moral distress and professional stress variables are distinct.

Nurses frequently commented on moral issues that had occurred in the past but which still elicited a stressful response. This is very relevant as to how an employee may



make moral decisions. Jameton (1984) described moral decision-making in nursing and the need to act empathetically and equally to all patients. Hough (2007) noted that nurses need to incorporate a “focused reflection” in ethical decision-making, referring to the concept that one’s past experiences aid in framing one’s reaction to the present experience. Therefore, it is vitally important for nurses to identify their emotions and actions in moral dilemmas. This provides a framework for them to recognize and make changes in their responses.

The moral distress items were based on questions such as “I have followed the physician’s request not to discuss death with a dying patient” (item 40); “I have responded to a patient’s request for assistance with death when the patient has a poor prognosis” (item 37); “ I have followed the physician’s request not to discuss “Code Status” with the patient” (item 48); “ I have increased the dose of morphine in end of life situations that I believe will hasten the patient’s death” (item 34); and “I have continued to participate in care for a hopelessly injured person who is being sustained on a ventilator when no one will make the decision to ‘pull the plug’”(item 14). Many of the individual comments related to these types of moral distress issues, such as keeping patients alive when there is no chance of survival, dealing with the emotional issues of dying patients and their families, and not providing adequate care to dying patients. These morally distressing items place great stress on the nurses and affect their desire to remain at the institution.

The employee responses for intent to stay showed that 67% were satisfied and desired to remain at the institution. However, 33% noted that they would leave within the year. This is distressing for any employer. Retaining employees is a crucial factor in

maintaining the stability of an organization (Collins, 2001). A 33% intended resignation rate is indicative of the present climate in nursing. Many nurses are ill prepared to deal with the level of stress that they encounter (Bowles & Lori, 2005). This work related stress leads to burnout and emotional exhaustion, as previously identified by Skinner et al. (2007). In addition to emotional exhaustion, physical symptoms may occur, which further affect employee attendance and patient care (Humphrey, 1988; Shirey, 2004; Wolfgang, 1988).

The factors of professional stress and moral distress closely related to the Kim et al. (1996) model of intent to stay. The model describes environmental, structural, and individual factors that relate to job satisfaction, organizational commitment, and search behavior for a new job. The participants did identify a few environmental issues, such as family conflicts with work; however, the most strongly related variables were those classed as individual and structural. Individual variables centered on a feeling of being adequately trained and prepared for the job, as well as a positive affinity for the job. Many comments noted that the employee was stressed about a certain aspect of the job and did not feel positive about the work environment. Most of the items, though, dealt with structural variables that were related to employee recognition, job stress, pay, autonomy, and promotional opportunities. This suggests that 33% of the employees may leave the institution for the reasons noted above. In addition, even though the other employees did not express a desire to leave, if the stressors continue, they may be motivated to engage in job search behaviors. Therefore, it is crucial for managers to acknowledge the presence of these factors and improve the institutional structure to address these issues.

### *Management Strategies*

Some critical factors that need to be addressed are those related to employee recognition, pay, autonomy, and promotional opportunities. Many authors have identified strategies for improvement in these areas (Bost & Wallis, 2006; Donnelly, 1984; Leners et al., 2006; Naude & McCabe, 2005; Stordeur & D'Hoore, 2006). These strategies may be employee involvement in decision-making, committee participation, and employee position laddering. Magnet programs have been identified as possibly improving nursing empowerment and involvement (Stordeur & D'Hoore; Upenieks, 2005). Other strategies may include management and education programs, as well as tuition reimbursement to encourage positive incentives and motivation (Nedd, 2006; Wilson, 2005).

In addition to the structural factors, managers must make every effort to address job stress. As noted, nursing stress can lead to burnout, exhaustion, and an inability to adequately care for patients. Jex, Cunningham, De La Rosa, and Broadfoot (2006) previously noted that when stress is prolonged and distressful, employees have difficulty performing task-related behaviors. They may find it difficult to concentrate, may make negative remarks, have difficulty interacting with other team members, and may develop a behavior of learned helplessness. Stressors over time may also be related to work-related illnesses and poor attendance (Rossi, 2006).

What, then, can be done by managers to ease the problem of professional and moral distress in the workplace? Based on the current research, I propose that they do the following:

1. Make the staff aware of the concept of moral distress and professional stressors.
2. Be aware of the effect of stressful events on the staff.
3. Provide opportunities for the staff to express their feelings.
4. Provide for counseling when needed.
5. Watch for employee changes in behavior, absenteeism and employee separations.
6. Educate new employees regarding ethical issues and professional stress and inform them of counseling options.

In all, it is imperative that nursing leaders take an active stand in understanding the stressors that nurses in the acute care setting face and do everything in their power to assist the staff to relieve this stress. Simendinger and Moore (1985) noted that the most critical factor in relieving employee stress is the recognition and support given by front-line managers. Therefore, it is necessary for nursing managers to be aware of what factors comprise stress in the nursing workplace and do all in their power to relieve it.

Nursing managers must acknowledge the presence of job related stress and present programs to deal with these issues. This study has shown that multiple factors affect the desire of nurses to leave the workplace. These factors differ in frequency and intensity but in general are related to moral distress and professional stress issues. In light of the current nursing shortage and need for employee retention, managers should work diligently to promote employee satisfaction and retention. Nurse educators also should be cognizant of the need for more courses that address ethical dilemmas and stress in the nursing environment. New graduates should not be shocked by some of the patient issues

and should have at least some knowledge-based concepts related to ethical and moral issues.

### *Limitations of the Study*

The study was conducted using a convenience sample of nurses at one hospital in Northeast Florida. As such, the data may not be generalizable to all nursing populations. Many in this group of nurses had relocated within units and acquired new equipment in the months preceding the survey, which may have affected their responses. In addition, the participants completed the survey in the workplace and, because of this, may have been rushed or inadequately completed the survey. They also may not have felt comfortable reporting all stressors because of the fear of supervisor review of the results.

The demographic profile of this sample was consistent with those in other studies (Goodin, 2003; Norman et al., 2005). The age group most frequently chosen was between 41-50 years of age and their years of experience were reported as between 11-20 years. There were more bachelor's degree nurses than nurses at other levels and most were employed full-time. The intended retention rate of 67% was similar to those noted in other surveys and the stress responses were also closely related to those reported in many nursing studies conducted over the past 20 years. The response rate for the participants was high (68%).

The institution did not have Magnet certification and even though it had a high patient acuity, it did not have a large patient capacity. The hospital would typically be considered to have a low nurse-patient ratio for the area, with the average four to five patients per nurse in most areas and one to two patients in the critical care units. The

institution does have tuition reimbursement for some staff, but not a clearly defined laddering or promotion system. Efforts are underway to include staff members on committees, but this is in the beginning stages. Overall, it should be concluded that the responses of this sample provide valuable information that could be utilized in future research.

### *Future Research*

The data indicated that in answer to the four research questions, moral distress and professional stress are distinct factors, both of which are related to an employee's intent to stay at an institution and which demonstrate some differences in certain clinical areas. However, the research should not end here. The area of nursing workplace stress and moral distress must continue to be researched and addressed by the nursing profession. Moral distress remains a little known factor, even though research has grown and new tools have been employed. It is imperative that nursing managers recognize this issue and make every effort to assist their staff with these problems. Nursing professionals can no longer ignore the stressors that affect the workplace. They must provide a method for stress relief and counseling. They should provide opportunities for advancement and employee recognition, and they must provide a system through which the staff can address these concerns. All too often, managers tend to maintain the status quo and addressing these issues may not always be a priority. Yet, if stress related factors are not alleviated, the risk of losing staff may become a reality. Nursing research must continue to address stress related factors. Larger populations should be studied, as well as the relationship between moral distress and work-related factors. The exploration of

stress-relieving strategies is also needed as well as possible experimental studies that could further investigate these strategies. The results of this study will be shared with the institution and further research incorporating other nursing populations will be explored. It is important to expand this study using other nursing work units and institutions, possibly relating those with Magnet certification to others. In all, the results of this descriptive study must be shared with the nursing profession; it is important for the voice of these nurses to be heard by others. Their responses are critical in providing nursing and the public a view into the nursing environment and the stressors that nurses encounter every day as they strive to provide the best possible care for their patients.

## Appendix A

### Moral Distress/Health Professions Stress Inventory

#### *Introduction*

The following inventory is based on research concerning the effect of moral distress and professional stress experienced by nurses in the acute care setting. I, Cynthia Sorensen, am the primary investigator and my research focuses on the effect that these stressors have on nursing retention. I am interested in discovering if moral distress and /or other stress related items affect nurses' intent to stay in the acute care setting. The following inventory is a culmination of moral distress and professional stress related factors, as well as an area for personal comments at the end. Please take a few minutes to complete the demographic questions below and the inventory itself. The total time is approximately 15 minutes.

Your participation is strictly voluntary. By completing and submitting the survey, you will be consenting to having your data used for nursing research. In addition, all responses are anonymous and will be kept confidential. An outside survey processor will collect the information and your answers will not be shared with anyone in the health system. Your data submission will be privately coded by the company, and I will not have access to any identifiable data. For information regarding your rights as a research participant, contact the Chair of the UNF Institutional Review Board, Dr. David Kline, at 904-620-2498.

If you want to contact me for information about the study or other concerns, I can be reached at [cynthia.sorensen@unf.edu](mailto:cynthia.sorensen@unf.edu). The cumulative results of this study may be obtained by contacting me at the above address after December, 2008.

Your assistance with this study is greatly appreciated for I feel that the distress that nurses experience every day needs to be conveyed to the profession. So, again, thank you for your participation and assistance with this endeavor.

Please respond to a few demographic questions below:

#### *Demographic information*

1. In what type of clinical setting are you currently or have you been employed?
2. How long have you been a nurse?
3. What is your highest level of education?
4. What position do you currently hold?
5. Are you employed?



6. Have you ever taken a course in applied ethics?

7. How old are you?

*Moral Distress/Professional Stress Inventory*

The following situations occur in clinical practice. Please indicate how frequently you experienced each item described and how disturbing the experience was for you. If you have not experienced this situation, select never for frequency. Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practice.

1. I find myself providing less than optimal care due to pressures to reduce costs.

2. I have so much work to do that I can not do everything well.

3. I have asked the patient's family about donating organs when the patient's death is inevitable.

4. I have experienced conflicts with supervisors and/or administrators at work.

5. I have followed the family's wishes to continue life support even though I did not feel that it was in the best interest of the patient.

6. I often feel ultimately responsible for patient outcomes.

7. I have initiated extensive life-saving actions when I think that it only prolongs death.

8. I feel that I have not received the respect or recognition from the general public that I deserve as a nurse.

9. I have followed the family's request not to discuss death with a dying patient who asks about dying.

10. I have been uncertain about what to tell a patient or family about the patient's condition or treatment.

11. I carry out the physician's orders for what I consider to be unnecessary tests and treatments for terminally ill patients.

12. I find myself caring for the emotional needs of patients.

13. I have disagreed with other health professionals concerning the treatment of a patient.

14. I have continued to participate in care for a hopelessly injured person who is being sustained on a ventilator, when no one will make a decision to “pull the plug.”
15. At times, I have not had opportunities to share feelings and experiences with colleagues.
16. I have experienced conflicts with coworkers.
17. I follow the physician’s order not to tell the patient the truth when he/she asks for it.
18. I have had work-related duties which conflict with family responsibilities.
19. I find myself allowing personal feelings/emotions to interfere with the care of patients.
20. I have assisted a physician who in my opinion is providing incompetent care.
21. I am keeping up with new developments in order to maintain professional competence.
22. I have the feeling that opportunities for advancement on the job are poor.
23. I have prepared an elderly person for surgery to have a gastrostomy tube put in who is severely demented and a “No Code.”
24. I am trying to meet society’s expectations for high-quality medical care.
25. I supervise the performance of coworkers.
26. I have let medical students perform painful procedures on patients solely to increase their skill.
27. I find myself dealing with “difficult” patients.
28. I feel that I have not been recognized or accepted as a true health professional by other health professionals.
29. I have provided care that does not relieve the patient’s suffering because I fear that increasing the doses of pain medication will cause death.
30. I feel that I may be inadequately prepared to meet the needs of patients.
31. I have found myself lacking adequate information regarding a patient’s medical condition.

32. I have followed the physician's request not to discuss "Code Status" with the family when the patient becomes incompetent.
33. I have not received adequate feedback on my job performance.
34. I have increased the dose of intravenous morphine in end of life situations that I believe will hasten the patient's death.
35. I have found myself in situations where there was not enough staff to adequately provide necessary services.
36. I have had non-professionals determine the way that I must practice my profession.
37. I have responded to a patient's request for assistance with death when the patient has a poor prognosis.
38. I have worked in situations where I did not know what type of job performance was expected.
39. I have found myself being interrupted by phone calls or people while performing job duties.
40. I have followed the physician's request not to discuss death with a dying patient who asks about dying.
41. I have found myself not being allowed to participate in making decisions about my job.
42. I have worked with nurses who are not as competent as the patient care requires.
43. I have found myself not being challenged by my work.
44. I have ignored situations of suspected patient abuse by caregivers.
45. I feel that I am inadequately paid as a health professional.
46. I ignore situations in which patients have not been given adequate information to insure informed consent.
47. I have cared for terminally ill patients.
48. I have followed the physician's request not to discuss "Code Status" with the patient.
49. I have not been able to use my abilities to the fullest extent on the job.

50. I have followed orders for pain medications even when the medications prescribed do not control the pain.

51. I have feared that a mistake will be made in the treatment of a patient.

*Intent to Stay and Personal Comments*

Please select which of the following statements most accurately fit your present situation.

1. I plan to leave the organization as soon as possible.
2. I may leave the organization within the next year.
3. Under no circumstances would I voluntarily leave this organization.
4. I would be reluctant to leave the organization.
5. I plan to stay with this organization as long as possible.

Have you ever experienced a morally distressing situation that you would like to share? If so, please describe in the space below.

Thank you so much for your participation with this survey. It is greatly appreciated and hopefully will benefit all nurses.

## Appendix B

### Permissions

Dr. Wolfgang, Health Professions Stress Inventory

Cindy:

I don't recall receiving your previous e-mail, but I apologize if I missed it. You certainly have permission to use the HPSI in your study. Good luck with your research.

-----Original Message-----

From: cksorensen@comcast.net

To: wolfgang@rx.uga.edu

Date: Sat, 08 Sep 2007 17:02:03 +0000

Subject: Health professions stress inventory

Dear Dr. Wolfgang, I emailed you in August about having your permission to use the Health Professions Stress Inventory as a tool in my dissertation. My topic is Moral Distress among critical care nurses and I would like to administer your tool along with the Moral Distress scale. Please let me know if this would be possible. You can reply at cksorensen@comcast.net or at sorensen.cynthia@mayo.edu.

Thank you for your help with this,

Cindy Sorensen

Alan P. Wolfgang, Ph.D.

Assistant Dean for Student Affairs

UGA College of Pharmacy

Athens, GA 30602

E-mail: wolfgang@rx.uga.edu

Phone: (706) 542-7287

Dr. Kim's Intent to Stay Scale

Dear Cynthia Sorensen,

It's nice to hear from you about my model. Yes, you can go ahead and use the items for your research. Your research looks pretty interesting to me.

Sincerely,

Sang-Wook Kim.

## Dr. Corley's Moral Distress Scale

**From:** Mary C Corley/FS/VCU <mccorley@vcu.edu>  
**To:** cksorensen@comcast.net  
**CC:** mccorley@vcu.edu  
**Subject:** Re: moral distress scale  
**Date:** Monday, August 20, 2007 9:09:06 AM

*sent 9/10*

Cindy,

I am happy to learn of your interest in the Moral Distress Scale and will attach it to this e-mail. In addition, I suggest that you contact Dr. Ann Hamric at the University of Virginia who has used a shortened version of the Scale in her research.

In return for permission to use the Moral Distress Scale, I am asking all users to provide me with their data so that I can use it to improve the Scale. Please let me know if this will work for you.

You did not indicate how soon you were going to conduct your research. I am hoping that a factor analysis will soon be done so that the Moral Distress Scale can be shortened (it is 38 items). This would be particularly important to you since you hope to administer other instruments.

Thank you,  
Mary Corley

-----cksorensen@comcast.net wrote: -----

**To:** mccorley@mail2.vcu.edu  
**From:** cksorensen@comcast.net  
**Date:** 08/12/2007 03:08PM  
**Subject:** moral distress scale

Dear Dr. Corley, I am a doctoral candidate at the University of North Florida and presently the nurse manager of the SICU for St. Luke's/ Mayo Clinic hospital in Jacksonville, Florida. I am writing to ask your permission to use the Moral Distress scale as part of my dissertation research. My topic is the relationship between moral distress, burnout, anxiety and the intent to stay in the acute care setting. I would like to use part of four instruments and send them as a survey to all of the nurses in the Mayo clinic system. Being an ICU nurse and manager for a number of years has lead me to see this topic as extremely important. Every day I work with nurses who are burnt out and frustrated because of moral and ethical issues. We are a large transplant facility and this, in addition to the wide variety of other acutely ill patients has caused many nurses to rethink their ideas about transplant and DNR status. The survey group will include about 7,000 nurses from the three Mayo sites. I would love to share the results with you and would greatly appreciate any ideas that you may have on this research. Please reply at cksorensen@comcast.net . I can also be reached at 904-620-8681 or at sorensen.cynthia@mayo.edu .

Thank you, Cindy Sorensen RN, MSN

## Appendix C

IRB for the University



Office of Research and Sponsored Programs  
1 UNF Drive  
Building 3, Office 2501  
Jacksonville, FL 32224-2665  
904-620-2455 FAX 904-620-2457  
Equal Opportunity/Equal Access/Affirmative Action Institution

**MEMORANDUM**

**DATE:** March 28, 2008

**TO:** Cynthia Sorensen

**VIA:** Dr. Russell Mays  
Educational Leadership

**FROM:** Dominique Scalia, Research Integrity Coordinator  
On Behalf of the UNF Institutional Review Board

**RE:** Review by the UNF Institutional Review Board IRB#08-036:  
"Moral Distress and its affect on Nursing Retention in the Acute Care  
Setting"

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This is to advise you that your study, "Moral Distress and its affect on Nursing Retention in the Acute Care Setting," has been reviewed on behalf of the UNF Institutional Review Board and has been declared exempt from further IRB oversight.

This approval applies to your project in the form and content as submitted to the IRB for review. Any variations or modifications to the approved protocol and/or informed consent forms as they relate to dealing with human subjects must be cleared with the IRB prior to implementing such changes.

Should you have any questions regarding your approval or any other IRB issues, please do not hesitate to contact me at 620-2443 or [d.scalia@unf.edu](mailto:d.scalia@unf.edu).

Thank you.



## Appendix D

## Scores on Moral Distress/Health Professions Stress Inventory

1. In what type of clinical setting are you currently or have you been employed?

Med/Surg	Specialty	Critical Care	Pediatrics	Obstetrics	Clinic
59 (25.2%)	65 (27.8%)	70 (29.9%)	0	0	40 (17.0%)

2. How long have you been a nurse in years?

0-2	3-5	6-10	11-20	21 or greater
19 (8.1%)	30 (12.8%)	49 (20.9%)	70 (29.9%)	66 (28.2%)

3. What is your highest level of education attained?

Diploma	Associate	Bachelor	Master	Doctorate
38 (16.2%)	84 (35.9%)	92 (39.3%)	19 (8.1%)	0

4. What position do you currently hold?

Staff Nurse	Charge Nurse	Education	Manager	Other
168 (71.8%)	26 (11.1%)	4 (1.7%)	11 (4.7%)	25 (10.7%)

5. Are you employed?

Full-time	Part-time
190 (81.2%)	44 (18.8%)

6. Have you ever taken a course in applied ethics?

Yes	No
108 (47.0%)	122 (53.%)

7. How old are you?

21-25	26-30	31-40	41-50	51-60	60 or older
13 (5.6%)	22 (9.4%)	66 (28.2%)	71 (30.3%)	55 (23.5%)	7 (3.0%)

## Frequency Scores

Item	Never	Almost Never	Sometimes	Frequent	Very Frequent	Mean	SD	N
1.	23(13.5%)	34(20%)	74(43.5%)	32(18.8%)	7(2%)	2.80	1.03	170
2.	3(1.8%)	25(14.7%)	72(42.4%)	42(24.7%)	28(11.9%)	3.39	.987	170
3.	119(70%)	30(17.6%)	16(9.4%)	2(1.2%)	3(1.8%)	1.47	.851	170
4.	27(15.9%)	62(36.5%)	64(37.6%)	13(7.6%)	4(2.3%)	2.44	.929	170
5.	52(30.6%)	20(11.8%)	46(27.1%)	35(20.6%)	17(10%)	2.68	1.361	170
6.	5(2.9%)	21(12.4%)	56(32.9%)	57(33.5%)	31(18.2%)	3.52	1.022	170
7.	35(20.7%)	24(14.2%)	60(35.5%)	35(20.7%)	15(8.8%)	2.83	1.23	169
8.	15(8.9%)	35(20.7%)	53(31.4%)	32(18.9%)	34(20.1%)	3.21	1.234	169
9.	60(35.9%)	52(31.1%)	42(25.1%)	9(5.4%)	4(2.3%)	2.07	1.021	167
10.	9(5.4%)	42(25%)	93(55.4%)	21(12.5%)	3(1.7%)	2.80	.791	168
11.	19(11.3%)	30(17.9%)	61(36.3%)	36(21.4%)	22(13%)	3.07	1.171	168
12.	1(0.6%)	1(0.6%)	20(11.9%)	52(31%)	94(55.9%)	4.41	.769	168
13.	3(1.8%)	28(16.7%)	119(70.8%)	14(8.3%)	4(2.3%)	2.93	.643	168

14.	66(39.3%)	22(13.1%)	43(25.6%)	24(14.3%)	13(7.7%)	2.38	1.335	168
15.	10(6%)	39(23.2%)	74(44%)	37(22%)	8(4.7%)	2.96	.941	168
16.	10(6%)	64(38.1%)	79(47%)	11(6.5%)	4(2.3%)	2.61	.796	168
17.	84(50.3%)	47(28.1%)	27(16.2%)	5(3%)	4(2.3%)	1.79	.981	167
18.	18(10.8%)	35(21%)	71(42.5%)	29(17.4%)	14(8.4%)	2.92	1.072	167
19.	31(18.6%)	94(56.3%)	39(23.4%)	2(1.2%)	1(0.6%)	2.09	.718	167
20.	17(10.2%)	57(34.1%)	74(44.3%)	12(7.2%)	7(4.1%)	2.61	.917	167
21.	0	1(0.6%)	25(15.1%)	77(46.4%)	63(37.9%)	4.22	.714	166
22.	10(6%)	27(16.3%)	55(33.1%)	41(24.7%)	33(19.9%)	3.36	1.150	166
23.	64(38.6%)	40(24.1%)	49(29.5%)	9(5.4%)	4(2.4%)	2.09	1.055	166
24.	3(1.8%)	1(0.6%)	10(6%)	46(27.7%)	60(63.8%)	4.51	.792	166
25.	20(12%)	30(18.1%)	58(34.9%)	25(15.1%)	33(19.9%)	3.13	1.266	166
26.	93(56%)	54(32.5%)	17(10.2%)	1(0.6%)	1(0.6%)	1.57	.749	166
27.	1(0.6%)	5(3%)	49(29.5%)	66(39.8%)	45(27.1%)	3.90	.857	166
28.	15(9.1%)	49(29.7%)	58(35.2%)	26(15.8%)	17(10.3%)	2.88	1.107	165

29.	66(39.8%)	71(42.8%)	25(15.1%)	4(2.4%)	0	1.80	.780	166
30.	30(18.1%)	72(43.4%)	57(34.3%)	6(3.6%)	1(0.6%)	2.25	.814	166
31.	9(5.5%)	64(38.8%)	74(44.8%)	15(9.1%)	3(1.8%)	2.63	.798	165
32.	103(62%)	38(22.9%)	19(11.4%)	3(1.8%)	3(1.8%)	1.58	.896	166
33.	33(19.9%)	36(21.7%)	61(36.7%)	22(13.3%)	14(8.4%)	2.69	1.180	166
34.	114(69.1%)	24(14.5%)	20(12.1%)	6(3.6%)	1(0.6%)	1.52	.888	165
35.	2(1.2%)	9(5.4%)	51(30.7%)	48(28.9%)	56(33.7%)	3.89	.981	166
36.	20(12%)	27(16.3%)	54(32.5%)	29(17.5%)	36(21.7%)	3.20	1.286	166
37.	130(79.3%)	15(9.1%)	13(7.9%)	6(3.7%)	0	1.36	.782	164
38.	37(22.4%)	74(44.8%)	45(27.3%)	8(4.8%)	1(0.6%)	2.16	.850	165
39.	1(0.6%)	2(1.2%)	27(16.3%)	60(36.1%)	76(45.8%)	4.25	.814	166
40.	104(62.7%)	39(23.5%)	19(11.4%)	1(0.6%)	3(1.8%)	1.55	.856	166
41.	10(6%)	25(15.1%)	66(39.8%)	35(21.1%)	30(18%)	3.30	1.114	166
42.	2(1.2%)	22(13.3%)	88(53%)	33(19.9%)	21(12.6%)	3.30	.896	166
43.	39(23.6%)	64(38.8%)	56(33.9%)	5(3%)	1(0.6%)	2.18	.850	165
44.	153(93.3%)	10(6.1%)	0	1(0.6%)	0	1.08	.332	164

45.	2(1.2%)	8(4.9%)	50(30.5%)	31(18.9%)	73(44.5%)	4.01	1.030	164
46.	102(61.8%)	43(26.1%)	18(10.9%)	2(1.2%)	0	1.52	.738	165
47.	1(0.6%)	3(1.8%)	57(34.5%)	60(36.4%)	44(26.6%)	3.87	.852	165
48.	95(58.3%)	37(22.7%)	21(12.9%)	5(3.1%)	5(3.1%)	1.70	1.013	163
49.	22(13.4%)	65(39.6%)	50(30.5%)	21(12.8%)	6(3.6%)	2.54	.999	164
50.	15(9.1%)	37(22.4%)	77(46.7%)	28(17%)	8(4.8%)	2.86	.968	165
51.	2(1.2%)	27(16.4%)	72(43.6%)	43(26.1%)	21(12.7%)	3.33	.938	165

### Intensity Scores

Item	None	Almost None	Small Extent	ModerExtent	GreatExtent	Mean	SD	N
1.	19(11.3%)	18(10.7%)	32(19%)	57(33.9%)	42(25%)	3.51	1.286	168
2.	6(3.6%)	8(4.7%)	27(16%)	68(40.2%)	60(35.5%)	3.99	1.015	169
3.	85(52.1%)	15(9.2%)	21(12.9%)	26(16%)	16(9.8%)	2.22	1.462	163
4.	21(12.7%)	28(17%)	25(15.2%)	53(32.1%)	38(23%)	3.36	1.343	165
5.	28 (16.7%)	12(7.1%)	34(20.2%)	56(33.3%)	38(22.6%)	3.38	1.357	168

6.	6(3.6%)	11(6.5%)	39(23.2%)	62(36.9%)	50(29.8%)	3.83	1.044	168
7.	20(12%)	12(7.2%)	30(18.1%)	70(42.2%)	34(20.5%)	3.52	1.239	166
8.	23(13.8%)	23(13.8%)	44(26.3%)	38(22.8%)	39(23.3%)	3.28	1.335	167
9.	32(19.6%)	25(15.3%)	33(20.2%)	44(27%)	29(17.8%)	3.08	1.388	163
10.	12(7.2%)	23(13.9%)	65(39.2%)	50(30.1%)	16(9.6%)	3.21	1.038	166
11.	14(8.5%)	16(9.7%)	39(23.6%)	63(38.2%)	33(20%)	3.52	1.167	165
12.	7(4.2%)	13(7.8%)	32(19.3%)	62(37.3%)	52(31.3%)	3.84	1.086	166
13.	6(3.6%)	18(10.8%)	59(35.5%)	64(38.6%)	19(11.4%)	3.43	.956	166
14.	38(23%)	8(4.8%)	18(10.9%)	56(33.9%)	45(27.3%)	3.38	1.508	165
15.	10(6.1%)	29(17.6%)	63(38.2%)	50(30.3%)	13(7.9%)	3.16	1.008	165
16.	13(7.9%)	32(19.4%)	42(25.5%)	45(27.3%)	33(20%)	3.32	1.220	165
17.	45(27.8%)	23(14.2%)	21(13%)	33(20.4%)	40(24.7%)	3.00	1.568	162
18.	16(9.9%)	22(13.6%)	30(18.5%)	51(31.5%)	43(26.5%)	3.51	1.287	162
19.	27(16.6%)	48(29.4%)	39(23.9%)	31(19%)	18(11%)	2.79	1.246	163
20.	10(6.2%)	22(13.6%)	25(15.4%)	42(25.9%)	63(38.9%)	3.78	1.266	162

21.	18(11.3%)	27(16.9%)	31(19.4%)	44(27.5%)	40(25%)	3.38	1.326	160
22.	13(8.1%)	28(17.4%)	45(28%)	42(26.1%)	33(20.5%)	3.34	1.214	161
23.	41(25.3%)	19(11.7%)	35(21.6%)	43(26.5%)	24(14.8%)	2.94	1.413	162
24.	9(5.6%)	9(5.6%)	25(15.4%)	52(32.1%)	67(41.3%)	3.98	1.139	162
25.	19(11.7%)	26(16%)	40(24.7%)	45(27.8%)	32(19.8%)	3.28	1.277	162
26.	57(36.1%)	23(14.6%)	25(15.8%)	26(16.5%)	27(17.1%)	2.64	1.524	158
27.	3(1.9%)	6(3.7%)	32(19.9%)	71(44.1%)	49(30.4%)	3.98	.908	161
28.	14(8.7%)	35(21.7%)	35(21.7%)	43(26.7%)	34(21.1%)	3.30	1.264	161
29.	47(29.6%)	33(20.8%)	22(13.8%)	34(21.4%)	23(14.5%)	2.70	1.452	159
30.	22(13.8%)	36(22.5%)	36(22.5%)	31(19.4%)	35(21.9%)	3.13	1.356	160
31.	10(6.3%)	31(19.5%)	38(23.9%)	51(32.1%)	29(18.2%)	3.36	1.172	159
32.	60(38%)	31(19.5%)	24(15.2%)	25(15.8%)	18(11.4%)	2.43	1.420	158
33.	23(14.3%)	29(18%)	45(28%)	44(27.3%)	20(12.4%)	3.06	1.236	161
34.	75(47.2%)	22(13.8%)	21(13.2%)	20(12.6%)	21(13.2%)	2.31	1.488	159
35.	4(2.5%)	3(1.9%)	12(7.4%)	39(24.1%)	104(64.2%)	4.46	.899	162
36.	20(12.4%)	15(9.3%)	23(14.3%)	37(23%)	66(41%)	3.71	1.404	161

37.	71(45.5%)	16(10.3%)	18(11.5%)	22(14.1%)	29(18.6%)	2.50	1.604	156
38.	27(16.9%)	39(24.4%)	32(20%)	41(25.6%)	21(13.1%)	2.94	1.306	160
39.	1(0.6%)	5(3.1%)	31(19%)	66(40.5%)	60(36.8%)	4.10	.855	163
40.	61(39.1%)	24(15.4%)	24(15.4%)	26(16.7%)	21(13.5%)	2.50	1.479	156
41.	8(4.9%)	16(9.9%)	30(18.5%)	57(35.2%)	51(31.5%)	3.78	1.141	162
42.	3(1.9%)	8(4.9%)	28(17.3%)	61(37.7%)	62(38.3%)	4.06	.960	162
43.	32(20.1%)	47(29.6%)	50(31.4%)	25(15.7%)	5(3.1%)	2.52	1.078	159
44.	77(49.7%)	13(8.4%)	5(3.2%)	15(9.7%)	45(29%)	2.60	1.786	155
45.	1(0.6%)	12(7.5%)	28(17.6%)	42(26.4%)	76(47.8%)	4.13	1.001	159
46.	58(36.9%)	28(17.8%)	23(14.6%)	20(12.7%)	28(17.8%)	2.57	1.524	157
47.	9(5.6%)	18(11.2%)	39(24.2%)	58(36%)	37(23%)	3.60	1.126	161
48.	56(35.9%)	29(18.6%)	26(16.7%)	26(16.7%)	19(12.2%)	2.51	1.430	156
49.	19(11.9%)	48(30.2%)	41(25.8%)	35(22%)	16(10.1%)	2.88	1.182	159
50.	12(7.5%)	19(11.8%)	35(21.7%)	60(37.3%)	35(21.7%)	3.54	1.173	161
51.	3(1.9%)	19(11.8%)	30(18.6%)	32(19.9%)	77(47.8%)	4.00	1.146	161

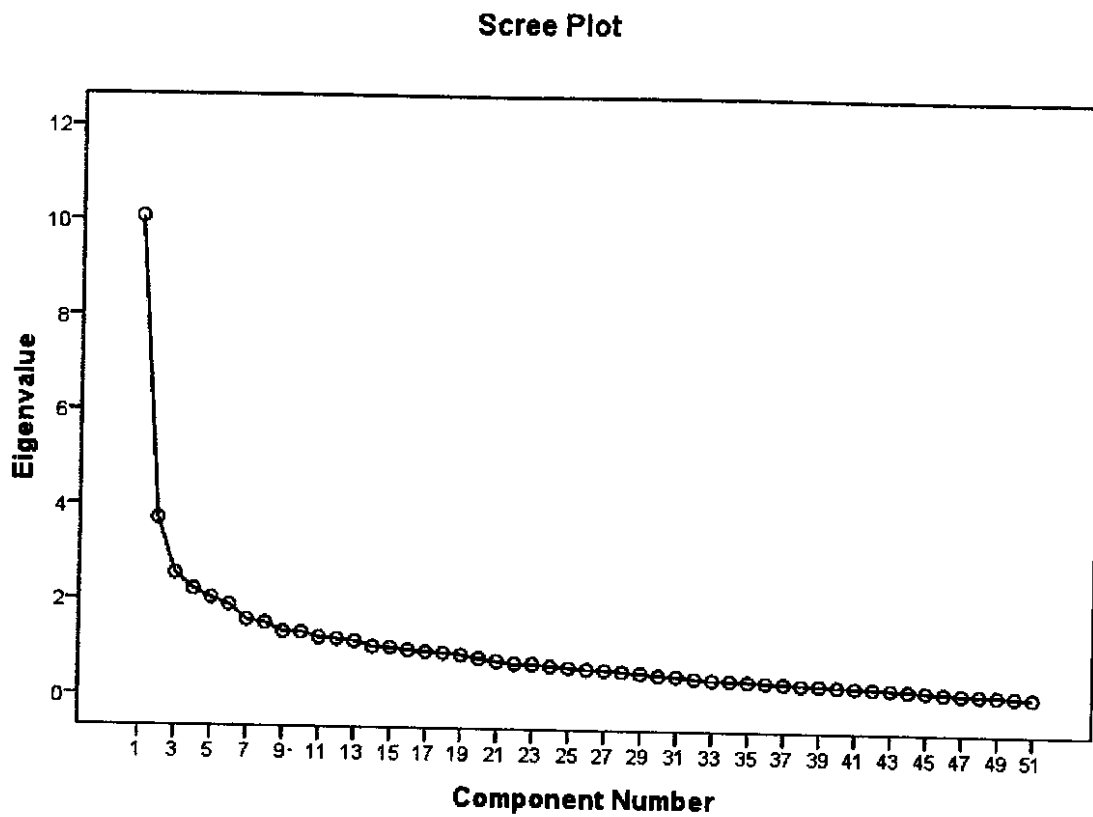


## Intent to Stay Scores

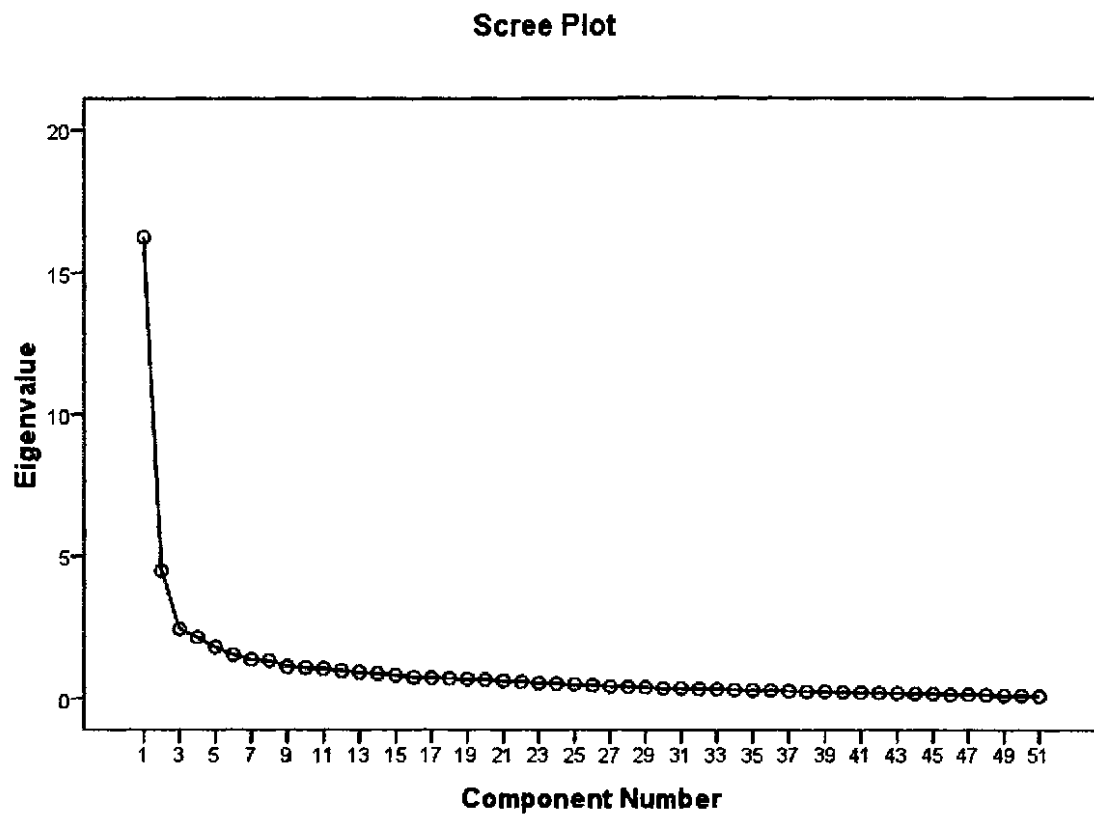
	<i>N</i> (%)
1. I plan to leave the institution as soon as possible.	14 (8.4%)
2. I may leave the organization within the next year.	41(24.7%)
3. Under no circumstances would I voluntarily leave the organization.	6 (3.6%)
4. I would be reluctant to leave the organization.	30(18.1%)
5. I plan to stay with this organization as long as possible.	75(45.2%)

## Appendix E

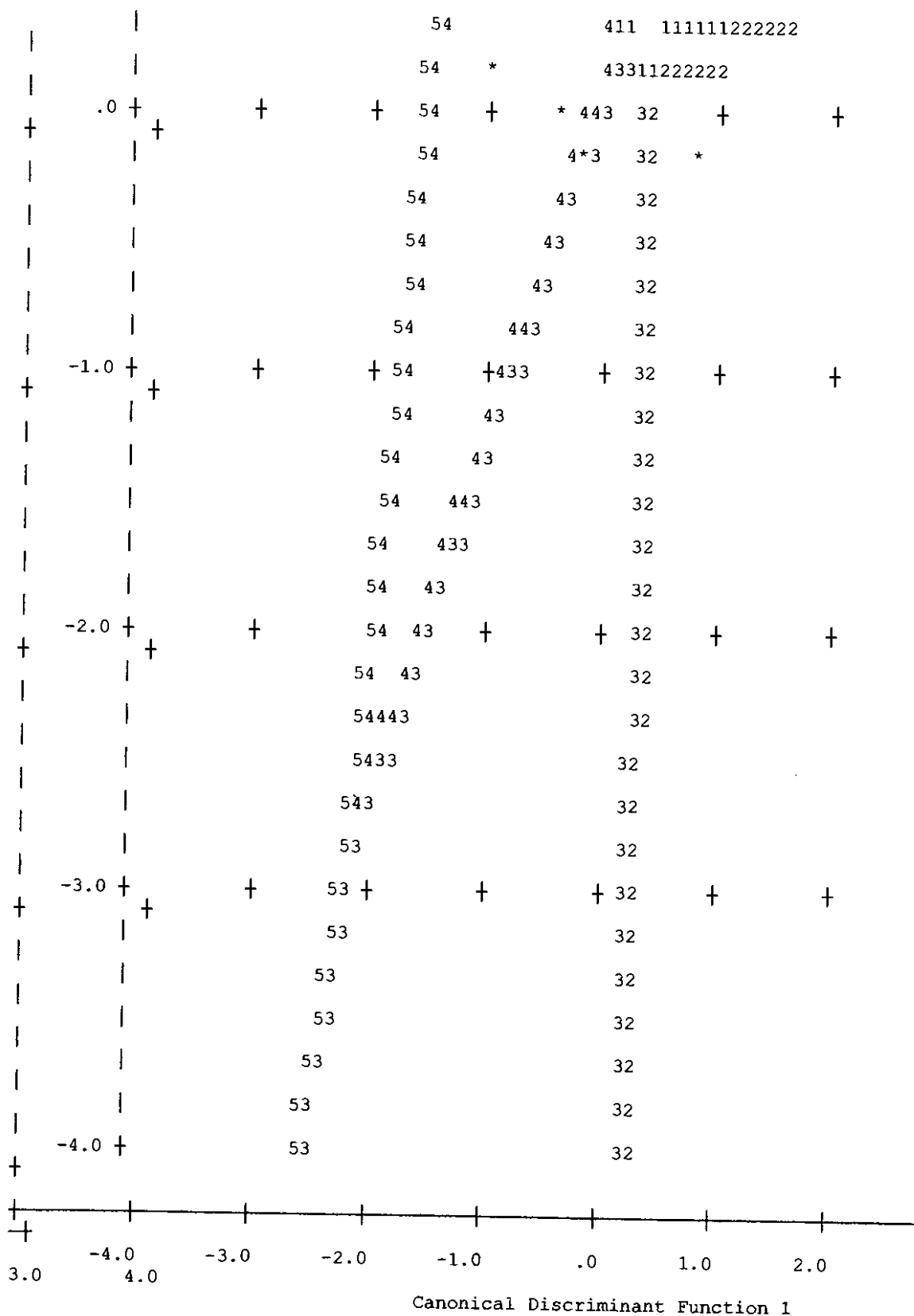
## Scree Plot for Frequency



## Scree Plot for Intensity







## Symbols used in territorial map

Symbol	Group	Label
1	1	I plan to leave the
2	2	I may leave the orga
3	3	Under no circumstanc
4	4	I would be reluctant
5	5	I plan to stay with
*		Indicates a group centroid







Symbol	Group	Label
1	1	acute care-medical-s
2	2	acute care-specialty
3	3	acute care-critical
4	4	clinic or outpatient
*		Indicates a group centroid

## Appendix H

### Nurses' Response to Moral Distress Situations They Have Encountered

1. 5/1/08      Micromanagement, anal-retentive management, unable to meet family obligations or needs, bullying on the job.

2. 5/1/08      There are almost too many to share...One in particular, I alerted a physician's assistant in regards to one of my patients loosing a significant amount of blood through a JP drain post surgery. The patient had a rare blood type and I was informed there were only 2 units of blood left in the state that matched her blood. Rather than call the attending physician and or surgeon on call in the middle of the night, the PA ordered to transfuse 2 units of blood and check an H & H afterwards. THIS WAS NOT ACCEPTABLE TO ME! I called the surgeon and attending docs myself and transferred the patient to the OR by the end of my shift. I don't know if the PA didn't care or didn't know any better, but he is no longer working at this institution. I also had to take an admission during this ordeal and had two other stable patients.

3. 5/1/08      Not having the physical strength to perform chest compressions on a 500 lb. man. I was surrounded by nurses who were smaller than I was. No matter how hard I tried I could not press down hard enough. The hospital was staffed but hot (*sic.*) according to experience. They were not equipped to handle the critical care needs of the patient. I do not feel the surgery should have taken place in such a facility.

4. 5/1/08      Spending 5 hours in interventional radiology with one critically ill patient while another equally sick person was in the SICU with Team Leader attempting to watch. Patient was pretty much on "auto pilot."

5. 5/1/08      I was involved in an inaccurate sponge count that resulted in a sponge being left inside the patient. There were multiple persons involved and so it was unable to be determined who was the person actually responsible for the incidents leading up to the inaccurat4e (*sic.*) count. I feel extremely responsible since my name was one of those involved. The patient was taken back to the OR from the recovery area, after an xray of the abdomen was taken and the sponge was removed. The process was evaluated and policies were changed. I regret this incident and am still bothered by it to this day.

6. 5/1/08      When other staff do not provide the level of care of compassion to patients and or family members it is very distressing to me.

7. 5/1/08      A patient was a "no code" there was an order to give 10 mg of morphine for "pain." The patient was not coherent and was not intubated. I did not give the morphine as I believed it would end her life. She died naturally shortly after my shift began.

8.5/2/08 Dealing with family dynamics when it comes to making a patient a full code or DNR when the patient is incompetent to make the decision. The family usually never agrees on the decision and calls for a great deal of discussion and counseling and hard decision-making for the family and the medical staff.

9. 5/2/08 Elderly woman- 80's, dx with dementia but non-responsive set for surgery in am, during am care I informed the patient during her bath she would be going to surgery for GT for feeding purposes, she woke up and told me "no." I gave her a date/time of day and year and told her I would be back in 5 minutes to see if she would remember the date given and then I called family and advised them. I told them I would not release patient to surgery until they came and saw patient. Surgeon came and demanded I release the patient, I continued to refuse and when family came, mother was able to tell them no and so they cancelled the surgery. Patient died a few day later at home.

10. 5/2/08 The phones are constantly going off when I am helping a patient and this disturbs the patients as well.

11. 5/2/08 I remember working with a patient who was in respiratory distress. He was fairly young and apparently had had difficulties in the past, you could see his trach scar. We ended up putting him on a bipap which helped his respiratory status, and gave him narcan, which perked him up. One of my colleagues said we need to discuss code status and called the doctor. They kept asking the patient if he wanted to be intubated and he kept saying no. But no one addressed his coded status or his prognosis. My colleague just gave him a DNR form and told him where to sign. The patient kept asking his brother if he should sign it. Finally he did sign the form, but his signature was illegible. I did not feel it was right for someone whose mental status might be impaired by narcotics and by his respiratory status to be signing a DNR, especially with no understanding of what his prognosis was. I couldn't believe a physician and an NP had no qualms with what they were doing. The guy ended up being fine and went home, but the situation still bothers me.

12. 5/2/08 The extreme measure we go to continue a body to function when life is long since over bothers me on a daily basis.

13. 5/2/08 I have taken care of more dying patients than I want to remember. I believe a person has the moral and legal right to end their suffering by refusing treatment. However, I have seen DR's pull the family aside outside the room and tell them a made up story that the dying patient is not thinking clearly and so that's why the doctor will not stop the treatment. That is morally wrong!! To lie!! And brush away the patients wishes by saying that they are incompetent and can no longer make decision about their care. Have you ever had a patient grab your arm and whisper to you "I'm not crazy, please tell my family to let me go, the DR won't listen to me." In the name of medicine we do horrible things to patients that would be considered torture in a a prisoner-of-war camp or a federal prison system. What good comes from forcing a patient to live on life-support machines for months and spend \$500,000 just to end up dying anyway, was that quality

of life. NO!! was that prudent use of limited ICU resources.. NO!! Is it worth a half million dollars or more to be in pain, intubated, watching your insides drain out of a rectal tube while your family watches blood leak from you eyes!! You think I'm exaggerating ?? come to the SICU, the wretched truth is here everyday!!!!

14. 5/3/08 IT IS DIFFICULT AND DISTRESSING TO WORK WITH PHYSICIANS WHO RESPOND CASUALLY TO PATIENT WITH ACUTE CONDITION CHANGES, I.E. INCREASED PAIN, RESPIRATORY ISSUES, SURGICAL COMPLICATION-THE LACK OF URGENCY REGARDING PATIENT CARE AND THE LACK OF PROFESSIONAL RESPECT WHEN NOTIFIED BY NURSES THAT PATIENT CONDITION HAS ACUTELY CHANGED.

15. 5/3/08 When it comes to liver transplants, I become very distressed when a patient that has caused their own liver failure with ETOH can get a liver before a patient that has an idiopathic liver disease just because they have the funds to cover the transplant.

16. 5/3/08 Not being able to adequately care for the needs of high acuity patient due to lack of nursing and ancillary staff, persistent unrealistic workloads.

17. 5/4/08 morally vs ethical MD lied to a patient and administered a placebo.

18. 5/5/08 Patient a DNR with comfort measures. His MD talked him into dialysis-prolonged patient's life and made patient miserable. Wife would not allow dialysis to stop once started and patient not competent to make decision.

19. 5/5/08 low pay

20.5/6/08 I had a doctor intubate a patient that had requested to be made a no code at the beginning of my shift. The doctor was informed of the patient's wished but did not respond until 10 hours later when the patient was hypoxic. The doctor refused to honor the patient's wishes insisting that the patient was hypoxic and could not make a rational decision. The patient was a 38 year old end stage heart patient who died on the ventilator the next day—without ever getting to say good bye to his wife and kids. My administrators did not support me when I refused to administer etomidate to the patient, I will never forget the patient, his wife and kids or the doctor.

21. 5/6/08 As a charge nurse, being given a set number of nurses with definitely different levels of skills and having to make patient assignments based on that number and not the level of care needed by the patient. I hate it and feel guilty having to put other nurses in what they feel are compromising situations because of this.

22. 5/6/08 I have experienced physicians and a charge nurse ignoring a patient in respiratory distress due to the fact the patient was a DNR. I called respiratory therapy multiple times and worked with the therapist first hand to assist the patient to become more comfortable. I called the resident twice asking for orders for comfort. When asked

what I suggested, I suggested morphine. Once the morphine was ordered and administered the patient's status changed dramatically. It wasn't until the patient's husband insisted on seeing the MD's in the room that blood gases, chest x-ray, CPAP, etc. were ordered STAT. In the end the morphine and the CPAP reversed the respiratory distress. The patient grabbed me by hand and mouthed "thank you" which make the entire experience worthwhile.

23. 5/8/08 PCT that has slept for 7.5 yrs. received the hospital's highest recognition, supervisors receiving nurse of the year, it should only belong to the bedside nurse.

24. 5/8/08 I have never been treated with such disregard as a RN like I have in my current job. I am an old nurse who respects patients, co-workers and peers, however I am totally appalled at the lack of respect shown to RN's and NO FLEXIBILITY that I have ever seen. My focus has turned from being totally proud and committed to my job, to just let me get into what I have to do and leave, nor do I have any desire to go above and beyond anymore, but I promise my patients are given outstanding care from me, but I will never, never, never feel bad about calling in ever again for I do realize I am just a number and insignificant at my current place of employment. I can recall many, many positions I have been in where not only am I respected by my nurse supervisors, co-workers, but most importantly by administration and all physicians for it is evident by just giving us a lunch card on B day's, gift card for Christmas and so, so, so much more.

25. 5/8/08 This hospital has been the most professional organization that I have ever worked for. Every one of my negative comments has taken place while working in other hospitals with the exception of being included in decisions about my job. I find it annoying to have people make decisions about the way a nursing unit works when they are not competent to make the decisions. The people doing the day to day work should always have the greatest say in how things flow by in my experience this never happens. People in positions above the line level are always making the decisions for work flow when they should never be allowed to make the decision at all. Organization should always listen to the people doing the work. Costly errors often occur because they seldom ask the ones who know how things work. More often, suggestions for improving work flow, saving time or saving money are completely ignored to the detriment of the bottom line. Managers would be more inclined to respond to cost or time saving ideas, if it was their own money being spent. They tolerate great wastes because it has no personal impact on them. Only one hospital I worked for had a plan for saving money on a regular basis. They called it the BAD idea plan. I stood for Buck A Day. Anyone coming up with an idea that could save at least a Buck a day was listened to and given a mug with the saying "I had a Bad Idea". My greatest stress in the workplace is living with stupid ideas that have been forced upon us by people who don't know or care what the nurse do on a daily basis. I have personally spoken with every line level all the way to the top about silly work routines, including Nursing administration and computer technology personnel, with absolutely no change. It is very frustrating watching hospital money being thrown away and not being able to get anyone to care about it at all.

26. 5/9/08 I have had assignments where I've had 7 patients with no tech help. Supervisors have cancelled nurses or sent nurses home to leave us in this situation. I have continually complained to the coordinator regarding staffing issues and nothing has been done since the beginning of 2008. The other units in the hospital are sufficiently staffed with 4-5 patients, techs and float nurses helping with admissions.

27. 5/9/08 Once, a DNR patient, who was terminally ill and mentally confused was to be discharged with hospice and the niece of the patient showed up and wanted the patient to have a peg/feeding tube to extend his life. The issue had to go the ethics committee for review. In the end the patient received a peg tube and was discharged with the family. The patient was in a lot of pain and I think they would have benefited from the services of hospice. Another time I had an elderly patient that had ovarian cancer and had a total abdominal hysterectomy with bilateral salping-oophorectomy to remove the cancer. She was discharged, developed an ileus and was readmitted to the hospital. The ileus, which turned into a bowel obstruction did not resolve and the patient was in the hospital for two weeks without eating or supplements and continual nausea and vomiting. After two weeks, an NGT was finally placed to low intermittent wall suction to relieve the buildup in the stomach. Her abdomen was very swollen and tight and she still had the staples in the abdomen from the hysterectomy extending from above the umbilical midline to just above the pelvic area. She was finally told there was nothing more that could be done for her they were going to send her home with hospice but planned on putting a peg tube in for drainage of gastric contents. After the peg tube was placed, the staples were removed and the patient was immediately discharged and hospice was to meet the patient at home. Upon arriving home the patient's abdominal wound split open. The hospice nurse sent the patient back to the hospital where we packed the wound and sent her back home. It was very distressing to see this woman who seems to have gotten lost in the system, The doctors felt that since she was going to die from cancer anyway that they didn't really need to do anything else. They sealed her fate in a way. The doctors indicated they thought it was a waste to fix the ileus or blockage since she was eventually going to die. I thought this was a poor attitude, but I could not do anything about it, except give palliative care. I think it lessened this person's quality of life even if she was going to die. We all are going to die someday.. it's inevitable for everyone. I felt her dignity was taken from her.

28.5/9/08 Often, it occurs more at my present facility than I have ever seen, ethical dilemmas concerning patients and doctors.

30. 5/17/08 When an orthopedic surgeon was verbally aggressive inside the patient's room towards me and did not bother to apologize, the nurse manger does not even seem to be an advocate for her own nurses, which is very distressing.

31. 5/28/08 Would love to get out of the ICU. Not properly staffed, unable to find experienced nurses to fill vacant positions, having to "pull" orientees off of orientation to staff the unit due to nursing shortage. Upper management seems "blind" or oblivious to it al (sic.) and patient care has been unsafe since we moved, have had 6 nurses cry or

breakdown in a 24 hour period due to job frustrations, new equipment and assignments having too high acuity... 4 were VERY experienced nurses.

32. 5/28/08 Continuously taking care of patients who are critically ill or terminally ill with inadequate pain/sedation and other medically necessary medications. Resident staff who are unprepared to care for and understand how to care for the critically ill in the ICU and specialty MD's who refuse to be called during PRN shifts or become irate and belligerent when called regarding a critically ill patient. Continuously being put in the middle of physician and specialty staff over the care of patients with conflicting order and plan of care. Having to continuously work short staffed and carry work loads that are unsafe practice for both patients and RN's. Working for an institution who does not value their employees and especially the skill level required of the ICU RN.

33. 5/28/08 I hope that you will share the results of this survey with the administration of the hospital. Thank you for the opportunity to take this survey and communicate some concerns of mine regarding the current practice environment.

34. 5/28/08 Physician determined patient incompetent, and I didn't agree and daughter of patient POA wanted to withhold food and water due to aspiration, and did not want NGT or peg, and patient kept saying she was thirsty, but would choke if given fluids. Daughter of patient was also an RN.

35. 5/28/08 When family felt that their loved one would not want to be intubated and the physician kept them intubated for a recovery period. I felt distressed over the situation, when the patient's rights should be honored.

36.5/29/08 A DNR community patient had a cardiac paracentesis performed by a resident, the community MD ordered no further treatments and the resident punctured through the ventricle. Additionally a community patient who was declared brain dead was allowed to remain on a vent in a room for 5 days.

37. 5/29/08 A lot of nurses have voiced to me their own fears and frustrations with the job. The one motto of the nurses hold true," This hospital is all about the patients and not about the nurses." Every nurse so far has felt this or voiced this that I have come in contact with. Nurses feel that the hospital is not considerate of making life easier or better for nurses. We still use saline that you have to draw up and possibly stick yourself with a needle. Why can't we have prefilled syringes? Patients deserve our fast and efficient care. It slows a nurse down constantly to have to draw this up and potentially stick herself. Other hospitals in the area have them. People need to be nicer to each other. I worked my first shift as a nurse after the move and no one seemed eager enough to help me. It seems like most of the time nurses eat their young. At the old hospital it was all about team work, here its about "knowing someone" things need to change and they need to start think of the nurses at least sometimes. We did not need the hospital to spend \$100,00 on a party, we want them to spend the money to make our lives easier. It is too busy making rules for everyone who works for them, ie, you can't have bags with you, but you don't get a locker or you can't eat anything outside of the breakroom, no one will watch your

patients or offer you a lunch break, so they would rather you starve, etc.... This hospital needs to think of their nurses who are the ones in the front lines taking care of the patients. If you have happy nurses, then doesn't it make sense that the patient's satisfaction would be higher? Think about it!

38. 5/30/08 Having to run equipment, I felt I was not adequately trained to do in the OR.

39. 6/1/08 I enjoy my job, my patient and working with families. I truly enjoy the staff that I work with. Right now I think staff is having more stress because no one likes change. As we become more comfortable with the equipment, things will get back to normal.

40. 6/1/08 My hours were decreased unfairly, working midnights has increased stressors.

41. 6/2/08 I feel less stress with these MDs here than the others I have worked with. I do feel the physician's care is better. The most distressing thing at the moment is the fact that 87% of our employees take an HMO and have been satisfied with it and our institution is going to 80/10 and 90/10 PPO's. So, there will be more out of pocket. I'm sure the institution will benefit more at the expense of their so called "valued" employees.

42. 6/5/08 COPD patient, vent dependent, no facility would take patient, patient wanted to die. MD ordered MS q 1 hr around the clock. Gave med knowing what this would mean. Patient died after 23 doses. No remorse at the time, many years ago.

43. 6/5/08 Administering contrast to an 84 yr old incoherent, possible GI bleed patient, it broke my heart to do this to her and then to also send her for a colonoscopy.

44. 6/11/08 I may look to leave my area, but not this institution.

45. 7/8/08 I feel that the most distressing situations in the critical care environment occur on a daily basis because of inadequate staffing. The demands of taking care of two critical patients and providing support to families is very stressful. As nurses, we have high standards and desire to give the very best care possible, but institutions make it difficult. Taking care of one very critical patient is stressful, but rewarding because great focus and care can be given. However, nurses are frequently pulled in two directions with two critical patients, and this is where the stress and moral distress occurs. Nursing, sadly is not a career that I highly recommend anymore. Institutions and the public expect the best, but want to do it all for less money. Ultimately patients suffer because experienced nurses leave the profession.



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## Vita

Cynthia L. Cummings EdD,RN

**Date and Place of Birth****Previous Experience**

August 2007 to present	University of N. Florida Nursing Instructor, clinical and classroom
May 2002 to July 2008	St. Luke's/ Mayo Clinic hospital Clinical Nurse Educator, Nurse Manager
Jan. 1996 to May 2002	Florida Community College of Jacksonville Nursing Faculty

**Degrees Obtained**

April 2009	University of North Florida, obtained EdD in Educational Leadership
Jan. 1985	University of Maryland, obtained M.S. in Nursing, Major in Nursing Education, Minor in Medical- Surgical nursing
May 1978	University of Maryland, obtained BSN in Nursing,

**Presentations, Awards**

March 2009	Presented "Issues in the Nursing Workplace" for the American Red Cross group.
February 2009	Presented "Issues with Nursing Retention" at the monthly Jacksonville Area Nurse Educator meeting.

- Jan. 2008  
Published an article in Respiratory Therapy, vol.2(6), entitled, "The process and results of Implementing the Ventilator Bundle in Ventilator Associated Pneumonia."
- Oct. 2007  
Presented two seminars at Brooks Rehab hospital on "Implementation of a Rapid Response Team."
- May 2007  
Awarded Great 100 Nurses of Northeast Florida
- Feb. 2007  
Presented a paper on "Interpreting Structure, Function and Commonality Coefficients" at the Southeastern Research Association Conference in San Antonio, TX.
- Feb. 2006  
Presented a paper on "Improving Achievement Motivation in Undergraduate Nursing Students" at The Southeastern Research Association Conference In New Orleans, LA
- April 2004  
Published an article in Nursing Spectrum on Nurse-Physician Collaboration.