Nurses Are Not Leaving Health Care;

They Are Leaving Hospitals

Curt W. Coffman, MBA

New research indicates that the nursing shortage is not so much a health care issue as it is a hospital one.[1] In review of nurse turnover and the reasons behind it, a related but separate discovery has been made. Nurses are:

1. Frustrated with the current inefficiencies and conflicting priorities of the hospital workplace
2. Being told (indirectly) to not be who they authentically are
3. Not abiding by the natural instincts that drew them to nursing[2]
4. Feeling as though they have no voice in quality-of-care issues

While these issues are recognized by many, they are being confronted by only few. Why? There is a dearth of proactive answers to the intertwined emotional issues within this critical profession. For years, hundreds of millions of dollars have been thrown at the nursing shortage, and, in the end, it has not been about monetary economics; the nursing shortage has clearly been about nurses' emotional link between their unique talents and abilities and the opportunity to have a real impact on their patients.

Through a review of what motivates and attracts *great* nurses, the Coffman Organization (formerly the MAJERS Research Institute) has identified specific actions that hospitals must take hold of to rejuvenate nursing quality and thus retain the *best* in health care. The answers come from a bold review of the specific reasons noted above why nurses are leaving hospitals and medical centers from Bangor, Maine, to Chula Vista, California.

Let's begin with #1—Nurses are frustrated with the current inefficiencies and conflicting priorities of the hospital workplace. In evaluating the past 25 years of hospital-based nursing, one thing is obvious–we

have added more work to work than we have created additional efficiencies. Some hospitals have even replaced performance management with "examining conformance to standards" to assess a nurse's impact. We're now at a point where we need to take the work out of work and establish more efficient systems of getting things done.[3]

This must start with an appreciation of human energy conservation. We all have a limited amount of energy to expend to create the best results. The key to efficiency lies in how we apply that energy. Being able to recognize the most efficient systems (the ones that have the means of getting there *reliably, repeatedly,* and *predictably*) that produce the most satisfying outcomes is paramount.[4] Any human energy invested at work tends to have only one of two conclusions: dynamic or static. Dynamic energy has direct and observable impact on the goals each person truly wants to achieve. It also creates a positive feedback loop, generating even more energy. Static energy is the result of inefficiency and actions that do little to move one toward the most important outcomes.

Hospitals and medical centers everywhere have forged a definition of quality that is inconsistent with that of patients and, frankly, nurses.

New research strongly suggests that there are 10 human systems that must be intentionally established to conserve energy at work. The following 10 can be characterized as systems that reliably and predictably move one toward the key priorities:

1. Metrics management
2. Goals and priorities
3. Operating cycles
4. Communications
5. Performance feedback
6. Sustainable solutions
7. Knowledge management
8. Rewards and recognition
9. Skills acquisition
10. Value demonstration

Everyday, every nurse in every workgroup uses some kind of system to attend to these 10 areas. Whether these areas are being attended to with intentional **design** or **default** methods is the key question. We find very few work units that don't have a communications system, but we do find that the majority are default (random, pieced together, and unintentional) in nature. Through establishing the most efficient **design** system (reliable, repeatable, and predictable), one can take the work **out** of work, as opposed to creating additional inefficiencies.

Now for #2—Nurses are being told (indirectly) to not be who they authentically are. It is impossible to talk with a hospital RN or LPN for more than 5 minutes without sensing the tremendous *fatigue* rampant among hospital nurses today. There are so many leadership initiatives to *control* the concerns of patient safety, drug errors, medical protocols, and patient dissatisfaction. While no one disagrees with the goal of minimizing errors and risk, problems arise when one realizes that zero errors does not necessarily equal strong quality. We are rendering nurses helpless by partitioning them into camps dictated by what *not* to do, with no clear vision about the real desired outcome: emotional patient engagement and healing.[5]

On the flipside of this initiative-based leadership is weakness-prevention approaches (eg, scripting). Nurses are required to memorize exact words and phrases to use with their patients! Yes, nurses are unplugging their innate care-giving talents to be "one size fits all" robotic messengers. This cuts to the core of the very reason they chose this profession in the first place.

By studying excellence in nursing, we know that the very best nurses know *precisely* the right emotional outcomes for a patient, and they use their gifts to get there. They are encouraged to develop their talents and to find a clear path to impacting every touchpoint, with every patient, every day.

It's time we realize that the means of quality and productivity lie in the heads and hearts of our nurses—not in their hands and feet. We need to stop the "changing behavior" language that may play out in a laboratory but fails in real life. It's not about a greater level of conformance to establish a scalable level of quality. It's about seeing that quality or nonquality is the result of every touchpoint between a caregiver and the patient (or family). *Legislate the outcomes—not the steps!*

On to #3—Nurses are not abiding by the natural instincts that drew them to nursing. Believe it or not, nurses did not enter health care with the primary objective of making boatloads of money. They entered health care because of a visceral pull to be a significant part of a significant system, impacting lives directly every day. The appeal is emotional, not rational.

Hospitals and medical centers everywhere have forged a definition of quality that is inconsistent with that of patients and, frankly, nurses. In an attempt to monitor quality, administrators identify events and activities that can be easily measured, arriving at a working definition of quality—a rational attempt at an emotional issue. Case in point, the traditional patient satisfaction survey items: bathroom cleaned daily, call light answered in a reasonable amount of time, and so forth.

While this approach is well-intentioned, the consequences are severe for the emotional attachment built between the institution and nurses and the nurses and their patients. Have you ever been told, either directly or indi-

rectly, to be something that you naturally are not? And we wonder why nurses leave hospitals…

And finally, #4—Nurses are feeling as though they have no voice in quality-of- care issues. While it is not remarkable to find that virtually all nurses have participated in an employee survey in the past year, it is shocking to see that not one had a positive experience with this tool. Many report to being "scorecarded" (being compared to other peer work units) or pressured to achieve a goal set by administration. While results come back indicating an 85th percentile level of engagement, nurses report feeling further removed from having an honest voice about issues that really matter to them.

Gathering opinions through a survey is not a bad idea, but using survey results to replace dialogue between nurses and leadership definitely is.[6] While survey results get lots of attention, nurses and nurse managers are left not knowing how to use the data to drive productive change.

The broader issues identified in opinion surveys are helpful but not sufficient. While the issue of staffing levels will always be observed, the statistical nature of the survey does not address specific needs of those close to the action. Of course, everyone wants lower nurse-to-patient ratios, but what if one has the chance to have 45% greater impact by having the right systems in place? What if long-term patients are staffed with long-term caregivers? What if nurses are allowed (and even required) to focus on whom they are and how they can employ more of their "sweet spot" every day?

It is distressing that we hire nurses because of who they are, but then we take them down a road of development around which they are *not*.[7]

CONCLUSION

Nurses are vital to health care, including hospitals. Yet many nurses opt for various roles outside of acute care settings. Unless the underlying issues are addressed in every hospital, the shortage is likely to intensify. Capitalizing on outcomes rather than dictating details enhances the possibility of nurses remaining engaged and committed to patients in the acute care setting.

References

1. Nursing Executive Center. Conclusion 3. In: Health Resources and Services Administration. The Registered Nurse Population: National Sample of Registered Nurses, 2000, 2004, Engaging the Nurse Workforce Best Practices for Promoting Exceptional Staff Performance. Washington, DC: The Advisory Board Company; 2007.
2. Nursing Executive Center. Conclusion 5. In: Engaging the Nurse Workforce Best Practices for Promoting Exceptional Staff Performance. Advisory Board Nursing Engagement Database, 2006. Washington, DC: The Advisory Board Company; 2007.
3. Nursing Executive Center. Conclusion 31. In: Engaging the Nurse Workforce Best Practices for Promoting Exceptional Staff Performance. Advisory Board Nursing Engagement Database, 2006. Washington, DC: The Advisory Board Company; 2007.
4. Nursing Executive Center. Conclusion 96. In: Buerhaus P, et al. "Registered Nurses' Perception of Nursing," May-June 2005, 110-143. Advisory Board Nursing Engagement Database, 2006. Engaging the Nurse Workforce Best Practices for Promoting Exceptional Staff Performance. Washington, DC: The Advisory Board Company; 2007.
5. Nursing Executive Center. Conclusion 111. In: Engaging the Nurse Workforce Best Practices for Promoting Exceptional Staff Performance. Advisory Board Nursing Engagement Database, 2006. Washington, DC: The Advisory Board Company; 2007.
6. Nursing Executive Center. Conclusion 62. In: Engaging the Nurse Workforce Best Practices for Promoting Exceptional Staff Performance. Advisory Board Nursing Engagement Database, 2006. Washington, DC: The Advisory Board Company; 2007.
7. Nursing Executive Center. Conclusion 45. In: Engaging the Nurse Workforce Best Practices for Promoting Exceptional Staff Performance. Advisory Board Nursing Engagement Database, 2006. Washington, DC: The Advisory Board Company; 2007.

Curt W. Coffman, MBA, is xx with the Coffman Organization in Denver, Colorado. A researcher, bestselling author, speaker, and consultant, he spent 22 years at The Gallup Organization and served as its global practice leader for employee and customer engagement consulting. He can be reached at curt@curtcoffman.com.

1541-4612/2008/ $ See front matter

Copyright 2008 by Mosby Inc.
All rights reserved.

doi:10.1016j.mnl.2008.09.007