Striving to be heard and recognized: nurse solutions for improvement in the outpatient hemodialysis work environment

by Jane Gardner, Joni Walton

Goal

To provide an overview of the satisfaction of nephrology nurses in the hemodialysis workplace setting and its impact on retention.

Objectives

1. Discuss reasons for nephrology nurse turnover and discontent.

2. Identify Magnet[R] attributes as indicators for positive nurse and patient outcomes.

3. Explain how nurse leaders and managers can improve nurse morale in the workplace.

4. List ideals of a healthy work environment for nephrology nurses providing patient care in the hemodialysis setting.

Nurse retention and satisfaction is an organizational leadership responsibility, and the failure to retain registered nurses (RNs) has been wasteful and costly (Pricewaterhouse Coopers, 2009), and is demeaning to the human spirit. The cost to replace one RN has been estimated to range from approximately $82,000 to $88,000, depending on the experience level of the replacement nurse (Jones, 2008). Research indicates that incurred costs are not only monetary because there is a correlation between patient care and nurse satisfaction, including nurse-to-patient ratios (Kazanjian, Green, Wong, & Reed, 2005; Needleman & Hassmiller, 2009). With more satisfied RNs and higher RN-to-patient ratios, patient lengths-of-stay are shorter, and there is a reduction in complications (including hospital-acquired urinary tract infections or pneumonia). Further, nurse productivity, including coordination efforts, is increased, and the likelihood of mortality is reduced (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Kazanjian et al., 2005; Kutney-Lee et al., 2009; Needleman & Hassmiller, 2009). Additionally, patients report a higher level of satisfaction with their hospital stay (Kutney-Lee et al., 2009).

There are many reasons for nurse turnover and discontent. "A serious disconnect exists between what hospital executives think about medical workforce shortages and how they address them"
Nurses have a keen insight regarding problems in the workplace and an understanding on how to correct these problems (Ebright, Urden, Patterson, & Chalko, 2004). The current nursing workforce model is broken, and nurses are employed in dysfunctional systems that do not staff efficiently (Pricewaterhouse Coopers, 2009). Adequate staffing and nurse-to-patient ratios have been found to not only increase nurse satisfaction, but to also increase the quality of patient care (Aiken et al., 2002, Kazanjian et al., 2005; Kutney-Lee et al., 2009; Needleman & Hassmiller, 2009). In recent national surveys of RNs, nurses reported that the most important changes for the reconsideration of leaving their positions included better staffing, higher salaries and benefits, more respect from management, and more flexible schedules (Buerhaus, Donelan, Ulrich, Norman, & Dittos, 2005). Two similar studies of critical care nurses supported these findings and also found that over 40% of nurses considering leaving their current positions said better leadership would very likely cause them to reconsider leaving (Ulrich, Auerbach, & Staiger, 2009).

Although current economic conditions have eased the current RN shortage, as nurses change from part-time to full-time hours, and nurses delay retirement or return to work, there is a projected shortage of 260,000 full-time-equivalent RNs by 2025 (Buerhaus et al., 2009). "The magnitude of the 2025 deficit would be twice as large as any nurse shortage experienced since the introduction of Medicare and Medicaid in the mid-1960s" (Buerhaus et al., 2009, p. 664). The projected 2025 shortfall and slower growth in the nurse workforce will be due to the mass retirement of Baby Boomer nurses, insufficient numbers of nurses replacing them, nursing schools rejecting qualified applicants due to a shortage of nurse educators, poor nurse retention, and an expected increase in demand for care as the new health care reform bill will extend health care coverage to a predicted 32 million individuals (Aiken, Cheung, & Olds, 2009; Buerhaus et al., 2009; Cleary, Barron McBride, McClure, & Reinhard, 2009; Office of Management and Budget [OMB], 2009; Tri Council for Nursing, 2009). There are serious concerns about the capacity of the current workforce to safely accommodate this future demand (Iglehart, 2009).

Although there are more nurses today than in the past, with a 75% increase since the 1980s, and nursing school enrollment at an all-time high (Cleary et al., 2009), nurse employers and policymakers are warned to view the easing of the nurse shortage brought about by the recession as a chance to refocus efforts on the changing composition of the RN workforce (Buerhaus et al., 2009). Data were studied from the Current Population Surveys conducted monthly from 1973-2008, and the age and supply of RNs were projected with the impact of recessions through 2005. Significant findings included a projected increase in the proportion of the nurse workforce that will be 50 to 64 years of age and foreign-born. Thus, the expected shortage will occur at a time when there are far older RNs and a larger proportion of foreign-born RNs whose language and communication skills could impact safety. Buerhaus and colleagues (2009) suggest further investigation into ergonomic improvements in the nurse work environment for older nurses and into the relationships between nurse communication skills and patient safety.

The increasing patient acuity combined with the nursing shortage has impacted retention of nurses, and it is evident that nurse dissatisfaction in the workplace is a major problem impacting patient outcomes (Aiken et al., 2002; Kazanjian et al., 2005; Kutney-Lee et al., 2009; Needleman & Hassmiller, 2009). One group of nurses not frequently studied but who have felt the burden of the nursing shortage is that of nephrology nurses. A 2008 study of hemodialysis nurses by Thomas-Hawkins, Flynn, and Clarke provided empirical evidence that RN staffing, as well as the processes of care provided by RNs, is essential to reducing the odds of adverse patient events in dialysis settings. A study by Gardner,
Thomas-Hawkins, Fogg, & Latham (2007) reported significant correlations between nurses' satisfaction with the work environment and nurse turnover and patient hospitalizations. These findings provided the impetus for further research exploring the problems identified by nurses and for soliciting their input on solutions within the outpatient hemodialysis work environment. Furthermore, nurses' input can assist in building strategies for alleviating nurses' dissatisfaction with the work environment, and targeted interventions can be implemented. The voices of nurses must be heard and acted upon in a timely manner to improve workplace environment, and as a result, patient outcomes (Kutney-Lee et al., 2009).

Review of Literature

The nurse work environment has been studied for its impact on nurse satisfaction and other important outcomes since the 1980s (Aiken et al., 2002; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Kazanjian et al., 2005; Kutney-Lee et al., 2009; Needleman & Hassmiller, 2009). Amidst the nursing shortage of the 1980s, the American Academy of Nursing studied hospitals with successful recruitment and retention of nurses (McClure, Poulin, Sovie, & Wandelt, 1983). Findings revealed that hospitals successful at recruiting and retaining RNs shared a set of organizational characteristics, named "magnet attributes."

Magnet[R] Research

Magnet[R] attributes have proven to be an excellent indicator for the presence of professional nursing practice and the associated positive nurse and patient outcomes (Aiken, 2000; Needleman & Hassmiller, 2009). Professional nursing practice exists in a work environment where nurses a) are valued for their participation in policy and decision making; b) are valued for their professional contribution to patient outcomes; c) have managers who are leaders and advocates of nursing; d) have resources necessary to provide quality care; and e) have professional, collaborative relationships with physicians. Magnet attributes can be measured using the Practice Environment Scale-Nursing Work Index (PES-NWI) (Lake, 2002), a widely respected instrument for measuring the nursing practice environment (National Quality Forum, 2003). Today, hospitals that meet the forces of magnetism contained within the five model components (transformation leadership, structural empowerment, exemplary professional practice, new knowledge, innovation, and improvements and empirical quality results) can achieve Magnet status (American Nurses Credentialing Center [ANCC], 2008). Evidence is building, not only for Magnet hospitals' increased ability to recruit and retain nursing staff, but for Optimizing the Nurse Work Environment

Aiken and colleagues (2008) analyzed the net effects of nurse practice environments on nurse and patient outcomes after accounting for nurse staffing and education. Work environments were measured with 10,184 nurses and 232,342 patients in 168 hospitals in Pennsylvania in 1999 using the PES-NWI. Outcomes measured were nurse job satisfaction, burnout, intent to leave, and reports of quality of care, as well as mortality and failure to rescue in-patients. Findings revealed that hospitals with better care environments had nurses reporting more positive job experiences and fewer concerns with care quality. Most important, patients had significantly lower risks of death and failure to rescue (Aiken et al., 2008).

A healthy nurse work environment is directly related to patient satisfaction (Kutney-Lee et al., 2009). It was found that patient satisfaction was highest when nurse satisfaction was highest. For instance, nurses reported they were generally more satisfied when they cared for fewer patients (on average, nurses who
reported being satisfied in their job cared for 4.6 patients, whereas nurses who reported being
dissatisfied cared for an average of 5.3 patients). Patients who were cared for by nurses who reported
positive work environment were satisfied with their stay and would recommend the hospital to family or
friends.

Creating healthier nurse work environments for improved patient and nurse outcomes has gained
momentum from the time when the Institute of Medicine published its report on the importance of the
nurse work environment on patient safety (Page, 2004). A study with 296 RNs, 1137 patients, and 16
unit managers was designed to determine the impact of a work environment intervention to improve
resource availability on nurse and patient outcomes (Hall, Doran, & Pink, 2008). RNs involved in the
intervention reported higher perceptions of their work and their work environment. According to Hall et
al. (2008):so for the association between Magnet status and better patient outcomes (Aiken et al., 2008).

Patient-to-nurse ratio was one of
the most consistent unit characteristics
to have a harmful effect on
nurse outcomes, with high patient-to-nurse
ratios negatively impacting
nurses' perceptions of work
and the work environment, on
unit-based nursing leadership, and
on nurses' job stress (p. 45).

In addition, patients in units with higher RN ratios reported higher levels of independence and self-care
ability.

Hemodialysis Nurse Work Environment

At least four nurse work environment studies have been conducted with registered nurses working in the
outpatient hemodialysis setting. In 2003, Thomas-Hawkins, Denno, Currier, and Wick conducted the
first major study of nurses' perceptions of the outpatient hemodialysis work environment. Nurses
revealed a perception of inadequate resources for the provision of quality care. Their work environments
did not support a participatory role or valued status for their unique contribution to patient care. Twenty
percent of the nurses studied reported they intended to leave their jobs within the next year, and for
nurses intending to leave their current job, there was a significantly lower reported presence of Magnet
characteristics (Thomas-Hawkins et al., 2003).

Today, nurses still report a desire to leave their current job. In a study conducted by Wieck, Dols, and
Landrum (2010), data were collected from staff nurses at 22 different southern hospitals. Job satisfaction
and the perception of safety were measured utilizing the Nurse Manager Desired Traits Survey and the
Nursing Work Index-Revised Scale.

Although satisfaction with work environments was higher than earlier reports, subscale scores
demonstrated that nurses were still not satisfied with autonomy and nurse control of practice. Nurse
safety concerns were reported by 40% of the population studied. Finally, one-third of millennial nurses
reported they intend to leave their jobs within the next two years, two-thirds plan to leave within the
next five years, and over 60% of all nurses studied reported they intended to leave their job within the
next 10 years. Conclusions from the study included creating model managers, empowering staff with 
nurse councils, stabilizing staffing, revamping incentives, and focusing on a culture of safety.

In the second nephrology nursing study, Gardner and colleagues (2007) were the first researchers to link 
the work environment in outpatient hemodialysis facilities to patient outcomes, such as morbidity. 
Gardner et al. (2007) studied the critical problem of nurse retention in a national dialysis company, 
exploring the relationship between nurses' perceptions of the work environment, nurses' intentions to 
leave their job, nurse turnover, patient satisfaction, and patient hospitalization. Using correlational 
research, Gardner and colleagues (2007) found the following subscales of the nurse work environment 
as predictors of increased hospitalization: a) Nursing Foundations for Quality of Care, b) Staffing and 
Resource Adequacy, and c) Collegial Nurse-Physician Relations. This research was conducted in 55 
outpatient hemodialysis facilities in six different states using the PES-NWI tool to measure nurses' 
perceptions of the nurse work environment and possible relationships with nurse and patient outcomes.

The third study conducted with nephrology nurses examined the relationships between registered nurse 
staffing, processes of nursing care, and nurse-reported patient outcomes (Thomas-Hawkins et al., 2008). 
Findings revealed that high patient-to-RN ratios in dialysis facilities and increased numbers of nursing 
tasks left undone by nurses were associated with increased occurrences of dialysis hypotension, skipped 
and shortened hemodialysis treatments, and patient complaints. The authors recommended that dialysis 
providers foster staffing structures and processes of care in hemodialysis units that effectively utilize the 
skills and services of professional RNs. Although Kane, Shamliyan, Mueller, Duval, and Witt (2007) 
reported that higher RN staffing, or lower patient-to-RN ratios, was associated with superior outcomes 
in inpatient hospital settings, the 2008 Thomas-Hawkins et al. study provided evidence for the outpatient 
hemodialysis setting.

In a fourth study conducted by the American Nephrology Nurses' Association (ANNA) in 2008, the 
nurse membership was surveyed using a descriptive qualitative design. This survey was specifically 
designed by a special interest group to assess the needs of nephrology nurses working in dialysis. The 
main themes identified were a) improving communication, b) overcoming clinical challenges, c) 
reviving education, d) strengthening the team, and e) upgrading staffing (ANNA, 2008). Nurses 
identified that their managers needed more support from senior leadership and that nurses and patient 
care technicians (PCTs) needed a standardized orientation and training program. Staff nurses also 
wanted to improve nurse competency, skill levels, and the ability to think critically. Nephrology nurses 
valued ANNA's Nephrology Nursing Journal and felt it was their lifeline to education and evidence-
based practice. Staffing patterns and ratios, on-call issues, inadequate pay, inexperienced staff, 
increasing acuity, and increasing workload were key issues identified. Staff morale and dissatisfaction 
were identified by survey participants as predictors of nurse retention. From this valuable feedback, 
ANNA has developed a Leadership Academy and will be introducing this program in the near future.

Improving nurse work environments will not only help retain nurses and avoid or at least alleviate the 
predicted future nurse shortage, but could also reduce patient morbidity and mortality, as well as 
increase patient satisfaction. Qualitative research exploring the voices of nephrology nurses and their 
perceptions of the work environment has not been done. The dialysis stakeholders need to hear the 
voices of nurses to improve the work environment, and thus, improve patient outcomes. The purpose of 
this study was to explore reported nurse satisfaction and dissatisfaction with the work environment in
Methodology

The guiding principle of qualitative analysis is to provide enlightenment and enhance the current understanding of a problem or phenomenon. Focus groups are broadly defined as a research technique that collects data through group interaction (Morgan, 1997). Focus groups have the advantage of allowing the researcher to observe group interaction on a topic in a limited amount of time. However, individual interviews provide more depth and detail related to the phenomena studied. Both focus groups and personal interviews were employed for this study since there were hemodialysis facilities participating in the study that only had one RN.

Study Participants

Participants were English-speaking RNs employed in a non-managerial position in an outpatient hemodialysis facility for greater than one year and who had participated in the original nurse study conducted by Gardner et al. (2007) or had been surveyed with the PES-NWI in a subsequent national survey conducted by Gardner (unpublished) on behalf of a dialysis company. The demographic characteristics of the participants are shown in Table 1. There were 101 nurse participants from 45 outpatient hemodialysis facilities. Saturation occurred after completion of approximately 35% of the focus groups and interviews; however, data collection continued to include nurses from 32 states.

Protection of Human Participants

Nurses were informed that the PES-NWI survey results had been analyzed (Gardner et al., 2007) and that the dialysis company wanted more information from nurses about their identified areas of satisfaction and dissatisfaction. Nurses were informed that the purpose of this study was to explore reported nurse satisfaction and dissatisfaction in the outpatient hemodialysis work setting and to develop strategies to alleviate any problems identified. They were told that the goal of participation would ultimately be to create a more positive work environment. Nurse participants were informed of their voluntary participation and assured their privacy would be guarded, with no names associated with data or findings from this study. They were asked for their consent to record the interview via audiotape and were instructed that they could stop the tape at any point in the discussion. It was explained that the moderator would take notes but that the tape recordings would assist with filling in accurate detail from the discussion. It was understood by the participants that tape recordings would be erased after transcription was complete. Institutional Review Board approval was obtained and required strict adherence to anonymity between nurses and their employers.

Data Collection

The nurse focus groups were moderated using a guide composed of questions written by the moderator and based on the nurse work environment subscales (see Table 2) contained in the survey instrument, the PES-NWI (Lake, 2002). Nurses were told before the focus group or interview began that information was desired from the nurses about their identified areas of satisfaction and dissatisfaction (from PES-
Participants were asked to rank order the nurse work environment subscales as a measure of their satisfaction and how they provide care to their patients. Next, they rated the subscales as to their presence in their current job, with 1 = terrible and 10 = ideal. The moderator recorded the rank orders of work environment subscales for each focus group and interview, and averaged the rating of subscales for importance in each focus group. The top three most important subscales and their ratings were discussed. Next, participants identified possible solutions for improving specific problems in the nurse work environment. Each focus group averaged approximately 60 to 90 minutes in duration and was audiotape recorded. A transcript of every focus group was constructed from notes taken during the group and from recapturing exact wording and detail from tape recordings of each group discussion. This was done immediately after each focus group concluded to ensure accurate reconstruction. Nurse focus groups were conducted over a four-month period in 2006.

DatKrueger's (1998c) six systematic steps in analyzing qualitative data from focus group interviews were used for data analysis: a) sequencing of questions for maximum insight into participant's personal experiences and opinions, b) reconstructing the critical point through capturing and handling data, c) labeling an idea or opinion by coding it, d) ensuring that the moderator accurately understood the intent of the participants through verification, e) debriefing immediately after the focus group concludes, and f) sharing the preliminary results, as well as the final report, with participants and stakeholders. Krueger (1998c) stated that the most useful strategy in qualitative analysis is finding patterns, making comparisons, and contrasting one set of data with another. This is necessary to form and establish the boundaries of a category, to assign data to a category, and to summarize the content of each category.

Rigor

Professional consultation from market researchers specializing in focus group methodology provided input into the development of the focus group interview guide. The finished interview guide was shared with 10 RNs for their assistance with interview questions. Adherence to Krueger's (1998a, b, c) guidelines for questioning, moderating, and analyzing focus group strengthens the rigor of this study. For focus group analysis to be verifiable, there must be sufficient data to constitute a trail of evidence. For another researcher to arrive at similar conclusions, there must be a data stream that begins with the notes taken in the field, electronic recordings, and verification of key points during the focus group.

Researcher Bias and Study Limitations

The primary researcher (Gardner) acknowledges that there may be biases related to the results from the quantitative study (Gardner et al., 2007). The research analyst (Walton) acknowledges bias in the area of organizational accountability to provide healthy work environment education, training, and staffing. A limitation of this study was that some focus groups had less than the recommended number of participants, with only three or four nurses involved. In addition, individual interviews were conducted with 10 nurse participants using the identical interview guide. A missing component in this research is the voice of nurse managers. Focus groups with nurse managers would assist in gaining deeper insights, and combined with nurse focus group results, would provide evidence for building strategies for industry-wide improvements.
Findings: Striving to Be Heard And Recognized

The overarching category of this study was Striving to be Heard and Recognized, which reflects the work environment angst of the nurses studied. Nurse focus group participants expressed a strong desire to strengthen the role of nursing in outpatient nephrology nursing and believed their opinions were not valued by administration. Participants wanted to be actively involved in the organizational culture of the workplace and have a strong voice in decision making, such as policy development, supply choices, facility procedure changes, scheduling (patients and staff), and interdisciplinary rounds.

a Analysis

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Rank Order of Practice Environment Subscales

The ranking order of the nurse work environment subscales and the rating of each subscale in the current job by RNs working in outpatient hemodialysis units who participated in this study are listed in Table 2. Nurses ranked the subscale Nursing Foundations for Quality of Care as the most important area to their job satisfaction and how they provide care to their patients, and rated its presence in their current job the highest (7.52 out of 10) of the five subscale ratings. The Staffing and Resource Adequacy subscale was ranked second highest in importance to their job satisfaction and how they provide care to their patients, but its presence in their current job was rated the second lowest (4.78 out of 10) of the five subscale ratings. Nurses ranked the Manager's Ability as a Leader and Advocate for Nurses as third in importance to their satisfaction and how they provide care to their patients, and rated its presence in their current job as second highest (6.72 out of 10). There was a consistent refrain throughout the groups, reflecting nurses' frustration with the manager's inability to confront and resolve difficult situations consistently. Nurses also empathized with the managers and stated they needed more support and mentoring from the director. RN Participation in Dialysis Provider Affairs was ranked as the fourth most important subscale to their satisfaction and how they provide care for their patients, and it had the lowest rating (4.75 out of 10) for its presence in their current job. The Collegial Nurse-Physician Relations subscale was ranked last (5 out of 5) among the subscales, and its presence in their current job was rated 6.2 out of 10. Nurses consistently stated they do not spend enough time with physicians to develop trusting and teaching relationships. As a result, the professional connection is lost.

[FIGURE 1 OMITTED]

The subcategories within the Maintaining Competency category were a) improving the hiring practices for PCTs and b) standardizing the education and training of PCTs. Participants were committed to competency and promoting quality patient care, and on a daily basis, nurses were striving to create a therapeutic environment. Despite their best efforts, they did not have adequate resources and felt frustrated. One nurse stated:

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Nurse work is different than other jobs. We have a moral responsibility to care for our patients and to do what is best. Our patients are very dependent on us in the dialysis environment, and trusting us is essential. They are vulnerable and tied down by bloodlines.
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Participants were committed to maintaining their own competency but expressed frustration of the overall competency of the PCTs.
Improving hiring practices. Focus group participants stated that the quality of patient care was compromised by the caliber of unlicensed staff. Participants believed nursing staff must be involved in the interviewing process. Solutions provided by participants were more stringent hiring practices, screening of applicants, and manager follow through on probationary period allowances. Staff nurses did not have time to appropriately monitor the performance of new hires. Participants wanted educators to spend more time monitoring and mentoring new hires in clinical practice after orientation and routinely evaluate their performance.

Standardizing PCT education and training. Participants identified a lack of understanding by PCTs of the clinical consequence of deviating from treatment prescription and the impact on patient care. The solution recommended by participants was ongoing education of PCTs on the rationale behind patient care policies and procedures. Participants recommended implementation of a clinical ladder for the PCT role and mandatory certification to progress in the role. One nurse suggested: "PCT education should develop levels of competence so that there would be a gradual process of being expected to take care of four patients at one time."

Category II: Resolving Inadequate Staffing and Resources

Participants identified the inadequate staffing category with four subcategories: a) policing PCTs, b) providing time for nursing care, c) lack of nursing presence, and d) back-up staffing. This category was closely linked with the category Maintaining Competency because inadequate hiring, education, and training impacted outpatient hemodialysis staffing and resources.

Monitoring PCTs. Participants were concerned that patient assignments were not made based on the level of competency of the PCTs. One participant stated: "I feel like I have to watch over or police their [PCTs'] behavior in order to protect the patients." Another participant stated: "I don't take care of the patients; I take care of the PCTs."

Participants discussed the behavior problems of the PCTs and recommended that improved manager education and support for the manager's role in the disciplinary process be provided. Participants did not feel that when confronting organizational leadership about the problems with PCTs that the issues would be addressed. Participants were afraid to confront PCTs due to fear of horizontal violence. A participant stated: "We tolerate more and more of their [PCTs'] behavior because we are afraid they will leave or quit and then we will have to do all of their work. They say, 'You need me, so you won't fire me.' They hold us captive." Participants expressed fear that PCTs would quit, and even though their behavior/work was substandard, they would rather have them doing the little bit they do rather than being alone without them and having to do more work. One nurse reported: "PCTs do not respect us ... why should they? ... We do the same job as them." Another stated: "They [PCTs] can't see the difference [between RN and PCT job], so they don't respect us as professionals."

Providing time for nursing care. Due to the additional burden of policing PCTs, nurses reported they were not able to complete their nurse work (assessments, medication reviews, patient education, charting or reading charts, rounding with physicians), and this was an intense source of frustration and dissatisfaction. With all of the various tasks and monitoring of PCTs, participants felt extreme
frustration that they did not have time to provide nursing care. One stated: "There isn't time for the patients. The patients apologize for bothering us. I go home and worry about what I didn't do. I miss going home with the feeling that I did a great job."

Inadequate staffing made participants feel overwhelmed with their job. One stated:

Nurses are leaving because they are overwhelmed. We leave here at night and worry about what we didn't do for the patients. It's awful when you don't think you had time to do things to the best of your ability for the patients.

Nurse participants felt guilt and expressed a sense of job failure because there was not adequate time to do a good job. Another nurse stated:

When you talk to a patient and ask, 'How are you today?' you are hoping that they say fine' and aren't sick or need to talk because you don't have the time. Makes you feel terrible that they can't count on you as a nurse.

Lack of nursing presence. The lack of participation of nurses in patient care conferences, quality or continuous quality improvement (CQI) meetings, and rounding with physicians was a major source of dissatisfaction with study participants. One participant stated: "RNs are not perceived as doing patient care because that is the PCT role." The participants expressed role ambiguity and confusion regarding the RN and PCT roles. Participants wanted time to implement the plan of care and provide patient teaching. Many felt overwhelmed by the non-nursing tasks expected of them, which caused great dissatisfaction. One stated: "If nurses are not involved in the plan of care, then we are being pushed or letting ourselves be pushed into the role of a technician." Others recommended eliminating non-nursing activities from their nursing job description with the purpose of providing time to carry out the role of the nurse and implement the nursing process. Another participant expressed frustration: "Our quality goals are unrealistic because they are based on outcomes that are dependent on consistent patient education by the nurse ... we do not have the time." Another stated: "I feel like a robot with somebody on my back cracking a whip ... everything is in a hurry," and "I don't feel like a nurse anymore. This is an assembly line." Not only was dissatisfaction and frustration expressed by participants, but it became clear that the stressful workplace culture impacted the nurses' self-concept as a professional.

Back-up staffing. Participants expressed concern over the unavailability of back-up staff for call-ins, vacations, family medical leave absences (FMLA), and other absences. They believed the inadequate staffing, whether due to RNs or PCTs, was impacting the continuity and quality of care. Some participants recommended that a float pool of back-up staff be implemented and incentives for working overtime be established. Participants were advocates for patient safety and reported that productivity targets must not be compromised by patient care. Facility staffing should be based on patient acuity and state regulations regarding unlicensed staff's limitations in patient care. Some participants recommended solutions, such as managers being provided with guidance/education in staffing, organizational staffing
specialist to counsel managers or self-staffing, and more dialogue between manager and staff regarding staffing needs.

Category III: Strengthening Organizational Leadership

There was an overall consensus of focus group participants that leadership skills in the broadest sense were lacking in the management of the outpatient hemodialysis facilities. Strengthening leadership skills of managers, strengthening the role of the nurse, and delineating the role of the PCT were subcategories of Strengthening Organizational Leadership. Participants identified problems in the following areas: staffing, time management, conflict resolution, and delineation of staff roles, unit education, and mentoring staff. There was a perceived general lack of leadership mentoring within most facilities. Frequently, novice nurse managers were strong dialysis nurses who were brought into leadership positions without management training or education.

Strengthening leadership skills of managers. In addition to strengthening staffing strategies, focus groups identified that the nurse manager's ability as a leader and advocate for nurses needed strengthening by the provision of manager education in disciplinary action and confrontation. Participants identified employee misconduct and manager's inability to discipline and follow through with consequences as having a negative impact on the nurse work environment. Examples of focus group participants' comments included:

Real-life examples should be used for education, such as case studies with discussion of outcomes desired.

Directors should be more available to help new managers with disciplinary action. They need more support and help with this role.

Managers need more help in learning how to enforce rules and follow through consistently with unlicensed staff. Unprofessional staff outnumber manager and nurses. This imbalance alone makes it difficult. Managers need help with understanding retaliatory behavior and how to prevent the feeling of being held hostage.

Participants identified that managers were good friends with too many of the staff and recognized this gets in their way of being objective, enforcing rules, and providing follow through in disciplinary action. Another problem discussed was the lack of communication between managers and staff nurses. Participants felt they did not have a voice or were allowed to participate in decisions that involved clinical practice. One nurse stated: "We find out things after the fact, yet we are the ones who have to implement change." Participants wanted to be involved in teambuilding and have a collective voice. They also wanted to understand the manager's goals or tasks and help enforce or reach them. One stated: "Nurses need to know what's going on. They should be more involved in helping to make decisions. Their perspectives should be sought more often."
Strengthening the role of the nurse. Participants wanted to foster relationships with physicians as well as being the coordinator of the health team and the primary advocate for their patients. Nurses wanted to be involved in care planning and to advocate for their patient at team meetings. One nurse stated: "These [physician rounding and patient care conferences] should not be done by the manager as it is the staff RN who takes care of and knows the patient best." Poor staffing, lack of patient acuity guidelines, and inadequate leadership forces nurses to do PCT work, causing nurses to be displaced from their role. Participants were concerned that nurses were doing PCT work due to several factors: the shortage of PCTs, inadequate PCT training, and PCTs not doing an adequate job. One participant stated: "We are not utilizing nurses for what they were educated to do or for what they are paid to do." The introduction of unlicensed staff in hemodialysis shifted the nurse's role into a position of being on the defensive and policing PCTs to promote patient safety. Participants felt that by strengthening organizational leadership, providing education for nurse managers and directors, and delineating the role of the PCT that they could return to the intended role of the registered nurse.

Delineating the role of the PCT. Participants reported doing PCT work on a regular basis and frequently being assigned patients for PCT responsibilities in addition to RN responsibilities. Participants expressed their displacement to PCT work led to lack of respect from PCTs due to role ambiguity. One participant stated: "PCTs do not respect nurses. They think they are doing our work." Participants identified a need for role clarification and differentiation between nursing and PCT job descriptions in outpatient hemodialysis facilities, and how these two roles relate and overlap.

Category IV: Rebuilding Relationships

For nurse participants, it was important to develop strong relationships with the healthcare team to achieve optimum patient outcomes and improve nurse satisfaction. Nurse relationships with physicians and patients as well as team building were priorities for improvement.

Nurse-physician relationship. Participants reported the nurse-physician relationship had suffered because of poor staffing, lack of role delineation, and spending too much time doing non-nurse tasks. Participants valued rounding with physicians, facilitating patient care conferences, participating in CQI, and discussing their patient concerns with the physician. Participants reported that collegial nurse-physician relations are compromised due to nurses not spending enough time with physicians to develop trusting and teaching relationships. This has caused the loss of a professional connection between nurse and physician, and ultimately, has resulted in patients no longer perceiving the nurse and physician as partners in their care. Suggestions to improve nurse-physician relationships were a) identifying rounding and team meetings as a top priority in the job description of the outpatient hemodialysis nurse, and b) management providing adequate staffing for implementation of the role of the nurse. A participant stated:

We make rounds with doctors when there is enough staff, but often they walk in during patient shift change, and there's nothing we can do. They are not respectful of our time. They ask the manager a question, but not us.
Another reported: "Doctors are not interested in what the RN thinks. RNs are not involved in patient care conferences and our care plans are not really nursing care plans ... they are a cookie-cutter requirement." All focus group participants identified a basic need to be recognized and treated professionally. One stated: "Hemo nurses are dying to be treated with respect. We don't have the time to talk with the doctors or give them any patient feedback, so doctors talk with the manager. Nurses play such an insignificant role." In addition, another said: "They think we are glorified technicians. No respect for nurses. They don't seem to trust us. I have to chase MDs for answers to my questions about the patients." Nurse participants have identified the healthcare team is disjointed and ineffective.

Nurse-patient relationship. Since each category impacted another, lack of time, insufficient staffing, performing PCT duties, uncooperative PCT behavior, and the nurse's inability to provide patient education due to lack of time all led to the deterioration of the nurse-patient relationship. There was inadequate time to build a therapeutic nurse-patient relationship. In addition, participants identified the hemodialysis staff needed more education to promote healthy, long-term relationships with their patients, such as setting boundaries. Specifically, "We need to understand the challenges associated with boundaries in taking care of patients with end stage renal disease." Participants also identified they needed more education due to the increased acuity of patients and multisystem problems, and requested education on chronic kidney disease (CKD) co-morbid conditions. One participant reported: "We do not have time to educate patients or follow through with anything. I have a PCT assignment often, so I don't have time to talk with patients about their labs, problems, medications." Another said: "There is not enough hands-on work with the patients for RNs to be satisfied here." Nurses reported the nurse-patient relationship was impacted by the lack of a unit secretary. Throughout the United States, participants reported inconsistent staffing of a secretary, causing the nurse to fulfill dual roles. One participant said: "Paperwork should be put to the side if RNs need help with patients. There is no way we can provide the care the patients need if we don't have back up." This also increased frustration and nurse dissatisfaction.

Team building. Participants identified collegial relationships had deteriorated due to stress of work environment, high acuity, lack of facility leadership, and lack of time. Participants felt the foundation of a good team was a facility manager with strong leadership skills, and unless the role of the manager was strengthened through education and training, the team would remain dysfunctional. For instance, one RN said:

RNs do not have a collective voice here. There are different sides, and they are not supportive of each other ... it trickles down. The manager is not supportive of us. We do not have RN-only meetings. RNs do not go to quality or patient care conferences. Because management doesn't support us, nurses say things like, "This is your patient, not mine." This attitude trickles down from the top.

In addition to issues between RNs and management, there are similar relationship issues between PCTs and RNs, and among RNs. For example one nurse stated: "There is no camaraderie amongst the PCTs. They cannot trust or count on each other." Another RN said: "You don't want to get the PCTs mad at you or you will be on your own. They get even." One nurse mentioned: "There is no time to talk with
other RNs regarding patient issues and problem solving. Nurses do not have one voice here. That is not good for our profession." Another stated: "Collaboration is important because then everyone feels that they are a part of the decision-making process, and they feel obligated to make it work." Many nurses felt they were often "dismissed" when expressing their concerns or making suggestions for improvement. Most participants stated it was rare to have the opportunity to sit down and talk with their colleagues about problems in the dialysis facility. The focus groups provided this opportunity, and the nurse felt valued.

Summary

These focus groups have provided a window into the perceptions of nurses working in outpatient hemodialysis. From the categories identified by this study, nurses appear to be isolated, overwhelmed, under-utilized, and disconnected from their original expectation of being a nurse professional. Organizations supporting nephrology nurses, hospitals, clinics, and private dialysis facilities must face the challenge of improving nurse workplace satisfaction. Nurse focus group participants identified many key strategies to remedy the problems and improve the work environment. These findings can be generalized and applied to outpatient hemodialysis facilities across the United States.

Discussion

Research on nurse work environments and on the outcomes of Magnet status has provided substantial evidence for the importance of nurse involvement in solving workplace problems. After identifying problems in the nurse work environment and having the opportunity for discussion among themselves, nurses in this study were eager to participate in problem solving. Nurses were able to clearly articulate the problem of the work environment and express their feelings of frustration within a positive and respectful atmosphere.

Striving to Be Heard and Recognized

Nurses in this study expressed feelings of being disconnected from their profession. Most important was their concern that the integrity of their patient relationships had suffered due to the lack of time for them to provide nursing care. A focus group participant stated: "We are without a collective voice." They expressed the feeling of being diluted into a technical role. One stated: "Technical things are taking precedence over patient care." Nurses agonized over these feelings of impotence when attempting to provide nursing care with unqualified technicians, managers with minimal leadership training, and insufficient staffing and resources. Another focus group participant stated: "It's important to me to have a feeling that I am making a difference ... that our patients live a little bit longer and better because of our care ... I don't feel this way anymore." When nurses were asked about the nurse work environment, there was clear affirmation of the importance of nursing's role. They enthusiastically and accurately defined the problems, carefully identified the cause, and created realistic solutions.

Problem Solving

In addition, the focus groups gave nurses a sense of control over their practice and provided opportunity within a professional forum to create strategies for improvement. The researchers believed each focus group was a therapeutic intervention in itself. Nurses were invited to be involved in this study and
allowed to engage in a professional dialogue about their dissatisfaction and their strategies from improvement. Nurses were incredulous that someone would travel across the country to hear their voices, and they felt honored and recognized. The focus groups and individual interviews provided the opportunity for outpatient nephrology nurses to collectively state that providing quality care to their patients is most important to their satisfaction; however, this is also dependent on adequate staffing, resources, and supportive management, which is only possible if nurses have more involvement in clinical and operational decision making.

The current predictions of a shortfall in the supply of 260,000 RNs by 2025, the changing composition of the nurse workforce, and a new healthcare bill that will bring an estimated 32 million newly insured into healthcare settings across America all provide strong impetus to provide new solutions for a changing healthcare landscape. The nursing workforce will shoulder the day-to-day patient care responsibilities inherent in the passing of the new healthcare legislation, and nurses should be included in high-level discussions about future opportunities for strengthening the nursing workforce and elevating nursing to a new type of public accountability. Focus group nurses were ready and willing to create an atmosphere of change where they would collectively assist in building a better future. However, there is a risk to soliciting feedback and solutions without taking forward action for change. If ignored, a vicious circle of negative feedback could occur, creating an exacerbation of dissatisfaction, depression, and nurse turnover. It is vital to listen to the voices of nurses as they are striving to be heard and recognized, and to act upon input from nurses to improve the nurse work environment within a virtuous cycle.

Virtuous Cycle

In economic terminology, nurse's involvement in focus groups would be called a virtuous cycle or circle that is a complex set of events that reinforces itself through a feedback loop (Schlesinger & Heskett, 1991). Applying this model to the hemodialysis work environment, nurses would transition through five phases:

* Nurses' involvement in regularly scheduled focus groups would reinforce their sense of value to the organization for having been asked for their insights and opinions.

* Nurses are frontline staff who will accurately define the problem.

* Nurses have a unique role, putting them in an advantageous position to identify causal factors that lead to problem solving.

* Group dynamics of focus groups enables finding the solutions within the interactions between RNs.

* Thus, nurses will accurately identify the communication that is necessary and action steps to resolve the problem.

Nursing Foundations For Quality Care

Most nurses spoke highly of the dialysis company's focus on quality and labeled it "genuine." However, nurses expressed frustration that dialysis providers do not recognize that the quality of care is
compromised by weak staffing and managers lacking leadership ability, and RNs performing non-nurse tasks instead of providing patient education and attending patient care or quality meetings. Many nurses stated that there wasn't enough time spent with other RNs or patients, both of which are essential to their satisfaction. Similar to the findings of this study, Eaton-Spiva and colleagues (2010), utilizing nurse focus group sessions and surveys, identified staffing (patient nurse ratios) and resource adequacy as compromising the ability to provide quality care. Nurses complained about the time spent on charting, obtaining, and hunting supplies; transporting patients; and obtaining access to computers or charts, and they preferred spending time at the bedside.

Professional Camaraderie

A strong and consistent message heard throughout the focus group sessions was the loss of professional camaraderie among fellow RNs. Due to being isolated in outpatient hemodialysis facilities, with sometimes only one RN per patient shift, nurses often do not see or have the opportunity to discuss patients or other issues with their peers. RNs want to be with other RNs. Nurses suggested that managers provide regular nurse-only meetings for professional sharing and learning. They need the opportunity to vent frustrations, share solutions, and provide encouragement in stressful situations. This type of professional dialogue validates a sense of individual value as well as collective worth to nephrology nurses and patients receiving care. This cross fertilization of ideas also improves nursing practice, provides opportunities for developing a collective voice, and improves nurses' confidence as clinical leaders within a cross functional team.

Nurses must have active involvement in improving quality and efficiency of care, and process improvement research has consistently identified the engagement of frontline staff as central to achieving and sustaining change (Needleman and Hassmiller, 2009). Nurses develop in-depth knowledge of the work environment, its systems, and processes. Healthcare providers should "take full advantage of nurses' knowledge and commitment to patients for increasing safety and reliability, patient-centeredness, and efficiency of care" (Needleman & Hassmiller, 2009, p. 632). Nurses should be represented at the highest levels in healthcare leadership and integrated in decision-making. Increasing the visibility and participation of nurses in administrative and executive affairs is also part of the Magnet accreditation program, and along with a system of shared governance, empowers nurses to be effective in influencing system processes and collegial working relationships with other disciplines.

Another model for engaging frontline staff is Transforming Care at the Bedside (TCAB), a national program of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement. Frontline staff and leadership engage in innovative improvement efforts to ensure a high-quality work environment to attract and retain nurses, and make improvements in the patient's experience, the quality and safety of care, and the effectiveness of the entire care team. This model nurtures frontline staff empowerment by involving them in process improvement efforts. Initial program results are positive for improving quality and efficiency (Robert Wood Johnson Foundation, 2008).

The Manager's Ability As a Leader

The subscale on the manager's ability as a leader and an advocate for nurses was highly valued by participants in the study's focus groups; however, it was also perceived to be a major weakness. In a qualitative study conducted by Anthony and colleagues (2005), nurse managers were found to play a
pivotal role in nurse retention. Focus groups were held with nurse managers to ascertain their skill sets and solicit their strategies for improvement in nurse retention. The researchers highlighted the multiple and competing demands nurse managers must balance to meet the goals of the organization (financial) as well as those of their profession (quality and continuity of care for patients). In addition, they noted that "managers are well aware of the critical impact of the work environment on nurse satisfaction, and they only neglect attending to their staff's professional needs due to rivaling demands of the institution" (Anthony et al., 2005, p. 147). Findings validated the manager's role as multifaceted with contending priorities and one of the most overloaded positions in health care. Managers agreed that their role was instrumental to nurse retention, but requested support and resources. The nurses who participated in this study's focus groups validated the critical importance of the nurse manager role and empathized with the nurse manager's difficult situation. In light of the nurse focus group results, there appears to be little information on how nurse managers perceive the nurse work environment and their solutions on making improvements.

Nurse Focus Groups

Nurse focus groups and nurse interviews are an effective method for providing a constructive environment for professional discussion and problem solving, and supplied a voice for a sample of nephrology nurses. The nurses affirmed the value provided by the PES-NWI as discussion items and accurate representations of their nurse work environment, and were readily able to discuss and rate them. They had more difficulty with ranking the subscales as to their importance in job satisfaction and how they provide care to their patients. After selecting the top two, they would often cry out, "This is impossible; they are all so important." Nephrology nurse focus group participants felt all subscales and related Magnet attributes were of high value to their professional practice.

In the last decade, focus groups have been used to obtain nurses' professional opinions on improving the work environment. Janney, Horstman, and Bane (2001) conducted focus groups to solicit information regarding RN retention that resulted in nurse-created solutions. Actions taken resulted in a reduction of 6.2% in the RN vacancy rate and a decrease in mandatory overtime by 75% in the first year. A charge nurse program was developed for succession planning, and four charge nurses were promoted to managers within a year. Nurse focus group participants in the current study stated they wanted to be valued by their organization, and to have standardized processes in place, staff empowerment, and strong leadership. In 2004, Heath, Johanson, and Blake conducted nurse focus groups with recommendations to encourage nurse leaders to set the tone and standard of practice for healthier work environments by effective communication and collaborative relationships, and by promoting decision making among nurses.

In 2005, The Pennsylvania State Nurses' Association conducted focus groups with direct care RNs to gain insight into the perceptions and opinions of RNs working directly with patients in the acute, home, and long-term settings relative to workplace satisfaction and retention. For increased retention, nurses prioritized their needs:

* Recognition by administration and management of the value nurses bring to patients and families.
* Accessible, qualified, and trustworthy management.
* Adequate staffing based on acuity, volume, and staff competence.

* Employee accountability to institutional harassment policies, including physicians.

* Compensation/benefits programs sensitive to new graduate vs. seasoned nurse salaries.

* Time and compensation for continuing education/training opportunities.

* Adequate supplies and equipment to undertake their jobs.

The majority of the items are Magnet attributes proven essential to Nurses emphasized that managers are key to maintaining a healthy work environment and that it is necessary for managers to communicate with respect and mentor nurses. Nurses also stated that the top three significant relationships in their job were with other nurses, their manager, and physicians.

A study designed to evaluate a baseline for how RNs perceived their practice environment, empowerment level, and culture was conducted using the PES-NWI and nurse focus groups (Eaton-Spiva et al., 2010). Results demonstrated that patient-to-nurse ratios and physician relations were areas of concern. When RNs reported higher patient-to-nurse ratios on surveys and in focus groups, their perceived quality of care was decreased as well as their perceptions of good nurse leadership. Nurses working in hospital units reporting the presence of more Magnet characteristics also reported feeling more empowered and more satisfied with the work environment. After data analysis, unit action planning meetings allowed nurses and managers to prioritize a final problem list and create action plans to manage the issues. A six-month evaluation will be conducted to assess the impact of nurse work environment interventions. The authors highlighted the importance of using focus groups due to their ability to further clarify survey-identified issues and to uncover previously unidentified issues in the work environment. Data provided the evidence for creating action plans, and the action-planning process empowered nurses to take more control over their practice.

Recommendations

The valuable insights of nephrology nurses should inform a timely national initiative to provide leadership in the development and implementation of the following:

* Continual leadership education for nurse managers.

* Role clarification and job descriptions for PCTs and RNs working in outpatient hemodialysis facilities.

* A position statement for safe staffing ratios.

* Easy-to-use patient acuity scales specific to CKD.

* Team building for the CKD healthcare team.

* Clinical or career ladders for RN and PCT education and development.
Future research should include nurse managers using the PES-NWI survey with follow-up focus groups. There should be regular qualitative interaction between management and nurses. Future research should be conducted to assess nephrology nursing work settings by soliciting nurses' input for redesign.

Implications

Nephrology nurses across the United States have spoken, and dialysis stakeholders must respond to the reported dissatisfaction of nurses in outpatient hemodialysis work settings. RNs have identified problems and solutions for creating healthier work environments. There is powerful evidence for fostering healthy work environments, and nurse leaders and dialysis company executives should reap rewards through improved patient, nurse, and financial outcomes. Accountability now lies on the leadership within professional organizations and dialysis providers to incorporate these findings within strategic planning to create models for healthy nurse work environments.

Conclusions

Best practices for improving the nurse work environment in outpatient hemodialysis facilities were identified by RN focus groups. Strategies based on the findings of this study and others must be pursued to improve nurses' satisfaction with the work environment, resulting in greater efficiency in the utilization of government and company resources and improved patient outcomes. In light of recent healthcare legislation, the expected influx of 32 million newly insured individuals would add significant new stresses on the current nurse work environment. This makes it even more essential to utilize the insights of current nurses for increased satisfaction and retention.

References


Additional Reading


Jane Gardner, DNP, RN, is a Health Care Consultant at Jane K. Gardner, Inc., was formerly Director of Operations and Nurse Development, Renal Care Group, Nashville, TN, at the time of this study, and is President of ANNA's Windy City Chapter. She may be contacted via e-mail at jane_gardner@comcast.net

Joni Walton, PhD, RN, ACNS, BC, is an Adult Clinical Nurse Specialist and Associate Professor of Nursing, Carroll College, Helena, MT, and a member of ANNA's Big Sky Chapter.

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Table 1
Demographics of Focus Group Participants

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<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
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<td>Age</td>
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<td>Years in current job</td>
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### Table 2
Nurse Rank Ordering and Rating of Practice Environment

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<th>Magnet[©] Characteristics of the Nurse Work Environment</th>
<th>Category</th>
<th>Category Rating</th>
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<tbody>
<tr>
<td>Nursing foundations for quality of care</td>
<td>1st</td>
<td>7.52</td>
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<tr>
<td>Staffing and resource adequacy</td>
<td>2nd</td>
<td>4.78</td>
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<tr>
<td>Manager's ability as a leader and advocate for nurses</td>
<td>3rd</td>
<td>6.72</td>
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<tr>
<td>RN participation in dialysis provider affairs</td>
<td>4th</td>
<td>4.75</td>
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<tr>
<td>Collegial nurse-physician relations</td>
<td>5th</td>
<td>6.20</td>
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