

**What Is Important to Arizona's Nurses?
A Report of a Qualitative Analysis of Nurses' Responses to a Statewide Survey**

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In 2001, the Arizona State Board of Nursing commissioned a pilot study to examine nursing workforce trends and the needs of Arizona's nurses. The team that designed the survey tool included Anne McNamara, PhD, RN (Rio Salado College, chair of team), Karen Saewert, PhD, RN (Arizona State University), and David Hrabe, PhD, RN (Arizona State University). The team collected demographic data, information about current employment, plans to continue in working in nursing, and opinions about a number of variables (e.g., work intensity, adequacy of staffing, compensation). Members returned over 12,000 surveys.

While funding and limited resources have been a barrier to a complete analysis of the data, a qualitative study was completed by the author on a small subset of returned surveys. The focus of this report is the analysis of narrative responses to two items from the survey:

- Item 26: "If you are not employed in nursing, what would it take to get you to return to the nursing work force?"
- Item 40: "Please identify your top three dis-satisfiers in nursing and SOLUTIONS for making improvements to each area."

Study Aims and Approach

The study's aims were to

1. Identify factors that would motivate nurses who have left nursing to return to work in healthcare.
2. Describe dis-satisfiers and proposed solutions offered by practicing nurses.

A subset of the 12,000 returned surveys were randomly selected and then screened according to predetermined criteria. Screening Criterion 1 was a response to Item 26. It was reasoned that if someone had left nursing and was responding to this item, it would be important to know what would bring them back to the workforce. If the respondent wrote a response to Item 26, it was transcribed word for word.

If the respondent did not answer Item 26, the respondent's work setting (Screening Criterion 2) was examined next. Since many studies of work environment focus on hospital nurses (see works by Linda Aiken, Mary Blegen, Peter Buerhaus, Barbara Mark and their colleagues) the board was interested in hearing from nurses whose voices were often not heard in research: nurses who worked in nonhospital settings. If the respondent worked in any setting other than a hospital (e.g., long-term care, school, community), the survey was then examined to determine if he or she wrote a response to Item 40 (dis-satisfiers/solutions). If the respondent answered Item 40, the response was transcribed word for word. Surveys that did not meet the screening criteria were simply numbered and put aside.

Surveys that met the screening criteria were transcribed along with the following demographic information: age, gender, highest education, credentials, work setting, employer location, and type of nursing position. Surveys were transcribed in batches of 100 and then coded. After

2,000 surveys had been screened, the team found 798 surveys that met the screening criteria. At this point, it was apparent that no new insights were forthcoming; further screening of the surveys for more data ended.

Analysis Approach

Data were examined using content analysis (Ryan & Bernard, 2000). This involved a line-by-line examination of each narrative response, making a judgment about its meaning, and applying a code that represented its essence. Management of large amounts of text and codes was achieved through a specialized software package used for qualitative research: Atlas.ti. This is a sophisticated, state-of-the-art database that organizes data, catalogs codes as they are developed, tracks frequencies of quotations and codes, and allows for the examination of emerging themes from a variety of perspectives. It does not analyze data—the investigator creates and controls all aspects of the analysis. Its main purpose is organization and information retrieval for close examination and auditing.

Findings

Demographic Data

Because some respondents did not answer some or all the demographic questions, the following categories do not sum to the total number of respondents ($n = 798$). Participants ranged in age from 23 to 78 (mean age = 48.8). Most were women (713; 93.7%); 48 (6.3%) were men. The majority (93.3%) of the respondents worked in ¹nonhospital settings (most often in Clinic/Ambulatory, $n = 103$ [18.2%] and Long-Term Care, $n = 123$ [17.1%]). Most worked in staff positions ($n = 306$, 48.0%) as RNs. In terms of education preparation, ADN-prepared nurses ($n = 233$, 28.0%) were the largest group of the sample, followed by BSN-prepared nurses ($n = 203$, 24.4%). The majority of those responding to the survey lived in Tucson ($n = 205$, 28.2%) or Phoenix ($n = 351$, 48.3%), although a substantial portion of the respondents lived in rural areas/small or medium-sized cities ($n = 170$, 23.4%). More complete demographic data from this sample are presented in Tables 1 through 5.

¹ Demographic questions collected information about the respondent's current work setting. Some participants commented that they had left hospital nursing because of the dis-satisfiers they listed. Therefore, while the sample is mostly of nonhospital nurses, the comments may reflect their dissatisfaction from a previous work setting.

Category	<i>N</i>	%
LPN	133	17.0
MD	1	0.1
NP	27	3.5
RN	610	78.0
Other	11	1.4

Category	<i>N</i>	%
Certificate	43	24.4
ADN	233	28.0
Diploma	136	16.3
BS/BA nonnursing	76	9.1
BSN	203	24.4
MS/MA nonnursing	47	5.6
MS nursing	79	9.5
Doctorate	15	1.8
NOTE: Total <i>N</i> exceeds 798; some respondents indicated two degrees.		

Category	<i>N</i>	%
Rural/small city	125	17.2
Medium-sized city	45	6.2
Tucson	205	28.2
Phoenix	351	48.3

Category	<i>N</i>	%
Administrator/Assist	37	6.2
Case Manager	74	12.4
Consultant	10	1.7
Faculty	17	2.8
NP	42	6.6
QI/Management	4	0.6
School Nurse	6	0.9
Staff	306	48.0
Supervisor/Mgr/Assistant	105	16.5

Table 5. Setting		
Category	<i>N</i>	%
Clinic/Ambulatory	103	18.2
Corrections	13	1.8
Education	23	3.2
Government: Nonmilitary	42	5.8
Home Health	56	7.8
Hospice	48	6.7
Hospital	48	6.7
Long-Term Care	123	17.1
Managed Care	21	2.9
Nonhealth Care	16	2.2
Occupational Health	11	1.5
Office	50	7.0
Other	70	9.7
Psychiatry/Drug Treatment	9	1.3
Public/Community Health	26	3.6
School Nursing	39	5.4
Self-Employed	21	2.9

Qualitative Data, Codes, and Major Categories

Data were reviewed line by line and codes ascribed to each comment. While very succinct comments (e.g., Dis-satisfier 1: “Salary!”; Solution: “Pay more!”) did not provide insight into the respondent’s situation, the volume of comments were catalogued and helped to determine if a response was rare versus more prevalent.

Dis-satisfiers

The top 20 dis-satisfiers and their frequency are listed in Table 6.

Table 6. Top 20 Dis-Satisfiers	
Code	Frequency
Poor salaries	482
Inadequate staffing	299
Poor benefits package	110
Overwhelmed by paperwork/regulations	108
Scheduling	92
Lack of respect	91
Workload	75
Ineffective immediate supervisor	73
Work intensity	65
Lack of growth opportunities	59
Inadequate resources	58
High stress/burnout	56
Co-worker competence	50
Ineffective administration	48
Nurse/physician relationships	47
12-hour (or lengthy) shifts	44
Nurse/nurse relationships	30
Tuition/workshop funding	28
Long work hours	22
Childcare issues	22

Each code represents one respondent (some respondents wrote the same dis-satisfier more than once for emphasis). The top 20 dis-satisfiers, along with less frequently occurring dis-satisfiers, were grouped into seven larger categories, which helped to focus on the major dissatisfactions cited by this group.

WORKLOAD AND STRESS ($n = 767$): When grouping all related comments about workload and stress, this category contained the most common dis-satisfiers. Respondents expressed that workload and stress were oppressive. Overwhelming paperwork, demanding schedules (shift work, long hours, too many overtime hours), intense work, and the hard physical labor of nursing seemed unmanageable, especially for nurses in their mid to late careers.

COMPENSATION AND BENEFITS ($n = 651$): As a category, compensation and benefits were the second most mentioned dis-satisfier. This category encompassed salary (the Number 1 single dis-satisfier), benefits, retirement, payment practices (mostly related to overtime), and salary compression. Resentment was expressed regarding higher salaries for registry and sign-on bonuses for new staff. Some respondents perceived that much more employer effort was spent on recruitment than on retention.

ISSUES IN THE PROFESSION ($n = 437$): These included comments about lack of professionalism, working with unlicensed assistive personnel, and scope of practice issues.

RELATIONSHIPS ($n = 424$): Respondents expressed distress regarding relationships among co-workers and with physicians, managers, and administrators. Codes included in this concept appeared to elicit the most affect. For example, "lack of respect," "loss of dignity," "hostile work environment," "no voice," and "feeling used."

STAFFING AND CARE DELIVERY ($n = 342$): Inadequate staffing was the second most cited single dis-satisfier and was part of this category. Other examples within this category include "delegation of duties," "nurses diverted to nonnursing tasks," "poorly trained CNAs/aides," and "replacement of RNs with less qualified staff."

EMPLOYER PRACTICES ($n = 303$): Thirty-six employer practices (unrelated to compensation/benefits and inadequate staffing) were identified as dis-satisfiers. Examples include "forced floating to areas not qualified for," "bureaucracy," "guilt inducements to work overtime," "mandatory overtime," and "12-hour shifts."

EDUCATION ($n = 138$): A high degree of dissatisfaction was expressed regarding availability and format of both continuing education (noncredit) offerings and degree advancement. Cost, lack of tuition/workshop fee benefits, and accessibility were the major dis-satisfiers regarding education.

Solutions

The solutions field (Item 40: Solutions) of the survey yielded very few innovations. Respondents repeated their grievance, expounded upon it, or offered no solution. The Top 10 solutions offered by respondents are displayed in Table 7.

Code	Frequency
1. Tuition/workshop funding	28
2. Unionization	27
3. Acuity, not ratios	26
4. Computerized documentation	17
5. Refresher courses	13
6. Mandated RN: Pt ratios	10
7. Zero tolerance policy (disrespect, abuse)	6

8. Tax support of salaries	5
9. Recruitment-into-the-profession incentives	5
10. Mandatory CE	3

Six main categories related to solutions were extracted from the data.

EXTERNAL CONTROLS ($n = 77$): While some respondents demanded mandated RN: Pt ratios ($n = 10$), others insisted that ratios were counterproductive. Rather, 26 respondents called for staffing “by acuity rather than by numbers of patients.” Unionization, increased regulatory monitoring, and mandatory CE are examples of external controls proposed to improve working conditions.

FINANCIAL INCENTIVES ($n = 55$): Solutions here revolve around improved salary, benefits, and retirement packages. Some suggested shifting recruitment bonuses to retention bonuses in recognition of longevity and performance. Several proposed that nurses should receive tax credits for working in clinical areas.

EDUCATION SOLUTIONS ($n = 38$): These comments ranged from improving nursing candidate qualifications to examining entry into practice issues (some argued for BSN, others for ADN). Also included here were calls for leadership development of supervisors and administrators.

STREAMLINING WORK ($n = 20$): Some proposed that more cross-training among staff would help improve teamwork, while others wanted more support staff to deal with nonnursing work. Computerized documentation was seen as a solution to deal with paperwork and repetitive documentation.

INTERNAL CONTROLS ($n = 12$): These solutions included improving personal responsibility, recognizing one's value, participating in support groups and communication facilitation meetings, as well as participating in a “think tank” to improve conditions.

MANAGEMENT BEHAVIOR ($n = 9$): Respondents suggested that supervisors and administrators should focus on improved leadership, constructive coaching (rather than focusing exclusively on negatives), and communicating the value of employees.

Return to Work

The intent of this item was to retrieve ideas about what would bring nurses back into the healthcare arena. The most frequent response to this question had to do with respondents' reasons for not returning. The “when hell freezes over” code ($n = 22$) captured those individuals who were quite adamant that they would never return to nursing. Other **IMPLACABLE BARRIERS** include illness, family obligations, and safety concerns.

Responses that expressed some willingness to return to nursing were categorized into four main categories: **CARE DELIVERY MECHANISM**, **EDUCATION/RETRAINING**, **EMPLOYMENT ISSUES**, and **WORK ENVIRONMENT**. These ideas mirrored solutions

offered by nurses working in the field and did not yield significantly different insights.

Study Conclusions

It should be emphasized that the data discussed in this brief report are from 2001 and mostly from nurses in nonhospital settings. In this sample at that time, the category of workload and stress was the Number 1 concern, closely followed by compensation and benefits. It should be noted, however, that "poor salaries" was the most often cited, single issue in this sample. It is unknown if the issues identified by respondents 4 years ago have improved, worsened, or remained the same. The strength of this study lies in the methodology and holds promise for the future. A survey conducted by the Board of Nursing, not one's employer, may result in information that is unencumbered by concerns for one's confidentiality or negative repercussions.

Reference

Ryan, G. W., & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 769-802). Thousand Oaks, CA: Sage.