

Magnet Hospitals

Attraction and Retention of Professional Nurses

(The Original Study)

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The hospital nursing shortage poses a serious threat to the health and welfare of this nation. Since sufficient numbers of professional nurses are essential if hospitalized patients and their families are to receive quality care, and since nurses provide 95% of the care that patients receive while hospitalized (American Hospital Association, n.d.), these essential care needs will not continue to be met unless hospitals can solve the “nursing shortage problem” – that is, their inability to attract and retain competent, experienced professional nurses.

Over 20 years ago, Linda H. Aiken succinctly described the scope of the problem as it existed in the early 1980s:

Despite an aggregate national supply of nurses that is larger than ever before, over 80 percent of America’s hospitals do not have adequate nursing staffs. There are currently some 100,000 vacancies in hospital nursing positions and this has had a crippling effect on the day-to-day operations of many hospitals (Aiken, 1981).

To help to solve this problem, the Governing Council of the American Academy of Nursing appointed a Task Force on Nursing Practice in Hospitals in 1981, charging it “to examine characteristics of systems impeding and/or facilitating professional nursing practice in hospitals.”

The task force members were already familiar with the many factors that had been identified in various studies as the “causes” of the hospital nursing shortage. Both the National Commission on Nursing’s *Initial Report and Preliminary Recommendations* and the National Academy of Sciences’ *Six Month Interim Report by the Committee of the Institute of Medicine for a Study of Nursing and Nursing Education* had been carefully reviewed (National Commission on Nursing, 1981; National Academy of Sciences, 1981). The task force members also knew that, although a large number of hospitals did have serious nurse shortages, certain of these facilities across the country had succeeded in creating nursing practice organizations that served as “magnets” for professional nurses. In other words, they were able to attract and retain a staff of well-qualified nurses and were therefore consistently able to provide high-quality care. Hospital nursing in these select institutions had proved to be an excellent career choice for professional nurses.

The task force recommended, therefore, that the American Academy of Nursing authorize a study to identify a national sample of what would henceforth be referred to as “magnet hospitals” – that is, those that had demonstrated ability in attracting and retaining professional nurses in their employment – and to identify the factors that seemed to be associated with their success in doing so. This work was expected to yield a variety of successful approaches that could be reviewed, adopted, and/or modified by other institutions eager to resolve their nursing shortage. The Governing Council approved the proposal. Thus the study – *Magnet Hospitals: Attraction and Retention of Professional Nurses* – was initiated in the fall of 1981 (McClure et al., 1983).

The Problem

The two main questions to be answered were:

1. what are the important variables in the hospital organization and its nursing service that create a magnetism that attracts and retains professional nurses on its staff; and
2. what particular combination of variables produces model(s) of hospital nursing practice in which nurses receive professional and personal satisfaction to the degree that recruitment and retention of qualified staff are achieved?

More specifically, the purposes of the study were:

1. to identify magnet hospitals in each of eight regions of the country that had demonstrated success in recruiting and retaining the complement of professional nurses essential to assure high-quality nursing care;
2. to identify and describe the organizational variables that had helped to create nursing practice and hospital environments that promote the nursing staff's job satisfaction, with accompanying fulfillment of both professional and personal needs;
3. to analyze the variables within these magnet programs and explicate replicable strategies for use by hospital and nursing practice organizations striving for these same results; and
4. to assemble and share through a national publication the details of selected successful strategies and programs that could be replicated to produce a hospital magnetism resulting in the recruitment and retention of a full complement of satisfied, professional nurses

Methodology

The mechanics of sampling and data collection were first tested by the investigators in a pilot study conducted in Washington, D.C., after which changes were made in the processes. The methodology was then refined and implemented as described below.

The study procedure called for (1) identifying a national sample of magnet hospitals and (2) holding group interviews (one session for directors of nursing in those hospitals, another for the staff nurses) in each region in an effort to identify the variables associated with success in recruitment and retention of nursing staff.

Selected Fellows of the American Academy of Nursing from 8 designated regions of the United States were asked to nominate from 6 to 10 hospitals (of varying sizes, if possible) in their respective regions as potential magnet hospitals. For the purposes of this study, the 10 geographic regions designated by the Bureau of Labor Statistics (BLS) were used as a starting base for determining regions. BLS Regions I and II were combined, as were Regions VII and VIII, for a total of 8 regions. The Fellows were asked to use their personal communications network to learn about the hospitals. It was suggested that the network include local hospital and nursing associations, professional nurses working in hospitals, faculty members, students, and recent graduates from the schools of nursing in the regions. Three criteria were specified.

1. Nurses considered the hospital a good place to practice nursing and a good place to work.
2. The hospital had the ability to recruit and retain professional nurses, as evidenced by a relatively low turnover rate.
3. The hospital was located in a geographic area where it had competition for staff from other institutions and agencies. (This third criterion was essential to eliminate hospitals that were the single source of employment in a particular area.).

For each nominated hospital, the Fellow wrote a paragraph describing those attributes that led to the hospital's selection. The names of the nominated hospitals, along with the supporting rationale, were sent to the Center for Health Care Research and Evaluation at the School of Nursing, the University of Texas at Austin, which had been selected as the site for data collection, tabulation, and analysis.

Selection of Magnet Hospitals

A total of 165 institutions were nominated by the Fellows as potential magnet hospitals. With these nominations in hand the task force then began the process of final selection of the magnet hospitals

sample.

First, each nominated hospital’s director of nursing was sent a letter announcing the study and including other documents, such as a copy of the study proposal; a data collection instrument (Hospital Index form) that asked for descriptive personnel and hospital statistics; an outline of what would be expected of the hospitals and their representatives if they were selected for the final sample; and a return postcard to indicate willingness to participate in the study if selected. (Willingness to participate included an agreement that the hospital underwrite the expenses of the director of nursing and a representative staff nurse to participate in the interviews.)

One hundred fifty-five hospitals responded. The forms they submitted, accompanied by the nominators’ rationales, were then organized into the regional categories, and the four task force members independently reviewed and evaluated the recruitment and retention records of each of the hospitals. They then ranked the hospitals and submitted their top 10 choices for each region to the Center for Health Care Research and Evaluation, where a numerical score was calculated for each. On the basis of these rankings, 46 institutions were selected as magnet hospitals for the purposes of this study. Subsequently, 5 of the 46 were unable to participate due to scheduling problems and the final sample, therefore, was comprised of 41 hospitals. It must be noted that the sampling procedure was not in any way designed to identify all the magnet hospitals in the country, and there were undoubtedly many other excellent institutions that did not appear in the selection process.

Sample Characteristics

Data gleaned from the Hospital Index indicated that the 41 magnet hospitals were predominantly private, nonprofit institutions, all affiliated with some educational program in nursing. Table 1.1 illustrates the ownership of these hospitals, and Table 1.2 shows the distribution by numbers of hospital beds. Occupancy rates ranged from 72% to 98%, with a median occupancy of 84%.

The ability to attract and retain professional nurses is illustrated by the fact that almost all of the magnet hospitals reported having at least 85% of their budgeted registered nurse positions filled on an annual basis. Information from the Hospital Index form also revealed a predominantly professional nursing staff providing care in magnet hospitals.

The educational preparation of the leadership staff in these magnet hospitals is illustrated in Table 1.3.

TABLE 1-1 – Magnet Hospitals by Type of Ownership.

Type of Ownership	Number of Hospitals	Percentage (%)
Private (for profit)	2	4.9
Private (nonprofit)	32	78.0
Public	7	17.1

TABLE 1-2 – Magnet Hospitals by Numbers of Beds.

Size by Number of Beds	Number of Hospitals
99-200	4
201-300	7
301-400	10
401-500	7
501-600	4
601-700	6
701-800	2
over 1,000	1
total	41

TABLE 1-3 – Educational Preparation of Nursing Leaders in Magnet Hospitals

Positions	Total Number	Percentage Holding					
		PhD or EdD	MSN	MS (non-nursing)	BSN	BS (non-nursing)	No Degree
Directors of Nursing	41	12.2	68.3	12.2	2.4	4.8	0.0
Associate or Assistant Directors / Clinical Directors	258	5.4	46.5	8.9	14.7	5.4	19.0
Area Supervisors	297	0.4	18.5	3.9	28.0	6.5	42.7
Head Nurses	696	0.0	11.0	0.8	32.4	3.6	52.2

The interviews

The initial letter to the nominated hospitals had given the date on which the interviews would be held in the respective regions. Once the final sample had been selected, a letter went out to the directors of nursing in the chosen (magnet) hospitals, informing them that their institutions had been selected to participate in the study. The letter reminded them of the date of the interview, gave them the specific place and time, and asked that they select a staff nurse to accompany them as a representative of the staff nurses in that hospital.

The directors were also asked to bring to the interviews their hospital and nursing service organizational charts, as well as materials that had been developed to promote, describe, or support the nursing programs in their hospitals and that they believed to be relevant to the study. Enclosed with the letter was a release form to be signed, granting permission for publication of any of the above materials in the project report, and a copy of the agenda for the interview day.

Group interviews were then conducted in each of the eight regional locations, with two different interview sessions held at each site. The first, held in the morning, consisted of the directors of nursing from each of the magnet hospitals in the region; the second meeting, in the afternoon, was with staff nurses from these same hospitals. The directors were instructed to select a staff nurse who was assigned to direct nursing care of patients and who did not regularly have charge duty assignment or administrative responsibilities. The two groups were interviewed separately to assure that the data would represent the unique perceptions of each group.

At least one task force member was present to conduct each interview. To assure consistency in the data collection, an interview guide, which included the following nine questions, was used with both groups of interviewees.

1. What makes your hospital a good place for nurses to work?
2. Can you describe particular programs in your situation that you see leading to professional and personal satisfaction?
3. How is nursing viewed in your hospital and why?
4. Can you describe nurse involvement in various ongoing programs and projects whose goals are quality of patient care?
5. Can you identify activities and programs calculated to enhance, both directly and indirectly, recruitment and retention of professional nurses in your hospital?
6. Could you tell us about nurse-physician relationships in your hospital?
7. Please describe staff nurse-supervisor (various levels) relationships in your hospital.
8. Are some areas in your hospital more successful than others in recruitment and retention? Why?
9. What single piece of advice would you give to a director of nursing who wishes to do something about high registered nurse vacancy and turnover rates in her hospital?

The group interviews were conducted in such a manner as to ensure that each hospital's representative responded to each question. The investigator would direct a question to a participant and then, using group process techniques, engage all participants in the discussion of that question. Participants could expand on a point previously made by another participant or add a new and different component to the discussion. The interviewer's role was to guide, direct, and seek clarification where necessary, as each of the groups

of directors and staff nurses addressed the nine questions. At each site two individuals kept a record of the responses to the questions, and all interviews were taped in order to allow verification of material if necessary.

Immediately following the interviews, participants were asked to indicate on a post-interview comments form those activities, programs, policies, and the like that they believed to be effective in enhancing the professional and personal satisfaction of nurses, thereby contributing to their retention on hospital staffs. They were also asked for their individual assessments of the factors or combination of factors that they perceived as most effective in accomplishing this objective.

The data gathered from the interviews and the post-interview comments were carefully reviewed, and categories were then developed based on the commonalities that emerged. Subcategories evolved related to the specifics of the major categories. These were used to analyze the data and to provide a framework of the presentation of the findings.

Definition of Terms

While titles vary among hospitals, for the purpose of this study the following definitions were used.

- *Staff nurse* – A registered nurse responsible for the direct care of patients in the hospital.
- *Director of nursing* – A nurse executive responsible for the total nursing program in the hospital.
- *Head nurse* – A nurse manager responsible for one clinical unit in the hospital.
- *Supervisor* – A nurse manager responsible for more than one clinical unit in the hospital.
- *Hospital administrator* – The chief executive officer of the hospital.
- *Trustee* – A member of the governing body of the hospital.

Limitations of the Study

This was a descriptive study that sought to identify variables that contribute to the retention of registered nurses in hospitals. Limitations included the following.

1. Selection of participating hospitals was based on self-reported hospital index data and the evaluations of the nominators.
2. The interviews were conducted by different members of the task force, and individual interview styles may have varied and influenced groups differently.
3. The staff nurses who participated were not randomly selected but were chosen by their respective directors of nursing.

It was also recognized that the dominant variables that were identified as contributing to the magnetism of the study hospitals were the perceptions of the respondents in both groups. These perceptions were undoubtedly influenced by a variety of factors, such as age, education, experience, clinical specialty, previous positions, and length of time employed at the magnet hospital, none of which were a part of this study.

Summary and Analysis of Findings

One of the very interesting outcomes of the study was the degree of congruence between the data that were gathered from the staff nurses and the directors of nursing. While it is clear that their perspectives differed, the elements that they identified as significant in making for magnetism in their hospitals did not.

Furthermore, the generalities that emerged did so regardless of the size of the institution or region of the country. Thus, similarities were found between hospitals as small as 99 beds and as large as 1,050 beds, and in institutions located in Boston and in Sioux Falls. These ingredients of magnetism will be presented and analyzed in three broad categories: administration, professional practice, and professional development.

Administration

Management Style

It is quite evident that participative management was the management style practiced in these magnet hospitals and it was equally apparent that the success these institutions had achieved was attributed to this approach. The involvement of staff at all levels in committee work and in the development and enhancement of programs was a common thread, tying the diverse settings together. Without question, such participation was sought, encouraged, and valued.

Most striking was the large number of instances in which the word “listen” was used by both the directors and the staff nurses. It emerged frequently, for instance, in response to the question, “What single piece of advice would you give to a director of nursing who wished to do something about high registered nurse vacancy and turnover rates in her hospital?” Typical of the responses given by the directors of nursing was this statement: “Listen to the staff ... the best consultants are on your own staff.”

Staff nurses tended to say much the same kind of thing. For example, one nurse said, “Listen to the patient contact people, they know what they are talking about.” There was the clear implication that the listening would be done well – that is, with careful consideration given to what was being said and with the intent to utilize the ideas put forth whenever possible and appropriate. There was every evidence that the listening was genuine, not in any way patronizing or placating, because the listener believed that the staff members had important contributions to make.

Communication obviously worked both ways in magnet hospitals. Not only was the staff encouraged to provide input, they were also kept well informed about what was taking place in the broader organization. Many mechanisms such as staff meetings and hospital and departmental newsletters were used to ensure this information flow. Most important was the fact that there appeared to be an administrative commitment to maintaining openness with the nurses as well as with other members of the staff.

In keeping with the participatory approach, the director of nursing was viewed, and viewed herself, as both visible and accessible. It was quite evident that opportunities were purposely developed for the director to become known to the staff and, in turn, for the staff to be known to the director. This was accomplished through a variety of means, such as rounds on patient units, formal staff meetings, and informal coffee hours. Clearly, the size of the institution had some bearing on the approach selected: yet, almost without exception, efforts were made by the directors of nursing to maintain regular contact, in one way or another, with all units, on all shifts. The director of nursing was no stranger to the nurses.

To a lesser degree, the staff nurses mentioned opportunities for contact with hospital administrators and board members. In only a few instances were regular rounds by members of either of these groups reported, although in those cases in which such practices occurred, they were viewed as positive by the staff nurses.

On the other hand, the directors of nursing had a great deal of contact with both hospital administrators and board members. As they were part of the top executive team of the institution, such interaction is hardly surprising. In a few instances, the directors of nursing were themselves trustees; in many others, the directors reported that they regularly attended board meetings and/or served on board committees. Nursing thus had a voice at the top decision-making level of the hospital, and there was a perception that others at the same level fully understood and valued the contribution that the profession makes not only to patient care but also to the institution’s reputation in the community.

Quality of Leadership

The leadership in the study hospitals was clearly the key to their success in recruiting and, more importantly, retaining registered nurses. In almost every case, a picture was painted of an unbroken chain of able and qualified leaders at each level of the organization, starting with the board of trustees and ending with the head nurses. The leaders were perceived by both the directors and the staff nurses as knowledgeable and strong individuals. The nursing leaders were described as being highly qualified within their respective professional realms, as well as skillful in managing the employees for whom they had responsibility. Further, they were regarded as having the courage to take risks in order to accomplish their goals.

It was also evident that a meaningful philosophy of patient care was made explicit in the day-to-day

operations of the department. The staff found this philosophy to be particularly important because it resulted in high standards and high expectations for their performance.

If the word “listen” appeared predominant in relation to management style, the word “support” was equally dominant in comments describing the quality of leadership in the institutions. In other words, the staff nurses repeatedly alluded to their feeling of being supported by nursing administration; likewise, the directors of nursing spoke of the support they perceived for nursing and for nurses from hospital administration and the board of trustees. Each level, then, had a sense of advocacy from those above them at the next level of the organization, with the result that an overall positive sense of support was achieved.

This support was operationalized in a number of ways, ranging from the provision of adequate and appropriate supplies and equipment for patient care to the provision of hot meals in the cafeteria for the night staff. Of particular importance was the responsiveness of other departments such as dietary, pharmacy, laboratories, and radiology to the nurses caring for patients. This was attributed to support from hospital administration and was seen as especially important in freeing the nurses from non-nursing duties.

It is interesting to note how often the nurses mentioned the attention given to the physical plant and commented about the adequacy of the working environment and space. Again, cleanliness, upkeep, and aesthetics of the work surroundings conveyed a sense of support from the administration, and the staff saw this as contributing to their own sense of well-being. Nursing administration operationalized its support for nurses in much the same way with the added element of being viewed as more understanding than general administration of problems unique to the profession. Thus nursing administration would be most supportive of changes related to such issues as scheduling of work hours, professional practice problems, and educational programs. Finally, it was not uncommon for the nurses to report that the administration of their respective settings viewed nursing as the most important ingredient in the institution’s successful reputation. Quite often this emphasis on nursing was reflected in publications and/or promotional materials developed by the hospital for the community.

Nursing Managers

The managers in nursing were viewed as pivotal to the success of the organization. In particular, the head nurses were singled out by the directors and the staff nurses alike as having a significant role to play in this regard. Almost without exception, the head nurses in the magnet hospitals were reported to be clinically expert and therefore able to serve as knowledgeable resources to the staff. Equally important is the fact that they were good managers, who treated their subordinates with respect and consideration; as a consequence, the nurses were made to feel professionally and personally important.

While supervisors were not mentioned as often as the head nurses in the interviews, it is clear that they too were viewed quite positively and made an important contribution to the magnetism of these institutions. Their ability and willingness to assist unit personnel in dealing with clinical and administrative problems was definitely valued. In several instances, evening and night supervisors were cited by the staff nurses as being particularly helpful.

Magnet hospitals apparently recognize the importance of middle managers. A number were conducting various training programs, some of which were inter-departmental in nature, for individuals at this level. Thus an inservice education course might be offered for selected department heads that would include head nurses and nursing supervisors; it might even be planned at a retreat site away from the hospital so that those attending could be completely free of their responsibilities and also have the opportunity for some social interaction, resulting in improved working relationships among departments when they returned to the hospital. In other cases, the programs were offered within the nursing department itself and were open to incumbents as well as prospective nurse managers.

Nursing Directors

The nursing director was another position viewed as absolutely critical to the development of a positive nursing situation. This was mentioned time and time again both by the staff nurses and by the directors themselves.

What were the qualifications of these particular directors? The data gleaned through the Hospital Index form made one point clear. The educational preparation of the directors of nursing in the magnet hospitals was well beyond the national average for others in comparable positions. Almost without exception, these administrators were prepared at the graduate level; several of them held earned doctorates. Further, it

became apparent in the course of the interviews that the directors tended to be very active professionally, beyond the boundaries of their own institutions. As a result, they were knowledgeable about ideas within the larger nursing world and attempted to apply that knowledge in their own settings.

What emerges from the data is a general sense that high-quality leadership has magnetism for equally high-quality leadership. In other words, an able hospital administrator attracts and retains an able director of nursing, who in turn attracts and retains able middle managers. Together, this group of leaders provides the environment that becomes a magnet for staff nurses.

Organizational Structure

The organizational charts that the participating hospitals were asked to supply yielded an important piece of information: In almost every instance, the directors of nursing were placed at the executive level of the organization, reporting directly to the chief executive officer. Moreover, their titles reflected this relationship, with most nursing directors having either vice-president, associate administrator, or assistant administrator as a part of their formal designation.

Decentralization

The great majority of magnet hospitals appeared to have decentralized department structures. While no effort was made to determine the details of these arrangements and while they undoubtedly varied from hospital to hospital, certain commonalities emerged in the interviews. For most participants, decentralization meant a sense of control over the immediate work environment at the nursing unit level, including opportunities to formulate the budget and experiment with innovative staffing patterns. Examples were cited of new and flexible arrangements for work hours conceived and implemented by a head nurse and her staff without the need for an elaborate approval process involving various layers of hierarchy. In addition, there was motivation to develop clinical programs and resources, focused on both patient and staff needs. These were quite varied and, as might be expected, sometimes originated on one unit and eventually spread to others on the same service or to the entire nursing department.

Once again, the trend was for titles to reflect the change in relationships within the organization. In several instances, head nurses were given department head titles in an effort to recognize their level of responsibility.

Committees

As mentioned earlier, there was significant nursing involvement in the committee structure of these hospitals. Nurses were members of a variety of committees of the medical board, as well as those of the hospital and nursing department. The medical board committees were quite similar across institutions and tended to follow the Joint Commission on the Accreditation of Hospital Organizations' guidelines. The committees created within the departments of nursing, however, varied more from hospital to hospital and included RN recruitment, nursing research, patient teaching, clinical ladder, and inservice education. There was also a good deal of evidence that ad hoc committees were utilized frequently as a means of creating change.

Almost all of the directors of nursing regularly attended the meetings of the executive committees of the medical board. Some had the status of guests, while others were full voting members. Many also attended meetings of the boards of trustees and were members of various board committees. There was considerable evidence that nurses were not merely appointees to the committees in these hospitals but were in fact active participants who viewed their membership as an opportunity and a responsibility for making change.

Staffing

The hospitals included in this study were viewed by the participants as being adequately staffed. While this might have been expected, it must nonetheless be emphasized. The nurses stressed the importance of this factor, indicating that the quantity of registered nurse staff was critical to their satisfaction and, indeed, to their pride at being a part of the institution. Frequently mentioned were the favorable nurse-patient ratios and nurse-nonprofessional ratios. The nurses spoke of being able to deliver safe, adequate care as a result of these staffing patterns.

The *quality* of the staff was apparently viewed to be as important as the *quantity*. Many of the

institutions had employed large numbers of baccalaureate-prepared nurses, and there was a general sense that it was quite important to the staff nurses that they have bright, able colleagues with whom to work. Perhaps one of the most interesting elements related to the quality of staff was the question of nurse-nonprofessional ratio. In many instances staff nurses commented that they were able to render direct care to patients without the need to delegate much of it to lesser-prepared individuals such as licensed practical nurses and nurses' aides.

Many of the hospitals employed clinical specialists, who added a dimension of nursing expertise that would otherwise not have been available to patients and their families. The participants in the study considered these individuals, because of their advanced knowledge and skills, to be valuable resources to the staff as well as enriching to the practice environment.

With few exceptions, the magnet hospitals did not employ nurses from temporary agencies. On the few occasions where mention was made of employing such individuals, there was general agreement that this practice was not a positive one. This was especially true among the staff nurses; in fact, one nurse even indicated that she left a previous position because she wanted to avoid working with large numbers of agency nurses.

Personnel Policies

The interview data revealed enormous variation among the magnet hospitals in regard to their personnel policies. In spite of this, though, there were also great commonalities, the most important being that the salaries and benefits in these hospitals were at least competitive with and occasionally ahead of others in their respective communities. Two additional areas related to personnel policies stand out as being especially important to the retention of registered nurses: hours of work and opportunities for promotion.

Work Schedules

Without question, one of the most important factors in attracting and retaining nurses in the magnet hospitals was the attention that was paid to scheduling hours of work. In most instances, shift rotation was minimized, if not eliminated, and great efforts were being made to reduce the number of weekends that the nurses were required to work. A number of creative and flexible arrangements had been developed that were tailored to meet the needs of the staff. These efforts conveyed the feeling that the administrators were trying hard to accommodate the personal lives of the staff and this was greatly appreciated.

Promotion Opportunities

Another important positive factor was the development of career ladders that made promotion opportunities available to the nurses. While promotion to managerial positions had always been possible in the magnet hospitals and others, there was now emphasis on the development of promotional systems that rewarded clinical expertise with both title and salary changes. A number of the study hospitals had these clinical ladders already in place; the majority of those that did not were planning for such programs and had timetables worked out for the implementation process. Both the directors and the staff nurses saw the clinical ladder as important to keeping nurses in hospital nursing and at the patient's bedside. There is no doubt that this approach legitimizes the importance of nursing care to patients. It represents an effort to invest status and compensation in those who contribute most directly to the consumer, acknowledging that increased competence is worthy of recognition.

Professional Practice

The reader will recall that the first question in the interview for this study was, "What makes your hospital a good place for nurses to work?" Significantly, replies to this question elicited similar data from all respondents. The two major components that emerged from both the directors and staff nurses were (1) the environment and (2) the practice mode; in combination, these make professional nursing practice possible.

From the directors' perspective, the quality of both the staff and the staffing patterns constituted the main reason for their hospitals being good places for nurses to work. These were seen, however, not as isolated factors but as integral components of a professional practice environment. The quality is derived from such factors as adequacy, competency, level of professionalism, proportion of registered nurses, proportion of baccalaureate-prepared nurses, and quality of middle managers and administration. For the

directors, high-quality staffing was the sine qua non for excellence in practice.

The staff nurses, on the other hand, stressed such factors as autonomy, primary nursing, mentoring, professional recognition, respect, and the ability to practice nursing as it should be practiced. Again, these factors all converge on the single element of professional practice; they are evidence of the expectation of quality performance that emerges from the nursing leadership.

Quality of Patient Care

Stated simply, nurses in these magnet hospitals took enormous pride in the fact that they believed themselves to be providing high-quality nursing care to their patients. Moreover, family members of patients were considered integral members of the team, and nurses assisted them in making significant contributions to the care of their loved ones. The directors of nursing were viewed as responsible for developing the environment where such care could flourish; they were also seen as responsible for communicating a philosophy supportive of high standards. Of particular importance were such factors as the caliber of staff, professional practice models, autonomy, quality assurance programs, and availability of expert consultation and resources.

Professional Practice Models

A variety of models for the delivery of nursing care were utilized in the study hospitals. Primary nursing, professional model, family-centered care, district, and holistic care were but a few of the labels used to describe these various approaches. In all of them, however, the major thrust was to give the nurse the responsibility and related authority for the care of a group of patients.

In all models, nurses viewed themselves, and were similarly viewed by their directors, as being accountable for their own practice. They were coordinators of care; they set standards and limitations for nursing practice and functioned on a par with other disciplines in meeting patient care needs. The models were perceived as providing for continuity of patient care and allowing the practitioner to spend adequate amounts of time with patients, particularly in settings where there was a high registered nurse to nonprofessional ratio, since less time was spent in supervising others.

Autonomy

While autonomy was very important to nurses, it was invariably discussed within the context of a freedom for professional practitioners to assume and carry out responsibility. The ability to establish standards, set goals, monitor practice, and measure outcomes was part of this freedom and is essential to quality patient care. Staff nurses viewed themselves as responsible practitioners, capable of making decisions about the nursing care needs of patients. Magnet hospitals provided the environments in which this was possible.

Many patient care programs had come into existence in these hospitals as a result of the nurses' ability to function in an autonomous manner. Innovation and creativity flourished side by side with accountability for the various programs and projects. Examples included:

- nurse-managed clinics;
- outreach programs to educate nursing personnel in other settings within the community;
- exchange nurse programs in which staff nurses in hospitals and nursing homes exchanged work settings;
- preadmission programs for children;
- counseling for pregnant adolescents; and
- support services for senior citizens.

All these programs were seen as elements of nursing practice, as the nurses' responsibility to initiate and coordinate, even though many were interdisciplinary endeavors. Such activities contributed to self-actualization for the practitioners involved and to an enhanced image of the hospital in the community.

According to staff nurse respondents, the encouragement and support of the director were major factors in influencing their scope of practice. However, in some of the smaller settings, the absence of house staff was also cited as a factor. Where there were no interns or residents, staff nurses apparently perceived themselves as having greater responsibility and autonomy in decision making and in the management of patient care.

Consultation and Resources

Another variable that contributed to high-quality care was the availability of consultants and resource personnel. A variety of specialists were seen as providing necessary support for staff nurses and physicians; for example, a psychiatric liaison nurse who assisted with communication problems and provided individual and interpersonal counseling. In another setting an ethicist made rounds to discuss problems or issues identified by staff members.

In many of the study hospitals, clinical specialists in nursing and in medicine were either on the staff or were available from neighboring agencies and universities. One institution with an all-RN staff employed clinical specialists in management positions only. The staff nurses were considered competent professionals capable of dealing with practice issues and were expected to seek out resources as needed. In all the hospitals, access to a competent medical staff was clearly valued.

In general, the climate appeared to be one of peer support, both intra- and inter-professionally, and there was great awareness and appreciation of organizational and community interchange of resources.

Teaching

One of the most prominent findings was the high value placed on education and teaching by nurses, particularly staff nurses. Not only were they interested in education for their own personal and professional growth, they valued their role as teachers of others. The opportunity to teach patients, to participate in educational programs, and to serve as preceptors to students or newly graduated nurses was emphasized repeatedly as contributing to the magnetic quality of the hospitals. Examples of a variety of teaching involvement were provided and gave evidence of nurses' commitment to this activity; it was both an expectation and an especially satisfying aspect of their practice.

Many of the nurse-managed programs mentioned earlier were educationally oriented, involving a great deal of patient and family teaching. Peer-focused activities included nursing grand rounds, development of learning modules, and inservice education to increase the competency of colleagues.

Very positive attitudes were also apparent in relation to students and affiliated educational programs. The educational environment was clearly stimulating and offered many kinds of teaching options. In fact, in a number of the settings, the criteria for promotion included specific teaching activities. As with many other factors, teaching was both an expectation in the position and an opportunity to practice as a professional.

Image of Nursing

Both the directors and the staff nurses had very positive perceptions of the image of nursing in their hospitals. In virtually every instance, they said that nursing was viewed as professionally competent and credible and that it was valued and respected.

As one director said, "Nursing has proven its worth." Nursing represented a powerful force that was seen as necessary for the survival of the hospital. This positive image reflected views among administrators, patients, the larger community and, most importantly, nurses themselves.

The question of the image of nursing raised the matter of relationships with other departments. Because nursing in magnet hospitals clearly enjoyed high status, many participants in the study mentioned the need to be sensitive to the feelings of resentment that such status engenders among others. On the other hand, there was a single exception to the overall positive image; this occurred in the discussion of physicians' perceptions of nursing. Here the reviews were quite mixed. Many of the respondents commented that physicians in their hospitals valued the opinions of nurses and respected them as professionals, but there were also instances in which the physicians were perceived as feeling threatened by the competence of the nurse and desirous of maintaining the traditional handmaiden image. According to some of the respondents, nurse-physician relationships require constant attention and nurturing.

The common factor among the magnet hospitals was that the nurses felt supported by nursing and hospital administrators when the physician's image of the nurse led to conflict. Strategies had obviously been devised for coping with such situations, with the result that the nurse's self-image was not diminished. This kind of support, coupled with the knowledge that many patients selected their hospitals because of the fine nursing care provided, helped to build the nurses' self-esteem, an important ingredient for magnetism.

Professional Development

The growth and development of personnel were clearly emphasized in magnet hospitals. The focus on education was viewed as a commitment to improving the quality of nursing care and appeared to be extremely important to the nurses in this study. The directors of nursing understood this and sought to ensure quality educational programs through a variety of approaches. As one advised, "Put your money into education." Data from the staff nurses reinforced this approach, particularly in regard to their own teaching role. They indicated that they were expected to teach and that they received assistance in their development in the learning and teaching area as preparation for these responsibilities. They recognized the importance of baccalaureate and higher degree education and valued the tuition reimbursement benefits that most magnet hospitals provided. Employers were perceived as supportive, promoting, and encouraging education in a number of ways.

Orientation

Staff development starts with orientation and was considered a strong influence on retention. Preceptors, who also served as role models and mentors, were highly valued by the nurses. Orientation periods varied from several weeks to several months, and the fact that work responsibilities were introduced gradually was seen as particularly important to nurses in beginning practice.

Inservice and Continuing Education

Once the individual was properly introduced to the system, inservice and continuing education related to the area of practice were viewed as essential. In the magnet hospitals, these opportunities were available in sufficient quantity and quality, and many were open to nurses from other agencies within the community. It was also evident that staff believed they gained a great deal from the opportunities to attend professional conferences offered by outside groups, because of the added benefits of exposure to new people and new ideas.

Formal Education

Support for formal education through tuition reimbursement, flexible scheduling, and leaves of absence was common practice. Financial support was provided for activities ranging from part-time study to full scholarship aid, complete with leaves of absence. Again, it was clear that these kinds of arrangements were very important to the nurses and played a significant role in both recruiting and retaining staff.

Career Development

Throughout the data there was an obvious emphasis on career development. Mechanisms for this development included competency-based clinical ladders with specific requirements for each level, advancement programs along either a clinical or management track, and planned continuing education leading to certification. The staff nurses particularly stressed the advantage of opportunities for growth through participation in professional activities. Clinical ladders were viewed very positively as a motivating factor in professional growth as well as a form of recognition for clinical competence. In every case, such advancement was accompanied by salary and title changes. The opportunity for lateral mobility from the clinical to the management ladder and for internal transfers from one specialty to another were also viewed as important to career development.

Management development was also seen as important. As mentioned earlier, the directors emphasized the need for quality middle managers and therefore provided appropriate programs for assessment and training in this area. Staff nurses were frequently eager to participate in these offerings and viewed management training as a form of recognition.

Research, while not widespread, was part of the development focus in a number of the hospitals. They emphasized the need to carry out research, and many studies in nursing care were reported. Several hospitals indicated that they had either doctorally prepared staff members and/or collaborative working relationships with university faculty on a variety of research activities, some of which had resulted in publication. It was apparent that research was an emerging component of the practice role for nursing.

Change Is Possible

It is evident that there is enormous interrelationship and overlap among many of the elements identified in the areas of management, professional practice, and professional development. These, after all, were artificial categories developed solely for data analysis and reporting purposes and do not hold up as mutually exclusive in the real world. Indeed, what does come through rather vividly from the data, is that magnet hospitals have the total picture in place. Simply stated, the management is supportive of professional nursing practice within the context of a teaching and learning environment.

This concept may seem easy to comprehend, but it is a difficult one to operationalize. And it is clear that the hospitals in this study continuously grappled with the problems inherent in maintaining their magnet status. It was certainly not a simple matter to put all the pieces in place and keep them there, especially when there are competing, and sometimes contradictory, forces at play. For example, nurses value the opportunity to work in a hospital that renders consistently high-quality nursing care, and they also value work hours that are scheduled to accommodate their personal needs. These two variables, both of great importance, are not necessarily compatible, and reconciling them takes a great deal of creativity and flexibility. These magnet hospitals, however, have demonstrated that it can be done.

The hospitals in this study varied considerably in terms of the lengths of time they had been perceived as good places for nurses to work. A number had enjoyed such status in the eyes of the nurses in their respective communities for some years, while others had changed rather dramatically within a relatively short period of time prior to the study. In several hospitals, the turnover had decreased more than 30% within two years; interestingly enough, this tended to follow a change in key leadership people, such as the hospital administrator and/or the director of nursing.

One of the most significant conclusions to be drawn from the data is the importance of making continuous efforts toward improvement. Throughout the interviews, there was a constant allusion to changes that were in progress or were planned for the future. While discussion of these changes most often occurred among the directors of nursing, there was ample evidence that the staff nurses were cognizant of them and were participating in some aspect of the planning. In the final analysis, magnetism requires that there be constant striving for improvement and that this striving be a joint effort involving all levels of staff.

Discussion

There are a number of significant concepts undergirding the management practices in the magnet hospitals that were not directly reported by the subjects; rather, they may be inferred from the data. This section represents interpretations that have been derived from reflecting on the substance and the tone of the interviews. Several phenomena common to all of the hospitals in this study are identified. Included are the value systems, the role definitions and the exercise of power that are evidenced in these hospitals and that appear to be fundamental elements of magnetic environments.

Differences in Perspective: Similarities in Values

The data from this study demonstrate that, while there is a high degree of agreement, there are apparent differences in perspective between the directors of nursing and the staff nurses. The former take a more conceptual view, while the latter tend to be less abstract. The directors of nursing were explicit concerning their philosophy and the value systems on which they based the provision of high-quality care to patients in their hospitals. They spoke of the institution's mission and the need to get that message across to the staff. They discussed the needs of people and they talked about the programs and practices that focus on meeting these needs, for example, adequate and competent staff, career development programs, and consideration of life styles. They were concerned for both the institution and its goals as well as for the department of nursing.

It would appear that from the staff nurse's point of view the directors were on target. Staff nurses were concerned with actual practice. They probably had less understanding of the corporate structure but still appreciated the totality of the institution, mainly as it affected the department of nursing and the provision

of patient care.

The staff nurses identified specific factors that reflected the operationalization of a philosophy and value system and these tended to parallel the programs and practices identified by the directors: adequate and competent colleagues, flexibility in scheduling, educational programs that allow for professional growth, and recognition as individuals. Even though these differences in perspective emerged, in no instance did the “we versus they” dichotomy of employee-management relations materialize. On the contrary, staff nurses generally credited supportive administrators and managers for the positive climate that existed in their hospitals.

There was significant evidence of shared values underlying the practice of both groups of respondents. In explaining their own responsibilities, the directors emphasized the need to respect the staff, to be open and honest in relationships, and to strive for integration of individual and organizational goals. This was in keeping with the staff nurses’ desire for a director who is open, who is “believable” and keeps her word, and who strives to accommodate to individual life styles. Both groups recognized the need for trust and the need to listen to each other. More importantly, their concerns conveyed a basic belief in the worth and dignity of the individual, a value that permeated the total patient care environment. In other words, there was a *caring* climate in relation to employees, as well as patients.

The staff nurses’ emphasis on scheduling that accommodated personal needs and life styles represented a change in values from earlier generations of nurses, but this undoubtedly reflected a corresponding change in the values of the larger society. Moreover, it did not necessarily mean that the work ethic is dead. Rather, it was tempered with the expectation that the work setting would contribute to self-actualization, a part of which is derived from nonwork components. The need to examine organizational values in light of such expectations was made clear by these findings. There is no doubt that personal and professional goals are important to nurses. The nursing and hospital administrators who recognize this and provide the means to assist the staff in meeting personal goals, while contributing to the goals of the organization, are viewed as able administrators and receive respect and recognition in return. They are considered effective leaders. There is a perception of mutuality of goals and a linkage of these goals with underlying values.

Organizational values as determinants of organizational behavior must therefore be considered in any hospital that seeks to maintain a stable nursing staff. A value system shared by all participants, from members of the board to every employee, may be one of the most crucial requirements for sound management in the changing health care agency of the future.

Role Definitions

Speaking very generally, the roles of both directors and staff nurses have been changing over the years. Both groups have more clearly defined their roles in relation to each other as well as to other disciplines, and this was reflected in the findings of this study. These directors and staff nurses had become more collegial and collaborative. Both expected to participate in management decisions; the director at the executive level in all matters pertaining to the institution, and the staff nurse in all matters related to care of patients and the role of the nurse.

The staff nurses in this study defined their professional role as an increasingly autonomous and multifaceted one. In addition to the provision of nursing care, the role included a large component of teaching and a major function in the coordination of care. Nurses considered themselves professionals, and the congruency of role expectation between the director of nursing and the staff nurse appeared to be a strong retention factor. Staff nurses did not accept role substitution; instead, they expected that support services would indeed be supportive to the care of patients. They identified positively with nursing and were obviously convinced that nursing is significant to the well-being of patients as well as to the well-being of the hospital and the community. They were career-oriented and expressed a desire for sound experience and quality education. In short, they expected to be treated as professionals.

In a similar vein, the directors of nursing seemed to possess a clear conception of both their own role and that of the staff nurse. The quality of care provided was a result of the director’s competence in this dual role of nurse and administrator. While the director served as advocate for both nurse and patient, the ultimate goal of the advocacy was patient care of a high quality. The provision of adequate, competent staff and an environment that is conducive to professional nursing practice were the two major

components. Effective role enactment was seen as resulting from both personal and professional competence, in combination with support and commitment to high-quality care on the part of the chief executive officer and members of the board of trustees. Directors of nursing in magnet hospitals played an influential role in organizational goal achievement and communicated a sense of control and confidence in this role.

Autonomy, a frequent emphasis throughout this study, deserves particular consideration. Both groups of respondents recognized autonomy as a necessary condition for the professional role. However, this was not viewed as total independence but rather the ability to practice in accordance with professional nursing standards. Interdisciplinary effort and shared decision making were perceived as essential ingredients. The situation was one of increasing independence as nurses, and of increasing interdependence as care providers acting in collaboration with members of other health disciplines.

In primary nursing and similar professional modes, the staff nurse is a coordinator of care. It is a core role for a comprehensive approach to the care provided by all health professionals. While there is some resistance from other disciplines to such role definition, there is also evidence of evolution and increasing validation of the professional role for nursing. Accommodation of differences is facilitated by participatory management with built-in structures for joint decision making.

Obviously, these magnet hospitals were not free of stress. Stress management workshops, interpersonal relations problems, and role conflict were frequently mentioned. The interesting phenomenon was the attitude of coping that was described. Although there was some stress in dealing with medical dominance, as one example, it was minimized when staff nurses felt increasing competence and sensed support from administration in dealing with the issue. Stress was also eased by the knowledge that their role is essential to the mission of the institution and that they have legitimate accountability to patients for the quality of their care.

The need to continually interpret the professional nurse role as well as to interpret needs of patients and to stand up for one's principles came through in the study. The apparent need to "defend" the patients and their nursing care needs – the *raison d'être* of hospitals – requires careful consideration and evaluation by leaders in administration, nursing, and medicine.

Concept of Power

The search for autonomy is a search for control over one's work. It is Rollo May's (1972) concept that power can be defined as the ability to make or prevent change. For the nurses in this study, it was not a question of power for power's sake. In fact, with few exceptions, there was little discussion of power per se. Rather, what comes through is a sense of what might be called a lack of powerlessness.

These staff nurses saw themselves as influencing decisions and being in relative control of their own practice. They could and did make decisions that affected nursing care; these ranged from decisions about admissions to standards of care. They saw themselves as having rights as well as responsibilities, possessing a body of knowledge and expertise of significance to the organization, and expecting support in carrying out their legitimate role. They acknowledged the locus of control in the director of nursing and appreciated the quality of leadership in the exercise of the position's power. They recognized the power held by physicians in the admission of patients to the institution and could balance this with their role as coordinators of the care.

The directors of nursing conveyed a similar lack of powerlessness. It was obvious that the director who had a clear vision and was supported by a competent chief executive officer perceived herself as powerful. Placement at the executive level of the organization served to reinforce this position of power and was so perceived by the staff. This clearly built a constituency among the staff nurses in such a way that the power of both was enhanced and expanded. The power base for the director of nursing and the staff nurses evolves from a complementary "fit" of vision and competence between the hospital's chief executive officer and the director of nursing. The director of nursing can serve as a synergizing force at the executive level in matters of patient care. However, unless there is a meeting of the minds with the executive officer, the director of nursing will lack the influence and ability to bring about change. Whereas the power base for the staff nurse was perceived as emerging from the support of the director of nursing and chief executive officer, the power base for the director of nursing emerges both from the nursing staff and from the chief executive officer and the board of trustees. Without that power structure,

there can be little change.

In magnet hospitals, there appears to be some shifting of power. Confident of their own competence and concerned that their clients receive the best care possible, nurses are changing the balance of power. They know that patients are in the hospital because they need nursing care. This is a strong determinant of behavior. Their own sense of value will no longer allow them to accept situations where they do not have a voice. Accommodating to this single idea may be the major imperative for hospital administrators and boards of directors.

The specifics may vary, but the fact remains that in the magnet hospitals it is a combination of elements that creates a positive practice environment. More than a matter of strategy, it is the quality of administration and leadership that distinguishes magnet hospitals from others. Competent managers are apparently successful in finding the appropriate balance between the needs and interests of consumers, employees, and the organizational entity that is the hospital. It is hoped that this report provides the necessary abstract and concrete ideas that will prove helpful to those who would emulate these success stories.

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