PERSPECTIVES ON SOCIALIZATION: AN EXPLORATION OF NURSING CAREER SATISFACTION

by

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Abstract

The current nursing shortage is complex, and reported to be like no other. Hospitals nationwide report job vacancy rates of up to 20%, affecting overall operations and patient care. Historical issues, changes in both technology and education, as well as changes in the healthcare model have all contributed to the nursing shortage vis-à-vis nursing dissatisfaction. The aim of this study was to conduct in-depth interviews with hospital staff nurses to evaluate the extent that disparate role expectations and inadequate socialization contribute to dissatisfaction. Using a qualitative methodology, this study employed the grounded theory strategy to explore the daily life of nursing experiences. Participants of this study consisted of 20 nurses who represented 12 acute care hospitals in Washington State. Findings revealed a lack of consistent socialization techniques and practices for both novice nurses entering the profession, and veteran nurses entering a new role, unit, and/or organization. Nurses who entered the profession with personal expectations, the role of a supportive mentor alleviated disparate role expectations, and provided support, clarity, and guidance. New nurses who lacked a mentor struggled to adequately socialize into the role and lacked purpose and clarity. Veteran nurses, particularly those changing roles and/or units, required additional knowledge transfer to assimilate into a new role that may have required different or unique clinical skills.

Dedication

To Lauren and Claire,

and Nurses Everywhere

"Every social scientific study is improved by a clearer understanding of the beliefs and experience of the actors in question"

J. McCraken, *The Long Interview*

"I am interested in knowing the hospital, I want to be invested, but I cannot look past the orientation; it took all of my energy and I did not feel successful"

Monica, Research Participant

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Table of Contents

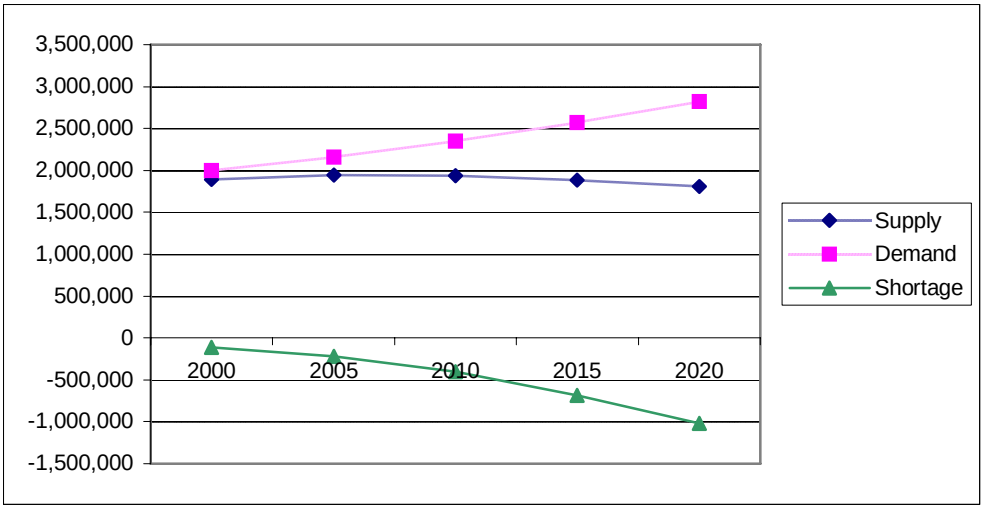
List of Tables

List of Figures

CHAPTER 1. INTRODUCTION

Across the United States (U.S.), nurses report job dissatisfaction as the primary contributor to both job and professional turnover; as such, the U.S. is facing another nursing shortage. The U.S. Department of Health and the Human Resources: Health Resources and Services Administration (HRSA, 2004) and conclusions from its Bureau of National Center for Health Workforce Analysis (2002) predict a nursing shortage of greater than one million nurses by the year 2020 (Figure 1). A confluence of events, including changing demographics, supply and demand issues, and inadequate resource allocation, supports this prediction.

Figure 1. Projected U.S. Registered Nurse Supply, Demand, and Shortages



From Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020. U.S. Department of Health and Human Services Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis (2002), p. 3. Reprinted with permission.

A broad term, job dissatisfaction refers to a panacea of events and circumstances contributing to the current shortage. Many studies cite the shortage itself as the primary source of nursing dissatisfaction (Aiken, Clarke, Sloan, Sochalski, Silber, et al., 2002; Burke, 2003; Parsons, 1998). Other researchers report that shortage-related retention issues contribute to recruitment challenges across healthcare (Joshua-Amadi, 2003; Laschinger, Finegan, & Shamain, 2002).

Researchers and practitioners continue to question the nature of the nursing shortage. Is it cyclical or unique (Robert Wood Johnson, 2002; Upenieks, 2003a)? There is agreement that distinct variables, such as changes in technology and the nurse's work environment, the advancement of women's rights, and preceding decisions (e.g., shifts in educational policy, programming, etc.) have contributed to previous shortages. It also appears that the nursing profession has been unable to recover from these earlier shortages, generating a larger cyclical event (Robert Wood Johnson, 2002). Upenieks (2003a) refers to the latest shortage unlike any other, noting that many variables play a significant role distinct from previous shortages.

Nationwide, nurses are voicing concerns about how the current nursing shortage impacts their workload by causing staff shortages in their work settings. Problematic shortages are also creating endemic strains in countries other than the U.S. (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001; Armstrong-Stassen, Al-Ma'aitah, Cameron, & Horsburgh, 1998; Fung-Kam, 1998; Mryaan & Acorn, 2004). The current shortage is a global issue that is philosophically challenging a traditional strategy of importing nurses from other countries to offset nurse shortages in the U.S.

Background of Study

Hospitals are complex organizations employing individuals in multiple professional and lay positions, from pharmacists and therapists to health-technicians and aides. Nursing constitutes only one of several workforces in the hospital environment; nonetheless, it plays a significant part in hospital operations. Although hospitals and healthcare organizations are experiencing shortages in numerous positions (U.S. DOH, 2004) nurses allege greater degrees of dissatisfaction (Albaugh, 2003), and report higher instances of shortages than their healthcare colleagues (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001).

The average age of nurses in the U.S. is 44 (American Hospital Association [AHA], 2001; HRSA, 2002, Robert Wood Johnson, 2002), representing up to 60% of the current nursing workforce who are "expected to retire within the next 15 years" (Cordeniz, 2002, p. 237). Like many professions, nursing is part of a disproportionately aging workforce with fewer candidates to fill positions. In addition to the aging workforce, fewer new graduates have been entering the profession (Cordeniz, 2002; Laschinger et al., 2002), and a significant number of nurses under the age of 30 report greater instances of extensive career dissatisfaction. Aiken, Clarke, Sloane, Sochalski, Busse, et al. (2001) found 19% of U. S. nurses under 30 were dissatisfied. Koukkanen, Leino-Kilpi, and Katajisto (2003) findings agreed with Price (2002) noting that a significant sample of nurses between 21 and 40 were either dissatisfied or had considered leaving the profession within a year. In addition to inadequate numbers entering the nursing workforce, coupled with those leaving the profession early because of dissatisfaction, the majority of baby boomer nurses are retiring. In fact, the numbers of

retiring baby boomer nurses will increase through 2015 as an increasing number reach retirement age. The resulting multiple vacancies will further tax an already stressed system.

Professional demands have increased the need for nurses throughout healthcare. The proliferation of nursing jobs has been augmented by technological and environmental changes. These changes increase the need for nurses within hospital operations as well as outside in general healthcare. Perpetuated by the onset of the market-driven healthcare era (Scott, Ruef, Mendal, & Caronna, 2000; Wong, 1998), expanded demands for nursing services represent a strategic shift among healthcare providers, as healthcare systems have integrated operations both vertically and horizontally (Byrne & Ashton, 1999; Garcia, 2002).

Healthcare providers increasingly face competition for nurses by employers outside the healthcare system. Law firms, the insurance industry, and even software companies have offered nurses attractive, professional opportunities. Nursing schools have been unable supply enough nurses to meet these additional demands. Enrollments to nursing schools have been negatively affected as the expansion of career opportunities for women outside of nursing have increased over the past four decades. Many non-nursing career options, once considered inaccessible to most women, have diminished the pool of female applicants to nursing programs. Moreover, there has been no significant increase in male applicants to nursing schools, as nursing is primarily still perceived as a female career (Robert Wood Johnson, 2002). A 2000 survey conducted by the AHA indicated that males represent only 5.4% of the nursing population.

Innovations in nursing education offer a portable degree contributing to a more mobile nursing workforce. For nearly 100 years, hospitals educated and maintained their own supply of nurses. This diploma model for nursing education typically consisted of courses taught by physicians and senior nurses in the acute hospital setting. In addition to classroom instruction at the institutional site, student nurses receive two to three years of hands-on experience supervised by the more senior nurses. Traditionally, diploma-nursing students were housed by and within the hospital, living and working in a highly restricted environment.

Diploma nurses were frequently tethered to their employer hospital. In part because the diploma certificate was unique to the issuing hospital, and inculcation into its culture made them hospital specific nurses (Donley & Flaherty, 2002). Moreover, the onset of nursing education outside of the hospital left diploma nurses with little opportunity for educational advancement. Newly formed college based nursing programs did not recognize the diploma education as a transferable degree; nurses aspiring to advance were often required to repeat their education within the college infrastructure (Garner, J., MSN, RN, Dip., personal communication, December 1, 2003).

Hospitals began to experience the initial surge in nursing demands after World War II (WWII). Improvements in health care, science and technology, coupled with increasing regulations, all generated significant healthcare growth. The post WWII growth in healthcare also commanded more sophisticated nursing techniques and skills. Additionally, many military nurses left the profession to begin families after the War. Demand for nurses continued to exceed supply following a 1965 recommendation by the American Nursing Association (ANA) to pursue college based nursing education.

The ANA's controversial position was based in part to model nursing education after the University of Minnesota and Columbia University, among others, and to be more aligned with physician education by emphasizing a foundation in the sciences (American Association of Colleges of Nursing [AACN], Fact Sheet, 2005; Donley & Flaherty, 2002, Robert Wood Johnson, 2001). Moreover, a baccalaureate education standard would increase the chronological time for nursing students, and decrease the number of student nurses providing marginally reimbursed nursing care in hospitals having diploma programs. Hospitals would be required to wait for graduate nurses to provide patient care, rather than utilizing student diploma nurses at will. The late 1960s and early 1970s period also represents the initial creation of many nursing specialties and the proliferation of nursing specialty organizations. Increasing specialization meant that many nurses were no longer as mobile or transferable between hospital units or wards (Donley & Flaherty, 2002). Without the ability to control their own workforce populations, hospitals were unable to maintain a constant supply of nurses at a time when environmental changes and demands were increasing the need for nurses.

Graduation rates reported by all pre-licensure nursing programs (Diploma, BSN and ADN) have been in decline since 1965, creating an unavoidable supply problem (AACN, 2003; Donley & Flaherty, 2002). The AACN (2002, 2003) reported that enrollment in baccalaureate nursing programs has been declining for the past seven years, though the AACN did report an increase of 9.6% in 2005 (AACN, 2006). Despite the fluctuations in baccalaureate enrollment and graduation rates, many two-year nursing schools have seen an increase in applications (HRSA, 2004). The influx of new applications is partly due to the continued growth of nursing employment opportunities as

predicted by the Department of Health and Human Services Health Resources and Services Administration and the U.S. Department of Labor, and the marketing of the profession as highly desirable by such entities as Johnson and Johnson.

According to the AACN, nursing schools across the U.S. turned away nearly 15,000 applicants during the 2003-2004 academic years because of insufficient faculty and budget constraints, among other issues. Increases in nursing school applications have influenced nursing program admission practices at many colleges and universities. For example, some nursing schools are using grade point average (GPA) for applicant selection. Others consider selection based on previous healthcare experience and personal interviews. Despite the overall growth and expansion of nursing schools (Miller, 2005), enrollment in nursing programs is limited. Contributory factors to enrollment limitations are reflected in the operating costs of nursing programs, limited faculty population, and restrictive clinical sites.

Enrollment capacity of a nursing program is defined by the education model, curriculum, accreditation expectations and requirements, number of faculty, clinical site availability and the program's resource allocation from its governing institution, as well as other factors, ability to secure external funding. Significant improvements in most of these factors have taken place over the past few years. However, faculty shortages and limited clinical sites continue to be two of the greatest challenges to the expansion of nursing programs and/or admission (AACN, 2003; Miller, 2005; Robert Wood Johnson, 2002). Masters- and doctoral-prepared nurses can earn greater income in professional positions within health care provider systems than they can in faculty positions (AACN, 2006; Health Care Task Force, 2002). The competition for nursing faculty and clinical

placements has become “fierce” in many areas (Miller, 2005). Drop-out rates among student nurses can average 50% per year, severely limiting graduates, and further restricting supply. Regional data collected from the Tacoma-Pierce County Workforce Development Council during 2000 and 2001 points to the rigors of nursing school and the conflicting realities of the nursing students as, influencing drop out rates (Sturzenegger, D., personal communication, April 17, 2003).

The demands of nursing school severely limit the amount of time that nursing students can work outside of the classroom. The lengthy clinical period is both unpaid and demanding, restricting student income opportunities. Life events such as, auto accidents and child care expenses were identified as the primary indicator for drop-out rates among students attending ADN nursing programs in Pierce County, WA. Though data collected reveals regional concerns and challenges, they are representative of the average demographics of student nurses across the U.S.

California State University at Fresno (CSUF) has observed a shift among its contemporary nursing students. The current student body is comprised of older students when compared to previous nursing cohorts. Other organizations tracking nursing enrollments report similar statistics. Both the AACN (2003) and AHA (2006) have documented a five-year increase in the average age of student nurses since 1977. Furthermore, the shift to an older nursing student body reflects a change in the overall student population.

A 2003 AACN white paper revealed that current nursing students are markedly diverse, reflecting differences in financial status, living arrangements, and previous work experience. For example, CSUF indicates that only 27% of nursing students are living

with parents, while the remaining 73% have other living conditions, 79% of those students work at least 22 hours per week. Given that 96% of nursing students are female (AACN, 2002) implies that a significant burden of household responsibilities may fall to them making nursing school completion challenging, and a subordinate priority. This population may also be representative of what Miller (1991) referred to as opportunistic nurses, those who enter the nursing profession to take advantage of the multiple opportunities and demands, rather than dedication to the profession.

The shortage itself is the greatest potential threat to nursing (Albaugh, 2003). Nurses cite shortage-related issues as challenging to the body, mind, and spirit of nursing (Nathanial, 2004). The situation is particularly dire in hospitals, where staff shortages place patient care in danger, threatening hospital operations. Aiken, Clarke, Sloan, Sochalski, Busse, et al. (2001) noted that the shortage is diminishing quality patient care, as staff shortages and increased job duties create an environment of stress that results in serious errors injuring or contributing to patient death. In turn, this creates a ripple effect of regulatory non-compliance and liability risk responsible for mandatory overtime and additional stress. Furthermore, the perception of poor patient care can inflict state or federal investigations, increasing legal liability. Outcomes of flawed patient perceptions can generate licensure complaints stigmatizing nurses throughout their professional careers.

Not only is the acute care environment the entry point for most nurses (Mahaffey, 2002), hospitals remain the single largest employer of nurses making them the most vulnerable to nursing shortages. Employing 60% or over 1.2 million of the nation's nurses (AACN, 2004; Donley & Flaherty, 2002), hospitals are reporting a 20% average

vacancy rate for registered nurses (RN) across multiple units (AHA, 2001; Muliira, n.d.; Upenieks, 2003b). The majority of the shortages are experienced in the acute care settings where skilled nursing care is critical to patient assessment, treatment, and recovery (AACN, 2005). Patients and physicians alike rely on nurses for 24-hour surveillance, assessment, and care (Aiken, Clarke, Sloan, Sochalski, Silber, et al., 2002; Mahaffey, 2002).

Concurrently, unit shortages contribute to increased and/or mandatory overtime and additional tasks (Muliira, n.d.). In an effort to fill shift shortages and ease overtime burdens, many hospitals contract with agency staff. In fact, 56% of hospitals report the use of agency or contract personnel (AHA, 2001; Muliira). While contract employees fill shift and unit vacancies, their presence contributes to additional frustration among hospital personnel. Agency staff frequently struggles with procedures, routine to hospital staff, while demanding premium schedules, leaving undesirable shifts to staff nurses. Furthermore, agency nurses are paid higher wages than hospital personnel resulting in aggravation among hospital staff as well as increasing operating costs.

Unlike physicians and other healthcare professionals, nursing is historically reflective of various role changes (Wong, 1998) and educational improvements that have contributed to the professional advancement of nurses (Donley & Flaherty, 1998; Robert Wood Johnson, 2002). Historically, nurses have been considered both a servant (Robert Wood Johnson, 2002; Thoemmes Encyclopedia, n.d.) and a physician handmaid (Tieman, 2001). Today's nurse is recognized as healthcare professional (Donley & Flaherty, 2002; Startup & Wilson, 1992), and as an integral part of an interdisciplinary team (AACN, 2005).

Prior to the 19th century nurses received little training: thought of primarily as domestic servants, their roles were limited to wet/dry nurses and midwifery (Trimble, n.d.). Expansion of physician practice vis-à-vis advancements in medical knowledge combined with the establishment of hospitals increased nursing scope to offer basic patient care and housekeeping duties (Robert Wood Johnson, 2002; Trimble). The primary tasks of early nurses were to clean wards, feed patients, dress wounds, scribe physician notes, and "perform adequate services for her patients and doctors" (Anonymous, n.d.; Thoemmes Encyclopedia, Trimble). Nursing shifts in early hospitals lasted as long as 13 or 14 hours (Trimble).

Progressive advances in healthcare knowledge increased the standing of nurse from hospital servant to physician assistant. Despite the increase in need for nursing services, physician education continued to steadily advance. To meet demands, hospitals eventually began to train their own nurses creating the diploma model of nursing education. True advancements in nursing education did not transpire until post-World War II when technological advancements and medical science advanced beyond nursing capabilities of the era (Robert Wood Johnson, 2002).

Contemporary nursing is noticeably different than nursing from even 20 years ago (Bronson, Pam, RN, personal communication, July 19, 2005). The modern market-driven healthcare era has generated a business model designed to maximize profits, through strategic expansion (Garcia, 2002) and liability reduction (Scott et al., 2000; Wong, 1998). Changes in the healthcare industry have changed nursing practice (Wong, 1998) and nursing education (Yura-Petro & Brooks, 1991), as well as altered employment practice requirements (Williams O'Rourke, 2003). Healthcare systems--

replacing stand-alone hospitals--require nurses to spend proportionately more time documenting patient care, executing ancillary services, and administrative related tasks, versus directly caring for patients. Cost-containment efforts often re-engineer nursing services. Staff reductions challenge nurses, as do changes in both required skill sets and role expectations. Ultimately, these changes not only affect decision-making and task assignments of nurses: they redefine expectations for patient care. Williams O'Rourke suggests that an inherent danger exists in healthcare's efforts to alter the nursing role. Nurses no longer spend the majority of their time providing patient care. This shift creates a potentially inherent organizational challenge: conflicting expectations.

Hospitals administrators, physicians, patients and patient family members all have different, often conflicting, expectations of nurses (Hemingway & Smith, 1999; Janseen, de Jong, & Bakker, 1999; Nathaniel, 2004; Lopopolo, 2005). Nurses themselves have a set of personal expectations based on a paradigm of perceptions described to them by friends and relatives in nursing (Albaugh, 2003), portrayed in media and pop culture (Takase, Kershaw, & Burt, 2001), and self-actualized in nursing school (Oleson & Whittaker, 1968; Simpson, Back, Ingles, Kerchkoff, & McKinney, 1979). Many nurses report that they enter the field to care and/or advocate for patients and take great pride in providing quality patient care (Newman & Maylor, 2002; Newman, Maylor, & Chansarker, 2002). According to Upenieks (2003a), however, "the present shortage may be considered momentous as a result of nurses opting out of the nursing profession due to their dissatisfaction with their roles in the hospital setting" (p. 83).

Healthcare stakeholders have a unique set of expectations stemming from specific demands and limitations. Hospital expectations derive from the need of nurses to

conform to the nursing role, and the need to maintain operational compliance. Hospitals are obliged to federal regulatory operating practices, legal constraints, and financial solvency. Regulatory and liability obligations have furthered the need for nurses to fill these positions. Moreover, the current business model of healthcare has increased the need for strategic operations which includes patient satisfaction (Lait & Wallace, 2002; McNeese-Smith, 1999).

Nurses have a very different set of role expectations from other stakeholders. Parker (1993) claims that the nursing role exemplifies one of the most stressful professional roles because of the associated demands and limited control. Nurses are frequently afflicted by a lack of authority despite the responsibility associated with patient care and the accountability attached to carrying out physician orders. Price (2003) asserts that like most professionals, nurses desire to be treated as healthcare professionals. They want to be, respected for their role which includes patient care-related tasks. This desire is common among professionals who want to utilize their education and knowledge to perform their role (Scott, 2003).

The inability to directly provide patient care activities has been noted as the greatest cause for dissatisfaction among nurses (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001; Albaugh, 2003; Buerhaus, Donelan, Kirby, Norman, & Dittus, 2005; Cline, 2003; Gurley, Spence, Briner, & Edwards, 2003; Joshua-Amadi, 2003; Thomas-Hawkins, Currier, Denno, & Wick, 2003). Some of these studies attribute dissatisfaction among nurses to administration's perceived lack of support or response to patient care-related concerns (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001; Thomas-Hawkins et al., 2003). For example, one nurse iterated her concern over administration's decision to

discontinue the use of mattress pads on patient beds. Administration took the position that mattress pads were an expensive patient luxury, while the nursing staff believed that the mattress pads were something more than a luxury, that they enhanced the quality of the patient care (Roeger, D., RN, personal communication, April 10, 2006). Despite the divergence of expectations, both hospitals and nurses remain committed to patient care, albeit for different reasons.

Significance of the Study

Nursing retention is imperative for the maintenance of stable hospital operations and quality patient care. Aiken, Clarke, Sloane, Sochalski, Busse, et al., (2001) has suggested that the structure of nursing work contributes to dissatisfaction. Organizational socialization is dependent upon the composition of both organization and role. Formal organizations and task-arduous positions require employees to assimilate more information, such as processes and artifacts, in order to effectively operate in their roles. Hospitals and nursing are both structured and rigid, relying on numerous procedures, techniques and forms, quality control measures and liability requirements, all of which leave little room for variation or deviation. Changes in the operating environment, coupled with the structure of both organization and work role, support the need for adequate socialization within the nursing population.

Patient acuity continues to rise due in part to changing demographics. The incidence of chronic diseases and need for health care services increase with aging. The U.S. population consists of proportionately more, as well as numerically more, older people. Patient acuity also increases with the influx of immigrant populations, arriving at

U.S. hospitals under-treated, if not mistreated. Patient acuity rises when preventative care diminishes and a larger proportion of Americans, including young adults and children, do not have health care insurance or a designated health care provider. Finally, rises in patient acuity is associated with more of the population being obese, engaging in high risk behaviors, and/or seeking health care services in response to crisis.

Across the country, non-related nursing tasks (Buerhaus et al., 2005) are changing the workload of nurses in acute settings, thereby decreasing the nurses' ability to care for patients. This combination is placing burdensome requirements on hospital nurses. Currently, relatively little has been done to influence the educational supply chain and/or the structure and make-up of hospitals; therefore, it is imperative to focus efforts on the adequate preparation of nurses in order to ensure retention within the clinical and professional workforce.

Increasingly, more nurses are in greater positions to influence hospital operations. Employing nurses in over 60 unique positions, a lack of qualified nurses could critically impair hospital functionality and patient care. Aside from disrupting patient care, disabled ancillary roles could jeopardize the ability of hospitals to manage infection control, risk management, and discharge planning, among many other functions. The inability to admit, treat, and timely discharge patients could significantly reduce revenue.

There is a common reliance upon nurses to provide more than care within hospitals. For example, a nurse deficit could potentially suspend numerous strategic and tactical functions, such as the continuity of cost-effective care (Muliira, n.d.). The prospective payment system (PPS) establishes limitations and guidelines for the cost of medical procedures and/or diagnosis for federally-funded Medicare patients. Given that

nursing care is directly correlated with adequate patient outcomes, a shortage of nurses could result in extended patient stays ultimately costing the hospital millions of dollars annually in lost Medicare payments. Diminishing patient outcomes could impair expansion efforts, thereby limiting services such as specialty care, such as cardiac or neurological surgical centers, and/or by limiting technological advances, such as advanced imaging diagnostics.

This study contributes to the current literature by exploring socialization to improve satisfaction and tenure among hospital nurses. As such, this study will contribute a new perspective to both the nursing literature and the socialization literature associated with organizational behavior. The body of research has consistently demonstrated that socialization has been an effective method of inculcating new employees into the cultural folds of the organization (Ashforth & Saks, 1996; Ashforth et al., 1998; Bravo et al. 2003; Cable & Parsons, 2001; Cooper-Thomas & Anderson, 2002; King & Sethi, 1998). This demonstration will be accomplished through a rich and detailed narrative designed to capture the nursing experience. Chapter 4 will introduce the interview guideline (Appendix A) and participant narrative at length, and will include final research results.

Purpose

The purpose of this study is to explore unmet expectations of hospital staff nurses to determine the extent that inadequate and/or inappropriate socialization contributes to disparate expectations and professional dissatisfaction. Dissatisfaction among nurses has been reported as being the highest in acute settings (Health Care Personnel, 2002),

partially as a result of the low volume of nurses employed relative to the high volume of nurses needed. The low ratio of volume of nurses employed to the high volume of nurses needed contributes to excessive and costly nursing turnover.

This research is specifically interested in the perceptions of registered nurses (RNs) in the acute care or hospital settings. Currently, hospitals and acute care settings are both a professional entry point (Mahaffey, 2002) and the single largest employer of nurses. Together they employ nearly 60% of the nation's nursing workforce (AACN, 2004; Donley & Flaherty, 2002). Furthermore, this study will explore how institutional socialization practices can better prepare nurses for entry into practice in acute care settings.

Rationale

The body of socialization literature is relatively limited (Ashforth et al., 1998; King & Sethi, 1998) and therefore is an ideal subject to apply to the exploration of nursing dissatisfaction. The current body of both nursing and socialization literature lacks theoretical development and adequate research studies to determine how nurses transition into their organizational roles and learn to manage unmet expectations vis-à-vis role stress, as well as if a lack of socialization contributes to dissatisfaction vis-à-vis role stress. Moreover, missing from the body of nursing satisfaction and the socialization literature is how socialization strategies can mitigate unmet role expectations.

Theoretical Framework

The framework for this study stems from the representative yet limited scope of research necessary to understand nursing dissatisfaction. Surprisingly, the current body of research related to nursing dissatisfaction is unique and limited given that it has been assessed exclusively from a nursing perspective and is largely positivistic yet lacking a theoretical base (Joshua-Amadi, 2003). Given that the current base of research is from a limited nursing perspective, it may be constrained by invalid or biased assumptions, measuring incorrect hypotheses (Chang, Hancock, Johnson, Daly, & Jackson, 2005). Furthermore, excessively narrow views often fail to take into account successful programs within other professions and industries. Anaconda, Goodman, Lawrence, and Tushman (2001) emphasizes that the application of a different lens may call attention to a new perspective of a given phenomenon.

The intent of this study is to present a more comprehensive strategy for the exploration of organizational socialization within the nursing workforce that is perceived as mutually beneficial to both nurses and hospitals. This research is presented from the perspective of organizational behavior and organizational management relying on both historical nursing literature and current organizational research. Differing from previous studies, this research will rely more on the organizational socialization specifics, a variable largely ignored by nursing, which are notably correlated with organizational job satisfaction.

Research Questions

Research questions guiding this study:

Question 1: *To what extent does individual socialization contribute to dissatisfaction among nurses?*

Question 2: *To what extent do unmet career expectations contribute to nursing dissatisfaction?*

Question 3: *To what extent does individual socialization contribute to unmet role expectations?*

Question 4: *How can professional socialization contribute to the clarity of role expectations, thereby improving job satisfaction of professional nurses?*

Definition of Terms

The following terms will be used in this study:

*Individual Socializatio*n. The individual socialization model is comprised of an isolated experience (individual and disjunctive) that is casual (informal), unstructured (random), lacks a specified timeframe (variable), and strips away independence (divestiture) (Ashforth & Saks, 1996; Ashforth et al., 1998; King & Sethi, 1998).

Institutional Socialization. The institutional socialization practices include a shared experience (collective) of purposeful socialization activities (formal), within a defined structure (sequential), during a specified timeframe (fixed) with a mentor (serial) designed to build on existing skills (investiture). The institutional socialization model orients employees on all three organizational levels: content; context; and social; and is

therefore considered more supportive of newcomer commitment and job satisfaction (Ashforth & Saks, 1996; Ashforth et al., 1998; King & Sethi, 1998).

Job Satisfaction. Broadly defined in the extant literature as the perceived attitude an individual holds about his/her job (Moorhead & Griffen, 1995).

Nurse. An individual possessing a registered nursing (RN) license. This includes diploma (Dip), associate degree nurse (ADN), and/or baccalaureate- (BSN) prepared nurses.

Organizational Socialization. Based on the definition originally put forward by Schein (1968 as cited in Dose, 1997) socialization is a process by which a new organizational member internalizes organizational values, beliefs, norms, and tasks. This also includes adapting to the required behavior of an organizational work group.

Professionalization. Differing from socialization, professionalization refers to the inculcation of individuals into an occupation or profession, instilling common values, norms, and behaviors common to a profession or vocation. Also referred in the literature as professional or vocational socialization (Lui, Ngo, & Wing-Ngar Tsang, 2003).

Role Ambiguity. Uncertainty about role expectations (Katz & Kahn, 1978), role behavior and meeting expectations (Monahan, 1999), and information and clarity related to tasks within a role (Iverson, 2000).

Role Conflict. Katz and Kahn define role conflict as "simultaneous occurrence of one or more role expectations such that compliance with one would make compliance with the other more difficult" (p. 204).

Role Expectations. Expected behavioral patterns assigned to a position in an organization and/or social unit (Robbins, 2003). Role expectations may also extend to

personal and organizational characteristics, style, values, and/or beliefs (Katz & Kahn, 1978).

Role Stress. Defined by Chang and Hancock (2003) as the "consequence of disparity between an individual's perception of the characteristics of a specific role, and what is actually being achieved by the individual currently performing the specific role" (p. 156). For the purposes of this paper it will also include the combination of role ambiguity, role conflict, and/or role overload when taken together.

Assumptions and Limitations

As with any study a certain number of assumptions and limitations are inherent. For this research, it is important that the researcher have an adequate understanding of nurse history and contemporary issues to sustain a meaningful dialogue and conduct interviews with nurses. As such, this research about nursing dissatisfaction by a non-nurse holds various assumptions.

Assumptions and limitations of this study are as follows:

1. the nursing shortage is dependent on the inability of today's nurses to understand truly the nurse's role due in part to changes in both education and the present healthcare model;
2. the nursing profession will benefit from an outside perspective (non-nursing perspective) and will somehow contribute to current unmet needs within the nursing profession;
3. there is indeed a problem that can be addressed through organizational behavior;

4. as is natural with qualitative research, researcher assumptions may influence either research outcomes and/or participant responses; and
5. both the genre and stream of current nurse literature related to perceived assumptions made by other nurse researchers is incorrect, and driving invalid research findings.
6. finally, the non-nurse status of the researcher must be addressed because of the assumption that as a non-nurse the researcher lacks a fundamental knowledge necessary to understand or ascertain which issues challenge nurses, and that a non-nurse can understand what it means to work under the constant threat and pressure of licensure revocation. The researcher acknowledges that a lack of nursing knowledge is a limitation of this study; however, it is the hope that the introduction of a fresh perspective may invite innovative ideas to address the discourse of nursing dissatisfaction.

Summary

Nursing shortages are affecting hospitals nationwide. Aside from the operating challenges, acute care facilities are spending millions of dollars on a revolving door of nurse recruiting efforts, sign-on bonuses, overtime, and agency fees. The initial chapter outlines the historical and complex conditions that have shaped contemporary nursing practice. Modifications in education and healthcare models, as well as in nursing practice, have influenced the nursing role; changes have contributed to role stress, and potentially to unmet career expectations, contributing to nursing dissatisfaction.

The remainder of this paper is organized into four subsequent chapters. Chapter 2, the literature review, details the current body of literature outlining related job and nursing dissatisfaction, role stress, and socialization. Chapter 3 details the use of grounded theory as the selected research strategy for exploring nursing dissatisfaction. Chapter 4 provides a narrative account of researcher findings as well as data analysis; finally chapter 5 details research findings and conclusions.

CHAPTER 2. LITERATURE REVIEW

The foundation and research questions guiding this study consider the extent that an absence of organizational socialization contributes to unmet career expectations and dissatisfaction. This chapter reviews three distinct areas of empirical research, exploring the literature related to job satisfaction, role stress, and socialization. Research has demonstrated an undeniable relationship between inadequate socialization with job dissatisfaction (Ashforth & Saks, 1996; Cable & Parsons, 2001; Cooper-Thomas & Anderson, 2002; Lui, Ngo, & Tsang, 2003), role stress (Ashforth & Saks, 1996; Bravo, Peiro, Rodriguez, & Whitley, 2003; Finkelstein, Kulas, & Dages, 2003; King & Sethi, 1998), and turnover (Ashforth et al., 1998; Payne & Huffman, 2005).

A gap in the literature reveals the lack of nursing socialization addressed within either the nursing or socialization literature. As the researcher conducted the literature review, three strands of existing research emerged to form the subsequent literature review: job satisfaction, role stress, and socialization. Each of these threads was explored at length to examine as broad a range of knowledge as possible. For example, the role stress variable was broadened to include role conflict, role ambiguity, and role expectations. Moreover, each thread within the body of literature was assessed to determine the existence of literature relating to nursing dissatisfaction as well as overall dissatisfaction. For example, the role stress literature was assessed from the nursing

perspective, as well as within the general employee population, that is clergy, educators, and so forth. The observed gaps produced the four research questions in intent to provide a fresh insight into nursing dissatisfaction.

The job satisfaction literature has addressed many job characteristics commonly associated with dissatisfaction, such as pay (JayRay, 2002; Gurley et al., 2003; Joshua-Amadi, 2003), work hours (Armstrong-Stassen et al., 1998; JayRay, 2002; Newman & Maylor, 2002), lack of autonomy (Hamilton, 1993; Fung-Kam, 1998; Laschinger et al., 2001; Price, 2002), and role stress (Wong, 1997; Chang & Hancock, 2003; Chang et al., 2005). Role stress, a variable strongly and consistently correlated to job dissatisfaction, has demonstrated significant reductions through socialization. Finally, socialization has established noteworthy reductions in role stress (King & Sethi, 1998; Ashforth & Saks, 1996) and intent to quit (Ashforth & Saks, 1996; Waung, 1995), while increasing satisfaction (Ashforth & Saks, 1996) and organizational commitment (Ashforth & Saks, 1996; Reichers, Wanous, & Steele, 1994). A variety of socialization literature was reviewed from current social science venues including business, sociology, and psychology.

Job Satisfaction

Job satisfaction, often used as an umbrella term, describes the perceived attitude and happiness of an individual with his/her job. Job satisfaction is unique; therefore, defining it is difficult given that individual perceptions about satisfaction are as multi-faceted and distinctive as the experience itself. Particular elements of job satisfaction are common; however, these include work-related experiences that individuals perceive as

gratifying or produce a positive experience (Lopopolo, 2002). Locke, (as cited in Matus & Frazer, 1996, p. 41) described job satisfaction as a "pleasurable or positive emotional state, resulting from the appraisal of one's job or job experience." (Yousef (2001) defined job satisfaction as the "extent to which a worker feels positively or negatively about his or her job" (p. 251). Chu, Hsu, Price, and Lee (2003) presented job satisfaction as the "affective orientation that an employee has towards his or her work" (p. 176).

Job and Organizational Characteristics

One measure of job satisfaction is job and organizational characteristics, identified as work-related variables that influence job satisfaction. Job characteristics include task variety, autonomy, professional interaction, responsibility, knowledge, and experience (Berkhout, Boumans, Nijhuis, Van Breukelens, & Abu-Saad, 2003; Chiu & Chen, 2005; van den Berg & Feij, 2003). Conversely, organizational characteristics, also considered essentials of job satisfaction, include span of control, mechanistic or organic structure, leadership, sub-cultures, and formal or informal business requirements, which refer to the structural make-up of the organization (Glisson & Durick, 1998; Lok & Crawford, 2001). Glisson and Durick suggested that job characteristics have "received the most empirical attention in studies of job satisfaction" (p. 66).

A wide variety of job satisfaction characteristics have been measured in the literature. Jauch and Sekaran (1978) explored job and organizational characteristics such as pay, tasks, and coworkers. The findings substantiated a positive relationship with each variable as a significant, influencing factor. Lopopolo (2002) hypothesized that work-related outcomes influence job satisfaction. Job tasks, fragments of work-related

outcomes, must resemble the employee's actual work experiences; therefore, increasing tasks that do not appear to be aligned with the actual work or role will fail to generate a positive response.

Hochwarter, Kiewitz, Gundlach, and Stoner (2004) found task efficacy to be a variable strongly associated with job satisfaction. Increasing task-related proficiency, they stressed, would improve job satisfaction over measures of social efficacy. Van den Berg and Feij (2003) revealed only a slight confirmation of self-efficacy and job satisfaction, in addition to a positive relationship between skill variety and autonomy with job satisfaction. Chu et al., noted that the personality trait of "positive affectivity" and "involvement" had the greatest impact on job satisfaction, commenting:

> [b]ased on these results, nurses who have…negative outlooks on life have lower levels of job satisfaction. Nurses who have a positive outlook on life and are willing to put extra effort into their jobs have higher levels of job satisfaction. (p. 180)

A 1985 meta-analysis by Loher, Noe, Moeller, and Fitzgerald confirmed a moderate relationship between job satisfaction and job characteristics.

Nursing Dissatisfaction

The body of literature on nursing dissatisfaction is extensive. As such, current studies have generated a broad, though ill-defined, knowledge base representing a panacea of frustrations and challenges related to nursing dissatisfaction. Job and organizational characteristics associated with nursing have both been linked to dissatisfaction. This representation includes, but is not limited to, characteristics such as pay (Gurley et al., 2003; JayRay, 2002; Joshua-Amadi, 2003), work hours (Armstrong-

Stassen et al., 1998; JayRay, 2002; Newman & Maylor, 2002), changes in acuity (Aiken, Clarke, Sloan, Sochalski, Busse, et al., 2001; Chang & Hancock, 2003), poor leadership (JayRay, 2002; McNeese-Smith, 1999; Strodeur, D'hoore, & Vandenberghe, 2001), lack of autonomy (Fung-Kam, 1998; Hamilton, 1993; Laschinger et al., 2001; Parker, 1993; Price, 2002; Schwartz, 1990), and an increase in tasks and demands (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001; Chang et al., 2005; Lopopolo, 2002).

Significant changes in the healthcare environment have contributed to changing job and organizational characteristics. Scott et al. (2000) identified three environmental periods: the physician-led period (1945-1965), the Federal era (1966-1982), and the managerial control and market mechanisms era (1983-present), each influencing hospital operations. The shift from the physician-led era brought forth noteworthy changes related to Federal mandates and regulatory oversight. However, the shift from the Federal period to the current one has resulted in restructuring, downsizing, and merging, resulting in a cost-effective business model (Burke, 2003; Scott et al.; Wong, 1997). These changes are responsible for encumbering hospitals with providing good care and quality outcomes at low cost (McNeese-Smith, 1999).

Nursing shortages have occurred during each environmental period. The researcher compiled a table to demonstrate the increase in tasks throughout each environmental period (Table 1). This could suggest that nursing dissatisfaction may transcend basic job characteristics and is rooted in environmental changes associated with increasing tasks. Aiken, Clarke, Sloane, Sochalski, Busse, et al., (2001) contend that the structure of nursing work and burdensome workloads (Aiken, Clarke, Sloane, Sochalski, & Silber, et al., 2002) are to blame for the ongoing shortage. For example, during the

nursing shortage of the 1960s, hospitals responded by assigning nurses with additional paperwork. Responding to changes in federal Medicare reimbursement rates in the 1980s, hospitals closed units to downsize and maintain financial solvency. As a result, nurses have consistently been burdened with additional tasks. With each shift in the healthcare environment, operating practices have changed. With each change, the nursing role appears to be fraught with the operating changes of a continuously shifting environment over which they have little, if any, control (Donley & Flaherty, 2002).

Wong (1997) contends that nurses have experienced the greatest impact as a result of these changes which place additional demands on nurses; the nurses are no longer centered on patient care. Health care is now controlled by bureaucratic policies aimed at cost containment. Burke (2003) is supportive, noting that healthcare restructuring has been associated with an increased workload while trying to meet more demanding patient needs. It is this critical change in care delivery that challenges the traditional nursing model: "nurses are now having to think in terms of their productivity value, connecting work effort with financial return" (Wong, p. 474).

Job Characteristics

The changing healthcare environment and related nursing shortage has increased role and related tasks, increases that have frequently been attributed to dissatisfaction unrelated to patient care. Complaints with job characteristics, such as documentation and other administrative tasks (Hamilton, 1993), technological advances, such as patient monitoring equipment (Haddad, 1987; Leatt & Schneck, 1982, 1985), and patient satisfaction measures, which includes service tasks not normally associated with care-

giving (Cangelosi, Markham, & Bounds, 1998; McNeese-Smith, 1999) are common variables associated with nursing dissatisfaction (Janseen, de Jong, & Bakker, 1999).

Table 1. Nursing shortages and increasing tasks 1965 – current

1965 – Nursing Shortage	1983 – Nursing Shortage	2000 – Current Nursing Shortage
Educational changes: Education moves away from the hospital into the college classroom; Increases in medical science and healthcare technology; Emergence of specialty nurses, such as cardiac, neurosurgery; Supply now limited to what the colleges can graduate, supply can no longer keep up with the demand.	Prospective Payment System: Changes in Federal reimbursement rates require that hospitals take Medicare patients later and are released sooner increasing patient acuity, reducing hospital census and revenue; Nursing demands increase as the macro environment expands to include specialty providers; Federal oversight increases regulatory compliance; supply cannot keep up with increased demands.	Demand continues to increase as hospital systems introduce specialty clinics, like cardiovascular disease; Technological advances limit nursing sub-skills; Increasing regulations demand an increase in licensed staff; Business model: healthcare fails to prepare for the increase in demands; Changing demographics, aging and immigrant populations, for example increase acuity levels; Supply unable to keep up with the increase in demands.
Nursing Tasks Increase ----------→		

Increasing Tasks. Increasing patient documentation, a consequence of the current environment, has commonly been associated with routine, mechanistic nursing tasks. Liability mitigation has further burdened hospitals with regulatory and legal obligations requiring nurses to spend as much as 90 minutes, per patient contact, charting

and documenting patient interactions (Health Care Personnel, 2002). The Robert Wood Johnson report on the nursing shortage (2002) indicated that this increased need for documentation is a significant burden on the nursing workforce.

Additional paperwork demands have not only increased nursing tasks, but have also increased the need for nurses to support non-clinical operations thereby contributing to an increase in nursing demand. Clinical discharge paperwork, record keeping, and charge slips are examples of tasks that have typically been pushed out to nurses (Donley & Flaherty, 2002). Third party payors, Medicare and private insurance for example, have also demanded additional documentation ensuring compliance, while mitigating risk (Scott et al., 2000).

Mäkinen, Kivimäki, Elovainio and Virtanen's (2003) research suggested that the mechanistic manner of task-oriented nursing is highly distressing. Task-oriented (functional) nursing, the routine work of ward nursing, is commonly associated with floor or staff nurses. Conclusions by Mäkinen et al. verified that nurses in task-oriented nursing roles were most likely participating in task completion and ward (unit) maintenance, required activities which "take precedence over the needs of individual patients" (p. 198). Buerhaus, Donelan, Kirby, Norman, and Dittus' (2005) study revealed that nearly forty percent of nurses surveyed felt that non-nursing tasks interfered with patient care. Additional task requirements were also found to be a noteworthy variable in Fung-Kam's (1998) study of dissatisfaction among Hong Kong nurses. Aiken, Clarke, Sloan, Sochalski, Busse, et al. (2001) noted that nurses have increasingly experienced tasks unrelated to patient care. For example, housekeeping, meal tray delivery, and

ancillary services coordination have absorbed nurse time leaving necessary nursing care undone.

Technological advances have also increased nursing tasks (Haddad, 1987; Janseen et al., 1999) while decreasing nurse response time, subjugating patient care to technology (Quintana, Hernandez, & Haddock, n.d.). Findings by Quintana et al., revealed how increased technology in wards and units has created homogenous nursing units with limited skill sets, limitations that have diminished skills making nurses ineffective outside of their unit. Quintana et al., echoed earlier findings by Leatt and Schneck (1982, 1985) who demonstrated that unit technology amplified task uncertainty, ultimately increasing demands placed on nurses by both physicians and unit charge nurses.

Finally, hospitals are increasingly using satisfaction surveys to measure patient satisfaction, measures typically based on patient perceptions of nursing care. These additional demands place nurses in a boundary-spanning role, making them "accountable to those higher up in the organization as well as to their clients who are external to the organization" (Lait & Wallace, 2002, p. 470). Cangelosi et al., (1998) stress that the word-of-mouth publicity generated about nursing care can increase hospital admissions and therefore revenue. Given that patient satisfaction surveys are associated with nursing care, the increase in demands may be greater than the original expectations anticipated in the nursing role (McNeese-Smith, 1999).

Autonomy and Empowerment. Thomas-Hawkins et al., (2003) differentiated between clinical autonomy and organizational autonomy. Organizational autonomy is an environment supportive of active participation in hospital policy-making, whereas

clinical autonomy, they noted, relates to the "scope of practice for which nurses are accountable" (p. 175). Their study revealed that nurses perceive themselves to have little organizational autonomy.

This perception among nurses has been considered a significant factor of dissatisfaction. Parker (1993) has shown that nurses with higher perceived control and autonomy were less likely to exit the organization. In the same study, however, nurses who perceived a lack of control or less autonomy did not engage in dissenting behavior. While Parker's research did not consider satisfaction as a variable, it did suggest that nurses with greater self-efficacy would remain committed to the organization. Lok and Crawford (2001) concluded that unit culture had a greater influence on job satisfaction than on autonomy. Hierarchical and mechanistic decision-making, autocratic unit structure and empowerment deficiencies were found to be negatively associated with nursing satisfaction. Chu et al. (2003) reported a positive correlation between both autonomy and empowerment and nursing job satisfaction in Taiwan nurses; however, their study did not delineate between organizational and clinical autonomies.

Basing his findings on the current dynamic healthcare operations, Hamilton's (1993) research stressed the need to flatten units as a means of improving nurse empowerment and autonomy. This is contradicted by Schwartz's (1990) literature review that cites a litany of past research representing a negative relationship between flattened unit structures and dissatisfaction. Flattened units, notes Schwartz, represented diminished managerial support thereby increasing decision-making, tasks, and stress, all of which are correlated to dissatisfaction. Flaherty and Donley (2002) shared a similar point-of-view noting that nurses in flattened units are left without representation for

issues resolution. Laschinger, Finegan, Shamain, and Wilk (2002) affirmed previous research hypotheses demonstrating that current downsizing in nurse-management staff often resulted in weakened organizational structures, which increased work and/or prevented quality patient care. Job satisfaction, they found, was rooted in environmental structures that supported access to information and resources required to fulfill job tasks, primarily patient care.

Price (2002) found that nurses believed the ideal nursing role to be a highly autonomous role. Though nurses indicated a higher degree of autonomy was desirable, they preferred a high degree of social integration between physician and nursing peers. This finding disagrees with Hochwarter, Kiewitz, Bond, and Stoner (2004) who concluded "[i]n sum…high social efficacy is not enough to ensure desirable job performance or satisfaction levels for individuals in organizations; some degree of task efficacy is needed also" (p. 35). While their study did not include nurses, it indicates on a broader level that for many, employees may be more concerned with task mastery than workplace social development.

Laschinger et al., (2001) found nurses experienced greater degrees of job satisfaction when they perceived themselves to be autonomous and empowered to complete nursing tasks. A later study by Laschinger et al. (2002) stressed the need for environmental structures that support the ability of nurses to complete their clinical tasks rather than a need for absolute role autonomy. This study further supports Thomas-Hawkins et al.'s (2003) position of clinical autonomy, or control over the scope of work that nurses are accountable for completing.

There appears to be a great disparity in the nursing literature between clinical autonomy and workplace autonomy. Some studies have measured nurses' need to loosen barriers and obstacles to task completion. Others view autonomy as an absolute: removing practices and barriers to affect decision-making at the policy level. Donley and Flaherty (2002) note, however, that there is "little opportunity for the majority of practicing nurses to engage in clinical or health care policy" (p. 12).

Workplace Culture. The nursing profession has frequently referred to itself as bullying, a profession that demonstrates strength by "eating its young" (Arnold, B., RN, personal communication, September 16, 2004; JayRay, 2002). Bullying tactics are often overlooked and carried out in collusion, encouraging a culture of oppression and violence. Bullying and intimidation were defined by Stevens (2002) as significant variables contributing to dissatisfaction among nurses confirming an inverse relationship to satisfaction. Additionally, noted Stevens, the problem is perpetuated by managerial ambivalence and a culture that tolerates rather than values nurses. Jackson, Clare, and Mannix (2002) emphasized that bullying comes primarily from the nursing manager. Nurse managers, they note, frequently allow bullying and intimidation in order to generate complicity, with the events occurring more frequently during staff shortages. The abusive environment is a possible response to combined factors: the need to demonstrate unit hierarchy in a predominately male profession, and reactions to the perception that nursing is a task-imperative vocation rather than part of an interdisciplinary team of healthcare professionals (Farrell, 2001).

Pay and work hours are other frequently cited variables of nursing dissatisfaction. Staff shortages and demands compel many part-time nurses to work full-time hours.

Armstrong-Stassen et al. (1998) presented strong evidence to suggest that the increasing nurse demands, coupled with shortages, prevented many from working desired part-time schedules. Those nurses are reported to experience greater levels of dissatisfaction than designated full-time nurses. Newman and Maylor's (2002) qualitative results stressed that nurses were burdened by the constant demands on their time. Most nurses experienced an increase in working hours due to increased workloads and staff shortages, overtime, and unfinished work from previous shifts.

Findings by Joshua-Amadi (2003) emphasized a belief by nurses that their efforts should be rewarded with equitable pay based on competence rather than role. Brown, Sturman, and Simmering (2003) attested that increased pay levels ensured a more qualified and motivated staff. Fung-Kam (1998) noted that low pay was correlated to dissatisfaction among nurses, as pay is an indicator of professional status. Gurley et al., (2003) found contradictory findings in their mixed methodological study. Qualitative findings revealed that nurses felt an increase in compensation would improve overall satisfaction though quantitative results revealed no difference between "actual and perceived satisfaction related to higher wages" (Gurley et al., p. 133).

The quantitative findings by Gurley et al., agree with a several other studies. Aiken, Clarke, Sloane, Sochalski, Busse, et al. (2001) for example, found that nearly 60% of U.S. nurses in their study believed their compensation was adequate. Jauch and Sekaran (1978) demonstrated that pay was not considered a noteworthy contributor to dissatisfaction. Like Jauch and Sekaran, Chu et al. (2003) found pay to be the only variable not demonstrating a significant correlation to job satisfaction. Cangelosi et al. (1998) found an insignificant relationship between current salary and current position

level. This finding suggests that higher-paid nurses are not any more satisfied with their jobs than lower-paid nurses. Nevertheless, hospitals have repeatedly used money, pay increases and retention or sign-on bonuses for example, to mitigate dissatisfaction (Cangelosi et al., 1998). Upenieks (2003a) agrees, stressing that monetary rewards act only as a temporary fix. Moreover, many United States hospitals are unionized; compensation therefore is contingent on labor contracts, ultimately making pay a variable that few hospitals can control.

Organizational Characteristics. The increase in demands has been punctuated by the current nursing shortage, contributing to burdensome workloads (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001, Aiken, Clarke, Sloan, Sochalski, Silber, et al., 2002; Burke, 2003, Gurley et al., 2003; Joshua-Amadi, 2003; Laschinger et al., 2002; Newman & Chansarker, 2002; Parker, 1993; Parsons, 1998; Upenieks, 2003a). Nurses express their inability to provide adequate nursing care, feeling powerless to care for patients (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001; Aiken, Clarke, Sloan, Sochalski, Silber, et al., 2002; Albaugh, 2003; Cline, Reilly, & Moore, 2003; Gurley, et. al., 2003; Joshua-Amadi, 2003; Newman & Maylor, 2002; Parsons, 1998). Additionally, staff shortages and poor relationships with physicians account for dissatisfaction within the profession. Blegen's (1993) meta-analysis of nursing dissatisfaction identified organizational traits and characteristics to be closely associated with satisfaction and commitment.

Inadequate Leadership. Current research has identified poor leadership as a source of dissatisfaction. Moss and Rowles (1997) found that job satisfaction measures among nurses increased as unit leadership moved closer to participatory style. Results

from Strodeur et al. (2001) confirmed that the interactive dialogue and open climate among nurses was influenced by the transformational leadership style. The transformational style, they noted, created a better working environment and relieved stress among unit nurses.

Ironically, patient and staff perceptions of good managerial-leadership style differed significantly. McNeese-Smith's (1999) study indicated that patients preferred nurse managers with a greater need for power motivation; the same nurse-managers, however, were liked less by staff. This finding suggests that the less participatory leadership styles may instill a greater sense of confidence among patients, yet are seen as authoritarian by staff. Anecdotal evidence purports that nursing leaders are unsupportive of nurses in the hospital environment, suggesting that nurses feel undervalued and unappreciated, frequently left to fend for themselves against physicians, administrators, and/or patients (JayRay, 2002).

Poor Nurse-Physician Relationships. Relationships among nurses and physicians have frequently been measured as a dissatisfaction variable. Historically, nurses have had little control over their practice; many feel they are viewed as a physician's handmaiden (Kramer & Schmalenberg, 1992; Schull, 1984; Tieman, 2001). This idea is supported by Cangelosi et al. (1998) who affirmed "many physicians still view nurses as subordinate and continue to give orders without considering the 'give and take' of communication" (p. 33).

Leatt and Schneck (1985) noted that the unavailability of physicians, physicians' critical nature towards nursing, and poor communication were general predictors of nursing dissatisfaction in hospital units, influencing dissatisfaction over other

environmental and unit issues. In his 2001 study, Tieman reported positive satisfaction results for magnet hospital nurses, due in part to the better nurse-physician relationships common in magnet hospitals. Magnet hospitals have been recognized for higher nursing satisfaction, and for their ability to attract and maintain nurses. Magnet designation is awarded by the American Association of Nursing (AAN) to hospitals that regularly meet stipulated requirements, such as establishing nursing as a hospital priority. Tieman notes, "hospitals that recognize nurses as more than physician aides – by giving them a voice in clinical decisions…have an easier time keeping the nurses they have" (p. 25). The lack of collaboration and poor communication potentially leaves nurses with greater patient care burdens and an inability to meet patient and/or family member's needs. Thomas-Hawkins et al. (2003) correlated poor nurse-physician relationships with higher incidents of patient mortality. However, Aiken, Clarke, Sloane, Sochalski, Busse, et al. (2001) reported that many nurses believe they work with high-quality physicians, reporting that nurse-physician relationships may not be as strained as previously thought.

Acuity Changes and Staff Shortages. Scott et al. (2000) established that the changing healthcare macro-environment has created a strategic shift among healthcare providers. Federal programs such as PPS and payor contract restructuring, coupled with emerging *health systems*, have dramatically changed the operating environment. A clear majority of nurses in the U.S. and Canada reported a consistent increase in patient acuity (Aiken, Clarke, Sloane, Sochalski, Busse, et al., 2001). This shift has increased the acuity level in hospitals to the point that nurses are increasingly caring for more acutely ill patients, contributing to stress and dissatisfaction.

Physician-patient contact is usually limited in the hospital setting, making nurses the majority care providers in hospitals; after all, patients go to hospitals to receive 24 hour nursing care (Parker, C., PhD, RN, personal communication, March 3, 2006). Cangelosi et al. (1998) stressed, "nurses provide the majority of care in hospitals. Patient contact with physicians is usually limited to a few minutes daily, whereas they are constantly being attended to by nursing staff" (Cangelosi et al., p. 26). Aiken, Clarke, Sloan, Sochalski, Silber, et al (2002) concured, stressing that nurses provide 24-hour patient observation and assessment. The effectiveness of the nursing-patient relationship is questioned when there are not enough nurses available to provide patient care and assessment.

Staff shortages have been overwhelmingly attributed to dissatisfaction among hospital nurses. Moreover, the lack of adequately staffed units has burdened an already struggling profession with increasing patient, physician, and organizational demands. Researching a variety of units in British hospitals, Newman et al. (2002) interviewed participants who consistently ranked unit shortages as the most significant measure of job dissatisfaction.

Aiken, Clarke, Sloan, Sochalski, Silber, et al (2002) studied nursing job dissatisfaction, revealing how consistent staff shortages contributed to greater stress and patient-care-related anxiety, punctuated by intent to leave the hospital or profession. The 2003 study by Burke supported the findings by Aiken, Clarke, Sloan, Sochalski, Silber, et al., revealing that shifts in nurse-patient ratios resulted in a "consistent and predicted pattern" (p. 106) of decreased job dissatisfaction and overall performance. Newman and Maylor (2002) presented strong evidence to substantiate a correlation between nursing

dissatisfaction and staffing inadequacy. According to respondents, staff shortages implied a significant increase in individual workload and adverse affects on patient safety.

Aiken, Clarke, Sloane, Sochalski, Busse, et al.'s (2001) study of 43,000 nurses from five countries indicated that the declining nursing workforce is a worldwide problem leading to dissatisfaction. Moreover, the researchers noted, a clear majority of nurses surveyed believed that patient care suffered from as a direct result of understaffed units. Cut-backs in nurse manager positions have increased responsibilities among staff nurses for "managing services and personnel at the unit level, which take time away form direct patient care" (Aiken, Clarke, Sloane, Sochalski, Busse, et al., p. 49).

Stress and Burnout. Between the increase in tasks and patient acuity levels, the nursing workforce is faced with emotionally-, physically-, and mentally-exhausting workloads. With nearly 50% of the nursing workforce aged 40 and above (Joint Commission for the Accreditation of Healthcare Organizations [JCAHO], Laschinger et al., 2002, Chang et al., 2005) the workload and staff shortages result in dramatically increased stress. The physical demands of nursing increase the likelihood of injury on an over-burdened and aging workforce. Moreover, Chang et al. suggested that rising patient acuity levels have placed additional physical demands on a veteran workforce.

Incidents of death, pain, and constant illness for the nurses have an associated emotional and mental cost on them. Strodeur et al. (2001) noted that extreme emotional exhaustion accompanies nurses due in part to the workload associated with environmental stress. Specifically noted was the stress and emotional exhaustion resulting from the increase in demands and overall decline in satisfaction. Upenieks

(2003a) stressed that demands on the existing workforce shortage puts today's nurses in a "grueling, physically exhausting, and intellectually draining" (p. 83) environment.

According to Mrayyan and Acorn (2004), student nurses in Jordan identified burnout as problematic. Burnout, associated with increased incidents of stress and emotional exhaustion, was common among nursing students who experienced understaffing, increasing workloads, unsupportive cultures, conflicts with physicians and peer nurses, a poor public image, and role stress. Aiken, Clarke, Sloan, Sochalski, and Silber (2002) stressed that nurses were suffering from burnout in part due to burdensome workloads, inadequate patient care resulting from insufficient staffing, and emotional exhaustion. Burke (2003) also noted the increase in demands and workload among nurses had resulted in overall work related stress and tasks.

Role Stress

There is a well-established and inexorable link between job satisfaction and role stress. The literature consistently demonstrates a strong, positive relationship between role stress and job dissatisfaction (Gregson & Wendell, 1994; Tubre & Collins, 2000). Advances in technology, changing healthcare models, and persistent staff shortages require that nurses increasingly perform greater organizational and administrative tasks than before. These increases represent the erosion of quality patient care, making the reality of nursing much different than the perceived ideal role of nurse caregiver (Chang et al., 2005).

Characteristically, role stress is comprised of three distinct variables: role conflict, role ambiguity, and role overload. Each variable has been associated with job

dissatisfaction and commitment, (Ashforth & Saks, 1996; Koustelios, Theodorakis, & Goulimaris, 2004) uncertainty (Bedian & Armenakis, 1981), job performance and role stress (Chang et al., 2005; Lopopolo, 2002), and intent to quit and turnover (Iverson, 2000; Waung, 1995). Koustelios et al. (2004) asserted that role conflict and role ambiguity are "two of the most common characteristics of the work setting that affect job satisfaction" (p. 87). Though they may appear similar, clear delineations can be made distinguishing each.

Role ambiguity refers to the lack of clarity associated with specific tasks within a role. The lack of clarity is directly associated to confusion or uncertainly of key tasks, responsibilities, and performance expectations. As explained by Monahan (1999), role ambiguity is comprised of three parts, each relating to uncertainty about 1) expectations, 2) how to meet those expectations, and 3) how others will respond to the performance. Iverson (2000) defines role ambiguity as task-related information, such as feedback, whereas role conflict is described as incongruent requirements specific to the job role. Conversely, role conflict occurs when multiple groups have conflicting expectations or, as stated by Koustelios et al., "when meeting one set of expectations makes it more difficult to meet other expectations" (p. 87). According to Katz and Kahn (1978) role conflict remains associated with physiological strain and decreased effectiveness. Finally, role overload often occurs when an employee perceives that role expectations are too great to achieve (Lopopolo, 2002; Chang & Hancock, 2003; Chang et al., 2005).

Each is stressful alone. When considered together, however, role conflict, role ambiguity, and role overload produce role stress considered to be the "consequences of disparity between an individuals perception of the characteristics of a specific role"

(Chang et al., 2005, p. 58). Despite the suggestion by some researchers to maintain variable distinctiveness, this research will consider role overload, role conflict, and role ambiguity as *role stress*. According to Gregson and Wendell (1994), this combination is common when referred to as a grouping of variables. Fujino and Nojima (2005) expanded role stress to include role underload and role over-qualification.

Nursing Role Stress

Role stress being prevalent in nursing is supported by the available research. In fact, it is cited as a common contributor to dissatisfaction among nurses (Burke, 2003; Chang & Hancock, 2003; Chang et al., 2005; Wong, 1998). Organizational requirements, federal mandates, and patient demands make role stress an inherent feature of nursing. Too frequently, these expectations are in conflict with patient care, personal expectations, and professional nursing values (Biton & Tabak, 2003; Hemingway & Smith, 1999).

Role stress is readily apparent in the nursing literature as evidenced by conflicts between nursing theory and reality. The literature is replete with examples of real-life nursing scenarios that conflict with nursing theory and current evidence-based research. Startup and Wilson (1992) identify these discrepancies as ritualistic nursing, practices still "rooted in traditional rituals and myths on many hospital wards" (p.26) and in the classroom (Oleson & Whittaker, 1968). Often it is the junior or novice nurses who will complete the ritualistic tasks as assigned; their novice status often inhibits their ability to consider the rationale of their actions:

> [e]ven in cases where students sought to perform these kinds of skill 'properly' the fact that they were relying on memory with a near absence of support from ward staff meant that failures were frequent. Most of the teaching staff were

> concerned at the anxiety that the dichotomy between school and ward and the difficulties of surmounting it engendered in many students. Indeed these latter tended to perceive the discrepancy between instruction given by the school and the expected practice on the ward as conflict between right and wrong. As a result they felt powerless to do anything but conform. (Startup & Wilson, p. 26)

Oleson and Whittaker (1968) noted the constant dilemma posed to clinical faculty in which it was "incumbent upon faculty to indicate what they thought were the best ways of doing things, ways that sometimes ran counter to what students saw staff doing on the wards" (p. 143). Yura- Petro and Brooks (1991) addressed nursing perception and reality gaps, resulting in the culture shock of nurse graduates. Culture shock occurs as the gaps between intellectual, interpersonal, and technical competencies widens between nursing student and nurse (Yura-Petro & Brooks), while being unable to uphold the imparted values of nursing education (Duncan, 1997).

Changes in the healthcare environment have redistributed organizational and job characteristics, creating an environment that contributes to role stress throughout nursing. Scott et al., (2000) argued that it is the hyper-turbulent healthcare environment which has significantly changed health care's professional roles, increasing demands that have created stress and ambiguity. These changes are reflected in the job and organizational characteristics now common in nursing, represented by a transformation in the healthcare model (Lopopolo, 2002; Scott et al., 2000; Wong, 1998). Leatt and Schneck (1985) found a positive relationship between role stress, ambiguous nursing responsibilities for example, and overall work-related nursing stress. For many healthcare professionals the increase in nursing tasks "symbolize[s] a loss of traditional professional responsibilities, such as providing hands on patient care" (Lopopolo, p. 985).

Unmet Career Expectations

New nurse graduates are the most likely group to experience role stress. The transition from student nurse to practicing nurse is a highly stressful time. As nurse graduates prepare to enter a profession characterized as *bullying* (Jackson et al., 2002; JayRay, 2002; Stevens, 2002), they often experience greater degrees of role stress than veteran nurses do. The 1991 framework for education and professional partnerships presented by Yura-Petro and Brooks stressed the necessity to diminish the *culture shock* of graduate nurses to enhance professional esteem and job satisfaction. Jansseen et al.'s (1999) research findings indicated that "turnover intentions were clearly and mainly determined by the unmet career expectations" (p. 1367) of nurses. Most recently, Lindsey and Kleiner (2005) found that new nurses were unprepared for the realities of healthcare, noting the lack of preparation's significance to nursing dissatisfaction. Specifically they cited the relationship between the lack of preparation and job dissatisfaction.

Many nurse graduates are unprepared for the realities of the nursing role. Chang and Hancock (2003) acknowledge the "nature of nursing is more stressful, less satisfying and offers fewer rewards" than it previously presented (p. 156). Elaborating further, Chang et al. (2005) note that the "new graduate [has] other pressures to contend with simultaneously. These pressures may include a lack of confidence, unrealistic expectations by clinical staff,…and a lack of support" (p. 60). Role conflict was identified by Mrayyan and Acorn (2004) as the number one issue pertaining to practice issues among Jordanian nursing students. The concern of Jordanian nurses stemmed from unclear or ambiguous nursing expectations and blurred professional roles, which

contribute to disparate patient care. Findings from Hemingway and Smith (1994) indicate that role conflict and ambiguity predicted higher levels of turnover intentions. Hemingway and Smith did not limit their research to new nurses; tenure among participants ranged from one to 38 years, unlike Chang and Hancock (2003) whose sample represented new nurse graduates.

Research by Chang and Hancock (2003) consisted of two surveys. The first measured new nurses with two to three months' experience. The first group of participants indicated decreased job satisfaction resulting from both role ambiguity and role overload. The second survey was conducted on the same sample after ten months. Findings indicate that role overload was more significant after the first year, but did not influence job satisfaction. Chang and Hancock contend that new graduates experience increased role ambiguity resulting from a lack of confidence, support, and unrealistic expectations, noting that:

> [c]onflict between graduates' own ideals and values developed during training and the actual practice of a registered nurse has also been reported as a major source of stress for new nursing graduates…[f]or example, the emphasis on performing tasks and adhering to ward routines rather than meeting the patients' needs produces conflict. (p. 156)

This supports earlier work by Hemingway and Smith (1999) who noted that role conflict is frequent among healthcare providers because they are caught between providing quality care, meeting patient satisfaction and coping with family demands concurrent with organizational and administrative expectations. Hemingway and Smith found role conflict was the only variable that predicted turnover intentions over all other sources of work related stress.

Jackson et al. (2002), however, found results inconsistent with other previous research. In a qualitative study, Jackson et al., found three related issues of self-image and changing status, doing the job, support, and expectations. As reported by Jackson et al., new nurses found their own self-expectations to be more rigorous than those of experienced staff nurses and unit managers. Jackson et al., suggests that novice nurses are less comfortable in the nurse role because they lack identity and self-confidence and lack guidance-seeking behavior.

Yura-Petro and Brooks (1991) discussed the role of nursing education programs, which are "designed to approximate the practice competencies expected of nurses in the future" (p. 2). Regardless, gaps exist between what nurses are taught and the realities of nursing; with few references available for nurses to bridge the ethical and practice gaps, nurses are frequently faced with challenges that are not routinely discussed in school (Biton & Tabak, 2003).

Biton and Tabak's (2003) findings affirmed that Israeli nurses desire to execute ethical patient practices. Their conclusion revealed, however, an inability of nurses to practice ethical considerations given environmental demands and limitations, thus contributing to moderate role conflict.

Employees and employers alike cling to perceived and ideal role expectations. Employers send messages and signals about employee role expectations (Stone-Romero, Stone & Salas, 2003) in an attempt to establish a set of perceived behaviors relative to task completion, behavior, and performance (Katz & Kahn, 1978). Based on interactive messages between role sender and role receiver, it is doubtful that two individuals would generate common role expectations given differing perceptions and communication

patterns. Divergent communication patterns increase the likelihood of disparate perceptions, making ideal expectations limited at best. This has been demonstrated by Oleson and Whittaker (1968) and Simpson et al. (1979), whose work revealed that such differing expectations existed at the onset of nursing education and materialized yet again at the commencement of the graduate nurses' career.

Ideally, a novice's transition into the organizational perceived role occurs through a dynamic process that consists of transitioning from one set of expectations to another (Jackson et al., 2002). Some individuals, however, have such deeply held beliefs and values that they ultimately limit the employee's ability to transition or adapt (Dose, 1997). Janseen et al. (1999) evaluated unmet career expectations and nurses' intent to exit, finding an association between the two.

Additional Role Demand

Lopopolo (2002) contended that it is tenured or veteran nurses, not novices, who experience the greatest role stress. Experienced nurses are more likely than new or novice nurses to compare prior tasks with current tasks by reflecting on nostalgic nursing times, indicating the increasing organizational demands and job tasks are overwhelming. Emerging technology and boundary spanning are considered highly stressful features of nursing, in part because the role demands continue to increase.

Veteran nurses cite frequent technological challenges as obstacles to care when working in different acute care units within the same organization (Jansseen et al., 1999; Leatt & Schneck, 1982, 1985). Technological advances coupled with the increasing use of automation has amplified, not simplified, unit burdens. Unaccustomed to computers,

many nurses experience difficulty with basic computer navigation. One nurse manager shares the technological frustrations of herself and her staff:

> there is no relief from tasks and duties even as additional tasks increase. Unlike our business associates who use computers daily, we aren't used to navigating around applications and browsers. We have to overcome our limited [computer] skills when learning how to maneuver through new computer programs. Often, nurses will just get frustrated and walk away because they have a million other things to do. (Fulmer, I., RN, personal communication, February 17, 2006)

Lait and Wallace's 2002 research outlined the relationship between job satisfaction and role stress among human service workers citing a definite association between job satisfaction, role stress, and professional conditions. Human service workers, much like nurses, experience a multitude of challenges in the workplace; among them are job and organizational characteristics that inhibit their real work. Above all, claim Lait and Wallace, this additional burden places greater demands on human service workers, requiring them to perform duties above and beyond their routine tasks. The organizational demands were noted as a significant source of role conflict due to the considerable interactions with patient-clients and other outsiders, such as visitors, family members, a nd so forth. (Lait & Wallace). According to Chang et al. (2005) changes in acute care settings and care models bring about a new focus on patient education and self-care rather than total nursing care. Many patients however, still expect nurses to do everything for them. This change in the nursing-healthcare model often leaves nurses in an untenable situation, as nursing care is the predominant measure of patient satisfaction.

General Role Stress

Role stress has an insidious reputation as a contributor to job dissatisfaction in professions other than nursing. Long-standing research across multiple industries and job roles has consistently demonstrated that role stress is associated with a lack of job satisfaction and commitment, increased anxiety, intent to quit, and turnover. Tubre and Collins (2000) re-evaluated the 1985 meta-analysis by Jackson and Schuler finding stable and consistent results with the original work: role stress remains a significant problem in many organizations and professions.

Job Satisfaction and Commitment

Job satisfaction and commitment are desirable for maintaining positive organizational outcomes (Koys, 2001), and are particularly relevant in an environment where supply is limited. A number of recent studies have confirmed a correlation between role stress and job satisfaction. Bedian and Armenakis (1981) studied the results of role stress establishing that high levels of job related stress had a much greater impact on job satisfaction than originally expected. Gregson and Wendell (1994) demonstrated that job-related self-esteem was negatively related to role stress and therefore negatively related to job satisfaction. King and Sethi's (2000) findings substantiated a positive correlation between role stress and intent to quit, and a negative one with overall job satisfaction. These findings support later research conducted by Yousef (2001) who noted that "employees who perceive higher levels of role conflict and role ambiguity would be less satisfied with the job and consequently less willing to remain in the

organization" (p. 261). Koustelios et al., (2004) found role conflict to be inversely related to supervisor satisfaction diminishing overall job satisfaction.

Stress and Job Performance

Monahan's (1999) study demonstrated that role ambiguity among clergy was determined by the size and make-up of churches. Clergy in larger congregations experienced less role ambiguity possibly due to the more rigid job descriptions, clearly defined duties, and greater staff than smaller churches. The 1998 research conducted by Fried, Ben-David, Tiegs, Avital, and Yeverechyahu addressed the effects of role stress and its relation to job performance. Findings indicated only moderate relationships between role ambiguity and decreased performance, and role conflict and decreased performance. When role conflict and ambiguity were experienced simultaneously, however, results indicated a significant decrease in job performance. Research by Acker (2004) on role stress among social workers also demonstrated findings consistent with previous studies. When combined with role stress, other variables, such as longer hours of work, and increasing caseloads, increased the risks of job related stress. Social workers typically enter the profession out of their desire to help others. Incongruent demands on their time and perceived role may influence their ability to fit in the highly bureaucratic environment that now exists in social services (Armstrong-Stassen et al., 1998; Vandenberghe, 1999).

The empirical research base is highly supportive of long-standing assumptions that role stress is an indicator of decreased performance, commitment, and job satisfaction, signifying a serious problem within organizations and across industries.

Further, role stress is associated with increased stress and intent to exit the organization. Research results specify role stress as a serious problem in organizations, resulting in significantly reduced commitment. When considering the context of Withey and Cooper's 1989 research, which indicated a strong propensity for job neglect by employees who were unable to exit the organization, role stress should be considered problematic.

A review of the literature suggests that job dissatisfaction among nurses exists on many levels. The nursing profession has demonstrated a wide array of job and organizational characteristics contributing to dissatisfaction as outlined in by the researcher on the following page (Table 2). Currently, nurses express frustrations as increasing demands, tasks, and expectations and staff shortages restrict their ability to provide patient care. Role stress has also been frequently cited as a contributor to dissatisfaction. When combined with staff shortages, nurses are limited to the amount of work they can contribute to patient care. Several studies outside of the U.S. have been conducted indicating that nursing dissatisfaction is not a problem unique to American healthcare. It is possible that variables contributing to dissatisfaction in other countries may differ from dissatisfaction variables in the U.S. because of cultural differences.

Socialization

Socialization begins with the education process and lasts the length of one's career. Widely recognized as a contributory process to enhance professional internalization, organizational socialization is proven to improve both job satisfaction and organizational commitment. Moreover, organizational socialization has demonstrated an

ability to reduce role stress and intent to exit amongst newcomers. It must be noted, however, that socialization exists on two levels: professional and organizational.

Table 2. Dissatisfaction Variables in the Nursing Literature

Dissatisfaction Variable	Researcher
Burdensome workloads	Aiken, Clarke, Sloane, Sochalski, Busse et al. 2001; Aiken, Clarke, Sloan, Sochalski, Silber, et al., 2002; Burke, 2003; Gurley et al. 2003; Jay Ray, 2002; Laschinger et al. 2002; Newman et al., 2002; Newman & Maylor, 2002; Parker, 1993; Parsons, 1998; Stodeur et al., 1990; Upenieks, 2003a.
Declining patient care resulting from inadequate staffing	Aiken, Clarke, Sloan, Sochalski, Silber, et al., 2002; Albaugh, 2003; Buerhaus et al., 2005; Cline, 2003; Gurley et al., 2003; Joshua-Amadi, 2003; Newman & Maylor, 2002; Parsons, 1998; Thomas-Hawkins et al., 2003.
Poor nurse-physician relationships	JayRay, 2002; Kramer & Schmalenberg, 2003; Price, 2002; Upenieks, 2003a.
Emotional, physical, mental exhaustion	Aiken, Clarke, Sloan, Sochalski, Silber, et al., 2002; Burke, 2003; Joshua-Amadi, 2003; Laschinger et al., 2002; Nathanial, 2004; Strodeur, et al., 2001; Parker, 1993.
Leadership and/or bullying culture	Jackson et al., 2002; JayRay, 2002; Moss & Rowles, 1997; Strodeur et al., 2001; Stevens, 2002.
Pay	Gurley et al., 2003; JayRay, 2002; Joshua-Amadi, 2003.
Lack of autonomy of decision making	Fung-Kam, 1998; Hamilton, 1993; Laschinger et al., 2001 Parker, 1993; Price, 2002; Schull, 1984.
Role stress	Chang & Hancock 2003; Chang et al. 2005; Mrayyan & Acorn, 2004.

Occupational or Professional Socialization

Occupational or professional socialization embodies the values, norms, and practices of the occupation, ensuring individuals conform to fulfill the required occupational duties to sustain professional motivation (Buckenham, 1998; Lui et al., 2003; Oleson, & Whittaker, 1968; Simpson et al., 1979). Certain professions assert Lui

et al., may require a greater degree of professional socialization due to increasing expectations and demands. These professions are frequently found in healthcare in which professional requirements have become "incompatible with the organizational requirements" (Lui et al., p. 1194) and with demands placed on the professionals. Nathaniel (2004) refers to the professional socialization process as professionalizing, an "inculcation of certain unique cultural norms learned in nursing school and early practice" (p. 48).

Oleson and Whittaker's 1968 study of nursing students outlined the professional induction process that occurs as novice-nursing students begin their education through their first year of practice. Students internalize occupational attributes as they advance educationally, a necessary step for role and task clarity. Oleson and Whittaker note that the difficulty with the socialization process comes with the right-of-passage that occurs as the nurses progress through their education and enter the nursing role. Of note were the changes in role expectations as students adopted the role-perception displayed by faculty, abandoning their own idealistic student-nurse role, culminating in the integration of self and role.

Simpson et al., (1979) research on nursing socialization found comparable results to Olseon and Whittaker. Simpson et al., described seven processes common in three phases of professional socialization. The authors assert that disparity within anyone of these three phases contributes to professional anxiety and reduces commitment. Their analysis explained how the disparity in nursing education between the education model and student expectations has reduced the professional maturation of nursing students requiring re-socialization. Ultimately, nurses in the Simpson et al. study were unable to

reconcile differences between their educational goals, personal values, and professional/organizational expectations.

Degree requirements and accrediting bodies mandate that nursing students participate in clinical rotations and/or preceptorships. Preceptorship provides nursing students with an opportunity to practice newly acquired skills under the supervision of a clinical instructor. The preceptorship experience is primarily an orientation to nursing work, allowing students limited hands-on clinical experience, varying significantly from school to school. Lui et al. (2003), considered the intern process an important part of the anticipatory professional socialization; a period that prepares students for job entry and continues after an employee assumes his/her professional role. The goal of anticipatory professional socialization is for individuals to "acquire new and specialized knowledge and skills as well as to master the formal and informal norms of work" (p. 1195). While physicians use the residency experience to acquire task-knowledge after graduation, nurses must complete their clinical experience prior to graduation and licensure. However, student exposure to hands-on practice is limited at best, as expressed by one nurse educator who stressed, "most nursing students are fortunate if they have had the opportunity to practice one skill on one patient during preceptorship" (Olson, P. MSN, RN, personal communication, November 16, 2005). Miller (2005) concurs, noting that "nursing students often relate that they did not get enough clinical experience in their undergraduate nursing programs" (p. 169).

Preceptorship is recognized as a mutual recruitment phase between student nurses and employers. Nurse graduates are frequently offered positions in the hospitals where they complete their preceptorship (Duncan, 1997). While a preceptorship is intended to

be an educational experience, it frequently fails to educate nursing students about the reality of nursing work, such as the healthcare industry or task variety in an acute care setting (Startup & Wilson, 1992), resulting in reality shock (Yura-Petro & Brooks, 1991).

It is important to recognize that individuals are not only socialized to their profession and occupation, but must also be adequately socialized into the organization too if they are to understand and accept the organizational-cultural nuances (Buckenham, 1998).

Organizational Socialization

Successful organizational socialization strategies are essential for both the organization and the employee if there is to be hope of a mutually beneficial and long-term relationship. As such, crucial elements of organizational socialization include structured knowledge assimilation about the job and organization by providing both organizational context and content (Cooper-Thomas & Anderson, 2002). Organizational socialization is best summarized as a process in which an employee "acquires the attitudes, behavior, and knowledge needed to participate as an organizational member" (Cable & Parsons, 2001, p. 2). In the following table, (Table 3) the researcher outlines how socialization strategies overlap with content, context, or social areas.

Organizational socialization was originally developed by Van Maneen and Schein as a framework of processes that occur when newcomers enter an organization. Their original design consists of six polarities: collective or individual; formal or informal (casual); fixed or variable, sequential or random; investiture or divestiture; and serial or

disjunctive. Jones expanded on these polarities by labeling them institutional or individual depending on their orientation.

Typically, organizational entry is marked with a brief orientation. The purpose of the orientation is to expose new hires to relevant organizational information. Too often, though, orientation programs are short-lived, and fail to address many of the required cultural characteristics and essential tasks required for employees to succeed with a smooth entry. Often orientation stresses only the organizational context, such as policies and history (Ostroff & Kozlowski, 1992), leaving employees to navigate any remaining and unmet needs on their own. Socialization, however, is a longer-term process that "facilitates[s] positive attitudinal outcomes by providing the context for organizational learning" (Cooper-Thomas & Anderson, 2002, pp. 430-431).

Individual Socialization

Individual socialization includes an isolated experience that is unstructured and casual (Table 3). Characterized as a highly laissez-faire approach to socialization, the individual strategy often leaves employees to learn the organizational artifacts and nuances in isolation. Individually-socialized employees frequently demonstrate a lack of organizational commitment, indicative of low job satisfaction and increased intent to exit (Ashforth & Saks, 1996), increased role ambiguity and conflict (Ashforth & Saks; Ashforth et al., 1998; King & Sethi, 1998), and decreased job commitment (Reichers, Wanous, & Steele, 1994). Stress and anxiety are common and elevated as newcomers learn their way around the organization (Cable & Parsons, 2001; Ostroff & Kozlowski, 1992) and the role (Reio & Callahan, 2004). Organizations that leave newcomers to

experience socialization in isolation "create uncertainty for newcomers, encouraging them to respond in innovative, individualized ways to succeed in their environment" (Cable & Parsons, 2001, p.6).

Institutional Socialization

Institutional socialization, the alternative to individual socialization, is an inclusive method of socialization (Table 3). Differing considerably from the individual socialization strategy, it is considered more supportive of newcomer commitment and job satisfaction (Ashforth & Saks; Ashforth, et al., 1998; King & Sethi, 1998). Institutional practices orient employees on all three organizational levels: content; context; and social; and is therefore considered more supportive of newcomer commitment and job satisfaction (Ashforth & Saks, 1996; Ashforth et al., 1998; King & Sethi, 1998). The institutional socialization practices include a shared experience (collective), purposeful socialization activities (formal), a defined structure (sequential), during a specified timeframe (fixed), and socialization with a mentor (serial) designed to build on existing skills (investiture).

As a whole, the body of literature is more supportive of the structured practices associated with institutional socialization. Institutional tactics are designed to increase conformity among newcomers by tightly controlling individual practices that may conflict with existing organizational practices. This controlled process adheres to a prescribed method of socialization ensuring that newcomers accept and understand their new role, maintaining the organizational status quo while preserving the cultural artifacts (Ashforth & Saks, 1996; King & Sethi, 1998). Ashforth et al. (1998) state that

institutional tactics "structure the early work experiences of newcomers" (p. 903) by including a mentor and formal structured activities.

Table 3. Socialization Models and Tactics

Socialization Models			
Socialization Tactics	Institutional	Individual	Addresses
	Collective	Disjunctive	Organizational Context
	Formal	Casual	Organizational Context
	Sequential	Random	Organizational Content
	Fixed	Variable	Organizational Content
	Serial	Non-Serial	Organizational Social Elements
	Investiture	Divestiture	Organizational Social Elements

(Ashforth & Saks, 1996; Ashforth et al., 1998; Griffen, Colella, & Goparaju, 2000; King & Sethi, 1998)

The 1996 research conducted by Ashforth and Saks established a strong relationship between all aspects of institutional socialization and the tested variable, demonstrating that the implementation of institutional practices was inversely related to an employees' intent to quit. Later work by Ashforth et al. (1998) tested institutional practices with newcomer adjustment; findings suggested a strong relationship between the dependable serial tactics of mentoring and guidance during the socialization process. Both studies supported the use of institutional practices because of its ability to "reduce the uncertainty (role conflict/role ambiguity) and anxiety (stress symptoms), that impair newcomer adjustment" (Ashforth & Saks, p. 170) producing both affective and cognitive commitment.

Cooper-Thomas and Anderson (2002) found that institutional socialization practices improved information acquisition, supporting both job satisfaction and commitment. This study advanced a different position from conventional socialization

wisdom demonstrating that significant newcomer adjustment transpired within two months rather than the six to nine months common in previous work. The researchers suggest that the intensity and complexity of military socialization contributed to the divergent findings in the broader literature. These findings suggest that intensive socialization practices may reduce the amount of time necessary to attain employee compliance and reduced role stress (Cooper-Thomas & Anderson). Moreover, these findings have broad implications for intensive socialization programs, challenging the long-standing belief in both the person-environment fit (O'Reilly, Chatman, & Caldwell, 1991) and socialization (Black & Ashford, 1995) literature that longevity mediates dissatisfaction.

Information Acquisition

Gibson (2004) stressed that mentoring is important for "facilitating knowledge transfer, organizational socialization, social support, communication, access to networks, and other key connections that are critical to the success of employees" (p. 260). Cooper-Thomas and Anderson (2002) revealed strong support for the mentoring tactic recording findings correlated to satisfaction (.26 at the .01 level) and commitment (.22 at the .001 level).

Mentoring and investiture practices decrease bootlegged knowledge: knowledge acquired from sources outside the organizational-cultural confines (Oleson & Whittaker, 1968). Research agrees emphasizing those employers should exercise caution when placing new hires with others (Ashforth & Saks, 1996) in part because independent and uncontrolled information can be confusing and misleading (Ostroff & Kozlowski, 1992).

Allen and Meyer presented strong evidence demonstrating that employees socialized with divestiture tactics were more likely to take on an innovative role orientation. Investiture strategies, on the other hand, developed a custodial role orientation among newcomers. Existing practices are dismantled encouraging newcomers to foster new techniques ensuring conformity to tasks and procedures (Allen & Meyer, 1990). A custodial role orientation is important in organizations that require tightly controlled environments and adherence to prescribed tasks and procedures.

Finkelstein et al., (2003) addressed the specific needs of employees based on their age and information gathering techniques: covert or overt. Results supported an inverse relationship between covert information gathering and job satisfaction. Additionally, employees with a propensity for covert information-gathering experienced greater degrees of role stress, presumably due to a lack of task clarity. Implications of this study suggest that younger employees may require greater mentoring opportunities and that effort should be made to provide information to new hires, make information easily accessible, or provide a "safe" atmosphere for information seeking.

Task Efficacy

Reio & Callahan (2004) contend the very ability to practice skills and tasks without the anxiety and stress of having to master said skills and tasks increased newcomer curiosity and skill development. In a 2002 literature review, Ralph demonstrated strong support for the use of mentors as a significant source of both task knowledge and support for novice teachers.

Tactics related to task readiness were proven to be noteworthy moderators of anxiety and role stress. Research by Cable and Parsons (2001) and Ostroff and Kozlowski (1992) both presented findings supportive of content knowledge as opposed to context knowledge. Cable and Parsons stressed the need for supportive guidance to reduce the feelings of anxiety related to task uncertainty. Serial socialization tactics provide newcomers with guidance and experiences by which they can master tasks. Newcomers socialized with a mentor had the ability to discuss issues and receive feedback, thereby reducing their anxiety and uncertainty. Cable and Parsons were unable to correlate a relationship between context socialization (collective and formal tactics)--information specific to the organization--and organizational fit. However, they positively correlated content knowledge (sequential and fixed tactics) with organizational fit. Finally, their hypotheses related to social tactics (serial and investiture) were also positively correlated to both fit and an increase in values congruence. While Cable and Parsons research did not address job satisfaction, it did demonstrate the importance of content knowledge and mentoring on organizational fit, considered important for job satisfaction (O'Reilly, Chatman, & Caldwell, 1991; Parkes & Bochner, 2001).

These findings support Ostroff and Kozlowski's (1992) research related to job tasks commonly associated with organizational content. Ostroff and Kozlowski note that socialization has generally focused on context rather than content: "[t]raditionally…socialization theory has been on the organizational domain; that is, learning the values, norms, goals, and culture of the organization" (p. 896). Results, however, support the opposite, indicating that acquiring information about organizational issues is less imperative than developing tasks essential to the newcomer's role.

Demonstrating the importance of hands-on task orientation, the researchers' work established the importance of practical skill building and knowledge acquisition. Findings supported the need for experimentation in order to develop task mastery. Observation, they noted, was acceptable, but only as a means of understanding and acquiring knowledge related to unit social norms, this being the contextual knowledge.

Bravo et al., (2003) isolated the mentoring variable as a measure of new hire success. Mentoring, they established "provides newcomers with social or interpersonal information from experienced organizational members who provide them with a social definition of reality" (Bravo et al., p. 197). This organizational reality includes task clarity and knowledge assimilation by easing stress and anxiety (Reio & Callahan, 2004). This is highly supportive of Ostroff and Kozlowski's (1992) research, which also demonstrated a critical link between task clarity and supportive colleague interaction.

Role Stress and Anxiety

Role ambiguity and role conflict have been identified as two of the most stressful newcomer experiences within organizations. As an organizational practice, research is supportive of mentoring as it has been linked to both a reduction in role stress and increased commitment to the organizational role among newcomers. Supervisors, coworkers, and mentors all work together to clarify both roles and tasks. Further consideration was given to the relationship between commitment and socialization by King and Sethi (1998) when they examined the effects of institutional socialization specifically related to role orientation (conflict and ambiguity). King and Sethi's results supported two specific variables, the serial (mentoring) and investiture practices, which

were found to reduce significantly stress associated with role orientation. Duncan (1997) revealed the need and desire for supportive orientation amongst nurse graduates. Her research findings indicated that nurse graduates clearly seek out acute care settings with a reputation of orienting staff over benefits, pay, and advancement opportunity.

Anxiety is considered by some to be a variable most likely to contribute to newcomer stress. Effective socialization, however, has demonstrated a reduction in anxiety associated with organizational entry. Unabated, anxiety--either state or trait--can interfere with skill and knowledge acquisition. Reio and Callahan (2004) found that job performance and learning were sharply curtailed during heightened states of anxiety. Anxiety, specifically state anxiety, had a negative relationship with curiosity, thereby deterring the socialization process and ultimately job performance (Reio & Callahan).

*Value*s

Values have been questioned and studied at length. Currently, the literature is abundant with studies relevant to both values (Dose, 1997) and the significance of values-fit among employees and organizations (O'Reilly, Chatman, & Caldwell; 1991; Parkes, Bochner, & Schneider, 2001). Identified as Person-Environment (PE) fit, research has solidified the need for appropriate PE fit on the values scale for a mutually beneficial employment relationship. Wood (1981) noted that satisfied employees express similarities between their own values and those of the workplace.

Dose (1997) created a framework for integrating values along a continuum of morale obligations and personal preferences. Dose's work identified values as socially expectable and organizational obligations, commonly experienced by nurses (Biton &

Tabek, 2002; Nathaniel, 2004). While morale and personal values are nearly impossible to change, more loosely held work or social values are easily influenced, being learned rather than deeply entrenched, personal beliefs. Social values, then, are ideal for transitioning role expectations through institutional socialization.

Organizational or even unit newcomers are often unaware of the social norms and work practices and organizational, unit, or role functions. This lack of knowledge severely limits or restricts the abilities of newcomers to contribute to decision-making, role tasks, and other related requirements. This limited ability makes socialization an attractive method of organizational adjustment (Black & Ashford, 1995). Reichers, Wanous, and Steele (1994) agree stressing, "rapid rates of adjustment and high levels of organizational commitment are desirable goals that can relate from particular socialization practices" (p. 17). Black and Ashford posit that some organizational members may never fit in despite socialization efforts. Those individuals that have a higher locus of internal control are less likely to be influenced by socialization efforts, perhaps because of their strong morale beliefs (Dose, 1997).

Socializing Nurses

While magnet status has become the iconic designation among acute care settings, it is not realistic for every hospital. Magnet status designation is costly in terms of resource distribution, cultural changes, and organizational restructuring. Hospitals seeking magnet designation are required to engage in an organizational-cultural paradigm shift associated with additional resources and restructuring. Cultural shifts in magnet hospitals facilitate and support an environment that encourages effective nurse-physician

relationships. Magnet hospitals encourage flattened units that break down barriers to improve nurse autonomy and control over practice. In addition, a requisite Chief Nurse Executive is hired as a mandatory condition of attaining magnet status.

The shift in nurse-physician relations may be more of a paradigm shift than a culture and/or organizational shift. Hospitals and health systems are relying on physicians to play a strategic role while hoping to capitalize on recognition and/or credentials in order to broaden market share and increase revenue vis-à-vis both patient base and boundary spanning (Lait & Wallace, 2002; McNeese- Smith, 1999). The importance placed on physicians suggests that they will continue to dominate both hospital culture and operations (Scott et al., 2000). Rural hospitals often struggle to attract physicians, and may be unwilling to risk physician status to enforce long-standing, albeit flawed, mental models.

The associated financial costs of magnet status have also contributed to a lack of interest in rural hospitals. The actual cost of magnet status designation is in initial certification and development costs, on-going certification fees, and the executive nurse's salary. According to both the American Nursing Association (ANA) (2004) and the AACN (2003), nurse executives can earn approximately $60,000 more annually than associate nurse professors.

Many rural hospitals have expressed concerns about the disruption in operations as well as financing the associated administrative costs (Lundgren, D. RN, Personal Communication, October 19, 2004). Rural hospitals have also struggled with the ability to recruit for professional positions, and have been reported as some of the most critical

healthcare shortage areas (National Health Services Corp, 2005). As a strategy, organizational socialization proposes an alternative to magnet status.

Upenieks (2003b) notes that magnet hospitals demonstrate organizational characteristics that enhance the work environment for nurses. Many researchers disagree, arguing that the magnet status designation flattens units to the point where staff nurses are forced to make difficult decisions without managerial support (Donley & Flaherty, 2002; Laschinger et al., 2002; Schwartz, 1990). The Robert Wood Johnson Foundation respondents reported that:

> [m]ost nurses said their nurse managers were no longer able to support them because they had two to four units to oversee. Nurses also said that managers are feeling as exhausted as front-line nurses, and that this makes it difficult to do a good job. (p. 45)

Flattened units may be particularly stressful for novice nurses as many are still developing task and role competencies. New or transferring veteran nurses may also experience stress when changing units or entering the unit from another organization.

Several researchers have addressed the lack of clearly-defined role guidelines and information about the nursing role and related tasks both upon graduation and through the first years of nursing (Chang & Hancock, 2003; Chang et al., 2005; Donley & Flaherty, 2002; Mrayyan & Acorn, 2004; Oleson & Whittaker, 1968; Simpson et al., 1979; Startup & Wilson, 1992; Yura-Petro & Brooks, 1991). Chang et al., stressed that the "lack of clear and consistent information about the role" (p. 60) contributes to role stress and dissatisfaction. Mrayyan and Acorn (2004) surveyed novice Jordanian nurses who reported "fear of making a mistake, feelings of inadequacy, and unavailability of staff support" (p. 82). Ashforth et al., (1998) provided further support for institutional

socialization practices emphasizing their effectiveness in large and/or mechanistic organizations "given their proclivity toward reproducing the status quo and exerting greater control over newcomers attitudes and behaviors" (p. 919).

Despite the holistic view and individualized patient care represented in nursing education ideology, hospital rules and regulations stress a more bureaucratic role for the nurses, with an emphasis on physical care of patients guided by physician orders. The skills and knowledge required of the occupation to treat patients differs considerably from the skills and knowledge that need to be learned in order to understand the job, the role, and the tasks in the workplace.

Even though the clinical preceptorship is intended to provide a hands-on clinical experience, it may not improve task efficacy, a necessary component of effective socialization. Faculty members also hold positional power over students in the form of grades and evaluations (Oleson & Whitaker, 1968). As mentors, clinical educators may increase anxiety, thereby reducing the student nurses' inability to process new skills or tasks critically. Furthermore, clinical faculty may restrict skill development because students are restricted from learning new or innovative skills that may be more intuitive or comfortable.

It could be argued that the diploma-nursing model reduced role stress and anxiety by providing content, an element that is a task-specific role requirement. Early nursing education was loosely based on an apprenticeship model. As such, nursing students received on-the-job training as part of their education. Known as the diploma model of education, it consisted of *working on the floor*, providing patient care, while attending evening or weekend classes taught by physicians or veteran nurses. Unlike modern

preceptor programs, diploma models of nursing education served not only as an education model, but a socialization model as well, addressing all six institutional tactics of socialization needs of novice nurses.

In spite of the many problems with the diploma model, it provided student nurses with a skill set desirable for entry into nursing practice: a real life experience of the nursing role. Donley and Flaherty (2002) clarify, "[i]t is not surprising that new diploma graduates required little orientation to the hospital workplace. The transition from senior student to new graduate was seamless. Many diploma graduates practiced in the settings where they completed training" (p. 4). This is supportive of Hochwarter et al. (2004) who called attention to the need for task efficacy as a means of improving overall satisfaction.

Summary

A variety of contributing elements has influenced dissatisfaction within the nursing community, and may be contributing to the current shortage within acute care settings. Nurses report that job dissatisfaction is the leading cause of both professional and job turnover. While elusive to define, job dissatisfaction is reflected in a variety of challenges representative of both the job and the profession.

Job and organizational characteristics are widely represented in the extant nursing literature outlining frustrations and challenges experienced by nurses in acute settings, including but not limited to increasing tasks and demands, lack of autonomy, nurse culture, and stress resulting from increasing acuity levels and staff shortages. Many nurses experience distress at the initial point of professional entry as nursing expectations

frequently differ between nurse educators and nurse managers. Role stress has also been associated with nursing dissatisfaction in that many nurses experience and report instances where contradictory and/or ambiguous expectations negatively influence the perception that nurses hold about their role.

Socialization has been broadly recognized as a method of combating both job dissatisfaction and role stress by mediating differences between perceived and actual tasks and duties. A process of institutional socialization nurtures and indoctrinates new hires into the organization through a series of specific tactics. The body of socialization literature was presented to demonstrate how a cohesive process could prepare new hires, and veteran employees, to meet organizational demands and expectations.

CHAPTER 3. METHODOLOGY

The purpose of this study is to explore unmet expectations of hospital staff nurses to determine the extent that inadequate socialization contributes to disparate expectations and professional dissatisfaction. Additionally, this study will explore how individual organizational socialization cultivates dissatisfaction through a systematic failure of unmet organizational needs of nurses as they enter the workforce, as either novices or veteran nurses.

The selection of an appropriate research method relies on the intended purpose and study design (Blaikie, 2000; Silverman, 2004). For the purposes of this exploratory research the qualitative methodology was selected for its reliance in understanding the phenomenology of the participants' reality (Moustakas, 1994) in relation to the process of inculcating nurses into the profession and organization.

Qualitative Research: Benefits, Limitations, and Assumptions

Over the last several decades, the use of qualitative methodology has improved in both application and scope. Researchers, specifically social scientists, have increasingly used the qualitative methodology as a means of exploration to understand the phenomenology of human actions (Creswell & Miller, 2000; Maletrud, 2001; Morgan & Smircich, 1980; Moustakas, 1994; Ritchie & Spencer, 2002). During this time the methodology has expanded to include a wide variety of research areas, while refining and

strengthening its strategy. Researchers have recognized the unique perception of qualitative or flexible methods to appreciate more fully the complex, social concepts persistent in social policy fields to understand complex behaviors, needs, systems, and cultures which cannot be explained by statistics (Ritchie & Spencer, 2002).

Qualitative research is used in conjunction with theory development and exploration, validating generalizations, and/or appraising outliers. Theory development and exploration are generated through the narrative dialogue common in qualitative research. Qualitative research does not attempt to develop a structured method of data control or manipulation. Rather, it utilizes a subjectivist epistemological approach to capture a unique perspective or phenomena from the participants by seeking to discover an understanding of their experiences and perceptions (Addison, 1989).

One of the greatest strengths of qualitative research is the ability to explore marginal experiences, a feature uncommon in quantitative research. From his viewpoint, Silverman (2001) identifies this ability as an immense advantage over quantitative research because it can provide a richer perception of the participant's reality than could be acquired from quantitative data. Research participants comprised of humans each with a unique perception cannot be controlled through rigid experimentation.

Surveys, common in quantitative research, often fail to capture the thoughts, emotions, and experiences of research participants adequately (Addison, 1989). Arbnor and Bjerke (1997) describe this potential failure as the basis of qualitative epistemology that captures the essence of qualitative research: there is no single answer. The strength of the qualitative methodology is in its ability to "uncover the hidden meaning" (Gephart,

1999, p. 2) of research participants by creating and developing an understanding of actors in social situations through the voice of the participant.

Assumptions and limitations of qualitative research are as follows:

1. Both researcher and participant can agree on common interpretations of words as an accurate reflection of the truth as narrated from participant to researcher (Moustakas, 1994);
2. Contradictions, bias, and subjective reality are inherent in the participant's world, making qualitative methodology appear somewhat irresolute;
3. As is natural with qualitative research, researcher assumptions may influence either research outcomes and/or participant responses;
4. Participants may bolster their responses to create a heightened sense of reality; and
5. Participants may limit their responses based on a perceived threat and therefore may be unwilling or unable to engage in dialogue.

Misunderstandings in qualitative research are commonly referred to as dialectical paths. These may occur frequently because researcher and participant hold different perceptions about words and body language (Arbnor & Bjerke, 1997; Moustakas, 1994). The researcher must ensure that he/she has a clear understanding of the intentionality and meaning behind each participant's words. This includes quelling any temptation by the researcher/interviewer to finish sentences of participants, or imply any meaning into a word, phrase, or body language that can lead to researcher assumptions. Moreover, nurses face valid licensure threats from occurrences that jeopardize patient safety, increasing the likelihood of limited or reserved interactions between the researcher and

the participant. This possibility of restraint on behalf of the participant poses a serious threat to the validity of this study.

To meet these challenges, the interview questions proceeded through field-testing with to five nurses prior to participant interviews. Interview questions (Appendix A) have been developed by the researcher to address the research questions guiding this study. Final narrative will be discussed at length in chapters 4 and 5.

Assumptions and limitations were mitigated through the use of validity measures common to qualitative research: credibility, transferability, dependability, and confirmability (Trochim, 2005).

1. *Credibility*: Establishes realistic or believable results achieved through the use of detailed narrative and direct quotations as told or narrated by the participant. Further, it ensures that researchers and participants internalize a universal understanding of words and their meanings;
2. *Transferability*: Includes identifying appropriate research context and assumptions

   central to the research question or situation. In addition, it ensures that participant experiences are transferred or shared by other nurses;
3. *Dependability*: Data analysis reveals patterns and themes making the research findings dependable;
4. *Confirmability*: Established through the process of member-checking data as it emerges, confirming the accuracy of participant dialogue.

These measures are unique criteria, standards reflective of the distinctive nature of the qualitative methodology. Developed by qualitative researchers, these measures counter

the claims by quantitative researchers that the qualitative methodology lacks testable validity.

Research Design

The aim of this study was to explore institutional socialization to understand how it contributes to disparate expectations related to nursing. In addition, this study explored nursing dissatisfaction, primarily by assessing the extent that incongruent job expectations contribute to dissatisfaction as outlined in chapter 2. The lack of suitable, qualitative research within the body of nursing literature has limited the understanding of nursing dissatisfaction to a quantitative perspective, germane to a specific point in time, or has limited participant responses to a specific set of criteria. Therefore, the application of a qualitative methodology will explore nursing dissatisfaction in greater depth using grounded theory, the proposed research strategy for this study.

Healthcare, rooted in the data derived from traditionally defined hard sciences, has been slow to transition and accept qualitative research. The medical and scientific community remains cynical at best of qualitative research, indicting it for its subjective nature and the absence of facts (Maltrude, 2001). This bias may contribute to the resistance on the part of healthcare researchers to review and accept qualitative research. As a part of healthcare, nursing has been equally reticent to adopt wholly qualitative research as a valid means to further theory exploration, despite the on-going and unmediated questions about nursing dissatisfaction (Chang & Hancock, 2003). Schwartz (1990) suggested that the current body of nursing literature is largely quantitative and as such is unbalanced and biased, based on exaggerated information or false positives to

"create appeals for more decision-making influence" (p. 551). Joshua-Amadi (2003) has also criticized the body of nursing literature, citing its lack of a theoretical base for solidly understanding nursing dissatisfaction.

However, nursing research has embraced the grounded strategy method as a valid, defensible data collection and analysis method. The introduction and subsequent relationship between nursing and grounded theory emerged after Glaser and Strauss used it to explain and predict the social phenomenon in healthcare (Wilson & Hutchinson, 2006). In addition to the participation of social actors, grounded theory follows a systematic approach to data collection and analysis, which may appeal to the more rigorous quantitative collection and analysis methods common to natural science and medical research. Characteristically, grounded theory is used to explore investigations in need of a new perspective (Franchuck, 2004; Samik-Abrahim, 2000), as well as the contribution of processes, activities, theories, and events (Creswell, 2003).

The grounded theory technique emerged during the 1960s while Glaser and Strauss studied patient experiences. Their diverse backgrounds introduced the utilization of a systematic research method (Rust, 1993) that could capture the experiences of research participants generating theory (Samik-Abrahim, 2000). Grounded theory addresses specific phenomenological needs through the development of substantive or formal theory. Ideally, grounded theory assesses responses grounded in the data generated from interviews, field notes, and observations to discover social behavior patterns of the participants, thereby developing theory. Moustakas (1994) claims the use of grounded theory facilitates theory development based on the experiences of people in a particular setting.

The purpose of grounded theory is twofold: to explain social human behavior, and to modify and broaden existing theories (Eaves, 2001; Glaser & Strauss, 1967). Data are vetted through coding and the subsequent review of field notes, developing either substantive or formal theory. Substantive theory relates to a conceptual area, whereas formal theory is grounded in a specific content topic.

The grounded theory method employs constant data comparison (Glaser & Strauss, 1967). Field research, interviews, and notes are used in a systematic method of data collection and analysis (Eaves, 2001). Constant data comparison allows research to identify patterns and relationships within the data that might not reveal itself otherwise. Dick (2005) suggests that data analysis is an overlapping process of constant data comparison of collection, note-taking, coding (both open and axial), and field notes, all occurring simultaneously.

Research Participants and Sampling Plan

This study adds to the body of knowledge by exploring nursing dissatisfaction from a qualitative perspective. In order to gain understanding for generating effective solutions, research must begin by factoring in the voice of the primary actor: the nurse. It is the purpose and intent of this qualitative study to understand professional dissatisfaction from the nurses' perspective through semi-structured, in-depth interviews.

This research utilized the grounded theory strategy for data collection and inquiry. The focus of the researcher participants in this research will focus on the foundation of nursing and/or healthcare activities: the related expectations of nursing, and how those expectations are communicated to nurses. While many opportunities exist for nurses

within the hospital, the purpose of this research is to explore dissatisfaction from staff nurses those working directly with patients and physicians--or those considered to work at the patient bedside--potentially challenged by multiple and conflicting demands, and contradictory role expectations.

Grounded theorists suggest a sample size of 20 to 30 participants (Creswell, 2003; Franchuk, 2004), relative to the specific environment (Maxwell, 2005) or to the point of theoretical saturation. The number of participants reflects an assumption that data saturation can be reached with this allotment of participants, more may be required for a thorough grounded theory study. Purposive samples are ideally suited for grounded theory research (Robson, 2002), because of the constant data comparison required for adequate data analysis in grounded theory research. Probability samples would offer a group too large and diverse for grounded theory research, given the comparative design of grounded theory. Convenience or representative sampling offers a more simple solution to participant recruitment, but may present questionable representative findings (Robson).

This research will use a purposive sampling plan to recruit 20 to 30 hospital staff nurses licensed as a registered nurse (RN). Purposive or criterion-based selections are utilized in research settings where the participants are selected intentionally to reflect the unique experiences of their situations; theirs are often situations that cannot be explained or described by any other body of participants (Maxwell, 2005). Furthermore, the selection of a theoretical-purposive sample is ideal for developing diversity (Dick, 2005; Franchuk). The flexibility represented by a diverse sample embodies adequate theory development through data saturation.

Participants were limited to staff nurses who provide direct patient care, and were recruited from a local coaching/consulting organization. Participants' represented nurses from a variety of hospitals and acute care centers across Washington State. Staff nurses can bring a unique nursing perspective free from any biases or perceived assumptions made by nurses with an advanced nursing degree, in management positions, or working in non-clinical positions. Permission to recruit, contact, and interview nurse participants was obtained through an interview with the organizations Executive Director.

Dissatisfaction points to the structure of the nursing role as experienced by hospitals both nationwide and worldwide (Aiken, Clarke, Sloane, Sochalski, Busse, et al, 2001). The intent is to understand and identify comparable results by utilizing a purposive sample, representative of a larger and more diverse population of hospital nurses. For this reason, nurses from multiple hospitals and acute care centers were utilized for the purpose of this study rather than those from hospital units. These units may have unique structural or cultural elements that may or may not influence socialization (Kramer & Schmalenberg, 2003). Participants from a variety of hospitals and acute care centers enabled the researcher to produce a wider array of responses generating both transferability and dependability of data and results.

Transferability is the degree in which results from a qualitative study can be transferred or generalized (Trochim, 2005). Dependability, derived from quantitative reliability, reflects how often the same result can be achieved more than once (Trochim). From a qualitative perspective, reliability is sometimes difficult to achieve because the individual perceptions of each participant may differ. While each research participant may eventually bring a unique perception, data analysis reveals patterns and themes

making the research findings dependable across a heterogeneous sample (Maxwell, 2005).

It was the concern of this researcher that information related to nursing practices could result in the complaints against nursing licenses; such related information might include known medication errors, charting errors, and calculated risks. These examples are unfortunate daily occurrences given the current hospital environment and its related demands. The burden falls to this researcher to ensure that nurses understand that all collected data will remain confidential.

Due to the sensitivity of the topic and the potential for licensure revocation, a serious concern among nurses, confidentiality was guaranteed both verbally and in writing. Participants received signed copies of confidentiality agreements prior to the initial interview. Furthermore, they were assured that their contributions were voluntary, and as such they were free to terminate participation at any time. The researcher provided personal contact information to all participants should they have questions, comments, or concerns during the duration of study. Upon the conclusion of this study, participants received a copy of the concluding findings if it had been requested.

In an effort to protect the research participants, this study adhered to the guidelines recognized by Capella University in Minneapolis, Minnesota, and the University's Institutional Review Board. All appropriate procedures and applications were followed in accordance with policy to ensure the privacy and confidentiality of participants is protected. Furthermore, research participants completed a "Consent for Participation" form. The consent form presented detailed, narrative statements which outlined the intent and purpose of the research, the researcher's contact information, the

statement of confidentiality, and the participant's right to exit. Participants were informed of the research intent, interview procedures, time commitments, and research topic prior to research participation.

Data Collection Methods

It was the intent of this research to explore the experiences of nurses leading to and causing dissatisfaction. In an attempt to understand that dissatisfaction, a variety of tools captured the rich, detailed narrative, content that is typical of qualitative research (Creswell, 2002). Primary data were collected through the interview process, enhanced and supported by field notes and audio taped interviews.

Interview questions were intended as means to answer research questions; as such, interview questions were methodical and related specifically to the research questions (Maxwell, 2005). While the unstructured approach is considered ideal for exploring phenomena and developing theories, it is inherently challenging on many levels (Maxwell, 2005; Miles & Huberman, 1994). Maxwell contended that an unstructured approach leads to volumes of data that can become overwhelming. The structured approach was not applied either as it fails to provide thorough researcher/participant interaction. For that reason, the structured tool or survey was better suited to the tightly-controlled, fixed methodological approach as a means of distilling causal relationships. Therefore, this research utilized a semi-structured questionnaire, which, encouraged dialogue yet produced only a moderate amount of data.

The use of semi-structured interview questions is recommended to maintain a modicum of control over the questioning process and data analysis. Additionally, semi-

structured questions are a better tool for representative comparability (Maxwell, 2005) because they allow the researcher to ask probing questions to clarify, add greater detail, or develop a new train of thought. The use of comparability is relevant for this research due in part to the potential number of hospitals represented by the sample (Miles & Huberman, 1994).

The data collection instrument (Appendix A) was developed by the researcher to account for each variable identified in the conceptual framework and literature review. The semi-structured questionnaire served as the interview guide.

It is common for qualitative researchers to spend time with participants necessitating that the interview and the observation to work in tandem. When possible, interviews were conducted in a familiar environment, such as the participant's hospital cafeteria. Familiar surroundings set participants at ease, enabling them to feel more secure and comfortable. In this instance, the researcher was more likely to establish a rapport and observe subtle nuances such as body language--a telling and indicative sign of true feelings.

While participants may allude to or say something in an interview, most will have a difficult time maintaining what Addison (1989) referred to as a "calculated stance" (p. 42); therefore, the idea of immersion through observation has become increasingly important in qualitative studies. Qualitative researchers gain increased familiarity with the infrastructure they are observing. Both Addison and Van Maanen (2002) experienced a deeper understanding of participant's common language after their experiences of cultural immersion.

The researcher's role consisted of interviewer, transcriber, and data coder. There were no events of participants requesting follow up counseling, most stated that they found the discussion and experience itself therapeutic.

Data Analysis

Grounded theory relies heavily on the researcher to develop and prepare a rigorous data collection protocol (Pandit, 1996). Participant interviews were transcribed with field notes and researcher notes accounting for and documenting verbal cues, body language, and researcher thoughts. Data from transcribed field notes were coded with the aid of qualitative coding software: Qaulrus. While coding is not a feature specific to grounded theory, it is central to the grounded theory strategy. Data analysis was an iterative process beginning with data transcription. By transcribing the data, the researcher gained an immediate familiarity with the data and began assigning codes and memos, one of the first strategies of data analysis.

Data analysis is comprised of three specific methodological parts that include identifying relevant data, organizing data, and drawing conclusions from the data. This begins by ordering the data into relevant data displays, either networks and/or matrices. These displays present the data in an organized and logical structure, supported by the coding process, which allows researchers observe notable patterns and themes. Next, data assessment reports the participant's story by drawing findings and conclusions. These combined analysis strategies produce research results that adequately capture and relay the experiences of the participants without jeopardizing the validity of the data and/or findings.

In addition to the use of Qualrus and audio recordings of participant narrative, no other technology or computer software was utilized in this study. An over-dependence upon technology may contribute to inadequate coding structures and/or false conclusions, based in part on a failure to either understand the data or by drawing false conclusions. Morison and Moir (1998) caution researchers that an over-reliance on computer applications for data analysis can lead a researcher into a "programmatic type of data analysis based upon the systematization of the research process" (p. 114). Additionally, poor data analysis may contribute to a silo effect resulting in the support of researcher assumptions (Miles & Huberman, 1994). For these reasons, this researcher relied on a broader data analysis strategy which included the within-case analysis practice as part of the overall analysis approach.

Data Coding

Data analysis was completed in overlapping steps. This is consistent with simultaneous data collection and analysis process common in grounded theory, as recommended by Eaves (2001) and Dick (2005). The purpose of the overlapping data analysis steps is to reveal patterns and theories within the data. Coding data used for comparison and analysis proceeded as follows as suggested by Pandit (1996) and Borgatti (n.d.).

Specifically, data ordering, an important part of early data analysis, was comprised of arranging data events to facilitate easier analysis. Data ordering included reviewing and coding data from field notes. The use of matrices and memos provided researchers with the tools to order data cohesively (Miles & Huberman, 1994), and to tie

the data to the research questions (Glaser & Strauss, 1967). Data ordering is consistent with grounded theory, in part because it collects additional data to cover gaps while identifying additional areas for data saturation. This research used specific tools such as an interview summary form (Appendix B).

Data analysis uses open coding to develop concepts, categories, and properties, and is designed more to fracture data and rearrange it into categories (Maxwell, 2005). Three sets of data analysis were used in the coding sequence.

1. Organizational coding develops broad areas or categories;
2. Substantive coding develops a broader sense of concepts and beliefs as they originate from the data organization;
3. Theoretical coding provides a more general framework representing the researcher's concepts which are developed by the substantive coding.

Substantive and theoretical codes were developed as central themes and patterns emerged from the initial organizational coding as developed and outlined below by the researcher.

Table 4. Initial Format Codes – Organizational Coding

Variable	Code
Values	V
Role Expectations	RE
Role Conflict	RC
Role Ambiguity	RA
Role Stress	RS
Professional Perceptions	PP
Socialization	SOCN

Triangulation

Triangulation uses a variety of data sources, such as participants themselves, to examine and validate data (Creswell, 2003). Adding merit to validity, triangulation is important because it helps readers establish accurate findings. Creswell stressed the use of other validity checks such as member checking and rich, detailed narrative, both of which enhance the narrative setting culminating in a shared experience between participant and reader.

Transcribed narrative was provided to the participants for feedback, validation of occurrences, and member checking. These actions ensured that recorded interviews and field notes documented accurate information. Member-checks provide assurances to the researcher, participant, and research community that perceived or inferred participant intentions were accurately captured. Otherwise, failure to adequately determine participant intentions through words and key phrases may have lead to invalid assumptions regarding findings and outcomes. Van Maanen, (as cited in Huberman & Miles, 2002) makes keen observations regarding the likelihood of false assumptions made on the basis of perceived key phrase understanding; as such, making false assumptions about dialogue and intentionality may lead to invalid conclusions altering both research findings and future research. These data collection techniques of triangulation ensured validation within the research.

More recent bodies of work by Johnson (1997) and Maxwell (2002) offer an entirely new set of validity criteria to examine some strategies that have been developed to take advantage of validity in qualitative research. The basic epistemological and ontological differences of quantitative and qualitative research are so different, they

suggest, that it is nearly impossible to use one set of standards to judge the other. While it is important to recognize issues of validity in qualitative research, Johnson writes, it is important to think of it as "plausible, credible, trustworthy, and therefore, defensible" (p. 282). Maxwell (2002) contends that understanding is a far more crucial and fundamental concept in qualitative research, noting that the participant's perspective is more important than applying quantitative validity standards. Johnson (1997) and Maxwell (2002) recommend the use of descriptive, interpretive, and theoretical validity criterion for qualitative research.

Descriptive

Descriptive validity ensures factual accuracy, assessing the accuracy of reported events. To ensure descriptive validity, Johnson offered strategies which include member or crosschecking data, and triangulation, a method that uses multiple source points to ensure data accuracy. Triangulation alone, noted Johnson (1997), may involve crosschecking information using a wide variety of sources including data, methods, investigator, and theory.

Interpretive

The focus of interpretive validity is to make certain that both interpretation and meaning are in alignment. Maxwell (2002) advocates the use of interpretation because "this aspect of understanding is most central to interpretive research…which seeks to comprehend phenomena not on the basis of the researchers perspective and categories, but from those of the participants in the situations studied" (p. 48). This includes

gathering participant feedback to portray participant accounts of reality accurately. Johnson suggests the use of rich, thick narrative and verbatim quotes to ensure that events were recorded truthfully rather than influenced by researcher bias.

Theoretical

Theoretical validity ensures that both the theoretical explanation and the data are cohesive and defensible. Johnson's (1997) recommended strategy for theoretical validation is developed through the use of extended fieldwork (immersion), interviews, and observations. This extensive investigation alleviates inconsistent answers and actions.

Summary

Qualitative methodology has been increasing in scope and application offering an alternative to quantitative research. Chapter 3 summarized many of the features of qualitative analysis beneficial for phenomenological discovery and theory generation. Additionally, this chapter outlined the use of grounded theory technique to capture participant data. Grounded theory is widely accepted as a strategy for theory exploration. Theory is revealed through data retrieved through participant interviews, emerging at the saturation point. A purposive sample of hospital RNs was utilized to draw out participant narrative through a semi-structured interview process. The remaining chapters provide detailed narrative about nursing experiences related to participant socialization experiences and expectations.

CHAPTER 4. DATA COLLECTION AND ANALYSIS

This chapter includes the presentation and analysis of the data collected for this study. A description of the sample will be discussed, and then the research questions will be presented for a framework of the organization and presentation of the data analysis. The central research question posed in this study explored the extent that individual socialization contributes to nursing dissatisfaction. To answer this question and provide an understanding of if and how socialization contributes to nursing dissatisfaction, a qualitative method with a ground theory design was used. A purposive sample consisted of acute care nurses. This chapter provides the data results that were gathered and analyzed from nurses within local area hospitals.

Qualitative Data Collection

Purposive sampling was used for participant selection. Data were collected from RNs through in-depth, face-to-face interviews, using a semi-structured Interview Guideline (Appendix A) developed by the researcher. Interviews were conducted from nurses representing a variety of acute care hospitals in Washington State during an 18-week period beginning in January of 2007 through mid May of 2007.

The sample for this study was comprised of 20 nurses recruited from a Washington-based organizational development and consulting organization specializing

in health care and nursing. This organization was selected for participant recruitment based on its existing database of staff RNs.

Participants were introduced to the research opportunity by the organizations president, done in part to maintain the confidentiality agreements of prior research. Interested participants contacted the researcher for further information and initial, pre-interview meetings. The initial meeting was conducted as per the participant's preference, either via phone, email, or in person. These options were designed to provide adequate information allowing the participant to determine if there was further interest in research participation.

Interested participants were contacted for a face-to-face interview. Participants were provided with an explanation of the interview process, as well as the nature of the questions and scope of the study. Informed consent agreements were procured at this time as was consent to obtain audio recordings.

Prior to conducting participant interviews, the interview questionnaire underwent pilot-testing with five nurses practicing in like-environments. The testing process ensured that interviews proceeded in a cohesive manner and questions were framed in a logical sequence. As a result, the interview questionnaire was modified to include questions about age, organizational structure, and nursing unit.

The triangulation strategy of collected data was completed through participant observation, member-checking, extensive narrative feedback, and current literature. Triangulation has historically been used as a validation method (Silverman, 2004). The use of appropriate triangulation constructs varies based on research methodology: quantitative or qualitative. Qualitative methodology has adopted the use of triangulation

as a measure of credibility, the evaluation of validity associated with qualitative research (Trochim, 2005). Introduced to qualitative research during the 1960s triangulation was offered as a means of arguing that social science research, then dominated by sociology, should not become reliant upon a single research event (Blaikie, 2000).

Janesick (1994) acknowledges four methods of triangulation frequently used in qualitative research: data, theory, methodological, and investigator. Data triangulation refers to the method of triangulating three types of data sets. In the qualitative experience this might include the comparison of data from a variety of participants, records, and field notes. Interpretation of data from multiple perspectives is referred to as theory triangulation. Methodological triangulation requires the use of multiple methods to study a single problem. Investigator triangulation includes the use of more than one investigator or researcher to validate data. Investigator triangulation also includes researcher-participant corroboration (Key, 1997) also known as member-checking or participant feedback (Ebenal, 2006). Silverman (2004) puts forth the term respondent validation to describe the member-checking process. The use of member-checking

includes returning the participant's findings to the participant confirming their experience, corroborate findings and interpretations. Introducing a fifth type of triangulation to qualitative research, Janesick suggests the consideration of interdisciplinary triangulation, designed to broaden triangulation beyond the scope of social science research which has been dominated by psychology. It is the investigator strategy that was used as the triangulation technique for this research study.

Interviews

Interviews were conducted in a location determined by the participants. Half of the interviews were conducted in a neutral location with the remaining ten conducted in the participants work environment. Most interviews lasted for one hour; two were less than an hour, and only two exceeded one hour. Extensive field notations were recorded during the data collection process. The field notes provided the researcher with insight into the participant's thought process, mindset, and salient thoughts, and aided recall when reviewing interview transcripts.

Upon completion of the interviews, the researcher completed an Interview Summary Form (Appendix B). The participant summary form captured emerging thoughts and initial coding, and identified potential patterns.

Participant Characteristics

The participants comprised of 20 nurses who participated in personal interviews. The sample was limited to nurses who met the criteria, which were those working in direct patient care with a Dip., ADN, or BSN nursing degree. The sample was limited to staff nurses to ensure that nurses with advanced degrees or those in management positions were not unduly influenced by education or position.

The experience and ages varied among the nurses. Participants ranged from novice nurses with less than one year of experience, to veteran nurses with more than 30 years of experience. The wide range of ages provided a broad sample and variety of socialization experiences. The range of experiences demonstrated a lack of consistency

among acute care facilities, and a lack of established best-practices to adequately establish or transition nurses into a new role, unit, or organization.

Table 5. Characteristics of Participant Sample

		Total
Gender:	Male	1
	Female	19
Age:	20 – 29	5
	30 – 39	5
	40 – 49	5
	50 – 59	5
	60 +	0
Nursing Degree:	Dip	1
	ADN	10
	BSN	9
Years in Nursing:	0 - 5	5
	6 – 10	0
	11 – 20	7
	21 – 30	5
	30 +	3
Years at Current Organization:	0 - 5	9
	6 – 10	2
	11 – 20	6
	21 – 30	2
	30 +	1
Unit/Department:	Medical/Surgical	5
	Clinical Education	3
	OR/Surgical	1
	Oncology/Palliative	2
	Cardiac Telemetry	2
	Emergency Dept.	1
	Medical Renal	1
	Critical Care Unit	4
	General Nursing	1

A variety of hospitals across Western Washington were represented from the participant sample, described in Table 5. Hospital structures ranged from both small

rural to large inner-city hospitals, and included both for profit and not-for-profit hospitals. Characteristics of the sample are shown in Table 6.

The wide range of hospitals and hospital units further described sporadically applied socialization practices. Of the three hospitals with multiple participants (hospitals 4 and 11) unit practices varied among two of them. Consistent socialization practices were used by one health system, represented by hospitals 3 and 9, and three participants Darla, Jennifer, and Marla.

Table 6. Characteristics of Representative Hospitals

Hospital Code	Demographic Representation	Profit Status	Participant Sample
01	Urban	For Profit	1
02	Urban	Not for Profit	1
03	Inner – City	Not for Profit	2
04	Urban	Not for Profit	6
05	Inner – City	Not for Profit	1
06	Rural	Not for Profit	1
07	Urban	Not for Profit	1
08	Urban	Not for Profit	1
09	Rural	Not for Profit	1
10	Urban	For Profit	1
11	Rural	Not for Profit	3
12	Urban	For Profit	1

Participant Coding

Participant name and contact information was organized and coded in an Excel spreadsheet. This document served as the Participant Coding Matrix (Appendix C). The intent of this document was to maintain participant information and contact methods, without jeopardizing participant confidentiality. This was an important step given that

some sensitive questionable practices were shared by participants. Once participant codes were assigned, they were used to identify all related paper and/or electronic documentation. The Participant Coding Matrix remains a separate document to ensure participant confidentiality. Participant's names were changed in the final presentation of data and data analysis.

Data Coding

Transcribed interviews were copied into Qualrus, data coding software for coding. The first step in coding data was to provide initial format codes, a simple configuration designed to quickly and conveniently identify particular trends and patterns based on emerging themes (Table 7).

Table 7. Initial Format Codes – Organizational Coding

Variable	Code
Values	V
Role Stress	RS
Professional Perceptions	PP
Socialization	SOCN

Initial format coding included codes to represent nursing degrees, number of years in the nursing profession, gender, employment duration, and a broad assessment of socialization practices and role stress. Subsequent and more detailed axial coding was later applied to identify particular emerging patterns and themes.

The constant coding comparison provided the researcher with the opportunity to capture thoughts and feelings related to participant's work and socialization experiences.

As new information emerged from subsequent interviews, additional codes were added. With each new code added, the researcher reassessed previous data to identify if any previous data fit the added codes. This method of constant coding comparison provided the researcher with a continuous assessment of trends and patterns, which made up the final analysis.

Once data were coded in the Qualrus software, links were established between variables to express logical and empirical relationships. Linking variables provides a conceptualization of variable relationships as themes emerged, changed, and stabilized with the addition of new data. Furthermore, linking variables within the coding software allowed the researcher to validate emerging themes and transferability within the data.

Finally, case dynamics matrices were used to display data in a manner that would identify situations and outcomes as observed by the researcher. Two matrices were developed to demonstrate overall socialization experiences and expectations. The case dynamics matrix is part of the family of explanatory matrices used primarily to identify emerging trends and themes.

Qualitative Analysis and Summary of Findings

Data generated for this grounded theory research provided support for the four research questions presented in this study. Further, five themes emerged from the data and will be discussed herein.

Summary of Findings and Emerging Themes

Central Question: *To what extent does individual socialization contribute to dissatisfaction among nurses?*

Based on the data analysis, the central research question is supported. Nurses who experienced individual socialization, represented by a lack of structured knowledge transfer and/or lack of mentor support, experienced dissatisfaction associated with role stress and general lack of support. Additionally, those nurses without adequate socialization experienced more stressful events related to their overall role. These participants readily displayed stress and anxiety related to unmet expectations and role stress. For example, tone and volume of voice, hand-gestures, facial expressions, and body language changed noticeably when they discussed related role challenges.

Question 1: *To what extent do unmet career expectations contribute to nursing dissatisfaction?*

Research question one was somewhat supported by the research. Participants who entered the profession with prior expectations, such as perceptions from other nurses close to them, or a "calling" to enter nursing, had unmet expectations or dissatisfaction if they had an individual or negative socialization experience. Half of the participants interviewed stated that they did not enter the profession with any preconceived role expectations.

Question 2: *To what extent does individual socialization contribute to unmet role expectations?*

Research question two is supported by the evidence presented through in-depth interviews. The seven participants who experienced individual socialization lacked a

common understanding of the responsibilities and magnitude of the role in relation to how to manage both patients and one's time, and how to follow a defined protocol. In addition, they were less prepared to handle difficult situations adequately.

Most participants indicated that they were unaware of how to handle difficult and/or conflicting situations. Managing both a patient caseload and complex nursing problems simultaneously appeared to be the most daunting task for novice nurses. These participants tended to exhibit more stress, anxiety, and anger during the interview as evidenced by their tense body language, facial expressions, and language tone. The researcher sensed these participants felt a sense of professional betrayal.

Question 3: *How can institutional socialization contribute to the clarity of role expectations, thereby improving job satisfaction of professional nurses?*

Observations from interviews revealed a difference in nurses who had a positive socialization experience from those who did not. Participants who experienced a more institutional approach to socialization--structured knowledge transfer through either specific content information and/or a mentor acting in a supportive capacity--were generally more relaxed and self-assured than nurses who did not share this experience. Participants who experienced institutional socialization, defined by mentor support and/or structured knowledge transfer, appeared much more at ease and had fewer negative comments about the profession and role of nurses in acute care. This ease of appearance was demonstrated by the participants' casual and relaxed body language and general demeanor.

The comparison of those nurses who experienced a more positive socialization experience, 13 of 20, discussed how the role of mentor provided both role and task

clarity. Therefore those nurses demonstrated more resiliency and understanding about how to cope with challenges specific to the role. For example, mentor relationships provided resources and tools to novice nurses, enabling them to enhance their clinical skills development, patient and time management, and tools in order to balance patient acuity. While all participants acknowledged the strain of limited resources, these nurses were better able to transition to employee status after their residency.

Content knowledge, competing procedural events and/or completing organizational-specific paperwork for example, was important to alleviating the stress and anxiety associated with licensure loss and liability. Knowledge transfer also provided nurses with a greater degree of security related to understanding how they as nurses could manage patient-and/or care-related practices. The transfer of content-specific knowledge related specifically to procedures, forms, and processes was more important to veteran participants than novices.

Patterns and Trends

The qualitative data analysis of personal interviews in this research included the constant data comparison and analysis of coded information. Emerging themes appeared quickly in key areas relative to socialization and dissatisfaction. Most notable was dissatisfaction resulting from conflicting and/or ambiguous expectations, lack of support, role stress, and knowledge transfer.

Inconsistent and Unmet Expectations

Participants with prior role expectations stated they anticipated nursing to be somewhat different. These differences in perceptions were centered on the nurses' ability to provide more direct, hands-on patient care, or be more influential in the care-giving nurse role.

Half of the participants entered the profession with a preconceived sense of the nursing role (Table 8). Two participants, Carole and Nancy, shared that they considered themselves "born to be nurses." Seven participants, Marla, Dena, Kim, Angie, Tracy, Peggy, and Elizabeth, had worked in the acute care setting prior to attending nursing school and had some idea about what nursing would be like. Robyn gained exposure to the nursing profession from her mother who was a nurse in a physician's office.

Participants who indicated a prior expectation about nursing had mixed socialization experiences. Among the ten with preconceived expectations, six experienced institutional socialization (Mindy, Marla, Nancy, Dena, Robyn, and Darla). The remaining four, Kim, Elizabeth, Carole, and Angie, were socialized individually. The six participants who experienced institutional socialization were strongly aided by the mentor relationship. The serial tactic of mentoring not only assisted with their clinical skill development but provided them with tools and resources to understand the scope of their job better. These participants had far fewer instances of unmet expectations and dissatisfaction. The four whose socialization experience was based on the individual process, those without any mentor support or knowledge transfer, expressed a greater degree of dissatisfaction.

Table 8. Previous Expectations and Socialization Experiences

Participant	Prior Expectations	Socialization Experience	Unmet Expectations	Dissatisfaction
Sharon	No	Positive	No	No
Sarah	No	Positive	No	No
Jack	No	Positive	No	No
Tami	No	Positive	No	No
Linda	No	Positive	No	No
Tracy	No	Positive	No	No
Mindy	Yes	Positive	No	No
Marla	Yes	Positive	No	No
Nancy	Yes	Positive	No	No
Dena	Yes	Positive	No	No
Jennifer	No	Positive	No	Yes
Robyn	Yes	Positive	No	Yes
Monica	No	Negative	Yes	Yes
Peggy	No	Negative	Yes	Yes
Susan	No	Negative	Yes	Yes
Kim	Yes	Negative	Yes	Yes
Elizabeth	Yes	Negative	Yes	Yes
Carole	Yes	Negative	Yes	Yes
Angie	Yes	Negative	Yes	Yes
Darla	Yes	Positive	Yes	Yes

This dissatisfaction was based in part on disparate expectations and the stated inability to perform tasks to the best of their capacity. Each of the four participants socialized in the individual model expressed both unmet expectations and dissatisfaction.

Participants shared thoughts related to their frequent inability to live up to their personal expectations. Furthermore, participants indicated that they felt unable to live up to the "nursing code of conduct" described in nursing school. In this distressing statement, Carole described the internal angst she has experienced:

> There is never an empty moment yet it is often accompanied by a sense of failure because you can never get anything done. You often leave knowing that you have left things undone for the next shift, knowing that this is adding to their

> workload…the worst part is going home feeling disgusted with yourself for not providing good patient care

Darla explained that nurses rarely escape conflicting expectations:

> There is a level of responsibility that stays with nurses long-past shift end …[thoughtful]…most people get to go home and forget about their jobs; nurses can't just forget about their work. You constantly worry about forgetting a critical piece that can jeopardize a patient's life. Working shift to shift is difficult; sometimes you follow a shift that was supervised or managed by a nurse with poor nursing assessment skills, with work left undone. Or, to leave a shift with an incompetent nurse to follow on critical issues with a patient, you just never stop thinking about it

Kim shared her thoughts related to conflicting expectations, "you do what you know can be done. Try to meet the expectations as best you can; unhappy family members will complain to the charge nurse though."

Robyn and Nancy articulated how their frustrations stem from their perceived inability to provide adequate patient care. Nancy asserts that the profession has "given away our bedside role, we forget that there is a patient in that bed." Like Nancy, Robyn declares she is must frustrated during the "days…when I could not devote to patients, and they get upset with me. Nursing is very demanding, there are good days when I feel that I have made a difference, the stress comes when there is too much going on." Angie claims that nursing has become mechanistic, a machine more concerned with chart notes and tasks unrelated to patient care:

> We have gotten so specialized that we lost site of our basic philosophy of nursing, too much specialty and not enough general practice…[thinking] the specialization leads you astray from the patient. You get used to the machinery…you forget how to rely on the gifts of nursing. I miss the art of nursing: there is little creativity. The goal of a large health system is to standardize our practice…we lose sight of the art and humanity of nursing

Marla's frustrations stem from the lack of respect. Marla had worked in an acute care setting as a certified nursing assistant (CNA) prior to earning her nursing degree; she expressed that she expected her title to bring her more respect from other healthcare professionals and patients:

> Peers are the most frustrating, the egos of other staff members: doctors and other nurses. There is a lot more asserting yourself than I expected. I was surprised that people did not accept the RN title; you must prove yourself as a new nurse. You expect to be treated as a colleague, a professional; there is a lot of struggle between peers. There is also a lack of professional acceptance among the public. I heard one patient's daughter refer to me as 'just a nurse'"

Role Stress

Role stress among nurses was a predominant theme. All 20 of the participants expressed a degree of role stress, even the 13 who had positive socialization experiences. The associated anxiety with conflicting expectations, increasing tasks, and lack of support related to decision-making ability appeared to have the greatest influence on dissatisfaction among the participant sample.

Participants involved in individual socialization experienced conflicting and/or ambiguous expectations (physicians, administration, patients, and patient families) related to patient care and patient care priorities. Participants often referred to their socialization as lonely, accompanied by a general feeling of "unsupported." Additionally, participants noted they lacked necessary tools and/or resources to care for patients safely and respond to patient needs (Monica, Kim, Elizabeth, Tami, Carole, and Peggy). They also felt increased vulnerability to licensure and/or liability instances (Monica, Kim, and Elizabeth).

Administrative demands to reduce overhead costs and increase revenue frequently result in conflicting challenges among nurses. Additionally, a lack of support, such as ancillary or technical staff, managerial support, or clinical/educational support, was frequently cited by participants as a cause for increasing and conflicting demands and expectations on nurse's time. Participants shared a broad sense that these demands diminished quality patient care. Diana shared that "[t]here is usually too much to do in a short duration of work hours, while the patient's needs are continuous at times."

Other participants recall similar experiences orienting in a variety of units. The situation described by Elizabeth below portrays many of the multiple and often conflicting demands placed on nurses:

> The constant and demanding workload [increases stress]. I recently observed [another] nurse simultaneously discharging two patients—this required two sets of paperwork, you know, she had two charts in front of her, each with discharge instructions - she was on her spectra-link phone that each nurse carries admitting another, and providing care to another patient. It is just not possible to mentally process all of this information: it is dangerous. The throughput issues [moving patients from one unit to another for related treatment] are huge. We have nurses discharging patients while others [patients] are stacking up in critical areas. The other day for example, we had 11 MRSA patients, and admitting wanted us to take another – we just couldn't do it; it is not safe for other patients or for staff. The cost of beds in critical units is charged by the minute, so admitting and throughput are always trying to move those patients out of high cost units to admit other patients into those beds. The rapid turnover causes a lot of dissatisfaction because of the stress and anxiety. We are expected to discharge 30% of our patients by 11:00a.m. every day. If a patient needs critical care, all hands respond to that patient, which eventually skews our numbers, and then we hear about it from administration. Just this morning, I discharged a patient that was being discharged by another nurse. She got called to assist with a code, and left me to complete the discharge. The patient's attending physician would not give up the chart, and I had no way of knowing that the patient —an IV drug user—had a central line. Because the physician would not give up the chart, the previous nurse did not chart that she removed the central line. I discharged the patient without realizing he had a central line. This could have led to a serious complication with this patient [participant was visibly shaken by the event and became upset upon recalling it]. The constant demands, and the push and pull of

> today's expectations and the reality of that: Physicians, patients, family, the public. The public has very skewed expectations. It is hard to focus on the accomplishments because the two are constantly at war with one another. Patients and family members have such unrealistic expectations of nurses; it places an extreme burden on the nurse. The part [of nursing] that does not meet my expectation is the inability to provide good patient care – good patient care is really all it is about

Elizabeth's vulnerability and stress about the above situation were obvious during the interview; she was very thoughtful, serious, and visibly shaken from the incident above (from field notes).

Sharon, a 32 year veteran nurse, relayed her frustrations:

> This is the greatest challenge – conflicting expectations from administration. They staff by number of patients rather than acuity of care. Family members expect a different level of service than we are able to provide. There are nights that I feel overwhelmed with patient load. You have to do patient education and then readmit new patients, which means doing a thorough patient assessment

Kim, a novice nurse presented her frustrations with physicians, noting that:

> The different doctors all have different expectations – they challenge your nursing assessment and abilities, and their expectations are often fragmented. The patients are always changing as well; there is no way to get a baseline. I feel like there is no way for me to make a difference in the hospital. There is not time to really provide the level of care that I would like to, and no time for patient education. There is not additional help when needed, you always feel short-staffed, and there is a terrible lack of resources [field notes: from either a lack of nursing staff, shifting resources to the primary care model, or administrative needs to reduce productivity]; it is difficult to care for patients in these situations

The researcher sensed that Kim was very angry about the conflicting and unrealistic Expectations. When asked about her greatest sense of dissatisfaction, she offered:

> You can't get the job done – there is no time. A lack of experience makes it more challenging to get the work done. There are too many expectations within the hospital. The patients are demanding and the increased acuity is very challenging. There are charge nurses on the floor with two years of experience; everyone else on the floor has six months. I switched to the day shift for more support, but days are busier. There are more orders, more doctors, and more meals, in addition to basic nursing [field notes: showers, dressing changes, etc.]. Families are

> challenging too, they expect *so much* [participant stressed] from the nurse, [Researcher asked, such as?] They expect the nurse to hand the patient a tissue when there are six or seven of them in the room and the tissue box is right next to them

The participant was noticeably agitated (from field notes). Another novice nurse, Jennifer, shared her frustrations with learning how to cope with multiple demands on her time:

> Taking more than two patients, all the charting and documentation, doing the medications, and IVs. The most challenging part was learning how to manage the patient load given all of the documentation and charting; we spend so much time charting

Monica echoed these challenges, and appeared very conflicted by her lack of ability to care for patients in a demanding acute care oncology unit:

> [thinking, very thoughtful]…getting the most basic things done and learning to walk away…on the floor, there is no one to relieve you [researcher asks: relieve you for what] breaks or attending to other patients…you just have to leave what you are doing. It is difficult because you hate to leave your patients, but if you do not take a break, you will exhaust yourself

Carole is a veteran nurse trained in the diploma model; she offered the following insights:

> Lack of staff and a full-house when there are lots of admissions – this makes the job more demanding and much more challenging. Our admission paperwork is 20 pages long. Things can get very chaotic very quickly. There is just too much work, and not enough people do get everything done. Our hospital has recently out-sourced the pharmacists. We cannot get into Pyxis [a medication administration system] until the pharmacist has reviewed the order. These orders are being sent all over – these pharmacists are not in Washington, they could be anywhere. It may take an hour or two before the pharmacists approves the order, so we cannot start routine meds until then. This makes providing good care very difficult. [Researcher asked: what about medications that need to be started right away? Like those intended to meet national patient safety goals?] Some things can be overridden if it needs to be started immediately, but others can be easily forgotten about. Just the other day, I was over two hours late giving a patient their insulin

Carole was noticeably upset by her perceived inability to provide adequate patient care. Throughout the interview, Carole demonstrated tension, anger, and stress (from field notes).

Jennifer, a novice nurse, was socialized in a highly structured and supportive environment. Despite the support she received during her first residency, she too has experienced frustration with multiple and often conflicting demands on her time: "The patient load is the greatest source of frustration; this contributes to a lot of dissatisfaction. Caring for patients is a lot of work, particularly on night shift when there are only two nurses."

Related to conflicting patient care expectations, Kim, a novice nurses revealed her current experiences and concerns about liability and losing her license in a busy medical-surgical unit:

> There is constant stress of liability and licensure issues in addition to the workload and expectations. Several doctors just expect you to do a procedure [researcher asked: without an order?] Yes [emphasis on yes] even though it is illegal, [researcher asked: such as?] Foley catheters, PRN medications without orders, etc. You really need to have thick skin because so many of the docs will yell at you if you question their instructions. For example, we were required to do complicated procedures even though we did not have ACLS certification. The preceptors were too busy to help; they had their own patient loads and were more interested in training the resident nurses [new, orienting nurses]. Everything we do is about maintaining patient safety, and our licenses [emphasis added by participant] There is the added stress that you take home; there are the constant battles with doctors, other nurses, and administration. The lack of responsiveness from physicians is very frustrating. They do not respond to patient care needs, and you are left holding the liability. During the NOC shift [field notes: night shift], we had two patients coding. We completed two back-to-back intubations and the physicians would not do anything to support us. We did the best we could to keep the patients stabilized through the night……it was very stressful. You learn the right way of doing things in nursing school and clinicals, but the doctors and charge nurses expect you to do things on the floor that you know are not right. [Field notes: asking for an example] The charge nurse will assign a MRSA patient and an immune-compromised patient to you in the same shift. You can

> complain to the charge nurse and tell her that it is not right, but they are too busy. Many are too young and inexperienced, some just don't know [that the patient load is either too demanding or compromising], others just don't care. [Researcher asked: can you request to change patients if you feel that the load isn't right?] Yes, you can change to ease the risk of infection to patients and yourself, the charge nurses doesn't care, they are too busy

Nancy, a 30 year veteran nurse recalls the many changes in the nursing role:

> Thirty years ago when I began in nursing, care was much different. We did not have to sacrifice patient care. We are too much into the business model; we are having to change and shift on a daily basis to meet the constant outside demands. [Researcher asked: What are the greatest challenges of nursing today?] Well besides the staff limitations, the new technology…things are changing so rapidly

Robyn, a novice nurse with one year of experience agrees:

> There is a lot coming at you: the charting; id bands; patient verification. The tasks are sometimes too much; there are too many challenges…[thinking] The tasks conflict with patient care. It is a balancing act that gets in the way of the really important things, but it is tough to leave the little things. [Researcher asked: is time management crucial to the job?] I learned time management skills from my previous work – no one here taught me. The younger staff, like me, is more adaptable. The older nurses have a much more difficult time with the addition of the new tasks, just trying to assimilate the information; knowing that certain meds have to be given within certain guidelines then trying fitting everything into those guidelines is challenging

Peggy, a nurse with 27 years of experience, stressed that the constant changes are her biggest source of frustration:

> All the joint commission hoops and the constant changes…[thinking]…the constant documentation and the high expectation of wanting to do a better job, but knowing that you can't because of the time. Once, we would change the [patient's] bed, but now we have to minimize the linen use. There are a lot of frustrations with limitations on the resources. We are still expected to crank out the quality even with the increase in acuity. [Researcher asked: Has this contributed to your dissatisfaction with nursing?] Yes, for a lot of us. How many more things are they going to throw at us [emphatically]? They want the same quality…leave us alone and let us do our job. I am happy with my job, but the multiple demands are just too much

With 32 years of nursing experience, Linda expressed many of the same disappointments:

> The constant multi-tasking and increasing demands: we are doing so much more with less [Researcher asked: Such as?] Prioritizing the care – the patients and families are still expecting the same level of care even with all of the technical changes. The families are in denial, management doesn't know where we are coming from, and the patients are unrealistic

Jeanette has 15 years of nursing experience, and explained how she manages the multiple and conflicting demands on her shift, "Do what you can; it is really frustrating… [thinking]…you just can't do everything. I ask myself what can I dump that will not affect patient care."

Lack of Support

A general theme related to a lack of support emerged early during the data collection. Lack of support had a broad range and differed significantly among the participants, regardless of their socialization experiences. Common occurrences were delineated into five categories: administration, unit or charge nurse, peers, support staff, and preceptors.

Administrative support was characterized by broadly-applied policy decisions that added tasks and/or reduced resources. Nancy began her career 30 years ago, she explains:

> Many years ago we had plush staffing ratios. The financial crisis during the 1980s has required a shift in the patient care model, which drove patient care ratios down. Since then, the constant financial burdens have limited the staff, and we did not have to sacrifice patient care – it is too dangerous…[thinking] we have gone from a community of care to an isolation model

The constant financial constraints have contributed to the reduction in support staff requiring nurses to leave the bedside to attend to other duties. Tami explains:

> Administration frustrates me the most…they don't understand the hands-on part of our worries about safe staffing levels; they just worry about the money. Our facility tends to add tasks to nursing [Researcher asks: such as?] taking reception calls, cleaning patient rooms, things like that…because nurses do whatever is asked. This takes away from patient care

Carole provided a sense of overall administrative issues that she found troubling:

> Working with administration and people who oversee nurses despite their own lack of nursing knowledge; administration manipulates people to get their favorites into positions. I also get frustrated when I do not feel supported, not just for medical decisions, but for other related situations. We had a patient, an unemployed member of the community, who came to the emergency department for a sore throat and ended up with a $1200.00 bill that she could not pay. I referred her to accounting, and the employee from accounting was mad that I sent her because she claims that the patient ended up wasting 45 minutes of her time

Angie was quite blunt with her dissatisfaction toward administration. Working for a large healthcare system, she referred to them as "being out of touch." When asked for clarification, Angie explains further, "They are very out of touch with our community needs. They [administration] are not in our county…let alone in our world, yet they try to run things from afar." Peggy provided her thoughts related to administration and her perceived lack of support:

> It's the little stuff. The budget constraints impact our ability to provide patient care, the hospital is top-heavy with administration, yet we are the ones who are asked to cut. They ask us to take more patients with less resources, yet we are told to keep our patient satisfaction scores up

Unit or charge nurse support referred to the level of leadership support at the unit level. Lack of support from unit or charge nurses was widely referenced from participants. For example, participants who spoke to this lack of support referred broadly to supervisors who allowed negative or disruptive behavior to occur within the unit. Monica's sense of being *unsupported* appeared to be deeply distressing to her, she

commented, “There is a lack of recognition, support, and praise; [the nurse manager] has a history of driving out staff.” Carole experienced a complete lack of support from the unit manager while trying to learn new procedures within a new unit, “The nurse manager gave me 12 hours to learn the clinical policies and procedures for a unit that I had never worked in.” Tami had a supportive preceptor, but after she moved to night shift she felt alone, abandoned by the charge nurse:

> I had a great preceptor during the evening shift, but when I started on night shift, the lead RN [charge nurse] would go outside to smoke or read while I worked alone. [Researcher asked: How did this make you feel?] I felt very alone and without a friend. On opposite days I had friends who worked as a team--they did everything together and were much happier than I was [thinking]…..they were less afraid

Kim, explained that support was situational, dependent on the charge nurse:

> It would depend on the charge nurse or who else was on the floor; most of the other nurses were just too busy. If there was no one to answer questions or provide assistance you could call the nursing supervisor – though they were usually only there during the day shift. If you work evenings or nights you are on your own

A lack of peer support represented “cliquish” relationships among nurses within the unit. Novice nurses specifically addressed the lack of peer support that occurred within the unit. Monica discussed her experience as a new employee, “new people get dumped on; it is very lonely.”

Kim also experienced the lack of support from peers. As a novice nurse, Kim expressed quite a bit of anger towards fellow nurses for their unsupportive behavior, “They want you to figure it out on your own; nursing is the survival of the fittest. There really is no one to provide resources.” Carole’s experience mirrored her peer

participants: even as a veteran nurse, she felt completely *unsupported*. "Staff was not supportive or at all caring, no one was there to mentor me."

As a novice nurse, Marla was frustrated from the lack of support she received from peer nurses in the unit:

> There is a lack of support from peers in my unit. I moved to the day shift because it was a more supportive team. I am much happier with the nurses who are willing to mentor me. I was very dissatisfied on the evening shift. So many of the older nurses believe in the baptism by fire method, they will just stand around and talk while the new nurses are working very hard. This jeopardizes patient care; it is the scary part of the profession. This lack of professionalism amongst peers and co-workers, this unprofessional conduct gets in the way of quality patient care. You rely on others to help you along, and when it does not happen it is a very scary thing. People come to you and place their lives in your hands…[very seriously]…that is not a small thing

Tracy expressed her gratitude for having a residency program to help her transition from student to nurse. She expressed the lack of support she experienced on the floor:

> The lack of support on the floor has driven some out, even with the residency program. There really was no one consistent to seek out and get answers from. It varied by day; some days I just had to make in on my own. They [peer nurses] would belittle you and be abusive, not supportive or safe at all

Linda expressed frustration with the resistance to change by her peer nurses:

> There is a culture on NOCs [night shift]…[very thoughtful]…so many are resistant to change. Their exterior is so [emphasis on so] thick they will not open up. You really have to prove yourself as a nurse, then they will open up

Lack of support staff related to the loss of ancillary employees, CNAs, health unit coordinators, and so forth, who completed non-nursing tasks such as ancillary paperwork, vital signs, and activities of daily living. As a veteran nurse, Elizabeth has years of clinical experience, but moving to a busy medical-surgical unit proved to be a highly stressful experience:

> There is just too much work and not enough people to get everything done. The lack of staff and a full-house when there are a lot of admissions – this makes the job more demanding and much more challenging

Monica moved from a large hospital to a smaller community hospital. In addition, she moved from a cohesive OR unit to a busy and less-staffed oncology unit. When critical care beds were at capacity, administration sent critical patients to the oncology ward, this added to the overall patient load and increased stress. Monica explains, "Now that I am at a smaller hospital they lack support staff; the unit is often short-staffed."

Despite her positive socialization Jennifer realized during the interview the lack of support staff was the greatest contributor to her dissatisfaction, "[thinking]…I guess I just realized that my level of dissatisfaction really comes from the lack of support staff; doing all of the extra tasks is stressful and it takes away from patient care."

Robyn entered nursing a little over a year ago, as a novice nurse she explains that the lack of support staff adds to the challenge of providing good care:

> it makes it challenging to do the extra care, the vitals, hair, etc. Three patients is fairly comfortable, four patients makes it very challenging. It is the manic events --just one thing can occur that can throw everything off. [Researcher asks: Like what?] An unexpected occurrence with a patient that you thought was stable, those types of events. Without any staff [support] it is really tough to get the important stuff done

Though a veteran nurse, Tami only been employed by one hospital throughout the duration of her career. She explained that it was the surprise occurrences, such as unexpected labor or codes that she felt least prepared for because "we had to do these on top of our regular assignments and needed to learn great prioritization."

Finally, the lack of preceptor support referred to the lack of a supportive preceptor during participant residency or orientation. The role of the preceptor varies by hospital,

but the function is primarily that of a new employee liaison. The preceptor's role is to orient new staff to the unit, providing them with a clinical and procedural overview. Unfortunately for many nurses, not all preceptors have the resources to adequately function effectively in this role.

In her interview, Deena, a fairly new nurse, mentioned that she was taking a preceptor class so she could help orient new nurses. Deena had a positive experience, but shared that "a lot of nurses taking the class said they wanted to be preceptors because their own experience was so bad."

Participants most frequently cited the inability of the preceptor to provide adequate attention to new employees as many worked in the capacity of both preceptor and staff nurse. This reflects Monica's experience, "She was always in a rush and couldn't be found; she was just too busy." Kim, who experienced individual socialization, explained how tools and resources were completely lacking in her unit. In an effort to be more successful as a novice nurse, she created her own tools, she comments:

> the preceptors didn't sit down with you and help you organize, it was something you had to do on your own. [Researcher asked: such as?] You had to develop your own tools. I created my own patient history form, but I can only complete it before or after my shift--there is no time to do it during the shift. The preceptors are still working with patient loads; they do not have the time to help you with organization or teach you new procedures

When asked if she felt comfortable asking for clarification or help from her preceptor Tami commented, "No; I felt like after the 'see one, do one, teach one,' I should not have to ask for help if I had seen it or done it once before."

Role and Knowledge Content Transfer

Participants reported a lack of structured knowledge transfer related to expectations, patient care, and operational procedures in a specific unit or hospital. Without adequate and specific content knowledge many participants were unable to perform the tasks according to policy. This adds stress to nurses by compromising patient care and licensure. As a result, nurses felt the stress associated with changing roles, increasing tasks, conflicting expectations, and the risk associated with liability ownership and loss of licensure.

Monica recalls her experience moving to a new hospital and different unit:

> There is very little in nursing education that prepares you for nursing. On the unit, there was *nothing* [stressed], *nothing* in place. No guides or checklists. I was not allowed to spend time looking for or reading policies and procedures. I was told not to read critical procedures because they were all changing, but I needed something to go by, even if it was an old policy. There are no meetings; even if they are scheduled, everyone is too busy to attend, or they are after your shift, but we cannot get paid overtime for attending…there are no in-services or updates…[thinking]…we are without any direction or organization. There is *nothing* [participant emphasis]: you are just put on the floor and expected to go. The nurse is alone on the floor – even during orientation. The manager is never around to ask questions, and the preceptor is usually too busy to help; they just shout out an answer over their shoulder. There are pressures of being an experienced nurse, even while orienting to a new unit and hospital; one nurse manager wanted me to work alone even though I was still orienting

Sharon, another veteran nurse recalled her experience as a novice nurse entering the cardiac unit, “Nothing…[thinking]…it is come in and get to work. After three weeks I started working with my own patients.” Other participants, both novice and veteran, support Sharon’ experience. From Sarah, a novice nurse with little experience, jump in and go – no structure [to unit orientation] at all”. From Monica, a veteran nurse with 32 years, “There really was nothing, you just learn by doing, watching, and observing.

You often don't know the details, you just do what you can…[thinking]…there is just no time."

Jack, also a veteran nurse agrees:

> The orientation checklist was not taken seriously; you had a few days to get used to it after that you were on your own. New nurses usually start on evening shift, when there are fewer resources [Researcher asked: how do nurses get answers to questions with limited resources?] Someone observes a problem and the new nurses are generally counseled [Researcher asks: is this seen as punitive?] Yes, it is not constructive …we wait for something to go wrong and jump at the chance to punish that nurse. Sometimes you do a new skill completely independently, even as a new nurse…the assumption is that you know how to do the skill. Most get though it, but there is no way of knowing if you did it right or wrong …[pausing]…nurses don't do the wrong thing intentionally; they are afraid to ask for help because they are afraid they will be fired or punished [Researcher asked such as?] Oh…loss of hours, etc.

In most cases, both novice and veteran nurses experienced socialization processes that lacked structured knowledge transfer. When asked if her clinical experience prepared her for nursing, Kim discussed the difference between her clinical rotation and transitioning into a unit as a novice nurse:

> Some of the procedures were different [from clinicals]; the hospital takes a 'show you' approach – we had three days of classes and worked with a preceptor during that time, but there was no one to give me resources or tools: we just had to figure it out for ourselves. There are no distinguishing degrees of knowledge; novice nurses are expected to do difficult procedures without adequate in-service or guidance. For example, we were required to do complicated procedures in the medical-surgical unit even though we did not have ACLS certification. The preceptors were too busy to help; they had their own patient loads

When asked if the participant felt comfortable asking questions or for guidance, Kim replied:

> It would depend on the charge nurse, or who else was on the floor. Most nurses were just too busy [from field notes: the frustration of the participant was obvious]; if there was no one to answer questions or provide assistance you could call the nurse supervisor, though they were only there during the day shift. They want you to figure it out on your own, nursing is the survival of the fittest. There

> really is no one to provide resources. If all else fails and you have a patient who is de-compensating or coding, you can call the rapid response team

Monica, a veteran nurse with 32 years of experience, explained her transition to a new unit and hospitals. Despite her years of nursing, Monica's socialization experience was minimal at best, and left her feeling desperately alone and confused about her new role. The researcher sensed that Monica felt betrayed by her fellow nursing professionals (from field notes):

> There was someone who was my preceptor, but she was always in a rush and couldn't be found…she was always too busy. Everyone was nice, but they did not have the time to help you…[from field notes: participant leans in, while thinking]…they want to help, but there is no time

Even those participants with years of experience still refer to the anxiety associated with unit changes due to multiple unknown and sometimes conflicting variables. Sharon, a 32 year veteran with a positive experience reports:

> [without hesitation] I am least satisfied when I float to other units or have all discharges and re-admits in the same shift. [Researcher asked: Why?] There are too many unknowns; you cannot do a good job when there is this much change in one shift…nurses have a self-expectation about the level of care they can and will provide

Carole, a veteran participant, relates her very recent experience. Carole took a part-time position at a nearby hospital to improve her clinical skills in obstetrics due to the severe shortage of obstetrics nurses in her rural hospital:

> I recently took a part-time position in OB at another hospital, to learn about OB and delivery. We have a severe shortage of OB nurses at our hospital, even though there are only 40 babies born at our hospital a year. I didn't last long. I was doing a preceptorship; the nurse manager gave me 12 hours to learn the clinical policies and procedures for a unit that I had never worked in. I was expected to work on the floor on my second shift. On my third shift, I was expected to float to critical care. Because I have years of experience, they just expected me to pick up and work in a hospital and unit I had never [stressed never] worked in before. Staff was not supportive or at all caring; no one was

> there to mentor me. This was a tremendous liability and licensure issue, working with newborns without any exposure to this type of nursing. On my day of orientation, I asked to review policies and procedures and I was written up [Researcher asked: were there tools or resources available?] No, there was nothing, nothing in place to ensure I could do the work. There was no ability to learn the critical processes of delivering or caring for babies

Carole was visibly upset, and raised her voice during the relaying of this incident (from field notes).

Peggy's second nursing role occurred after she transferred to another hospital, and began working in a new unit. She related her experience:

> I came from a larger center to a smaller hospital; the first question they asked me was how soon could I start. I started in the OR; it was the only job available. There was no orientation or transition. I knew nothing about the unit, and I had to go find things that had no idea about. Working with these nurses was extremely hard

When asked if she felt comfortable asking for help during her initial time as a new hire she replied:

> I was made to feel that I could not ask; it was very taxing. They thought I should know their job, but it means noting when you don't know what anything is or where things are. I was very dissatisfied as a nurse at that point and I was looking for other jobs outside of acute care. I respected the fact that these nurses had more experience. The most difficult part of my life career-wise…there was a total lack of support, there was one person that was really hard on me…it was very cliquish. Don't ask how I did it; they were some of the most difficult people. I hung in there long enough: I was pregnant, and knew I wouldn't return. I wanted to get back into critical care nursing, to be providing care rather than in OR. I moved to a different hospital after I had my baby

Mentors and Mentoring Experiences

Participants who experienced a more supportive, institutional socialization reported an easier transition to the nursing role and/or unit. Additionally, they acknowledged better role clarity and content knowledge in relation to patient care

priorities and conflicting demands. Those most satisfied indicated an overall positive socialization experience punctuated by a highly supportive environment with multiple resources available for on-going, structured clinical experiences and role guidance. For many participants, a supportive preceptor acted as mentor; for others, it was a unique bonding experience with a veteran nurse within the unit who acted in the capacity of an ad hoc mentor.

Sharon's experience appeared to be somewhat unique, as she experienced a Structured mentoring relationship during the last quarter of nursing school, "I spent the entire last quarter [of nursing school] working one on one with a nurse mentor. By the end of the quarter, I was completely prepared to take on my own patient load."

Sarah, a veteran nurse, also had a positive mentor experience. Sarah's familiarity with nursing stemmed from her experience under the guidance of a supportive mentor:

> Without a mentor my experience would have been totally different. Nurses cannot succeed without a mentor – even someone to watch. We need someone to teach us the tricks of the trade. My mentor taught me how to be an OR nurse …about using equipment, instrumentation, etc. She was there to see that nothing bad happened to me – there was so much more to learn than what we learned in school. Preceptors need to be advocates for nurses, so we can be advocates for our patients

The interview with Sarah was interrupted for an urgent patient need. Sarah was very calm and certain of herself. She did not flinch when presented with the challenging situation; she sat back and had a very casual if not self-assured air about her (from field notes).

Like many others, Diane had the support of a mentor during her early days as a nurse:

> as a new nurse I was mentored by a few nurses I worked closely with. It was a very helpful for me to be a successful nurse. It impacted me personally and professionally, that stayed with me for my entire career. [Researcher asked: how so?] They told me how to be a nurse, how to behave, what my responsibilities were, when to contact physicians, when to question their orders, stuff like that

Jennifer, a novice nurse, discussed the uncertainty she experienced during her initial residency. Despite her close-to-ideal socialization experience—she benefited from a supportive mentoring relationship, structured approach, and ongoing support--Jennifer still experienced uncertainty and anxiety. She explained how mentors supported her during this transition:

> As a new graduate things were uncertain – there was a level of uncertainty and anxiety. Even after graduating there were a few drop outs in the residency program…[thinking]… it is just hard. I had a lot of support from my mentor: I cannot imagine entering nurses with it [mentor support]. It really helped having someone in that role. It helped with the fear and anxiety of nursing. I felt so relieved. During the residency period we were assigned to a mentor. The mentor covered everything from paperwork, routines, charting, etc. It was very helpful; we learned about completing paperwork and locating policies. In addition to our mentors, we have nurse educators and resource nurses, you can go to these resources anytime without any negative repercussions …they [the hospital] want you to succeed

Jennifer was very excited about her nursing career, and the support she received from both the hospital and her mentors. Furthermore, she was eager to discuss her experience and appeared happy and calm throughout the interview, repeatedly praising her employer for the support she received (from field notes).

Though Kim's initial exposure to acute care nursing was rocky, she described how a mentoring relationship developed after her move to dayshift:

> Once I got to dayshift, there was one nurse who I bonded with. She really knew how things worked, like which doctors I could go to with a question, which ones I could call at home, which ones I could joke around with

Elizabeth, also a veteran nurse, recalled her close relationship with a mentor:

> When I first started nursing, there was a charge nurse on the evening shift who loved to teach. She taught me so much; she was such a good nurse. She didn't care about getting more education or other degrees; she only cared about taking care of patients. The docs loved her because she was extremely good, and a great patient advocate. She really provided me with a solid grounding in nursing; she taught me many clinical skills. It was a very interesting "mini residency." She was the reason I stayed [participant said smiling]

Though Elizabeth had an encouraging mentor who supported her early work in the nursing role, she lacked a mentor when she transitioned from one role to another within the same hospital. This lack of support left her with considerable frustration and angst (from field notes).

Mindy recalled a similar experience, and reflected on the role of mentor when she encountered her first patient death:

> I remember two nurses who took me under their wings and helped me to learn the scope of oncology practice. They were very supportive with my very first patient who died. They were patient and did not make me feel stupid about the many questions I posed

Angie, explained how having access to mentors helped her "figure things out":

> There were a couple of people, nurses, who helped me figure things out as we went along. These were a great source of information and helped me to understand how to operate within the system [health system]. They helped me get through. This job was too much of a shock. There wasn't anything good except for the patients, the encouragement I got from them helped me get through. It would have been horrible without them [the mentors]

Nancy also credited her mentors with her success:

> I have vivid memories of outstanding mentors. Without that support I would not have been successful. One in particular protected me from other nurses and physicians. [Researcher asked: Protected you, how so?] She helped me understand how it really worked, which doctors I could go to for assistance, which nurses would be supportive

Finally, Jack recalled his experience with a mentor and how mentors provided Novice nurses with "Ah Ha" moments of nursing:

> Yes…[thinking] a rare, but really cool experience. You are learning constantly [as a new nurse]. Having a mentor, even for a short period of time, really helps, and speeds up the learning process. An hour spent with an experienced mentor is really helpful [Researcher asked: what would they coach you on?] Effectively cutting corners, the Ah Ha moments [thinking]. They were very valuable

Like Jack, the support of a mentor provided Marla with a growth opportunities and a greater sense of understanding:

> One that I bonded with, she was there to guide me through the good and the bad. She provided me with the opportunity to see patient care in a more global sense; she was always there to help. I felt more professional and safe and had much more growth as a result. I cannot imagine not having this level of support

Linda was grateful for the encouragement she received from her mentor after entering the cardiac unit:

> I came to the cardiac unit without any experience. I was comfortable working in the ICU, but not in cardiac care; everything was new. There was no preceptor program, but I was to work closely with the unit supervisor. She quite three days later and I was on my own. The LPN, who had years of experience, mentored me into the unit…when to push a med, when to call the docs. She encouraged me to always ask questions; she was very experienced, and I never felt that I had to it myself

Summary

Chapter 4 presented the findings from the grounded theory research, answering the central research question: to what extent does individual socialization contributes to nursing dissatisfaction. Participants for this research were 20 nurses from a variety of health institutions representing acute care facilities in Washington State. Qualitative findings were presented at length, representing the voice of the primary participant in this

research: nurses. Their interview responses developed into research findings that will be highlighted in chapter 5.

Emerging patterns from data collected through interviews was reflected in the trends presented within. Unmet expectations, though not a predominate finding, did provide insight into the role that personal expectations play in transitioning into the role of nurse. While not every participant had personal role expectations, those who did transition more easily when socialized with a supportive mentor. Dissonance related to expectations was greatest among the participants who were socialized in an individual approach.

Role stress was a predominant theme and played an active role in dissatisfaction among nurses in this study. Roles stress was recorded in the narrative from every participant, even those socialized in manners consistent with the institutional model of socialization. The ambiguities experienced by even veteran nurses were a frequent occurrence of stress among the participants.

Lack of support was a significant finding of this research. It included lack of support from peers, managers, and administration. This finding demonstrates the inconsistencies found in socializing nurses not only at the organizational level, but also within the entire profession. Additionally, the overall lack of support demonstrates a lack of leadership at the unit level of charge nurses and unit managers to motivate teams, moderate change, transfer knowledge, and manage organizational citizenship.

Consistent with the lack of support was the prevalent unwillingness of veteran nurses to share or transfer knowledge to new nurses. Demonstrated by the lack of

support from peer nurses, knowledge transfer is essential not only to successful inculcation into an organization, but also for quality patient care.

Finally, the role of mentor was a significant finding in this study. Mentoring affected the participant's ability to develop successfully as a nurse entering practice, a unit, and/or the organization. As it occurred among the participants, mentoring was a highly organic, almost serendipitous bonding transaction between a nurse entering either practice or a unit and a unit veteran. Those participants mentored in this study had fewer instances of dissatisfaction and role dissonance than nurses who were left un-mentored.

Chapter 5 will present the study results, conclusions, and recommendations. There will also be a discussion related to study implications presented in chapter 5.

CHAPTER 5. RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this research study was to understand the implications of socialization on nurses' as they enter the role. The 20 nurses interviewed for this grounded theory study revealed that socialization played heavily in their inculcation into nursing, the unit, and/or the organization. As discovered in this study the concept of "entering" nursing is broader than simply entering the role. Entry into nursing at any point, be it role, unit, or organization, was demonstrated to have a significant need for knowledge transfer. The importance of knowledge transfer was crucial in order for nurses to participate both adequately and successfully in the role and provide patient care in accordance with personal, organizational, and societal expectations.

The validation of this study included triangulation through the collection of analysis of qualitative data collected from nurses active in acute care nursing, audio-taped interviews, member-checking, extensive narrative, and current literature. A broad theoretical explanation of nursing satisfaction was determined by this research study. The grounded theory strategy utilized by the researcher developed a theory of understanding nursing dissatisfaction from an organizational behavior perspective grounded in nurses' perceptions. Patterns and themes emerged to answer the central research question, "To what extent does individual socialization contribute to dissatisfaction among nurses"?

Summary of Results

The intent of this study explored if and how unmet expectations contributed to disparate expectations and professional dissatisfaction among acute care staff nurses. Additionally, this study explored how individual organizational socialization cultivates dissatisfaction through a systematic failure to meet the organizational needs of nurses as they enter the workforce, either as novices or veteran nurses.

The basic premise of socialization holds that complex roles with a reliance on rigid procedures and complex tasks require more socialization than less structured roles. Nurses operate in increasingly complex and regulated environments. The nursing role is rapidly adapting to meet the demands of the consumer market, of current operating structure, and of regulatory requirements. The increasing regulatory and market demands continue to add complex tasks to nursing roles.

Electronic healthcare records (EHR), for example, are being mandated in many states. The EHR initiative will eventually provide more streamlined processes and notifications while improving patient care, but the increasing complexity associated with the transition from paper records to electronic ones will require nurses to become more proficient in electronic data records as part of their patient care routine. Adding to this complexity are other initiatives related to National Patient Safety Goals (NPSG) prescribed by JCAHO and patient satisfaction goals as assigned by the Federal government.

The primary learning model for nurses occurs on the job. While nursing school prepares nurses to understand the human body as a system and to introduce basic clinical skills, most participants reported that nursing school did not adequately prepare them for

practice. The first acute care residency is a time for novice nurses to develop existing clinical skills, while learning additional clinical skills not learned during their clinical rotation. To this end, mentors played a significant role.

Mentors provided valuable insight and support relative to patient care priorities, relationships with other healthcare providers, charting and documentation, patient management, and basic nursing practice. Mentors also provided role clarity, illuminating the multiple and conflicting expectations placed on nurses.

Varying degrees of nursing priorities emerged during the interviews. Novice nurses were heavily reliant on mentors for support related to skill development and validation. For novice nurses, clinical skill development and role clarity were important for a successful professional and organizational inculcation. Furthermore, for those nurses who entered the profession with prior role expectations, the serial tactic, or mentoring, associated with institutional socialization provided additional clarity. Nursing in acute care units today includes additional tasks and demands not readily associated with patient care. Understanding how these additional demands fit into the overall scope of nursing and how to reconcile these demands was determined to be essential to assimilating into the nursing role.

Veteran nurses differed in their socialization needs. Veteran nurses, those with developed nursing skills, were more reliant on the "operationalizing" their existing clinical skills and knowledge, and were therefore more reliant on policies, procedures, and documentation. Today's healthcare environment requires adherence to tightly controlled practices due to increasing regulations and liability. For that reason, clinical practices are driven by policies, procedures, and extensive documentation:

> Nursing skills are the basis of our practice, but a nurse is held to the clinical protocols; it is the basis of the facility and nurse liability. Every facility has different policies, some more aggressive than others, but they define care (Weiderholt, K., RN, personal conversation, 3/29/2007)

Jack agrees, noting that "acute care has placed a heavy burden on the adherence to policy rather than the basic principles of nursing." For veteran nurses changing roles, units, or organizations, the specific content-related knowledge related to the linear nursing processes and unit/organizational procedures appeared to be more important. Mitigating liability ownership was also important to veteran nurses, while the subtleties of patient care and time management appeared to be more important to novice nurses.

The only exception to this appeared to be the development of new clinical skills for veteran nurses, despite existing knowledge. Entering a new unit that required new skills, such as, moving from a medical-surgical unit to obstetrics, proved to be stressful for veteran nurses. Veteran nurses struggled with unit transfers when new clinical skills were required.

It is recognized among nursing practice that certain units, such as operating room (OR) nursing and obstetrics, require additional, specific clinical skills. These units have in fact established and implemented standard socialization practices to prepare nurses adequately. The OR is one such specialty unit and has recognized the need to provide comprehensive practice inculcation to nurses. As such, OR nurses receive a greater degree of socialization than nurses in other units. As described by Rodriquez (1997), OR nursing has expanded beyond basic assessment and care, encompassing "a more comprehensive preoperative approach to the surgical experience of the patient" (p. 2). This approach includes perioperative (pre), intraoperative (during), and postoperative

(after) surgery. Because of the specialized patient needs, and collaborative OR environment, Rodriquez stresses that OR nurses be re-socialized into the specific norms and practices of a specialized unit. This is verified by participant Sarah, a 32 year veteran of OR nursing at a local hospital:

> I worked with a [nurse] mentor who taught me a lot. The patient load is very different in OR: there are more one-to-one nurse-patient relationships. We have more time to learn. There was also a physician who taught me a lot about scrubbing-in, anatomy, etc. As OR nurses, there is so much more to know, like technical equipment, instrumentation, re-positioning, and being aware of your own body--like learning not to put your weight on the patient if you are leaning over them. Without a mentor my experience would have been very different! Nurses cannot succeed without a mentor; there is so much to learn. We need someone to watch – to learn the tricks of the trade

The lack of mentoring that Monica received may also explain why she experienced such discomfort and stress with her transition from the OR at one hospital into an oncology unit at another:

> There is nothing, nothing, [emphasis on nothing] in place to prepare nurses for entry into the oncology unit. No guides, no checklists. I was not even allowed to spend time looking or reading related policies. I was told not to read critical policies, because they were all changing, but I needed something to go by even if it was an old policy. There are no in-services, updates, or communication…[thinking]… we are without any direction or organization. There really was nothing; you just learn by watching and doing, and observing. You often don't know the details; you do what you can…there is no time

Likewise, the lack of mentoring explains why Carole felt that she was compromising her nursing license and endangering mothers and newborns as a result of her inadequate socialization into an OB unit.

Conclusions

The summary of results of this study of nurses within acute care demonstrated the need for the consistent application of socialization for both novice and veteran nurses. The findings of this research supported the current body of socialization literature. Additionally, this study demonstrated that nurses were more dissatisfied with their role in situations in which they did not receive adequate socialization. While the mentoring component and knowledge transfer played significantly in socializing nurses, other variables emerged necessitating a much greater degree of potential need in acute care enculturation. The variable was mainly supportive leadership abilities at the unit level (table 9).

Novice nurses entered the role with varying degrees of prior expectations. Those socialized in the institutional model indicated that they were better prepared to practice nursing than those nurses who did not receive adequate socialization. Further, those nurses socialized in the institutional model did not share the same level of anxiety or overall dissatisfaction, despite their prior role expectations. The serial tactic of mentoring helped mitigate role stress associated with nursing. Mentors guided novice nurses through patient care and time management, tools and resources, and unit specific navigation. Novice nurses who did not have the coaching and support of a mentor reported feeling lost, alone, and uncertain of how to manage patient care and related tasks.

Veteran nurses entering a different unit and/or organization were more reliant on content. Policy and procedure familiarity appeared to be a significant factor in socializing veteran nurses. Of the three veteran nurses who were not socialized

institutionally, the concern about liability and licensure loss influenced their decision-making and contributed to a palpable level of stress and anxiety.

This study also revealed the lack of leadership present at the unit level. The non-supportive unit culture expressed by lateral violence and knowledge hoarding is consistent with lack of leadership abilities by both unit and/or charge nurses. The influences of effective leadership are important to enhancing a supportive unit and organizational culture that sustain effective communication and knowledge transfer.

Leadership

Leadership has been addressed in the body of nursing dissatisfaction literature as a means of allowing the continuation and escalation of nurse-to-nurse violence (Jackson, 2002), and for its non-participatory style (Moss & Rowles, 1997). The lack of support associated with the participants in this study reflected a base line need for leadership among preceptors, charge nurses, and unit managers. The nurse-to-nurse or lateral violence commonly reported by nurses in other research (Jackson et al., 2002), coupled with the lack of support noted in this study, reflects power vacuums, which can occur in the absence of leadership (Eisenhardt, Kahwajy, & Bourgouis, 1997a, 1997b). Lack of leadership frequently promotes coercive power or bullying and other acts of poor organizational citizenship (Eisenhardt, Kahwajy, & Bourgouis, 1997a, 1997b). Employees without a legitimate power base therefore become incapable of effecting change.

Table 9. Nursing Dissatisfaction Model in Acute Care Settings

	Role Stress	Individual Socialization	Lack of Leadership
	Conflicting or ambiguous expectations, demonstrated by:	A lack of consistently applied assimilation practices, demonstrated by:	Lack of support at the unit level, demonstrated by:
Nurses enter: Practice, Unit, and/or Organization	Pre-existing role expectations, and/or Uncertain of role upon entry, and/or Lacks clear direction, and/or Lacks tools/resources the "how to" of nursing, and/or Conflicting expectations from unit/organization, peers, physician, patient, family members .	Lacks structure, formality, and a timeframe, and/or Lacks knowledge transfer, and/or Lacks mentor support, and/or Inconsistently applied to units, organizations, and/or field, Known to increase role stress, Known to decrease organizational commitment.	Creates power vacuums and potential for coercive power base, and/or Perpetuates nurse-to-nurse violence, and/or Establishes a basis for poor organizational citizenship, and/or Encourages knowledge hoarding, Increases overall organizational stress, Known to decrease organizational commitment.
Dissatisfaction increases ⋯⋯▶			

Leadership is essential to the establishment of a supportive culture, and must not be overlooked as a central feature of knowledge transfer (Block, 2003; Lang & Wittig-

Berman, 2000). Effective leadership also empowers, motivates, and inspires collaborative practices (Knutson & Miranda, 2000) promoting knowledge transfer and communication.

Organizational commitment and citizenship has been identified in the body of literature as an important component to both organizational longevity and benevolent behavior. Commitment refers to the engagement of an individual towards fulfilling organizational goals and dedication to organizational values.

Lok and Crawford (2001) identified three types of organizational-employee commitment: affective; continuance; and normative. The first, affective commitment, is related to an employee's attachment to the organization; the second, continuance commitment, is related to the utility or cost of exit associated with either staying with or leaving the organization; and the last, normative commitment, refers to employees' feelings of obligation to an organization. Each is important in its own right for continued employment and good organizational citizenship. To maintain a dedicated workforce, stress Lok and Crawford, organizations must strive for all three.

According to Lambert (2000), individual commitment exceeds the hygiene factors of organizational benefits: committed employees have basic needs that must be met in order to achieve organizational commitment. Individual needs such as employee security, organizational structure, and information sharing are all positively correlated to affective, normative, and continuance commitment (McElroy, 2001). In an earlier study, Withey and Cooper (1998) identified the importance of employee "voice" as an important element for establishing and maintaining organizational effectiveness and loyalty.

Attrition and dissatisfaction are reported to be the greatest in acute care settings. A variety of characteristics contribute to dissatisfaction and constant turnover as nurses move from acute care facility to acute care facility. With so many nurses exhibiting role stress, leadership at the unit level should be considered as a factor in nursing dissatisfaction. Furthermore, the challenges to acute care facilities require not only immediate attention, but immediate action to alleviate unnecessary nursing attrition.

Knowledge Transfer

The findings in this study also concluded that nursing lacks knowledge transfer within units or acute care cultures. According to Eisenberg and Witten (1987), open communication will vary departmentally based on leadership traits and abilities. Their assessment of openness in organizational communication lead them to the discovery that based on followers' perceptions of leaders, related interactions may stifle mutual dialogue and knowledge transfer. Employees working for managers with poor leadership abilities, such as, management by exception, were more inclined to conform, thereby avoiding disapproval and negative feedback associated with organizational retribution (Coad & Berry, 1998). This deviation from openness may be intended to preserve the individual's self interests, or to decrease lateral violence.

McElroy (2001) encourages the use of widespread information sharing as a practice to increase organizational commitment. Information sharing enhances trust and openness, as well as perceptions about organizational importance and stature. Individuals given preferential treatment with organizational information may hold erroneous perceptions about their own power within the unit or organization, thereby self-enhancing

their own status. This enhanced sense of self can contribute to unsuitable behavior by the persons who consider themselves to be holding power.

According to Anakwe and Greenhaus (1999) experienced employees play a vital role in the knowledge transfer and socialization process for new employees. Experienced employees, they discovered, play a vital role in preparing newcomers to master tasks and roles, function within the unit, and realize the culture.

Based on findings in this study, it is possible that veteran nurses at the unit level withhold vital information necessary for an adequate socialization experience of newcomers. This is evidenced in the study by comments made by participants who felt *unsupported* by peer nurses. It was reported by participants that veteran nurses would stand by watching novice or newcomer nurses struggle to gather information or tools necessary to perform the job. The non-supportive behavior demonstrated by withholding information provides further evidence to suggest that lateral violence among nurses is perpetuated by the lack of unit leadership and the inability to recognize and impede abusive organizational behavior.

Role Stress

A significant finding in this research was the role stress associated with nursing. Role stress contributes to increased anxiety, which in turn has been demonstrated to reduce critical thinking abilities among employees. Reio and Callahan (2004) reported the trait and state that anxiety negatively impacts curiosity and critical thinking abilities, thereby impacting socialization-related learning and job satisfaction.

The stress and anxiety associated with organizational entry was found to amplify covert information-seeking among some unit members, leading to inadequate knowledge assimilation in some cases. Finklestein, Kulas, and Degas (2003) presented findings that younger employees will tend to seek out information in a covert fashion, and are often more concerned about impression management. Younger, novice employees, they found, were more worried with relationship building than with adequate knowledge seeking. Additionally, covert information-seeking was related to decreased role clarity.

The consistent findings of role stress among the participant population in this study indicated that role stress is perhaps more significantly tied to the role than originally thought. The body of socialization literature has consistently concluded, and in many cases demonstrated (Ashforth & Saks, 1996; Ashforth, Saks, & Lee, 1998; King & Sethi, 1998; Klein & Weaver, 2000; Reichers, Wanous, & Steel, 1994), that institutional socialization models have diminished role stress. Conclusions from this study, however, indicate that despite mentor support and knowledge transfer, nurses remained conflicted about the role.

Institutional Socialization and Mentoring

This grounded theory research revealed the majority of participants was relatively satisfied. Those who reported satisfaction received adequate socialization and placed profound reliance on a mentor assisted their assimilation into the unit and organization. The need for institutional socialization eases anxiety and dissatisfaction associated with role stress (Ashforth & Saks, 1996; Ashforth, Saks, & Lee, 1998; King & Sethi, 1998;

Klein & Weaver, 2000; Reichers, Wanous, & Steel, 1994) by providing the content knowledge necessary for complex roles (Cooper-Thomas & Anderson, 2002).

Mentoring, the serial tactic of institutional socialization, has been established in the socialization and mentoring literature as an aide to reduce the stress and anxiety associated with organizational entry. This study affirmed the use of mentors to aid in knowledge transfer and assimilation within the nursing profession. The use of mentors reduced dissonant expectations, increased job satisfaction (Hayhurst et al., 2005; Ostroff & Kozlowski, 1992), and increased organizational commitment (Payne & Huffman, 2005).

According to transformational leadership theorists, the ability to support an employee through idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration is highly successful through behavior modeling and motivation (Northouse, 2004). When appropriately applied, the mentoring tactic provides all of the elements of transformation leadership necessary to transform behavior of both peers and newcomers, creating an environment more conducive to knowledge transfer. Gibson (2004) encourages mentoring to re-embrace the psychosocial constructs of mentoring that prepare newcomers through acceptance, counseling, and friendship, items frequently lacking for newcomers in the nursing units. Despite the widespread instances of nurse-to-nurse violence and abuse, acute care nursing units are exceedingly busy and demanding places offering few opportunities for social interactions. The role of mentor can potentially alleviate the loneliness of entering a busy unit as well as providing organizational assimilation.

Recommendations

Based on the knowledge presented in this research, the use of institutional socialization for nurses entering either the unit or the organization does improve satisfaction by reducing the stress and anxiety associated with dissonant expectations and role stress. According to the nurses in this study, the lack of a mentor and/or content specific knowledge contributed to unmet expectations, stress, and overall dissatisfaction. In general, participants lacked the tools and resources to effectively manage the conflicting demands and expectations of varying stakeholders. Research presented in this study reflects the need for increasing the availability and application of socialization as a means of ensuring adequate support and knowledge transfer. In some cases, this may mean customizing socialization programs based on individual need rather than a one-size-fits-all approach. Nurses entering the role with preconceived ideas about nursing may want to seek out additional resources better understand the role of nurse, and of healthcare system. Additionally, socialization practices should be considered for adoption by acute care units hoping to reduce voluntary turnover and build a tenured and committed workforce.

Joint Commission NPSG number two stresses the need for improved communication among caregivers. In an effort to improve communication among nurses, organizations should be willing to develop nurse leaders who can alleviate lateral violence and improve patient safety through enhanced communication among nursing staff.

The lack of consistently applied industry or practice standards to effectively assimilate nurses entering practice has recently been addressed by the National Council

of State Boards of Nursing. Current literature indicates that 30% of new nurses do not have any transition into practice. Additionally, residency programs are random at best (Spector & Suling, 2007), yet necessary to improve the annual nurse graduate attrition rate range of 20 – 60%. Spector and Suling addressed the recently recognized need for a practice entry model to improve nursing practice; it does not, however, address the industry's need to increase commitment or retention.

Organizationally, socialization and leadership opportunities should exist within acute care facilities to minimize personal expectations and role stress and increase organizational commitment. As demonstrated by the body of literature and this research, the serial tactic, or mentoring, potentially offers the greatest opportunity for development for a nurse entering the profession, unit, and/or organization. Leadership opportunities for charge nurses and unit managers should be expanded within health systems or organizations to improve unit culture. Improving unit culture would enhance opportunities for knowledge transfer and reduce poor organizational behavior. Within the education system, nursing programs may want to expand awareness of nursing roles in various settings to alleviate dissonance.

Recommendations for Future Research

The researcher reported qualitative data in this grounded theory study. Despite the data saturation with the sample size of 20 participants, transferability may not be widespread to all nurses in all acute care settings. The most notable feature of the sample was the lack of participants representing six to ten years of nursing experience. Therefore, the socialization experience of nurses who fall into this range were not

represented. This may be suggestive that the greatest number of nurses will exit the profession within that time frame. Also of particular interest were three participants who had either unmet expectations or remained dissatisfied despite their institutional, or positive, socialization experience.

Based upon the findings presented in this study, a model of nurse dissatisfaction in acute care settings (Table 10) demonstrates the patterns and themes identified that contribute to dissatisfaction according to participants. As part of the epistemological construct of grounded theory for theory development, this model may provide an opportunity for new or expanded theory into further dissatisfaction studies.

This research used a qualitative methodology to understand socialization practices through the voice of the nurse. As such, there is need for further quantitative research to validate the correlation of socialization practices and length of service related nursing dissatisfaction. Specifically, the role of mentor, or the serial tactic of institutional socialization, should be addressed to determine the strength of mentoring, knowledge transfer, novice tenure, and role stress. Leadership within the nursing unit should also be further studied to understand the relationship between it and nurse-to-nurse violence, as well as other culturally germane issues within nursing.

Implications of Research Study

The implications of the results in this research may benefit all of healthcare and potentially other ind ustries as well. This grounded theory study presented information related to the benefits of nurses when adequately socialized. In an era where worldwide nursing shortages exist, compromising patient care and healthcare operations, providing

adequate socialization at the point of entry. Improving nurse retention at the organizational and professional levels is critical for maintaining an adequate professional nursing supply to ensuring acute care operations, and patient safety.

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APPENDIX A

INERVIEW GUIDE

Participant Code: _____

General Questions:

1) How long have you been a nurse?
2) What nursing degree do you have?
3) Gender:
4) How long have you been employed by your current employer:
5) Age:
6) Organizational Structure:
7) Unit:

Central Research Question

To what extent does individual socialization contribute to nursing dissatisfaction?

Research Question 2

To what extent do unmet career expectations contribute to nursing dissatisfaction?

a) Does the nursing role meet your professional expectation?
b) What features of your job are the most frustrating and/or difficult?
c) What features of your job are the most rewarding?
d) Did you expect nursing to be personally or professionally rewarding?
e) How has the nurse role differed from your ideal expectations and perceptions?
f) Have these inconsistencies contributed to your dissatisfaction with nursing?

g) Did your clinical experiences as a nursing student adequately prepare your for nursing?

h) Nurses must meet the varying expectations of several stakeholders, such as: patients, physicians, administration. How do those expectations contradict or support one another? How do you reconcile those differences?

Research Question 3

To what extent does individual socialization contribute to unmet career expectations?

a) How did the hospital assist you to adjust to the differences between this current hospital or clinical experience and your previous hospital as a a) veteran nurse and/or b) a novice nurse.

b) As a newcomer or novice, were you expected to perform at the same level of proficiency as veteran nurses within your unit?

c) Was your time as a new employee structured to provide you with a comprehensive overview about your unit.

d) Was there an assigned member in the unit that could assist you, other than the preceptor.

e) Did you feel comfortable asking for help during your initial time as a new hire.

f) How important was it to understand the organizations benefits, mission, vision, etc., as opposed to understanding specific procedural protocols relevant to your role.

Research question 4

How can organizational socialization contribute to the clarity of role expectations, thereby improving job satisfaction of professional nurses?

a) Was there someone who mentored you in your nursing role? How did that impact your transition into the unit/hospital?

b) What components of hospital nursing were you least prepared for?

c) To what extent did your unit/hospital prepare you for specific tasks and/or procedures that differed from your clinical experience?

d) To what extent did your unit/hospital prepare you for specific tasks and/or procedures that differed from your previous unit or hospital or clinical experience?

APPENDIX B

INTERVIEW SUMMARY

Participant Code:_____

Interview Summary Form

Main points discussed during interview:

Summary Abstract

Interview Summary of main points related to research question:

Key Points	Theme/Code
Socialization/orientation 1. Data related to socialization/orientation activities here.	SOCN
Role Stress 2. Data related to role stress issues here.	RS
Role Expectations 3. Data related to personal/professional role expectations here.	RE

New or surprising information/data as a result of interview:

Cross reference with other format codes and themes based on pagination codes.

APPENDIX C

PARTICIPANT CODING MATRIX

Participant Name	Number	Hospital Code	Interview Date	Participant Code	Contact	Code Name
Confidential	01	01	01/09/07	01GS010907	email	Monica
Confidential	02	02	01/15/07	02SJMC011507	email	Sharon
Confidential	03	03	01/16/07	03SJ011607	email	Darla
Confidential	04	04	01/29/07	04PSPH012907	email	Sarah
Confidential	05	03	02/19/07	05SJ021907	email	Jennifer
Confidential	06	05	02/25/07	06PEMC22507	email	Kim
Confidential	07	04	03/08/07	07PSPH030807	email	Elizabeth
Confidential	08	06	03/17/07	08PSJ031707	fax	Carole
Confidential	09	07	3/23/07	09MAH032307	email	Jack
Confidential	10	04	3/26/07	10PSPH32607	email	Mindy
Confidential	11	08	4/3/07	11SMH0307	email	Tami
Confidential	12	09	4/30/07	12SC043007	email	Marla
Confidential	13	04	5/1/07	13PSPH050107	email	Nancy
Confidential	14	04	5/3/07	14PSPH050307	email	Dena
Confidential	15	04	5/3/07	15PSPH050307	email	Robyn
Confidential	16	10	5/7/07	16GH50707	email	Angie
Confidential	17	11	5/17/07	17PCH51707	email	Linda
Confidential	18	11	5/17/07	18PCH51707	email	Tracy
Confidential	19	11	5/17/07	19PCH51707	email	Peggy
Confidential	20	12	5/18/07	20AMC51807	email	Susan