Stabilizing and destabilizing forces in the nursing work environment: A qualitative study on turnover intention

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ABSTRACT

Background: The nursing work environment, which provides the context of care delivery, has been gaining increasing attention in recent years. A growing body of evidence points to an inseparable link between attributes of the nursing work environment and nurse and patient outcomes. While most studies have adopted a survey design to examine the workforce and work environment issues, this study employed a phenomenological approach to provide empirical evidence regarding nurses' perceptions of their work and work environment.
Aim: The aim of this study was to advance our understanding of the phenomenon of increasing nurse turnover through exploring frontline registered nurses' lived experiences of working in Hong Kong public hospitals.
Methods and participants: A modified version of Van Kaam's controlled explication method was adopted. Individual semi-structured interviews were conducted with 26 frontline nurses recruited from ten acute regional, district and non-acute public hospitals in Hong Kong. Their perspectives in regard to their work and work environment, such as workload, manpower demand and professional values, were extensively examined, and a hypothetical description relating the nursing work environment with nurses' turnover intention was posited.
Results: Contemplation of nurses' experiences revealed the vulnerable aspects of nursing work and six essential constituents of the nursing work environment, namely staffing level, work responsibility, management, co-worker relationships, job, and professional incentives. These essential constituents have contributed to two sets of forces, stabilizing and destabilizing forces, which originate from the attributes of the nursing work environment. Nurses viewed harmonious co-worker relationships, recognition and professional development as the crucial retaining factors. However, nurses working in an unfavorable environment were overwhelmed by destabilizing forces; they expressed frustration and demonstrated an intention to leave their work environment.
Conclusions: The nursing work environment is a complex entity comprising multiple constituents; its attributes affect nurses' perceptions of their work and work environment, which warrant special attention in addressing the phenomenon of increasing nurse turnover.

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What is already known about the topic?

- Nursing manpower is a crucial determinant of patient outcomes.
- Attributes of the nursing work environment are associated with nurse and patient outcomes.

• Qualitative studies examining nurses' perceptions of their work and work environment are lacking.

What this paper adds

• The vulnerable aspects of nursing work and the complexity of the nursing work environment, which comprises six essential constituents: staffing level, work responsibility, management, co-worker relationships, job, and professional incentives.
• Nurses are constantly interacting with two sets of forces at work: stabilizing and destabilizing forces, which originate from the attributes of the nursing work environment.
• Concerted organizational efforts are needed to transform the nursing work environment, which has important implications in addressing workforce issues.

1. Introduction

Along with the development of modern healthcare, nurses nowadays have to cope with increasing job complexity resulting from advanced medical science and technology; the health policies that promote fast patient turnover and quality health services, coupled with the ageing population, have imposed further demands on nurses. Nurses who are unable to cope with the changing healthcare context may choose to leave their work environment, resulting in increasing voluntary turnover.

The phenomenon of increasing nurse turnover has become a critical challenge faced by various countries, such as Canada, China, Germany, Scotland, the United Kingdom and the United States (Aiken et al., 2001; Lu et al., 2006). Hong Kong, which has adopted a Western healthcare system, is no exception to this global issue. In the local context, all public hospitals are managed by a statutory body called the Hospital Authority. Recent news has reported imminent concern regarding the shortage of nursing staff in local public hospitals, noting a staggering rise in the voluntary turnover rate from 3.2% in 2006/2007 to 4.7% in 2008/2009 (Moy, 2009). Since public hospitals account for more than 95% of hospital beds in Hong Kong, the phenomenon has provoked the public's concern regarding its potential threat to the provision of quality care. The local health authority has been adopting strategies such as better salary and promotion prospects to attract and retain nurses, but the effectiveness is yet to be evaluated. However, past studies have suggested that financial incentive is only one of the many factors determining turnover; the underlying causes are complex that need to be addressed by an integrated plan (Milisen et al., 2006).

Workforce issues have generated considerable scholarly interest, and their impacts on health outcomes have been studied extensively. The most prominent works are the two studies led by Aiken et al. (2002) and Needleman et al. (2002), who quantifiably evaluated the association between nurse staffing levels and patient outcomes. Aiken et al. (2002) conducted a study on surgical patients and found that higher patient-to-nurse ratios resulted in significant increases in patient mortality and failure-to-rescue rates. Needleman et al. (2002) undertook a similar study on

medical and surgical patients and concluded that nurses who spent more time on direct patient care could significantly reduce the duration of patients' hospitalization and the incidence of adverse events. There are, however, some researchers who have refuted the relationship between nursing manpower and quality of care (Currie et al., 2005; Feinstein, 2002). They argued that provision of care relies on the collective efforts of multidisciplinary members, and patient outcomes should not be attributable to the staffing level of a single profession. Yet there is no doubt that nurses, who offer round the clock surveillance, have been important guardians of patients' well-being. To ensure delivery of quality health services, an adequate and stable nursing workforce is a requisite.

A great deal of research has been conducted to explore the underlying factors contributing to the nursing shortage and voluntary turnover issues. The nursing work environment, which provides the context of care delivery, has been identified as the crux that determines nurse and patient outcomes (Aiken et al., 2008; Kotzer and Arellana, 2008). Magnet research, which originated in the early 1980s, has continued to prevail in the past decade. The studies explore the features of "magnet" hospitals, which are conducive to promoting professional nursing practice and nursing retention, and the findings have further consolidated the positive influence of the "magnet" environment on nurses' job satisfaction, autonomy, stress management and outcomes of care (Kramer and Schmalenberg, 2003; Spence Laschinger et al., 2001). Intensive voices have been noted regarding the need to create a healthy work environment for health professionals (Shirey, 2006). A wide range of attributes of the nursing work environment has been identified, including resources, managerial support, co-worker relationships, leadership, autonomy, financial incentives, care delivery models, and sense of professionalism. Researchers further inquired into the issues by devising instruments to capture the features of the nursing work environment. These comprise several well-known instruments such as the Nursing Work Index (NWI) (Kramer and Hafner, 1989), the Revised Nursing Work Index (NWI-R) (Aiken and Patrician, 2000), the Practice Environment Scale (PES) (Lake, 2002), and the Perceived Nursing Work Environment (PNWE) instrument (Choi et al., 2004). Since then, increasing attention has been drawn to the attributes of the nursing work environment, which have been measured through quantification of nurses' perceptions.

Though there has been a considerable amount of research conducted in the aspects of nurse turnover and the nursing work environment, the majority of the studies have adopted a survey design to measure the features of the nursing work environment. The findings have enriched our understanding of the attributes of the nursing work environment, but fall short in terms of reflecting how nurses conceptualize and value the attributes that influence their turnover intention. McGillis Hall and Kiesner's (2005) study was groundbreaking in pointing out that it might not always be possible to measure nurses' work quantifiably. The same principle applies to the attributes of the nursing work environment that might not be made explicit merely through quantitative evaluations.

While qualitative studies that examine nurses' perceptions of their work and work environment are lacking, empirical evidence generated from frontline nurses' lived experiences should be valued. Besides, it is noted that most of the past studies were grounded on western nurses; since each individual country has its own unique cultural, political and economic climate, the question as to whether their findings and/or recommendations fit the Hong Kong context is left unaddressed.

This study is part of a large-scale study undertaken from May 2006 to March 2009 to examine the attributes of the local public hospital environment. It intended to fill the gaps by adopting a phenomenological approach to provide an empirical, in-depth account of nurses' lived experiences of working in real-life contexts, so as to gain insights into the phenomenon of increasing nurse turnover.

2. The study

2.1. Aim

The aim of this study was to advance our understanding of the phenomenon of increasing nurse turnover through exploring frontline registered nurses' lived experiences of working in Hong Kong public hospitals.

2.2. Design

A modified version of Van Kaam's (1966) phenomenological method was adopted. Unlike the notion of positivism, which emphasizes establishing causal relationships in explaining a phenomenon, phenomenology focuses on exploring the meanings of human experiences in understanding a phenomenon, and this philosophical method of inquiry has been viewed as useful in increasing insights into phenomena that have been poorly conceptualized (Parse, 2001; Polit et al., 2001). Phenomenologists believe in the existence of the true essence of a phenomenon, and stress the importance of uncovering the essence of a phenomenon through understanding the meanings of people's lived experiences (Parse, 2001). This study employed the phenomenological approach to explore nurses' lived experiences of working in real-life contexts, which are crucial to understanding the essence of the phenomenon of increasing nurse turnover in local public hospitals.

Going beyond hermeneutic phenomenology, Van Kaam (1966) proposed a controlled explication method rooted in the philosophical science of existential phenomenology. The method delineates systematic operational processes to discover the structures and patterns of human experiences, and is composed of two phases: the pre-scientific and scientific phases of explication (Parse, 2001; Van Kaam, 1966). In the pre-scientific phase, the informants provide raw descriptions of their lived experiences. The descriptive expressions are then processed through a scientific explication approach that involves six overlapping steps: listing and preliminary grouping, reduction, elimination, hypothetical identification, application and final identification (Van Kaam, 1966). The process of inquiry leads researchers through a journey of intuiting, describing, reducing and

analyzing data to search for the essence of a phenomenon (Parse, 2001). It enables researchers to make explicit the implicit meanings of human perspectives and behaviors, so that researchers can formulate conceptual knowledge pertinent to the understanding of the phenomenon (Omery, 1983; Van Kaam, 1966). The operational processes of the control explication method are delineated in further detail in the analysis section.

2.3. Participants

Twenty-six frontline registered nurses (Table 1) were recruited by the snowball sampling technique. Snowball sampling involves recruiting informants through nominations by primary informants, who are invited to make referrals of eligible informants from among their acquaintances (Polit et al., 2001). This sampling strategy is one of the non-probability sampling methods that have been commonly applied in qualitative research; it allows researchers to reach informants who are willing to share their views in regard to the study issue, and has been upheld as practical and cost- and time-efficient (Gall et al., 2003).

Table 1
Demographic characteristics of nurses.

Total (N = 26)	n (%)
Gender	
Male	9 (34.6)
Female	17 (65.4)
Pre-registration training program	
Hospital-based	16 (61.5)
University	10 (38.5)
Highest education level obtained	
Diploma	1 (3.8)
Higher diploma	3 (11.5)
Bachelor	17 (65.4)
Master	5 (19.2)
[a]**Present enrolment in educational program**	
Bachelor	2 (7.7)
Master	4 (15.4)
Nursing-related course	9 (34.6)
Non-nursing related course	2 (7.7)
Nil	12 (46.2)
Type of employment	
Contract	10 (38.5)
Permanent	16 (61.5)
Present hospital	
Non-acute hospital	7 (26.9)
Acute regional hospital	17 (65.4)
District hospital	2 (7.7)
Present unit	
Medical	7 (26.9)
Surgical	3 (11.5)
Medical and geriatrics	4 (15.4)
Central nursing division	1 (3.8)
Isolation	1 (3.8)
Oncology	2 (7.7)
Orthopedics	3 (11.5)
Rehabilitation	4 (15.4)
Urology	1 (3.8)
Rank	
Registered nurse	20 (76.9)
Nursing officer	3 (11.5)
Advanced practice nurse	2 (7.7)
Hospital nursing manager	1 (3.8)
Years of working as an RN, mean ± SD	8.31 ± 7.103
Years working in the present unit, mean ± SD	3.04 ± 3.016

[a] Item in which nurses can choose more than one answer.

In this study, potential informants were referred by two initial contacts, a hospital administrator and a newly graduated registered nurse. Each of the two primary informants was then invited to nominate two potential informants from among their friends or colleagues who were nurses working in local public hospitals. Subsequent recruitments resulted from nurses making further referrals from among their acquaintances. The sampling of informants ceased when data saturation was noted, which refers to a stage when the analysis of emerging empirical data does not reveal any new findings. Analysis of the verbatim transcripts of the first 22 interviews identified a list of descriptive expressions that were categorized under segments, while further interviews with four nurses revealed only variations in the existing segments without emergence of other new findings. The 26 nurses were recruited from ten acute regional, district and non-acute public hospitals in the local context, and their demographic characteristics are presented in Table 1.

2.4. Ethical considerations

This study was approved by the Ethics Review Committee of The Hong Kong Polytechnic University. Full explanations were given about the study's purpose and the procedures involved. Written consent was obtained from the nurses regarding their voluntary participation and agreement to record the interviews. They were assured that any personal information obtained would be kept confidential, and that they had the right to withdraw from the study at any time.

2.5. Data collection

Individual semi-structured interviews were conducted to explore nurses' lived experiences of working in local public hospitals. All the interviews took place in a private meeting room at the university or hospital, or in a comfortable setting convenient to the nurses. Interviews were conducted in Chinese and began with a general question: "Do you enjoy working in your present work unit and why?" Subsequent questions were open-ended questions related to specific areas of interest that had been identified from the literature. These included the aspects of work responsibility, workload, staff mix, manpower demand and turnover intention. Special issues that emerged from the first five interviews were extensively discussed within the research team, which included two experienced researchers and two newly graduated registered nurses. Supplementary guiding questions were incorporated into the subsequent interviews to inquire on aspects such as staff morale and job satisfaction. The interview guide is presented in Table 2. All the interviews lasted from 45 to 90 min and were digitally recorded and transcribed verbatim for subsequent analysis.

2.6. Data analysis

In the pre-scientific phase, nurses provided descriptive expressions of their lived experiences of working in local public hospitals. The verbatim transcripts were number

Table 2
Interview guide.

Do you enjoy working in your present work unit and why?
Questions in relation to work responsibilities, workload and staff mix
How do you view your work responsibilities and workload? Do you find them reasonable and why?
With regard to your present work responsibilities, in which aspect(s) would you consider yourself irreplaceable and why?
With regard to your present work responsibilities, which aspect(s) would you consider delegable to others and why?
How do you view the current staff mix? Do you find it effective and why?
Questions in relation to manpower issues
How serious would you consider the nursing shortage and voluntary turnover issues in your present work unit?
What suggestions would you make to retain nurses in public hospitals?
Questions in relation to staff morale, job satisfaction and turnover intention
How would you describe nursing morale in your workplace, and why?
Do you find your job/work satisfactory and why?
Have you ever thought of leaving nursing and/or your present work unit, and why?
What kind of changes would make you happy to continue to stay in nursing and/or your present work unit? (Changes can be in the form of healthcare policies, management aspects, work environment, work conditions, nursing image, etc.)
Would you encourage your relatives or friends to join the nursing profession, and why?

coded and stored in a word processor file for analysis. The inquiry process then proceeded to the phase of scientific explication, which involves the six steps of listing and preliminary grouping, reduction, elimination, hypothetical identification, application, and final identification (Van Kaam, 1966). All the verbatim transcripts were read at least twice to gain an initial intuitive understanding of nurses' lived experiences. Phrases that described nurses' perspectives on their work and work environment were extracted and listed. Descriptive expressions that conveyed common meanings were grouped and categorized into segments. Researchers further examined the unifying meanings of the descriptive expressions; overlapping and vague expressions were reduced and modified into more precise terms, while extraneous descriptions were eliminated. Ten randomly selected transcripts (40%) were read again by the research team members and eight final year nursing students who were involved in the later part of the study, so as to ensure that the list of descriptive expressions identified was exhaustive and integral to nurses' experiences.

Nurses' experiences uncovered the essence of nursing work and the essential constituents of the nursing work environment; further contemplation of their experiences revealed that nurses have different levels of turnover intention. Four distinct groups were identified: (1) those who had not considered leaving nursing, (2) those who had considered leaving nursing, (3) those who had considered leaving public hospitals in particular, and (4) those who had left once or had already decided to leave nursing. For hypothetical identification, it was postulated that nurses' turnover intention was related to the essential constituents of the nursing work environment. The research team

Table 3
Descriptive expressions and coded segments.

Examples of descriptive expressions	Coded segments	
Although my work gives me much satisfaction, it poses too many threats to my family...	Seg1	Personal satisfaction in present work unit
Our work involves both direct and indirect patient care... We have more paperwork to do now... I have to fill in a four-page form in order to transfer a patient to another unit.	Seg2	Description of present work responsibilities
There is too much paperwork, which is time-wasting... I don't see its value...	Seg3	General evaluation of the reasonableness of work responsibilities
This (paperwork) deprives me of time to spend with patients.		
Most of our work cannot be done by others, for example, patient education and handling patients' and relatives' concerns and queries...	Seg4	Aspects of irreplaceable work responsibilities
We used to delegate simple duties to the healthcare assistants, for example, bathing and oral feeding...	Seg5	Aspects of delegable work responsibilities
Many experienced nurses left before, so we have more junior nurses now...	Seg6	Description of staff mix in present work unit
Most of the time I have to be the ward-in-charge and work with less experienced nurses during the night shift; I find this very stressful...	Seg7	Comments on current staff mix
We are short of staff, the problem of turnover is serious...	Seg8	Description of seriousness of manpower shortage/nurse turnover in present workplace
We don't have adequate manpower to cover our vocational leave...		
Private hospitals offer better employment terms, I think improving these could help retain them (nurses)...	Seg9	Factors to be taken into account in easing manpower shortage/nurse turnover in present workplace
Staff morale is good... There is solidarity among us.	Seg10	Description of nursing morale in present workplace
Morale is poor...colleagues here are segregated into territorial groups...		
Our morale fluctuates, especially when infections recur successively...	Seg11	Factors contributing to high/low morale
When these complaints are reported to the manager, the manager simply scolds us, assuming that it is always our fault... This has affected our morale badly.		
I am proud to be a nurse because I help people when they are most vulnerable...	Seg12	Personal sense of commitment to nursing as a career
Nurses do not work for monetary benefits, but for patients' sakes.		
Nursing is harsh work; I don't recommend it to my relatives or friends...	Seg13	Introducing nursing to acquaintances
Some of my colleagues are planning to leave... I think the situation will worsen if the authority does not introduce any strategies to deal with this...	Seg14	Views on future nursing manpower situation
Offering professional development opportunities is important... The hospital can consider offering official releases for staff to take part in training courses...	Seg15	Suggested changes that will make one happy to stay in nursing/present work unit
The hospital should recruit more nurses... We are already physically exhausted; we can't tolerate any more if the condition persists...	Seg16	Views on manpower retention in local public hospitals
I feel more stressed working in an isolation unit as I know I am exposed to a higher risk of infection.	Seg17	Perceived work stress
The mass media fails to truly illustrate the professional image of nurses.	Seg18	Recommendations on strategies to improve the nursing workforce: Improve professional image and recognition
Our sense of job security is affected by the contractual employment.		Improve job incentives
Our morale fluctuates, especially when infections recur successively... When the moment (of infection outbreak) comes, things are still messy. The management team then reacts by changing guidelines rapidly; this further increases our work stress.		
All of us are under stress, especially now that there is not enough manpower ... I hope that the managers can help improve our work conditions by listening to our concerns and addressing our needs...		Improve morale
		Improve managerial support Improve work condition Reduce work stress

members and students further selected the most representative cases from each group, and the transcripts were revisited to validate the list of descriptions. A total of 265 descriptive expressions were identified and categorized under 18 coded segments (Table 3) that resulted from systematic processes of comparison, contrast and pattern identification. The segments and descriptive expressions were then translated into English, the accuracy was ensured by translation and back-translation, and the list of expressions was validated by the research team.

For the final parts of the scientific phase, the application and final identification operation processes were undertaken in a subsequent survey study (Choi et al., 2008), involving a total of 1271 registered nurses to verify the findings generated in this study. Such modification was made with reference to the work of Pang et al. (2004), who incorporated a survey study to validate their empirical findings regarding Chinese nurses' concepts of nursing. This paper reports on the findings of the phenomenological study, while the results

of the survey study will be presented in a subsequent publication.

3. Results

Contemplation of nurses' experiences revealed two significant aspects: the vulnerable aspects of nursing work and the essential constituents of the nursing work environment. Two sets of forces, stabilizing and destabilizing forces, were noted to have stemmed from the attributes of the nursing work environment, which have potential influences on nurses' turnover intention. The vulnerable aspects of nursing work and the essential constituents of the nursing work environment are delineated below, annotated with verbatim transcripts.

3.1. Nursing work: the vulnerable aspects

Nurses' descriptions of their experiences revealed their concerns over various aspects of nursing work. Nurses perceived nursing work as stressful and comprising various vulnerable aspects that emerge from its inherent work nature. Concerns over health and occupational hazards such as back injuries were manifested frequently in their descriptions. Although nurses are provided with education and training regarding body mechanics, musculoskeletal injuries are still reported by more than half of them. Infection is another unavoidable risk that can be a source of tension to nurses. A nurse who was working in an isolation unit stated:

> I feel more stressed working in an isolation unit as I know I am exposed to a higher risk of infection. We wear respiratory masks at work; sometimes we may have to wear a full set of PPE (personal protective equipment), which makes it difficult for me to breathe. (Nurse 15)

In addition to the potential hazards of work-related injuries and infections, nurses have to handle unexpected incidents and life and death issues that arise from sudden changes in patients' conditions; such changes can sometimes be imminent enough to cause emotional distress. A nurse who intended to resign from her job mentioned that:

> Stress seems to be unavoidable, since my work deals with life and death issues. I have to manage my emotions well, and to always be prepared for sudden incidents that may happen at anytime. Meanwhile, I also have to be patient when caring for grieving or mentally disoriented clients, whose behaviors can be quite aggressive toward us. (Nurse 18)

In describing their work stress experiences, some nurses raised concerns regarding their responsibility for patients' health. Nurses have to bear the legal responsibility for any errors that happen in daily practice. A few nurses emphasized the need to be extremely cautious at work, which results in a drain on energy that affects their family lives. A nurse who intended to leave the public hospital described that:

> We cannot allow any errors to happen. If we do something wrong, even a single error can affect the patient a lot, and ultimately may affect the patient's life. This really puts a lot of stress on us. (Nurse 14)

A nurse who was married further revealed her tension, commenting that:

> Nursing work is harsh: I need to keep my brain working relentlessly when I am on duty, and my brain does not stop thinking about work even when I am off duty. This affects my pleasure moments with my children and my family... We are also vulnerable to infections, which can easily be transmitted to children. Although my work offers me much satisfaction, it poses too many threats to my family. It is unfair of me to have put my family in this kind of jeopardy. (Nurse 17)

3.2. Nursing work environment: the essential constituents

In explicating nurses' work experiences, various covert and embedded aspects of the nursing work environment were uncovered and noted to have a bearing on nursing work. Researchers dwelled on the descriptive expressions and identified six essential constituents of the nursing work environment, namely staffing level, work responsibility, management, co-worker relationships, job, and professional incentives.

3.2.1. Staffing level

Apart from the vulnerable aspects of nursing work, extensive attention has been drawn to the issue of inadequate staffing. Nurses described being deprived of rest days; issues such as accumulated leave, absenteeism and heavy workloads were commonly identified. The majority of them were aware of the impacts of understaffing, which results in increased vulnerability to work stress and work-related injuries, increased liability to errors, and a poorer perception of care. A male nurse who was working in an acute regional hospital illustrated that:

> The nursing workforce is depleted in many units in which staffs have to work hard every day. There are only 22 staff nurses in my present work unit, among whom two are pregnant and three are on long-term sick leave. Only 17 are left to manage the workload, which is impossible... I wish the manpower allocation can be more flexible. (Nurse 1)

Nurses were alert to the phenomenon of increasing nurse turnover, which undermines staff morale and results in frustration. A nurse in a supervisory role described that:

> We are short of staff; the turnover problem is serious... We keep recruiting new members and offering them training, but the situation is getting worse, they cannot bear the heavy workload, and they leave within one or two years... That's really a waste of my time and effort in training them... It really frustrates me. (Nurse 22)

3.2.2. Work responsibility

Nurses' descriptions of their work responsibilities portrayed a multifunctional nursing role that covers a wide range of work duties; however, the work responsibilities assigned may sometimes not be in alignment with nurses' expectations. Nurses expressed dissatisfaction regarding the need to take on non-nursing duties such as machine maintenance and staff welfare. When depicting her work responsibilities, a nurse who was in a supervisory role revealed that:

> Apart from patient care, I am also responsible for overseeing the operation of the unit. This includes handling matters such as blockage of the toilets' flushing system, and seepage of water from pipes and through windows. I have to resolve all these problems by contacting the respective departments to come to fix them. I do not see how they relate to my role as a nurse... (Nurse 15)

When explaining their work responsibilities, nurses also raised concerns regarding the increasing demand for documentation and the implementation of frequent audit exercises that are a "flavor of the month" that places an extra burden onto nurses. A male nurse who was a university graduate commented that:

> Nursing work is more than simple patient care; we have to take care of patients' and their relatives' emotions and concerns... Besides, we have to manage audit exercises, which fail to assess the real level of nursing practice and are therefore a waste of time. We have more paperwork to do now, such as the observation charts for patient positioning and restraint... I have to fill in a four-page form in order to transfer a patient to another unit. This deprives me of time to spend with patients. (Nurse 6)

In delineating their role as patient advocates, nurses valued their role in bridging communications between patients and physicians; however, the majority of them reported lacking autonomy in making patient care decisions. Some of them showed indignation at their autonomy being overridden by physicians, especially for certain common procedures for which nurses have been formally trained. A university-trained nurse who intended to quit his job illustrated that:

> Nurses are capable of making patient care decisions; however, we are always required to consult the physicians... An example is the procedure of wound dressing: we are asked to consult the physicians about what dressing solutions to use, but in fact they have not been formally trained for prescribing wound treatments. (Nurse 1)

3.2.3. Management

Contemplation of nurses' experiences revealed two components of managerial support, namely support for staff and support for nursing work itself. The former manifests as an intangible emotional support offered to subordinates, while the latter relates to managers' leadership ability in facilitating nursing practice. Nurses mentioned managers' not spending time understanding their thoughts, and they showed resentment towards management leaders in regard to their ways of handling patients' and relatives' complaints. A nurse who was working in an acute regional hospital expressed his desire for supportive management:

> I wish that the manager can view situations more from nurses' perspectives when handling complaints from patients and their relatives, and not merely blame us for everything... When these complaints are reported to the manager, the manager simply scolds us, assuming that it is always our fault... This has affected our morale badly. (Nurse 1)

Some nurses felt that their leaders empathized with their heavy workloads but were incapable of changing the unfavorable work conditions. Managers' leadership ability in coordinating and facilitating nursing work was also highlighted by most of the nurses, and disorganized management was viewed as a crucial factor that affects staff morale. A nurse who was working in an isolation unit observed that:

> Our morale fluctuates, especially when infections recur successively. We have learned from the past experience of SARS (Severe Acute Respiratory Syndrome), and management leaders have also done a lot to prepare for outbreaks of infection; however, when the moment comes, things are still messy. The management team then reacts by changing guidelines rapidly, which further increases our work stress. (Nurse 15)

3.2.4. Co-worker relationship

The nature of the co-worker relationship depends upon interactions among the staff, which differ across individuals and work contexts. Most nurses described cooperating well with their colleagues, and a few identified harmonious and supportive co-worker relationships as a reason for remaining in their workplace. A senior nurse described that:

> I haven't left because I love working with them... We have been working together for many years... We trust each other and we support each other at work... (Nurse 4)

By contrast, some nurses cited the presence of disharmony, mistrust and disrespect among their team members. Their descriptions further uncovered the presence of a fault-finding and blaming culture, which threatens their sense of security at work. A young male nurse who intended to leave his current work unit illustrated that:

> I enjoyed working in my previous work unit where colleagues cooperated well and got all the work done together. Colleagues here are segregated into territorial groups; the relationship is not harmonious. They like picking on each other and amplifying faults, and they will gang up on you if you do not belong to their group. This makes me feel insecure. (Nurse 6)

3.2.5. Job incentives

Job incentives refer to financial incentives such as salary and benefits. The majority of the nurses were generally satisfied with the financial aspect and commented that the job offers a stable income. However, loud protests were heard from a group of nurses who were employed on a contractual basis. Some of these nurses were experiencing inequitable employment terms resulting from salary cutbacks caused by the financial deficit of the authority in the past. A nurse who belonged to this group expressed that:

> We have experienced cutbacks twice... There is a strange phenomenon here that some of our senior nurses' salaries are lower than those of the juniors. This sounds ridiculous and should not have happened... Of course we are not happy about this: we have been working for five years, we assume more responsibilities at work, but we earn less than the juniors. This really frustrates us. (Nurse 7)

When being asked about their recommendations for promoting nursing retention, some nurses made comparisons between the financial incentives offered by public and private hospitals; there is a general understanding that private hospitals offer more competitive incentives, while public hospitals offer more job and learning opportunities. A junior nurse offered the following opinion:

> I think new nurses would choose to work in public hospitals... Though private hospitals offer higher salaries, there are relatively more job opportunities here... Patient complexity is greater in public hospitals, so working here can help broaden one's horizons. (Nurse 24)

3.2.6. Professional incentives

Professional incentives refer to the non-financial incentives that contribute to nurses' sense of professionalism. Two common elements were identified: the recognition gained from oneself and others, and the sense of accomplishment acquired through personal growth and professional development.

Appreciation from care recipients and significant others such as friends is an important reward for most nurses, while recognition also originates from oneself, manifesting as a self-appreciation of nursing goals and values. A nurse shared her sense of satisfaction gained from witnessing patients' improved health outcomes:

> I am pleased when I witness patients being discharged home. Even trivial matters like observing wound healing after persistent dressings make me happy... Satisfaction also comes from patients' and their families' compliments, which have been an important reward to me. (Nurse 23)

Public recognition influences how nurses value their work. When asked to comment on the image of nurses, a nurse who found her work satisfactory said that:

> Most of my friends are nurses, and those who are not nurses find us brave... Though the nature of shift work is harsh, the general public values us as being competent in dealing with different situations such as sudden death, which may not be easily handled by ordinary people. (Nurse 13)

Professional value is also gained from personal and professional advancement. Nurses valued the opportunities to acquire different skills, and they mentioned gaining a strong sense of accomplishment through advancing knowledge in the patient care process. A nurse who was working in an acute regional hospital revealed his devotion to work and learning:

> I am proud to be a nurse because I help people when they are most vulnerable... I enjoy learning so much and I treasure the opportunities given to acquire different skills... We have to pursue further training and education; when we learn more, our knowledge becomes an invaluable asset and our experiences enrich us with the passage of time. (Nurse 5)

3.3. Perceived nursing work environment: a dynamic equilibrium between stabilizing and destabilizing forces

Nurses' descriptions of their lived experiences revealed a complex phenomenon in which they struggle between two sets of forces: stabilizing and destabilizing forces at work. Both the stabilizing and destabilizing forces were perceived as having stemmed from the attributes of the nursing work environment. The results of the study showed that harmonious collegial relationships, appreciation from stakeholders and professional enhancement are the key elements that support nurses. A favorable environment that supports nursing work with stabilizing forces such as effective management and appropriate incentives can further alleviate nurses' vulnerability at work. However, an unfavorable environment that overwhelms nurses with destabilizing forces such as inadequate staffing, unsupportive management and inequitable employment terms can lead to frustration and dissatisfaction among nurses, which have potential impacts on their turnover intention.

Fig. 1 presents a hypothetical model that explicates a dynamic equilibrium between nursing work and the stabilizing and destabilizing forces in the nursing work environment. Nurses' work has been sustained by an embedded sense of professional value gained from recognition, personal and professional development, and a sense of support contributed by intimate and supportive co-workers. Meanwhile, nurses who work in the contexts are constantly interacting with other factors. Unfavorable factors that emanate destabilizing forces cause nurses to lose their equilibrium; nurses who lack support from the organization may not be able to tolerate the overwhelming vulnerability, and a disequilibrium (Fig. 2) then arises. To sustain an equilibrium between the two sets of forces, organizational efforts are needed to improve the nursing work environment; destabilizing forces have to be transformed to stabilizing forces in order to support nursing practice. If not, turnover intention and voluntary turnover may result.
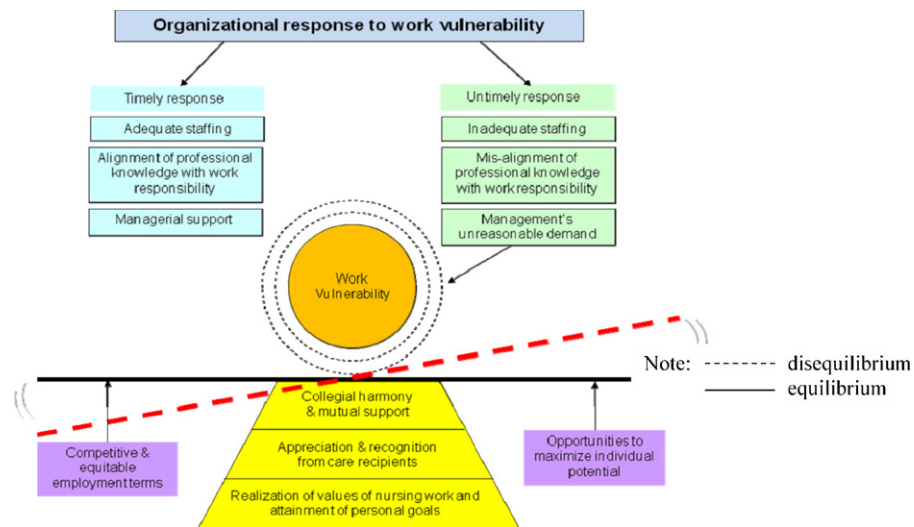
Fig. 1. Dynamic interactions between nursing work and the stabilizing and destabilizing forces in a nursing work environment.
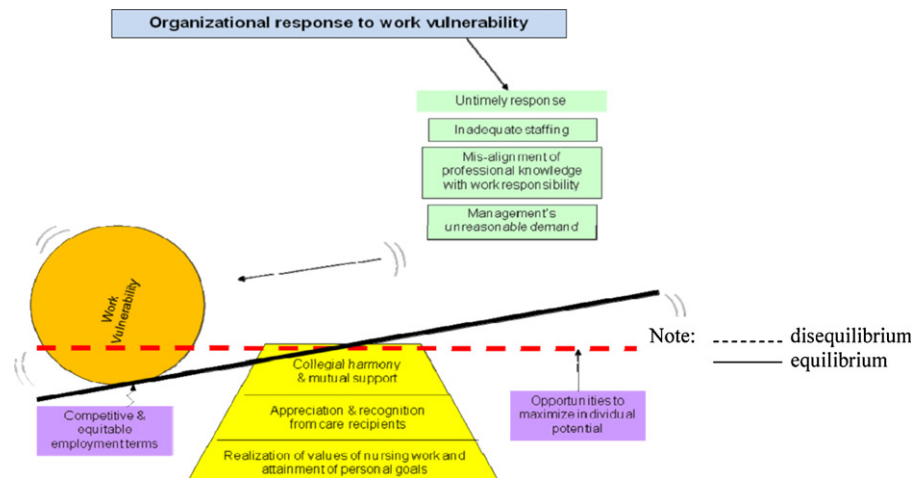

Fig. 2. A disequilibrium: results of an imbalance between the stabilizing and destabilizing forces in a nursing work environment.

4. Discussion

4.1. Discussion of findings

The findings provide invaluable insights into the contemporary nursing work environment, whose attributes have contributed to two sets of forces that have bearings on nurses' work and turnover intention. The contemporary nursing work environment was noted to have been overwhelmed by destabilizing forces such as inadequate staffing and ineffective management; the finding of an imbalance between two coexisting but opposing forces or situations is comparable to the results of both McGillis Hall and Kiesners's (2005) and Hallin and Danielson's (2007) works, which are the few qualitative studies that have examined nurses' work environment and experiences. McGillis Hall and Kiesners (2005) described nurses as working in an environment with high effort and low reward, while informants in Hallin and Danielson's

(2007) study perceived their work situations as more stressful than stimulating. This disequilibrium, which results in work stress, can have a detrimental effect on nursing practice and nurse and patient outcomes; the attributes of the nursing work environment therefore require special attention.

The nature of nursing work is a source of stress and tension for nurses (Milisen et al., 2006). Nurses in this study gave negative appraisals of the need to manage sudden and unexpected incidents and to bear the legal responsibility for work. This was in contrast to McNeese-Smith's (1999) study, which revealed nurses showing enjoyment at the challenging nature of their profession. Further analysis of nurses' characteristics indicated that younger nurses tend to tackle challenges more positively, while senior nurses tend to view them as a burden. Stress induced by the fear of making errors has also been consistently reported in past studies (Gallagher et al., 2003; McNeese-Smith, 1999). In the local context,

government and media reports on the occurrence of errors and sentinel events have further drawn the public's attention to the performance of healthcare personnel (Lui, 2008). Nurses, as the largest workforce among the health professions, are seen as accountable for any errors that happen during the caring process. When asked about their responsibility for patient safety, 96% of nurses and more than 90% of physicians, administrators and pharmacists viewed it as the primary responsibility of nurses (Ramsey, 2005). Meurier et al. (1997) found most nurses willing to take responsibility for their errors, but they experienced emotional distress that resulted in diffidence at work. The researchers further highlighted the need to cultivate a positive culture of learning from errors, so as to build defenses for patient safety.

Among the various destabilizing forces of the nursing work environment, the aspect of inadequate staffing has received considerable attention. Nurses are alert to its potential impacts on staff well-being, which render them more liable to errors and injuries. Absenteeism was also commonly reported in previous studies (McGillis Hall and Kiesners, 2005; Verhaeghe et al., 2006). The issues of understaffing and absenteeism have combined to form a vicious cycle. Nurses who are unable to cope with the work burden are absent from work, which further increases the workload of the remaining staff. Those who find the work conditions unbearable gradually develop an inclination to leave their current positions, which leads to increasing voluntary turnover. Tremendous efforts have been dedicated to tackling this global issue by establishing minimum nurse staffing ratios: a one-to-five nurse to patient ratio was proposed for general medical-surgical units (Chapman et al., 2009; Harrington et al., 2000). Yet skeptics contended that the ratio could not be a gold standard that fits all countries, and quality care should not only be attributable to this single factor (Chapman et al., 2009; Wharrad and Robinson, 1999). To solve the problem, researchers asserted the importance of understanding nursing work and nurses' context of practice (Spitzer et al., 2006).

Besides the staffing issue, mounting evidence from past studies has upheld the role of management in supporting nursing work. By offering support and maintaining open communications, management leaders can help counteract nurses' emotional exhaustion resulting from their demanding work environment (Bakker et al., 2000; Schmieder and Smith, 1996). Supervisory support was also noted to have a significant impact on reducing nurses' intention to leave the nursing profession (Van der Heijden et al., 2010). Nurses in this study described management leaders as not understanding their thoughts and needs, and the quality assurance measures imposed as further increasing their workloads. Consistent with their responses, Cooke (2006) noted that nurses are overloaded with audits. Some managers admitted that audits did not reveal much new information; the problems unveiled in audits had already been reflected from other means such as patient complaints and litigations (Cooke, 2006). Other studies also reported the increasing demands of paperwork, which deprives nurses of direct patient care time (Hallin and Danielson, 2007; McNeese-Smith, 1999).

The harmonious and supportive relationship among nurses has a symbolic meaning of intimacy, trust and connectedness in supporting their work. Findings from previous research advocate the importance of teamwork and social support from colleagues, which influence nurses' job satisfaction and their intention to leave the nursing profession (Estryn-Béhar et al., 2007; Van der Heijden et al., 2009). Unlike in other studies (Bucknall and Thomas, 1997; Budge et al., 2003), nurses in this study rarely discussed their relationships with other interdisciplinary members. Physicians, as the closest partners of nurses, were only mentioned when nurses argued over their autonomy being overridden by them. The discontent over the autonomy issue might have been so intense as to have masked the discussion of the nurse-physician relationship. The debate over autonomy might be explained by the fact that the majority of nurses are baccalaureate nurses, and more educated nurses tend to have higher role expectations (Lu et al., 2006). Other studies also reported nurses as having limited opportunities to influence patient care decisions and change their work situations (Hallin and Danielson, 2008; Milisen et al., 2006). This might indicate that the culture of hospital practice is still hierarchical in structure. The findings warrant attention since provision of healthcare requires collaborative team efforts; the struggle of power between the two disciplines can hinder communications, which affects provision of quality care.

Regardless of the influence of various sources of destabilizing forces, nurses in this study demonstrated strong professional values that have been sustaining them at work. The sense of professionalism was gained from recognition from the public and care recipients. Some researchers attributed it to the past outbreak of Severe Acute Respiratory Syndrome (SARS), following which nurses' professional image and work values became more widely recognized (Lu et al., 2006). Besides gaining satisfaction from recognition, nurses acquire a sense of accomplishment from advancing knowledge through the patient care process. Professional incentives, such as the opportunities given to fulfill their own potential, were commonly identified in past studies (Lu et al., 2002; Teng et al., 2007). Nurses touched only lightly on the issue of financial incentives, showing an understanding that experience and time are needed for promotion. To a certain extent, this reflects that nurses are not mammonists, they look to provide quality care that underpins their personal and professional values. There remains a concern that this sense of professionalism might gradually be undermined by the less favorable work environment, thus hindering them from providing good nursing care.

4.2. Limitations

The strength of this study is its trustworthiness, which was assured by grounding on nurses' descriptions of their experiences in real-life contexts. However, it is important to note that the findings may not be transferable to other healthcare environments, whose contexts are subject to variations in cultural, political and economic systems. Researchers might also risk overlooking certain valuable

information because of a pre-understanding of the study issue shaped by their own experiences (Patton, 2004). Nevertheless, this study has contributed to a fuller understanding of nurses' lived experiences of working in local public hospitals, providing important implications for policy makers.

4.3. Practical implications

This study has revealed nurses working in less favorable work environments, which is alarming since the evidence from many studies points to a close association between the nursing work environment, nurse turnover and patient outcomes (Aiken et al., 2002; Armstrong and Laschinger, 2006; Kramer and Schmalenberg, 2008). Among the various essential constituents of the nursing work environment, the issue of inadequate staffing has received considerable attention, which takes time to be resolved through professional training and detailed resource planning. Limited focus has been placed on other aspects that can be addressed through organizational efforts, such as the inappropriate handling of patients' and relatives' complaints, the sense of deprival of autonomy in patient care, and the existence of work constraints such as frequent audits and documentation. A thorough examination of the healthcare environment should be initiated to identify the obstacles that affect nursing practice and provision of quality care.

Though frustration at work has been widely observed, nurses seldom vocalize their appeals. They tend to be modest and reserved, and readily accept compromised work conditions (Hallin and Danielson, 2007). This further casts light on the need to cultivate management leaders' sensitivity to frontline nurses' needs. Mounting evidence points to the crucial role of management leaders in providing a productive environment for health professionals. Managers who demonstrate visible leadership are seen as central to success in transforming the work environment; they can foster professional practice by collaborating closely with the organization to streamline the work processes and provide the necessary resources to facilitate provision of care (Armstrong and Laschinger, 2006; Mrayyan, 2004; Shirey, 2006). More channels of communication should be provided to facilitate interactions between frontline nurses, managers and policy makers. Frontline nurses are the health professionals who provide immediate care to patients and the community; they are an invaluable resource in directing healthcare policies. It should be noted that health policies should never negate nurses' ethical obligation to provide holistic care that underpins the professional values of nursing (Aroskar et al., 2004).

4.4. Further research

This study has provided empirical evidence regarding nurses' perceptions of their work and work environment. The findings generated from these nurses who worked in local public hospitals cannot be taken to represent those who work in different healthcare contexts. While the attributes of private hospitals are known to be different from those in public hospitals, further study may be conducted to explore nurses' experiences of working in private hospitals. In addition, human perceptions are dynamic, and both nurses' work and their work environment are also subject to changes induced by education, policies, economics and the public's expectations regarding healthcare. It would be meaningful to conduct a longitudinal study in the future, to examine the impacts of different changes on nurses' perceptions of their work and work environment.

5. Conclusion

Nurses' descriptions of their experiences have uncovered the vulnerable aspects of nursing work and the essential constituents of the nursing work environment. The nursing work environment, which resembles a complex entity, merits attention in addressing the phenomenon of increasing nurse turnover. Concerted organizational efforts are needed to transform the destabilizing forces that exist in the contemporary healthcare environment, so as to retain the nursing workforce and ensure provision of quality care.

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