

The Self-described Experience Of Coping And Adaptation Associated With Workplace Stress Of Registered Nurses In The Acute Care Setting In Florida: An Ethnographic Study

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THE SELF-DESCRIBED EXPERIENCE OF COPING AND ADAPTATION ASSOCIATED
WITH WORKPLACE STRESS OF REGISTERED NURSES IN THE ACUTE CARE
SETTING IN FLORIDA: AN ETHNOGRAPHIC STUDY

by

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A dissertation submitted in partial fulfillment of the requirements
for the degree Doctor of Philosophy
in the College of Nursing
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ABSTRACT

Little is known about how nurses learn and use coping and adaptation skills in the workplace. Quantitative studies have identified the factors, nature, and outcomes of nursing stress. However, qualitative studies describing the human experience associated with workplace stress are lacking. The phenomenon of interest for this study using focused ethnographic method is the self-described experience of coping and adaptation associated with workplace stress of registered nurses working 12-hour shifts employed in acute care hospital facilities in east central and central Florida. Three aspects of the phenomena were examined: the self-described experiences of stress, the manner in which coping skills are acquired, and the manner in which adaptation strategies are developed by experienced bedside nursing working 12-hour shifts in acute care hospital facilities. The purposive sample included nine female bedside nurses with five or more years' experience, working 12 hour shifts in acute care hospital facilities on bedside units, with patient ratios of 4:1 or greater. Data were collected using semi-structured, digitally recorded interviews at mutually convenient locations. The qualitative data were analyzed using inductive, constant, comparative process of coding, sorting, generalizing, and memoing to guide exploration and identify emergent themes and patterns. The predominant theme of stress emerged as the overwhelming sense of duty to the patient. Additional themes of coping and adaptation were noted. Recommendations for research, education, practice and policy are offered to support a healthy and sustainable nursing workforce.

This dissertation is dedicated to my Grandpa Tom who believed in the power of education, to my Grandma Susie, my husband Glen, my parents Ed and Gloria Phalen, my siblings and their families, to my devoted four-legged companions past and those ever present for this work:

Maggie, Mario, Maya, and Micki

Thank you for setting sparks, fanning fires, and bearing the heat that is the love and light I call life.

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CHAPTER I: THE PROBLEM

Introduction

Nursing is a stressful profession. The ability of nurses to cope and adapt impacts the physical, emotional, and financial health and welfare of the nursing profession, healthcare organizations, and the public they serve (Adams & Bond, 2000; Buerhaus et al., 2005; Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2006; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Shaver & Lacey, 2003; Wheelan, Burhill, & Tilin, 2003). The healthcare work place is consistently described as a challenging physical and emotional environment where nurses are charged with maintaining balance and caring for others. Workplace stress, an internationally recognized issue, has been implicated in the current world wide nursing shortage (Lambert et al., 2004; Li & Lambert, 2008), the phenomena of burnout (Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001; Taylor & Barling, 2004), horizontal violence and poor interpersonal relationships (Farrell, 1997a; McKenna, Smith, Poole, & Coverdale, 2003; Rowe & Sherlock, 2005). Workforce health, absenteeism, job satisfaction, intent to leave, and turnover have been linked to workplace stress (Callaghan, Tak-Ying, Wyatt, & Callaghan, 2000; Chang et al., 2007; Lambert, et al., 2004; Li & Lambert, 2008; McGrath, Reid, & Boore, 2003). Quantitative research has identified the factors associated with stress in nursing. Focused ethnography, the ideal qualitative method for examining a limited topic within a familiar culture, was used to explore the self-described experience of coping and adaptation associated with workplace stress of experienced registered nurses working 12-hour shifts employed in acute care hospital facilities.

Background

Stress has a direct link to declines in wellbeing and has been labeled the disease of modern man (Wein, 2000). Stress in the nursing workplace has considerable influence on health, job satisfaction and performance (Buerhaus, et al., 2005; Jarrin, 2006; Murphy, 2004; NIOSH, 2008). The National Institute for Occupational Safety and Health (NIOSH) identifies healthcare occupations among the highest for mental health hospital admissions and at greater risk than other occupations for substance abuse, suicide, depression, and anxiety related to stress in the workplace. A familiar list of factors associated with stress appears in the NIOSH data: understaffing, role conflict, inadequate resources, unfamiliar work areas, excess noise, lack of control, lack of administrative rewards, shift work, underuse of talent, and exposures to toxins and disease (NIOSH, 1998, 2008).

The effects of workplace stress directly influence the health of the nursing workforce and costs to individuals and institutions. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) reports growing patient acuities and the day to day demands on the nursing workforce is increasing and contributes to the nursing shortage (HRSA, 2010). Although the current economic turndown has reduced nursing turnover, healthcare administrators still face the steady depletion of the nursing employment pool, and must confront expensive recruitment and retention challenges. The 2011 total cost of an RN, including salary (based on a \$45/hour wage), insurances, recruitment and non-productivity time was reported as \$98,000.00 per year (KPMG Healthcare & Pharmaceutical Institute [KPMG], 2011). The cost of nursing personnel turnover varies with locale and the turnover cost formula used (Jones & Gates, 2007). Estimates range from 1-2% of salary to dollar figures of \$10,000 to \$67,000 per nurse depending upon region, role, and specialty, (Hayhurst, Saylor, & Stuenkel,

2005; HSM Group Ltd., 2002; Jones, 2005; Jones & Gates, 2007; KPMG, 2011; McConnell, 1999). In 2011, the reported average turnover rate for 82% of U.S. hospitals was 14%; average RN recruitment takes 37 days in addition to about 28 days of orientation (KPMG, 2011). This figure is down from 21% reported in 2002, but remains a costly statistic responsible for loss of productivity, longer wait times, admission restrictions, and degraded quality of care (HSM Group Ltd., 2002; KPMG, 2011). Other factors implicated are burnout, a predictor and consequence of poor job satisfaction (Kalliath & Morris, 2002) and horizontal violence, also called bullying. Curbing healthcare costs, absenteeism, illness and injury is in the best interest of every industry, but understanding workplace stress, effective coping and adaptation for the purposes of intervention and education is essential for the well-being of nurses, patients, the nursing profession, and the healthcare system.

Purpose of the Study

The purpose of this focused ethnographic study was to explore the self-described experience of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12-hour shifts employed in acute care hospital facilities. Personal experience as a hospital-based nurse, a nurse educator, and as an observer of bedside nursing lead to the overarching question: what coping strategies are being used by experienced bedside nurses in response to workplace stressors?

Phenomena of Interest

1. Explore the self-described experiences of stress experienced by bedside registered nurses working 12-hour shifts in acute care hospital facilities.

2. Explore the manner in which coping skills are acquired by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.
3. Explore the manner in which adaptation strategies are developed by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.

Assumptions

These general assumptions guided this study:

- All participants will respond honestly.
- Nursing is a high stress occupation.
- Coping involves an individual adaptation response to actual or perceived stress.
- Nursing practice in an acute care setting is guided by standardized policies and procedures.

Evolution of the Study

Rationale

The stakeholders affected by stress, coping, and adaptation of registered nurses in the workplace run the gamut from the vulnerable newborn in a neo-natal intensive care unit to massive government and healthcare regulatory agencies. From a top down perspective the United States federal government is maintaining data and reporting national projections for the nursing shortage, examining workforce health issues, and making recommendations for controlling occupational stress (Centers for Disease Control and Prevention [CDC], 2003; HRSA, 2007; NIOSH, 1998, 2008; Occupational Safety and Health Administration [OSHA], n.d.). Although stress has been linked to declines in mental and physical health, it is not considered a serious

workplace hazard and remains unregulated by the United States Department of Labor Occupational Safety and Health Administration (OSHA) and the Occupational Safety and Health Act of 1970. OSHA has published recommendations for reducing employee stress, but it is an issue of self-regulation, not enforcement.

The Robert Wood Johnson Foundation, American Nurses Association (ANA), American Hospital Association, The Commonwealth Fund, and the Joint Commission have issued briefs, papers, and recommendations for changes in healthcare to address the interdependent situations created by the nursing shortage, working conditions, and healthcare delivery (Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2002; Keenan, 2003; NPR/Robert Wood Johnson Foundation/Harvard School of Public Health, 2012; The Joint Commission [TJC], 2008). The Joint Commission, an independent nonprofit organization that sets standards for healthcare agencies, has stepped forward by introducing staffing standards to reduce documentation burdens and improve nursing care. In addition, TJC has made specific recommendations for changes in hospital culture and design aimed at improving the work environment, and the safety and quality of healthcare. On the state level, the Florida Center for Nursing (FCN) monitors the workforce, maintains data, and makes recommendations to the legislature for policy making, funding, the Board of Nursing, and the nursing education system (FCN, 2007, 2008, 2012a). Gaining a deeper understanding of coping and adaptation associated with workplace stress of registered nurses may lead to changes in policy, healthcare, and workforce issues.

Historical Context

Research of stress, coping, and adaptation in the population of registered nurses (RNs) addresses specific nursing specialty groups primarily, using quantitative methodologies. Qualitative studies of stress and coping are extremely limited. Work environment, staffing, and workload are consistently identified as primary sources of nursing workplace stress (Bianchi, 2004; Foxall, Zimmerman, Standley, & Bene, 1990; Lambert, et al., 2004; Lim, Hepworth, & Bogossian, 2011; Murphy, 2004). Also noted are wages, time demands, frequent recurrent changes, (McGrath, et al., 2003; Verhaeghe, Vlerick, Gemmel, Maele, & Backer, 2006), dealing with ethical issues, death and dying (Corley, Minick, Elswick, & Jacobs, 2005; Foxall, et al., 1990; Lambert, et al., 2004; Zuzelo, 2007), interpersonal and professional relationships (Duddle & Boughton, 2007; Lim, et al., 2011; Murphy, 2004; Taylor, 2001), and job security, (Callaghan, et al., 2000). Sources of workplace stress identified in the early literature have not changed, and newly identified stressors add to a growing list.

Experiential Context

Interest in the culture of nursing began before this researcher entered the nursing workforce. As a radiographic technologist, I observed nurses multitasking while attending to the needs of patients and families. Nurses managed their responsibility, multiple patients, and complicated tasks, with organization, understanding, and compassion. How did they do it? Curiosity collided with opportunity; upon graduation in 1991 from an Associate's degree program in Nursing, this researcher was able to experience the challenges of nursing first hand. Eighteen years later, with a 26 year background in healthcare, including emergency nursing and nursing education, opportunity presented to return to hospital bedside nursing. Although hospital

nursing was familiar, I quickly became aware of the intense stress of bedside nursing in today's healthcare environment and readily identified phenomena I had been examining in my doctoral course work: reality shock, horizontal violence, and moral distress. Fellow nurses struggled to complete care and tasks within the confines of a 12-hour day. Registered nurses, new to the profession, spoke openly of disappointment in working conditions, lack of professional respect, unrealistic expectations, and job stress. Experienced nurses moved more smoothly through the day, but at times became overwhelmed, overtired, and frustrated.

These observations were not mine alone. Repeatedly patients, family members, doctors, ancillary personnel, hospital management and administrators asked, "how you do it?" Reflecting on my understanding of nursing, I began to look at those nurses with the most experience and wonder about the skills they used to adapt to the work environment. The research question for this proposed study formed while seeking to understand the experiences of coping and adaptation associated with workplace stress of my registered nurse peers.

Using focused ethnographic methodology, this study explored the self-described experience of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12-hour shifts employed in acute care hospital facilities. The findings have the potential to contribute to the body of nursing knowledge and professional practice. A greater understanding of coping and adaptation associated with workplace stress may better prepare nursing students during transition-to-practice (TTP), assist administrators in planning and modifying work place environments, and bolster strategies to retain nurses in the work force.

Importance and Knowledge Acquisition

Stress, as a nursing workplace issue, contributes to poor job satisfaction, intent to leave and turnover, burnout, horizontal violence, the costs associated with declines in physical and emotional health, and the nursing shortage (HRSA, 2010; Kovner, et al., 2006; NIOSH, 2008; Stacciarini & Troccoli, 2004; Verhaeghe, et al., 2006). Healthcare systems and policy makers worldwide are facing the challenges of the current nursing shortage and acting to stabilize and reverse this trend. The importation of nurses from other countries is not an adequate solution in the light of global scarcity. The tradition of “throwing money at the problem” is not working, and salaries and benefits are threatened by economic constraints. Federal policy developers responded with the Nurse Reinvestment Act of 2002, an amendment to the Public Health Services Act (Title VIII), allocating financial resources to promote nursing education and diversity. The economic downturn which began in 2007 has strained the federal budget (Isidore, 2008). Nursing organizations such as the American Nurses Association (ANA) must proactively fight for Title VIII funding for nursing workforce development (Gonzales, 2011; "Nurse Reinvestment Act," 2002).

Nurses are the largest employee segment in the United States (U.S.) healthcare workforce (Institute of Medicine [IOM], 2010). The United States Department of Health and Human Services (HHS) projects that while numbers of nurses continue to rise, this will quickly be outstripped by demand associated with projected U.S. population growth and an increase in consumers over the age of 65 (National Advisory Council on Nurse Education and Practice [NACNEP], 2010). The literature identifies factors that contribute to the nursing stress. This examination of coping and adaptation associated with stress in the nursing workplace presents a greater understanding of how experienced nurses learn to cope and adapt with implications for

nursing practice, education, research, and policy. An understanding of coping and adaptation skill development identified by experienced bedside nurses may encourage incorporation of skill building activity into the work place and nursing curricula. Skill building may lessen the impact of workplace stress helping to stabilize and strengthen the workforce.

Summary

Four additional chapters are presented in the remainder of this dissertation. Chapter II contains a review of the literature addressing nursing workplace stress, coping, and adaptation; supportive literature, and an overview of the ethnographic method. Chapter III addresses the specifics of the focused ethnographic method, and key concepts. Chapter IV contains an overview of the participants and the findings related to the three research questions. Chapter V presents a discussion of participant attributes, the findings in relation to each research question and the literature, implications for nursing, healthcare policy, recommendations for future research, study limitations, and conclusions.

CHAPTER II: REVIEW OF THE RELEVANT LITERATURE

Work place stressors are generally perceived as negative and threatening. Destructive stress results in mental and physical symptoms, burnout, and professional decay. Eustress, the positive stress that challenges, encourages creativity, and promotes personal and professional growth, is rarely examined and has been found to be readily overpowered by distress (Verhaeghe, et al., 2006). Coping is generally addressed as the oppositional force to stress and adaptation is the positive outcome of the coping process. Influences on stress and coping in nursing include forces in the workplace, nursing experience, and co-worker relationships.

Content of this chapter presents a general overview of the literature related to stress and coping research, supportive literature, and an overview of ethnographic methodology. The chapter concludes with a summary of knowledge and overview of how this study addresses the gaps in the research.

Review and Evaluation of the Literature

Stress in nursing has been studied extensively using quantitative methods worldwide. Internationally, research participants are principally female, married, and range in age from 21 to 55 years old, with various levels of experience in nursing and in specialty areas. The Nursing Stress Scale, (Chang, et al., 2007; Foxall, et al., 1990; Li & Lambert, 2008), The Ways of Coping Questionnaire (WOCQ) (Bianchi, 2004; Hays, All, Mannahan, Cuaderes, & Wallace, 2006; Lambert, et al., 2004), and the Maslach Burnout Inventory (MBI) (McGrath, et al., 2003), are the tools used most often to provide frequency and intensity ratings of standardized items associated with stress and coping. Research populations include nursing students and members of high stress nursing specialties, principally intensive care and mental health (Cole, Slocumb, &

Mastey, 2001; Edwards & Burnard, 2003; Farrell, 1997b; Foxall, et al., 1990; Hays, et al., 2006; Taylor & Barling, 2004; Timmins & Nicholl, 2005; Tully, 2004).

Fewer studies focus on the generalist or medical-surgical bedside nurse, although research with organizational implications addresses this population. Mark, Salyer, and Wan (2003), examined professional nursing practice in a population of medical-surgical nurses (n=1682). Organizational structure and outcome elements commonly associated with stress in the workplace: autonomy, collaborative relationships with physicians, work satisfaction, and nursing turnover, were included in this multilevel causal model study. Although stress was not directly addressed, findings support the implementation of smaller units and adequate support services to enhance nursing professional practice. Andrews and Wan (2009) in an exploratory cross-sectional survey of staff nurses (n = 308) studied the relationship of job strain, coping behaviors, professional practice, and propensity to leave. Significant in the findings is the relationship between poor mental and physical health, as influenced by coping behaviors and the practice environment, with decreased job satisfaction and increased intent to leave.

The definitions of stress, coping, and adaptation vary based on use, situation, and discipline. Concept analysis has failed to provide a meaningful consensus for either stress or coping. What is agreed upon is that stress defines a situation to be coped with (Keil, 2004). Stress, as a concept, originated in the discipline of physics to describe the impact of force and load on a object and ability to withstand those forces (“Physics,” 2008). This definition also applies to stress experienced by human beings attempting to withstand the pressure of external and/or environmental forces on person and psyche (Keil, 2004; Seaward, 2006). Stress is aligned with destructive forces, acting upon an individual within the emotional realm, manifested by

anger, fear, and anxiety (Keil, 2004). The attributes of stress include situation dependency, individualization, and a threat to homeostasis that initiates the coping process.

Coping is aligned with management, control, and success, and has been defined as both a trait and/or a process (Keil, 2004). In common usage coping is defined as the ability to deal with or meet successfully (Read, 1978). The greater and more meaningful the threat or stressor, the greater the significance of controlling the outcome (Folkman, 1984).

Biological science defines adaptation as conformation to changes in the environment, and in physiology as change in response to repeated stimuli. Adaptation defines the ability to adjust to requirements and a return to a homeostatic state. Adaptation is bordered by hardiness as related to health, and resilience (Jacelon, 1997; Richardson, 2002). In the literature, the terms of resilience and hardiness may be used interchangeably. The concept of resilience from a physiologic and psychological perspective is related to the ability to withstand stress, to mobilize coping resources, and emerge from adversity in an improved state (Tusaie & Dyer, 2004). The personal stress resiliency of RNs has been associated with improved job performance, job satisfaction, and intent to stay (Larrabee et al., 2010). It has been suggested that personal coping and resilience can be developed and strengthened through targeted educational programs (Andrews & Wan, 2009; Jackson, Firtko, & Edenborough, 2007).

Stress Research

Using a quantitative study design, Foxall, et al., (1990) examined, compared and contrasted, the sources and frequency of job stress perceived by nurses in three practice areas: intensive care (ICU), hospice, and medical-surgical. The Nursing Stress Scale (Peeters, de Jonge, Janssen, & van der Linden, 2004), which identifies eight stress subscales: physician relationship,

emotional demands/uncertainty, communication on the unit, patient aggression, overload, death, floating, and supervision was distributed to 250 RNs with a return rate of 55% (ICU n=35, hospice n=30, medical/surgical n=73). Stress was identified as statistically significant ($p < 0.05$) in all specialties although ratings and rankings differed. ICU and hospice nurses ranked death/dying highest, while medical-surgical nurses identified overload/staffing as the primary stressor in rank ordering. Although limited by a single time point data collection, this study supports the premise that stress is not unique across disciplines. In a meta-analysis of nursing workplace stress, McVicar (2003) concludes despite discrete differences among nursing specialties which warrant discrimination, on the whole, all nursing is stressful.

Hallin and Danileson (2007) described the experience of RNs, (n=15) six years post baccalaureate graduation. Findings reveal the perception of excessive demands on time, self, and workload creates patterns of control in an effort to maintain balance between stimulation and stress, difficulty managing and prioritizing workload, and impeded teamwork. Consulting with colleagues in conversation and the rewards of patient care were ineffective compensating mechanisms. Teamwork, a core value of nursing, is impeded by work overload and interpersonal conflict (Jex & Thomas, 2003). Patient outcomes have been linked directly to the strength of team cohesion (Wheelan, et al., 2003).

A growing body of stress and coping research is emerging from Eastern and Asian countries. This demographic provides new information and validation of earlier studies undertaken in the West. The findings are especially significant when taking into consideration the culturally bound concepts of teamwork, cooperation, group harmony, and a reticence to discuss feelings and beliefs, (Li & Lambert, 2008). Callaghan, Tak-Ying, Wyatt, and Callaghan (2000) used the Anxiety Stress Questionnaire (ASQ), which addresses three subscales: job

induced tension, somatic tension, and general fatigue, to study stressful influences on Chinese nurses in Hong Kong (n=168). The study identified workload, relationships, and administration as major sources of stress. Coping mechanisms included cognitive avoidance, family support and friendships outside of the work environment. Li and Lambert (2008) also found workload to be the primary stressor (mean 11.0, SD =/- 3.72 range 4-18) in a survey study of stress, coping, and job satisfaction among Chinese ICU nurses (n = 102). In this study, the higher education of younger nurses positively correlated to the coping styles of planning and self-blame. The researchers propose that the younger age of higher educated nurses may account for this relationship.

Lim, Hepworth and Bogossian (2011) examined stress, uplifts, and coping in the personal and professional lives of Singapore nurses (n=23) using e-mail interviews in a qualitative descriptive study. Three themes of stress emerged from the findings: time pressures, nature of nursing work, and multiple roles. These were countered by patient improvement, emotional support, and drawing upon personal beliefs. The use of e-mail interviews is a unique feature of this study.

Coping Research

Although similar stress factors exist across a broad spectrum of nurses, the research identifies a variety of coping strategies. Positive reappraisal is a significant emotion focused coping mechanism in nursing populations (Bianchi, 2004). To achieve temporary emotional relief, an individual translates a stressor from threat to non-threat status. Emotion focused coping is ineffective in the long run, but may be the best or only choice when problem solving efforts are ineffective or little situational control is possible (Lazarus, 1993). Murphy (2004) used semi-

structured interviews to examine the experience of stress and coping in nephrology nurses (n=10) from Northern Ireland with a mean of 15 years nursing experience. Along with the familiar list of workplace stressors, the participants self-disclosed negative coping mechanisms such as smoking and drinking along with the benign activities of reading, friendships, sports, and humor. Macintosh (2007) explored the daily experience of surgical nurses (n=16) using a descriptive qualitative approach. Three themes of coping emerged from analysis: relationships with patients, being a person, which involved separation of work and personal self, and the influence of personal experience. The development of a previously unidentified work persona is significant in these findings.

The outcome of ineffective coping and unresolved job stress is the negative psychological state known universally as burnout. This phenomenon contributes to poor workforce retention, loss from the profession, and horizontal violence or bullying (Buerhaus, et al., 2006; Dunn, 2003; Farrell, 1997a; Pugh, 2006; Taylor, 2001). The original concept, initiated by a genuine social issue, focused on the provider-recipient relationship in the helping professions. Burnout is defined as a condition of emotional exhaustion, depersonalization, detachment, frustration, and the loss of a sense of personal accomplishment (Gillespie & Kermode, 2003; Maslach, 2003; Maslach, et al., 2001). The dimension of exhaustion identifies the individual basic stress response; this exhaustion leads to depersonalization. Three dimensions are the key identifiers: emotional fatigue, loss of passion for one's job and self-inefficacy. Maslach (2003) highlights the significance of the traditional triad of burnout being greater in depth and scope of definition when compared to one-dimensional concepts of stress. The theme of conflict in the relationship between person and the work environment is consistent with the theoretic constructs of stress and coping defined by Folkman and Lazarus (1985). Distancing and cynicism are the primary

coping mechanisms of burnout. The personal outcome is inefficacy and loss of accomplishment. McGrath, Reid, and Boore (2003) studied occupational stress in a random sample of staff nurses in Northern Ireland (n=171) using the MBI and General Health Questionnaire. The most significant finding was the prevalence of coping by means of avoidance behaviors. Coping by avoidance is symptomatic of burnout, reflects nursing as an action with purely physical objectives, and conflicts with a holistic patient centered care model of nursing (Cody, 1999).

Horizontal violence is a form of inappropriate coping, which manifests as workplace hostility characterized by power wielding and poor interpersonal relationships. It may be displayed between nurses, as rude, abusive, critical language and hurtful humor. McKenna et. al., (2003) identified supervisors as one of the greatest sources of abuse, either overtly or by ignoring complaints. Horizontal violence is associated with absenteeism, poor team work, the cycle of decreased job satisfaction, turnover and loss to the profession (Buerhaus, et al., 2006; Sofield & Salmond, 2003; Taylor & Barling, 2004). At its worst, horizontal violence extends from the nurse to the client in the form of verbal abuse and poor quality of care.

Supportive Literature

Nursing Experience

A nurse's personal experience influences both approach to practice and situational perspective. Benner (2001) described five levels of skill acquisition in a model of nursing practice, from novice to expert, based on situational performance and outcomes. Proficient and expert define the upper most levels of clinical expertise and knowledge. The proficient nurse uses past experience to understand patient situations beyond rules and tasking, and is able to set and meet patient driven goals. Proficient practice is organized, holistic, flexible, and clinically

competent. The expert nurse is at the highest level of nursing skill. The expert nurse uses knowledge and skills based on personal experiential learning that transcend formal models and forecasts. It is at this level the use of clinical judgment described as nursing intuition was identified by Benner. The expert nurse understands the language and nuances of practice, is focused, discriminating, and straightforward in decision making and action. It is the expert nurse who functions with responsive flexibility in demanding situations (Benner, 2001, p. 193). Expertise, according to Benner, is related to situation and not directly related to seniority. Nurses with three to five years' experience in a nursing area likely have attained proficient to expert knowledge (Benner, 2001, pp. 27-29).

Nursing Socialization

In 1974 Kramer published *Reality Shock: Why Nurses Leave Nursing*. This seminal work summarizes eight years of study into the phenomena described as reality shock; the "total social, physical, and emotional response" to the discrepancy between the "perceived and actual reality" of the nursing work world (Kramer, 1974, p. 3). The study focuses on the experience of the BSN graduate, and the conflict between the values engrained in nursing school and those encountered in the workplace. This disequilibrium is equally applicable to the workload stress experiences described in the current literature (Gelsema, van der Doef, Maes, Akerboom, & Verhoeven, 2005; Hallin & Danielson, 2007; Lambert & Lambert, 2008; McGrath, et al., 2003). The conflict between the realities of the work environment and differing views of good nursing, leads to dissatisfaction, turnover, and loss to the profession.

Magnet Designation

An overview of Magnet® hospital status could provide insights for examining influences on stress, coping, and adaptation in the nursing workplace. Magnet Recognition® signifies a health care organization has made a commitment to nursing excellence by meeting the nationally acknowledged standards established by the American Nurses Credentialing Center (ANCC). Magnet® designation has been deemed the gold standard of nursing excellence nationally and internationally. In 1983, fourteen positive characteristics associated with professional nursing work environments were identified and became known collectively as “The Forces of Magnetism™” (American Nurses Credentialing Center [ANCC], 2012a). In 2008, a new Magnet Model® was presented by the ANCC. The original 14 forces were incorporated into five model components: Transformational Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge, Innovations and Improvements, and Empirical Quality Outcomes. Focus changed from one of structure and process to one of outcomes (ANCC, 2012b) Magnet® status is associated with the terms "excellence" and "autonomy," improved staff recruitment and retention, positive patient outcomes, and effective marketing and public relations programs (ANCC, 2012a; Brady-Schwartz, 2005; Drenkard, 2010; Upenieks, 2003). The Magnet Recognition Program® encourages decentralized nurse empowered environments which encourage role development, professional practice models, community involvement, and value recognition for nurses. Programs of research and innovation for the delivery of safe, evidence based care are a requirement for Magnet® designation. Achievement of Magnet® recognition is a rigorous and costly process, but the return on investment in time and dollars may be worthy of the effort. Drenkard (2010) estimates the outlay of \$46,000 to \$251,000 for a 500 bed hospital may produce an overall financial return of \$2,308,350 to \$2,323,350.

Evidence supports the initial positive impact on nurse retention and overall job satisfaction, but new research indicates that maintenance may be more challenging than anticipated (Brady-Schwartz, 2005; Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2007; Upenieks, 2003; Wolf & Greenhouse, 2006). In a survey of nurses (n=1,169) at six University of Pittsburgh Medical Center hospitals, Wolf and Greenhouse (2006) concluded that overall staff response to magnet status has been positive, although the impact of “forces of magnetism” may be unit specific. Researchers have noted that managers and staff employed at institutions with Magnet® recognition and pre-designation status may experience increased work responsibilities. This creates a situation which may interfere with effective research efforts addressing Magnet® effects (Brady-Schwartz, 2005; Upenieks, 2003; Wolf & Greenhouse, 2006). Upenieks conducted a mixed method comparison study of nursing staff and leadership at two Magnet and two non-magnet hospitals to examine levels of job satisfaction and empowerment using a convenience sample of clinical nurses (n=305) and nurse leaders (n=16). Magnet® hospital staff returned 44% of the questionnaires compared to the 47% return from non-Magnet® organizations. Scoring on the Nursing Work Index revised (NWI-R) and Conditions of Work Effectiveness Questionnaire revised (CWEQ-II) indicate job satisfaction and empowerment to be greater at Magnet hospitals ($P<.001$). It is noteworthy that nurses in both environments indicated that there was insufficient time and resources to provide quality patient care. Although Magnet hospitals consistently rate higher in job satisfaction surveys, rating may degrade over time as institutions struggle to maintain the momentum of the process of magnetism (Ulrich, et al., 2007).

Ethnography

The methodological focus of ethnography used in this research studies cultural patterns, shared meanings, rituals, beliefs, and semantics to identify and document processes and problems (LeComptee & Schensul, 1999; Morse & Field, 1995; Polit & Beck, 2004; Richards & Morse, 2007). The hallmarks of ethnography include research, holistic in nature, conducted in the natural setting or field addressing emic and etic perspectives and an understanding of the overall interaction of events, encounters, and situations. Ethnographers ask the question “what’s happening” to open the possibility of discovering patterns of behavior and culture.

Background

Philosophically, ethnographers strive to achieve the emic perspective, the view from within the culture, while discovering the tacit knowledge (core beliefs) of that culture. Savage (2006) touches upon the influence of the Chicago School, the pragmatic philosophical grounding of sociological study, based at the University of Chicago in the beginning of the 20th century. Essentially the pragmatism of Dewey, Mead, and later James, focused on practicality and “rejection of the dualism between mind and matter, subject and object, knowledge and things known” (Bulmer, 1984, p. 29; Rogers, 2005). Different forms of ethnography, (naturalist, realist, feminist, holistic, cognitive, topic or hypothesis oriented, for example) are based in various understandings of epistemology and ontology, knowledge and power, identity and interests (Munhall, 2007; Savage, 2006). Generally, the philosophical grounding of ethnography is dependent upon the discipline and the researcher. An essential dimension in traditional ethnography is that the study be conducted within the naturalistic setting of the culture, using multiple data gathering methods, to learn from, as well as about the culture (Savage, 2006).

Traditional Ethnography

In general, all ethnographers explore from the perspective of the members of the target culture. By asking the question “what’s happening” the ethnographer addresses the possibility of discovering recurrent patterns of behavior and belief. Examination of the phenomenon of interest occurs in four defined but uncontrolled phases since fieldwork by nature, may be unpredictable. The phases of traditional ethnography include: entry into the culture, observations and informal conversation, cooperation and acceptance (productive data making), and withdrawal (analysis).

Data are made using researcher experiences, insights, observed facts, and multiple data gathering strategies, including participant observation, field notes, narratives, and journals. These investigative strategies provide the means to learn about the culture (Munhall, 2007; Savage, 2006). The goal is a rich detailed description and analysis of the culture (Richards & Morse, 2007). This description of traditional or conventional ethnography is provided for clarity.

Focused ethnography is described in Chapter III: Methods.

Summary

Nursing is a care giving profession, where the primacy of patient care guides nurses to attend to other’s needs, and deal with stress that may overwhelm personal and informal coping methods (Andrews & Wan, 2008; Jarrin, 2006; Taylor, 2001). The literature indicates stress, coping, and the associated phenomena, are well researched using quantitative methods.

Researchers have identified the global presence of stressors in the nursing workplace including but not limited to lack of autonomy, poor communication and lack of cooperation, bullying, time constraints, workload, and work environment. Intensity of perceived stress varies with unit specialty and individual coping skill. Not found in the literature were formal support systems to

bolster coping. Nursing education programs and employers do not prepare nurses to cope with the stress presented in the dynamic, demanding, modern healthcare environment. An inability to cope may result in bullying and burnout, which add to the individual and overall stress burden of the workplace. Support systems outside of the workplace have been identified as positive coping resources. Efforts to counter work place stress include enlisting the support of family and social networks, and both positive and negative endeavors to separate from the work persona. Training, support, and education to combat stress within the workplace remain essentially unaddressed and unavailable, leaving nurses to develop coping skills based on individual experience and personal nursing ethic.

Organizational efforts have focused on improvements to support recruitment and retention of the nursing workforce. Magnet Recognition® addresses autonomy and a professional practice environment but also presents new challenges in increased work and time demands in an effort to maintain certification effectively swapping one set of stressors for another.

The expert nurse is most likely past the immediate challenge of "reality shock" and exhibits the flexibility and responsiveness to the demands in the workplace that imply effective coping. Using focused ethnographic method, this study has explored the self-described experience of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12-hour shifts employed in acute care hospital facilities. This research provides a more complete understanding of coping and adaptation associated with workplace stress, addressing the knowledge gap and providing insights previously unavailable. Coping and adaption, as a nursing skill, is an important consideration when preparing nursing students for transition-to-practice, for administrative consideration in planning and modifying healthy work

environments, for workforce education programs; and for developing and retaining a stable, healthy nursing work force.

CHAPTER III: METHODS

A qualitative study design, using focused ethnographic method as identified by the disciplines of anthropology and sociology, was used to explore the experience of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12-hour shifts employed in acute care hospital facilities. This chapter provides an overview of focused ethnographic method, population and sampling, setting, and data considerations. A detailed description of procedures, including data collection and analysis are also addressed. The chapter concludes with a summary of highlights.

Identification of the Research Design: Focused Ethnography

Focused ethnography, also referred to as mini-ethnography and compressed ethnography, maintains the ethnographic assumption that meaning and interpretation can only be found within the context of culture. These qualitative studies are smaller in scale, within a shortened time frame, and focus on a specific aspect or small element of a culture that is familiar to the researcher (LeComptee & Schensul, 1999; Richards & Morse, 2007; Wolf, 2007). As a method, focused ethnography is a “family” of studies, with resemblances to each other and to traditional ethnography. A singular method or methodological authority is not followed (Knoblauch, 2005). Focused ethnography is concerned with actions, interactions, and the study of communication. Hallmarks of the method include prior knowledge, short term or no field visits, data intensity, use of technology for data collection and analysis, a focus on communication, and time intensity (Knoblauch, 2005). Focused ethnography is adaptable for contemporary, socially, culturally, and functionally differentiated groups and is found in the literature of sociology, information science, engineering, and nursing. Studies have addressed subcultures, workplace organizations and

institutions, and marketing research (Knoblauch, 2005; Richards & Morse, 2007). Unlike traditional ethnography, which is comprehensive in nature and every aspect of a culture is approached and catalogued without past knowledge, the focused ethnographer has some prior understanding of the phenomenon. This focused method compliments, rather than contradicts traditional ethnographic methods (Knoblauch, 2005; LeComptee & Schensul, 1999; Nadai & Maeder, 2005; Richards & Morse, 2007).

A combination of LeCompte and Schensul (1999) and Roper and Shapira (2000) guide the understanding of ethnographic method. This study will be framed by the interpretive paradigm of ethnographic study as described by LeCompte and Schensul (1999). Interpretivists share the cognitive-mentalist view of reality with phenomenologists, and constructivists. The interpretive paradigm is based on the construct that truths and beliefs are constructed as individuals “interact with one another over time in a specific social setting” (LeCompte & Schensul, 1999, p. 48). This truth is malleable, influenced by time and interaction. Culture is the abstract creation of the dialogue and shared interaction of individuals. There is a duality, where culture is the product of interaction and one of the situational factors, (age, gender, social, political and economic influences), that direct the actions of the population. Interpretivists are participative, observing and interacting with participants so they can tell complex and multilayered stories reflecting the voices of multiple sources. One of the goals of the ethnographic interpretive paradigm is shared understanding of behavior related to setting.

For all forms of ethnography, the general definition of “a field” is a naturalistic setting, as opposed to a clinical setting. More specific definitions of “the field” are varied and vague, and critiqued and criticized between disciplines. Focused sociological ethnography has challenged the traditional anthropologic concept of the field, and introduced “fuzzy fields” including multi-

sited, technologic, and theoretically linked groups. The value of the “single tribe approach” in modern society is challenged, and yet the need for clear identification of the locus of study to provide a framework is acknowledged (Nadai & Maeder, 2005, para 5). Therefore, in focused ethnography the researcher defines the field.

Data making is less dependent on linguistic authorship, uses technology; observation supported by technology, and may be more objective than traditional field notes. Participants are group members who may share behavior or the experience of culture without being in proximity, or having knowledge of each other, as required by traditional ethnography. Study participants “spotlight” to lead the researcher to significant features related to phenomena (Knoblauch, 2005). Data making by collecting narratives is a method used in a variety of qualitative methods and is effective for exploring phenomena that cannot be validated by observation. Data for focused ethnography may consist exclusively of interviews (Richards & Morse, 2007). Unlike narrative study which represents “the experience of the individual alone” (LeCompte & Schensul, 1999, p. 87), ethnographers use narrative to focus on culture and typify group behavior and beliefs, in keeping with ethnography’s anthropologic roots. Interviews using technologies are one of the hallmarks of this method.

As ethnography has evolved outcomes for the various subtypes have become more method precise. The outcome of focused ethnography is the “understanding of essential cultural schemas” (Hupcey, 2005, p. 217). Description, analysis, and thematic patterns emerge from the data into a descriptive, insightful, story.

Rationale

The use of qualitative methodology allows the researcher to make sense of the world in ways unavailable to quantitative researchers. Through holistic, focused and flexible methodologies, the qualitative researcher pursues topical depth and understanding. Currently much is known about the factors, nature, and outcome of stress in nursing. Little is known about how nurses learn and use coping to adapt in the workplace. Factors relating to successful workplace coping remain best examined by qualitative means.

Focused ethnography is suitable for the question “what is happening here.” Focused ethnography was appropriate for exploration of the subculture of bedside nurses in the acute care workplace, by a researcher familiar with the culture and setting. As the primary investigator (PI) and a nurse, I have the unique emic perspective required for a focused ethnographic study. My emic perspective developed over 26 years as a healthcare worker; 21 years as a registered nurse, and 18 non-concurrent years as an acute care hospital employee. For these reasons focused ethnography is deemed to be the appropriate method for exploration of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12 hour shifts employed in acute care hospital facilities in Florida.

Methodological Assumptions

The assumptions of focused ethnography grounded this study. It was assumed that culture is identifiable, learned, and shared. Language and communication are integral to focused ethnography. What people do, say, and why is framed within sociopolitical and historical content and must be understood in context to discover meaning. The researcher is capable of understanding the customs of culture under study. Results are interpreted through a cultural lens,

with a focus on community and not individuals (Garson, 2008; LeCompte & Schensul, 1999; Morse, 1994).

Methodological Limitations

Limitations of this study included threats to credibility, transferability, confirmability, and dependability. The greatest threats were participant willingness to discuss experience, “eager to please” responses, and researcher inexperience. Attempts to counter these threats to rigor included purposive sampling, interview guide, redundancy, emic perspective, member checks, analysis of contradictory data, multiple data sources, audit trail, reflexive journaling, and peer review of data and techniques.

Population and Sample

Registered nurses constitute the largest healthcare occupation in the United States. RN's are educated in standardized and/or accredited programs, and licensed for practice by individual states. The majority of registered nurses across the U.S. and in Florida are graduates of associate degree programs, followed by baccalaureate degree graduates, and a steadily decreasing number of diploma nurses. Just over 8% of RNs who work in the U.S. are internationally educated nurses (IEN). Overwhelmingly, the majority of RN's are female (93.8%), work in hospitals (62.2%), and are white-non Hispanic (83.2%). Most RN's are married (73.8%) and have children or other adults living in the home (HRSA, 2010). The national “graying” of the nursing population has stabilized primarily due to the rise in the number of employed RN's under age 30. The average age of an employed RN's in 2008 was 46 years, slightly lower than the 46.8 of 2004. The Florida Center for Nursing (FCN, 2010c, 2011) reports Florida RNs are slightly older (48.6) but have a similar profile to the national average; greater than 90% female and greater than 70.5%

white non-Hispanic. Bedside nursing is identified by standard nursing education, role expectations and responsibilities, standards of practice, state licensing, and patient, peer, and organizational expectations. Cultural artifacts include nursing tools, manner of dress, professional language and jargon. Area of practice for the purpose of this study will be the acute hospital setting. Bedside nurses are defined as licensed registered nurses employed in acute care facilities providing direct patient care. Bedside nurses often are referred to as a staff nurses (HRSA, 2010).

Benner's (2001) definition of skill acquisition as a state of clinical proficiency and understanding was used to define the nursing expertise of the participants as five years of nursing practice with three years of bedside nursing service on a single nursing unit. Nurses were asked to self-identify their level of professional expertise. At this level of mastery and experience, it was anticipated the expert nurse had experienced stress, tested coping strategies, and developed successful stress management skills. Excluded from the study were novice nurses, advanced beginners and competent skill levels identified by Benner. Recently licensed novices focus on developing skill, clinical competence, socialization, and acculturation while managing the same workload as experienced nurses (Kovner et al., 2007). This creates a situation of imbalance and stress for the novice nurse in a hospital system. Turnover for recent graduates is greater than for nurses overall. "Nearly 40% of recent graduates planned to leave their current jobs within three years" and estimates of 52% leaving first employers within two years have been reported (HRSA, 2010, p. xxxv; PricewaterhouseCoopers Institute, 2007).

Purposive sampling was used to obtain study participants which reflected the general population of acute care hospital bedside RNs from Florida (LeCompte & Schensul, 1999). Purposive sampling is used when attempting to study the same phenomena in similar settings

using multiple sites as in this study (LeCompte & Schensul, 1999). Leads provided by key informants, potential, and actual participants were used in the tradition of snowball sampling to increase sample size as guided by the study (Richards & Morse, 2007). Prior to recruitment a review of focused ethnographic studies, using narrative data collection, identified sample sizes of 5 to 22 participants (Austin, Luker, & Ronald, 2006; Fisher, 2007; Green, McSweeney, Ainley, & Bryant, 2009). The PI identified nine female participants meeting the inclusion criteria addressed in the next section. Depth of data was more significant than a designated sample size for the purposes of this research. Data making and the point of saturation, identified by redundancy, the point at which there are no new ideas, nothing new is learned, and information becomes repetitive, determined final number of study participants.

Participant Inclusion Criteria

Nine interested experienced, licensed, female RNs meeting inclusion criteria were recruited from the eastern central and central regions of Florida, U.S.A. RN peers, former students, and nurse educators were asked by the PI for referrals that met inclusion criteria. The following list identifies inclusion/exclusion criteria for the self-identified proficient or expert bedside RN participant for this research (See Form 1: Participant Inclusion/Exclusion Criteria).

Inclusion criteria:

- An unrestricted RN license to practice in the state of Florida.
- Five or more years of nursing experience.
- Hospital based bedside nurse employed for three or more years on a nursing unit for 12-hour shifts totaling 24 or more hours per week.
- Ability to read, write, and speak English fluently.

- Nurses assigned to units with a nurse/patient ratio of 1:4 or higher.

Exclusion criteria:

- Registered nurses from high acuity units with nurse/patient ratio of 1:3 or less including but not limited to intensive care (ICU), neonatal intensive care (NICU), cardiovascular intensive care (CVICU), and burn units.
- Nurses from units with transient populations including surgical services and emergency departments (ED).
- Float nurses.
- Travel nurses.

Setting

The field, as defined by the researcher, is the natural work environment for bedside nurses in Florida acute care hospitals. An acute care hospital provides inpatient medical care and other related services for surgery, acute medical conditions or injuries, usually for a short term illness or condition (HHS, 2009). Review of the literature reveals that the experience and stressors within the culture of hospital nursing are universal. Due to the potential conflicts created by access to organizations, protection of participants, anonymity, confidentiality of data, and conflicts of interest, place of employment were ruled out as a potential meeting and data collection sites (Toffoli & Rudge, 2006).

Rigor

Trustworthiness of qualitative research is dependent upon validity and reliability of the process and findings. Validity, defined as credibility, transferability, and conformability.

Reliability, also called dependability. Strategies used to insure rigor described below (see Table 1).

The first step in assuring credibility was appropriate choice of method, focused ethnography to examine the phenomenon of interest, the experience of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12-hour shifts, employed in acute care hospital facilities. Strategies used to insure credibility included an adequate purposive sample of participants, data collection to the point of redundancy, and methodological congruence. The threat of researcher bias was countered by the emic perspective of the PI, data triangulation through the use of field notes, logs, journals, and independent review by an experienced qualitative researcher. Accuracy was achieved by returning 100% of the transcripts to participants for review and additional comments, with a 44.4% return (Mackey, 2007; Tuckett, 2005). No additional comments or clarifications were received. Outliers were not identified in the data.

Insufficient data is a threat to transferability (external validity). In depth interviews, using open ended neutral questions, and data collection to redundancy offset this threat. Confirmability (descriptive validity) offset researcher bias through journaling and memo making. Other proposed strategies to insure confirmability included multiple forms of data, and the maintenance of a reliable audit trail.

The greatest threat to dependability (reliability) was researcher inexperience. Use of an interview guide reviewed by an experienced qualitative researcher, insured consistency of interview technique and data collection, and offset researcher inexperience. In addition, digital recording of face-to-face interviews and the independent examination of data and analysis by an experienced qualitative researcher promoted dependability.

Table 1: Summary of Elements of Rigor

Elements of Rigor	Threats	Strategy	Action
Credibility (Internal validity)	<p>Informant eager to please</p> <p>Unwillingness to discuss experiences</p> <p>Fears related to confidentiality or reprisals</p> <p>Researcher bias</p> <p>Inaccuracies</p>	<p>Adequate sample Purposive sample Redundancy</p> <p>Methodological congruence insures adherence to confidentiality standards</p> <p>Data Triangulation Emic perspective</p> <p>Member checks Multiple sources</p> <p>Identification of regularity and irregularity</p>	<p>Snowball sample of nine participants, based on focused ethnography literature meeting inclusion criteria. Data collection to the point of redundancy.</p> <p>Personal identifiers removed and data secured.</p> <p>Data checked across multiple sources including participant interviews, PI experience and familiarity with culture, field notes, logs, journals, and memos.</p> <p>Transcripts returned to 100% of participants to be checked for accuracy, clarity, and additional comments. 44.4% verified validated, without comments or clarifications</p> <p>Outliers retained to compare, contrast, and clarify data.</p>
Transferability (External validity)	Insufficient data	Thick description Redundancy	In depth interview, open ended neutral questions. Adequate sample size (n=9) to reach redundancy
Confirmability (Descriptive validity)	<p>Interview technique</p> <p>Researcher inexperience</p> <p>Researcher bias</p>	<p>Interview guide</p> <p>Audit trail – Log, journal, memos, transcriptions</p> <p>Reflexive journal, memos</p>	<p>Reviewed interview guide and revisions with experienced qualitative researcher</p> <p>Audit trail began at onset of research included documentation of observations, feelings, interpretations, data collection and analysis.</p> <p>Journaling began at onset of study, memos were part of data analysis</p>
Dependability (Reliability)	<p>Researcher inexperience</p> <p>Data analysis</p>	<p>Use of interview guide Peer review of data</p> <p>Analysis review by experienced qualitative researcher</p>	<p>Ensured consistency of data collection by use of single interviewer, the PI. Used interview guide. Consistency of data collection ensured using digital recording of face to face interviews. Transcription by PI, member checking, interater review, coding.</p>

Researcher Role

In preparation for this study, the primary investigator (PI) reentered the workforce as a bedside nurse, working three 12-hour shifts per week at an east coast Florida acute care hospital. As an established and participating member of this cultural group, there was a need to step back to reflect on the culture, beliefs, and behaviors. For conducting a focused ethnography, the PI took an observer/interviewer role rather than active participant role. Past and present nursing activity informed the experience of this PI.

Protection of Human Subjects

Application for authorization was made and received from the institutional review board (IRB) at the University of Central Florida (UCF) on December 21, 2010, prior to beginning this study. Removal of personal identifiers from the data addressed confidentiality to prevent participant exposure, stigma, and threats to reputation and employability. Participation was voluntary; refusal of specific questions and withdrawal was available to participants at any time without penalty. Risks were not anticipated or reported. Participants were aware that personal and professional reflection might result in discomfort and/or benefit from reflexive insights. Digitally recorded interview transcripts linked with demographic data using a numeric and date code. The original participant master list and all data, PI field notes, journals, analysis notes and additional copies maintained on a separate dedicated USB drive, were locked in a file draw in the home office of the PI when not in use. Digitally recorded interviews were erased, following transcription using HyperTRANSCRIBE software. The personal computer used exclusively by the PI for transcription and data were password protected.

Procedures

Recruiting

Prospective RN participants for this study were recruited from the current hospital nursing workforce in south, central, and eastern Florida by word of mouth and active recruiting using snowball technique. Three original key informants and electronic communication (e-mail, Facebook, and UCF list serves) resulted in ten key informants that provided 19 potential study participants over time for contact by phone, face-to-face, and electronic means. The principal investigator (PI) provided a brief overview of the study and verified inclusion eligibility verbally or electronically, and PI contact information for addressing questions or concerns. Unanticipated difficulty in recruitment resulted from trouble in finding experienced nurses who met inclusion criteria currently working at the bedside. In addition, potential participants opted out principally due to time constraints, the face-to-face interview, or reported fear of potential employer retaliation. Explanation of Research (written consent exemption), inclusion/exclusion criteria check list, and a demographic questionnaire was provided to participants at the time of interview to confirm eligibility, establish rapport, as a warm up for interview questioning, and to begin the reflective process by the participant. A \$15.00 gift card to Wal-Mart was provided to participants after completion of the interview. Recruitment continued to the point of data saturation.

Interviewing

Interview meetings lasting 50 to 120 minutes were conducted at times and locations convenient for participants in east central and central Florida. Settings were mutually agreed upon comfortable locations with minimal distractions including restaurants, coffee shops, schools, and recreational facilities chosen with consideration for confidentiality and safety.

Procedures

Data making for the proposed focused ethnographic study was restricted to interviews of participants who met inclusion criteria, observations and emic understanding. The steps of data collection and analysis occurred concurrently and in a nonlinear manner in accordance with ethnographic methodology.

- Participants met with the researcher at a mutually comfortable and agreed upon location.
- Participants received an Explanation of Research to review and retain.
- Participants completed a 15-20 item demographic questionnaire at the beginning of the interview.
- Face to face, 50-90 minute semi-structured ethnographic interviews were digitally recorded.
- The PI maintained field notes and an activity log recording impressions immediately following interviews.
- The PI evaluated and refined data making techniques based on the experience with the first two participants.
- Prior to transcription, recorded interviews were audited by the PI.
- The PI transcribed interviews verbatim using HyperTRANSCRIBE software.
- Identifiers were removed from the data and demographic data were linked to recorded interviews using a numeric and date code.
- Transcripts were reviewed by the PI and matched to digital recordings for accuracy and content.

- The digitally recorded interviews were removed from recording equipment and computer files after transcription review.
- 100% of transcripts were returned to participants by mail with self-addressed stamped envelopes for return for participant verification of accuracy, clarity, and additional comments. The PI followed up with phone or e-mail to ensure clarity and review. Four of nine (44.4%) participants validated transcript data during or after follow-up. This process of member checking insures accuracy and contributes to validity.
- Participants received \$15 gift certificates to Wal-Mart upon completion of interview data collection.
- The PI maintained a journal to provide an opportunity and outlet for reflexivity, the exploration between self and data; to determine bias, influence, and interpretation (Congdon, 2003).
- Data was collected to the point of redundancy and saturation.

Data Analysis

Data analysis occurred on several concurrent levels beginning with data collection. Immersion in the data and review of PI journaling, logs, and memos enhanced meaning and understanding. The coding and ethnographic data analysis of transcribed interviews was performed by the researcher using HyperRESEARCH software and the inductive, constant comparative, four step process described by Roper and Shapira (2000) as coding, sorting, generalizing, and memoing. A paper trail was carefully maintained.

Coding

- Data in the form of transcribed written transcripts, PI journals, and memos of observations was grouped and coded for overall descriptive labels to summarize content.
- Codes were assigned to acknowledge broad categories based on patterns emerging from the interview responses.
- Codes were revised, changed, and documented along with rationale.
- Key words were identified.

Sorting

- Data were coded for patterns of regularity and irregularity (outliers).
- Emerging and recurrent themes were identified.
- Outliers were not identified.

Generalizing

- A data matrix was constructed using key words and codes, to clarify the fit of patterns and relationships and identify links between emic meaning and etic interpretation.
- Exploration of emerging concepts and connections theory to enhanced understanding of data from an ethnographic perspective.

Memoing

- Impressions of the PI, coding, and analysis were recorded in memos, a form of reflective coding.

- Memos were used to question, enhance understanding, guide exploration, and further study (Roper & Shapira, 2000).

Summary

This chapter highlighted focused ethnography, population and sampling, setting, data collection and data analysis. This study was supported by the interpretive paradigm of ethnography. Nursing is a cultural group defined by shared behavior and experience. The field was defined by the researcher as acute care hospital facilities. Focused ethnography was the appropriate method to explore the experience of experienced bedside nurses working 12-hour shifts in acute care hospital facilities. Data making consisted of semi-structured interviews captured with digital recording technology. Analysis of transcribed data was accomplished using the inductive four step process of coding, sorting, generalizing, and memoing. Threats to validity and reliability have been addressed and limitations acknowledged. The researcher is familiar with the culture of nursing and prepared by 18 years of acute hospital nursing experience to carry out this study.

CHAPTER IV: FINDINGS

Chapter IV addresses the attributes of the participants and the findings in relation to the three research questions. Findings are underscored by the purpose of this study: to explore the self-described experience of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12 hour shifts in acute care hospital facilities. The relationships of cultural schemas are also explored, consistent with focused ethnographic methodology.

Participant Attributes

A purposive sample of nine experienced registered nurse participants were recruited using snowball sampling and included in the data analysis for this study. Approximately one hour interviews were conducted at various locations throughout east central and central Florida from January to August of 2011. Participants were employed as bedside nurses at acute care hospital facilities in the Florida counties of Indian River, Brevard, Volusia, Orange, and Lake. Pseudonyms have been provided for each participant to protect anonymity.

Age and Level of Expertise

Participant attributes are summarized in Table 2. The age of participants ranged from 30 to 55 years. It should be noted that due to a reluctance to share exact age information in years, age categories were created. All participants self-identified as nursing experts in their practice areas after the PI verified their understanding of the five point scale of expertise demographic question, based on Benner's five levels of skill acquisition.

Licensure and Education

The years of initial RN licensure spanned from 1991 to 2006 yielding a range of experience from 5 to 20 years (mean 12.89). No gaps were reported in any RN's work history. Six of the nine participants reported 10 or more years of continual RN experience. Two of the nine participants, each with 20 years of RN experience, were licensed practical nurses (LPNs) and one was a certified nursing assistant (CNA) prior to entering their initial associate degree nursing (ADN) programs. Six of nine participants received their initial nursing education in Florida. Of the remaining three, two were educated in the southeastern U.S. and one in the northeast. Two participants initially graduated from Bachelor of Science in Nursing (BSN) programs. The majority, (seven of nine) attended ADN programs pre-licensure. Four of these participants continued on to complete a BSN. A total of five participants are enrolled in graduate programs. Four of the original ADN graduates and one original BSN graduate are completing a Master of Science Nursing (MSN) or Doctorate of Nursing Practice (DNP) program.

Employment and Experience

Nursing experiences included employment in acute facility unit specialties of medical/surgical care (Med/Surg), progressive care (PCU), cardiac and cardiac intensive care (CICU), oncology, neurology (Neuro), orthopedics (Ortho), and labor and delivery (L&D), as individual or combination units. In addition, past employment in non-acute physician's offices, hospice, and home care was reported. Currently four of the nine participants are employed on a medical-surgical unit, three on cardiac units, and two are on other acute care units. Current employment spans from 5 to 18 years (mean 7.66) and assignment to current unit varies from 5 to 10 years (mean 6.72). The majority of participants are employed by hospitals not seeking or

awarded Magnet® status (77.78%) and scheduled to work 36 hours (three 12 hour shifts) per week (88.89%). Participants are overwhelmingly employed by “not for profit” hospitals (88.89%). Six of nine participants (66.67%) reported working 38-39.5 hours per week, less than the 40 hours required to be classified as “overtime.” These additional hours extend the scheduled 12-hour shift to “13 or 14 hours most days.” The remaining three participants reported that they will not work any hours in addition to those scheduled. Most participants currently work the day shift (77.78%) and regularly scheduled weekends (88.89%). Assigned nurse/patient ratios were reported from 4:1 to 7:1 (mode 6:1) but frequently a nurse may care for “10 or 11” patients, on a single shift, with admissions and discharges. The majority of participants are partnered (77.78%) and primary wage earners (55.56%). The remaining 44.44% are contributing wages to the household, and supporting (66.67%) one or more dependents (mode =2).

Nursing: “A Calling”

Participants were asked their reasons for choosing a nursing career during the rapport building segment of the interview. The overwhelming response (88.9%) to the question “Tell me a little bit more about why you became a nurse?” was a description of what is known within the nursing culture as being “called” to nursing. A calling is a strong impulse which draws the individual to a specific action. Eve described it in the following manner.

So truly for me it was a calling, and I listened to that calling and here I am, and I still love it, and I’m very happy . . . I feel like I’m doing work that I was ordained to do; something I was born to do, and it’s just natural.

Others reported an innate knowing which drew them into the profession. Fran stated, “I knew I had to go into nursing.” A few participants felt this draw from childhood and delayed entry to practice due to a variety of life events. Other influences within the context of being

“called” included tending to infirm family members and following in the footsteps of parents and grandparents. A continual commitment, described in terms of love, to “love what you’re doing” was a recurrent theme. Only one of the participants indicated nursing was a calculated career choice, yet expressed the same heart felt, long term commitment as those who were “called.” All participants identified nursing as part of their inner being, fulfilling a desire to be “helping people” and “to nurture.” Cathy stated it particularly well, “Nursing is in your heart . . . what you’re doing is what you’re feeling. What you’re feeling is what you’re doing.”

Giving Back

The desire to “give back to nursing” is a key attribute of the participants. Being interviewed for this study met a need for these nurses to “be heard” and “contribute” to the nursing profession. Some of the participants identified advanced education and mentorship as a means “to help nursing in a bigger way” and an “opportunity to give back.”

An almost selfless commitment to the profession and patient care is part of the cultural expectation of experienced nurses. It was indicated that novice nurses entering the profession may not share this as a cultural norm. This cultural conflict was identified as a stressor, even while mentorship has been identified as an adaptive tactic which allows the nurse to “give back.”

Table 2: Participant Attributes (N=9)

Attribute	N	Percent
Age		
30-40 years old	3	33.33%
41-50 years old	4	44.44%
51-55 years old	2	22.22%
Gender		
Female	9	100%
Ethnicity		
White	5	55.56%
Black	2	22.22%
Asian/Pacific Islander	2	22.22%
Year of RN licensure		
1991-1995	3	33.33%
1996-2000	2	22.22%
2001-2005	3	33.33%
2006	1	11.11%
Median: 2000		
Years of RN experience		
5-9 years	3	33.33%
10-14 years	2	22.22%
15-20 years	4	44.44%
Mean: 12.89 years		
Median: 11 years		
Nursing Education		
Original education program		
ADN	7	77.78%
BSN	2	22.22%
Location of original nursing education program		
Florida	6	66.67%
Outside of Florida: Southeast	2	22.22%
Outside of Florida: Northeast	1	11.11%
Highest level of nursing education completed		
ADN	3	33.33%
BSN	6	66.67%

Attribute	N	Percent
Higher level of nursing education in progress		
MSN	3	33.33%
DNP	2	22.22%
Higher level of nursing education attempted, no longer in progress		
BSN	1	11.11%
Nursing Certifications		
No nursing certifications	5	55.56%
One nursing certification	3	33.33%
More than one nursing certification	1	11.11%
Professional Nursing Organizations		
No organization membership	4	44.44%
Membership in one organization	3	33.33%
Membership in more than one organization	2	22.22%
Employment		
Magnet® Status Hospital		
Yes	1	11.11%
No	7	77.78%
In progress	1	11.11%
Hospital profit status		
For profit	1	11.11%
Not for profit	8	88.89%
Years with current employer		
5-6 years	4	44.44%
7-8 years	1	11.11%
9-10 years	2	22.22%
11-12 years	1	22.22%
17-18 years	1	11.11%
Mean: 7.66 years		
Median: 8 years		
Years on current unit		
5-6 years	5	55.56%
7-8 years	2	22.22%
9-10 years	2	22.22%
Mean: 6.72 years		

Attribute	N	Percent
Type of nursing unit		
Medical/Surgical	4	44.44%
Cardiac	3	33.33%
Other	2	22.22%
Average nurse/patient ratio on the unit		
4:1	3	33.33%
6:1	4	44.44%
7:1	1	11.11%
“Varies”	1	11.11%
Median: 6:1		
Mode: nurse/patient ratio 6:1		
Scheduled work hours/week		
36 hours	8	88.89%
24 hours	1	11.11%
Actual work hours/week		
38-39.5	6	66.67%
36	2	22.22%
24	1	11.11%
Shift		
Day (0645-1915)	7	77.78%
Night (1900-0700)	2	22.22%
Regularly scheduled weekend hours		
Yes	8	88.89%
No	1	11.11%
Self-identified level of nursing expertise on 1 (novice) to 5 (expert) scale		
4.5	1	11.11%
5	8	88.89%
Life status		
Single	2	22.22%
Partnered	7	77.78%
Number of dependents		
0	3	33.33%
1	1	11.11%
2	4	44.44%
3	1	11.11%
Median: 2 dependents		
Mode: 2 dependents		

Attribute	N	Percent
Primary wage earner		
Yes	5	55.56%
No	4	44.44%

Participant pseudonyms: Amy, Brooke, Cathy, Donna, Eve, Fran, Gina, Helen, Irene

Content Analysis

The focus of the data analysis is the overarching question and the phenomena of interest.

Data analysis is presented for each of the research questions. Discussion of the findings will be presented in Chapter V.

Research Question 1

Explore the self-described experiences of stress experienced by bedside registered nurses working 12 hour shifts in acute care hospital facilities.

Study participants readily identified situational experiences of stress in the workplace. Immediate responses included a litany of common issues: workload, workflow, physical environment, staffing, communication with physicians and other healthcare team members, computers, charting, and frequency of changes in routine activities. Stressors described by study participants reflected much of what was found in the literature. The significance of these individual issues is the contribution made to understanding the principal theme of stress: the “overwhelming sense of duty” to the patient. Subthemes and topics are identified and described in this section.

Overwhelming Sense of Duty

The common thread in the interviews of experienced bedside nurse participants was that although patient care is challenging, the patient is not what is stressful in the workplace. There is

an understanding among experienced bedside nurses of the “overwhelming sense of duty” in caring for the patient. What is stressful are impediments to providing that care and meeting that duty.

The primary theme of stress, the “overwhelming sense of duty” to the patient, includes three subthemes: the disruption of the nurse-patient relationship in providing care, the ability to provide “good care” (a culturally and personally mediated standard), and change. Change of any kind is generally considered stressful. Change significantly impacts the other two subthemes. Participants provided examples of their experience of workplace stress in the form of short narrative stories and comments.

Disruption of the Nurse-patient Relationship in Providing Care

Events and actions that keep the nurse from being with the patient or the limit time available for nurse-patient interactions disrupt the nurse-patient relationship in providing care.

Workload

Patient assignment (patient load), documentation, and multiple competitive tasks, described as “workload” were reported as significant disruptions in the nurse-patient relationship. The nurses’ day is comprised of interactions and tasks to be completed in the 12-hour work shift which includes maintaining the primacy of the nurse-patient relationship, providing “good care,” and appropriate documentation (also known as “charting” or “the paperwork”). Increased workload has the potential to disrupt the nurse-patient relationship and interfere with providing “good care.”

Patient assignment varies with the unit nurse-patient ratio, patient acuity, number of admissions, and discharges. There is an inverse relationship between nursing time available for

each patient and number of patients assigned to each nurse. Cathy related some of the additional influences which increase patient assignment.

Mostly it's your patient load, although I put there [points to the demographic form] 4:1, most of the days we're busy, and we're short, and somebody called off, and our patients goes up, that's a difficult thing – if you have too much patient load.

Admissions and discharges add to the overall patient load of the individual nurse.

Documentation for admission and discharge was described as “time consuming,” with “multiple forms” to be completed; tasks that take the bedside nurse away from patient care.

I think one of the biggest stressors is having a heavy turnover of patients and getting admissions and having to do discharges at the same time . . . and then taking *care* of your patient that to me is one of the most stressful things (Irene).

Nurse-patient ratio does not account for the additional documentation and patient interactions that accompany admissions and discharges and may be a poor indicator of actual workload. Helen reported, “You know, um, six patients is a lot but you may take care of 10 in the day considering discharges and admissions.” Irene’s assigned nurse patient ratio is slightly higher which is reflected in her statement about overall patient assignment: “I think too it’s the ratio of patients to nurses [7:1] . . .at the end of a day you can end up having gone through 10 or 11 patients . . .[with] admissions and discharges.” Experienced nurse participants indicated that the “sense of duty” to this number of patients is “too much.”

A regional, seasonal, rise in patient population increases the number of admissions and discharges during the fall and winter months in eastern and central Florida. Workload is increased during this “season.” Helen commented.

Especially if it's season and you're the only nurse who's discharging then you're gonna get hit with patients [admissions] . . .that can be very stressful . . .you know when you have two admissions coming in at once, you can only do one at a time . . .hopefully . . .the other nurses are not terribly busy that they can stop and help you take off orders or you know, something. But that's taking away from [their] patient care.

Documentation, “the paperwork,” so called even when completed by computer, competes with patient care for the focused attention of the nurse. There is a familiar phrase used in nursing “if it isn’t documented, it isn’t done” and non-urgent patient care may be diverted by the need to document completed care and assessments. This pulls the nurse from the bedside resulting in frustration and stress, as clearly expressed by Irene:

You’re spending a lot of time going back and forth between the computer . . . and the paperwork that you have to fill out . . . lots of paperwork . . . and you wanna be taking care of the *patient!!!* And you try to fit that in, that to me is the most important thing of all, you know.

There was a consensus among participants that patient care is being “fit” into “the paperwork.” The importance of documentation creates a perception of time stress and urgency. Helen expressed an understanding of documentation stress and how she attempts to curtail it; “I like to have my assessments in. I try to have them in [the computer] by noon because for me that takes a big load of stress off of me. They [assessments] are very time consuming.” Documentation stress, even when recognized may not always well managed.

I feel the stress on me is that I have forgotten everything I’ve done by the time I’m charting it and I keep getting more and more wound up until I get my assessments in the computer . . .it’s gotta be in the computerI stress myself (Gina).

Additional documentation stress is related to frequent changes in documentation requirements. Computer use for documentation was not directly implicated as participants expressed individual preferences for “paper” vs. computer charting. Documentation changes and frequency of adaptations were reported to consume an even greater portion of the nursing day than usual; increasing the competition between patient care time and documentation.

We have a charting system at our hospital that is relatively new and it’s cumbersome and it’s very slow, and I can tell you that’s probably my greatest stress right now. “. . .since it moves so slow we have to move at a faster pace, it kinda slows everything down. I think

that's the major stress right now...it takes up a lot of our time away from patient care (Donna).

Documentation that is not completed during the 12-hour shift accounted for additional reported work hours. Cathy stated, "12 hours is not really 12 hours, maybe 13 or 14 sometimes to catch up with things that you need to document." Administrative imperatives to limit additional paid time were reported to heighten the importance of "getting out on time" and add to the cumulative stress.

In addition to documentation, multiple competitive tasks pull the nurse from patient care. Each additional task increases the time it takes to return to the patient and reduces the total time for nurse-patient interaction.

I think that's the major stress right now, 'cause the way we have to chart and it's very long and involved and it takes up a lot of our time, away [from] patient care...I would say about 10% of my nursing care a day is spent with my patients, the rest is charting, answering phone calls, chasing down physicians, doing other things, pulling up meds, making meds, taking [vitals] . . . talking with the techs . . . but actually going to a patient, talking to them, and giving them meds, the time is just maybe 10%. I think that's realistic (Donna).

All of the study participants reported stress was created by the experience of juggling multiple competitive tasks, time, and patient care. Irene stated this outright, "Not being able to spend time with your patient because you are pulled in so many directions is very stressful, I think, for me." Fran and Gina gave examples.

It's really, really tough when you're on the floor and you're being pulled in five different directions (staccato speech). A doctor's on the phone, somebody wants you on the phone, the patient is in the room asking for pain meds, a therapist is asking to work with one of your other patients, that's tough (Fran).

How do you give chemo, and do discharge papers, and do an admission, that all have to be done within the next 20 minutes? You're responsible for all three of them and you're one person. I can't stretch 20 minutes into an hour. They all should be done ...but it's not practical! So something's gotta give somewhere. Figure out which one to give, then how to make it happen so that you're still keeping patients satisfied . . . (Gina).

Ability to Provide “Good Care”

The importance of providing “good care” is the second prominent theme of stress which emerged from the data. The ability of the experienced nurse to provide “good care” is dependent upon unambiguous and open communication with all members of the healthcare team. Any break in this complex support system disrupts the ability to provide “good care” and creates stress for the nurse.

Nurse-physician Interaction

Several study participants addressed nurse-physician interaction issues and the importance of interdisciplinary respect in relation to providing “good care.” Participants proposed dissonance may be due to a limited understanding of the bedside nurses’ role and responsibilities by the physician. Eve provided a good example.

Most of our doctors are easy to get along with, but there’s a couple of doctors that the nurses talk about and they can be very short with the nurses, and that definitely adds to the stress. I think part of this is that they don’t understand, you know, the load of work that we have and they think that we should drop everything we’re doing at the moment and assist them, which we would like to do; but sometimes you’re in the middle of giving medication or doing an admission or helping somebody that really needs some help...that’s hard, especially if you have seven patients.

Interviews included vignettes describing the difficulties with communication, patient advocacy, clarifying “orders,” reporting patient status changes, and receiving timely responses from physicians and other licensed healthcare providers. It was reported that the nurse is legally and ethically required to address these and similar issues to clarify care parameters. These activities further limit time available for providing care once it has been delineated. A “charge nurse” when available, may intervene, enabling the nurse to “pass it on” and return to the bedside. Fran summarized this aspect of the charge nurse role.

Having worked on the desk as a clinical charge nurse I was there to support the staff, and the families, and the patients, so I had a very low tolerance for physicians that weren't respectful of what my staff would be concerned about.

Workflow

Poor communication also affects work flow. Information and orders may jam at any point in the process, creating stress for the nurse and impact efficiency of patient care. Amy gave an example of a delay in receiving "patient orders" that could have changed the patient outcome, but fortunately did not.

If we have a bunch of doctors coming at one time, charts pile up at the desk. The doctor was by at about eight o'clock in the morning, wrote some orders...I didn't know anything about the order till two o'clock in the afternoon...that was an issue for me . . .I spoke to the doctor about that later and I said . . .please just tell me to do it because I didn't have time to go up front and look through my charts to see what the doctor had written and I wasn't expecting that to be happening that day because I heard they were going to monitor the patient for two to three days and then think about it. It could have been an issue, it wasn't . . . but it very well could have been.

Providing "good care" is dependent upon the nurse's ability to set "priorities." Delays in workflow disrupt the progression of care, and the nurse's ability to plan, organize, and reorder work patterns based on known and potential patient care priorities.

Delegation

Tasks that do not require the skill level of the RN are delegated by the nurse to unlicensed assistive personnel (UAP) in a "team effort" approach. The nurse is "ultimately responsible" for overseeing this care, which must meet the nurse's professional and personal standard for "good care." Poor delegation skills and "doing their job" increases the nurse's workload. Irene addressed this issue: "So then the nurses pick up the slack where the CNA's [certified nursing assistants] can't do, you know. So we're picking up CNA jobs, secretary jobs, and charge nurse jobs on top of our own duties." Another participant shared.

They [CNA's] usually have about ten, ten patients that they're taking care of and if they're busy doing something else, then you're having to do what would normally be considered their job, because we all work together. But you're spending time doing what they normally do in addition to *what you are already doing!* Now it's putting you a little farther behind, so that's creating a little more stress (Amy).

Several participants reported a general tendency "not to delegate" indicating that "sometimes it's more time consuming to try to find the CNA to do it" (Helen). Poor delegation competence and unmet delegated care expectations erode efforts on the patient's behalf. The lack of comfort with delegating was also addressed.

I don't delegate well. I'd rather take it on myself than have a confrontation with somebody, so I load it all that on me...I'd rather do it myself than ask somebody else. I think that what I notice is stressful is the act of delegating (Gina).

Delegation was reported as having been "taught in nursing school" and emphasized by the "preceptor," but participants indicated that they did not readily adopt this skill until they found themselves "overwhelmed" and "drowning." It was reported that delegation is especially challenging for the novice nurse.

I find it's [delegation] an area of stress for LOTS of nurses, especially new nurses, because when I see new nurses and they're doing all sorts of bedpans constantly and I tell them 'you need to tell your tech to do that' and [they say] 'well, she looks at me funny when I tell her'. And I'm like 'she's just testing you...A lot of them are really good ones that just do what they need to do, but for the most part it's just – oh my God, it's a challenge. Like I said when you're younger than that person it's even more challenging...so I think that's stressful (Eve).

Bedside nurses work with UAP to facilitate patient care. Delegation and its relationship to workload and communication exacerbate stress in a variety of ways. The time available for care that can only be provided by the RN is reduced when the assigned tasks of UAP are completed by the nurse.

Defining “Good Care”

A patient will be cared for by multiple nurses during a hospitalization. Not all nurses share the same definition of “good care.” Asynchronous care expectations are another source of stress for experienced bedside nurses.

Other nurses [are a source of stress]. Well, ones that aren't as sensitive to patient's needs or aren't as understanding of you know, their disease process, um, or the ones that are so casual about it. That irritates me (Fran).

Eve commented “You think that they *should* get it! Not everybody agrees with your level of care” and provided this example:

I give report ...and I said ‘this is what’s going on’ and she says ‘well you did what you could do as a nurse. Just leave it alone.’ Leave it alone, and that, that is just unacceptable. I felt like yeah, maybe I did do what I could as a nurse, but the patients the one that’s going to suffer.

This disharmony may or may not be overtly addressed. Brooke expressed the need to communicate: “Basically . . . if I think you did a bad job you’re gonna know about it. I don’t pussyfoot around the issue.”

Intensified distress was reported in situations where the nurse perceived that the patient was provided with less than “good care” based on their actions, inactions or the actions of their team.

And there were no rooms anywhere in the hospital and I know it sounds stupid but you know this lady was sick. I didn't have room to put her in and we were treating her out in the hallway. Yeah, something like that, I think it's stressful because it was my fault . . . *I will never make that mistake again* (Donna).

That one stuck with me for a long time, well it still has. I don’t know what happened, it just didn’t flow right...I should have said ‘you gonna look at the [patient] more?’ But then there was that many people from a higher level of care saying ‘the [patient is] fine.’ It lead to a lot of . . . paperwork for me...it never should’ve happened to begin with (Brooke).

Learning provided by this type of experience may mediate the associated stress and provide skills and resources for similar situations in the future.

Experienced bedside nurse participants also expressed concerns about the ability of novice nurses to define and provide “good care” based on inexperience and a perceived “casual” attitude. The novice may miss signs and symptoms leading to a delay in interventions and poor patient outcomes.

Right, they [novices] don’t do it, they don’t miss it, and they don’t pick up little things, little hints. They can’t put together different things that are going on with the patient. They can deal with a patient with one diagnosis and our patients are coming in with complex issues, so that’s kind of scary for me (Eve).

Because they [novice nurses] are so casual about their patient care that you know, when you follow them with their patients the next day you feel like you’re kinda having to (short pause) re-revise some of the things that they’ve done for the patient... They have such a laissez-faire attitude where they’re not as serious about it as I think they should be (Fran).

All the participants reported a sense of personal responsibility for guiding and nurturing novices during transition-to-practice; formally through the preceptor role or informally as a co-worker. This was identified as “the best of all nursing,” both rewarding and stressful. Participants spoke with understanding regarding novice “greenness” and their own ability to assist with transition-to-practice. Gina reported, “If my day is manageable I’m delighted to be a resource person for others. I *like* to share my knowledge. I *like* one on one teaching.”

Get It All Done

Integral in providing “good care” is completion of tasks and closure of the workday, the ability to “get it all done” within the confines of a 12 hour shift. Gina described the stress, “I’m a failure; I’m a failure because I can’t get it all done. And the more overwhelmed I become the less

effective I become, so it just snowballs. Amy addressed how increased workload from changes in patient acuity has altered her ability to “get it done.”

We’ve become very busy, um, patients are sicker than they were which means they're more involved as far as their care goes. Um, there's a lot of needing to prioritize your time, ‘cause you can really get bogged down if you’re not careful. Um, running all through the day, sometimes just to keep up with what's going on through the day. Its chaos, its organized chaos.

The ability to organize and prioritize is crucial to “getting it done.” Participants described their individual approaches. According to Eve, “It’s just something that, you know, I have to do. So I tough myself up and say ‘I gotta go get this stuff done’ so that’s an area of stress.” Irene outlined her strategy.

It’s time management. Just, um, frequently turning things over in my mind; like what is the most important thing to do at this point . . . I have a list in my head . . . what I have to do next, and that can change in a heartbeat.

Helen shared her experience in this regard.

I try to organize my day when I’m getting report in the morning . . . I’m assessing, who I’m gonna see first . . . what patient needs to see me first, so I try to stay organized with patient care. It doesn’t always happen that way . . . I try to stay organized and any moment that I find time -chart, or do something that needs to be done. I try to stay on track with those things. So far, you know it works. Like I say it gets overwhelming, it gets stressful, but I just get in my groove.

The “team” and “team work” are themes embedded in nursing culture. Participants reported the significance of the “team” in creating an efficient and harmonious work environment.

We help one another. When we get admissions we jump in and help each other. So, overall, I mean we’re stressed, we’re overworked, we’re overwhelmed, but because we work so well as a team it makes it somewhat easier for us to cope with the stress (Helen).

Also reported was a reluctance to request assistance from other RN team members unless it becomes a necessity to prevent “drowning.” Even with assistance, it is not always possible for the experienced bedside nurse to complete their “work” within the confines of the 12 hour day.

In these instances “work” is passed to the oncoming shift in “report.” Donna sums it up, “If you can’t get everything done sometimes you have to pass it onto the next shift...you wanna do it, but they [administration] are looking at the time clock.”

Experienced bedside nurses take personal responsibility for completing their workday tasks. The completion and closure of providing “good care” is the impetus to “get it all done.” Stress results from poor communication and skill in dealings with other healthcare team members, workflow interruptions, asynchronous definitions of “good care,” and failure of strategies for organizing, prioritizing and completing “work.”

Change

Change is one of the greatest nursing stressors. Acceptance, learning, and adaptation to change disrupts routine activities and workflow impacting the nurse-patient relationship and the ability to provide “good care.” This is true for change perceived as either negative or positive.

Adapting to Change

There was an expressed understanding among the experienced bedside nurse participants that change is part of the work environment. Amy conveyed, “Change is always...difficult to deal with, you know whenever change comes around, whenever they want you to do charting a little bit different, or you have a requirement that’s needed...that becomes a little stressful.” Another aspect of change stress is when changes are desired and not implemented. Brook shared her perspective, “I’d say besides myself there’s maybe two other ‘seasoned nurses’ so we understand that there’s something’s that are not going to change, and there’s something’s that we’re excited about change wise.” Cathy indicated the negative stress of change was balanced by the possibility of improvements for the patient.

Sometimes, you know as far as the first reaction to change is like ‘oh my god, they’re gonna change again, here we go!’, but if you think it’s for the positive, it’s for the good or the better, it’s for better patient care, less mistakes, then you know – you go for it. Yeah, it’s difficult, but once you learn the procedure or the task it’s easier and I think it’s for the better.

Actively participating in the decision making process may not relieve, but may mitigate the effects of stress related to change. Fran provides a good example.

I’m very excited about it. I’m on the clinical resource group, so I work with clinical informatics [moving to paperless charting for nurses and physicians]...to me this is very exciting. I can’t think of a better avenue for safety for patient care. So I’m embracing it and I think it’s great . . . You know with anything there’s a learning curve, it will be a little trying, but no, I’m very excited.

Change is principally perceived as being administratively driven. Administration was referred to as “they” throughout the interviews. Stress accompanies those changes implemented by administration without nursing input or when input is disregarded. There was a tone of apathy in Brookes comment on administration, “You just don’t even know who they are, yet these rules are coming down.” Concerns related to change may be voiced to administration after implementation of changes. In these cases the stress continues while the nurses await administrative decisions for revision. Cathy and Fran communicated their experiences and hopes for acceptable outcomes.

They change it every week, there’s a new thing, and change. They add on documentation or something. The most, the worst change that we have is the patient ratio which went to 5:1 and that is not good. I mean, with the kind of patients we have...it’s really hard...Of course, you know we complained. Complain and express your concerns, thoughts and feelings and explain how things [are]. It’s hard to accomplish that change so, and since we are doing that, I think they are going to change it back. (Cathy).

Our new manager recently moved the med room...we just didn’t agree...it is smaller and it is more crowded so it’s a little more frustrating and adds to the patient care. So there’s something’s that we’re still working on and you know we feel like if we continue to communicate our concerns with our manager then things *will change!* (Fran).

There is also an element of stress related to the participant's reported perception that "things will never change." Experienced bedside nurses are problem solvers and solution seekers and welcome changes "for the better." Irene asked "What's the point of venting if you don't see the changes in the long run? I would like to see more changes happen. The significant stressor is not always the change itself, but the lack of control and input to both initiate and halt change.

Changes in the Role of the Charge Nurse

Another stressor related administrative change is the alteration of the traditional role of the charge nurse on the unit. Five of the nine participants reported having charge nurse experience. All participants expressed the importance of the varied and complex charge nurse role in creating appropriate "assignments," providing support by "calling physicians," facilitating admissions, "taking off orders," assisting with issues and problems, ensuring staff has "breaks," interacting with families, and acting as a "resource" to the bedside nurse. Administrative removal of the charge nurse or assignment of additional duties limits the availability of this first level support and thereby increases workload and stress. Restoration of the charge nurse reverses this process.

There've been some changes in our hospital regarding the charge nurse. Before this year, the charge nurse was actually the 'charge nurse' and would be in charge of the floor and help with a lot of problems that would occur...there's been a lot of shifting around of duties in the last year, and the charge nurse now takes patients. So now their duties have actually disappeared and a lot of the duties they used to do; now the nurses have to do. So that has added to our stress level, *I must say!* Yeah, it's *very* hard, *v-e-r-y* hard on our unit, and the nurses complain about it constantly...we want our charge nurses back as being 'charge nurses'. They're there physically, but they have their own assignment and frequently they'll tell us 'I don't have time, because I have *my* own patients to take care of (Irene).

Helen reported the changes for her unit after charge nurses were reinstated; "You know now we finally have a charge nurse so that's taken some of our work load. Not a lot, we still have the

bulk of everything to do but, it does take some of the stress off.” She goes on to give this example, “If there’s something I can’t handle I move it to the next level... I’ll send the charge nurse in and see if she can give any solutions to the problem.” The charge nurse acts as the primary support for the bedside nurse. The efficacy of this support is dependent upon the charge nurse’s assigned duties and availability. Charge nurse duties which include a patient assignment or multiple nursing units effectively limit access and reduce resource effectiveness for the bedside nurse.

Changes in Nursing Culture

Nursing standards are national education and practice dictates that outline performance and safety guidelines for professional nursing practice (“Nursing Standards”). Beyond these standards are variations in nursing culture influenced, in part, by location. Three localities of cultural stress are the region, hospital facility, and nursing unit. Regional cultural stress was described by participants that had relocated to Florida after nursing employment in another area of the United States (north and southeast). Acculturation to the regional work environment, physician-nurse communication and collaboration, pay scale, and employer relationships was described as creating stress. The influence of the hospital facility on regional perceptions was not explored in this study.

Hospital facility culture is influenced by administrative activity and decision making. The Magnet® journey is also a facility specific stressor. One participant is employed at a Magnet® hospital and one reported being on the Magnet® journey. Although participants spoke proudly of the accomplishments of the facility and the nursing staff, they also reported stress related to

increased uncompensated responsibilities directly related to obtaining and maintaining Magnet® status.

Unit cultural stress may come from poor team dynamics, unfamiliar staff members, physical environment and equipment, and uncertainty related to unit specific nuances. This can occur during periods of staff turnover, when units are combined in administrative or physical restructuring, or when a nurse is “floated.”

Four of nine participants reported a lack of trust between the nurse and facility, best described as a “threat” to job security. Fear of employer retaliation was cited as a reason for participant refusal during the recruitment phase of this study. Changes in body language and speech patterns were observed as participants thoughtfully described incidents of co-workers being ‘written up’ and ‘fired’. Brook leaned forward; her speech was accentuated and staccato as she shared this story:

Lately the big stressor for work has been if you do not clock in to work at 6:45 you are considered *late*. You can clock in at 6:46 and you are *late*. You get two of these in a three month time and you get *written up*. I mean people are literally running through the hallways so they don’t clock in *late*... Yeah, like one girl drove on the side of the road because she’s like ‘I can’t get late again because I’ve already clocked in at 6:46 once time.’ So it’s like *if I do this I’m gonna lose my job*.

Cathy was anxious and emotional when speaking about stress and the workplace. The topic of employer retaliation was discussed, and at one point the interview had to be stopped. Cathy, still tearful, went on.

Because they give you all these [patients], too much patient load, and then if you make a mistake, they reprimand you, so you cannot even refuse. If you refuse, you’re refusing the situation. You can get fired for that. So we have some nurses that get fired for refusing extra patients. They can fire you for *anything*!

Threats to job security and employer retaliation may erode employer/employee relationships and widen a gap identified in the data between administration and the experienced

bedside nurse. “I think administrators are kind of above all that and don't really see what's going on” was Donna’s reply when asked about her sense of connection to hospital administration.

Eve said, “They're not seeking after you; you're not seeking after them. They only hear about you if you cause trouble [laughs]. Otherwise they don't really know you.”

Another reported source of stress are perceived culture changes associated with novice nurses and the future of nursing. Participants identified changes in professionalism, values, role, and work ethic. Eight of the nine participants expressed concern that the level of commitment at practice entry was eroding. Professionalism plays an important role in the experienced bedside nurse’s identity and perceived loss of professionalism was identified as distressing. Eve described “frustration” with “nurses who don’t respect nursing as a profession” and her assessment that “nursing seems to be changing from a profession to a job.” Donna reflected on the changes in her unit over the past five years.

I can tell you when I first started [present position] five years ago we had all experienced nurses and they all worked as a team. We were so fantastic. We were such a tight unit. Over the years we’ve had a lot of people leave. We had a lot of new nurses come on that were younger. They’re all about their early to mid-twenties and they’re just not the team players that we had before. They’re all very [short pause] I consider them as islands. They kind of do their own thing.

Learning and continuing education were identified by participants as a professional nursing value. Helen reported that this does not appear to be the case for novices. Her comments reflect a perception that learning and continuing education are devalued by novices.

They offer lectures for CEU’s [continuing education units] and I often see myself and the other seasoned nurses on the floor going to the additional learning experiences and the younger ones aren’t...I’ve always thought that you’re always having to learn.”

Participants used the words “new” and “young” interchangeably when discussing novices, referring directly to level of nursing experience and not specifically to age. Fran commented.

A lot of the newer nurses are all about the clinical ladder...you know they all want to get up there and get more money and start working nights for the differential...Now they're right out of nursing school and they're all about the higher pay grade.

Perhaps the most prominent culture change is a perceived deterioration of the nurse-patient relationship, provision of care, and the values required to be "a good nurse." Gina reflected on her own principles and compared. "I think it's probably as much age and work ethic that I grew up with, because I see the younger nurses that don't have that sense of 'it's my responsibility' as much." Gina continued and thoughtfully shared her recent precepting experiences.

I knew while I was precepting that this really wasn't a priority for her, she was concerned about a vacation trip, her friends, doing things with her friends; you know, she wasn't eager to learn. The other one, I now work with, her value system is totally different. She's really good at good enough.

Fran, continuing to address the importance of the nurse-patient relationship, shared a recommendation for novices.

Never forget what's happening to this person is a life changing experience. I think a lot of new nurses don't understand that...but knowing how to be a *good nurse*, I think will allow the patient to feel that, and understand that, and it will make their nursing easier.

The patient remains central to the future of nursing in Eve's statement. Her final sentence summarizes her view of nursing and hope for the future.

I appreciate my nurses who've been nurses for 30 years or 40 years and I love to sit and learn techniques that they did, that I didn't learn in nursing school. But, I think that new nurses just don't have that respect, um, for nursing, in that manner anymore. It's just like out with the old - in with the new type of mentality. You know technology is great, but you know, technology can't train bedside nurses. A computer can't take care of a patient at the bedside. It doesn't matter. They might be able to plug in an assessment and get out something diagnostic but it takes a person to take care of a person and you just can't get rid of that.

Research Question 2

Explore the manner in which coping skills are acquired by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.

Experienced bedside nurses working 12-hour shifts in acute care hospital facilities were not able to directly identify how coping skills were acquired or how adaptation strategies were developed (Research question 3). The data support several coping and adaptation themes which intersect, but will be addressed as separate topics. Coping skills and adaptation strategies are acquired by the combined effects of mentorship, professional acculturation, and experiential learning over time. The influences of individual personality are acknowledged, but were not specifically addressed in this focused ethnographic study. The subthemes that emerged from the data identify the skills and adaptations of experienced bedside nurses working 12 hour shifts in acute care settings in Florida. The themes presented in this section are the significance of mentoring, acculturation, and years of trial and error.

Mentoring

The nursing mentor acts as a trusted guide, a role of significant importance in acculturation and setting the stage for a successful career.

Having a Mentor

Study participants spoke of the importance of a mentor relationship throughout their careers, whether a formal preceptor or an informal expert, who became their “go to person.” “If you have good mentors who can give you pointers that's very helpful” (Amy). Mentors may also be R.N. family members; “sister,” “mother,” “aunt,” or friends who inspired and guided the early years of the experienced bedside nurse. First mentors were spoken of with reverence, respect, and affection, as participants recounted lessons which have guided their practices and helped them cope and adapt to bedside nursing stress. Amy was told by her first mentor “just to make the most of your time . . . Take the time that you have and do the best that you can, cause that’s

all that's expected of you." Mentors inspired confidence and taught "survival" skills along with technical skill. These skills refined over time and used by experienced nurses when addressing stressful situations in the workplace. Participants shared what they learned from their mentors in brief vignettes.

When I first graduated from nursing school and started, I did my practicum; my preceptor for my practicum was wonderful. I still look up to her to this day and I still talk about her . . . things that she taught me I never forgot. She was *extra*-ordinary . . . it really helped me build self-confidence . . . she was very organized and . . . she had a calm demeanor . . . so my biggest thing is trying to stay organized and trying to stay, um, keep things on time . . . and you know, it seems to help me cope with my day (Helen).

I was *trained* as a new graduate by a nurse, a senior nurse, who insisted on breaks and who would mark me off for . . . lack of . . . time management if I didn't take a break. So I was taught early in my career that a break was important . . . I've always been able to, no matter what was happening, take a break . . . that's what I'll always have to look forward to. You know, every now and then it's like 'this day has gone so crazy, I can't believe it's this time!' I have to step away even if it's just for 10 minutes. It's just so important and I force other people to do it too. (laughs) 'I'll watch your patients- you gotta go now - nobody's dying'. I used to always say 'if nobody's dying right now, then I can take a break', because they're still going to be sick (Eve).

Remaining calm and in control during stressful situations is a skill, and an expectation in nursing culture. Comportment was role modeled by the mentor and addressed when Irene shared her story.

Yes, there was an elderly nurse who absolutely looked 30 years younger than what she was, and when I found out she was like 75 [years old] I was just *floored!* [laugh] She recently retired and I actually told her she was my mentor. Um, I could go to her for anything, and she gave me all kinds of tips. Especially in the oncology stuff, and in-in many ways, because she had been a nurse for *over 50 years!* I was just absolutely floored when I found that out and I thought, no wonder she's so cool, calm, and collected. I admire the nurses that have been doing it for a while . . . you know she says 'you can only do what you do when you are doing it; you can't do it all at once'. I think that basically is to take one thing at a time.

Mentors passed on "values" to mentees and some developed long standing relationships. Gina recounted her mentorship story.

She was in her 70's, um [short pause] she was an old nurse, been around forever *and* didn't take any *guff* from anybody. She saw the world kind of in black and white, but [short pause] she was just real. There was just something about her. I didn't always agree with her, but I always respected her . . . I had gone to back to work for hospice per diem and I actually got to make a nursing visit to her, while she was still alert and aware. I haven't seen her in about seven years . . . just to be able to go out and have my opportunity to say good-bye to her, meant a lot [spoken with emotion and reverence in voice] we-we shared a lot . . . We felt the same way about things a lot of times.

Being a Mentor

Being mentored has motivated these experienced bedside nurses to “pass along” their nursing knowledge. All of nine participants have precepted nursing students and/or new nurses on their units and have self-identified as a “go to” person. The role of mentor was called a “reward,” a “positive experience” that “adds to job satisfaction.” When asked about being a mentor Gina replied “It makes you feel good. Feeling good gets rid of stress.” Participants shared their suggestions for novice nurses. These suggestions provide insight into the coping skills developed by experienced bedside nurses. A positive attitude, doing your best, finding your niche in nursing, advancing nursing education, being a team member, delegating, using available resources including a mentor, learning from mistakes, and finding an outlet for stress were recommended. Cathy provides an example.

I think that you need to be good at what you do. Know things and if you know it, you'll be comfortable in doing it; and if you're comfortable in doing it, I think you'll survive. And, always think positive. And if you have a problem, just ask somebody to help you, don't do it on your own cause it's gonna be hard to survive . . . you can delegate tasks and you can always ask for help. Don't be afraid to ask questions and ask for help. Even though I'm an experienced nurse, I still ask for help and ask questions.

Mentorship provides support for developing foundational nursing skills and molds professional values, behaviors, and expectations. Mentors provide the framework for primary coping skills used in the workplace by bedside nurses.

Acculturation

Acculturation begins with nursing education, intensifies during transition-to-practice, and continues as nurses develop their professional identity. Experienced bedside nurses identified two primary coping skills acquired from nursing culture; venting and team relationships.

Venting

Venting is a coping method, which plays a significant role in immediate stress relief for experienced bedside nurses. Vent, as a noun is described as “a means of exit or escape; expression; utterance; release” and as a verb: to give public utterance to; to relieve by giving expression to something” (Vent, 2012). Both definitions apply to the term as used by nurses. Venting, embedded in nursing culture, quickly becomes part of the nurses’ professional persona. It is a means of immediate coping, learning, assimilating experiences, and bonding. Eve put it plainly: “...you know we can just vent to each other as nurses, that’s what we do.” Every participant described situations where venting was used for one or more of these purposes.

The medication room and the break room are the primary locations for venting. These areas provide the necessary privacy and are considered a “safe” haven. The positive impact of coping by venting in a private area was described by Irene.

So, um you know also the nurses vent to each other and we have a place that we can do that with closed doors [laughs] while we’re drawing up our medicine in the med room because it’s pretty sound proof, so you know the nurses can go in there and vent, and actually I think that’s a *really good thing*. The med room is a locked isolated area so the patients can’t hear you and you know, it’s good. We can just kind of let it out. You know everybody’s letting it out.

The use of venting allows the nurse to address the immediate stressor and then continue on to provide effective patient care. Participants shared their experiences.

Like I said we vent a lot. Our med room, because it's a locked room and that's where you pull staff in and go 'ah I can't believe that patient just yelled at me' or you know, you can go and calm down in order to stay ready for other patients (Eve).

We do that [venting] quite a lot with each other. It's like we go somewhere, we close the door and we're like [speech changes to a gruff tone] Arrrrrrrrrrhhhhhhhh!!!! [Speech changes to a sunny tone] and then you know, we feel better (Amy).

Being "talked down" by other nurses is another form of venting used for immediate stress relief.

Eve described addressing the outcome of a stressful event. "It was, that was, stressful, ah, and challenging...but I called one of my other charge nurses and she came and talked me down...and you know, I was OK to continue." Venting is used to make sense of experiences, to learn from, and to assimilate stressful events. Donna reported an assimilation encounter. "Oh yeah, just venting to somebody. It isn't that somebody is going to solve my problem, but just venting it, expressing it, that usually helps." Debriefing is another form of venting which serves to assimilate experiences and provides learning for similar situations in the future. Fran explains, "We all kind of try to debrief situations. You know like what happened, what we could have done better, what lead up to this situation, was there anything else we could have done."

Debriefing is helpful for assimilation and closure at the end of a shift.

So I found myself just hanging around so I could calm down before I go home. I just needed to talk about it to staff and to the supervisor and I needed debriefing ...I like to say 'what would you have done, did you see anything we could've done different?' That helps me...that's important for me (Eve).

Sharing unit and patient issues and experiences as a teaching/learning situation was also described as venting. Fran explained how patient care is addressed. "I think we all kind of sit around and say, you know 'I'm not sure about the guy in 710, what's going on.'" "Meetings" were identified as another venue for venting.

The participants described themselves as “seasoned” and having the role of the “go to” persons on their units. In this role they are sought out by others to engage in venting exchanges, “Because people know who they can go to too vent” (Amy). Experienced bedside nurses become “more the person who people are venting to than the person who’s venting” (Eve). Being a resource for others is a role with “informal authority” and was described as “deeply satisfying.”

Venting also has a bonding effect among team members. The concept of nursing as a team driven profession is ingrained in the culture. Venting is also a team activity. The boundaries of “the team” often extend beyond the workplace. Team members find commonalities in their lives and may meet outside of the workplace or contact each other “off shift” in a supportive stance. As Amy described “There’s a lot of people I work with that are in kind of similar situations , we sometimes compare our situations, because talking them out sometimes makes you feel better about them.”

I can call them [team members] up and say “you wouldn’t believe what happened ...and vent it out that way ‘cause they have a better understanding . . . like just this morning ‘cause I know they were short staffed last night, I texted one of the girls and said ‘how bad was it’? [she replied] ‘Bad really bad’ so we texted back and forth. So that kinda helped her . . . if she were to text me in that situation then you know that someone is out there thinking about you. And yeah, there’s bonding and friendship that helps get you through the night (Brooke).

Venting, as a coping mechanism, plays a significant role in immediate short term stress relief for experienced bedside nurses working 12 hour shifts in acute care hospital facilities. It is a meaningful part of nursing culture and learned through acculturation. Helen summarized her venting experience.

Yes, I vent to co-workers; I’ll vent to my nurse manager. If there’s a problem, I’ll vent. You know, keeping it in is not good. So expressing it, I feel this is a better way to try to cope with a situation. So yes, I will vent.

It's a Team Effort

As noted earlier teams are part of nursing culture. Participants reported their relationship with the “team” enables them to better cope with the complexities of the patient care setting. The threads of team relationship run through the data analysis. Study participants reported although they are each individually responsible for providing care to their patient assignment, they are part of a team. Cathy stated, “You cannot do things yourself; so as I said, it's a team effort.” A “good team” creates a desirable work environment. Amy discussed the team on her unit, “One thing about our particular unit is that we have a reputation for having really good team work . . . most of the staff has a good attitude and we pretty well like where we work.”

There is an understanding that team members will assist and support each other in their work. In addition to the responsibility to the patient, team members feel responsible to each other. Brooke gave an example:

Oh yeah . . . you got to rely on your co-workers . . . like last night there should have been five [RNs] and there was only three. One - you pray that the bus isn't gonna come in [figurative expression of speech] you can look at it and know; OK well, there's three, we work great as a team and they're there to help me.

Brooke went on to describe her respect for other team members.

I have every confidence in the world in their decisions. I think they're all very-very good nurses, they are very-very good at what they do, we all have a different style; very rarely do I question anything that they did.

Respect among members of the team provides cohesiveness and a resource for coping. A lack of professional respect within the team creates the opposite effect. Two participants reported reviewing work schedules to anticipate which shifts would be “harder.” Three participants reported working on “stable” units. These areas were described as having very little nursing turnover and teams that have become unified and strong. The nursing work of these units was

described as “collaboration.” Fran illustrated, “We have a really great group of nurses that communicate well with each other, and we have such good camaraderie, you know. We are *very* concerned about the folks that we take care of on our floor.” Helen described a similar team experience.

I think my floor is probably the most stable in the hospital. We don't have a big turnover of employees. They, a lot of nurses, want to come to our floor. Because we work so well together as a team. Day shift *and* night shift. There are more newer nurses on night shift, but um, for the most, it's pretty much the same staff and it has been for at least 3 years I would say.

Participants also reported the team provided incentive to remain “on the unit.”

We don't have the team nursing that I think they'd consider where you team up two nurses, you consider that team, we haven't done that. But we kind of do that as a natural thing. Our nurses on our unit in the daytime are absolutely helpful to each other and that's the one thing that keeps me there is our team nursing (Irene).

The ability to identify, access, and share resources was linked by participants to the collaborative team. When asked how important the team was Fran replied: “Very important, because nursing is not something you can do by yourself.” She went on to describe one way she uses the resources of her team.

No matter how much experience I feel like I have, I, you know, if I'm questioning something or I'm going to do a procedure with a patient, or I'm not-quite-sure-you know how; I would just talk to somebody about. I'd say ‘what would you do’ say if this occurred . . .If I need help I will ask for help and you know, the co-workers I work with, we work really as a team.

Teamwork is a vital part of nursing culture. Assimilating to a team is part of the acculturation on a nursing unit. Experienced bedside nurses, acculturated to working as part of a team use team support and resources to lessen the impact of stress in the workplace.

Years of Trial and Error

Experiential learning was reported as an important factor in the ability to cope with the challenges of bedside nursing. Specific experiences of learning could not be individually identified, but it was reported that years of accumulated knowledge and a vast understanding of the work environment enabled the experienced nurse to cope in ways unavailable to others. Amy described “Years of trial and error. I mean it just takes time; you just have to find out what works best, and that just takes time.”

Learning

Learning also occurs through repetitive actions. Brook described her learning process.

It's just what we do and it's just over and over and over again . . . So it's a process that gets tweaked as you do it longer, and you become more comfortable with it . . . I've become more confident because I've been there longer. I've been in these situations and you know you cope with it through that way.

Participants indicated through experience they have developed a “level of comfort,” “confidence,” “routines” and awareness of the nuances of their facilities, units, patient populations, and teams. Improved communication, time management, and technical skills were also attributed to years of experience. Fran talked about changes in her communication skills, “I understand people more. I understand myself better certainly. I know how to communicate with them and their communication styles and how they perceive things and how people perceive them.”

Problem Solvers and Solution Seekers

Experienced bedside nurses are not content to merely recognize a problem, but initiate problem solving and seek solutions. Part of problem solving is an understanding available

resources. Participants reported experience provided a greater understanding of resources and how to access them efficiently. Eve gave one example.

I'm on the unit and we have this heavy patient and I call down to the ER and say 'I need a couple of guys to come up here right now'. So I think a lot of it is, just um, pulling from resources.

Amy described how she now approaches a problem:

I look a little further than what's right in front of me . . . I'm just trying to think . . . thinking things through a lot more, um, coming up with rationales, more so than just complaining about things.

Skill acquisition through experiential learning has helped experienced bedside nurses to work more efficiently. Study participants reported that learning from experience resulted in an expanded knowledge base and enhanced critical thinking which decreases potential workplace stressors.

Research Question 3

Explore the manner in which adaptation strategies are developed by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.

Adaptation is the outcome of successful coping. Study participants described the ways they modified their work environment and behaviors to best meet their socioeconomic, emotional, and physiologic needs. Two themes emerged from the data, it works out better for me and the self-imposed personal/professional boundary. It works out better for me is defined by the ability to manipulate some elements of "the job" which improve the nurse/workplace relationship, and in turn, reduces the number of perceived stressors. A self-imposed personal/professional boundary, developed over time, represents the conscious and purposeful

separation of work life from the personal life of the nurse. These two themes are addressed in this section.

It Works Out Better for Me

Each study participant described shift and schedule configurations personalized within the limitations of their unit's personnel requirements. One of the participants works two 12-hour shifts per week; the remaining eight work three 12-hour shifts. All of the participants denied working additional shifts that would constitute "overtime" with very few exceptions.

Personalizing, Tradeoffs, and Attitude

Considerations for shift and schedule choices included lifestyle, physical stamina, school and family constraints and what was described as "a tradeoff." Brook and Eve both work "nights." Brooke reported that in addition to the family benefits, she is not a "day person."

I never worked days. It works out better for me, and it works out better for my family. I drop them off in school, I go back and I pick them up. I'm there for their activities; I'm there to help them with their homework.

Future orientation is one element of the "tradeoff." Participants indicated achievement of future goals is an acceptable "tradeoff" for present work situations. Eve explains, "The night shift is less stress and better for me in terms of school. I needed to eliminate some stress . . . so I stepped down from being in charge and went to the bedside at night." Eve also indicated that night shift is not "less busy" just "less stressful."

Attitude toward the work environment is another form of adapting. Maintaining a "positive attitude" and "doing your best" was recommended by five of the nine participants. Amy described how she uses attitude to cognitively reframe and manage her work schedule.

I only do two [shifts] in a row and then I have two or three days off. So, the first mornings not so bad, because you're nice and fresh, you've been off for 3 days, you go in, you're doing great, everything's fine. The next morning you get up and go "oh great I can sleep in tomorrow morning, I just have to make it through the day" so it's just you know, tricking your mind like that and it's not so bad . . . you trick yourself into staying.

Irene elaborated on how she has adapted her weekly schedule to maximize job performance and her ability to cope with 12 hour shifts.

The day before I go to work I go to bed *very* early, I mean I'm rigid with myself in that area . . . if I can do three days in a row and get it done and have my 4 days off, I almost like that better, especially if you have the same group of patients. *But* that's the key. If you don't [have the same patients] it's another situation.

Adapting work schedule may be especially important to the older nurse population with limited ability to withstand physical stressors. The desire to continue bedside nursing may depend upon schedule adaptability. Gina described her experience.

Since I went back to the hospital, I have basically a set schedule. I work Monday-Wednesday-Saturday-Sunday-Wednesday-Friday. It split up my 12 hour days so I wasn't working them back to back except on the weekend; which was traditionally slightly slower pace. So it didn't stress me physically as much. It was working great for me. New management came in and then '*nobody's going to have a set schedule*' [with sarcasm]. 'And your rationale is?' '*Well nobody's going to have a set schedule . . .*' So they arbitrarily changed what has been working for eight years . . .oh and how could *anybody not* work 2 and 3 days in a row? . . . I know my personal physical limitations. I don't need to retire from hospital work if I can work this schedule that works for me physically.

Over time, Gina reported she was able to return to the schedule that was most comfortable for her and remains a bedside nurse. Experienced bedside nurses maximize the personal advantages of shift and schedule flexibility provided in the nursing work environment. Individual control of to the highest degree possible strengthens the nurse/workplace relationship and in turn mitigates stress.

Breaks

“Breaks” are another area where bedside nurses have adapted the work environment. Seven of the nine participants responded negatively to the question “do you get your lunch and breaks.” Data revealed that experienced bedside nurse may not be taking formal, scheduled breaks, but do manipulate their workday to briefly tend to nutritional and physical needs in brief periods throughout the workday.

What I do is that instead of taking like a 15 minute break in the morning, I will just take 5 minutes, go back, get a drink of water, go to the bathroom and come back. I'll do that a couple of times and that works for me. The same thing with the lunch, even though the lunch is a half an hour, many times I only take a 15-20 minute lunch and it's like after 15-20 minutes I'm done eating so what else do I have to do? I need to get back to my patients (Irene).

Participants reported an understanding of the importance of breaks for physical and mental renewal. These experienced bedside nurses indicated break time is not left to chance; it is the product of experience with the general workflow of the unit.

If you can't take care of self, how can you take care of others? So I try to remember that and I say it, you know, I say it for my own satisfaction, to hear it, as well as to my co-workers. You have to take time to eat. I try to eat breakfast at home because the morning is the busiest time and you tend to not take the time to eat . . . I'll get report on my patients and depending on what needs to be done right away. If I have 7:30 meds and how long it takes me to get report, I might go ahead and eat something light. I may eat 1/2 a bagel or a bowl of grits or something, so at least eat something (Helen).

Well you don't actually get it [break]when you would prefer um you kinda have to look at what's going on . . .So you have to kind of time it and say ‘well I'll go eat now cause otherwise it's not going to be until five in the morning’ But for the most part, we get it (Brooke).

Teamwork is necessary to ensure breaks are available and patients are cared for in the nurse’s absence. “I'm usually pushed into the break room by a colleague or you know, I just say ‘I'm going to get off the floor for 15 minutes’ and I go down and grab a little soda or something”

(Fran). Break is considered “off the unit” time, even when brief and the nurse remains in the vicinity of her patient assignment. As Cathy reported, “when I’m on break, I’m on break.”

Self-imposed Personal/Professional Boundary

Participants described a purposeful and conscious emotional and cognitive adaptation, which creates a boundary separating work life and personal life. By creating this boundary, participants reported a separation work and personal stressors that may lessen the overall perception of stress.

My work, I don't bring it home, and my home, I don't bring it at work. Those are separate things for me, so one thing doesn't affect the other. I, as I said, I don't combine my family problem and my work problem . . . Um, my work is work. When I do my work I try to do it the *best* that I can. When I leave my work, it's there. I don't bring it home. I'm a person that my work is work and my home is home (Cathy).

Helen described her self-imposed boundary.

I have many stressors at home but I can't take that to work - that's home. I leave that home because work is not going to solve that problem. So I've always done very well at keeping home and work separate.

The flexibility of the self-imposed boundary between work life and personal life varies with the individual. Donna described a rigid boundary and then explained how she maintains it.

When I walk out those doors - that's it . . . I don't talk about my work with my husband. I don't talk about my work at home with anybody. It's left. I don't call. Some nurses will call on their days off and ask how this patient is. Once that door shuts, I'm out

I just say this is the way it is. It's just the way I want it to be. By not talking about it, I think, by not talking about work at home, I think that separates it. By not reliving it over and over, you know and at work I don't talk about my personal life. I don't talk about anything about personally, well that's the way I do it. I just don't share information like that with anybody. I don't think about it until I go back. *Never*. I *never* cross the two, *ever!*

Some boundaries are more diffuse. “You have your work life and you have your own personal and social life, your private life; and they shouldn't intermingle except for certain occasions”

(Gina). Co-workers may cross the boundary based upon the situation, such as “continuing education dinners” and “girls night out,” or being identified as “friends” outside of the workplace. Participants indicated that it is not always easy or possible to maintain the boundary.

Brooke disclosed:

I think I do a pretty good job of separating. You know, keeping them separate but, yeah, the job does add extra stressors to the family and yeah, vice versa. Job adds stress to family, family adds stress to job.”

Fran explained her experience when the boundary is breeched.

Oh yeah, oh yeah, I think you have too [separate]. You know, or else it would just eat you up. I don't say that there are days that I don't wake up crying thinking about a person I'm taking care of, or I have dreams about people that I take care of, I worry about people that I take care of, I mean I think that's just human nature. It's really hard to forget people, but that encourages me to be better, to learn more, to just understand what I can do better for these people.

Three participants reported “non-medial” family members are occasionally used to “just listen” when work life issues bleed over into their personal lives.

The act of “leaving” and “the ride” were identified as events that mark the transitions between work and personal life. Gina reported that the ride home was “my decompression time. It takes me about a half an hour to get home. By the time I'm home, most of that intense stress is *gone*. Irene and Eve commented on how the “ride” is used.

I really try not to [bring it home](laughs). The minute I walk out of the hospital I just, I get in the car and I turn the music up. That's the first thing that I do. It just takes my mind away. And I really try to forget about it. That's one of the good things about working in a hospital (Irene).

I try very hard not to take it home. I think, in terms of nursing, now I think I probably take things home a little bit more here because I live very close. I find that the drive home, like when I worked 40 minutes from home was enough for me to unwind before I got home. But, um, so like, so now that I'm like 15 - 10 minutes away from home I'm still a little edgy sometimes when I go home. But, I think I do ok. I don't shout or anything like that when I get home because of something that happened at work, um so in that I don't take it home . . . I think I'm able to swap off and be who I need to be (Eve).

Summary

Chapter IV has provided an overview of the attributes of nine experienced bedside nurse study participants and the iterative analysis of data obtained from participant interviews, PI logs, and journals. Multiple themes emerged for each research question, identifying patterns of stress, coping, and adaptation with respect to the milieu of nursing culture. Chapter V will focus on the interpretation of the data, identification of study limitations, conclusions, implications for nursing, and recommendations for future research.

CHAPTER V: DISCUSSION

Chapter V, the final dissertation chapter, provides a discussion of participant attributes, findings in relation to each research question and the literature, implications for nursing practice, education, research and health policy; study limitations and summary.

Phenomena of Interest

This study explores the self-described experience of coping and adaptation associated with workplace stress of experienced bedside registered nurses working 12-hour shifts employed in acute care hospital facilities in Florida. Workplace stress is a costly and continual problem for the nursing workforce. The outcome of workplace stress is loss; to nurses in physical and emotional health, and job satisfaction; to employers in unproductive time, recruitment, and retention; and to consumers in quality of care (Andrews & Wan, 2009). Economic events have recently impacted these stressors and work environments of RNs.

Across the U.S., the economic downturn that began in 2007 tempered the nursing shortage. Nurses projected to leave remained in the workforce, and non-working nurses returned due to economic constraints (Bauerhaus & Auerbach, 2011). In Florida, a workforce shortage slowdown was attributed to an influx of nurses and less loss than expected (FCN, 2010a). During this period, regional hiring practices resulted in decreased employment opportunities and increased retention of new graduates (Brewer, Kovner, Yingrengreung, & Djukic, 2012). It is anticipated that this stabilization is temporary. The Affordable Care Act (ACA) of 2010 aims to increase healthcare access for a greater number of Americans. The effect will be to increase nursing demand (FCN, 2010b). Anticipated economic improvements are projected to create a drop in workforce numbers and strengthen the projected shortage (Bauerhaus & Auerbach, 2011;

FCN, 2010a). A better understanding of stress, coping and adaptation associated with workplace stress is important to maintain a growing and healthy nursing workforce. This study has examined workplace stress and the manner in which experienced bedside nurses acquire coping skill and develop adaptations. A discussion of the emergent themes and the phenomena of interest, organized by research questions, follow below.

Participant Attributes

Nine participants interviewed for this study approximately match the demographic profile of RN's available to the workforce in Florida. According to data from FCN, the average age of a Florida RN is 50.1 years. Significantly, 46.5% of Florida's nurses are over age 50, making this the largest age related demographic (FCN, 2010a, 2010b, 2010c; 2011, p. 2). This older nursing population will be retiring over the next 15 years. Study participants are slightly younger, the majority (44.44%) in the 41-50 year age range, closer to the national RN age average of 46 years.

Ninety percent of Florida's RN workforce is female. Participants represent a gender match for the female majority. The ethnic mix of study participants underrepresents White (55.6%), and Hispanic (0%) nurses and over represents, Black (22.22%) and Asian/Pacific Islanders (11.11%) compared to the demographic of Florida. FCN reported the ethnicity of Florida RN's: White (70.5%), Black (12%), Hispanic (8.3%), and Asian (6.8%) (2011, p. 2).

A greater percentage of study participants (66.67%) have a BSN as their highest degree compared to Florida's RN workforce (36.6%) (FCN, 2010a). The majority of nurses interviewed for this study (55.56%) were enrolled in MSN or higher programs. This overrepresentation may be due to recruitment efforts associated with a university setting or the willingness of this segment of the nursing population to participate in research activities.

Employment status and working hours of participants and all Florida RNs closely aligned. Eighty percent of Florida RN's work full time (36-40 hours) for an average of 38-39 hours per week matching the 88.89% of full time participants working 36-39.5 hours per week (FCN, 2010a, p. 2).

The majority of nurses in this study (88.89%) described entering the profession in response to "a calling." "A calling is a deep internal desire to choose a task or profession which a person experiences as valuable and considers her own" (Raatikainen, 1997, p. 1111). The data support "called" study participants' dedication to the nurse-patient relationship, providing good care, nurturing patients and novices, and supporting change. Professionalism is evidenced by commitment to advanced education and professional respect, the desire to "give back" to nursing, and concern over perceived changes in nursing's cultural standards and values. Raatikainen (1997) in a quantitative study to clarify differences between nurses who responded to a calling (n=81) and those who did not (n=95), reported similar findings. Nurses who were "called" experienced high levels of work satisfaction and motivation, valued patient outcomes and "good patient care" and felt they "had the power to improve the quality of nursing practice" (p. 1113). The relationship between the desire to "give back to nursing" and motivation for entry to practice was not addressed by this researcher.

Experienced bedside nurses reported disappointment in the professional commitment of novices and the perception of nursing at "job" status. Generational expectations may contribute to this perception. Participants identified novices as generationally diverse. Divergent intergenerational views of the workplace have been identified as adding to workplace stress (Milliken, Clements, & Tillman, 2007). The relationship of intergenerational expectations and work commitment is recommended for future research.

The economic picture may also be influencing perceptions of commitment. The Florida economy, while still recovering from the 2004-2005 hurricanes, was heavily weighted in the real estate sectors when mortgages collapsed and recession began. Unemployment figures in Florida rose until 2009 and continually exceed national rates. Economic recovery is evident, but slower paced than the rest of the United States (Glasman, 2012). A widespread public perception that “a nurse can always find a job” may be drawing larger numbers of middle aged and second career applicants to nursing schools. The National League for Nursing (NLN) *2012 Annual Survey of Schools of Nursing* reported 44% of ADN and 14% of pre-licensure BSN students over the age of 30. The percentage of male students in nursing programs has risen from 10% in 2003 to 15% in 2011 (2012). These changes may be economically driven and the basis of the observed variation in novice commitment reported by experienced bedside nurses.

Research Question 1

Explore the self-described experiences of stress experienced by bedside registered nurses working 12-hour shifts in acute care hospital facilities.

Overwhelming Sense of Duty to the Patient

Overwhelming sense of duty to the patient is the major theme that emerged from the first research question. The sense of duty to the patient is foundational in nursing culture. The American Nurses Association *Code of Ethics* states “The nurse’s primary commitment is to the patient, whether an individual, family, group or community” (2001). The inability, actual or perceived, to address and satisfy duty to the patient is the outcome of multiple elements. Three subthemes developed from the data; the *disruption of the nurse-patient relationship in providing care, ability to provide “good care,”* and *change*. The contributing topics; workload, nurse-

physician interaction, workflow, delegation, defining good care, get it all done, and the elements of change, have been previously described in the international nursing literature (Andrews, Burr, & Bushy, 2011; Callaghan, et al., 2000; Foxall, et al., 1990; Hallin & Danielson, 2007; Lambert, et al., 2004; Li & Lambert, 2008; Lim, et al., 2011; McVicar, 2003). This researcher speculates it is the cumulative effect of stress, which forces the sense of duty to become overwhelming. This discussion acknowledges contributions to nursing workplace stress and examines ways to reduce burdens on the sense of duty to the patient.

Disruption of the Nurse-patient Relationship in Providing Care

Workload is the contributing stressor for the first subtheme, *disruption of the nurse-patient relationship in providing care*. Workload is identified as patient assignment, documentation, and multiple competitive tasks that disrupt the nurse's ability to fulfill the requirements of nurse-patient relationship. Nurse-patient ratio emerged as the foundation of workload. The single participant employed by a for profit hospital organization also reported the highest nurse-patient ratio (7:1). Maximizing workload, minimizes overall RN work hours, one of many strategies used by hospitals to maximize profitability (Chapman et al., 2009; Horowitz, 2005, Seago, Spetz, & Mitchell 2004). Admissions, discharges, patient acuity, and short staffing identified in this study, are unaccounted for factors contributing to overall workload. Admissions and discharges add to patient contact and documentation workload, while removing the nurse from the primary patient assignment. The ability to rapidly recognize changes in patient status and initiate interventions on the patient's behalf may be impaired due to contact limitations. Documentation and multiple competitive tasks pull the nurse's focused attention away from the bedside. Decreasing contact with patients creates an unsatisfactory experience for the nurse and

lowers the quality of patient care (Hallin & Danielson, 2007; Sveinsdottir, Biering, & Ramel, 2006).

Ability to Provide “Good Care”

The second subtheme emerging from the overwhelming sense of duty to the patient, *ability to provide “good care”* is the disruption of provision of care at the bedside. The first three of the five contributing topics; nurse-physician interaction, workflow, and delegation, originate in the work environment, arising from the action or inaction of others. Communication strongly influences these external stressors. The remaining two topics, defining good care and get it all done, are internal stressors, dependent upon individual interpretation of the nurse.

Ineffective nurse-physician interaction contributes to stress (McGrath, et al., 2003; Taylor & Barling, 2004). This study identifies professional disrespect and a perceived disparity between physicians’ conceptions and the realities of nursing work. Clear and rapid communication effectively conveys changes in patient status, physician orders and contributes to efficient workflow. Differences in communication styles may inhibit collaborative interaction on the patient’s behalf (Van Ess Coeling & Cukr, 2000). Failure to recognize communication differences between nurses and physicians precludes effective intervention. It is no surprise that the quality of nurse-physician communications impacts the efficiency of workflow. Nurses use critical thinking to continually reevaluate workload and reorganize. Research indicates 77% of nursing activities are of short duration (less than 30 seconds), and shift constantly in a pattern of reprioritization, review, and revision (Cornell, Riordan, Townsend-Gervis, & Mobley, 2011 p. 369). Workflow inefficiencies have the potential to disrupt this information/reevaluation pattern resulting in time loss and delayed care. Professional development addressing role, responsibility,

and communication styles for both nurses and physicians may improve nurse-physician collaboration and workflow.

Delegation, essential in *providing “good care,”* requires partnership between the RN and UAP. Earlier studies have described the components of delegation failure. Potter, Deshields, and Kuhrik (2010) report misunderstanding of the RN role and differences in work ethic are sources of conflict that create UAP resentment and erode delegation. False impressions and lack of cooperation lead to increased workload for the RN and missed care for the patient (Gravlin & Bittner, 2010; Potter, Deshields, & Kuhrik, 2010). Rapid changes and reprioritizing characteristic in nursing workflow may impede timely RN/UAP communication. Participants in this study reported receiving pre-licensure delegation education. Implementation began after negative experiences, well into their nursing practice. At the time of this study, six of nine participants completed education beyond the ADN level. Two of the remaining three had taken some BSN courses but not completed a degree. Leadership skills taught in BSN programs may better prepare nurses for delegation in real world situations (Saccomano & Pintio-Zipp, 2011). This researcher recommends formal, employer based delegation programs using guidelines such as the ANA *Principals for Delegation* (2005) for both RNs and UAP to strengthen existing skills and foster cooperative partnerships, thereby reducing the impact of this stressor.

“Good care” is grounded in professional nursing expectations and culture, and defined by individual nurses’ personal work standards. Higher personal work standards correlated with less perceived work stress in a population (n=426) of Masters of Business Administration (MBA) degree holders in Taiwan (Hsieh, 2004). Reasons for these findings are speculative and related to cognitive agreement with defined standards and choice. Similar studies were not found in the nursing literature. Unlike the MBA, the product of nursing work is human, defined as patient

outcomes. It is reasonable that personal work standards, ethics, and competence influence these outcomes. Asynchronous definitions of “good care” are identified as stressful in these findings. This researcher suggests that minimum expectations for defining “good care” are best practice nursing standards. It is a nurse’s professional responsibility to report breakdowns in nursing practice which erode trust and may potentially harm patients; intentional and unintentional “grey area” nursing, incompetence, neglect, abuse, and more extreme situations (Wolf, 2012). Subsequent action, mentoring, and education interventions for practice breakdowns may ease the additional responsibility, workload, and stress described by the experienced bedside nurses in this study.

The final topic to emerge from the *ability to provide “good care”* is *get it all done*. Personal expectations, workload, time pressure, and organization are contributing factors to the stress of *get it all done*. Internal stress triggered by personal expectations for work completion, manifest in feelings of inadequacy associated with an inability to get it all done (Hallin & Danielson, 2007). The literature consistently reports time pressure as generating moderate to high levels of nursing workplace stress (Lim, et al., 2011; McGrath, et al., 2003; Murphy, 2004; Taylor & Barling, 2004). This study identifies teamwork as a moderator of time pressure; employed with reluctance to interrupt or add to the work of others. The charge nurse, in the traditional role, may have particular influence in monitoring workflow and acting in a supportive and assistive manner. Findings related to the charge nurse were addressed as change in Chapter IV. The charge nurse role is “increasingly complex, ambiguous, and demanding” (McCallin & Frankson, 2010, p. 324) and participants report the charge nurse has been eliminated entirely in some Florida facilities.

Change

Change creates both distress and eustress, acting simultaneously as a threat and a challenge (Folkman, 1984). Frequent change, the charge nurse role, (as addressed above), and changes in nursing culture are identified as contributing to workplace stress. Experienced bedside nurses express an understanding of the process and inevitability of change. Positive changes, perceived as improving patient care, are more readily embraced. Negative appraisal results from frequency of change, perceptions of increased workload, time pressure, and change passed “down” from administration without input from effected parties. Recurrent changes in the nursing workplace have been associated with increased distress, decreased psychological well-being and lower job satisfaction (Verhaeghe, et al., 2006).

Lack of trust and threats to job security are unexpected findings in this population of experienced bedside nurses. Job insecurity may be amplified by the current economic situation. Five of the nine participants (55.56%) are the primary household wage earners. Nurse empowerment emerged after the “decade of downsizing” in the 1990’s as employers attempted to rebuild employee trust. Empowerment became a tool of recruitment and retention in the mid 2000’s in response to predictions of the growing nursing shortage (Laschinger & Finegan, 2004). Sound business models recommend fostering and maintaining employee/employer trust (Buhler, 2009; Carmel, Don, & Lester, 2005; de Nijs, 2006). Threats to job security imply a loss of empowerment and the misalignment of employee and organizational values. Further of exploration is needed.

Culture

Culture is fluid, localized, socially constructed and transmitted, and encompasses both actual and expected patterns of human behavior (LeCompte & Schensul, 1999; Wolf, 2007). Transmission of culture moves from existing sources to new entries. This study identified three forms of culture related stress emerging from socialization and locale: region, facility, and unit. Socialization was not acknowledged as part of the new employee experience for the novice or relocated RN. Emphasis on socialization beginning with nursing education, reinforced through TTP, and embraced as a cultural standard may reduce this stress.

Magnet® status is one of the influences changing nursing culture. Two of the nine participants described additional workplace stress related to achieving and maintaining hospital Magnet® status. The literature reflects these findings (Brady-Schwartz, 2005; Ulrich, et al., 2007; Wolf & Greenhouse, 2006). As addressed in Chapter IV, Magnet® status creates a delicate balance of pride and added work responsibility for experienced bedside nurses. Additional responsibility associated with obtaining and maintaining Magnet® status is uncompensated by time or money. This researcher suggests that the institutional pride provided by Magnet® achievement may not be enough to sustain a nursing commitment.

Stress threats emerged from the data identifying perceived changes in nursing culture associated with novices. According to Kramer, new graduate nurses “are the future of the community of nursing.” With advances in “scientific and humanistic” nursing education, they are prepared to improve patient care, nursing practice, and provide “actionary” leadership (1974, p. 28). Kramer’s work *Reality Shock* explains how education and socialization were the reasons this did not materialize as expected in 1974. Findings from this research indicate that expectations of novice nurse’s remain high, but unmet as evidenced by participants’ concerns and comments on

“casual” attitudes toward patient care and lack of professional values. The continuing nursing shortage and economic downturn have enhanced employment predictions for nurse vacancies and may be influencing the pre-licensure enrollment profile and education of nursing students. In response to increasing demand, 31 new ADN programs and three new BSN pre-licensure programs were established in the academic year 2010-2011 in Florida. A total of 121 ADN programs and 32 BSN pre-licensure programs were reported during this time, representing a significant increase from 2007, when 42 ADN programs and 25 BSN pre-licensure programs were reported (FCN, 2012b). Faculty shortages, new programs, novice faculty, limited clinical sites, student diversity, and differences in ADN vs. BSN education, may influence novice nurse output. Greater emphasis on mentored socialization, nursing culture and values, may be needed to avoid unwelcome cultural change.

Research Question 2

Explore the manner in which coping skills are acquired by experienced bedside nurses working 12 hour shifts in acute care hospital facilities.

The literature on coping principally addresses the type and classifications of coping skills used by nurses. This study provides new insight on the origins of coping skills used by experienced nurses working 12-hour shifts. Three themes emerged; *significance of mentoring, acculturation, and years of trial and error.*

Mentoring

Support for formal mentorship programs emerged in the 1970's and 1980's to keep new nurses in nursing. The terms mentor and preceptor are often used interchangeably, as in this study, but differ by definition. Both preceptors and mentors act as role models for

professionalism and socialization, in addition to guiding skills, tasks, and routines (Alspach, 2000; Beecroft, Santner, Lacy, Kunzman, & Dorey, 2006; Ketola, 2009) The value of mentorship in transition-to-practice is well documented (Ketola, 2009; Kramer, 1974; Molinari & Bushy, 2012). Mentorship is about the “past guiding the present” and the commitment of nurses to nursing (Ketola, 2009, p. 250). Considerations for mentorship must include continuing education to maintain current practice standards (Molinari, 2012). The definitions and length of mentorship and TTP should be extended to include first year of practice, at a minimum, and experienced nurses who are transitioning to new roles, localities, or units. The role of the mentor in teaching and modeling coping behavior was not found outside the end of life (EOL) literature (Caton & Klemm, 2006). Findings support the significance of mentorship in modeling and providing skills to build confidence and provide lifelong coping resources. Mentor pairing, with consideration for culture and values, is needed as nursing diversity increases (Wroten & Waite, 2009). Successful mentorship programs that go beyond skills, with greater emphasis on socialization, values, and norms have the potential to impart effective coping skills to novice bedside nurses. Findings indicate experienced bedside nurses recognize the value of mentorship and actively seek out this resource at all stages of their careers.

Acculturation

Coping skills identified by this research as engrained in nursing and transferred through *acculturation* are venting and team effort. Venting, provides effective, immediate, short-term relief of workplace stress for experienced bedside nurses. A form of emotion focused coping, venting is effective in temporary situations where there is little control. Problem focused coping is purported as superior to emotion focused coping, but evaluation of coping strategies based on

response is preferable to assigning a value of good or bad (Lazarus, 1993). Measured in context, one strategy may be better than another. Venting as a coping resource effectively addresses and resolves emotional distress, enabling the nurse to move past it, and continue with the work of the day. Short term problem solving may also result. Attempts to use venting for long term or chronic stressors may lead to negativity, cynicism, and apathy, characteristic of burnout (Leiter & Maslach, 2009). As defined in this study, learning, assimilation of experiences, and bonding are also functions of venting. Sharing experiences and attitudes brings individuals together, forming friendships and strengthening teams (Bosson, Johnson, Niederhoffer, & Swann, 2006; DiMeglio et al., 2005). Experienced bedside nurses play an important role as the “go to” person. This assistive role, identified as “deeply satisfying” by participants, enables cooperative problem solving, sharing of expectations, values, and culture. Satisfaction with work role has been identified with decreased intent to leave (Mary, 2005). Organizational considerations for opportunities and protected locations for venting activity may encourage and enhance use of this effective short term coping strategy.

The importance of “the team,” being “part of the team,” supporting the team, and relying on the team, are threads running through the data to describe this primary coping resource. As such, the team enables problem focused coping. Acting on the environment by using team resources changes the person-environment relationship and mitigates stress. Nurses are part of the team through assignment, but gain team membership and respect through acculturation. Team composition (skill mix), attitude, and workload influence team quality and cohesion. The practice of “floating” counteracts team building. Strong leadership and the creation of a dedicated “float pool” may foster team building within the pool itself, but the carry over effect to the unit team is questionable (Balik, 2011). High workload and inadequate staffing reduces team

effectiveness (Kalisch & Kyung Hee, 2011). This may be the reason for reluctance to access team resources demonstrated in this study. Effective teamwork promotes problem solving, positive patient outcomes, and job satisfaction (DiMeglio, et al., 2005; Kalisch, Hyunhwa, & Rochman, 2010; Milliken, et al., 2007; Wheelan, et al., 2003). Dependence on acculturation for team building is unpredictable proposition. Organizational professional development focuses on management team building without the nursing unit team. This researcher proposes employer initiated professional development for nursing staff to reinforce and strengthen team growth initiated through acculturation. Proactive team building efforts may promote team development, stability, and greater access to the team as a coping resource.

Years of Trial and Error

The final theme to emerge in response to research question two is *years of trial and error*. Lazarus (1993) describes learning to cope by trial and error as inconsistent. Stress encounters vary, skill and resources change over time. Participants identified those elements of experiential learning which provide coping resources and/or mitigate stress as: “level of comfort,” “confidence,” “routines,” “awareness”, communication, time management, and technical skill. Wendt, Tuckey, and Prosser (2011) in a qualitative study of experienced teachers and social workers (n=11) identified similar resources enabling participants to maintain successful careers in high stress professions. Experienced bedside nurse participants, using critical thinking skill developed over time, view workplace problems as challenges and opportunities, rather than obstacles. This perspective lessens the threat, as well as the stress response. Harnessing the collective wisdom of experienced bedside nurses for the purpose of transference to novices may provide a previously untapped source of coping resources.

Research question 3

Explore the manner in which adaptation strategies are developed by experienced bedside nurses working 12 hour shifts in acute care hospital facilities.

Personalized adaptations are developed through need or necessity, manifesting in control of potentially stressful situations in the workplace. Two themes emerge; *it works out better for me* and *self-imposed personal/professional boundary*.

It Works Out Better for Me

Psychological or environmental controls are necessary for adaptation. Level of commitment and degree of external control are important determinants in the evaluation of a situation as a stressor. Secondary evaluation of resources and situational appraisals of control provide the means for coping. Assessment of the situation as controllable leads to the adaptation (Folkman, 1984). Personal rules regarding overtime, shifts and scheduling, and the use of “tradeoffs” are adaptations of need, enabling the experienced bedside nurse to exert control over professional and personal life balance. Psychological well-being and health are positively associated with personal/professional equilibrium (Van der Heiden, Demerouti, Bakker, & Hasselhorn, 2008). Positive attitude, also called positive reframing is a form of problem focused coping. Positive reframing changes the meaning of a stressor from threat to non-threat status by acting on oneself instead of the environment (Lazarus, 1993). The resulting adaptation minimizes the importance and impact of a potential stressor.

Manipulation of the environment and using support are problem focused coping methods addressing threats to personal well-being or needs. Taking breaks is an adaptation of necessity developed in response to the nursing environment. Frequent short breaks are effective in

managing stress and fatigue during demanding work (Caruso & Rosa, 2012; Lim, et al., 2011). Findings reveal team cooperation as instrumental in the success of this adaptation.

Self-imposed Personal/Professional Boundary

The final theme, *self-imposed personal/professional boundary*, emerged from descriptions of the purposeful act of creating a physical and mental/emotional barrier to the events and stressors of the workplace. Development of the personal/professional boundary occurs with experience, over time. The self-imposed personal/professional boundary is the result of planning, a problem focused coping strategy. Equilibrium between the work and personal role is needed to avoid burnout, conflict, and depression (Ekstedt & Fagerberg, 2005; Majomi, Brown, & Crawford, 2003; Napholz, 1995). Integrity of the boundary is flexible due to the humanistic nature of nursing work. Macintosh (2007) describes a comparable self-protective separation, “switching off,” enabling a nurse to effectively engage in the nurse-patient relationship bounded by the work persona. Decreased levels of stress from home/work conflict are attributed to experience (Burgess, Irvine, & Wallymahmed, 2010). The existence of a purposeful self-imposed personal/professional boundary developed over time may account for this phenomenon.

Implications for Nursing

The findings of this study have implications for nursing practice, education, future research, and health policy.

Practice

Several considerations for practice arise from the exploration of self-described experiences of coping and adaptation of workplace stress of registered nurses in acute care settings in Florida. Based on the literature, workplace stress for the experienced bedside nurses in Florida does not differ from those in other locales. Situations contributing to stress identified in the early 1990's continue to plague nurses in the workplace (Foxall, et al., 1990). It does not appear that hospital administrations have responded to earlier research or acted to reduce workplace stress. Changes in the workplace, added responsibilities, perceived changes in nursing culture and pressure from economic adjustment have added to physical and psychological stress. These stressors, left unchecked, may be responsible for detrimental outcomes for both nurses and patients.

This research characterizes the workplace and not the work of nursing as stressful. As stakeholders and the keepers of the workplace, hospitals have a responsibility to monitor and modify the nursing work environment. Evaluation of actual workload, reasonable expectations for patient assignment, documentation, and time and task management, may lessen the cumulative effect of stress and relieve the “overwhelming” aspect of the sense of duty. This researcher has made recommendations for organizational interventions to facilitate nurse-physician communication, team building, and nurse/UAP delegation programs. If the workplace does not change, then it stands to reason, nursing will.

This study has identified experienced bedside nurses as mentors, leaders and problem solvers, advancing their educations, providing patient care and promoting a professional collaborative workplace. These nurses model three key recommendations from the IOM for transforming the nursing profession, by practicing “to the full extent of their education,”

achieving “higher levels of education,” and efforts to “be full partners with physicians and other health professionals” (IOM, 2010, pp. 2-3).

Based on these findings, experienced bedside nurses are a valuable resource with knowledge and skill in coping and adapting. The question now becomes how do we access this resource to maximize availability to the broader population of nurses at the bedside? Experienced bedside nurses identify the nursing unit team as a significant stress management resource. Staffing to minimize float assignments and proactive unit based team building is recommended by this researcher. Participants in this study reported the benefits and difficulties of precepting as part of their work assignment. This research supports the role of the mentor as significant in the early development of coping resources. Mentors are encouraged to acknowledge and share their resources, and provide insight and adaptation alternatives for managing stress and balancing work life. Decreased workload for preceptors and mentors is recommended for consideration.

Socialization of new unit members should be a priority. Mentorship for new employees or unit transfers may facilitate integration.

Breakdowns in practice and covering by the “next nurse” have an additive effect on stress and workload for the covering nurse. Efforts to move from a punitive “culture of blame” and punishment, associated most often with medication errors and other error reporting, to a non-punitive culture of safety can be extended to include practice breakdown (Gorini, Migloretti, & Pravettoni, 2012). Covering practice breakdown should be discouraged. Practice breakdowns can be addressed with action and education to reinforce adherence to unit nursing standards

Finally, the practice of venting should be encouraged for short term stress management. Unit locations with consideration for privacy, accessibility, and confidentiality identified and

secured. It is recommended administrative removal of these areas be discouraged and proactively addressed.

Education

Nursing education begins pre-licensure and continues throughout the professional career. Possible links between economic instability, the rapid growth of pre-licensure programs, and perceived changes in new graduate output and nursing culture have been discussed. Further examination of these relationships is warranted.

Nursing education has the potential to address clinical and communication skills, workplace expectations, and leadership needed to manage and redefine workplace stress. Reevaluation of RN curricula may be needed to foster coping and adaptation skills and seed stress resilience. Team building, mentorship, socialization, nursing culture and values have been identified in the findings as significant in stress management. Mentorship, team work, and delegation exercises, which mirror actual RN practice, may be introduced for collaborative skill building exercises with nursing students at different program levels. Nursing values may be reinforced during these exercises.

Leadership and delegation are essential for all RNs to practice effectively, and as such, considerations for delegation and leadership are needed in ADN education. Application of leadership principals at the BSN level may be practiced in clinical and simulation experiences before entering the workforce. Reinforcement and carryover into work site preceptor programs are recommended to bolster fledgling leadership and delegation skills and confidence.

The National Council of State Boards of Nursing is currently conducting phase one of a longitudinal study of newly initiated TTP programs in Illinois, North Carolina, and Ohio to

evaluate effectiveness based on patient outcomes and safety. Results are hoped to support adoption of this model. It is anticipated the new model will reduce stress, reduce turnover, and improve patient safety (NCSBN, 2012). In addition to mentorship, TTP programs may provide knowledge and skills enabling novices and nurses changing practice areas to adapt to new nursing environments.

Findings of this study support the Institute of Medicine *Future of Nursing: Leading change, Advancing health* (2010) recommendations for innovations in nursing education, TTP programs, increased baccalaureate educated nurses, and inter-professional classroom and clinical education for all healthcare providers. This study of the experiences of coping and adaptation to workplace stress of experienced bedside nurses provides data for creating stress management education opportunities in support of these recommendations.

Research

Implications for future nursing research are as follows.

Replication of this study with a similar population is recommended to bolster credibility and extend generalizability. Experienced male nurses were not included in this study. Replication with a representative sample of male nurses or with a population of male nurses exclusively, is suggested for contrast and comparison.

Two internal stressors are identified by these findings; asynchronous definitions of good care and get it all done. The relationship of self-imposed standards and stress has been implicated in negatively impacting patient outcomes and professional self-concept (Andrews, Burr, & Bushy, 2011). Few studies addressing the relationship of personal work standards in nursing to workplace stress were found in the literature. Future research is recommended.

The findings of this study imply a relationship may exist between professional commitment and motivation for entry to practice. Additional research is warranted by the changing profile students entering nursing education programs at all levels.

Team work, team relationships, and the charge nurse are identified as significant resources for workplace coping. Nursing unit team building interventions, the influence of float assignments on team cohesiveness and the effects of charge nurse reassignment are areas for future inquiry.

Future research is recommended to examine the mentorship role, influence, and effectiveness over time related to teaching, developing, and modeling coping skill and adaptation strategies.

Health Policy

This study has health policy implications for three key stakeholders: patients, nurses, and employers. The Affordable Care Act (ACA) is projected to provide healthcare access to an additional 32 million Americans (Teitelbaum & Wilensky, 2013). The current nursing workforce shortage is expected to balloon with this increased health services demand. The ACA provides project grants for institutions supporting nursing education, practice and retention (HRSA, n.d.). Data from FCN, cited earlier, indicates that Florida's nursing education programs are addressing multiple challenges while attempting to meet the workforce shortage. Additional funding may do little to remedy the immediate faculty shortage, lack of clinical sites, and the changes in applicant profile that have accompanied rapid program expansion.

Stress and stress management impact the health and productivity of the nursing workforce. NIOSH has called for employers to voluntarily examine practices that lead to errors,

decreased productivity, increasing absenteeism, and attrition. Recommendations include rest breaks every one to two hours, shift lengths of ten hours or less, light tasks for shifts of 12 hours, and a minimum of two rest days after three consecutive 12 hour shifts, (Caruso & Rosa, 2012).

The Florida Hospital Patient Protection Act of 2011, which would have provided minimum RN staffing requirements in Florida hospitals, died in the Florida senate in May of 2011 and was withdrawn ("Health Care," 2011). This study suggests patient assignments and nurse-patient ratios established by facilities or tradition do not provide a true picture of nursing workload. The minimum nurse-patient ratio legislation enacted in 1999 in California has demonstrated ratios improve the nursing work environment and job satisfaction, while maintaining patient outcomes and safety standards (Chapman, et al., 2009). Legislative action to establish minimum safe nurse-patient ratios should be reconsidered and supported.

Limitations

The following limitations may have influenced the findings in this study. First, difficulty in recruiting a traditional snowball sample of participants was not anticipated. This researcher found it surprisingly difficult to access experienced bedside nurses working 12-hour shifts at the bedside. The majority of bedside nurses working 12-hour shifts who volunteered to participate in this research did not have the requisite five years' experience. Recruitment efforts extended to the academic community resulting in a participant pool weighted toward the BSN and advanced education. Promotion of research in nursing education may have influenced these participants. Reluctance to be interviewed related to potential employer retaliation was also unanticipated.

Second, researcher familiarity with nursing work and the general work environment may be a source of bias. Narrative data is filtered through the researcher's own nursing socialization and experience.

Third, a year passed between data collection and analysis, removing the researcher from those immediate impressions which were not included in the journal or logged.

Fourth, although this study was guided and content validated by the dissertation chair, an experienced qualitative researcher, the inexperience of the PI with focused ethnographic method, narrative analysis, and computerized coding software is a potential limitation. Experience with all or any of these three factors may alter findings.

Summary

Nurses worldwide work in a dynamic and continually changing, challenging environment. Stress in the nursing workplace results in loss to employers, consumers and the profession. This focused ethnography explored the self-described experiences of coping and adaptation associated with workplace stress of nine registered nurses working 12-hour shifts in acute care settings in Florida. Findings support situations, persons, and events in the workplace combine to transform the basic directive of nursing, duty to the patient, into an overwhelming and stressful mandate. Use and development of coping and adaptations strategies by experienced bedside nurses have been identified. Chapter V, the final chapter, has provided a discussion of the findings, study limitations, implications for nursing and future research.

APPENDIX A: THEMES, SUBTHEMES, AND TOPICS

Themes, subthemes, and topics by research question

Research Question 1: *Explore the self-described experiences of stress experienced by bedside registered nurses working 12 hour shifts in acute care hospital facilities.*

Theme: Overwhelming sense of duty

Subtheme: Disruption of the nurse-patient relationship in providing care

Topic: Workload

Patient assignment
Documentation
Multiple competitive tasks

Subtheme: Ability to provide “good care”

Topic: Nurse-physician interaction

Topic: Workflow

Topic: Delegation

Topic: Defining “good care”

Between nurses
Patient harm
Novices

Topic: Get it all done

Organizing and prioritizing
Team work

Subtheme: Change

Topic: Adapting to change

Topic: Changes in the role of the charge nurse

Topic: Changes in nursing culture

Locality stress
Magnet® status

Threat to job security
Perceived culture changes associated with novices

Research Question 2: *Explore the manner in which coping skills are acquired by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.*

Theme: Mentoring

Subtheme: Having a mentor

Subtheme: Being a mentor

Theme: Acculturation

Subtheme: Venting

Topic: Where to vent

Topic: How venting is used

Topic: "Go to" person

Topic: Bonding

Subtheme: It's a team effort

Topic: Responsibility and respect

Topic: Stable teams

Theme: "Years of trial and error"

Subtheme: Learning

Subtheme: Problem solvers and solution seekers

Research Question 3: *Explore the manner in which adaptation strategies are developed by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.*

Theme: It works out better for me

Subtheme: Personalizing, tradeoffs, and attitude

Subtheme: Breaks

Theme: Self-imposed personal/professional boundary

APPENDIX B: EMERGING THEMES WITH SUPPORTING NARRATIVES

Research Question	Major/Sub Themes	Supporting Narratives
<p>#1 Explore the self-described experiences of stress experienced by bedside registered nurses working 12-hour shifts in acute care hospital facilities.</p>	<p>Major theme: Overwhelming sense of duty to the patient.</p> <p>Subtheme: Disruption of the nurse-patient relationship in providing care.</p>	<p><i>“Mostly it’s your patient load, although I put there [points to the demographic form] 4:1, most of the days we’re busy, and we’re short, and somebody called off, and our patients goes up, that’s a difficult thing – if you have too much patient load” (Cathy).</i></p> <p><i>“I think one of the biggest stressors is having a heavy turnover of patients and getting admissions and having to do discharges at the same time ... and then taking care of your patient that to me is one of the most stressful things” (Irene communication).</i></p> <p><i>“You know, um, six patients is a lot but you may take care of ten in the day considering discharges and admissions” (Helen).</i></p> <p><i>“I think too it’s the ratio of patients to nurses [7:1] ...at the end of a day you can end up having gone through 10 or 11 patients...[with] admissions and discharges” (Irene).</i></p> <p><i>“Especially if it’s season and you’re the only nurse who’s discharging then you’re gonna get hit with patients [admissions] ...that can be very stressful ...you know when you have two admissions coming in at once, you can only do one at a time ...hopefully...the other nurses are not terribly busy that they can stop and help you take off orders or you know, something. But that’s taking away from [their] patient care” (Helen).</i></p> <p><i>“You’re spending a lot of time going back and forth between the computer ...and the paperwork that you have to fill out...lots of paperwork...and you wanna be taking care of the patient!!! And you try to fit that in, that to me is the most important thing of all, you know” (Irene).</i></p> <p><i>“I like to have my assessments in. I try to have</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>them in [the computer] by noon because for me that takes a big load of stress off of me. They [assessments] are very time consuming” (Helen).</i></p> <p><i>“I feel the stress on me is that I have forgotten everything I’ve done by the time I’m charting it and I keep getting more and more wound up until I get my assessments in the computer...it’s gotta be in the computer... I stress myself” (Gina).</i></p> <p><i>“We have a charting system at our hospital that is relatively new and it’s cumbersome and it’s very slow, and I can tell you that’s probably my greatest stress right now. “...since it moves so slow we have to move at a faster pace, it kinda slows everything down. I think that’s the major stress right now...it takes up a lot of our time away from patient care” (Donna).</i></p> <p><i>“12 hours is not really 12 hours, maybe 13 or 14 sometimes to catch up with things that you need to document” (Cathy).</i></p> <p><i>“I think that’s the major stress right now, ‘cause the way we have to chart and it’s very long and involved and it takes up a lot of our time, away [from] patient care...I would say about 10% of my nursing care a day is spent with my patients, the rest is charting, answering phone calls, chasing down physicians, doing other things, pulling up meds, making meds, taking [vitals] ...talking with the techs...but actually going to a patient, talking to them, and giving them meds, the time is just maybe 10%. I think that’s realistic” (Donna).</i></p> <p><i>“Not being able to spend time with your patient because you are pulled in so many directions is very stressful, I think, for me” (Donna).</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>“It’s really, really tough when you’re on the floor and you’re being pulled in five different directions (staccato speech) A doctor’s on the phone, somebody wants you on the phone, the patient is in the room asking for pain meds, a therapist is asking to work with one of your other patients, that’s tough” (Fran).</i></p> <p><i>“How do you give chemo, and do discharge papers, and do an admission, that all have to be done within the next 20 minutes? You’re responsible for all three of them and you’re one person. I can’t stretch 20 minutes into an hour. They all should be done ...but it’s not practical! So something’s gotta give somewhere. Figure out which one to give, then how to make it happen so that you’re still keeping patient’s satisfied” (Gina).</i></p>
	<p>Subtheme: Ability to provide “good care”</p>	<p><i>“Most of our doctors are easy to get along with, but there’s are a couple of doctors that the nurses talk about and they can be very short with the nurses, and that definitely adds to the stress. I think part of this is that they don’t understand, you know, the load of work that we have and they think that we should drop everything we’re doing at the moment and assist them, which we would like to do; but sometimes you’re in the middle of giving medication or doing an admission or helping somebody that really needs some help...that’s hard, especially if you have seven patients” (Eve).</i></p> <p><i>“Having worked on the desk as a clinical charge nurse I was there to support the staff, and the families, and the patients, so I had a very low tolerance for physicians that weren’t respectful of what my staff would be concerned about” (Fran).</i></p> <p><i>“If we have a bunch of doctors coming at one time, charts pile up at the desk. The doctor was by at about eight o’clock in the morning, wrote some orders...I didn’t know anything</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>about the order till two o'clock in the afternoon...that was an issue for me . . .I spoke to the doctor about that later and I said . . .please just tell me to do it because I didn't have time to go up front and look through my charts to see what the doctor had written and I wasn't expecting that to be happening that day because I heard they were going to monitor the patient for two to three days and then think about it. It could have been an issue, it wasn't . . . but it very well could have been” (Amy).</i></p> <p><i>“They [CNA’s] usually have about ten, ten patients that they’re taking care of and if they’re busy doing something else, then you’re having to do what would normally be considered their job, because we all work together. But you’re spending time doing what they normally do in addition to what you are already doing! Now it’s putting you a little farther behind, so that’s creating a little more stress” (Amy).</i></p> <p><i>“Sometimes it’s more time consuming to try to find the CNA to do it” (Helen).</i></p> <p><i>“I don’t delegate well. I’d rather take it on myself than have a confrontation with somebody, so I load it all that on me...I’d rather do it myself than ask somebody else. I think that what I notice is stressful is the act of delegating” (Gina).</i></p> <p><i>“I find it’s [delegation] an area of stress for LOTS of nurses, especially new nurses, because when I see new nurses and they’re doing all sorts of bedpans constantly and I tell them ‘you need to tell your tech to do that’ and [they say] ‘well, she looks at me funny when I tell her’. And I’m like ‘she’s just testing you...A lot of them are really good ones that just do what they need to do, but for the most part it’s just – oh my God, it’s a</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>challenge. Like I said when you're younger than that person it's even more challenging....so I think that's stressful" (Eve).</i></p> <p><i>"Other nurses [are a source of stress]. Well, ones that aren't as sensitive to patient's needs or aren't as understanding of you know, their disease process, um, or the ones that are so casual about it. That irritates me" (Fran).</i></p> <p><i>"Basically . . . if I think you did a bad job you're gonna know about it. I don't pussyfoot around the issue" (Brooke).</i></p> <p><i>"And there were no rooms anywhere in the hospital and I know it sounds stupid but you know this lady was sick. I didn't have room to put her in and we were treating her out in the hallway. Yeah, something like that, I think it's stressful because it was my fault . . . I will never make that mistake again" (Donna).</i></p> <p><i>"That one stuck with me for a long time, well it still has. I don't know what happened, it just didn't flow right...I should have said 'you gonna look at the [patient] more? But then there was that many people from a higher level of care saying 'the [patient is] fine'. It lead to a lot of . . . paperwork for me...it never should've happened to begin with" (Brooke).</i></p> <p><i>"Right, they [novices] don't do it, they don't miss it, and they don't pick up little things, little hints. They can't put together different things that are going on with the patient. They can deal with a patient with one diagnosis and our patients are coming in with complex issues, so that's kind of scary for me" (Eve).</i></p> <p><i>"Because they [novice nurses] are so casual about their patient care that you know, when you follow them with their patients the next day you feel like you're kinda having to (short pause) re-revise some of the things that</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>they've done for the patient... They have such a laissez-faire attitude where they're not as serious about it as I think they should be"</i> (Fran).</p> <p><i>"If my day is manageable I'm delighted to be a resource person for others. I like to share my knowledge. I like one on one teaching"</i> (Gina).</p> <p><i>"We've become very busy, um, patients are sicker than they were which means they're more involved as far as their care goes. Um, there's a lot of needing to prioritize your time, 'cause you can really get bogged down if you're not careful. Um, running all through the day, sometimes just to keep up with what's going on through the day. Its chaos, its organized chaos"</i> (Amy).</p> <p><i>"It's just something that, you know, I have to do. So I tough myself up and say 'I gotta go get this stuff done'. So that's an area of stress (Eve).</i> <i>It's time management. Just, um, frequently turning things over in my mind; like what is the most important thing to do at this point . . . I have a list in my head . . . what I have to do next, and that can change in a heartbeat"</i> (Irene).</p> <p><i>"I try to organize my day when I'm getting report in the morning . . . I'm assessing, who I'm gonna see first . . . what patient needs to see me first, so I try to stay organized with patient care. It doesn't always happen that way . . . I try to stay organized and any moment that I find time -chart, or do something that needs to be done. I try to stay on track with those things. So far, you know it works. Like I say it gets overwhelming, it gets stressful, but I just get in my groove"</i> (Helen).</p> <p><i>"We help one another. When we get</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>admissions we jump in and help each other. So, overall, I mean we're stressed, we're overworked, we're overwhelmed, but because we work so well as a team it makes it somewhat easier for us to cope with the stress" (Helen).</i></p> <p><i>"If you can't get everything done sometimes you have to pass it onto the next shift...you wanna do it, but they [administration] are looking at the time clock" (Donna).</i></p>
	Subtheme: Change	<p><i>"Change is always...difficult to deal with, you know whenever change comes around, whenever they want you to do charting a little bit different, or you have a requirement that's needed...that becomes a little stressful" (Amy).</i></p> <p><i>"I'd say besides myself there's maybe two other 'seasoned nurses' so we understand that there's something's that are not going to change, and there's something's that we're excited about change wise" (Brooke).</i></p> <p><i>"Sometimes, you know as far as the first reaction to change is like 'oh my god, they're gonna change again, here we go!', but if you think it's for the positive, it's for the good or the better, it's for better patient care, less mistakes, then you know – you go for it. Yeah, it's difficult, but once you learn the procedure or the task it's easier and I think it's for the better" (Cathy).</i></p> <p><i>"I'm very excited about it. I'm on the clinical resource group, so I work with clinical informatics [moving to paperless charting for nurses and physicians] ...to me this is very exciting. I can't think of a better avenue for safety for patient care. So I'm embracing it and I think it's great . . . You know with anything there's a learning curve, it will be a little trying, but no, I'm very excited" (Fran).</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>“They change it every week, there’s a new thing, and change. They add on documentation or something. The most, the worst change that we have is the patient ratio which went to 5:1 and that is not good. I mean, with the kind of patients we have...it’s really hard...Of course, you know we complained. Complain and express your concerns, thoughts and feelings and explain how things [are]. It’s hard to accomplish that change so, and since we are doing that, I think they are going to change it back” (Cathy).</i></p> <p><i>“You just don’t even know who they are, yet these rules are coming down” (Brooke).</i></p> <p><i>“Our new manager recently moved the med room...we just didn’t agree...it is smaller and it is more crowded so it’s a little more frustrating and adds to the patient care. So there’s something’s that we’re still working on and you know we feel like if we continue to communicate our concerns with our manager then things will change!” (Fran)</i></p> <p><i>“What’s the point of venting if you don’t see the changes in the long run? I would like to see more changes happen” (Irene).</i></p> <p><i>“There’ve been some changes in our hospital regarding the charge nurse. Before this year, the charge nurse was actually the charge nurse’ and would be in charge of the floor and help with a lot of problems that would occur...there’s been a lot of shifting around of duties in the last year, and the charge nurse now takes patients. So now their duties have actually disappeared and a lot of the duties they used to do; now the nurses have to do. So that has added to our stress level, I must say! Yeah, it’s very hard. V-E-R-Y hard on our unit, and the nurses complain about it constantly...we want our charge nurses back as being ‘charge nurses’. They’re there</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>physically, but they have their own assignment and frequently they'll tell us 'I don't have time, because I have MY own patients to take care of' (Irene).</i></p> <p><i>"You know now we finally have a charge nurse so that's taken some of our work load. Not a lot, we still have the bulk of everything to do but, it does take some of the stress off" (Helen).</i></p> <p><i>"If there's something I can't handle I move it to the next level...I'll send the charge nurse in and see if she can give any solutions to the problem" (Helen).</i></p> <p><i>"Lately the big stressor for work has been if you do not clock in to work at 6:45 you are considered late. You can clock in at 6:46 and you are late. You get two of these in a three month time and you get written up. I mean people are literally running through the hallways so they don't clock in late...Yeah, like one girl drove on the side of the road because she's like 'I can't get late again because I've already clocked in at 6:46 once time.' So it's like if I do this I'm gonna lose my job" (Brooke).</i></p> <p><i>"Because they give you all these [patients], too much patient load, and then if you make a mistake, they reprimand you, so you cannot even refuse. If you refuse, you're refusing the situation. You can get fired for that. So we have some nurses that get fired for refusing extra patients. They can fire you for anything!" (Cathy).</i></p> <p><i>"I think administrators are kind of above all that and don't really see what's going on" (Donna).</i></p> <p><i>"They're not seeking after you; you're not seeking after them. They only hear about you</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>if you cause trouble [laughs]. Otherwise they don't really know you” (Eve).</i></p> <p><i>Eve described “frustration” with “nurses who don't respect nursing as a profession” and her assessment that “nursing seems to be changing from a profession to a job.”</i></p> <p><i>“I can tell you when I first started [present position] five years ago we had all experienced nurses and they all worked as a team. We were so fantastic. We were such a tight unit. Over the years we've had a lot of people leave. We had a lot of new nurses come on that were younger. They're all about their early to mid-twenties and they're just not the team players that we had before. They're all very [short pause] I consider them as islands. They kind of do their own thing” (Donna).</i></p> <p><i>“They offer lectures for CEU's [continuing education units] and I often see myself and the other seasoned nurses on the floor going to the additional learning experiences and the younger ones aren't...I've always thought that you're always having to learn...”(Helen).</i></p> <p><i>“A lot of the newer nurses are all about the clinical ladder...you know they all want to get up there and get more money and start working nights for the differential...Now they're right out of nursing school and they're all about the higher pay grade” (Fran).</i></p> <p><i>“I think it's probably as much age and work ethic that I grew up with because I see the younger nurses that don't have that sense of 'it's my responsibility' as much”(Gina).</i></p> <p><i>“I knew while I was precepting that this really wasn't a priority for her, she was concerned about a vacation trip, her friends, doing things with her friends; you know, she wasn't</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>eager to learn. The other one, I now work with, her value system is totally different. She's really good at good enough" (Gina).</i></p> <p><i>"Never forget what's happening to this person is a life changing experience. I think a lot of new nurses don't understand that...but knowing how to be a good nurse, I think will allow the patient to feel that, and understand that, and it will make their nursing easier" (Fran).</i></p> <p><i>"I appreciate my nurses who've been nurses for 30 years or 40 years and I love to sit and learn techniques that they did, that I didn't learn in nursing school. But, I think that new nurses just don't have that respect, um, for nursing, in that manner anymore. It's just like out with the old - in with the new type of mentality. You know technology is great, but you know, technology can't train bedside nurses. A computer can't take care of a patient at the bedside. It doesn't matter. They might be able to plug in an assessment and get out something diagnostic but it takes a person to take care of a person and you just can't get rid of that" (Eve).</i></p>
<p>#2 Explore the manner in which coping skills are acquired by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.</p>	<p>Theme: Mentoring</p> <p>Subtheme: Having a mentor</p>	<p><i>"If you have good mentors who can give you pointers that's very helpful" (Amy).</i></p> <p><i>"When I first graduated from nursing school and started, I did my practicum; my preceptor for my practicum was wonderful. I still look up to her to this day and I still talk about her . . . things that she taught me I never forgot. She was extra-ordinary . . . a lot of things that she taught me, it really helped me build self-confidence . . . she was very organized and . . . she had a calm demeanor . . . so my biggest thing is trying to stay organized and trying to stay, um, keep things on time . . . and you know, it seems to help me cope with my day" (Helen).</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>“I was trained as a new graduate by a nurse, a senior nurse, who insisted on breaks and who would mark me off for . . . lack of . . . time management if I didn't take a break. So I was taught early in my career that a break was important . . .I've always been able to, no matter what was happening, take a break . . .that's what I'll always have to look forward to. You know, every now and then it's like ‘this day has gone so crazy, I can't believe it's this time!’ I have to step away even if it's just for 10 minutes. It's just so important and I force other people to do it too. (laughs) ‘I'll watch your patients- you gotta go now - nobody's dying’. I used to always say ‘if nobody's dying right now, then I can take a break’, because they're still going to be sick” (Eve).</i></p> <p><i>“Yes, there was an elderly nurse who absolutely looked 30 years younger than what she was, and when I found out she was like 75 [years old] I was just floored! [laugh] She recently retired and I actually told her she was my mentor. Um, I could go to her for anything, and she gave me all kinds of tips. Especially in the oncology stuff, and in-in many ways, because she had been a nurse for over 50 years! I was just absolutely floored when I found that out and I thought, no wonder she's so cool, calm, and collected. I admire the nurses that have been doing it for a while . . . you know she says ‘you can only do what you do when you are doing it; you can't do it all at once’. I think that basically is to take one thing at a time” (Irene).</i></p> <p><i>“She was in her 70's, um [short pause] she was an old nurse, been around forever and didn't take any guff from anybody. She saw the world kind of in black and white, but [short pause] she was just real. There was just something about her. I didn't always agree with her, but I always respected her . . .I had gone to back to work for hospice per</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>diem and I actually got to make a nursing visit to her, while she was still alert and aware. I haven't seen her in about seven years . . . just to be able to go out and have my opportunity to say good-bye to her, meant a lot [spoken with emotion and reverence in voice] we-we shared a lot . . . We felt the same way about things a lot of times” (Gina).</i></p>
	<p>Subtheme: Being a mentor</p>	<p><i>“It makes you feel good. Feeling good gets rid of stress” (Gina).</i></p> <p><i>“I think that you need to be good at what you do. Know things and if you know it, you'll be comfortable in doing it; and if you're comfortable in doing it, I think you'll survive. And, always think positive. And if you have a problem, just ask somebody to help you, don't do it on your own cause it's gonna be hard to survive . . .you can delegate tasks and you can always ask for help. Don't be afraid to ask questions and ask for help. Even though I'm an experienced nurse, I still ask for help and ask questions” (Cathy).</i></p>
	<p>Theme: Acculturation</p> <p>Subtheme: Venting</p>	<p><i>“. . . you know we just vent to each other as nurses, that's what we do” (Eve). So, um you know also the nurses vent to each other and we have a place that we can do that with closed doors [laughs] while we're drawing up our medicine in the med room because it's pretty sound proof, so you know the nurses can go in there and vent, and actually I think that's a really good thing. The med room is a locked isolated area so the patients can't hear you and you know, it's good. We can just kind of let it out. You know everybody's letting it out” (Irene).</i></p> <p><i>“Like I said we vent a lot. Our med room, because it's a locked room and that's where you pull staff in and go 'ah I can't believe that patient just yelled at me' or you know, you can go and calm down in order to stay ready for other patients” (Eve).</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>“We do that [venting] quite a lot with each other. It’s like we go somewhere, we close the door and we’re like [speech changes to a gruff tone] Arrrrrrrrrrhhhhhhhh!!!! [Speech changes to a sunny tone] and then you know, we feel better (Amy).</i></p> <p><i>“It was, that was, stressful, ah, and challenging...but I called one of my other charge nurses and she came and talked me down...and you know, I was OK to continue” (Eve).</i></p> <p><i>“Oh yeah, just venting to somebody. It isn’t that somebody is going to solve my problem, but just venting it, expressing it, that usually helps”(Donna).</i></p> <p><i>“We all kind of try to debrief situations. You know like ‘what happened, what we could have done better, what lead up to this situation, was there anything else we could have done” (Fran).</i></p> <p><i>“So I found myself just hanging around so I could calm down before I go home. I just needed to talk about it to-to staff and to the supervisor and I needed debriefing . . . I like to say ‘what would you have done, did you see anything we could’ve done different?’ That helps me . . . that’s important for me (Eve).</i></p> <p><i>“I think we all kind of sit around and say, you know ‘I’m not sure about the guy in 710, what’s going on?’”(Fran).</i></p> <p><i>“Because people know who they can go to too vent” (Amy).</i></p> <p><i>“More the person who people are venting to than the person who’s venting” (Eve).</i></p> <p><i>“I can call them [team members] up and say “you wouldn’t believe what happened . . . and</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>vent it out that way 'cause they have a better understanding . . . like just this morning 'cause I know they were short staffed last night, I texted one of the girls and said 'how bad was it'? [She replied] 'Bad really bad' so we texted back and forth. So that kinda helped her . . . if she were to text me in that situation then you know that someone is out there thinking about you. And yeah, there's bonding and friendship that helps get you through the night" (Brooke).</i></p> <p><i>"Yes, I vent to co-workers; I'll vent to my nurse manager. If there's a problem, I'll vent. You know, keeping it in is not good. So expressing it, I feel this is a better way to try to cope with a situation. So yes, I will vent" (Helen).</i></p>
	<p>Subtheme: It's a team effort</p>	<p><i>"You cannot do things yourself; so as I said, it's a team effort" (Cathy).</i></p> <p><i>"One thing about our particular unit is that we have a reputation for having really good team work . . .most of the staff has a good attitude and we pretty well like where we work" (Amy).</i></p> <p><i>"Oh yeah . . . you got to rely on your co-workers . . . like last night there should have been five [R.N.s] and there was only three. One - you pray that the bus isn't gonna come in [figurative expression of speech] you can look at it and know; OK well, there's three, we work great as a team and they're there to help me" (Brooke).</i></p> <p><i>"I have every confidence in the world in their decisions. I think they're all very-very good nurses, they are very-very good at what they do, we all have a different style; very rarely do I question anything that they did" (Brooke).</i></p> <p><i>"We have a really great group of nurses that</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>communicate well with each other, and we have such good camaraderie, you know. We are very concerned about the folks that we take care of on our floor” (Fran).</i></p> <p><i>“I think my floor is probably the most stable in the hospital. We don't have a big turnover of employees. They, a lot of nurses, want to come to our floor. Because we work so well together as a team. Day shift and night shift. There are more newer nurses on night shift, but um, for the most it's pretty much the same staff and it has been for at least 3 years I would say” (Helen).</i></p> <p><i>“We don't have the team nursing that I think they'd consider where you team up two nurses, you consider that team, we haven't done that. But we kind of do that as a natural thing. Our nurses on our unit in the daytime are absolutely helpful to each other and that's the one thing that keeps me there is our team nursing” (Irene).</i></p> <p><i>“Very important, because nursing is not something you can do by yourself” (Fran).</i></p> <p><i>“No matter how much experience I feel like I have, I, you know, if I'm questioning something or I'm going to do a procedure with a patient, or I'm not-quite-sure-you know how; I would just talk to somebody about. I'd say ‘what would you do’ say if this occurred . . .If I need help I will ask for help and you know, the co-workers I work with, we work really as a team” (Fran).</i></p>
	<p>Theme: Years of trial and error</p>	<p><i>“Years of trial and error. I mean it just takes time; you just have to find out what works best, and that just takes time” (Amy).</i></p> <p><i>“It's just what we do and it's just over and over and over again . . .So it's a process that gets tweaked as you do it longer, and you become more comfortable with it . . .I've</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>become more confident because I've been there longer. I've been in these situations and you know you cope with it through that way” (Brooke).</i></p> <p><i>“I understand people more. I understand myself better certainly. I know how to communicate with them and their communication styles and how they perceive things and how people perceive them” (Fran).</i></p> <p><i>“I'm on the unit and we have this heavy patient and I call down to the ER and say ‘I need a couple of guys to come up here right now’. So I think a lot of it is, just um, pulling from resources” (Eve).</i></p> <p><i>“I look a little further than what's right in front of me . . .I'm just trying to think . . . thinking things through a lot more, um, coming up with rationales, more so than just complaining about things” (Amy).</i></p>
<p>#3 Explore the manner in which adaptation strategies are developed by experienced bedside nurses working 12-hour shifts in acute care hospital facilities.</p>	<p>Theme: It works out better for me</p> <p>Subtheme: Personalizing, tradeoff, and attitude</p>	<p><i>“I never worked days. It works out better for me, and it works out better for my family . . . I drop them off in school, I go back and I pick them up. I'm there for their activities; I'm there to help them with their homework” (Brooke).</i></p> <p><i>“The night shift is less stress and better for me in terms of school. I needed to eliminate some stress . . . so I stepped down from being in charge and went to the bedside at night” (Eve).</i></p> <p><i>“I only do two [shifts] in a row and then I have two or three days off. So, the first mornings not so bad, because you're nice and fresh, you've been off for 3 days, you go in, you're doing great, everything's fine. The next morning you get up and go "oh great I can sleep in tomorrow morning, I just have to make it through the day" so it's just you know, tricking your mind like that and it's not so bad</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>... you trick yourself into staying” (Amy).</i></p> <p><i>“The day before I go to work I go to bed very early, I mean I'm rigid with myself in that area ... if I can do three days in a row and get it done and have my 4 days off, I almost like that better, especially if you have the same group of patients. But that's the key. If you don't [have the same patients] it's another situation” (Irene).</i></p> <p><i>“Since I went back to the hospital, I have basically a set schedule. I work Monday-Wednesday-Saturday-Sunday-Wednesday-Friday. It split up my 12 hour days so I wasn't working them back to back except on the weekend; which was traditionally slightly slower pace. So it didn't stress me physically as much. It was working great for me. New management came in and then 'nobody's going to have a set schedule' [with sarcasm]. 'And your rationale is?' 'Well nobody's going to have a set schedule ...' So they arbitrarily changed what has been working for eight years ...oh and how could anybody not work 2 and 3 days in a row? ... I know my personal physical limitations. I don't need to retire from hospital work if I can work this schedule that works for me physically” (Gina).</i></p>
	Subtheme: Breaks	<p><i>“What I do is that instead of taking like a 15 minute break in the morning, I will just take 5 minutes, go back, get a drink of water, go to the bathroom and come back. I'll do that a couple of times and that works for me. The same thing with the lunch, even though the lunch is a half an hour, many times I only take a 15-20 minute lunch and it's like after 15-20 minutes I'm done eating so what else do I have to do? I need to get back to my patients” (Irene).</i></p> <p><i>“If you can't take care of self, how can you take care of others? So I try to remember that</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>and I say it, you know, I say it for my own satisfaction, to hear it, as well as to my co-workers. You have to take time to eat. I try to eat breakfast at home because the morning is the busiest time and you tend to not take the time to eat . . .I'll get report on my patients and depending on what needs to be done right away. If I have 7:30 meds and how long it takes me to get report, I might go ahead and eat something light. I may eat 1/2 a bagel or a bowl of grits or something, so at least eat something” (Helen).</i></p> <p><i>“Well you don't actually get it [break]when you would prefer um you kinda have to look at what's going on . . .So you have to kind of time it and say ‘well I'll go eat now cause otherwise it's not going to be until five in the morning’ But for the most part, we get it” (Brooke).</i></p> <p><i>“I'm usually pushed into the break room by a colleague or you know, I just say ‘I'm going to get off the floor for 15 minutes’ and I go down and grab a little soda or something” (Fran).</i></p> <p><i>“when I'm on break, I'm on break” (Cathy.).</i></p>
	<p>Theme: Self-imposed personal/professional boundary</p>	<p><i>“My work, I don't bring it home, and my home, I don't bring it at work. Those are separate things for me, so one thing doesn't affect the other. I, as I said, I don't combine my family problem and my work problem . . . Um, my work is work. When I do my work I try to do it the best that I can. When I leave my work, it's there. I don't bring it home. I'm a person that my work is work and my home is home” (Cathy).</i></p> <p><i>“I have many stressors at home but I can't take that to work - that's home. I leave that home because work is not going to solve that problem. So I've always done very well at keeping home and work separate” (Helen).</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p><i>“When I walk out those doors - that's it . . . I don't talk about my work with my husband. I don't talk about my work at home with anybody. It's left. I don't call. Some nurses will call on their days off and ask how this patient is. Once that door shuts, I'm out . . . I just say this is the way it is. It's just the way I want it to be. By not talking about it, I think, by not talking about work at home, I think that separates it. By not reliving it over and over, you know and at work I don't talk about my personal life. I don't talk about anything about personally, well that's the way I do it. I just don't share information like that with anybody. I don't think about it until I go back. Never. I never cross the two, ever!” (Donna).</i></p> <p><i>“You have your work life and you have your own personal and social life, your private life; and they shouldn't intermingle except for certain occasions” (Gina).</i></p> <p><i>“I think I do a pretty good job of separating. You know, keeping them separate but, yeah, the job does add extra stressors to the family and yeah, vice versa. Job adds stress to family, family adds stress to job” (Brooke).</i></p> <p><i>“Oh yeah, oh yeah, I think you have too [separate]. You know, or else it would just eat you up. I don't say that there are days that I don't wake up crying thinking about a person I'm taking care of, or I have dreams about people that I take care of, I worry about people that I take care of, I mean I think that's just human nature. It's really hard to forget people, but that encourages me to be better, to learn more, to just understand what I can do better for these people” (Fran).</i></p> <p><i>“My decompression time. It takes me about a half an hour to get home. By the time I'm home, most of that intense stress is gone”</i></p>

Research Question	Major/Sub Themes	Supporting Narratives
		<p>(Gina).</p> <p><i>“I really try not to [bring it home](laughs). The minute I walk out of the hospital I just, I get in the car and I turn the music up. That’s the first thing that I do. It just takes my mind away. And I really try to forget about it. That’s one of the good things about working in a hospital” (Irene).</i></p> <p><i>“I try very hard not to take it home. I think, in terms of nursing, now I think I probably take things home a little bit more here because I live very close. I find that the drive home, like when I worked 40 minutes from home was enough for me to unwind before I got home. But, um, so like, so now that I’m like 15 - 10 minutes away from home I’m still a little edgy sometimes when I go home. But, I think I do ok. I don’t shout or anything like that when I get home because of something that happened at work, um so in that I don’t take it home . . .I think I’m able to swap off and be who I need to be” (Eve).</i></p>

APPENDIX C: IRB APPROVAL AND CLOSURE OF HUMAN RESEARCH



University of Central Florida Institutional Review Board
 Office of Research & Commercialization
 12201 Research Parkway, Suite 501
 Orlando, Florida 32826-3246
 Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1
 FWA00000351, IRB00001138**

To: **Joyce P. Burr**

Date: **December 21, 2010**

Dear Researcher:

On 12/21/2010, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review: Exempt Determination
 Project Title: The Self Described Experience of Coping and Adaptation
 Associated with Workplace Stress of Registered Nurses in the
 Acute Care Setting in Florida: An Ethnographic Study
 Investigator: Joyce P Burr
 IRB Number: SBE-10-07302
 Funding Agency:
 Grant Title:
 Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Joseph Bielitzki, DVM, UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 12/21/2010 09:11:44 AM EST

IRB Coordinator



University of Central Florida Institutional Review Board
 Office of Research & Commercialization
 12201 Research Parkway, Suite 501
 Orlando, Florida 32826-3246
 Telephone: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Acknowledgement of Study Closure

From : UCF Institutional Review Board #1
 FWA00000351, IRB00001138

To : Joyce P. Burr

Date : August 31, 2012

Dear Researcher:

On 8/31/2012 the IRB conducted an administrative review of the FORM: Study Closure Request that you submitted in iRIS. The study has been closed within the system.

This report is in regards to:

Type of Review: Study Closure
 Project Title: The Self Described Experience of Coping and Adaptation Associated with Workplace Stress of Registered Nurses in the Acute Care Setting in Florida: An Ethnographic Study
 Investigator: Joyce P Burr
 IRB Number: SBE-10-07302
 Funding Agency:
 Grant Title:
 Research ID: N/A

As part of this action:

- The research is permanently closed to enrollment.
- All participants have completed all research-related interventions.
- Collection of private identifiable information is completed.
- Analysis of private identifiable information is completed.

Thank you for notifying the IRB of this modification.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 08/31/2012 03:22:30 PM EDT

IRB Coordinator

Submission Reference Number: 015273

APPENDIX D: EXPLANATION OF RESEARCH



EXPLANATION OF RESEARCH

Title of Project: The Self-described Experience of Coping and Adaptation Associated with Workplace Stress of Registered Nurses in the Acute Care Setting in Florida: An Ethnographic Study

Principal Investigator: Joyce P. Burr, MSN, RN

Other Investigators: NA

Faculty Supervisor: Angeline Bushy, PhD, RN, FAAN

You are being invited to take part in a research study. Whether you take part is up to you.

The purpose of this research is to explore the self-described experience of coping and adaptation associated with workplace stress of experienced bedside nurses working 12 hour shifts employed in acute care hospital facilities.

You will be asked to meet with the researcher at a mutually comfortable and agreed upon location. You will be asked to complete a 5-10 minute brief written demographic questionnaire and participate in a recorded interview. The interview will take 40-90 minutes. You will be asked to describe your experiences as a bedside nurse, your experiences of workplace stress, and your experience with coping and adapting to stress in the work place. Your identity will be kept confidential. No one but the researcher will know you participated in this study. Recordings will be transcribed and identified by code, and will be erased after transcription. Your name or other identifying information will not appear on the transcript or in notes.

Transcripts of the interview may be returned to you for you to review and make additional comments. A stamped self-addressed envelope will be provided for return of the interview transcript. A \$15.00 gift card to Wal-Mart will be provided after completion of the interview and return of the reviewed transcript. There will be no cost to you for participation in this study.

If you do not wish to be recorded you may not be able to participate in this study. Please discuss this with the researcher. You may withdraw and discontinue participation at any time without penalty.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints: Joyce P. Burr, Doctoral Candidate, University of Central Florida College of Nursing, (772) 559-1211 or by email at joyceb@knights.ucf.edu or Dr. Angeline Bushy, PhD, RN, FAAN, University of Central Florida, College of Nursing, (386) 506-4032 or by email at abushy@mail.ucf.edu

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

APPENDIX E: PARTICIPANT INCLUSION SCREENING TOOL

Form 1: Participant Inclusion/Exclusion Criteria

Name: _____

Please check YES or NO in response to the following questions:

Yes	No	QUESTION
		Do you have an unrestricted registered nursing license to practice in the state of Florida?
		Are you a newly licensed registered nurse?
		Do you have five (5) or more years of nursing experience?
		Are you employed as a hospital based bedside nurse?
		Have you been employed for three or more years on a nursing unit?
		Can you read, write, and speak English fluently?
		Are you a registered nurse, not assigned to a principal unit, but work on a variety of medical surgical and high census bedside care and specialty units, and may be titled as "float"?
		Are you a registered nurse employed in a high acuity, low census specialty nursing unit such as intensive care (ICU), neonatal intensive care (NICU), cardiovascular intensive care (CVICU), or burn unit?
		Are you employed as a registered nurse in a unit with transient populations including surgical services and emergency departments (ED).
		Are you employed in your current hospital as a temporary or travel nurse?
		Have you ever been treated for mental illness, drug or alcohol addiction?

APPENDIX F: DEMOGRAPHIC

Demographic information for lead in and establishing rapport:

Name			
Address			
Phone	Cell Phone	Preferred Method of Contact	
Year of RN Licensure			
Original Nursing Program	<input type="radio"/> Diploma <input type="radio"/> ADN <input type="radio"/> BSN		
Highest Level of Nursing Education achieved	<input type="radio"/> Diploma <input type="radio"/> ADN <input type="radio"/> BSN <input type="radio"/> MSN <input type="radio"/> PhD/DNP/other		
Certifications			
Professional Organization Memberships	Name: Name: Name:		
Current Employer	Magnet Facility <input type="radio"/> Yes <input type="radio"/> No Name of Facility:		
Length of Service with Current Employer	Years	Months	
Current Nursing Unit	Length of Service on Current Unit in years		
Your Level of Expertise on your Current Unit <i>I being Least</i> → → <i>5 being Highest</i> (1)Novice (2)Beginner (3)Competent (4) Proficient (5)Expert			
What is the nurse/patient ratio on your unit in number of patients per nurse _____ Patients/Nurse	How many hours are you scheduled to work _____ per week?	How many hours do you actually work per week?	
How many hours of overtime do you work per week?	Do you work weekends? <input type="radio"/> Yes <input type="radio"/> No	Do you principally work <input type="radio"/> Days <input type="radio"/> Nights <input type="radio"/> Evenings	
Age: Gender: <input type="radio"/> Male <input type="radio"/> Female	Single: <input type="radio"/> Yes <input type="radio"/> No Partnered: <input type="radio"/> Yes <input type="radio"/> No	Number of Dependents:	
Are you the primary wage earner: <input type="radio"/> Yes <input type="radio"/> No	Ethnicity: White <input type="radio"/> Hispanic <input type="radio"/> Black <input type="radio"/> Asian <input type="radio"/> Native American		

APPENDIX G: INTERVIEW GUIDE

Interview Questions and Prompts

Rapport established during demographics interview. Data collection questions for semi-structured interview as follows:

- I understand you have been a registered nurse for ____ years. Can you tell me a little bit more about why you became a nurse?
- Since beginning your nursing career, in what specialty areas have you practiced?
- Which is/was your favorite? Why?

Typical Day:

I would like to learn a little more about your experiences as a hospital bedside nurse:

- Tell me about the unit you work on currently.
- Can you briefly describe for me an example of a typical day in the work setting?

Stressors:

- Keeping your work environment in mind, what do you think about when I say the word "stress"?
- *Alternate question:* Can you give examples of the most serious or difficult situation in a typical day/shift.
- *Alternate question:* Could you elaborate as to why this stressor is serious or problematic.
- How have you adapted to the routine stresses on your unit?
- Can you clarify?
- Can you give me a specific example?
- Was this the first time you encountered _____(per response)?
- How do you typically deal with the situation you just described?
- Have you always responded/reacted in this manner? How have your responses changed?
- Tell me about other situations that are stressful in your life

Coping:

- How did you learn to deal/cope with _____(per response)?
- Is there anything in the work environment that helps you to cope?
- What in the work environment hinders your ability to cope?
- Is there anything I haven't asked you that you feel you would like to share on this topic?

Reflection and Clarification:

General broad statements may be used to elicit perception.

- I have heard that nurses _____ do you find that to be true?
Sharing of thoughts and feelings will be encouraged
- When you spoke about _____ you seemed _____ would you like to share more about that?
- Am I correct in understanding that you have told me _____ about stress/coping/adaptation?

Refocusing:

Refocusing techniques will be used as needed to return to topic and make the best use of time. PI will restate last statement related to topic by saying:

- A little while ago you said _____, can you tell me more about that?

Expanding Data:

Interview questions will be expanded and examples requested based on participant responses, in individual interviews and across interviews, to encourage deep rich description and clarification. Language and topics introduced by participants will be incorporated into interviews.

APPENDIX H: BURR CV

Joyce Burr, MSN, RN, AHN-BC

University of Central Florida College of Nursing
1519 Clearlake Road Bldg. 3 Suite 333
Cocoa, FL 32922
(321) 433-7857—Office
(321) 433-7863—Fax

EDUCATION

Year	Degree	Institution	Clinical Major	Role Preparation
Current	PhD	University of Central Florida, Orlando, FL (Doctoral Candidate, graduation expected 2012)	Nursing	Research/Academia
2002	MSN	Florida Atlantic University, Boca Raton, FL	Nursing	Holistic Nursing
1993	BSN	Barry University, Miami Shores, FL	Nursing	Administration
1991	ADN	Indian River Community College, Ft Pierce, FL	Nursing	Nursing
1986	AS	University of the State of New York, NY	General Ed	
1984	Certified	South Nassau Communities Hospital School of Radiologic Technology, Oceanside , NY	Radiology	Radiographer

LICENSURE/CERTIFICATION

RN	Florida, 2510182
AHN-BC	#886, 2004
CHTP	#2168, 2004

EMPLOYMENT

ACADEMIC APPOINTMENTS:

08/11-Present	Instructor , University of Central Florida College of Nursing, Cocoa, FL
09/10-08/11	Visiting Instructor , University of Central Florida College of Nursing, Cocoa, FL
08/09-09/10	Adjunct Instructor , University of Central Florida College of Nursing, Orlando and Cocoa, FL campuses
07/08-12/09	Adjunct Instructor , Florida Atlantic University Christine E Lynn College of Nursing, Boca Raton, FL (Port St. Lucie campus)
08/04-05/08	Visiting Instructor , Florida Atlantic University Christine E Lynn College of Nursing, Boca Raton, FL (Port St. Lucie campus)
06/04-08/04	Adjunct Instructor , Florida Atlantic University Christine E Lynn College of Nursing, Boca Raton, FL (Port St. Lucie campus)
01/02-05/03	Instructor , Indian River Community College, Nursing Department, Ft. Pierce, FL (Mueller campus)

CLINICAL APPOINTMENTS:

03/10-11/10	Staff Nurse , (Per Diem), Emergency, Sebastian River Medical Center, Sebastian, FL
07/08-12/09	Staff Nurse , Orthopedics, St. Lucie Medical Center, Port St. Lucie, FL
07/03-08/04	Clinical Specialist/Educator , Visiting Nurse Association of the Treasure Coast, Vero Beach, FL
01/02-6/03	Staff Nurse , (Per Diem), Emergency, Indian River Memorial Hospital, Vero Beach, FL
05/92-01/02	Staff Nurse , Emergency, Indian River Memorial Hospital, Vero Beach, FL
05/91-05/92	Staff Nurse , Medical/Surgical, Indian River Memorial Hospital, Vero Beach, FL
09/84-05/91	Radiologic Technologist , Special Procedures, CAT Scan, and Imaging Sciences, Indian

PUBLICATIONS**REFEREED JOURNALS:** (* Data-based articles)

Andrews, D.R., **Burr, J.** & Bushy, A. (2011). Nurses self-concept and perceived quality of care: A narrative analysis. *Journal of Nursing Care Quality*, 26(1): 69-77.

Burr, J. (2005). Jayne's story: Healing Touch as a complementary treatment for trauma recovery. *Holistic Nursing Practice* 19(5), 211-216.

OTHER FUNDING

Date	Role	Title	Agency	Type	Amount
2012	Faculty	WAC Starter Grant	UCF WAC Program	Intramural	\$350.00
2012	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services U.S.	Intramural	\$400.00
2011	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services U.S.		\$450.00
2011	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services U.S.		\$ 245.00
2011	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services U.S.		\$ 1000.00
2010	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services		\$ 1000.00
2010	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services		\$ 1004.00
2010	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services		\$ 1600.00
2009	Student	Advance Education Nursing Traineeship Award	U.S. Department of Health and Human Services		\$ 1600.00
2009	Presenter	Graduate Travel Award	University of Central Florida, Graduate Studies		\$ 255.00
2008	Student	Nursing Scholarship for Graduate Study	University of Central Florida, College of Nursing		\$ 750.00
2008	Presenter	Graduate Travel Award	University of Central Florida, Graduate Studies		\$ 300.00
2006	Student	Blue Cross/Blue Shield Nurse	University of Central		

Date	Role	Title	Agency	Type	Amount
2006	Student	Educator Scholarship SUCCEED-Florida	Florida, School of Nursing University of Central Florida, School of Nursing		
2005	Student	SUCCEED-Florida	University of Central Florida, School of Nursing		

PRESENTATIONS—LOCAL/REGIONAL/STATE

06/04/11	Poster	Reality shock revisited: Returning to the bedside	6 th Annual Sunshine Conference for Advanced Practice Nurses, Volusia Flagler Advanced Practice Nursing Council, Daytona Beach, FL	Refereed
06/04/11	Poster	The value of online post conferencing in undergraduate clinical education	6 th Annual Sunshine Conference for Advanced Practice Nurses, Volusia Flagler Advanced Practice Nursing Council, Daytona Beach, FL	Refereed
02/14/09	Poster	Reality shock revisited: Returning to the bedside	2009 Annual Conference Southern Nursing Research Society, Baltimore, MD	Refereed
02/22/08	Poster	The value of online post conferencing in undergraduate clinical education	2008 Annual Conference Southern Research Society, Birmingham, AL	Refereed

HONORS/AWARDS

Date	Award	Organization/Group
2011	Who's Who in Health Sciences Higher Education	Academic Keys
2005	Who's Who in Health Sciences Education	Academic Keys
1993	Academic Achievement Award	Barry University
1984	Mallincrodt Award for Outstanding Achievement	South Nassau Communities Hospital School of Radiologic Technology
1984	Squibb Outstanding Student Award	South Nassau Communities Hospital School of Radiologic Technology
1984	Association of Educators in Radiologic Technology, Gertrude L. Dourdounas Certificate of Achievement Award for Academic Excellence	South Nassau Communities Hospital School of Radiologic Technology

PROFESSIONAL ACTIVITIES & COMMUNITY SERVICE

PROFESSIONAL ORGANIZATIONS:

Date	Organization	Role
2010 - Present	Delta Epsilon Iota	Member

Date	Organization	Role
2010 - 2011	Emergency Nurses Association	Member
2008 - Present	Southern Nursing Research Society	Member
2007-2008	Organization of Doctoral Students in Nursing	Co-Secretary
2007 - Present	Organization of Doctoral Students in Nursing	Member
2002 - Present	Honor Society of Phi Kappa Phi	Member
2002 -2003	Florida Association of Community Colleges	Member
2001 - Present	Healing Touch International	Member
2001 - 2009	Society of Rogerian Scholars	Member
1999 - Present	American Holistic Nurses' Association	Member
1996 -1997	Emergency Nurses Association, Chapter 363	President elect
1994 - Present	Sigma Theta Tau	Member
1994 - Present	Iota Xi Chapter, Sigma Theta Tau	Member
2008 - Present	Theta Epsilon Chapter, Sigma Theta Tau	Member
1991 - Present	Phi Theta Kappa	Member

PUBLICATION EDITORIAL BOARDS AND REVIEW:

2004 - 2007	American Holistic Nurses' Association EAC	Education and CEU Program Reviewer
2004 - 2005	Lippincott, Williams, & Wilkins, N.Y.	Article Reviewer

COMMUNITY SERVICE:

Date	Organization	Role
May 5-6, 2012	Healing Touch International, Inc. Level One Training Course	Volunteer/assistant
Oct 1, 2011	Special Olympics of FL Aquatic State Championships, Sebastian, FL	Volunteer: Game Guide
Aug 20, 2011	Special Olympic Aquatic Area Games, Sebastian, FL	Volunteer: Time Keeper
Mar 19, 2011	Veteran's Administration of Brevard County, Cocoa Armory, Cocoa Beach, FL	Volunteer: VA Stand Down
June 16, 2008	Earth Day Community Celebration, Vero Beach FL	Presentation: Energy Therapies
Mar 9, 2005	FL Nurses Assn. Registered Nurses, Retired, Vero Beach Florida	Presentation: Introduction to Healing Touch
2004	Indian River Memorial Hospital Pre-operative Bariatric Program	Volunteer lecturer: Self Awareness
2004-2006	Visiting Nurses Association, Vero Beach FL	Healing Touch Hospice Volunteer Hospice Alzheimer's Disease and Related Disorders Training Provider

UNIVERSITY ACTIVITIES

UNIVERSITY SERVICE: (Cumulative)

Date	Level	Committee	Role
2010- Present	College	Curriculum Review	Member

DISSERTATION / THESIS / RESEARCH PROJECT ADVISING:

Dates	Student	Title	Level	Role
2012 –present	Stephanie Suarez	Interventions for Treatment Related Side Effects in Older Women with Breast Cancer	BSN/HIM	Committee
2011-2012	Cecelia Dinh	The Birth Experience: Reviewing the Efficacy of Complementary Medicine as Compared to Routine Medical Interventions During Labor and Delivery in Midwife Practice	BSN/HIM	Chair
2011-2012	Brille Burris	The Significance of Yoga Therapy for Improving Quality of Life in Breast Cancer Patients	BSN/HIM	Committee
2010-2011	Amber Major	An Investigation of Self-care Modalities for the Effective Treatment of Lymphedema	BSN/HIM	Committee

COURSES TAUGHT:

Semester	Course	Course Name	Enrollment	Role
Fall 2012	NUR 3065.0W58	Health Assessment	41	Instructor
	NUR 3065L.0M70	Health Assessment Lab	20	Instructor
	NUR 3065L.0M71	Health Assessment Lab	21	Instructor
	NUR 3165.0W58	Nursing Research	39	Instructor
	NUR 4177.0W58	Holistic Nursing	35	Instructor
Spring 2012	NUR4971.0202	Thesis or Project Works - Honors	1	Chair
	NUR 3065.0W57	Health Assessment	31	Instructor
	NUR 3065L.0W53	Health Assessment Lab	14	Instructor
	NUR 3065L.0W54	Health Assessment Lab	17	Instructor
	NUR 3065.0070	Health Assessment	36	Instructor
	NUR 3065L.0070	Health Assessment Lab	18	Instructor
	NUR 3065L.0071	Health Assessment Lab	18	Instructor
Fall 2011	NUR 3165.0W57	Nursing Research	40	Instructor
	NUR 4177.0W59	Holistic Nursing	34	Instructor
	NUR 4837.0W58	HealthCare Issues, Policy & Eco	15	Instructor
Sum 2011	NUR 3065.CW58	Health Assessment	32	Instructor
	NUR 3065L.CW53	Health Assessment Lab	15	Instructor
	NUR 3065L.CW56	Health Assessment Lab	17	Instructor
Spring 2011	NUR 3165.0W59	Nursing Research	40	Instructor
	NUR 3634L.0072	Community Nursing Clinical	13	Instructor
	NUR 3065.0W57	Health Assessment	33	Instructor
	NUR 3065L.0W57	Health Assessment Lab	15	Instructor
Fall 2010	NUR 3065L.0W56	Health Assessment Lab	17	Instructor
	NUR 3065.0W91	Health Assessment	37	Instructor
	NUR 3065L.0W56	Health Assessment Lab	23	Instructor
	NUR 3065L.0W59	Health Assessment Lab	14	Instructor
Sum 2010	NUR 3165.0W58	Nursing Research	26	Instructor
	NUR 3065.CW59	Health Assessment	36	Instructor
	NUR 3065L.CW58	Health Assessment Lab	18	Instructor
	NUR 3065L.CW59	Health Assessment Lab	15	Instructor

Semester	Course	Course Name	Enrollment	Role
Spring 2010	NUR 3065.0W92	Health Assessment	25	Instructor
	NUR 3065L.0W93	Health Assessment Lab	5	Instructor
	NUR 3065L.0W94	Health Assessment Lab	19	Instructor
	NUR 3755L.0074	Essentials of Nursing Prac Clinical	10	Instructor
Fall 2009	NUR 3065.0W61	Health Assessment	40	Instructor
	NUR 3065L.0W61	Health Assessment Lab	24	Instructor

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