THE CAREER PATHS OF FEMALE NURSES: DECISIONS ASSOCIATED WITH INTENTION TO LEAVE DIRECT PATIENT CARE

by

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STATEMENT OF DISSERTATION APPROVAL

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ABSTRACT

This study was designed in two sequential phases; 1) to describe the career paths of experienced nurses related to the intention to leave direct patient care and decisions associated with changing or advancing their education, and 2) to explore how pregnancy, childbirth, and mothering young children impact the lives of nurses working in direct patient care. A multimethod qualitative design with two qualitative components, $QUAL_1$ → $QUAL_{2,}$ was utilized. Study participants were female nurses educated in the United States and licensed in Utah from 6 to 12 years. The $QUAL_1$ core component consisted of unstructured interviews (n = 39), the results of which were used to form the $QUAL_2$ sequential component of semistructured interviews (n = 45). Findings from $QUAL_1$ revealed that mothering responsibilities and family obligations strongly influenced nurses with regard to career decisions and educational advancement. Organizational impacts such as lack of employer appreciation and inflexible scheduling/lack of control over the schedule by the nurse led to a "tipping point" for nurses, and to thoughts of *intention to leave* and ultimately resignation from their position. The second phase of the study focused on the nurse when pregnant and working in direct patient care and/or while having young children at home. Results revealed that there are distinct physical and emotional challenges and hardships experienced by female nurses. There were few accommodations in workload for pregnancy, and few supports, and major challenges

regarding breastfeeding. Financial necessity, and the satisfaction derived from working in patient care, kept nurses working at the bedside.

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TABLE OF CONTENTS

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CHAPTER 1

BACKGROUND AND SIGNIFICANCE

Statement of the Problem

It is indisputable that experienced nurses are essential to quality patient care in the hospital setting; their ability to independently practice using the nursing process and acquired skills of critical thinking are invaluable in delivering competent patient care (Archibald, 2012; Blegen, Vaughan, & Goode, 2001; Risjord, 2011). Experienced nurses are capable of collecting and analyzing patient data through the physical assessment, use of clinical judgment, to respond to unique patient needs, and then planning and implementing skilled nursing interventions including ongoing evaluations of the patient's condition (American Nurses Association, 2016; Benner, 1984; Christensen & Hewitt-Taylor, 2006).

The trajectory to become experienced and develop clinical expertise takes several years and has been associated with the context of the practice environment (Benner, Tanner, & Chelsa, 2009; McHugh & Lake, 2010). The nurse gains experience and attains expertise through practice in the healthcare environment and by utilizing the knowledge gained through formal education (Benner, 1984; Fero, Witsberger, Wesmiller, Zullo, & Hoffman, 2009; McHugh & Lake, 2010). At the approximate point a nurse becomes experienced and provides great value to the organization (Bobay, 2004; Ericsson, Whyte,

& Ward, 2007), she or he at the same time is positioned with multiple options to leave direct patient care for expanded role opportunities or to obtain further education. These nurses may leave without indicating to the organization their rationale for leaving.

The challenge of experienced nurses leaving direct patient care has long been a problem for hospital organizations (Day, 2009; Hill, 2010; Uhrenfeldt & Hall, 2007; Yarbrough, Martin, Alfred, & McNeill, 2016). The problem is multifaceted and may be the result of individual, organizational, or external factors. Nurses may leave to gain more pay, for promotional opportunities, or to advance their education; they may also do so to avoid unacceptable work conditions or shift work, to relieve job stress, or because of injury, illness, or family accountabilities (Borda & Norman, 1997; Chaing & Chang, 2012; Havaei, MacPhee, & Dahinten, 2016). Nurses may leave the current work unit, advance to an expanded role, take an extended leave, leave the organization, leave the nursing profession, or completely resign professional licensure; they may leave patient care for administrative opportunities or teaching opportunities, contributing to patient-care workforce shortages (Hill, 2011; Huston, 2013).

Antecedent to leaving direct patient care, the nurse contemplates and considers options with forethought and mental processing. This intellectual activity of emotionally and mentally identifying and considering possible choices is known as *intention to leave* (Carter & Tourangeau, 2012; Bobbio & Manganelli, 2015; Han, Trinkoff, & Gurses, 2015). Intention to leave serves to provide meaning toward the objective of leaving the job, which may ultimately result in turnover. Turnover of the experienced nurse is especially problematic because the loss of an experienced nurse is usually the loss of an individual who has reached competency, possesses expertise, and is highly capable of

ensuring quality patient care (Armstrong-Stassem, Freeman, Camerson, & Rajacicj, 2015; Galletta, Portoghese, Battistelli, & Leiter, 2013; Heinen et al. 2012).

It must be acknowledged that some turnover of experienced nurses is inevitable and that not all turnover is bad. For example, nurses need to return to school to achieve higher educational levels and academic degrees for the good of the profession and to ensure that there are always excellent nurses ready to fill faculty, research, practice, and leadership roles in nursing. Of course, of concern are those experienced nurses who leave the bedside or the nursing profession not for reasons of professional or educational advancement but because their individual, organizational, or external needs are unmet in the workplace, and they perceive no alternative other than moving away from the bedside when they would have stayed had conditions been supportive.

The purpose of this study was to understand experienced nurses—especially their career and educational decision making—and enable hospitals to then utilize that information to manage and appropriately support all nurses in their unique career paths.

Significance of the Study

Intention to leave is a reliable predictor of nursing turnover. Understanding it may allow management to implement positive strategies that will support the nurse, and will allow healthcare organizations to prevent resignations from direct patient care and/or facilitate nurse transitions within the organization to other roles in which they will advance the profession. This strategic, preventive, management focus could reduce turnover rates and reduce costs related to replacing experienced registered nurses, which is upwards of $60,000 per nurse (Choi, Cheung, & Pang, 2013; Dunffield, Roche, Blay, & Stasa, 2011; Hill, 2010; Intermountain Healthcare, 2016; Jones, 2008; Li & Jones,

2013; Kovner, Brewer, Fatehi, & Jun, 2014). In addition, this understanding would enable healthcare organizations to be supportive of the nurse, and ultimately would be in the best interests of the nursing profession. Most importantly, this approach could result in improved patient care and a more satisfied, committed, and loyal nursing workforce.

Purpose

The purpose of this study was to understand (a) the phenomenon of nurse intention to leave direct patient care, with a focus on the reasons, causes, and rationales associated with such intention; and (b) how experienced nurses determined their career path, with associated decisions.

Study Aims

The following research aims were progressively achieved through the various phases planned in the design of this study:

1. To describe the career paths of experienced nurses associated with nurse intention to leave direct patient care.
2. To describe the associated decisions for changing jobs or advancing their education.
3. To inform the profession of nursing and healthcare organizations with regard to the experienced nurse's professional desires for the good of the profession and the organization and to be supportive of the individual nurse.

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CHAPTER 2

REVIEW OF THE LITERATURE

Purpose of the Review

The purpose of this literature review was to identify what is currently known about registered nurse intention to leave direct patient care, with a goal of understanding the various definitions of intention to leave, associated predictors of nurse intention to leave, and strategies known to improve nurse retention and intention to stay in direct-patient-care settings. Additional purposes were to learn who the major authors and researchers have been in this content area, and to explore possible gaps in the literature.

Search Strategy

The electronic databases PubMed, PubMed Central, and CINAHL were searched using key terms, including *intention to leave*, *nurses*, *nursing staff hospital*, and *career mobility*. The search inclusion criterion was English-language articles and abstracts from 1980 to October 2015. The assistance of a reference librarian was accessed to obtain specified articles and expand the overall search process. A total of 176 article titles and abstracts were screened for use, with 85 full-text articles utilized for this review.

Definitions of Nurse Intention to Leave

The term *intention to leave* is used throughout the literature for multiple disciplines, with context related to organizational workforce issues (Rizwan et al., 2013). Nurse intention to leave is used in the nursing literature primarily associated with nurse turnover, nurse retention, job satisfaction, and nurse burnout and stress. Intention to leave may refer to the intention to leave the current work unit, advance to an expanded role, leave the organization, or take an extended or permanent leave from the work of nursing; some experienced nurses may leave the profession of nursing and resign their licensure.

Understanding nurse intention to leave and differentiating it from other nurse workforce terms, specifically *nursing turnover*, is important for hospital organizations and healthcare executives, primarily because the associated strategies and resources accessed will be different. Strategies for preventing intention to leave will be proactive and preemptive to reengage the nurse, while strategies for managing nursing turnover will be consequential and recuperative. Nurse intention to leave is a cognitive precursor, while nursing turnover is the result of the nurse having actually left employment (Takase, Teraoka, & Kousuke, 2015).

Intention to leave is defined as the reasoning that influences an individual to leave the profession of nursing, the organization, or the individual's work department, and is a deliberate and conscious desire to leave within a specified time period. The literature evidences that nurse intention to leave is a process of decision making and choices that always occur prior to the action of leaving. This process of gradual-withdrawal intention occurs from 2 months to 2 years prior to the nurse actually leaving (Cho, Johanson, & Guchait, 2009; Zeytinoglu, Denton, & Plenderleith, 2011).

Intention to leave is an antecedent of turnover—the actual act of leaving the organization. Turnover intention is a process consisting of psychological, cognitive, and behavioral components. In the literature, the term is used interchangeably with the term *nurse intention to leave* (Cortese, 2012; Takase et al., 2015).

The definitions of *nurse intention to leave* in the literature are relatively consistent and define the term as an objective with meaning to the nurse that may precede the nurse actually leaving the job, resulting in actual organizational turnover. Intention to leave may be intercepted and reversed if managers can become aware and recognize that the nurse is thinking of leaving.

Predictors of Intention to Leave

The literature abounds with studies indicating the factors, circumstances, and situations that are predictive of a nurse's intention to leave. It is important for hospitals to understand what factors and/or elements of a job situation may stimulate a nurse to think about and plan to leave the job. Understanding these elements and the context of their occurrence may provide an opportunity to examine problems, make improvements, and implement solutions.

Factors associated with intent to leave for nurses, have been identified as (a) individual characteristics such as age, education, experience, competency, stress, and coping ability; (b) the work environment, pertaining to control over practice, autonomy, advancement and promotion potential, and job satisfaction; and (c) organizational factors such as workplace relationships, supervision, and support (Beecroft, Dorey, & Wenten, 2008; Bobbio & Manganelli, 2015). Variable factors indicated as predictive for nurse intention to leave were identified as level of hospital, age, marital status, children,

educational level, currently in school for an academic degree, salary, experience, shift assignment, unit specialty, and experiencing a serious patient event. These variables are complex and do not necessarily occur as isolated variables, as they may be compounded adding a multifactorial effect.

Results of a study of more than 2,250 nurses employed in hospital settings evidenced that 50% of the nurses were dissatisfied and that of those nurses, 20% of the total nurse reported the intention to leave their current employment. These are startling statistics for hospital executives, with potentially serious implications for safe patient-care delivery and the associated recruitment and hiring expenses. Stress and depression were significant predictors, and the propensity for intention to leave was significantly higher in the emergency department and other high-intensity settings as compared with medical–surgical units (Chiang & Chang, 2012; Liu et al., 2012; Ma, Lee, Yang, & Chang, 2009).

The physical work conditions for the nurse and/or the presence of musculoskeletal or other health problems may be predictors of the nurse leaving direct patient care. Musculoskeletal problems such as neck, shoulder, or knee problems may have been caused by work injuries. These conditions are exacerbated by problematic working conditions that require heavy patient lifting or transfers. Additionally, the absence of patient transfer devices is associated with musculoskeletal health problems of nurses. These poor work conditions and the presence of health problems are strong predictors of the nurse leaving the job (Fochsen, Josephson, Hagberg, Toomingas, & Lagerstrom, 2006).

The pressures and problems that result from work interfering with family and

home responsibilities are real, and may result in stress, strain, sickness, and work absence. These outcomes evidence the need for hospitals to offer nurses job flexibility so they can meet the dual responsibilities of family priorities and work (Farquharson et al., 2012). Shift lengths of 12 hr or more are associated with nurse intention to leave, although studies show two contrasting considerations. Nurses prefer to work 12-hr shifts because they work fewer days, yet job satisfaction declines with longer shift lengths. These findings provide an interesting paradox, as each work option was found to have positive attributes, yet they compromised work–life balance and contributed to nurse intention to leave (Borda & Norman, 1997; Dall'Ora, Griffiths, Ball, Simon, & Aiken, 2015). Shift work can cause fatigue, exhaustion, and burnout. Undesirable scheduling may cause problems with productivity and work performance, and, in some cases, results in staff attrition. These problems add to employee morale issues associated with the nurse's work schedule. Family–work conflict is a significant factor related to nurse intention to leave.

Losing experienced nurses to competing organizations is frustrating and expensive considering that an organization invests upwards of $60,000 to orient and train a new nurse (NSI Nursing Solutions, 2016). In the case of specialty nurses for high-risk, complex patient populations, a nurse may be irreplaceable in terms of the vital training and experience she or he possesses.

A unique study by Rispel, Chirwa, and Blaauw (2014) revealed that nurses working for a secondary agency, or "moonlighting," increased the odds of actual nurse turnover and was associated with intention to leave; the experience of working an additional job and becoming involved with another agency or institution ultimately

became a plan for successfully exiting the current organization. Opportunities for other employment options in the job market have also been shown to play a role in intention to leave, as demonstrated in the Nurses' Early Exit (NEXT) Study (Hasselhorn et al. 2008), in which nurses were recruited away from their current employer to positions of higher respect, higher pay, and practice autonomy. The return on investment resulting from the contributions of experienced nurses is invaluable in terms of patient safety, continuity of care delivery, and overall workforce stability. Organizational efforts toward retention and improving intention to stay are potentially resources well spent.

Intolerable nurse workloads and perceived over participation in unskilled tasks that could be delegated to unlicensed assistive personnel have been seen to cause attrition of nurses. Repetitive tasks of activities of daily living compounded by high numbers of patients requiring complete care, were associated with nurse intention to leave. Mundane work not perceived to require nurses' critical thinking, education, and training was discouraging, and was associated with time spent in hard physical labor; this work was undesirable and was not perceived by the nurse as professional work (Lindqvist et al., 2014). A questionnaire study conducted by Sveinsdóttir and Blöndal (2013) further corroborated the aforementioned finding that having to perform nonnursing and nonprofessional clinical duties contributes to a decrease in nurse satisfaction and morale, resulting in intention to leave the nursing unit. Patient care delivery models should be designed to allow the nurse to work at the full extent of her or his education, training, and experience.

Stresses related to the challenging trajectory to clinical competence factor into a nurse's intention to leave the profession altogether. These challenges of gaining clinical-

skill competence and the associated stress lead to nurse burnout, a predictor of nurse intention to leave. Organizations that provide new graduate nurses with clinical coaching and residency fellowships tend to see lower rates of first-year turnover (Welding, 2011). Beyond the novice phase, nurses desire to continually grow and learn in the profession. Work organizations that allow for learning, professional expansion, and creative development enhance the capabilities of their workforce. These workforce structures build loyalty and result in a "win–win" for the institution and the employee (Abualrub & Al-Zaru, 2008; Cheng, Tsai, Chang, & Liou, 2014; Hevezi, 2016; Senge, 1990). As the organization evolves, the employees are supported and incentivized to advance in their knowledge and acquire upgraded skills to meet emerging demands of the workplace.

The best predictor of intention to leave is first and foremost work satisfaction, followed by workload or nature of the work, career opportunities, training opportunities, autonomy, the performance evaluation system, pay and benefits, and the physical characteristics of the work environment (Choi, Cheung, & Pang, 2013). If these components are negative, there is resultant nurse intention to leave and a chain-reaction process of withdrawal from the organization. These components of work can be situated to be positive, enhancing nurse retention, and mitigating the negative outcome of the nurse exiting the organization. In a cross-sectional study of 1,271 registered nurses in 10 hospitals, attributes of the work environment such as professionalism, peer relationships, management, staffing, and employee policies had a significant influence on the nurses' job satisfaction and their intention to leave the hospital (Choi, Cheung, & Pang, 2013; Cortese, 2012). Organizational leaders who round the units to listen to and interact with employees will be better able to gauge intentions and commitment to the workplace. This

interaction will allow for an overall approach to improve employee satisfaction and will result in the leadership being attuned to the unique needs of individual employees.

Emotional exhaustion and burnout are strongly related to nurse intention to leave. Emotional exhaustion is exhibited through psychosomatic complaints and diminished professional commitment. A positive work environment provided by good nurse managers and supportive hospital policies are known to ameliorate negative emotional experiences for the nurse in the workplace (Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2012). A longitudinal observational study investigated new graduates' intention to leave prospectively, by measuring burnout and disengagement. The study showed that burnout was related to intention to leave and that high levels of burnout increased the measured levels of intention to leave. Subsequent recommendations indicate that organizations should focus on improving human resource management practices to reduce burnout and emotional labor that cause nurses to want to leave the organization (Havaei, MacPhee, & Dahinten, 2015; Rudman, Gustavsson, & Hultell, 2013).

Lack of reciprocity between the efforts of a nurse and the rewards received by the nurse is indicative of a situation that is of high personal cost and low personal gain; the authors called this *effort–reward imbalance* (Hasselhorn, Tackenborn, Tackenberg, & Peter 2004). Multiple studies have shown a high correlation between effort–reward imbalance and a nurse's intention to leave (Hasselhorn, Tackenberg, & Peter, 2004; Li et al., 2013). Rewards can be extrinsic, such as pay or compensation, or can be intrinsic. Rewards can be motivating and may drive an individual to be productive. The effort–reward model was utilized to understand, analyze, and predict nurse intention to leave. Results from these studies indicate that effort–reward imbalance is a top risk factor for

actual voluntary turnover. While pay alone is not sufficient to successfully retain every nurse, commensurate pay and recognition for work well done were recommended as tactics to eliminate the imbalance between effort and reward (Hasselhorn et al., 2004; Li et al., 2013).

The most influential factor with regard to a nurse leaving his or her employment is job satisfaction. Work satisfiers include human resource policies and organizational structures that provide for flexible scheduling, recognition, professional autonomy, and adequate pay and benefits, in addition to positive working conditions with reasonable workloads (Chan, Tam, Lung, Wong, & Chau, 2013). The literature regarding predictors of nurse intention to leave provides key insights for hospitals and healthcare leaders. Because intention to leave has an associated time period, whether short or long, managers and human resource departments can take steps to retain nurses through improved work situations that increase nurse satisfaction and motivate intention to stay.

Stabilizing the Nurse at the Bedside

Retaining nurses is a prevalent topic in the literature, and there are a myriad of suggested interventions to prevent or reduce nursing turnover and the associated expense and organizational disruption that results from nurse-position vacancies. To stabilize nurses in direct-patient-care settings, strategies should be aimed to avert and reduce nurse turnover. To be effective, these strategies should be a routine part of the organizational structure in which the nurse is highly valued, recognized, and supported (Portoghese, Galletta, Battistelli, & Leiter, 2015). Nurses desire a practice setting with supportive management, the opportunity for advancement through educational programs, and policies that support professional practice. Additionally, high-quality relationships in the

workplace between supervisors, nurses, and physicians promote loyalty to the organization and improve nurse retention. Studies show that a supportive manager and a culture of mentoring also improve nurse retention (Armstrong-Stassen, Freeman, Cameron, & Rajacicj, 2015; Galletta, Portoghese, Battistelli, & Leiter, 2013; Lee, Lim, Jung, & Shin, 2012; Tei-Tominaga, 2012).

To thwart nurse intention to leave, organizations should cultivate an environment in which the following characteristics are allowed to flourish: (a) self-empowerment, explained as increasing in practical knowledge and responsibility, developing an identity as a nurse, gaining life balance, and accessing support; (b) self-control, defined as tolerance, avoidance, and performance; and (c) pursuit of opportunity, career advancement, educational advancement, and promotion. These individual characteristics are associated with reduced levels of nurse intention to leave and help the nurse cope with the challenges of the workplace (Valizadeh, Zamanzadeh, Habibzadeh, Alili, & Shakibi, 2015).

The American Nurses Credentialing Center's (2014) Magnet Model serves to structure a nursing organization with the principles of transformation leadership, structural empowerment, exemplary professional nursing practice, new knowledge, innovations and improvements, and empirical quality results for excellence in the nursing profession and excellence in patient care delivery. Magnet hospitals have long been recognized for their optimal work environments, which promote professional autonomy and allow the nurse to provide the best patient care. Hospitals with a "Magnet" designation have evidence of attracting and retaining nurses at higher levels than non-Magnet hospitals, in addition to higher patient satisfaction and reduced mortality rates.

Magnet hospitals have a practice environment in which nurses are at the highest levels of organizational leadership, and their frontline staff have input into policies that affect their professional practice, such as staffing and patient care standards. This environment fosters nurses to excel in their practice, which benefits the patients, the hospital, and the profession (Aiken, Havens, & Sloane, 2000; Schlag, Sengin, & Shendell-Falik, 1998; Taylor, Clay-Williams, Hogden, Braithwaite, & Groene, 2015).

Retention of experienced nurses was explored in the context of retirement, nurses' financial knowledge, and nurse intention to stay (Heinen et al., 2012; Hill, 2011). Studies by Heinen et al. (2012) and Hill (2011) indicate that retention could be improved by providing personal retirement financial education, so nurses could make informed decisions as they planned retirement timelines. Also evident is that as organizations address the issue of nurse intention to leave, they must take into account not only work conditions but also individual factors such as whether the nurse is early in her or his career, at midpoint in the career, or within a few years of retiring. Consideration of where the nurse is with regard to years in the career will be an indicator of the proactive strategy the organization should employ to retain the nurse.

A study by Nojehdehi, Farahani, Rafii, and Bahrani (2015) showed that organizational excellence with regard to quality patient care, supervisory leadership, employee polices, and employee participation and involvement reduced nurse intention to leave and increased nurse retention. The study compared organizational climate within several award-winning hospitals. Positive organizational climate, such as that present in award-winning hospitals, supports increased nurse commitment and loyalty to the hospital organization. Satisfaction with pay and benefits, scheduling, and responsibility,

and professional development opportunities, are positively related to nurses staying on the job (Coomber & Barribal, 2007; Steinmetz, de Vries, & Tijdens, 2014). Of interest is that the emergency department had the highest levels of nurse intention to leave because of emotional exhaustion and on-the-job stress. The following are recommended to reduce intention to leave: job rotation programs, and retraining into other patient-care specialties to allow a work option for recovery from a highly stressful clinical area. Provision of enriched professional opportunities, relationship enhancement activities to improve physician–nurse relationships, and understanding that status and pay can positively improve nurse satisfaction and prevent turnover are known to be improvements that may retain nurses (Cortese, 2012; Lee, Dai, Park, & McCreary, 2013; Steinmetz, de Vries, & Tijdens, 2014).

Conclusion

The problem of nurse intention to leave is complex and includes individual predictors such as stress, emotional exhaustion, and perceived job insecurity. The approach an organization takes to reduce the number of nurses intending to leave must include a variety of strategies and should focus on the individual nurse. This literature review revealed the multifaceted nature of nurse intention to leave and indicated that the associated issues are individual, organizational, or external.

Absent from the literature is important research specifically addressing the current problem of experienced nurses leaving direct patient care. Tactics and strategies noted in the literature are generic to the total nursing workforce and, as of late, most articles focus on new-graduate and first-year turnover. While the literature identifies that nurses leave direct patient care for other settings that offer better work–life balance, autonomy of

practice, and higher compensation, the strategies presented have not solved the problem. Also absent from the literature are study findings that address and resolve the unique individual and external factors that stimulate a nurse to leave patient care. The consensus is that a nurse should advance her or his education, but the unintended consequences are high turnover in direct patient-care areas and many novice nurses in direct patient-care roles. This good-yet-bad aspect is not addressed in the literature; what is addressed is the need for more baccalaureate-prepared nurses (Alspach, 2007; Armstrong-Stassen, 2005; Twigg & McCullough, 2014; Vance, 2016).

Recent studies specific to the female nurse and external factors such as family and other outside-of-work accountabilities that are unique and weigh heavily on female nurses were not found. In general, the literature is also generic to women in the workforce and not specific to women in nursing.

Evident from this search was that subsequent to the economic crisis of 2008, there was a brief period of inattention to both nurse retention and overall focus on the nursing workforce. While studies in Asia and Europe continued, scholars focusing on recruitment and retention in the United States seemed to take a hiatus as a result of the decline in hospital patients related to individuals losing health insurance, nurses losing their jobs, and a glut of nurses.

Currently, hospitals experiencing high turnover rates are challenged by the expense of high turnover and new training programs, but the more critical issue is that the supply of experienced and/or specialty nurses is inadequate. While hospitals may be able to recruit nurses to fill vacancies, the new recruits are not as experienced and in large part are new graduates who will take years to gain the expertise lost with the exit of

experienced nurses.

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CHAPTER 3

METHODS

Introduction

This research was purposely planned as a multiple-method study with two sequential phases. The progressive methodological design enabled the results of the first study, to target the second phase, thus enhancing validity. The study aims for Phase 1 were to (a) describe the career paths and factors of experienced nurses associated with intention to leave direct patient care, (b) describe associated decisions for changing jobs or advancing their education, and (c) inform the profession of nursing and healthcare organizations with regard to the experienced nurse's professional desires for the good of the profession and the organization. Achievement of these aims led to the formation of the research questions for Phase 2.

Phase 2 research questions included: How do pregnancy, childbirth, and the responsibilities of mothering children impact the careers and lives of nurses who are working at the bedside? Among nurses with young children, what are the reasons and rationales associated with nurse intention to leave or stay at the bedside? What are the experiences of nurses working at the bedside when pregnant? What are the experiences of nurses working at the bedside with young children at home?

Design

To address the complexity of this study, a qualitative multiple method design was utilized to explore and research the phenomenon of experienced nurses' career paths and career decision making. The theoretical drive for this study was inductive in order to understand the phenomena, discover variables (Morse, 2016c; Morse & Niehaus, 2009), and ensure validity. A $QUAL_1 \rightarrow QUAL_2$ design was utilized. The first study, $QUAL_1$, consisted of in-depth interviews to determine the domains of experienced-nurse career decision making. The sequential $QUAL_2$ study consisted of semistructured interviews constructed from $QUAL_1$ interviews. The sequential $QUAL_2$ study increased the scope, and provided in-depth knowledge of the nurse's working experience. Figure 3.1 depicts the study sequencing.

Participants

Study participants were female registered nurses educated in the United States and were licensed in the State of Utah between 3 and 12 years who had worked at the bedside for at least 3 years full time or the part-time equivalent. Rationale for the number of licensed years in the state was based on an assumption that most nurses licensed for 3 to 12 years have had the experience of making career decisions pertinent to advancing their education or changing jobs. The exclusion of nurses with more than 12 licensed years was pertinent to the researcher's interest in intention to leave and career decision making in an assumed age group of 23 to 45 years; the researcher's organizational experience indicates that this age cohort is at high risk for intention to leave direct patient care. Furthermore, for the purposes of this study, males were excluded because their inclusion would have necessitated nearly doubling the sample size to obtain adequate

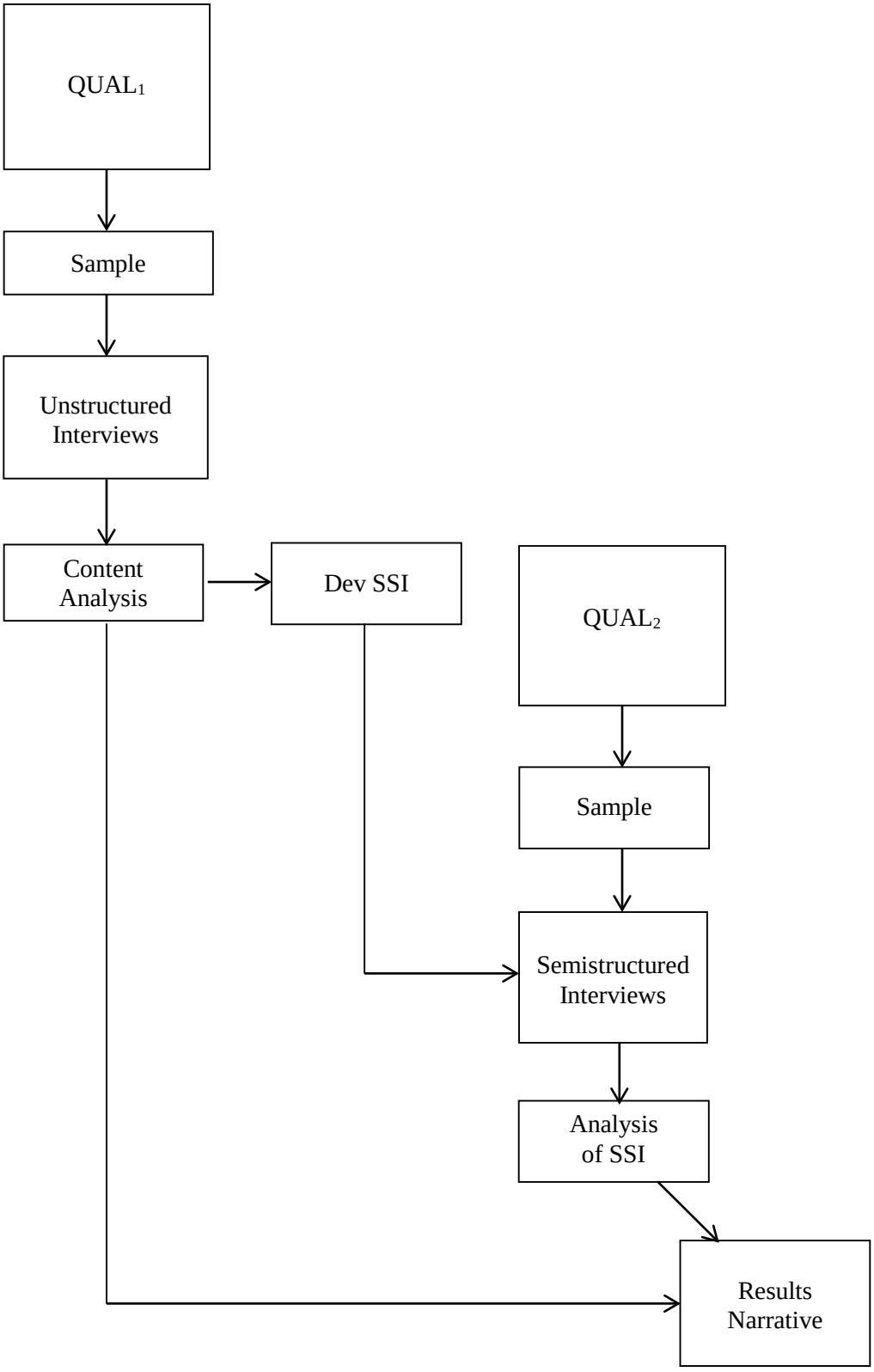

Figure 3.1 Study sequencing.

Note. QUAL = qualitative; Dev SSI = develop semistructured interviews.

saturation and significant results; this was not feasible, as it would have significantly increased the time and costs necessary to complete the study.

Sampling

This study initially utilized a purposive sampling technique to obtain a comprehensive list of nurses with 3 to 12 years of licensure in the state of Utah. This step was then followed by random ordering of the 13,243 registered nurses (RNs) in that sample, which was done with Statistical Package for the Social Sciences software. This sampling technique is appropriate for qualitative studies and produced a representation of nurses in the group of interest. This technique was also expected to improve the pattern and substance of results from an information-rich phenomenon. The nonprobability, purposive, and randomization sampling technique supported the feasibility and purpose of this study (Ruel, Wagner, & Gillespie, 2016).

To obtain a list of nurses for study recruitment, the researcher applied to the Utah Division of Professional Licensure (DOPL), submitting a request for the Utah Licensee List. A description of the study and the specific purpose for use of the list was also submitted, including that the list would be used for research. Upon approval from DOPL, the list was purchased and downloaded from the Utah.gov website.

The list query specified license dates from January 1, 2005 through December 31, 2012; the sample of nurses included RNs, advanced-practice RNs, and certified RN anesthetists with an active license. This yielded a list of RNs who had been licensed in the state of Utah for 3 to 12 years. Data from the Demand for Nurses in Utah survey, conducted by the Utah Medical Education Council (2015), indicates that 75% of Utah-licensed nurses were originally licensed in Utah. This information allowed for the

assumption that the majority of nurses in this population may have had approximately 3 to 12 years of experience at the bedside, as desired for the study.

The list obtained from DOPL, which was emailed to the researcher in a Microsoft Excel® file format, included each licensed nurse's name, home address and/or email address, phone number, profession, license type, license number, how obtained, license status, original issue date, expiration date, and agency disciplinary action status. The full list of 13,243 nurses was loaded into Statistical Package for the Social Sciences to obtain a random sample of 1,000 nurses.

Recruitment

Subsequent to study approval from the Instructional Review Board of the University of Utah, the random sample of nurses (n = 1000), email addresses were utilized to recruit study participants. Each licensee with an email address was sent a recruitment letter (see Appendix A) inviting the nurse to participate in the study. The letter explained the purpose of the study and its associated risks and benefits; it also explained that volunteers selected for the study would be provided with a $50 Amazon® gift card upon completion of the demographic survey and the 60- to 90-min interview with the nurse researcher. Individuals desiring to participate were instructed to complete the Research Electronic Data Capture (REDCap®)) demographic survey (see Appendix B), and to provide their name and contact phone number for potential selection to participate in one of the confidential unstructured $QUAL_1$, or semistructured $QUAL_2$ interviews. Gift cards were provided at the end of the in-person interview or were mailed to the participant's address.

Participant Volunteer Process and Selection

Individuals desiring to participate indicated their willingness by completing the electronic REDCap® demographic survey. There were 90 volunteers who returned surveys for participation in the $Qual_1$ phase, and 249 individuals volunteered to participate in in the $QUAL_2$ phase. Surveys were managed by the researcher and tracked in the secure REDCap® online database. As surveys were returned, the researcher screened volunteers using the eligibility and exclusion criteria. Volunteers eligible for study participation were listed in order of the survey's date of return until sample saturation for the $QUAL_1$ participant group (n = 39) and the $QUAL_2$ participant group (n = 45) was achieved. The sample size for $QUAL_1$ and $QUAL_2$ was determined as adequate and to have met saturation requirements, considering the aims of the study and the goal to provide sufficient information for content analyses, within the constraints of the resources and time available.

Inclusion and Exclusion Criteria

Inclusion criteria for the study included (a) being female, (b) being an RN licensed in Utah, and (c) having practiced as an RN for at least 3 years full time (or the part-time equivalent) in direct patient care at the bedside. Exclusion criteria included (a) being a foreign-educated RN, (b) being male, and (c) having practiced in direct patient care at the bedside for less than 3 years. A direct-care or bedside nurse is an RN who works in a hospital nursing unit, in homecare or hospice, or in a clinic providing hands-on care to patients using the nursing process: assessment, diagnosis, planning, implementation, and evaluation. For the purpose of this study, participants met inclusion criteria if they had practiced for at least 3 years in direct patient care and were licensed in

Utah after 2004 and before 2013.

Web Applications and Software

REDCap®, a secure Web application, was used to build and manage the online demographic surveys. The software Audacity® for Windows® was used to record and store digital audio interview files. Microsoft Excel® was used to store transcribed interview data for upload to QDA Miner® with WordStat®, a qualitative data-analysis software for coding, annotating, retrieving, and analyzing text mined from participant interview transcripts.

$QUAL_1$ Core Component

In the initial phase of the study, the researcher conducted 39 unstructured interviews. The objective was to gain an in-depth description of career decision-making and the rationale for job-transition junctures from the participants' perspectives. The majority of interviews were conducted over the phone, as preferred by participant which also accommodated participation from all regions of the state of Utah. The goal was to obtain comprehensive and detailed descriptions and stories for subsequent content analysis. The participants were encouraged to describe their work situations, current and past; stressors affecting their career path; and factors related to family life and other personal variables that affected their work life. The value of the unstructured interviews was the potential development of a new understanding of the experienced nurses' decision to leave direct-care nursing (Corbin & Morse, 2003).

The Unstructured Interview

To develop skills in the unstructured interview process, five volunteers who were not part of the research population underwent a practice interview with the researcher. The researcher utilized these practice interviews to ensure that the interviews were open-ended and that the interviewers' techniques did not lead the participants' responses. Practice interview results were also reviewed and considered to ensure that the types of responses expected for the descriptive data were obtained with the unstructured interview technique. Following these practice interviews, the researcher modified her technique as appropriate.

Participant Selection and Sampling for $QUAL_1$

The 1,000 RN email addresses were loaded into the REDCap® system, along with the recruitment letter, the consent cover letter, and the survey. The RedCap® system was programmed to send a reminder email to potential recruits who had not responded to the initial recruitment email. Ninety RNs responded to the recruitment letter, which is equal to a 9% response rate. A spreadsheet of volunteers was created for screening the potential participants, with the date of survey return, email address, phone number, and other demographic information. Volunteers were screened for inclusion and exclusion criteria and this information was documented on the spreadsheet.

Utilizing the order in which the surveys were returned and confirmed to meet inclusion criteria, the participants were contacted via phone to schedule a date and time for the interview. If the recruit agreed to participate, a notation was made of the phone contact, including date, time, and location of the interview.

$QUAL_1$ Participant Sample and Quality

At the scheduled interview time, prior to commencing the interview, participant understanding of the study risks and benefits were verbally reconfirmed and documented as verbal consent to participate. $QUAL_1$ unstructured interviews were conducted in-person or over the phone, according to the participant's preference. The interviews were audio recorded and field notes from the interviews were documented. A $50 Amazon® gift card was given to each participant at the end of the in-person interview or was mailed to the participant if interviewed by phone.

Audio recordings were uploaded to Audacity® and were duplicated for backup. All audio files and field notes were securely stored and encrypted. Audio files were then transferred to the transcriptionist for HIPPA (1996) compliant transcription. Transcribed files were read and compared to the audio files for accuracy and necessary corrections. Microsoft Word® document transcriptions were uploaded to QDA Miner® with WordStat®. Content analysis was conducted. Codes and themes were identified. From the $QUAL_1$ interviews, semistructured interview questions were developed and pretested.

The sample size (N = 39) was determined by considerations of data adequacy, data management, and data appropriateness, given the expected size of the domain and the demands of semistructured interviews. To ensure quality study participants, Spradley's (1979) criteria of willingness to reflect and articulately express, time to be interviewed without interruption, and time to establish trust and rapport with the investigator were utilized. "Poor" participant interviews were documented and replaced with interviews from additional participants meeting the quality criteria. Sampling ceased once saturation was reached.

$QUAL_1$ Data Collection

Unstructured interviews were 60 to 90 min in duration, allowing the interviewer to build rapport and encourage participant self-expression to narrate her experiences. The interviewer did not have set questions but assumed a listening stance, inviting conversation by offering broad discussion topics to enable the participant to have control over the interview. If the participant digressed to another topic, the interviewer asked her how those topics related to her experience. Participants were guided to describe pertinent issues surrounding their past and current work experience, career decision making, and their thoughts about their future work and career decisions. Participants were also encouraged to relate the knowledge they had about these same issues and what they had heard and seen their nurse colleagues experience in their work decisions (Corbin & Morse, 2003; Morse, 2001).

The interviews were conducted using a reflexive process, with analytic insights being verified as each subsequent interview progressed and was completed. This reflexive process supported data verification, using the data collected incrementally and in whole; for example, the interviewer verified data by asking participants, “Some say ____. Is this true for you?” In addition, participants were asked about others’ experiences; in this way, shadow data were used to identify perceived common and exceptional experiences. As the Phase 1 unstructured interviews progressed the process became increasingly structured and directed with associated saturation noted. Data also included notes taken during interviews, as an augment to the audio recordings.

$QUAL_1$ Data Transcription and Accuracy Verification

Upon completion of each interview, the recorded audio file was uploaded to a secure, encrypted computer; a backup of the audio file was stored on another secure, encrypted computer. Audio files were subsequently transferred for transcription and the transcripts were read and compared with the audio files for accuracy. This same process was utilized for the $QUAL_2$ interview data.

$QUAL_1$ Data Analysis

The primary purpose of the $QUAL_1$ data was to obtain a framework of categories to develop the semistructured questionnaire for $QUAL_2$ (see Appendix D) to be used in the $QUAL_2$ phase of the study. Transcribed interview files were uploaded to QDA Miner® with WordStat® software for data sorting, coding, categorization, and analysis. Text was selectively coded, merged, and grouped according to topics and categories. The researcher used the processes of theoretical memos and data segmenting for analysis of patterns and comparison. As categories emerged, the researcher compared the category content and made inferences to further merge and combine the categories. These categories 1) provided a rich descriptions of the nurses' work and home life leading to *intention to leave working at the bedside*, and 2) provided the question topic areas and ultimately the specific questions for Phase 2.

$QUAL_2$ Sequential Component

In the second phase of the study, the researcher conducted 45 semistructured interviews. The two-phased methodology was for the first phased to provide the content for the second phase semistructured interview questions. The interviews were conducted

in person or over the phone to allow for participation from all regions of the state of Utah. The interview questions were developed from the categories identified in the $QUAL_1$ unstructured interviews. The final questions developed using the participants' vocabulary, were organized into topical domains obtained from the categories and subdomains. For example, questions about work schedule or work relationships formed one domain. Each domain had several semistructured questions arranged in logical order for the sequencing of the interviewee's pregnancy. The semistructured questionnaires were developed including the following topical domains for questioning: 1) Demographic Questions, 2) Nurse Working and Working Pregnant, 3) Postnatally, Nurse on Maternity Leave, 4) Postnatal Working, 5) Nurse Working at the Bedside With Young Children at Home, 6) Quality of Childcare from Husband or Other Caregivers, and 7) Recommendations (see Appendix D).

Pretesting the Semistructured Questionnaire

To ensure clarity of question stems, four volunteers who were not part of the research population pretested the questionnaire. The researcher examined pretest responses to ensure that the question stems elicited the types of responses expected for the descriptive data. The researcher ensured that items were not ambiguous and elicited long, descriptive answers rather than short, closed-ended responses. The question stems were modified as needed.

Participant Selection and Sampling for $QUAL_2$

The spreadsheet list of RN licensees, randomly ordered using Statistical Package for the Social Sciences, was again used, excluding the 1,000 RNs initially recruited for

$QUAL_{1.}$ The next 2,000 RNs on thelist were emailed the recruitment letter, consent cover letter, and the survey. Recruitment efforts resulted in 248 RNs responding to volunteer—a 12% response rate. A spreadsheet with the date of survey return, email address, phone number, and other demographic information regarding the volunteers was created for screening potential participants. Volunteers were screened for inclusion and exclusion criteria, and this information was documented on the spreadsheet.

Utilizing the order in which the surveys were returned and confirmed to meet inclusion criteria, the participants were contacted via phone to schedule a date and time for the interview. At that time, the volunteers were again provided with the purpose of the study, and the risks and benefits of the study. If the volunteer agreed to participate, a date, time, and location for the interview was scheduled. Notation was made of the phone contact, including date, time, and location of the scheduled interview.

At the time of the interview, prior to commencing the interview, participant understanding of the study risks and benefits was verbally reconfirmed and the researcher obtained and documented verbal consent to participate.

$QUAL_2$ Participant Sample and Quality

The sample size of 45 participants was determined prior to recruitment, to allow for (a) qualitative saturation of each item, balanced with (b) data manageability, and (c) the use of nonparametric statistics between item analysis if necessary. This sample size was determined to be adequate, with high-quality data collected from participants. Spradley's (1979) criteria continued to be utilized to ensure quality participants, and "poor" participant interviews were documented and replaced with interviews from additional participants meeting the quality criteria. Sampling ceased once saturation was

reached.

$QUAL_2$ Data Collection

Semistructured interviews were 60 to 90 min in duration. This period allowed the researcher to build rapport and encouraged the participant to express herself when answering open-ended questions. The researcher followed an interview guide that consisted of open-ended questions. The value of the semistructured interview method is the provision of reliable and comparable qualitative data (by item) for systematic sorting, organization, and categorization for analysis. Divergence from the semistructured questions was accommodated to allow for further understanding of the phenomenon. While the process involved sequential questioning, the researcher allowed each participant to express her views in her unique way. Participants were also encouraged to relate the knowledge they had about these same issues and what they had observed their nurse colleagues experience in their work decisions (Corbin & Morse, 2003; McIntosh & Morse, 2015; Morse, 2001).

$QUAL_2$ Data Analysis

Word®-document transcriptions were uploaded to QDA Miner® with WordStat®. Content analysis was conducted to identify categories and patterns from the unstructured interviews. As each interview was transcribed, data were verified, then loaded into the software and preliminarily organized by item number; the file was then duplicated. For qualitative data analysis, each item was systematically coded and sorted into subcategories. Data also included notes taken during the interviews (field notes) to augment to the audio recordings. Each of the semistructured question items, and the

participant's response, was initially categorized within one of three groupings: the participant (a) had been pregnant at the bedside (full-time employment) and had young children at home, (b) had been pregnant at the bedside and had young children at home, and (c) had not been pregnant at the bedside but had young children at home. Item responses for each individual were compared and then coded for the group. Subsequent to content analysis and categorization into one of the three groups, each semistructured question and the participant's response was then compared to the other groups. Ultimately, all three groups were combined, resulting in the Phase 2 findings which indicated that there were similarities and commonalties between the 3 groups despite demographic and work status differences.

Rigor

Assurance of rigor was achieved by ensuring quality data throughout the research process. Reliability and validity are intertwined, and were sought to be attained during the unstructured interview component through prolonged engagement to reduce bias, a large and appropriate sample, use of the multiple data sets to answer questions, use of induction, use of negative cases to understand norms, and debriefing for conceptualization. Study reliability was ensured through use of a coding system and thick description detailing experiences and context, which provided overlap in data (Morse, 2015b).

The researcher prioritized validity over reliability as a way of supporting a quality and trustworthy representation of findings that accurately represent the phenomenon. The researcher included all data, whether concrete, subjective, perceptive, or experiential, and the reported experience of others. This focus on validity did not reduce the importance of

reliability; it strengthened the accuracy of perceived, subjective, and interpretive experiences related in the data-collection process. Strategies for establishing validity in this study were appropriately applied and prioritized relevant to unstructured or semistructured interview techniques. These strategies were also built into the study-method components of induction, sampling, and data collection (Morse, 2015a).

Protection of Human Subjects

A cover letter (see Appendix A) explaining the purpose of the study and the risks and benefits of the research, with information that participation was strictly voluntary, was provided to study recruits. Confidentiality was maintained by assigning identification numbers to demographic information, and no personal identifiers of any type were utilized. All data were stored in a locked office on an encrypted computer.

Ethics

The researcher was aware of her roles as a student nurse researcher, nurse executive, and nurse educator in the community. Considering that she might have known participants and/or that participants might have known her, and also considering research processes related to confidentiality, study participation, and the quality of research, the researcher used transparency and adhered to the highest research ethics.

Participant data will be securely maintained until the dissertation chair and the researcher agree on a date for the files to be destroyed. Submission for article publication in peer-reviewed journals is planned, as well as presentation of findings to interested stakeholders in the state and nationally.

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CHAPTER 4

EXPERIENCED NURSES: REASONS THEY LEAVE OR INTEND TO LEAVE DIRECT PATIENT CARE

Introduction Phase 1

Experienced nurses leaving direct patient care is a serious and costly problem for hospitals, yet the perspectives of those nurses have not been extensively explored. Many nurses today, just at the point at which they become "experienced," are also positioned with multiple options for expanded role opportunities to further their education or find a flexible, autonomous work position. In this study, 39 experienced nurses were interviewed to understand and describe their career path and to determine the associated reasons for changing job positions, advancing their education, and availing themselves of other opportunities.

The nurses' overall priority of responsibility to their child(ren) and husband/partner emerged as the dominant category, and was the primary rationale for job changes, resignation, and educational or career advancement. Lack of control over scheduling, lack of recognition, and the physical and emotional stress of the work environment were also found to prompt nurses to leave direct patient care. Experienced nurses with children and family responsibilities were often prompted to resign direct patient care positions to seek work environments and career paths that support or allow

for the fulfillment of mothering responsibilities and family priorities, and that provided appreciation for work contributions in an emotionally and physically stressful work environment. Other experienced nurses, for these same reasons, left bedside care and chose not to work outside the home; they stay at home with their children.

Background

Experienced nurses are essential to quality patient care in the hospital setting. Their ability to independently practice using the nursing process and acquired skills of critical thinking are invaluable in delivering quality patient care. Experienced nurses are capable of collecting and analyzing patient data through physical assessment, using clinical judgment to respond to unique patient needs, and planning and implementing skilled interventions with ongoing evaluations of the patient (Alspach, 2007; Conway, 1998).

The trajectory to become experienced and develop clinical expertise takes several years and has been associated with the context of the practice environment (McHugh & Lake, 2010). Following graduation, the nurse gains experience and attains expertise through active practice, supported by the knowledge gained through formal education (Benner, 1984; Fero, Witsberger, Wesmiller, Zullo, & Hoffman, 2009; McHugh & Lake, 2010). Ironically, at the point a nurse becomes experienced, possesses expertise, and provides great value to the organization (usually within 3 to 5 years of initial practice) (Ericsson, Whyte, & Ward, 2007; Flinkman & Salantera, 2014), she is positioned with multiple options to leave direct patient care for expanded role opportunities or to advance her education. Expertise and superior performance were described by Ericsson et al. (2007) as having skills, knowledge, clinical judgement, flexibility, and efficiency; these

are the characteristics of experience and expertise (Benner, 1984; Cowan, Norman, & Coopamah, 2005).

There are many studies in the literature related to turnover, as documented by Griffeth, Hom, and Gaertner (2000). Underpinning those studies of turnover are theories that define voluntary turnover as individuals who decided on their own to leave the organization, as opposed to involuntary turnover, wherein the individual is fired and forced to leave (Griffeth et al., 2000). Early in the management literature, *organizational equilibrium* (Barnard, 1938; Simon, 1947) was theorized as individuals staying as long as incentives meet or exceed their expectations of remuneration for their effort and participation. Additionally, Jackofsky and Peters (1983) conceived that individuals stay or leave a job in accordance with the level of their satisfaction, as weighed against the opportunity of moving to an alternative job perceived as offering higher levels of satisfaction.

The results of this study are closely aligned with “push” and “pull” factors described by Lee and Mitchell (1994). A theory of voluntary turnover describes indicators of why individuals leave an organization and serves to explain regrettable employee turnover, when a valued individual voluntarily leaves the organization (see Figure 4.1). Sociodemographic and personal push factors underlie employee intention to leave. These factors cannot be controlled and are associated with gender, marital status and number of children, education, and experience. Personal push factors are not controllable, and are associated with health, family, and perceptions about the job, such as job status and personality differences with management. Pull factors are controllable and are associated with salary, promotion, job security, and organizational support

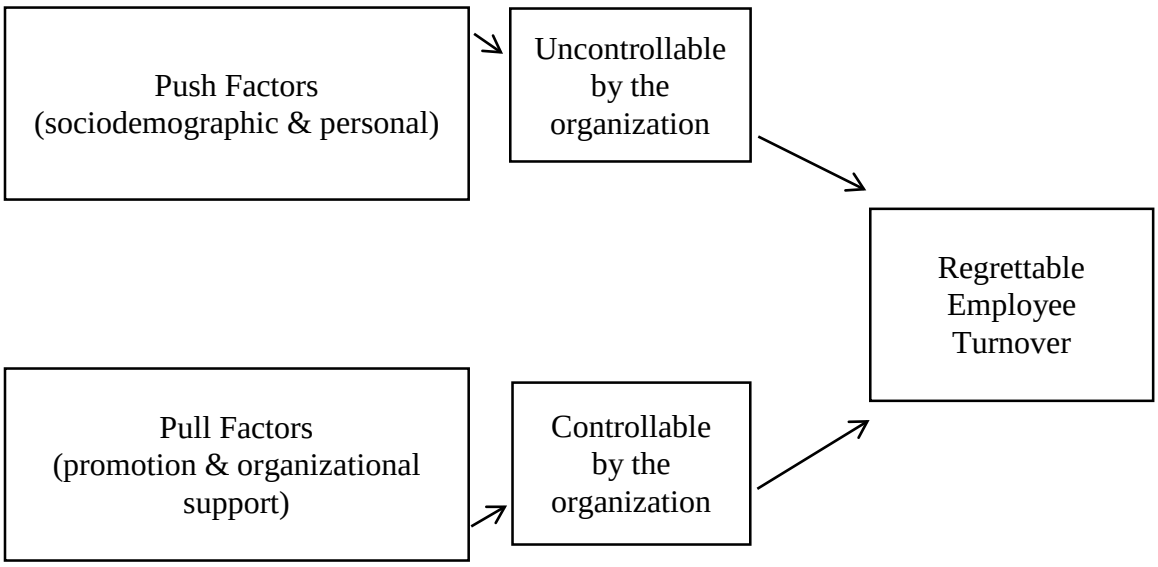

Figure 4.1 Factors identified in the literature leading to regrettable turnover.

(Ahmad, Fakhr, Shah, & Zaman, 2010; Mitchell & Lee, 1994, 2001).

Exit of the Experienced Nurse

Experienced nurses leaving direct patient care has long been a challenge for hospital organizations. The problem is multifaceted and may be the result of individual, organizational, or external factors (Beecroft, Dorey, & Wenten, 2008; Bobbio & Manganelli, 2015; Hayward, Bungay, Wolff & MacDonald, 2016). Nurses may leave to gain more pay (De Gieter & Hofmans, 2015), for promotional opportunities (Hofmans, De Gieter, & Pepermans, 2013), or to advance their education (Albrecht, 2015); they also may leave to avoid unacceptable work conditions or shift-work hr (Choi, Cheung, & Pang, 2013), relieve job stress (Chiang & Chang, 2012), or because of injury and illness (Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2009; Yassi & Lockhart, 2013) or family responsibilities and associated family-work conflict (Armstrong-Stassen, 2005; Borda & Norman, 1997; Cheng, Tsai, Chang, & Liou, 2014).

Nurses may leave the current work unit, advance to an expanded role, take an extended leave, leave the organization, or leave the nursing profession, completely resigning professional licensure. They may leave patient care for advanced nursing roles or for administrative or teaching opportunities, and while this contributes to the nursing profession at a higher professional level, it also contributes to direct-patient-care workforce shortages (Flinkman & Salantera, 2014; Hayes et al., 2006). Nurses may also leave to attend to family accountabilities related to their children or responsibilities to aging parents (Brody, 2003).

Prior to leaving direct patient care, the nurse considers her future, employment options that may be more beneficial as related to setting or reimbursement, and/or options to not be employed or to reduce hr of work. This decision-making process is referred to as *intention to leave*, and serves to provide rationale for leaving the job. The exodus of nurses from the bedside ultimately results in turnover that is costly for the institution and the profession (Rizwan et al., 2013; Takase, Teraoka, & Kousuke, 2014).

Although turnover of experienced nurses may be inevitable, not all turnover is negative in its impact on the profession. For example, nurses return to school to achieve higher educational levels and obtain academic degrees for professional advancement, and to fill faculty, research, practice, and leadership roles in nursing. Of concern are those experienced nurses who leave the bedside or the nursing profession not for reasons of job promotion/expansion or educational advancement, but because their personal needs are unmet in the workplace. These nurses leave because they cannot identify a better alternative to resigning their position; they would remain if conditions were flexible enough to accommodate their needs (Beecroft et al., 2008). Turnover of experienced

nurses is especially problematic because the loss occurs when they have reached competency, possess clinical expertise, and are highly capable of ensuring quality patient care (Bleich et al, 2009); by this time, the institution has provided extremely costly clinical orientation and training and has invested in the nurse.

Study Purpose

The purpose of this study was to investigate nurses' intention to leave direct patient care, focusing on the causes and rationales from the perspectives of the nurses themselves. Understanding why experienced nurses leave direct patient care will allow for the identification and implementation of positive strategies to support, accommodate, and potentially retain the bedside nurse. This information will provide healthcare organizations with information to intervene and help prevent the resignation of these nurses and could provide ideas that could support the overall well-being of nurses with children and families. Furthermore, the information may facilitate the organization's successful planning efforts to support advanced roles within the organization.

Review of the Literature

The factors, circumstances, and situations that are predictors of a nurse's intention to leave are important for hospital administrators to understand; specifically, the elements of a job situation may stimulate a nurse to think about and plan to leave the job. Major factors associated with intention to leave and turnover identified in the literature were lack of job satisfaction; stress and depression leading to burnout; overall workload and the physicality of the work; and family–work conflicts.

Job Satisfaction

The best predictor of intention to leave is first and foremost work satisfaction, or the emotional and intellectual fulfillment derived from the job. In summary, job satisfaction is followed by workload and the nature of the work. Career opportunities, training opportunities, increased autonomy, employee evaluation methods, pay and benefits, and the physical characteristics of the work also play into intention to leave. If these components are negative, there is resultant intention to leave and a chain-reaction process of withdrawal from the organization. If these components of work can be reversed to enhance nurse retention, the negative outcome of the nurse exiting the organization may be prevented (Han, Trinkoff, & Gurses, 2015; Ma, Lee, Yang, & Chang, 2009). In a cross-sectional study of 1,271 registered nurses (RNs) in 10 hospitals, attributes of the work environment such as professionalism, peer relationships, management, staffing, and employee policies had a significant influence on the nurses' job satisfaction and their intention to leave the hospital (Choi, Cheung, & Pang, 2013; Cortese, 2012). Organizational leaders who round the units to listen to and interact with employees will be better able to gauge intentions and commitment to the workplace. This interaction will allow for an overall approach to improve employee satisfaction and will result in the leadership being attuned to the unique needs of individual employees (Chênevert, Jourdain, & Vandenberghe, 2016).

Stress, Depression, and Burnout

Stress and depression are significant predictors of intention to leave, and the propensity for such intention is significantly higher in the Emergency Department and other high-intensity settings compared to medical–surgical units (Chiang & Chang,

2012; Flinkman & Salantera, 2014; Liu et al., 2011; Ma et al., 2009). Emotional exhaustion and burnout are strongly related to nurse intention to leave. Emotional exhaustion is exhibited through psychosomatic complaints and diminished professional commitment. A positive work environment provided by good nurse managers and supportive hospital policies is known to ameliorate negative emotional experiences for the nurse in the workplace (Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2012). A longitudinal observational study investigated new graduates' intention to leave prospectively, by measuring burnout and disengagement. The study showed that burnout was related to intention to leave and that high levels of burnout increased the measured levels of intention to leave (Rudman, Gustavsson, & Hultell, 2013). Havaei, MacPhee, and Dahinten (2015) recommended that organizations focus on improving human resource management practices to reduce burnout and emotional labor that cause nurses to want to leave the organization.

Overall Workload

Intolerable nurse workloads and perceived overparticipation of RNs completing unskilled tasks that could be delegated to unlicensed assistive personnel have been seen to cause attrition. In a study by Lindqvist et al. (2014), repetitive tasks related to activities of daily living, compounded by high numbers of patients requiring complete care, were associated with nurse intention to leave. Mundane work not perceived to require nurses' critical thinking, education, and training was discouraging, and was associated with time spent in hard physical labor; this work was undesirable and was not perceived by the nurse as professional work. A questionnaire study conducted by Sveinsdóttir and Blöndal (2013) further corroborated the aforementioned finding that having to perform

nonnursing and nonprofessional clinical duties contributes to a decrease in nurse satisfaction and morale, resulting in intention to leave the nursing unit.

Physicality of the Work

The physical work conditions for the nurse and/or the presence of musculoskeletal or other health problems may also be predictors of the nurse leaving direct patient care. Musculoskeletal problems such as neck, shoulder, or knee problems may have been caused by work injuries; these conditions are exacerbated by problematic working conditions that require heavy patient lifting or patient transfers. These musculoskeletal injuries have resulted in an epidemic of back pain and back injuries in nurses (Dawson, McLennan, Schiller, Jull, Hodges, Steward, 2007). Additionally, the absence of patient transfer devices is associated with musculoskeletal health problems of nurses. These difficult work conditions and the presence of health problems are strong predictors of the nurse leaving the job (Fochsen, Josephson, Hagberg, Toomingas, & Lagerstrom, 2006). Current statistics indicate that back injuries are epidemic in nursing worker populations and estimated to occur at prevalence rates in over 50% of nurses (Ovayolu, Genc, & Col-Arz, 2014; Rezaee & Ghasemi, 2014).

Family Responsibilities and Associated Family–Work Conflict

Family–work conflict is a significant factor related to nurse intention to leave. This conflict arises from work hr interfering with family responsibilities, family stressors associated with ill children or other ill family members, and the resultant absence from work to meet those responsibilities (Yamaguchi, Inoue, Harada, & Oike, 2016). In a comprehensive review conducted by Allen, Herst, Bruck, and Sutton (2000), family–

work conflict resulted in widespread and serious consequences to the individual, her or his family, and the employer. Significant findings were the work-related outcomes, nonwork-related outcomes, and stress-related outcomes. The pressures and challenges that result from work interfering with family and home accountabilities are real, and may result in stress, strain, sickness, and work absence. These outcomes evidence the need for hospitals to offer nurses job flexibility so they can meet the dual responsibilities of family priorities and work (Farquharson et al., 2012).

Work Schedules

Shift lengths of 12 hr or more are associated with nurse intention to leave, although studies show two contrasting considerations. Nurses prefer to work 12-hr shifts because they then work fewer days per week, yet job satisfaction declines with longer shift lengths. These findings provide an interesting paradox, as each work option was found to have positive attributes, yet they compromised work–life balance and contributed to nurse intention to leave (Borda & Norman, 1997; Dall'Ora, Griffiths, Ball, Simon, & Aiken, 2015). Shift work can cause fatigue, exhaustion, and burnout. Undesirable scheduling may also result in staff attrition. These problems add to negative employee morale issues associated with the nurse's work schedule. The scheduling and shifts impact the nurses' home life and responsibilities and become a factors in her intention to leave or dissatisfaction (Bogossian, Winters-Chang, & Tuckett, 2014; Tuckett, Winters-Chang, Bogossian, & Wood, 2015).

As stated previously, the most influential factor with regard to a nurse leaving her employment is job satisfaction. Work satisfiers include human resource policies and organizational structures that provide for flexible scheduling, recognition, professional

autonomy, and adequate pay and benefits, in addition to positive working conditions with reasonable workloads (Al Maqbali, 2015; Chan, Tam, Lung, Wong, & Chau, 2013). The literature regarding predictors of nurse intention to leave provides key insights for hospitals and healthcare leaders. Because intention to leave has an associated time period, whether short or long, managers and human resource departments can take steps to retain nurses through improved work situations that increase nurse satisfaction and strengthen intention to stay. This study adds to the current literature by further examining intention to leave the bedside from the unique perspective of the nurse early in her career but with valuable years of experience.

Methods

This was a qualitative exploratory study using unstructured interviews to engage experienced nurses in order describe rationales for intention to leave direct patient care. The Utah state RN licensee list was utilized to recruit nurses who had been licensed for 3 to 12 years. Participant inclusion criteria included the nurse to have been educated in the United States, female, and practiced for a minimum of 3 years in direct patient care, (defined as *working in a hospital nursing unit, in homecare or hospice, or in a clinic providing hands-on care to patients*). The study was approved by the University of Utah Institutional Review Board. Study participants were provided with a consent letter explaining the purpose and risks of the study prior to completing a demographic survey and prior to a 60- to 90-min interview with the researcher.

Thirty-nine nurses were recruited into the study from different healthcare institutions across the state of Utah. Of those who participated, the mean age was 30 years, with the majority being married (80%); 10% were divorced and 10% were single

Sixty-nine percent of the participants reported having three or more children, with the average age of the children being 5 years, and nearly 50% under school age (see Table 4.1).

The interview process was initiated with participants reflecting on a timeline of their nursing education and nursing work. The researcher then asked the participants to describe each of their various job positions. Participants were allowed freedom and control in the interview to talk about their current and past work as a nurse. The interview technique of probing was used to encourage participants to further explain details about the topics brought up in their interviews. The researcher used a reflexive process, with analytical insights being verified as each subsequent interview was conducted, allowing for the verification of data collected incrementally and in the whole to be verified for saturation. Shadowed data were used to identify common and exceptional experiences of individual participants; the researcher asked participants if their experience was similar to that of their nursing coworkers (Corbin & Morse, 2003; Morse, 2001).

Qualitative analysis began at the conclusion of each interview, with the researcher recording thoughts, impressions, and details from the interview as field notes. Each transcribed interview was reviewed and compared by the researcher to the audio recording for accuracy and completeness. The transcribed documents with the detailed descriptions, stories, and experiences of the nurses were uploaded, coded, and organized using QDA Miner® with WordStat® qualitative research software.

Table 4.1

Demographic Information

Demographics	Responses
Age	
Mean	31 years
Range	25–56 years
Ethnicity	
White	37 (95%)
Hispanic	2 (5%)
Marital Status	
Single (*n* = 6)	6 (15%)
Married (*n* = 31)	31 (77%)
Divorced (*n* = 3)	3 (8%)
Time as an RN	
Mean	6 years
Range	4–34 years
Years at the Bedside	
Mean	6 years
Range	3–20 years
Educational Level	
Associate degree	12 (28%)
Baccalaureate degree	23 (60%)
Doctorate degree	5 (12%)
Current Job Role	
Staff nurse	17 (41.5%)
Manager/administrator	2 (4.9%)
Nurse educator	2 (4.9%)
Nurse researcher	1 (2.4%)
Nurse practitioner	2 (4.9%)
Not currently employed	10 (24.4%)
Other	5 (12.2%)
Number of Children	
Mean	3 children
Range	0–13 children
Average Age of Children	
Mean	5 years
Range	0–29 years
Average Number of Children Under School Age	48%

Results

Mothering Responsibilities

Most nurses interviewed indicated that they "loved" nursing. Several nurse who were not presently employed indicated that they would return to the workplace when their children were in school (i.e., when their youngest child was in kindergarten). The tensions between responsible parenting and meeting employer expectations caused major conflicts for these nurses. Particularly overwhelming were inflexible scheduling and the number of work hr required to maintain part-time or full-time employment. Career-path decisions and job changes to move away from the bedside were heavily influenced and overshadowed by frequent scheduling conflicts and the lack of consideration by employers toward nurses' family obligations. Employers were unwilling to reduce the nurses' budgeted hr. Nurses said: "I wanted to work just one shift a week after I had my baby, but my manager said I had to work at least twenty-four hr [per week], so I quit."

Scheduling Conflicts

Lack of control over the schedule was so important that many nurses made the decision to return to school for additional education, hoping for a future position that would offer better work–life balance, such as teaching nursing with "office hr" and weekends off. Several nurses who stayed at the bedside worked the required nights, weekends, holidays, and rotating shifts, and reported that the schedule was overwhelming: "[It] was exhausting—I just can't do it anymore." Most of the nurses indicated that they wanted a set schedule, that family obligations were frequently in conflict with their assigned shifts, and that they needed control over the schedule to meet their family priorities: "With the short notice on my work shifts, it's hard for me to trade

to be off for my kids' activities." Rigid scheduling was seen as a top influencer for changing positions, even if it meant less pay or a less-desirable or -stimulating workplace. Some nurse's negotiated clinic positions with schedules that worked for their family and allowed them to meet family responsibilities.

The nurses related how overwhelming it was for them to work and be away from their young children for extended periods. They resented not being able to attend their children's school events and sports activities. One nurse said, "They don't respect that I have to take care of my family." Other complained that they were not able to "juggle all the priorities," and that conflict between work and schedules and family obligations ultimately reached a "tipping point" causing then to resign their positions to "stay at home to be a mom."

A Means to an End

Many of the nurses indicated that they were working only to make "ends meet" financially because their husband was in school or was unemployed. Some of the nurses related that as soon as their home finances were secure with their husband's income, they would cut back on their hr or completely resign and stay home with their children: "I never planned to work when I had kids." Many of the nurses indicated that they were working to supplement the family income and that their husband's job was the "priority"; Exceptions to this were nurses who indicated that they went back to work because of divorce, because they were single, or because their children were grown. It must be noted, however, that while having a salary was a priority, none of the nurses complained about the level of pay.

Leaving Children With Other Caregivers

Nurses in this study expressed angst and concern over leaving their very young and even teenage children to go to work. Although many of the nurses had help from their husband or other caregiver, the guilt of leaving their children was overwhelming. One participant stated, “My husband’s a great father but he sucks at being a mother.” Another nurse shared that although it was difficult to work the night shift, she did so “because I don’t want other people raising my kids.” Almost all of the nurses in this study expressed their love of the profession of nursing and the satisfaction they derived from caring for patients; nevertheless, the pull of their family was stronger, and they felt it was most important to be there for their children.

Lack of Employer Appreciation

A common category in the interviews was a lack of appreciation from the employer. The nurses indicated that they wanted their opinion “listened to,” and they wanted to be appreciated for “the kind of care I provide.” The nurses indicated that appreciation was absent for the most part, and that they wanted appreciation for even “the little things” they did, such as staying late on a shift or changing their home plans for the sake of staffing the unit and providing safe patient care. The recognition/appreciation desired was a kind word or acknowledgement of their contributions: “Sure, pay is great, but just being acknowledged once in a while for all I do for this unit would mean a lot!”

Emotional and Physical Fatigue

Despite finding nursing emotionally satisfying, it was also emotionally challenging; for example, one nurse who worked in the newborn intensive care unit

described how she could not go back after losing her own baby. When asked if there were debriefings for hard shifts and/or crisis situations on the unit, nurses indicated that they had never been offered a debriefing session: “I just went home to my bed. It really affected me, and I just can’t work there anymore with that kind of stress—it hits too close to home.” Additionally, many times the work was “physically impossible,” and nurses recognized that they could not continue to lift patients and endure the physical hardship of bedside nursing. They made plans to leave direct care, perhaps thinking to go into a clinic setting so they would have a physically easier job when they were older. These cumulating emotional and physical stressors continued to occur for the nurse until a final intolerable event occurred, such as not being able to get a day off for an important event in their life, and this was the “tipping point” for these women, causing them to take steps to change or completely quit their current job commitments.

Support From the Work Team

A “hard” unit is one that is emotionally, physically, and organizationally difficult. An emotionally difficult unit may be one in which patients are demanding and/or may die, have high levels of physical labor, and nonnegotiable work schedules. Such conditions may be mitigated with a supportive work team, including unit nurses and the nurse manager. Participants indicated that even if the nursing unit was hard, a supportive work team made all the difference. For some, the only reason they stayed at the bedside was because of the team environment: “Those nurses were like my family;” “They had my back.” The support or indifference of the nurse manager highly influenced retention on the nursing unit. Participants related concerning stories about nurse managers who did not show care or concern for them as individuals with a family and a life: “My manager

was mad at me for only being able to work certain shifts." Other nurses related positive stories about nurse managers who cared and showed concern for them as individuals, beyond simply staffing the unit: "She really cared about me and she always asked about my kids." "He was truly interested in me. You know, you can tell when they are just going through the motions and they really don't care."

Stimulating Work Environment

Opportunities to learn and grow in their work positions were significant. Nurses reported liking the challenge of the hospital setting and being in on "cutting-edge technology for patients." They perceived a stimulating work environment as a positive, especially if there were other, more experienced nurses who took time to teach and mentor them: "I could tell she loved to teach." Unit environments in which the nurses could learn and grow in the profession were a positive influence on the nurses staying at the bedside; feedback to improve their skills and become better nurses was important.

Primary Rationales for Leaving Direct Patient Care

The above categories may be further sorted into three primary patterns for intention to leave the bedside. These were "stopping out for a time" or *providing a hiatus*, *the option of flexible scheduling*, and moving for *career advancement*.

1. *Providing a hiatus*: After the birth of their first child, nurses may "stop out" of nursing for a time, with the intent of returning when their children are in school. These nurses may want to work again at a future date, but their current priority is being the primary caregiver for their child(ren).

2. *The option of flexible scheduling*: Nurses who were not in a financial position to quit their job completely required "scheduling flexibility" that would enable them to better meet family obligations. As this was not available in the current position, they resigned to work for a competing organization that offered them essential control over scheduling so they could balance family and work.

3. *Career advancement*: Other nurses perceived their work at the bedside as a means to an end; they had the goal of advancing their education so they could "advance their career" to become a nurse practitioner, certified registered nurse anesthetist, or nurse educator. These reasons for leaving the bedside, while problematic for the employer, may, if known, be leveraged for strategic stabilization of the bedside workforce.

Each of these rationales, at face value, appears problematic for the nurse and the organization, as they result in nurse turnover; however, if understood and managed, those alternatives could be leveraged by the organization to ultimately stabilize experienced nurses at the bedside through development of succession planning programs for nurses interested in advancing their careers, allowing for longer breaks in service to allow the nurse to return to the organization, and innovative flexible scheduling suited to the nurses' needs (see Figure 4.2).

Discussion

The results of this study are consistent with the earlier literature examining nurse intention to leave and retention strategies (Dietrich, Donnelly, & Domm, 2007). The study also supports that, for the nurse, the most important aspects of the job are control over scheduling, shift flexibility, a supportive manager, and a supportive work team. These work-environment characteristics are vital to support intention to stay and retention of the nurse.

Also in common with prior studies is the fact that pay is important and should be fair, but pay is not the major driver for the nurse with regard to career decisions, especially compared to schedule control and flexibility (Singh & Loncar, 2010). What this study adds are the findings that intention to leave and the success of retention strategies are first and foremost influenced and decided on by the nurse, dependent on her child(ren), family, and home responsibilities.

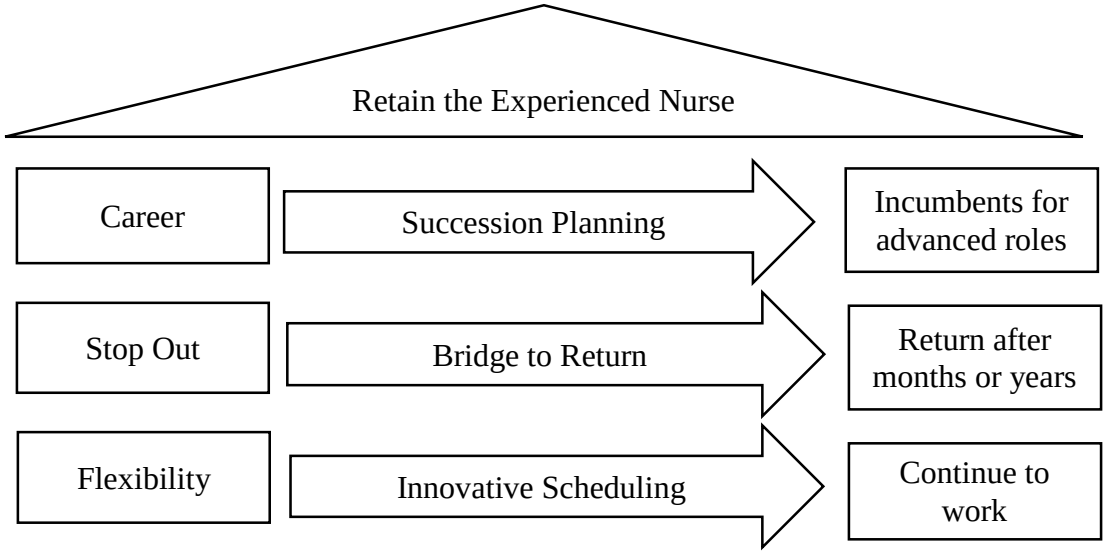

Figure 4.2 Organizational levers for stabilizing the bedside-nursing workforce.

While the literature clearly reveals that scheduling, flexibility, and a positive work environment are pivotal in retention, details as to the "why" of those factors do not appear; specifically, that schedule flexibility and the secondary issue of pay are determined to be desirable only if the nurse believes the work characteristics and situations are compatible with and a benefit to her overall responsibilities as a mother and wife.

Study Implications

Hospitals may use these findings for strategic workforce planning. For nurses who plan to stop out of their careers for a period of time, structuring "bridges" to rehire them through intermittent engagement and staying connected (e.g., offering educational workshops and other events) could increase the probability of their returning. Understanding that offering flexible scheduling and supporting nurses in the responsibilities and priorities they have in connection with their families may increase

loyalty and retention and could be a competitive advantage; for example, advertising that a work unit is “mother friendly” could be an enticement for recruitment. In addition, leveraging succession planning on the fact that a cohort of nurses want to obtain just the amount of experience needed to qualify for admission to graduate-school programs could be beneficial; supporting these nurses in gaining clinical expertise, knowing they are potential future candidates as the organization’s advance-practice clinicians, could be a win–win strategy for the nurses and the organization.

Future Study

These results require further research to understand what options may be instituted in order to retain and support nurses with young children and family priorities so they can continue to provide direct patient care at the bedside. Additional analysis withregard to the feasibility of costs associated with these employee supports should be considered.

Study Limitations

Participants in this study were female nurses in the state of Utah. Which may have limited generalizability of the results to other nurses in the United States. Due to demographics unique to the state population.

Summary

In contrast to earlier studies that focused on factors in the work environment as the primary reasons for nurses leaving direct patient care, in this study the conflict between the nurses’ personal lives and professional lives was striking. The responsibilities and obligations of being a mother emerged as the dominant category. A

tipping point occurred when the nurse was pushed beyond her perceived ability to manage both personal and professional accountabilities and when she recognized the need to relinquish one or the other. Ultimately, family obligations were perceived to be stronger. Scheduling conflicts and rotating schedules were primary factors in intention-to-leave decisions. Findings also indicate that bedside nursing may be a means to an end, that it may not be perceived as a "career." Some nurses were working only to secure home finances or to supplement their husband's job income, which was perceived as the priority.

Although some of the nurses were not currently in a position to leave their job because of the need to provide complete or supplemental income, they had a plan to reduce their hr to part time or to resign altogether so as to be at home with their children. This suggests that while there were options for childcare so they could work, the nurses felt guilt and angst at being away from their children and not attending to family priorities. Consistent with the Magnet model and recommended characteristics of a professional practice environment to retain nurses and reduce nurse turnover (Park, Gass, & Boyle, 2016), the study revealed that supportive colleagues and managers are a positive influence on nurses' intention to stay in a direct-care nursing position, and additionally that a stimulating work environment that allows them to learn, grow, and fully utilize their skills and expertise serves to improve positive perceptions of the work environment.

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CHAPTER 5

THE EXPERIENCE OF NURSES WORKING IN DIRECT PATIENT CARE WHILE PREGNANT AND/OR HAVING YOUNG CHILDREN AT HOME

Abstract

Experienced female nurses indicate that family responsibilities and associated priorities are important factors as they make career decisions to leave or stay in nursing positions or to advance their career. Approximately 40% of nurses working at the bedside are females in the childbearing or childrearing phase of their lives. The purpose of this study was to explore how pregnancy, childbirth, and the responsibilities of mothering young children impact the careers and lives of nurses who are working at the bedside. The study revealed that policies to support and/or protect pregnant nurses are largely absent or unknown to the nurse, and that few changes to accommodate the workload of pregnant nurses occur—even in the later stages of pregnancy. More than 90% of nurses breastfed and intended to express breast milk upon returning to work, yet just a few weeks after returning to work, due to the lack of support for breaks to express milk, many nurses stopped breastfeeding, and did so earlier than the overall breastfeeding population. The impact of working at the bedside with high-acuity patients resulted in the needs of these pregnant women going unmet or unrecognized, and resulted in frustration on the

part of nurses with young children because they missed out on important events in their children's lives as a result of working.

Background

This study was the outflow of an exploratory study to investigate experienced nurses' intention to leave direct patient care (Chapter 4). While findings commonly related to nurse intention to leave, such as scheduling, recognition, and the work environment were identified, a surprising finding was that obligations to family and children was the most influential factor for the nurse changing jobs or going back to school for the purpose of advancing her career. This evidence was the impetus for this study, which was focused on women in their childbearing and childrearing years who were working in direct patient care, to investigate the associated impacts and challenges.

To understand why nurses leave, many organizations administer employee exit surveys to departing nurses. The problem with these exit surveys is that they are generic in nature; the options for answering are quantitative and do not allow for explanation or description of the reason(s) for the nurse leaving; for example, the most common reason for leaving a position is "family/personal." Not having the specifics as to why a nurse leaves, in a qualitative, descriptive form, is not adequate for organizations to understand and actually make changes that could result in reducing turnover.

This research was focused on the largest cohort of nurses in the workforce: females. With research questions that solicited insights into the "family/personal" reasons nurses leave, the researcher used a qualitative study design utilizing one-on-one personal interviews with nurses, asking semistructured questions developed from the results of the previously conducted nurse-intention-to-leave study.

Study Purpose

The purpose of this study was to explore how pregnancy, childbirth, and the responsibilities of mothering young children impact the careers and lives of nurses who are working at the bedside. Understanding the experiences of nurses in this demographic will allow focused understanding of the reasons and rationales associated with their intention to leave or stay at the bedside. This information is important because 46% of the nation's nursing workforce is of childbearing (20 years-35 years) or childrearing age (21 years-55 years); in the state of Utah, 64% of nurses are in this age category (Utah Medical Education Council, 2016). Understanding the needs of mothers, bearing and rearing children may serve to inform healthcare organizations, which could support these nurses to continue working at the bedside.

Review of the Literature

Pregnancy, childbirth, and the responsibilities of mothering young children impact the lives of working nurses. Occupational work hazards, achieving work–life and family–life balance, and coping with the emotional and physical aspects of being a nurse at the bedside are some of the challenges faced by these nurses. Additionally, workload accommodations and protections for the pregnant nurse are seriously important. Provision of convenient lactation facilities for the purpose of supporting the nurse to breastfeed her baby for the recommended period of time for the health of her baby is of great concern for the well-being of the nurse and her family (Alex, 2011).

Occupational Hazards

Documented in the literature is evidence that registered nurses are exposed to occupational hazards that can harm an unborn baby. Teratogenic and fetotoxic exposures are in the patient care environment and can be difficult to avoid (Alex, 2011). Occupational exposure to infectious diseases and viruses is common in the patient care environment. Some of the common infectious diseases are cytomegalovirus, parvovirus B19, and influenza. To prevent infection, the use of universal precautions is required in addition to changing contaminated clothing before going home. In addition, the pregnant nurse should be up to date on all immunizations.

Pharmaceutical agents such as chemotherapy drugs are a serious hazard to a pregnant nurse and should be avoided for the prevention of fetotoxity. Aerosolized drugs such as pentamidine, used to treat pneumocystis, and ribavirin for the treatment of bronchiolitis pneumonia in children, may also be teratogenic risks. Waste anesthetic gases, including nitrous oxide and halothane, which are commonly used in the operating room, have been found to cause spontaneous abortion (Alex, 2011).

Organic solvents used to sterilize and clean include acetone, benzene, chloroform, ethanol, methanol, formaldehyde, gasoline, and industrial glues, and have been documented to be neurotoxic—especially in high doses. Pregnant women are advised to be cautious about any level of exposure to these solutions, as they are also evidenced to cause spontaneous abortion and preterm birth (Ahmed & Jaakkola, 2007; McDiarmid & Gehle, 2006; Till, Westall, Gideon, Nulman, & Rovet, 2005).

Ionizing radiation commonly used in imaging for diagnostic and therapeutic purposes is carcinogenic and fetotoxic. Depending on gestational age (especially during

the first weeks of gestation), exposure to ionizing radiation may cause miscarriage, stillbirth, or fetal abnormalities. A significant risk exists for pregnant nurses who work in nuclear medicine, and it may be prudent to exclude pregnant women or women who are planning to become pregnant from these work areas (Barber, Parkin, & Goldstone, 2003; Brent, 2009).

Shift Work

The literature is inconclusive regarding the effects of shift work on the nurse (Nurminen, 1998). There is documentation that working at night increases a woman's risk of preterm delivery. With regard to long work hr and physically demanding work, there are associations with preterm birth, the child being small for its gestational age, and preeclampsia (Barber et al., 2003; Lawson et al., 2009; Pompeii, Savitz, Evenson, Rogers, & McMahon, 2005; Whelan et al., 2007).

Ergonomic Considerations

Performing work such as lifting, pulling, and pushing may cause the pregnant nurse to be at risk for musculoskeletal injury. Because of the change in the nurse's center of gravity and because of progesterone levels, which loosen and relax muscles in preparation for birth (Alex, 2011; Waters, Collins, Gainsky, & Caruso, 2006), special consideration must be taken to protect the pregnant nurse. The use of patient lift equipment and staff assistance should be employed, especially in the last weeks of pregnancy (MacDonald, et al. 2013; Waters, Collins, Gainsky, & Caruso, 2006; Walters, MacDonald, Hudock, & Goddard, 2014).

Pregnancy Complications

The complications or problems that can occur during pregnancy can be related to either the mother or the baby. These can be related to health problems of the mother prior to becoming pregnant and/or related to the socioeconomic status of the woman (Ma, Chan, Tam, Hanson, & Gluckman, 2013). Of concern is the rise in obesity and gestational diabetes in pregnant women. The Office of Women's Health of the U.S. Department of Health (2017) published an online list of health problems that can occur during pregnancy:

- Anemia
- Depression
- Ectopic pregnancy
- Gestational diabetes
- High blood pressure (pregnancy-related)
- Hyperemesis gravidarum
- Miscarriage
- Placenta previa
- Placental abruption
- Preeclampsia
- Preterm labor

These problems can occur in a healthy woman and are assessed for by the woman's provider at regular pregnancy check-ups. The Centers for Disease Control and Prevention (CDC, 2017) collects data and conducts monitoring and surveillance of pregnancy complication rates in the United States. According to the CDC (2017), approximately 30% of women will experience a pregnancy complication. Of serious concern is the rise in maternal obesity, which can increase the risk of spontaneous abortion or congenital abnormalities (Catalano, 2007). Appropriate and safe weight gain in pregnancy is determined by the woman's body mass index (BMI). On average, the

recommended weight gain for women is 25 to 35 pounds for a normal-weight BMI (CDC, 2017).

If not controlled, diabetes during pregnancy can increase the rate of birth defects or other problems. Gestational diabetes may occur in women who have not previously had type 1 or type 2 diabetes. Generally, gestational diabetes can be controlled with diet, exercise, and in some cases, insulin. Gestational diabetes commonly goes away on delivery; unfortunately, according to the CDC (2017), 50% of women who have gestational diabetes develop type 2 diabetes at some time in their life.

Lactation Support for Nurses

Federal and state laws require employers to provide break time and a location that is not a bathroom for breastfeeding women to express their milk. Accommodation for this break time is to be for 1 year after the child's birth (U.S. Department of Labor, 2017). Break times are not required to be paid time, but are applicable to nonexempt employees covered by the Fair Labor Standards Act (United States Breastfeeding Committee, 2017).

In summary understanding the experiences of nurses working at the bedside in their childbearing and childrearing phases of life led to the following research questions:

1. How do pregnancy, childbirth, and the responsibilities of mothering children impact the careers and lives of nurses who are working at the bedside?
2. What are the reasons and rationales associated with nurse intention to leave or stay at the bedside, among nurses with young children?
3. What are the experiences of nurses working at the bedside when pregnant?
4. What are the experiences of nurses working at the bedside with young children at home?

Methods

This was a qualitative, exploratory study using semistructured interviews to engage experienced nurses who had been pregnant while working at the bedside and/or who had young children. The Utah RN licensee list was utilized to recruit nurses who had been licensed for 3 to 12 years. Participant inclusion criteria required the nurse to have been educated in the United States, to be female, to have practiced for a minimum of 3 years in direct patient care, and to have been pregnant while working at the bedside and/or have young children, defined as being under 13 years-of-age. The number of nurses who volunteered for potential study selection and participation was 248 respondents.

Forty-five nurses who met inclusion criteria were selected to participate. Of those who participated, the mean age was 35 years, with the following marital status: married, 94% (n = 42); divorced, 4% (n = 2); cohabiting, 2% (n = 1). Sixty-eight percent of the participants had been pregnant while working at the bedside and had young children at home. Thirty-two percent had young children, but had not been pregnant while working as a bedside nurse. The average age of the children for both groups was 7 years (see Tables 5.1 and 5.2).

Semistructured Questionnaire

The interview process utilized a semistructured questionnaire developed from a prior study, to elicit detailed information from childbearing and childrearing nurses working in direct patient care. Two forms were developed for use by the interviewer: one for nurses who had worked in direct care while pregnant and with young children at

Table 5.1

Demographic Information

Demographics	Pregnant at the Bedside & Young Children (FT) *n* = 15	Pregnant at the Bedside & Young Children (PT) *n* = 15	Young Children (FT & PT) *n* = 15	All Groups *N* = 45
Average Age	35	35	36	35
Average Years at Bedside	7	8	6	7
Average Years Licensed	10	10	8	10
Religious Preference, *n* (%)				
Christian	11 (73%)	12 (80%)	11 (73%)	34 (76%)
None	3 (20%)	3 (20%)	4 (27%)	10 (22%)
Islamic	1 (7%)	0 (0%)	0 (0%)	1 (2%)
Marital Status, *n* (%)				
Married	15 (100%)	15 (100%)	13 (87%)	43 (95%)
Divorced	0 (0%)	0 (0%)	2 (13%)	2 (5%)
Ethnicity, *n* (%)				
White	13 (87%)	12 (80%)	14 (93%)	39 (87%)
Hispanic	1 (7%)	3 (20%)	1 (7%)	5 (11%)
African American	1 (7%)	0 (0%)	0 (0%)	1 (2%)
Education Level, *n* (%)				
Associate Degree	2 (13%)	1 (7%)	7 (47%)	10 (22%)
Bachelor of Science, Nursing	8 (53%)	12 (80%)	3 (20%)	23 (51%)
Master's Degree	5 (33%)	1 (7%)	3 (20%)	9 (20%)
Other Degree	0 (0%)	1 (7%)	2 (13%)	3 (7%)

Note. FT = full time; PT = part time; Christian = Catholic, Protestant, and Latter-day Saint (Mormon)

Table 5.2

Working Variables

Demographics	Pregnant at the Bedside & Young Children (FT) *n* = 15	Pregnant at the Bedside & Young Children (PT) *n* = 15	Young Children (FT & PT) *n* = 15	All Groups *N* = 45
Average Number of Children (Range)	3 (1–5)	3 (1–8)	3 (1–8)	3 (1–8)
Average Age of Children	8 years	7 years	10 years	8 years
Average Number of Pregnancies (Range)	3 (2–6)	3 (1–5)	N/A (N/A)	3 (1–6)
Average Pregnancies at Bedside (Range)	2 (1–5)	2 (1–4)	N/A (N/A)	2 (1–5)
Average Years on Unit Before Pregnancy (Range)	2 (0–5)	2 (.5–8)	N/A (N/A)	2 (0–8)
Average Number Who Took Time Off Before Maternity Leave, *n* (%)	5 (30%)	5 (30%)	N/A	10 (33%) 10 (33%)
Average Number Who Had Early Pregnancy Workload Changes, *n* (%)	4 (27%)	4 (27%)	N/A	8 (27%)
Average Number Who Had Pregnancy Comps, *n* (%)	5 (30%)	7 (47%)	N/A	12 (40%)
Average Number Who had Late-Pregnancy Workload Changes, *n* (%)	6 (40%)	2 (13%)	N/A	8 (27%)
Average Number Who Were Lifting Patients in Late Pregnancy, *n* (%)	6 (40%)	7 (47%)	N/A	13 (43%)
Average Time on Maternity Leave (Range)	9 weeks (2–12)	15 weeks (4–28)	N/A (N/A)	12 weeks (2–28)
Feeding Method, *n* (%)				
Breastfeeding	12 (80%)	15 (100%)	N/A	27 (90%)
Bottle Feeding	3 (20%)	0 (0%)	N/A	3 (10%)
Average Time Breastfeeding (6wks-20wks)	15 weeks	20 weeks	N/A	18 weeks
Average Number Who Had Help at Home	14 (94%)	13 (87%)	N/A	27 (90%)

Note. FT = full time; PT = part time

home and another for nurses working in direct patient care who had not been pregnant at the bedside but did have young children at home. The questions were pretested with 4 nurses not associated with the selected study participants (see Appendix C). The questions were logically organized into the following topical domains: (a) demographic questions, (b) nurse working while pregnant and pregnancy data, (c) nurse on maternity leave postnatally, (d) postnatal working, (e) nurse working at the bedside with young children at home, (f) quality of childcare from husband or other caregivers, and (g) support recommendations. Nurses who had been pregnant while working at the bedside and who had young children at home were asked all questions (Form #1, see Appendix D). Nurses who had not been pregnant while working at the bedside but had young children at home were not asked the questions regarding pregnancy, postnatal working, or maternity leave (Form #2 See Appendix D). Each question was asked of each participant in the same order, with allowance for the participant to respond and speak freely. As appropriate, the researcher redirected questions and added focused questioning and probing to understand the participant's answers more fully.

Data Analysis

Each interview was audio recorded and transcribed verbatim. Data organization began with the researcher reviewing the transcript documents and interview notes to ensure data accuracy. Audio recordings were listened to and utilized for correction and verification of the transcribed text. Transcriptions were uploaded, text was highlighted and coded, and then organized into categories using QDA Miner® with WordStat®, qualitative data analysis software. Data was securely stored and participant anonymity was maintained with the use of participant codes.

Responses were analyzed according to the three samples: Nurses in Group 1 had been pregnant at the bedside, had young children, and were working full time (n = 15). Those in Group 2 had been pregnant at the bedside, had young children, and were on part-time work status (n = 15). Nurses in Group 3 had not been pregnant at the bedside, had young children, and were on part-time or full-time work status (n = 15).

Each participant response was reviewed and content analyzed. Participant responses were reviewed line by line to recheck codes for accuracy, after which the codes were compiled into categories. Then data from the other two groups were coded and categorized. Categories were entered into an Excel® spreadsheet and then uploaded to the content analysis software QDA Miner® with WordStat®. This allowed for item-by-item analysis, analysis of categories, and group-to-group comparison.

The comparison of codes and categories from each group revealed response similarities and differences between the groups. While the three groups were fairly similar in their responses and experiences, the primary differences were demographic: Group 3 was older by an average of 1 year, and Group 3's children were older by an average of 2 to 3 years. Interestingly, although Group 3 participants were not asked the pregnancy and postnatal working questions, however some participants did report postnatal information in their interviews as they related their working experiences with young children at home.

Results

Results in this section are presented according to the organization of the interview questionnaires utilized with the participants. Content analysis data and verbatim quotes from participants are included.

The Experience of Working at the Bedside While Pregnant

Early Pregnancy and Work

Of the nurses in Groups 1 and 2 (n = 30), all 30 disclosed their pregnancy to their manager and coworkers early in the first trimester. Prior to becoming pregnant, these nurses had been working in their bedside position for an average of 2 years. A few nurses (n = 3) who were newly hired to the unit and learned they were pregnant soon after being hired expressed feeling afraid to tell their manager for fear they would be perceived as having failed to disclose their pregnancy and planning an extended leave within less than a year of being hired. Most managers and coworkers expressed excitement on hearing of the nurse's pregnancy, although some managers were perceived by the nurses as uncaring. One nurse reported, "He wasn't really happy for me; just sort of indifferent. I think he was more concerned about having to cover my maternity leave."

Sixty percent (n = 18) of the nurses described having nausea and morning sickness in the first trimester of their pregnancy. One nurse stated, "It worked out fine. I worked labor and delivery and so the patients were really understanding." Some (n = 2) nurses described being embarrassed working on a medical–surgical unit and having to run out of the patient's room to vomit. One indicated problems with hyperemesis and needing to have IVs: "I remember feeling nauseous all the way up till I delivered him, then it went away."

The occupational hazards of bedside nursing to the pregnant nurse include infectious diseases, pharmaceutical agents, ionizing radiation, shift work, and a heavy workload (Alex, 2011; CDC, 2017). Nurses who were working at the bedside when pregnant (n = 8, 30%) indicated that there were changes in their workload and their

patient assignments. These changes were specifically related to radiation exposure, administration of chemotherapeutic drugs, and infectious diseases such as cytomegalovirus.

Twenty-two of the 30 nurses (73%) indicated that there were either no policies or they were unaware of any policies related to occupational hazards for pregnant nurses. One nurse stated, “The charge nurse just gave me a little lighter load, but I don’t know about any policies.” Another nurse stated, “Nothing on my workload changed. If I got an infectious patient I would just ask another nurse to trade assignments with me.” One participant indicated that she was exposed to cytomegalovirus in her third trimester, when working in the emergency department. She told the following story:

> The doctor was like, immediately, ‘Hey! This patient has CMV. You don’t want to be in here!’ So I went ahead and got tested, and while I didn’t have any symptoms, I was positive. And I did see a perinatologist and everything was taken care of. There was nothing wrong.

Pregnancy and Complications

Problems in pregnancy can be common or severe, and in some cases can result in maternal mortality. The CDC (2016) indicates that approximately 30% of pregnant women in the United States suffer a pregnancy complication. This study was consistent with national data in that 29% (n = 17) of the 30 nurses interviewed who had been pregnant while working at the bedside in direct patient care reported complications with their pregnancy. Complications for this sample population included preeclampsia, swelling, low amniotic fluid, acetabular impingement, gestational diabetes, chorionic hemorrhage, and premature contractions. Detailed data analysis of participant-reported pregnancy complications indicated that nurses in Group 1 had 26 pregnancies, 10 of

which had complication (38%); Group 2 had 33 pregnancies, 7 of which had complications (21%). Table 5.3 provides detailed information for each participant, each pregnancy, and each occurrence of a complication.

Of the nurses interviewed, 20 (67%) indicated that they worked up to their due date; 10 (33%) reported taking an early maternity leave, ranging from 1 to 12 weeks prior to the birth of their baby. Twenty-two nurses (73%) reported no change in their workload late in pregnancy; 8 nurses (27%) indicated they were still lifting patients late in their pregnancy and up to delivery.

The Americans with Disabilities Act provides protection for pregnant workers in that an employer may have to provide reasonable accommodations such as leave time or job modifications for pregnancy-related impairments (U.S. Equal Employment Opportunity Commission, 2017).

The Nurse Postnatally and on Maternity Leave

Twenty-eight (93%) of the nurses interviewed reported that they and their baby were well postnatally. Four nurses reported that their baby was required to stay in the newborn intensive care unit for times ranging from 2 days to 2 weeks. Twenty-seven (90%) of the new mothers indicated they had help at home after having their baby. This help was provided primarily by their husband but in some cases additional help was provided by their mother, mother-in-law, a sister, or a friend. Assistance included tending the baby so the mother could sleep; help with meal preparation and/or laundry; and caring for older children. None of the interviewed nurses returned to work early to attend staff meetings, conferences, or work shifts. On average their maternity leaves were 6 weeks in length.

Table 5.3

Pregnancy Complications in Groups 1 and 2

Participant #	Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4
Group 1: Pregnant at the bedside, young children at home, full-time status				
1	Preeclampsia	Miscarriage	Preeclampsia	—
2	None	—	—	—
3	None	None	Preterm labor	—
4	None	None	—	—
5	None	None	—	—
6	None	None	None	None
7	None	None	None	—
8	None	None	—	—
9	Miscarriage	Preterm Labor	Preterm Labor	—
10	None	None	None	—
11	None	None	—	—
12	Preterm Labor	None	—	—
13	None	None	None	None
14	None	None	None	None
15	None	GDM	—	—
Total # of Pregnancy Complications	3	3	4	0
Group 1 Total Complications = 10 out of 26 pregnancies (38%)				
Group 2: Pregnant at the bedside , young children at home, part-time status				
1	Emergency CS Decelerations	—	—	—
2	None	None	—	—
3	37wk	37wk	None	—
4	None	None	Precontractions	—

Table 5.3 (Continued)

Participant #	Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4
5	None	None	None	—
6	GDM	GDM	GDM	—
7	Miscarriage	Sciatica	GDM	—
8	None	None	None	—
9	None	None	—	—
10	None	None	None	—
11	None	None	None	None
12	None	None	None	—
13	None	None	None	—
14	None	None	None	Precontractions
15	None	None	None	—
Total # of Pregnancy Complications	3	2	2	1
Group 2 Total Complications = 8 out of 33 pregnancies (24%)				

Note. GDM = Gestational Diabetes Mellitus; Emergency CS Decel = Emergency C-Section with Decelerations.

The Experience of the Nurse Working Postnatally

Breastfeeding

Twenty-seven (90%) of the nurses interviewed indicated that they breastfed their baby from birth to at least 3 months of age (Table 5.1). Of interest were the stories these nurses related regarding returning to work and the challenge of expressing (pumping) their breast milk to be able to continue breastfeeding. More than 50% of the nurses related that working long shifts and trying to get a break to express milk was difficult. One nurse related, “It was not that easy because I got such limited breaks, and I had to eat and pump and chart at the same time.” Some stories were common to many nurses, which provided insight into their struggle with expressing breast milk at work:

> Pumping has been an ongoing issue because you are supposed to get a 30-min lunch break and then two 15-min breaks. And they tried to help me as much as they could, but then it does get so busy that sometimes those breaks were missed. The other thing too, that was my hardest part of going back to work, was there was not an adequate space to pump. There is a lactation room on the second floor, but by the time you get up there and get set up, your whole break is gone. So usually we are just using an empty room or sometimes even the bathroom. So that is not ideal.

> Well, I felt like when I did take the time to go pump it was a big process, and I couldn’t get it done in 30 min or less. If I was in a patient room, I would need another nurse to come in and take my spot and sedate or monitor the patient or whatever, and I would be gone for like forty-five min. I remember them asking all of the time, “Well, how long are you going to be?” That kind of thing. And I was like, “I don't know. Until I get enough milk.” So I felt like I had to be rushed to pump. I couldn't take a good break to pump. In the hospital, they have a lactation room but it is on a completely different floor, which would have just meant more time that I had to be away, and so I ended up just doing it in the nasty bathroom, a community bathroom that just everybody could use. I would sit in there. I would take a chair and I would pump in the bathroom.

> That was a challenge, especially because the hospital environment tends to be you get there and you are go, go, go your whole shift. It took a lot of planning. Of course you had to bring all of your supplies with you, but it took some planning, and then I just had to be really dedicated to taking those breaks. There were other times that I just waited until rounding was complete and I was engorged and

> uncomfortable and needed to go pump. So it was just a matter of taking care of myself and giving myself permission to do that. Nobody watches out for you, and nobody asks you if you need time; you just have to make it happen. There were times at work where, depending on the situation where I had a patient with a highly infectious disease or C-diff [clostridium difficile] or MRSA [methicillin-resistant Staphylococcus aureus], where I felt a little contaminated, and so I would dump that milk; I wouldn't take it home to the baby, even though I practice good hygiene. I think it was just something in my brain saying that milk is dirty. Don't use this. There were times where, because of possible disease risk, I chose not to take that milk home.

While the intention of these nurses was to breastfeed. Unfortunately, many of them indicated that they were only able to breastfeed until the end of their maternity leave. On average, they breastfed their babies for 18 weeks, indicating that on returning to work it was a hardship to get a break to express breast milk, so they lost their milk or switched to bottle feeding because breastfeeding was just "too hard." Two nurses reported getting mastitis after going back to work, repeatedly becoming engorged and not getting time to express breastmilk. Nurse who did express breast milk at work stored the expressed milk on ice in a cooling/refrigerator bag they brought from home.

The Nurse Working With Young Children at Home

The Emotional and Physical Experience of Returning to Work

Returning to work was articulated by the nurses as a "challenge" and "hard" after having a baby. As stated previously, the majority of nurses returned to work after approximately 12 weeks of maternity leave. The categories that emerged regarding emotions felt on returning to work were (a) worry and anxiety about leaving their young baby, (b) stress about the work schedule, (c) not getting enough sleep, and (d) sadness about leaving the baby to go to work. When asked how they felt physically, the nurses reported that they felt good and "bounced back." The concerns indicated by the nurses

centered on the mental and emotional aspects of returning to work.

Worry and Anxiety About Leaving the Baby

Nurses reported feeling anxious, worrying about the baby when they were at work and worrying about work when they were at home. One nurse stated, “You kind of have this feeling of abandonment, that you are leaving this poor, helpless little thing, and nobody can take care of baby as good as Mom can.” All of the nurses indicated they were able to call the caregiver when they were at work to check on their baby. Three nurses reported having postpartum depression and seeking antidepressant medications from their medical provider. The majority of childcare was provided by their husband. Some mothers worked night shifts or weekends so they could “juggle” childcare with their husband or a family member.

Stress About the Work Schedule

Nurses indicated that they were stressed about the work schedule, specifically the long shifts away from their baby and not being able to get the shift schedule they preferred. One nurse told this story:

> I was under so much stress because I wasn't able to get that schedule, like I said, and going back at six weeks with no help. And I wasn't anticipating it to be that hard because I struggled with the breastfeeding, I struggled with sleep.

Fatigue: Not Getting Enough Sleep

All of the nurses (n = 30) indicated they felt tired or exhausted, and that they did not get enough sleep. They attributed their lack of sleep to the long shift hr at work combined with caring for their young children, preparing meals, assisting with the children’s schoolwork, and being awakened in the night to attend to their children’s

needs. The nurses described being “exhausted” as having to go from work at work to work at home, and as a constant of being so tired that they could not “get it all done.” Several of the nurses were not only working but were also in school, which contributed to their fatigue. One nurse said,

> I remember what I would do if I knew I was going to go in that night. I would actually lay down on the living room floor with my daughter and I would just let her fall asleep nursing, and we would lay there on a sleeping bag on the floor together so that I could rest.

Another nurse stated, “I think it was mostly a concern about getting enough rest and getting enough hr on the schedule, since my husband wasn’t working.”

Sadness About Leaving the Baby to Go to Work

As the nurses talked about going back to work, they reported sadness at having to leave their baby, and that it was “hard” to leave the baby. Many of the nurses related a story of their first shift back at work, saying that they missed their baby, were “teary,” and that they cried as they walked out the door and drove to work. Some of the nurses talked about “baby blues” and postpartum depression, and that they were also stressed by “having to balance it all.” Some of the nurses felt like they needed more time on leave, but they were glad that their husbands “picked up the slack” and were there to care for their baby. While the nurses expressed sadness at having to leave their baby, they also talked about how good it was mentally to get back to work and be with adults; it was a break from “feeding and holding and changing diapers all day.”

Childcare

Childcare was primarily provided by the husband (n = 27, 90%), followed by a grandparent or a friend (10%). All of the nurses indicated that they could call the

caregiver during their shift and that the baby did well with the caregiver. They reported that if the baby was sick when they had to work, they would call in absent for their shift or their husband would stay with the baby if they could not get the shift off; sick care was provided exclusively by the nurse or her husband. Twenty-five (83%) of the nurses reported having called in absent because their child was ill or otherwise needed them.

Struggles and Challenges of Being a Working Nurse and Mother of Young Children

When participants were asked what the struggles and challenges were, several repeated categories emerged: accessing childcare, long shifts away from their children, and guilt related to being away from their young children and leaving their children with a caregiver.

Accessing Childcare

Mothers indicated that it was difficult to find childcare options that matched the shiftwork hr of being a nurse. Three of the 45 nurses interviewed did utilize hospital onsite daycare centers or other daycare options, adapting to the childcare hr available by having their husband take in or pick up their child at daycare; hr were usually 6:00 a.m. to 8:00 p.m. While a few of the nurses used daycare options, most arranged alternating shifts or days of the week with their husbands. The nurses indicated they did this for their young baby because they did not want to utilize a daycare option, citing reasons such as the expense and not wanting to leave their child with a caregiver other than a parent. The nurses accommodated the alternating schedule by working nights or weekends. They expressed that working these undesirable shifts was a hardship, but it was the only option they perceived as feasible. Mothers with other children utilized the daycare option and

after-school programs for their young children.

Long Shifts Away From Children

The nurses lamented the fact that they had to work 12-hr shifts. They indicated that the 12 hr often turned into 13 or 14 because they needed to finish charting or to complete other patient-care work before leaving. One nurse said, “On the days I worked, I never got to see my kids. I left when it was dark and they were in bed, and then came home when they were in bed.” The long shifts were often the reason for a nurse moving from a hospital setting to a clinic or homecare employment setting; while they preferred the acuity of the hospital, the hr were too hard on family life. Although the nurses indicated that the 12-hr shifts were a hardship, they did like having 4 days off; it took a day or so to recover from working each long shift.

Guilt Related to Being Away From Their Young Children and Leaving Their Children With a Caregiver

The nurses felt guilty about leaving their children and going to work. An example of one mother’s guilt was her story of leaving her son at the daycare center. Her son was “screaming as the daycare lady tore him away so I could leave to my shift.” The mother’s feelings of guilt were also associated with resentment: “I didn’t have a choice. I had to work—I was the breadwinner for my family.” Another mother indicated that she felt like a failure at being a good mother because she was not there for her children.

The Benefits of Being a Working Nurse and Mother of Young Children

For these mothers, the positive aspects of working were being a role model for their children, getting a mental and emotional break from children, the income, and the

satisfaction gleaned from being a nurse and caring for others.

Being a Role Model for Their Children

Over and over again, nurses indicated that the primary positive aspect of working was being a role model to their children—teaching their children the value of work and a good work ethic. One nurse said, “I want my daughter to be a strong woman, and she can see that I work hard as a nurse.” Another nurse related that her working had helped teach her children the value of work:

> When my little girl says, “Mom, why do you go to work?” I say, “Oh, so I can buy you things and we can have these extra things that you like.” . . . I think it helps them see [that] when you work hard for things, you can have fun things.

Nurses in this study indicated that having their children see them go to work and telling their children what they did as a nurse, “helping other little children who are sick,” was a great positive; it helped their children to be more competent and independent because they (the mothers) were not there all the time.

Getting a Mental and Emotional Break From Children

One nurse said,

> It gives me a break from being at home—you know what I mean. I work three days and my husband works four days, and all you do is baby, kids, kids, kids, kids. It kind of gives me a break to use my skills and feel like I am a productive citizen. It’s also a morale booster, going to work and earning a living for myself and my kids.

Another nurse said, “It’s very nice to be able to get out and talk to adults . . . and to be out and about and have something to do on my own, and be able to help with the finances of the home.” Another nurse stated,

> It is nice for me. I’m not meant to be a stay-at-home mom. I think if I was home nonstop all of the time, I would get kind of resentful and crabby. I don't think I

> would be as good of a mom. When I go to work, I feel like it is a little bit of a social outlet, and I get to do something just besides being a mom, which is really nice. I feel like I make a little bit of a difference, which is good. Getting out of the house is huge for me.

The nurses felt that although working and being away from their children was difficult emotionally, working was nevertheless a benefit.

The Income

Although pay was not a top motivator for these nurses to work, the income and financial benefit were perceived as positive aspects. One nurse stated, "Well, number one is, we rely on my healthcare insurance benefits, so that is definitely a positive having that." Another nurse explained that she had been divorced and had gone back to school to become a nurse. While she was currently married, having her education and the ability to "make a great income" was positive and made her feel she could be independent and not worry.

The Satisfaction Gleaned From Being a Nurse and Caring for Others

Many nurses described loving being a nurse and having medical and nursing knowledge. They expressed pride in having gone to school and being in a profession that gave them so much satisfaction. One nurse stated, "I love what I do!" Another nurse indicated that while she found satisfaction and joy in her job as a nurse, her nursing skills also helped her to be a "better mother and care for my own kids."

Advice From Nurses to Nurses

As part of the interview process, participants were asked to give advice to other nurses who were working at the bedside while pregnant, and to working nurses who had

young children at home. Their responses were sorted into seven categories: (a) self-care; (b) physical care; (c) knowing leave policies; (d) talking and communicating with managers and coworkers; (e) protecting oneself, one's baby, and one's family; (f) planning and organizing; and (g) emotional/mental self-care.

Self-Care

Participants encouraged other nurses to take time for self-care. Advice included taking care of their own needs first, so they would have the wherewithal to care for their family; remembering that the hospital would still be there when they were ready to go back, and not to rush; leaving work at work, and not stressing; making a true friend that could be counted on at work; making sleep a priority, especially if working nights; and not being afraid to ask for help when needed.

Physical Care

The second category that emerged was physical care. Nurses advised drinking enough water; taking time to go to the bathroom; having snacks available when needed; being sure to sit down and rest when they needed to; taking as much time off as they could afford; if pregnant, not lifting or pushing heavy patients; being sure not to overdo it; getting (and wearing) good shoes and compression socks; spacing out shifts so there would be adequate time to recuperate between them; and listening to their own body.

Knowing Leave Policies

Nurses were advised to be sure to understand work and leave policies that pertain to pregnant and working mothers, and to learn about policies in place to protect pregnant nurses from work hazards. Participants recommended researching leave policies,

including paid time off, the Family Medical Leave Act, and the Short-Term Sick Leave Act. They advised finding out how the employer arranges meal breaks, regular breaks, and pumping breaks, and being sure to take them.

Talking and Communicating With Managers and Coworkers

Participant nurses encouraged other nurses to ask for help when they need it, and not to be afraid to speak up if they need something. They were advised to cut back hr if they are feeling overwhelmed. Participants pointed out that nurses cutting back or taking a leave could come back pro re nata (PRN) and then work up to part time or full time, and that they should tell everyone they are pregnant so others can watch out for them.

Protecting Oneself, One's Baby, and One's Family

The nurses interviewed recognized many potential hazards that exist for working and pregnant mothers. They encouraged nurses to beware of infectious patients, to take precautions around radiation and viruses, and to advocate for and stand up for themselves, especially if pregnant or nursing. They advised asking for help to keep themselves safe, and to be around people who would help and support them. In addition, it was recommended that they look out for their family, and research what resources are available and take advantage of them.

Planning and Organizing

Finally, nurses shared that planning and organization improved their well-being and helped them manage working while being pregnant and raising children. They recommended setting up things for the baby as early as possible, arranging for childcare and having a back-up plan, and finding help with household chores. The participants

noted the importance of coordinating things—the more organized, the better—and of trying many things to discover what works best. They also recommended trying to organize work schedules with their spouse, so they can be available for support and advocacy.

Emotional/Mental Self-Care

Participants recommended that other nurses be aware of their emotional and mental well-being. They counseled that if others were judgmental, to just forget them; to remember that they could succeed, but also to recognize that it would be a sacrifice. They advised taking time off when feeling overwhelmed, being happy at what they are doing, taking it a day at a time, and confiding in people who would support them. They were encouraged to remember that it can be difficult to be a working mother, but that doing so can be the best of both worlds: “Figure out your balance, and it will be great.”

Recommendations to Employers From Nurses Who Had Been Pregnant at the Bedside and/or Who Had Young Children at Home

As part of the interview process, nurses were asked to give advice to employers and managers who may have nurses working at the bedside while pregnant and/or nurses who have young children at home. Their responses fell into seven categories: (a) policies,(b) emotional sensitivity, (c) caring, (d) support for breastfeeding/pumping, (e) schedules and breaks, (f) pay and benefits, and (g) a family-friendly workplace.

Policies

Participants suggested that employers inform their pregnant and working mothers about maternity leave policies and benefits. They stated that pregnant mothers should

have lighter workloads, especially in the last months of pregnancy. They shared that it would be nice to have policies that were fair and supportive, yet lenient enough that these mothers could take care of the legitimate needs of themselves and their families.

Emotional Sensitivity

The nurses indicated that employers need to be cognizant of family situations and the struggles that exist for their nursing staff. Employers should recognize that being pregnant and working as a nurse is hard on the body, and that it is challenging to experience and adapt to all of the changing hormones of pregnancy. Participants wanted employers to make things easier for nurse mothers; many nurses are afraid they will lose their job if they ask for exceptions, especially if they have no control over issues related to their children. Finally, employers should be understanding of the challenge it is to find balance while being a working mother.

Caring

Participants had several suggestions for employers to help pregnant and working mothers. They shared that knowing that an employer cared about them and their situation was of primary importance. They asked employers to remember that many of them had been in similar circumstances once, and to be understanding; to recognize that pregnant and working mothers are juggling work and children, and that the last months of pregnancy are physically and emotionally uncomfortable. Employers were encouraged to listen to their employees, and be accountable to keep them healthy and balanced; to spend time on the floor and know what is actually happening on the unit; and to get to know and develop relationships with the pregnant and working mothers.

Support for Breastfeeding/Expressing Breast Milk

Participants reported a concerning lack of support for working, breastfeeding mothers to express breast milk for their babies. They recommended that there be easier access and closer proximity of the lactation rooms to the nursing work units. This support could be a positive for employers who wanted to hire and retain nurses of childbearing age. They also indicated that there should be a lactation policy for nurses that is well-communicated so that managers and other staff understand time demands and constraints for pumping mothers. The environment and culture should be positive, and should encourage mothers to continue breastfeeding rather than making them feel that it is a burden, causing them to discontinue the practice.

Schedule and Breaks

The nurses interviewed wanted employers to work on scheduling and related policies for pregnant nurses and/or nurses with young children at home. They shared that some nurses did not return to work after giving birth because the work schedule was too regimented and inflexible, and felt it would be reasonable for employers to be understanding when nurses who are pregnant or mothering need help, when they need to be excused from a shift, or when they request a schedule change due to family demands and needs. They thought employers could be more flexible in rearranging shifts and having more flexible hr for mothers, stating that mothers need to have more days off to be with their children and take care of unexpected needs. Participants stated that they needed their meal breaks and other breaks to be able to make it through long shifts. They wished that employers would allow additional break time for pumping so they could continue to breastfeed while working full- or part time.

Pay and Benefits

Participant nurses shared that pay and benefits are important, pointing out that many nurses are the soul breadwinner for their family, and that these mothers do not have the option to remain at home even though they may have a tiny baby. They stated that it is demotivating when incentive pay is decreased, and they indicated that while pay is not the primary reason for staying on a unit, if given the opportunity to earn more, they would consider leaving. They expressed that employers should be supportive of employees, and should foster better pay policies, specifically call-back, incentive, differential, and base pay. They also advocated for better benefits for part-time staff, and expressed that they viewed the difference in benefits between full-time and part-time nurses as inequitable.

Family-Friendly Environment

The last category of advice for employers was creating a family-friendly environment for pregnant and working mothers of young children. The nurses stated that employers must recognize that family comes first and work is second. They noted that situations and emergencies may arise when it is necessary to call in absent for an ill child or leave early if their family needs them. The participants encouraged employers to remember that they (the employers) once had small children, and to remember the needs that come along with parenting.

How to Improve the Workplace for Pregnant Nurses and Nurses With Young Children at Home

As part of the interview process, nurses were asked what would make working while a mother with young children at home better. The categories that emerged from

their suggestions were shifts and scheduling, the manager and team, and the workplace.

Shifts and Scheduling

The majority of nurses interviewed reported that they were working 12-hr shifts. When asked what would make shift work better, most said that the 12-hr shifts were too long and were a hardship to their physical health, emotional health, and their family; however, the majority indicated that they preferred the 12-hr shifts because of the time off. A few of the participants indicated that split shifts and shorter shifts would be beneficial, but they did not see this as a viable option if they remained in a hospital setting. Another suggestion was for holiday work hr to be held at a minimum, so they could have more time with their children.

All of the participants recommended flexibility in scheduling, specifically as related to mothers being able to have time off for their children's/family's needs and events. They also suggested having a "set" schedule so they could plan, although they also indicated that even the set schedule would need to be flexible, as they could not always plan as far in advance as the schedules were published (for example, 4 to 12 weeks ahead, depending on the institution). Another suggestion was to offer a variety of shifts and shift start and end times so they could match their schedule with their children's school schedules.

The Manager and Team

Many of the interviewed nurses indicated that their manager, the team, and the other nurses they worked with were "great." When asked what made managers great, they indicated that the manager should be understanding, supportive, and should work

with her or his nurses, understanding that mothers have priorities and responsibilities to their children and family, which come first. The nurses wanted a manger who was compassionate, who remembered what it was like to have little children and the challenges that accompanied that phase of life. They wished the manager would take into consideration the unique situation of the nurse when she was asking for a change or time off a shift; these comments and suggestions were primarily related to scheduling flexibility and changes to the nurse's schedule.

When it came to the team and specifically their colleagues, nurses hoped that these nurse peers would "cover" for them and trade shifts with them when they needed a schedule change. They also indicated a need for understanding and good communication between team members. The nurses wanted to feel safe asking their peers questions, and they wanted the unit to be inclusive, kind, and have a spirit of commitment to each other.

The Workplace

The suggestions from nurses regarding the workplace included providing explanations of the policies related to leaves, time off, and breaks for pumping. In addition, the nurses desired to have longer maternity leaves that would be paid, regardless of time with the company. Another strong category was the desire for the workplace to support them in taking their full lunch time and break time; they suggested that perhaps a lunch relief nurse would be beneficial, so that when they took their break they could take it without the fear of work "piling" up in their absence, or of having another nurse "watch" their patients but not productively engage in patient care while they were away.

Discussion

The major findings of this study were fascinating in that the qualitative design and the technique of using semistructured interviews resulted in the nurses relating detailed stories and descriptive accounts of what they experienced working at the bedside when pregnant and as mothers of young children. The results of this study were thick and rich, and the interviews provided the narratives of experienced nurses with unique personal health needs when working in direct patient care while pregnant, and depicting the challenges and stressors of working and having young children at home. The following are important findings for nurses and for healthcare organizations that hire female nurses in the childrearing and childbearing phases of their lives.

Minimal to No Changes in the Routine of the Pregnant Nurse

While nurses in this study disclosed their pregnancies in the first trimester, few changes in workload occurred. Those that did occur were specifically related to occupational hazards, such as not allowing the nurse to provide care in areas with ionizing radiation therapy and not allowing the nurse to administer chemotherapy drugs; this was done to keep the pregnant nurse safe. Of concern was that most nurses indicated they were not aware of policies for pregnant nurses—regarding either workload or other protections. If the charge nurse was not aware of policies and the nurse did not speak up for herself, and/or if other colleague nurses did not intervene to help support the pregnant nurse, no changes or protections were instituted. The nurses indicated that late into their pregnancies there were no changes in their workload in direct patient care; the nurses continued to push beds and wheelchairs and lift patients until the day they delivered their baby. There are multiple large cohort studies in the literature which recommend

accommodation for the pregnant working nurse specifically related to lifting (MacDonald, et al, 2013; Pompeii, Evenson, & Delclos, 2011; Juhl, Larsen, Andersen, Svendsen, Bonde, Anderson, & Stranberg-Larsen 2014).

National Recommendation for Breastfeeding

The CDC and the American Academy of Pediatrics recommend that babies be exclusively breastfed for approximately 6 months, and then to 1 year of age continue to be breastfed with the introduction of complementary table foods (CDC, 2017). National breastfeeding rates are estimated to be 51% at 6 months of age; for Utah, the rate is 70% at 6 months (CDC, 2013). It was startling to hear from these nurses about the hardships and challenges they faced working in direct patient care and often being unable to take a break to express milk while still breastfeeding (U.S. Department of Health and Human Services, 2011).

State and Federal Statute Related to Break-Time

The Fair Labor Standards Act of 1938 (2017) requires an employer to provide reasonable break time for an employee to express breast milk for a nursing child for 1 year after the child's birth. Utah state code encourages employers to recognize the benefits of breastfeeding and to provide unpaid break time and an appropriate space for employees who need to express their milk (Utah House Joint Resolution 4, 2012). These nurses reported that while they went back to work after having their baby, they breastfed for substantially less time than either the national average or the Utah average; they breastfed their baby until the approximate age of 4 months, or on average for 18 weeks. The nurses indicated the many challenges they faced in getting break time to express

milk, in addition to challenges related to proximate access to lactation rooms. With so many organizations advocating the benefits of breastfeeding it is abysmal that these issues still exist for working postpartum mothers (Gettas & Morales, 2013; Hirani & Karmaloano, 2013; Mills, 2009; Murtagh & Moulton, 2011).

Work Schedule and Childcare

The work schedule is a high-priority factor related to the nurse staying on the unit or leaving employment (Chan, Tam, Lung, Wong, & Chau, 2013). Nurses in this study expressed anxiety, sadness, and angst over working long shifts and missing out on some important events for their children. They also reported challenges with coordination of childcare with their work schedule. The majority of the nurses did not use external daycare facilities; instead, they depended on their husband and family members to care for their children when they were at work. Daycare was primarily used when their children were older, at approximately 2 to 3 years old (Demir, Ulsoy, & Ulsoy, 2003).

Work Exhaustion and Satisfaction

The nurses also expressed that physically they felt “good,” but they were tired and did not feel they got enough sleep. They indicated that the 12-hr shifts were long and tiresome and “too long” to be away from their children, but acknowledged that they appreciated having more days off to spend with their family. While these nurses readily expressed the challenges and hardships of working and being a mother, they also expressed that working in direct patient care was a source of personal satisfaction and a reprieve and respite from childrearing (Clissold & Smith, 2002).

Mother's Guilt

Guilt and feelings of being a "failure" arose often in the interviews. As the nurses reported these feelings, they were identified as being self-imposed; the nurses had in their mind that being away from their children while at work made them less than a "good" mother. The nurses did indicate that these feelings of guilt lessened as they reacclimated to the work routine and as the baby got older. A few nurses felt guilt for working that was imposed on them from others in their family or their community; they coped with this by not engaging with and not talking to these negative individuals about their work, and they gained some resolution as they understood that while they would prefer not to work, it was best for their family and for accountabilities related to finances, so they felt they had to work (Guendouzi, 2006; Hall, Oates, Anderson, & Willingham, 2012).

Study Implications

Hospital employers may use these findings for strategic workforce planning and to increase the support for and satisfaction of this cohort of nurses who are of childbearing and/or childrearing age. While federal and state statutes are in place to protect these nurses, workplace policies may not be in compliance, or may not be strictly adhered to; therefore, this information could be utilized by employers to remind them of the need for current practices to be in compliance and support nurses with regard to regulated meal and break times. They could also use it to create not only reasonable but supportive accommodations for staff who are breastfeeding a baby and need to express their milk while on shift at work (Abdulwadud & Snow, 2007; Bonet, Marchand, Kaminski, Fohran, Betoko, & Blondel, 2013; Dodgson, Chee, & Yap, 2004).

Future Research

Further research is needed to better understand if nurses working in direct patient care have higher rates of pregnancy complications. The literature evidences that ionizing radiation and chemotherapy drugs are fetotoxic and that night shift work is associated with preterm births. While this evidence is clear further research regarding nurses and the accommodations for these known hazards is needed. Specifically, work options and alternatives for the nurse, so she can remain in the workforce, working safely to protect her unborn baby. Research regarding pregnancy complications among nurses working in direct patient care would be of benefit, especially if stratified to understand the various patient populations and the nurse's workload, such as newborn intensive care versus medical–surgical, versus adult intensive care, versus pediatrics.

Further research is needed to determine if there is evidence that nurses working at the bedside do not breastfeed for the recommended 1-year period, and details as to why or why not. A survey to investigate the knowledge level of charge nurses, nurse managers, human resource leaders, and staff nurses who may become pregnant concerning the occupational hazards of nursing work for pregnant women is needed. Additional a study related to minimal breast feeding and alternative patterns of breastfeeding could provide pertinent supportive information for working nurses. In summary this research could be the foundation for a quantitative national study to expand and confirm or refute these study findings.

Study Limitations

Population demographics unique to the state may impact and limit the generalizability of these results to nurses in other states. Additionally, it is not possible to

determine if the pregnancy complications suffered by these study participants occurred at the same complication rate as in the general population. This study did not focus on the reasons for the timing of breastfeeding termination.

Study Strengths

The strengths of this study were that it was the issue of experienced nurses leaving the direct patient care is currently and of great concern so the timeliness of the study was a strength. Further the study was not diluted in purpose as it was conducted with a specific focus on female nurses in a specific phase of their career which highlighted issues important to nurses and their employers, in this cohort of childbearing and childrearing nurses. Additionally the phased methodology and use of unstructured and semistructured questions, served to strengthen the study by not limiting result findings, which could have occurred with closed-ended questioning. This unique methodology allowed for the capture of important quantitative information drawn from a sample pool focused to distinct and detailed information from women of childbearing and childrearing age working as nurse in direct care.

Conclusion

This study sheds light on several issues of concern for female nurses working at the bedside during their childbearing and childrearing phase of life. Supports for continuation of breastfeeding were voiced to be minimal, inadequate or absent in the participants places of work. Understanding of the need for flexibility in scheduling to allow the mother to meet their priorities to their children and family were also voiced to be minimally addressed or denied altogether, as the nurse regardless of family obligations

was to meet the scheduling requirements of the employer. Of great concern was the data received from participants indicating that information related to workplace policies that were in place to support adequate breaks and protections from hazards were voiced by participants as unknown to them and not part of any structured orientation or known guidelines for supporting the pregnant nurse in the workplace.

It was surprising to find that breastfeeding and being able to express breast milk in the workplace were significant issues for many of the study participants. Also surprising was that while nurses reported “loving” their work as a nurse, they were resigned to missing the “firsts” and other important events in their children’s lives because they worked long hr away from home. The nurses were well able to articulate positives about working, which they indicated with confidence and rationale for continuing to work despite the challenges and struggles. Of note was that the physical aspects, while mentioned by some nurses as a challenge, were overshadowed by the mental and emotional aspects of working and being a mother. Another interesting finding was that many nurses felt that because they went to work, their husbands became more competent and able to partner in caring for their child(ren). Consistent with Phase 1 of this study, schedules and shift hr were a dominant category. Specifically, the nurses desired flexibility and employer support to be able to work and have a balanced home life, especially since they were required to work and bring in money for living expenses. Also of importance was the finding that many nurses were not aware of policies pertinent to maternity leave time, workloads, postpartum working, and breastfeeding accommodations.

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CHAPTER 6

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The aims of this study were met by progressively using two types of qualitative interviewing increasingly targeting the reasons why experienced nurses left bedside nursing. Phase 1 included unstructured interviewing to investigate experienced nurses' intention to leave direct patient care. Phase 2 was designed as a result of the Phase 1 findings, using semistructured interviews focused on experienced nurses who worked when pregnant and/or had young children at home.

The literature surrounding intention to leave does not inform us with regard to experienced nurses and their decision process for leaving/rationale to leave direct patient care, nor does it inform us with regard to the impact of pregnancy or being the mother of young children on nurses working at the bedside. Consequently, the workplace needs of these experienced nurses may continue to go unmet, contributing to high turnover rates and nurse dissatisfaction. This research was important because high turnover rates combined with the present nursing shortage demand that employers be more responsive to the needs of nurses in order to stabilize the nursing workforce.

The framework for Phase 1 was based on the theory of voluntary turnover by Mitchell and Lee (1994). This model was chosen because the "push" and "pull" factors

outlined in this theory closely matched the research intent and served as a framework for employee turnover, some of which can be controlled with management interventions, but overall, because of its timing, were extremely costly to the health care system. In this chapter, research findings are discussed for each research aim and question. Conclusions are presented regarding experienced nurse intention to leave and impacts to the working nurse who is pregnant and/or who has young children at home. The research methods, study limitations, implications for employers, and recommendations for future research are presented.

Discussion

This study began with a focus on exploring retention of experienced nurses at the bedside. These findings were surprising and expanded what is known by the profession of nursing and healthcare organizations regarding retention of experienced nurses (Hayes et al, 2012; Nei, Snyder, & Litwiller, 2015; Van der Heede et al, 2015). Of great importance was the finding that the nurse makes employment and educational advancement decisions based on what she believes is best for her family. While institutions may know that nurse turnover occurs because of “personal reasons” and “schedule,” the details of those reasons has not been well studied in the current literature. This study revealed that if scheduling flexibility or the work environment do not provide options for the nurse to meet her family accountabilities, intention to leave and possibly resignation may result. These family–work conflicts, when encountered by the nurse, will be resolved by what is perceived to be best for the nurse’s family rather than best for the workplace.

A large number of female nurses working in direct patient care (~ 40%) are in the childbearing and/or childrearing phase of life (National Nursing Workforce Study, 2015).

Despite published evidence for the need to accommodate pregnant nurses, especially with regard to physical workload (Alex, 2011), few changes in workload were actually made to accommodate the nurse even for the late stages of pregnancy. However, pregnancy complication rates for nurses in this study were similar to complication rates nationally at 29% *(n* = 17) (CDC, 2016).

Of further concern, on average, nurses in this study terminated breastfeeding their babies earlier than other mothers in the state or nation (Mirkovic, Perrine, Scanlon, & Grummer-Strawn, 2014; U.S. Department of Health and Human Services, 2011). Of concern most of the nurses who worked at the bedside when they were pregnant, were not aware of policies relevant to pregnant or breastfeeding nurses working in direct patient care, nor were they routinely instructed about these policies.

While these nurses expressed concern, sadness, and occasional guilt over having to work—and work long hr—while leaving young children at home, they also expressed joy in the satisfaction they gleaned from providing direct patient care and felt they were contributing positively to society. They felt positive about being a good role model for their children with regard to being educated, earning an income to support or help support the family and exemplifying a good work ethic.

What this study adds is detailed information from the voice of experienced nurses who were working at the bedside and clarifies, illuminates and names the reasons nurses leave direct care. Specifically they are holding true to their family values and priority of attending to their accountability as a mother. The nurses did express passion for the profession of nursing and they enjoyed their patient care work but they readily sought other employment options or resigned if they felt they were compromising their family.

This information is important to healthcare institutions so they can build support structures in innovative work environments that support the working nurse and mother. These supports could potentially decrease turnover and improve the wellbeing of the nurses.

Implications for Practice

The problem of experienced nurses leaving direct patient care has far-reaching implications for safe, quality patient care and the stabilization of the nursing workforce. The nurses in this study were in somewhat of a "double-bind" as they felt obligated and committed to "carrying the full patient load," and this was to a large extent expected of them as an employee. But they also felt impinged on because they were pregnant and in a vulnerable state. Experienced nurses leaving bedside care in this time of nursing shortage means employers and managers must do more to understand the causes of turnover for each and every nurse. This can be done by engaging the nurses and asking them what would retain them in a bedside role, and then actively implementing innovative processes and structures that will serve to meet the nurses' needs. The women who participated in this study were highly interested in this research, were open and positive, and provided advice and recommendations to make improvements. These nurses were cognizant as to the constraints of administration and management, and recommended the following for employers of nurse who are pregnant or breastfeeding a baby:

1. Pregnant Employees

    a. Provide information about leave time and the Family Medical Leave Act prior to a family event, perhaps in orientation and on an ongoing basis so that nurses know what to expect and plan for, and the possible options when taking a leave.

b. Consider allowing longer maternity leaves that would allow the nurse to return to work feeling that she had had enough time off to adjust to becoming a mother and was ready to return to work.

c. Consider paying for the full leave time or providing an incentive for return.

d. Ensure that nurses get their full meal and break time, supported by another nurse who could do productive work and provide patient care while they took their break.

e. Provide a structure of support and advocacy for these pregnant and or postpartum working nurses as they may feel inadequate, or they may not know what to ask for what they need to protect themselves or they baby.

f. Recognize that these nurses want to work, and that the company's investment in them could result in a reduction in turnover and better stabilization of staffing—with experienced nurses.

g. Ensure the facility is following institutional, state and federal policies to support and protect these nurses.

2. Nursing Employees

a. Provide explanations of the policies surrounding leaves, time off, and breaks for expressing breastmilk.

b. Understand that the younger and or smaller the baby the more frequently the nurse may need to express milk, for example every 2 to 3 hr, in order to keep her milk supply.

c. Support schedule flexibility and a variety of shift options, such as shorter shifts or the option to split shifts.

d. Ensure the facility is following institutional, state and federal policies to support and protect these nurses.

e. Recognize that these nurses want to work, and that the company's investment in them could result in a reduction in turnover and better stabilization of staffing—with experienced nurses.

Recommendations for Future Research

This study revealed that while there are good intentions to understand and reduce nurse turnover, research in this area needs to be more focused, perhaps specifically on the

various cohorts that make up the nursing workforce and then designing studies that would bring to light the unique aspects of nurse workforce entities. A purposeful, targeted, strategic plan could be instituted to reduce turnover, support working mothers who are in a temporary phase of life, and instill loyalty and trust on the part of the nurses; this could reverse intention to leave among at least some of them.

Research is needed with regard to occupational hazards for pregnant nurses, including stress and long shift hr at the bedside. In addition, research is needed into the emotional/mental and physical strains on nurses who have responsibilities to mother young children.

Best practices should be examined with regard to family-friendly work environments, including long-term support of the breastfeeding mother. Research into the duration of breastfeeding among nurses should be examined to understand if workplace supports could increase this time in order to benefit the health of the babies. This research could be extended through development of a quantitative survey questionnaire that could be administered to a larger sample of nurses in the state or in a nation-wide survey. Such a survey would provide statistics into rates of nurses involved in career interruption because of pregnancy and responsibilities of mothering young children. A quantitative study would provide data on the cost of career interruptions which would be of value to the healthcare system as a whole. These data may be used to influence policy to protect the pregnant, postpartum or you mothers. And may also be used to implement supportive workforce structures in staffing patterns.

Discussion of Research Methods and Limitations

Qualitative methodology, including the use of unstructured interviews (Corbin, & Morse, 2003), served to allow the participants in Phase 1 to drive and focus the semistructured research questions in Phase 2 (Morse & Field, 1995). The research design was methodologically rigorous and provided rich and thick interview data (Morse, 2015a; Morse, 2015b). As a novice qualitative researcher and interviewer, I experienced a learning curve and became more proficient as the interviews and study phases progressed. While my skilled approach had limitations, I was consistent and conscientious with this research undertaking.

Further, the strength of this QUAL-> *qual* multiple-method design (Morse, 2017) was that the unstructured and semistructured interviews uncovered information from experienced nurses that have not been part of routine satisfaction survey questions or employment exit interview questions. While it could be assumed that an unstructured or semistructured approach could result in extraneous, non-related data, the result in this study was consistency and ultimately saturation of data meeting the study aims and research questions.

The sample for this study was limited to female nurses in the state of Utah, specified to a cohort of experienced nurses with 3 to 12 years licensed and an RN in Utah. At the time of the licensee list query there were 13,243 RNs in this category. This query did result in a recruitment list that included nurses who had moved to the state and who had been RNs for longer than 12 years. There was no practical way around this other than through the volunteer screening process to eliminate those RNs who had more than the 12 years of licensure. The recruitment approach resulted in findings representing only

a portion of the population of nurses in the state and the nation. Cultural influences and norms common to the state of Utah may, in this qualitative study be considered as natural laboratory to study the effect of child bearing and child rearing on the nursing workforce, and for this initial qualitative study, increase validity of findings to understand this relationship. While this from a quantitative perspective may be considered a limitation it may have in fact, been a strength of the study because of the concentrated and limited focus on this specific sample of the state nurse population to meet the associated study aims. This setting may have provided appropriate data, for answering the research question (Ruel, Wagner, & Gillespie, 2016).

Considering that the researcher is a nurse executive and nurse educator in the community, some participants knew her; therefore, some interviews included conversations not related to the interview questions because participants asked questions and/or engaged in off-topic conversations. This as well may have been both a limitation and a strength, as the participants may have come to the interview with trust (or on the contrary with their own motives) because of knowing the researcher.

Recruitment for the study resulted in an ample response for participation for both study phases (Ruel, Wagner, & Gillespie, 2016). One issue of consideration was that a $50 gift card was offered for study participation which may have motivated different participant participation than if there was no incentive (Head, 2009). The positive aspect of the incentive was that there was broad interest from across the state. One consideration for strengthening this study may have been to interview nurses working at the bedside who were pregnant at the time of the interview. Freely participant interviews were conducted over the phone or in person as preferred by the volunteer participant. There

was no difference in the quality of the interview in-person versus phone.

Summary of Findings

The purpose of this study was to understand the phenomenon of nurse intention to leave direct patient care, with a focus on the reasons, causes, and rationales associated with that intention and how the nurses determined their career path, with associated decisions. The research process was achieved progressively through two design phases.

Study Aims, Phase 1

1. To describe the career paths of experienced nurses associated with nurse intention to leave direct patient care.
2. To describe the associated decisions for changing jobs or advancing their education.
3. To inform the profession of nursing and healthcare organizations with regard to the experienced nurse's desires for the good of the profession, and for the organization to be supportive of the individual nurse.

The findings described in Chapter 4 revealed that nurses initiated the decision-making process of considering future employment with forethought and careful consideration of options; this is known as *intention to leave* (Bobay, 2005; Cortese, 2012; Havaei, McaPhee, & Dahinten, 2016; Takase, Teraoka, & Kousuke, 2015). It is not possible to halt all nurse intention to leave, or nurse turnover, because there will always be a cohort of nurses who desire to return to school for academic degrees for career advancement (Carney & Mion, 2008; Fusilero, Lini, Prohaska, & Szweda, 2008; Ward & Goodrich, 2007). Surprisingly, mothering responsibilities and family obligations strongly influenced nurses to make a job change or go back to school for career advancement. Lack of control over scheduling resulted in work–family conflict (Allen, Herst, Bruck, & Sutton, 2000; Yamaguchi, Inoue, Harada, & Oike, 2016), which also pushed nurses to

change positions to meet family responsibilities. Leaving children with other caregivers was troublesome to the nurses and resulted in angst and concern, also pushing them to seek other employment that could allow them to meet child and family needs (Farquharson et al., 2012). Work at the bedside in direct patient care was a means to an end, in that in general, they were doing the work in order to support their family finances for a limited period of time while their husband was in school or because their situation changed due to divorce.

Employer lack of appreciation also pushed nurses to consider leaving a position. Appreciation and recognition were perceived by the nurses to be more valuable (Portoghese, Galletta, Battistelli, & Leiter, 2015) in most instances than a high level of pay. Working as a nurse was described as being satisfying but also emotionally and physically challenging. Emotional stress and burnout in the role (Chiang & Chang, 2012; Flinkman & Salantera, 2014; Liu et al., 2011; Ma et al., 2009), in addition to the physical toll (Dawson, McLennan, Schiller, Jull, Hodges, & Steward, 2007) exacted by bedside nursing, created a “tipping point,” pushing the nurse to leave the role (Rizwan, Shahid, Shafiq, Tabassum, Bari, & Umer, 2013). Support from the work team and the work environment were of great importance to these nurses. They wanted the nursing unit to be a place to learn and grow; they also wanted the unit to be supportive and compassionate so as to mitigate the difficulties of demanding patients, physically difficult work, and inflexible scheduling. The primary rationales for nurses leaving direct patient care were categorized and conceptualized to form a positive structure that would potentially retain the nurse pertinent to her career desires. These were (a) providing a hiatus and allowing the nurse to stop out of her career for a period, but supporting a “bridge” to return to the

workplace; (b) providing flexible options for the nurse though “innovative scheduling,” ensuring that she could to continue to work and meet her family obligations; (c) succession planning through supporting the nurse to advance her education, which would be a win–win for the nurse and the organization as there would be incumbents with advanced degrees who were well trained and loyal to fill advanced roles in the facility (Alspach, 2007; Bobbio & Manganelli, 2015).

Research Questions, Phase 2

1. How do pregnancy, childbirth, and the responsibilities of mothering children impact the careers and lives of nurses who are working at the bedside?
2. What are the reasons and rationales associated with nurse intention to leave or stay at the bedside, among nurses with young children?
3. What are the experiences of nurses working at the bedside when pregnant?
4. What are the experiences of nurses working at the bedside with young children at home?

The findings described in Chapter 5 were revealing in that even though nurses disclosed their pregnancy early to their manager and coworkers, very few of them were accommodated with lighter workloads, even in the later stages of their pregnancy; they were lifting patients throughout their entire pregnancy. Strict precautions were taken for pregnant nurses by not allowing them to mix or administer chemotherapeutic drugs, and neck and belly radiation-monitoring devices were required for pregnant nurses who worked in imaging areas with ionizing radiation, to protect them from these occupational hazards. A finding of interest was that most nurses were not aware of policies related to the workload for pregnant nurses. In some instances the charge nurse would rearrange a patient assignment or the pregnant nurse would take it upon herself to ask to trade patients to protect herself and her baby from infectious patients.

Twenty-nine percent of the pregnant nurses in this study indicated that they had pregnancy complications. This rate is similar to national pregnancy complication rates (Centers for Disease Control and Prevention [CDC], 2016). Most nurses reported working a shift the day they delivered their baby. On average, these nurses took 12 weeks of maternity leave; for most, since they were new to the unit, the leave was not paid time or was only partially paid. Over 90% of nurses had help at home in the immediate postnatal period, mostly from their husband, one of the baby's grandparents, or a sister.

A concerning finding was the hardship that was evident with regard to being able to continue breastfeeding and express breast milk at work. Nurses related not having time to pump due to patient care demands and having no accommodation for regular meal and rest breaks. They indicated that the lactation rooms were too far away and not convenient because of the limited time they had available to pump; several of the nurses disclosed that they expressed their milk in a public restroom, which was undesirable but the only reasonable option considering patient care demands and their workload on the unit. Nurses in this study breastfed their babies for an average of 18 weeks, which is lower than national rate of 51% at 6 months and the Utah rate of 70% at 6 months (CDC, 2017).

The emotional experience of returning to work was a "challenge," and was described as "very hard" by the nurses. Nurses expressed their worry and anxiety about leaving their baby, and sadness at leaving their baby with another caregiver. Additionally, they described the stress they experienced because of the work schedule, feeling overwhelmed, and incapable of adapting to and coping with working and caring for a young baby. While the nurse's related being tired and not getting enough sleep, their major issues were those of a mental/emotional nature.

It was interesting to find that very few of these nurses utilized daycare; instead, they alternated their schedule with their husband so he could care for the baby, or they worked nights or weekends so the baby was always cared for by a parent. Childcare was utilized more for older children, although accessing daycare that accommodated shiftwork hr was not possible.

The nurses were torn about working 12-hr shifts. They liked the consolidated hr, yet they all felt working 12 hr (which could ultimately turn into 13 or 14 hr, since they frequently could not leave on time) was exhausting, and that they needed to recover for at least a day after working a shift. They did like having 4 days off so they could be with their family. Guilt was a major category in the narratives of the nurses, specifically guilt about leaving their children with a caregiver.

The positive aspects of being a working nurse and mother were described by these nurses as being a role model for their children, instilling a positive work ethic, and earning an income for their family. Additionally, they felt working provided them with a mental/emotional break and was a positive outlet from the responsibilities of home and children. The nurses reported having a sense of satisfaction from being a nurse and caring for others; they also felt that the knowledge and skills they possessed as a nurse were beneficial to them as a mother.

Nurses provided advice to other nurses who were working and pregnant or who had young children. Their advice fell into the following categories: self-care; physical care; knowing leave policies; communicating with their manager and coworkers; protecting oneself, one’s baby, and one’s family; planning and organizing; and emotional/mental self-care.

Nurses made recommendations to employers and managers who may have pregnant nurses or nurses with young children at home; these included the following:

1. Inform nurses about policies and benefits.
2. Be cognizant of the struggles of a nurse who is pregnant and/or who has young children.
3. Be caring and sensitive to the nurse's situation.
4. Provide convenient support for breastfeeding/expressing milk.
5. Provide a structure that allows nurses to use their full meal and rest breaks.
6. Provide fair pay and benefits that could incentivize the nurse.
7. Support a family-friendly workplace.

The nurses also indicated what would make working at the bedside better and be supportive to them as working mothers with young children:

1. Provide innovative scheduling and scheduling options to accommodate the nurse.
2. Allow for flexibility in scheduling and support trades to cover the nurse's needed time-off requests.
3. As managers and coworkers, be understanding, supportive, and compassionate about the situation of each individual nurse.
4. Provide a workplace that is transparent with regard to policies.
5. Provide break-time coverage.
6. Consider allowing longer maternity leaves.
7. Provide lunch- and break-time coverage.

Conclusion

The research on experienced nurses' intention to leave direct patient care, and the impact of bedside work in direct patient care on the pregnant nurse and/or on the nurse with young children, is limited. The evidence and insights gained from this study can

serve to inform employers and nurses with understanding of this cohort. The two-part qualitative study design offered a lens into the reasons and rationales for these nurses leaving direct care, beyond “personal/family” reasons that are commonly checked in exit interviews. This study shed light on the challenges of being a working nurse and mother with young children and the unique challenges that accompany these stacked roles.

The results of this study were unique in that the current literature is general in nature and does not include focus and specificity pertaining to the underlying reasons nurses, who are young mothers, may leave the bedside or resign for another positon. Findings about reasons for intention to leave in the current study included:

1. Long shifts and/or inflexible schedules that do not accommodate a balanced family life;
2. Mental and emotional aspects of being a working nurse and mother, including guilt, depression, and feelings of being a failure;
3. Angst, sadness, and worry about leaving their child with a caregiver, even if it was a spouse or family member; and
4. Managers and employers who are not sensitive to and understanding of the priority the nurse has for her children and family over all other responsibilities.

This study provides the basis for a dialogue between employers and nurses, to engage proactively and ensure that there is support in the workplace in addition to standard policies that serve to protect and support the nurse who is managing work and a young family. The study also provides insights regarding the priorities and responsibilities most important to female nurses in the childbearing and childrearing phases of their lives. It also informs organizations that work environments and organizational impacts if not managed to support the nurse may culminate and result in the nurse resigning their position for better work-life balanced employment options. This

also reminds employers to ensure that they are not only supportive of these nurses but also compliant with statute and guidelines that support the wellbeing of the nurse.

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APPENDIX A

CONSENT COVER LETTER

Dear Experienced Nurse,

I am a PhD student from the University of Utah College of Nursing. I am writing to invite your voluntary participation in a research study, "The Career Paths of Female Nurses: Decisions Associated With Intention to Leave Direct Patient Care." Please take time to read the following information carefully. If you have any questions, or if there is anything that is not clear, please do not hesitate to ask the nurse researcher those questions. Take time to decide whether you want to volunteer to take part in this study. Participation in this research is voluntary, and confidentiality will be maintained.

BACKGROUND

The purpose of this research is to understand nurse intention to leave direct patient care. It will seek to describe experienced nurses' career paths, and associated reasons, causes, or rationales for changing job positions and/or advancing careers. This research is for my PhD dissertation and has received the approval of the University of Utah Institutional Review Board (IRB) and the University of Utah College of Nursing. All information provided on the demographic survey and within the context of the phone interview will remain confidential and will be reported in the aggregate. Participants' names and other personal information will be de-identified and will be held strictly confidential.

STUDY PROCEDURE

Volunteering for the study consists of 2 Parts:

Part I) "The RedCap Demographic Survey." This online survey will take less than 5 min to complete.

Part II) "The Phone Interview." The phone interview will be open-ended and will allow you to talk about your career and work as a nurse. The phone interview will take between 60 and 90 min during your personal, off-work time.

RISKS

There are no anticipated risks to you as a participant. You may decline to answer any question asked and can stop the interview at any time without any negative consequence. You may feel upset thinking about or talking about your experiences in nursing; these risks are similar to those you experience when discussing personal information with others. If you feel upset during or after the interview, you can tell me and I will inform you about resources available to help.

BENEFITS

There are no direct benefits to you for taking part in this study. I hope the information from this study will help develop strategies to prevent the loss of experienced nurses from the healthcare workforce. Participants who complete Part I and are selected for (and

complete) Part II of the study will receive a $50 Visa gift card.

CONTACT

If you have questions, complaints, or concerns about this study, you can contact Linda Hofmann, the Principal Investigator, at (801) 440-6822, or Dr. Janice Morse, the Dissertation Committee Chair, at (801) 585-3930. If you feel you have been harmed as a result of participation or have questions regarding your rights as a research participant, please contact the University of Utah IRB. Also contact the IRB if you have questions, complaints, or concerns which you do not feel you can discuss with the investigator. The University of Utah IRB may be reached by phone at (801) 581-3655 or by email at irb@hsc.utah.edu.

Thank you,

Linda C. Hofmann, RN, MSN (PhD Candidate)
University of Utah College of Nursing
Cell Phone (801) 440-6822

APPENDIX B

REDCap® DEMOGRAPHIC SURVEY, PHASE 1

Current instrument: **The Career Paths of Female Nurses: Decision Associated with Intention to Leave Direct Patient Care** Preview instrument

Variable: record_id * This field will NOT be displayed on the survey page.

Record ID

NOTE: The field above is the record ID field and thus cannot be deleted or moved. It can only be edited.

Add Field Add Matrix of Fields

Variable: consent

RESEARCH STUDY RISKS

I UNDERSTAND the risks and benefits of this research (before answering read the information below).

There are no anticipated risks to you as a participant, you may decline to answer any question asked and can stop the interview at any time without any negative consequence. You may feel upset thinking about or talking about your experiences in nursing. These risks are similar to those you experience when discussing personal information with others. If you feel upset during or after the interview you can tell me and I will inform you about resources available to help.

RESEARCH STUDY BENEFITS
$50 AMAZON GIFT CARD

There are no direct benefits to you for taking part in this study. I hope the information from this study will help develop strategies to manage and or prevent the loss of experienced nurses from the bedside care. Participants who complete Part I, and are selected for (and complete) Part II of the study, will receive a $50 Amazon gift card.

* must provide value

○ Yes
○ No

Consent

reset

Add Field Add Matrix of Fields

Variable: participation

I WOULD LIKE TO VOLUNTEER to be selected for "The Career Paths of Female Nurses: Decisions Associated with Intention to Leave Direct Patient Care" research study (before answering read the information below).

The purpose of this research is to understand and describe experienced nurse's career paths, and associated reasons, causes or rationales for changing job positions, advancing careers and other career decisions.

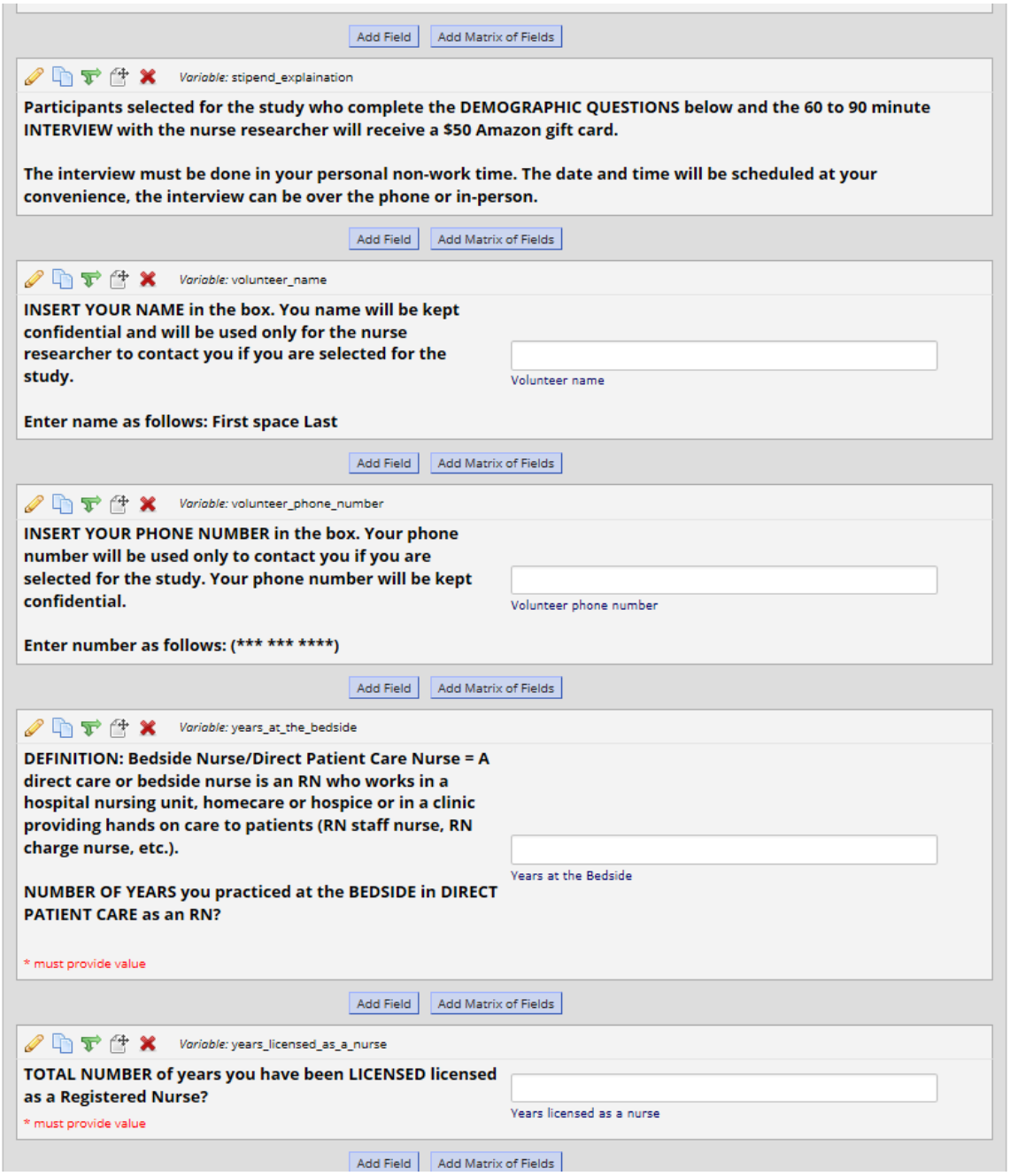
This research is not being conducted for any hospital or healthcare organization.

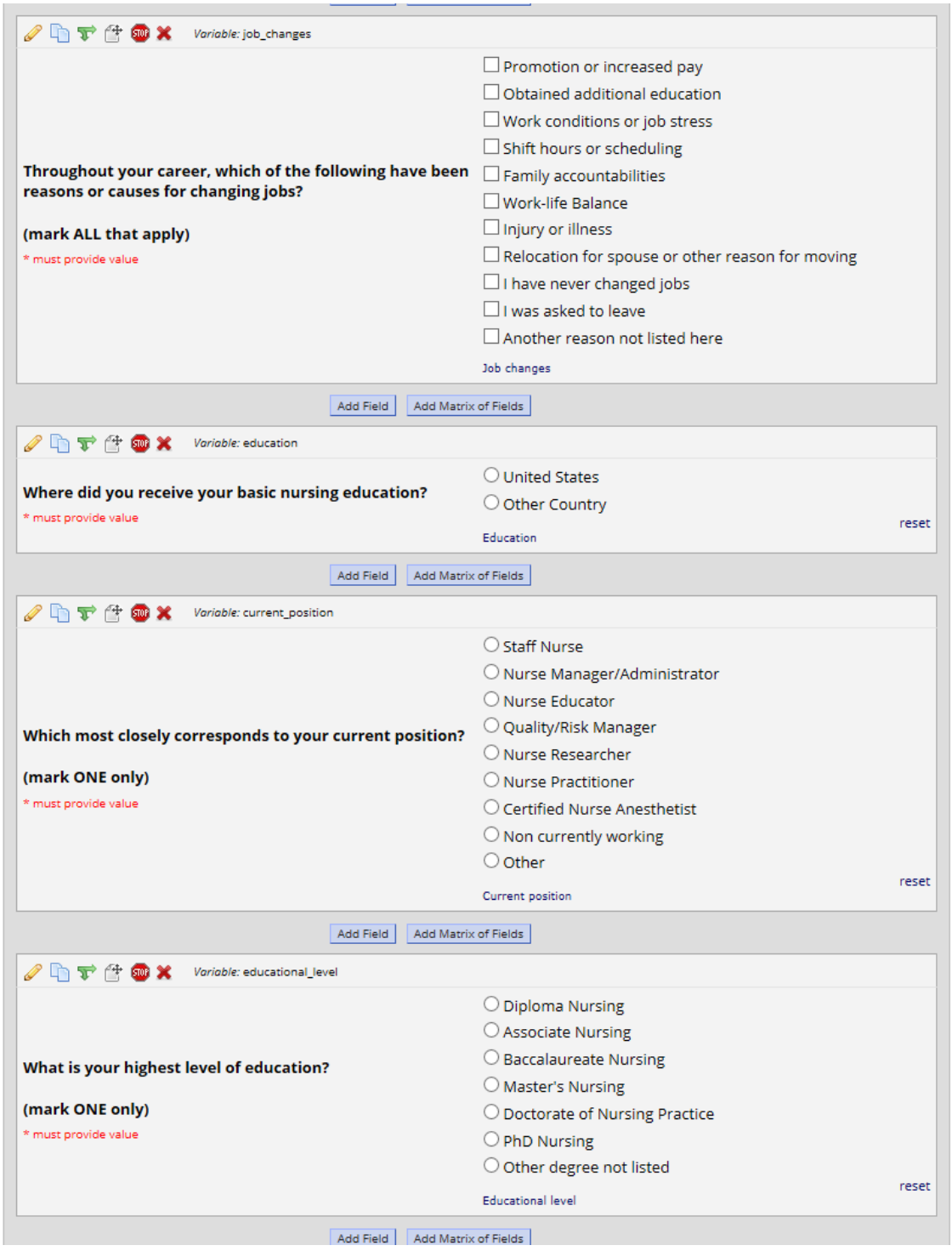
* must provide value

○ Yes
○ No

Participation

reset


Add Field
Add Matrix of Fields
Variable: stipend_explaination
Participants selected for the study who complete the DEMOGRAPHIC QUESTIONS below and the 60 to 90 minute INTERVIEW with the nurse researcher will receive a $50 Amazon gift card.
The interview must be done in your personal non-work time. The date and time will be scheduled at your convenience, the interview can be over the phone or in-person.
Add Field
Add Matrix of Fields
Variable: volunteer_name
INSERT YOUR NAME in the box. You name will be kept confidential and will be used only for the nurse researcher to contact you if you are selected for the study.
Enter name as follows: First space Last
Volunteer name
Add Field
Add Matrix of Fields
Variable: volunteer_phone_number
INSERT YOUR PHONE NUMBER in the box. Your phone number will be used only to contact you if you are selected for the study. Your phone number will be kept confidential.
Enter number as follows: (*** *** ****)
Volunteer phone number
Add Field
Add Matrix of Fields
Variable: years_at_the_bedside
DEFINITION: Bedside Nurse/Direct Patient Care Nurse = A direct care or bedside nurse is an RN who works in a hospital nursing unit, homecare or hospice or in a clinic providing hands on care to patients (RN staff nurse, RN charge nurse, etc.).
NUMBER OF YEARS you practiced at the BEDSIDE in DIRECT PATIENT CARE as an RN?
* must provide value
Years at the Bedside
Add Field
Add Matrix of Fields
Variable: years_licensed_as_a_nurse
TOTAL NUMBER of years you have been LICENSED licensed as a Registered Nurse?
* must provide value
Years licensed as a nurse
Add Field
Add Matrix of Fields



Variable: job_changes

Throughout your career, which of the following have been reasons or causes for changing jobs?

(mark ALL that apply)

* must provide value

- ☐ Promotion or increased pay
- ☐ Obtained additional education
- ☐ Work conditions or job stress
- ☐ Shift hours or scheduling
- ☐ Family accountabilities
- ☐ Work-life Balance
- ☐ Injury or illness
- ☐ Relocation for spouse or other reason for moving
- ☐ I have never changed jobs
- ☐ I was asked to leave
- ☐ Another reason not listed here

Job changes

Add Field | Add Matrix of Fields

Variable: education

Where did you receive your basic nursing education?

* must provide value

- ○ United States
- ○ Other Country

reset

Education

Add Field | Add Matrix of Fields

Variable: current_position

Which most closely corresponds to your current position?

(mark ONE only)

* must provide value

- ○ Staff Nurse
- ○ Nurse Manager/Administrator
- ○ Nurse Educator
- ○ Quality/Risk Manager
- ○ Nurse Researcher
- ○ Nurse Practitioner
- ○ Certified Nurse Anesthetist
- ○ Non currently working
- ○ Other

reset

Current position

Add Field | Add Matrix of Fields

Variable: educational_level

What is your highest level of education?

(mark ONE only)

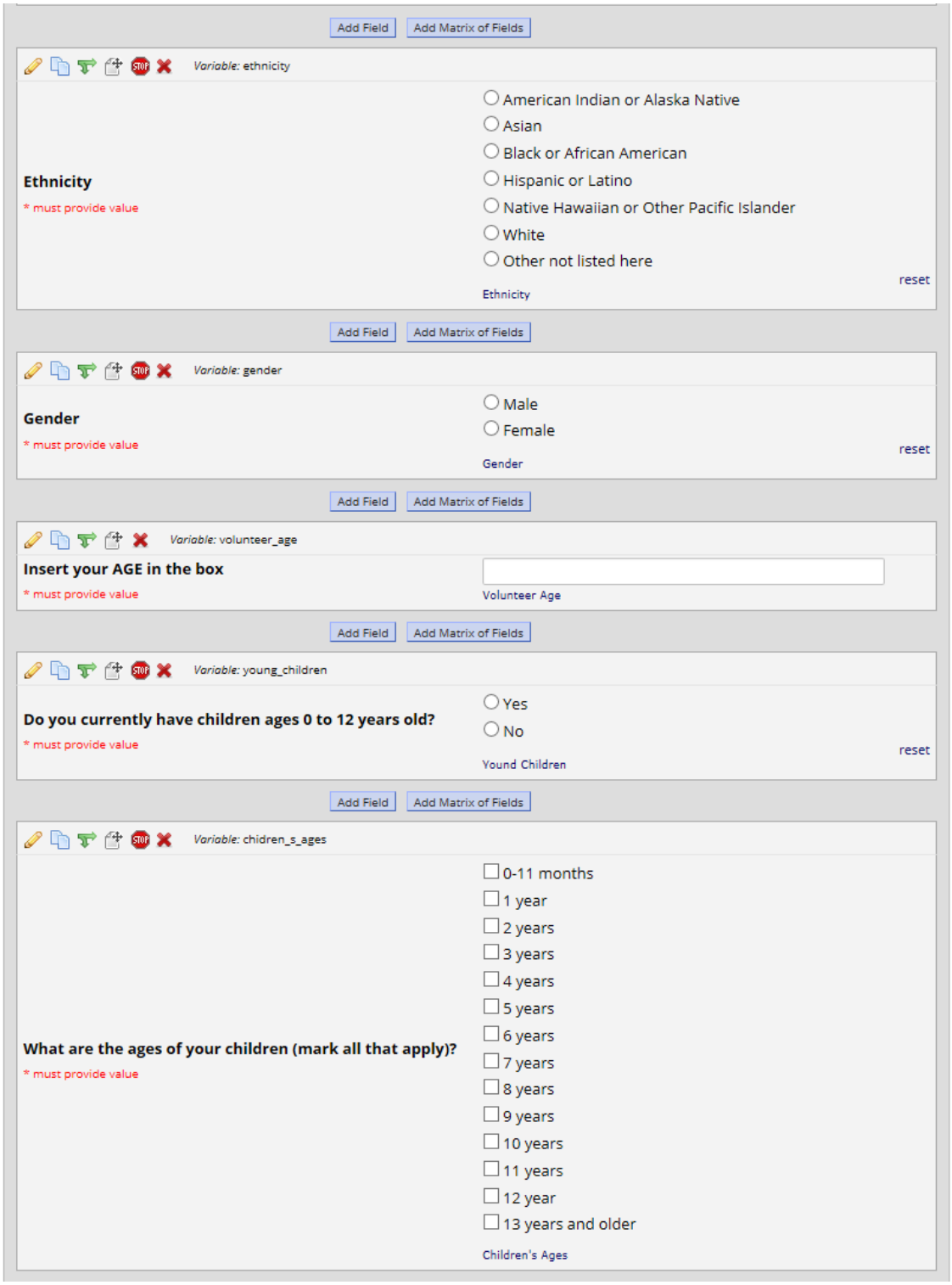
* must provide value

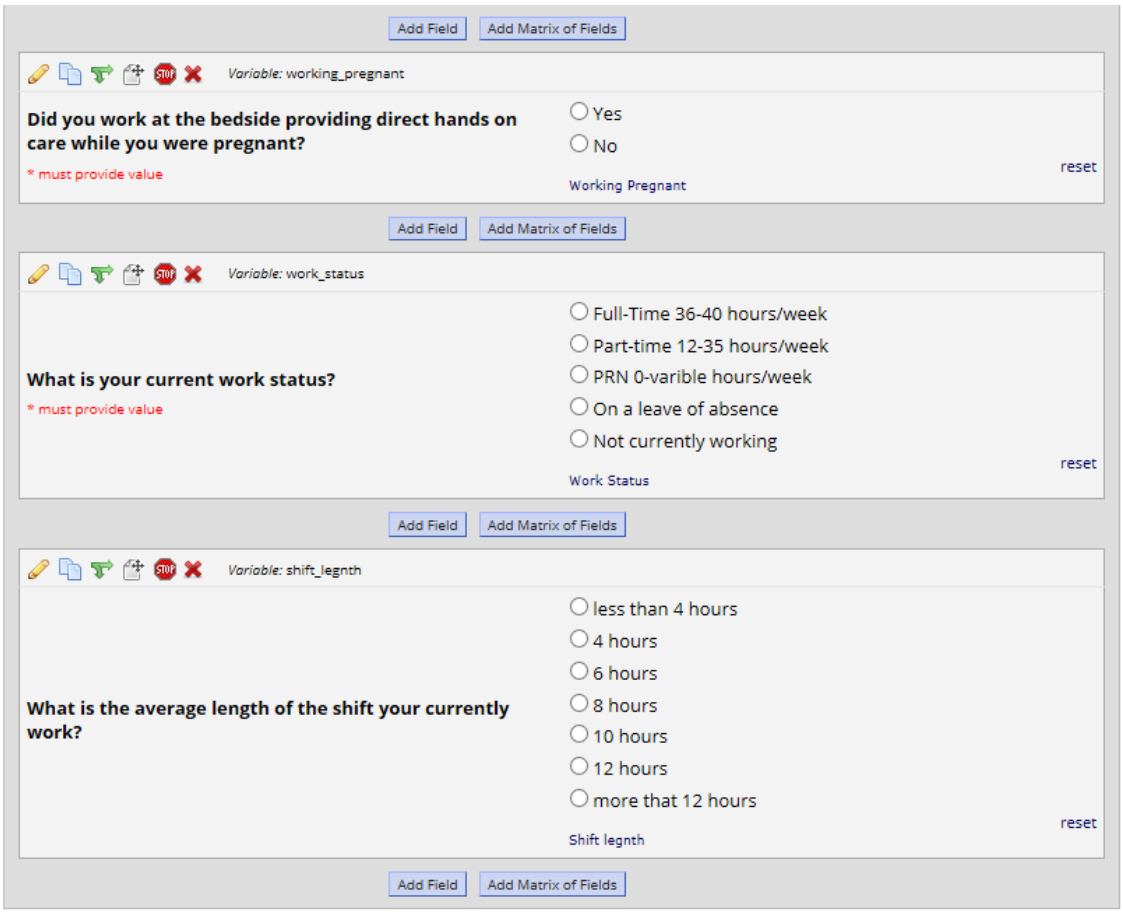
- ○ Diploma Nursing
- ○ Associate Nursing
- ○ Baccalaureate Nursing
- ○ Master's Nursing
- ○ Doctorate of Nursing Practice
- ○ PhD Nursing
- ○ Other degree not listed

reset

Educational level

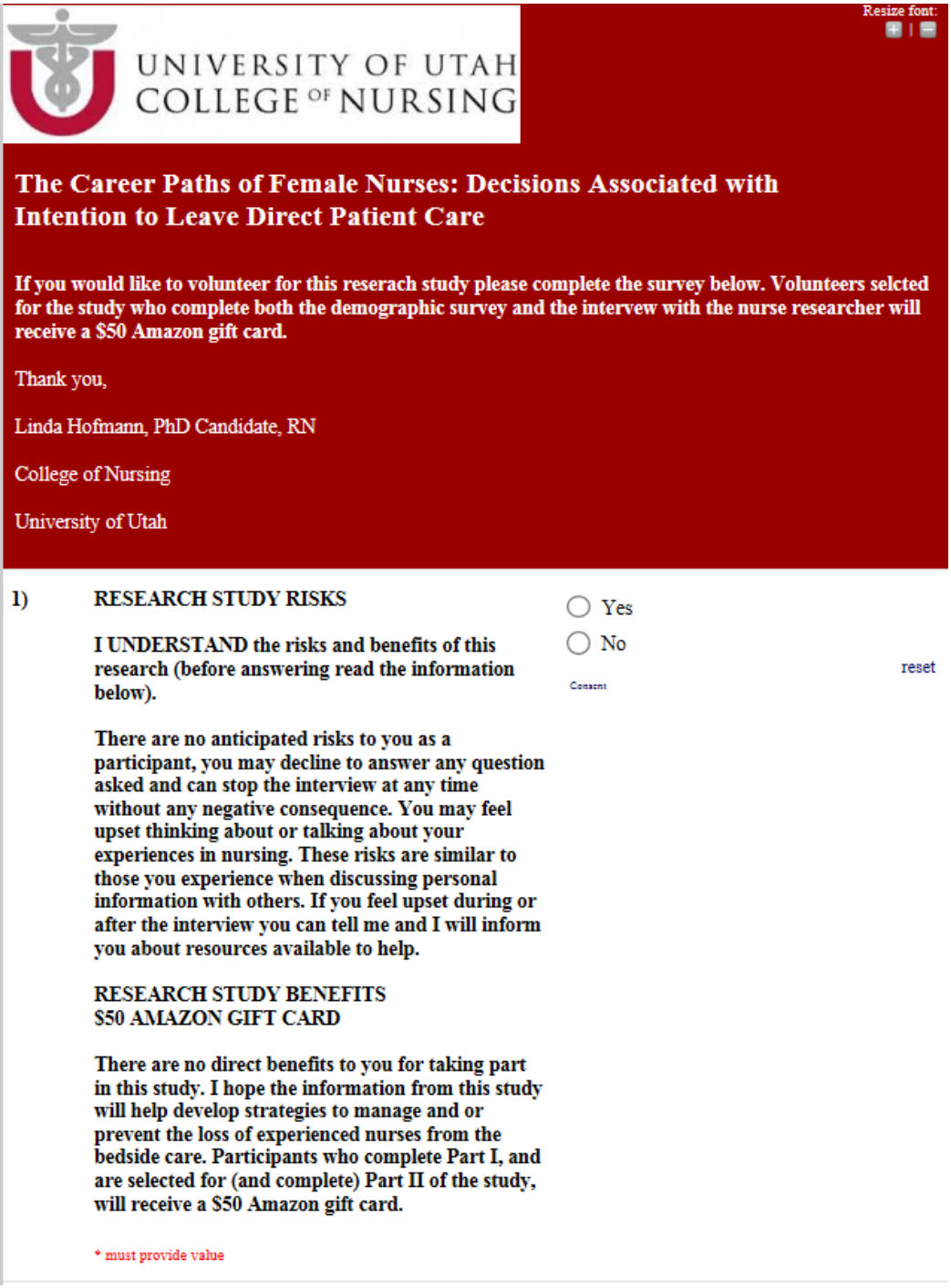
Add Field | Add Matrix of Fields


Add Field
Add Matrix of Fields
Variable: ethnicity
Ethnicity
* must provide value
American Indian or Alaska Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
White
Other not listed here
reset
Ethnicity
Add Field
Add Matrix of Fields
Variable: gender
Gender
* must provide value
Male
Female
reset
Gender
Add Field
Add Matrix of Fields
Variable: volunteer_age
Insert your AGE in the box
* must provide value
Volunteer Age
Add Field
Add Matrix of Fields
Variable: young_children
Do you currently have children ages 0 to 12 years old?
* must provide value
Yes
No
reset
Yound Children
Add Field
Add Matrix of Fields
Variable: chidren_s_ages
What are the ages of your children (mark all that apply)?
* must provide value
0-11 months
1 year
2 years
3 years
4 years
5 years
6 years
7 years
8 years
9 years
10 years
11 years
12 year
13 years and older
Children's Ages


Add Field
Add Matrix of Fields
Variable: working_pregnant
Did you work at the bedside providing direct hands on care while you were pregnant?
* must provide value
Yes
No
reset
Working Pregnant
Add Field
Add Matrix of Fields
Variable: work_status
What is your current work status?
* must provide value
Full-Time 36-40 hours/week
Part-time 12-35 hours/week
PRN 0-varible hours/week
On a leave of absence
Not currently working
reset
Work Status
Add Field
Add Matrix of Fields
Variable: shift_legnth
What is the average length of the shift your currently work?
less than 4 hours
4 hours
6 hours
8 hours
10 hours
12 hours
more that 12 hours
reset
Shift legnth
Add Field
Add Matrix of Fields

APPENDIX C

REDCap® DEMOGRAPHIC SURVEY, PHASE 2



Resize font:

UNIVERSITY OF UTAH
COLLEGE OF NURSING

The Career Paths of Female Nurses: Decisions Associated with Intention to Leave Direct Patient Care

If you would like to volunteer for this reserach study please complete the survey below. Volunteers selcted for the study who complete both the demographic survey and the intervew with the nurse researcher will receive a $50 Amazon gift card.

Thank you,

Linda Hofmann, PhD Candidate, RN

College of Nursing

University of Utah

1) **RESEARCH STUDY RISKS**

I UNDERSTAND the risks and benefits of this research (before answering read the information below).

Yes
No

reset

Consent

There are no anticipated risks to you as a participant, you may decline to answer any question asked and can stop the interview at any time without any negative consequence. You may feel upset thinking about or talking about your experiences in nursing. These risks are similar to those you experience when discussing personal information with others. If you feel upset during or after the interview you can tell me and I will inform you about resources available to help.

RESEARCH STUDY BENEFITS
$50 AMAZON GIFT CARD

There are no direct benefits to you for taking part in this study. I hope the information from this study will help develop strategies to manage and or prevent the loss of experienced nurses from the bedside care. Participants who complete Part I, and are selected for (and complete) Part II of the study, will receive a $50 Amazon gift card.

* must provide value

2) **I WOULD LIKE TO VOLUNTEER to be selected for "The Career Paths of Female Nurses: Decisions Associated with Intention to Leave Direct Patient Care" research study (before answering read the information below).**

○ Yes
○ No

Participation

reset

The purpose of this research is to understand and describe experienced nurse's career paths, and associated reasons, causes or rationales for changing job positions, advancing careers and other career decisions.

This research is not being conducted for any hospital or healthcare organization.

* must provide value

Participants selected for the study who complete the DEMOGRAPHIC QUESTIONS below and the 60 to 90 minute INTERVIEW with the nurse researcher will receive a $50 Amazon gift card.

The interview must be done in your personal non-work time. The date and time will be scheduled at your convenience, the interview can be over the phone or in-person.

3) **INSERT YOUR NAME in the box. You name will be kept confidential and will be used only for the nurse researcher to contact you if you are selected for the study.**

Enter name as follows: First space Last

Volunteer name

4) **INSERT YOUR PHONE NUMBER in the box. Your phone number will be used only to contact you if you are selected for the study. Your phone number will be kept confidential.**

Enter number as follows: (* *** ****)**

Volunteer phone number

5) **DEFINITION: Bedside Nurse/Direct Patient Care Nurse = A direct care or bedside nurse is an RN who works in a hospital nursing unit, homecare or hospice or in a clinic providing hands on care to patients (RN staff nurse, RN charge nurse, etc.).**

NUMBER OF YEARS you practiced at the BEDSIDE in DIRECT PATIENT CARE as an RN?

* must provide value

Years at the Bedside

6) **TOTAL NUMBER of years you have been LICENSED licensed as a Registered Nurse?**

* must provide value

Years licensed as a nurse

7) **Throughout your career, which of the following have been reasons or causes for changing jobs?**

(mark ALL that apply)

* must provide value

- ☐ Promotion or increased pay
- ☐ Obtained additional education
- ☐ Work conditions or job stress
- ☐ Shift hours or scheduling
- ☐ Family accountabilities
- ☐ Work-life Balance
- ☐ Injury or illness
- ☐ Relocation for spouse or other reason for moving
- ☐ I have never changed jobs
- ☐ I was asked to leave
- ☐ Another reason not listed here

Job changes

8) **Where did you receive your basic nursing education?**

* must provide value

- ○ United States
- ○ Other Country

reset

Education

9) **Which most closely corresponds to your current position?**

(mark ONE only)

* must provide value

- ○ Staff Nurse
- ○ Nurse Manager/Administrator
- ○ Nurse Educator
- ○ Quality/Risk Manager
- ○ Nurse Researcher
- ○ Nurse Practitioner
- ○ Certified Nurse Anesthetist
- ○ Non currently working
- ○ Other

reset

Current position

10)	**What is your highest level of education?** **(mark ONE only)** * must provide value	○ Diploma Nursing ○ Associate Nursing ○ Baccalaureate Nursing ○ Master's Nursing ○ Doctorate of Nursing Practice ○ PhD Nursing ○ Other degree not listed reset Educational level
11)	**Ethnicity** * must provide value	○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Hispanic or Latino ○ Native Hawaiian or Other Pacific Islander ○ White ○ Other not listed here reset Ethnicity
12)	**Gender** * must provide value	○ Male ○ Female reset Gender
13)	**Insert your AGE in the box** * must provide value	Volunteer Age
14)	**Do you currently have children ages 0 to 12 years old?** * must provide value	○ Yes ○ No reset Young Children

15) **Skip to next question if you have no children.**

What are the ages of your children (mark all that apply)?

- ☐ 0-11 months
- ☐ 1 year
- ☐ 2 years
- ☐ 3 years
- ☐ 4 years
- ☐ 5 years
- ☐ 6 years
- ☐ 7 years
- ☐ 8 years
- ☐ 9 years
- ☐ 10 years
- ☐ 11 years
- ☐ 12 year
- ☐ 13 years and older

Children's Ages

16) **Skip to the next question if you have not been pregnant.**

Did you work at the bedside providing direct hands on care while you were pregnant?

- ○ Yes
- ○ No

Working Pregnant reset

17) **What is your current work status?**

* must provide value

- ○ Full-Time 36-40 hours/week
- ○ Part-time 12-35 hours/week
- ○ PRN 0-varible hours/week
- ○ On a leave of absence
- ○ Not currently working

Work Status reset

18) **What is the average length of the shift you currently work?**

- ○ less than 4 hours
- ○ 4 hours
- ○ 6 hours
- ○ 8 hours
- ○ 10 hours
- ○ 12 hours
- ○ more that 12 hours
- ○ Not currently working

Shift legnth reset

Submit

APPENDIX D

SEMISTRUCTURED INTERVIEW

QUESTIONS, PHASE 2

Revised 4/7/2017

SEMISTRUCTURED INTERVIEW QUESTIONS, PHASE 2:

GROUP #1 NURSE WORKING AT THE BEDSIDE WHEN PREGNANT AND/OR AS THE MOTHER OF YOUNG CHILDREN

GROUP #2 NURSE WORKING AT THE BEDSIDE AS THE MOTHER OF YOUNG CHILDREN

Questions Group #1

Have been pregnant while working at the bedside and **currently have young children 0–12 yo**.

Consent

[*Study Purpose: Consent explanation*]

Demographic Questions

[*Purpose: To verify information*]

Verify/Update information on RedCap® Survey

1. Marital status
2. Religious affiliation
3. Current work status
4. Verify number of pregnancies
5. Ask how many of pregnancies there were while they were working at the bedside.
6. Verify from RedCap®, number of children and ages

Nurse Working and Pregnant—Pregnancy Data

[*Purpose: To obtain information about working and the nurse's pregnancy*]

Ask the following, specifying for each of the pregnancies:

7. Tell me about your pregnancies.

8. Were you working at the bedside?

[*Purpose: To find out about early pregnancy and work*]

9. How long did you work at the bedside before getting pregnant?

10. What type of unit did you work on?

11. Tell me about when you first got pregnant and were working as a nurse.

12. Did others know you were pregnant?

    a. Were they supportive?

    b. Were there any changes in your workload early in your pregnancy?

[*Purpose: To find out about working in later pregnancy*]

13. Tell me how your pregnancy progressed and how work was going.

14. Later in the pregnancy, how did you manage?

15. Were you still lifting patients?

16. Did you have any pregnancy complications?

[*Purpose: To find out about maternity leave*]

17. Did you have to take time off because of your pregnancy before your maternity leave?

18. Tell me about your decision to take time off work for maternity leave.

19. How much time did you <u>plan</u> to take off when your baby was born?

Postnatally, Nurse on Maternity Leave

[*Purpose: To find out about the decision to return to work*]

20. Did you come home from the hospital with your baby?

    a. Tell me what happened if your baby stayed in the hospital.

21. How much time did you <u>actually</u> take off for your maternity leave?

22. Did you have help at home?

    a. Who helped you?

    b. What help was provided?

23. Was the baby well?

24. Were you well?

25. Were you breastfeeding or bottle feeding?

26. Tell me about your decision to go back to work.

27. How old was your baby?

28. Did you have child care?

    a. Tell me about your childcare.

29. During your maternity leave, did you

    a. Maintain contact with work colleagues?

    b. Attend meetings or conferences?

    c. Engage in any professional reading or other activities?

30. How were you feeling about going back to work?

Postnatal Working

[*Purpose: To find out about reintegration into the workplace setting*]

31. Were you still nursing when you went back to work?

32. Tell me about your experience of having a baby and working as a nurse.

33. Were you working full time or part time?

34. Tell me how you felt emotionally, working with a young baby.

35. Tell me how you felt physically, working with a young baby.

Nurse Working at the Bedside With Young Children at Home

[*Purpose: To find out about working at the bedside with young children at home*]

36. Tell me about your experience of being a bedside nurse while also having young children.

    a. What struggles or challenges do you experience?

    b. What positives or benefits have you experienced?

37. How has becoming a mother of young children affected your decision about staying

as a bedside nurse or leaving that role?

a. If you have stayed continuously working at the bedside, tell me about why you decided to stay in that position/those positions.

b. If you decided to leave working at the bedside, tell me about why you decided to leave that position/those positions.

38. Tell me about what type of support you have for you to have time for you when not at work and not with your young children.

a. How often do you get this time away for yourself?

Quality of Childcare From Husband or Other Caregivers

[*Purpose: To find out about leaving the baby with caregivers while working*]

39. Who cared for your baby when you were at work?

40. Were you able to contact the caregiver during your work day?

41. Tell me how the baby did with the caregiver.

42. Who cared for your baby if the baby was sick?

43. How many times did you have to be absent from work because the baby was sick?

Recommendations

[*Purpose: To find out from the nurse her thoughts and recommendations*]

44. What <u>has been</u> helpful or supportive for you working as a bedside nurse while also becoming and being a mother of young children?

45. What <u>would be</u> helpful, or what would have been helpful to you while being a bedside nurse and also becoming and being a mother of young children?

a. How would this help you to decide to stay working at the bedside?

b. How would this help you personally with your life or your quality of life?

c. How would this help you in your work as a nurse?

46. Others have mentioned a number of possible areas for supports or changes to help with being a bedside nurse and a mother of young children. What are your thoughts of each of these:

a. How could shifts be better for you?

b. How could scheduling be better for you?

c. How could the team relations be better for you?

d. How could your manager be more supportive of you?

e. How could the workplace be more supportive of you?

f. How could time off or leave time be better for you?

g. Do you have any other suggestions?

47. What advice do you have for other nurses who are pregnant and working?

48. What advice do you have for others who are mothers of young children?

49. What recommendations do you have for employers and managers who have nurses working while pregnant and/or with young children?

50. Directive focused questions and probing as appropriate.

51. Close interview.

Question Group #2

Have **not been pregnant when working** at the bedside, but **have young children 0–12 yo.**

Consent

[*Study Purpose: Consent explanation*]

Demographic Questions

[*Purpose: Verify Information*]

Verify/Update information on RedCap Survey

52. Marital status
53. Religious affiliation
54. Current work status
55. Verify number of pregnancies
56. Ask how many of pregnancies there were while they were working at the bedside.
57. Verify from RedCap®, number of children and ages

Nurse Working at the Bedside with Young Children at Home

[*Purpose: To find out about working at the bedside with young children at home*]

58. Tell me how you feel emotionally about working with young children.

59. Tell me how you feel physically about working with young children.

60. Tell me about what type of support you have for you to have time for you when not at work and not with your young children.

    a. How often do you get this time away for yourself?

61. Tell me about your experience with being a bedside nurse while also having young children.

    a. What struggles or challenges do you experience?

    b. What positives or benefits have you experienced?

62. How has becoming a mother of young children affected your decision about staying as a bedside nurse or leaving that role?

    a. If you have stayed continuously working at the bedside, tell me about why you decided to stay in that position/those positions.

    b. If you decided to leave working at the bedside, tell me about why you decided to leave that position/those positions.

Quality of Mothering From Husband or Other Caregiver

[*Purpose: To find out about leaving the baby and other children with caregivers while working*]

63. Tell me about your childcare.

64. Who cares for your children after school and/or on the weekend when you are at work?

65. How do you feel about working?

66. Who cares for your children when they were sick and you have to work?

67. Do the children contact with you when you are working?

68. Have you ever had to leave a shift or call in absent because the children needed you?

Recommendations

[*Purpose: To find out from the nurse their thoughts and recommendations*]

69. What has been helpful or supportive for you, working as a bedside nurse while also being the mother of young children?

70. What would be helpful or what would have been helpful to you while being a bedside nurse and being the mother of young children?

a. How would this help you to decide to stay working at the bedside?

b. How would this help you personally with your life or your quality of life?

c. How would this help you in your work as a nurse?

71. Others have mentioned a number of possible areas for supports or changes to help with being a bedside nurse and a mother of young children. What are your thoughts of each of these:

a. How could shifts hr be better for you?

b. How could scheduling be better for you?

c. How could the team relations be better for you?

d. How could your manager be more supportive of you?

e. How could the workplace be more supportive of you?

f. How could time off or leave time be better for you?

h. Do you have any other suggestions?

72. What advice do you have for other nurses who have young children and are working at the bedside?

73. What advice do you have for others who are mothers of young children?

74. What recommendations do you have for employers and managers who have nurses working with young children?

75. Directive focused questions and probing as appropriate.

76. Close interview.