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Nursing Crisis: Retention Strategies for Hospital Administrators

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Abstract

High nursing turnover and shortages are symptomatic of the problems faced by many hospitals around the world. While the recruitment of agency and foreign nurses may provide temporary relief to staffing issues, hospital administrators are faced with the perennial problem of losing highly trained nurses with many years of experience. This paper discusses a number of retention strategies for hospital administrators to consider. It is argued that hospital administrators must pay attention to the employment status of nurses, the psychological contract and the immediate environment in which they work, if they are to effectively motivate and retain nurses.

INTRODUCTION

The high turnover and shortage of nurses in many hospitals around the world presents a challenge for hospital administrators. For example, across the United States, the number of graduating nurses has declined by 20 per cent in the last five years and there is a 10 per cent vacancy rate for nursing position (Sliby 2003). In Australia, the Australian Council of Deans of Nursing predicts that by 2006, Australia will have only 60 per cent of the registered nurses it needs (Dow 2003). In Canada, there is concern about the exodus of a third of the registered nurses due to retirement (Sibbald 2003). Similar trends are observed in Europe, Asia, and Africa (Rutter 2001, Prystay 2002, Choo 2003). Consequently, hospitals in developed countries are compelled to recruit foreign nurses from developing countries (Hardill & MacDonald 2000, Armstrong 2003). However, the hiring of foreign nurses presents another set of challenges. For example, the number of qualified nurses from these developing countries will be depleted when hospitals in developed countries try to fill vacancies (World Health Organisation 2003). There are important ethical ramifications associated with the migration of nurses, including adverse effect on the quality of health care in developing countries (Aiken, Buchan, Sochalski, Nichols & Powell, 2004), wage exploitation where foreign nurses are paid less than domestic nurses and discrimination faced by foreign nurses (Kline, 2003). Moreover, there may be a need for hospitals to incorporate diversity management initiatives to reduce potential difficulties in language, communication and the social integration of the foreign nurses (Martin, Wimberly & O'Keefe 1994). Such initiatives illustrate how nursing turnover and shortage has the dimensions of a global crisis.

In order to address this nursing crisis, hospital administrators are encouraged to endorse or review a crisis management plan that deals with labour shortage. Integral to effective crisis management is a series of four steps, which include prevention, preparedness, responsiveness and recovery (Nathan & Kovoor-Misra 2002, Sapriel 2003, Sheaffer & Mano-Negrin 2003). According to the United States (U.S.) Department of Education, the four phases deal with how an organisation may reduce or eliminate risks, plan for the worst case scenario, respond to crisis, and learn from the experience. The health care sector is believed to be searching for strategies to deal with the current nursing shortage and turnover crisis, and thus, is in the responsiveness stage. In this stage, it is important for hospital administrators to explore successful initiatives undertaken in other hospitals that have proven successful in retaining nurses (e.g., flexible rostering arrangements, including the use of web-based rostering).

Before discussing retention strategies for nurses, there is a need to understand some of the environmental pressures affecting nurse turnover and shortages. Nursing work has been deeply affected by government and management led initiatives to deliver quality patient service at lower costs (Bolton 2004). A number of commentators regard target setting, clinical budgeting, performance indicators, and quality audits as Taylorist forms of 'performance control' designed to weaken nurses' occupational autonomy (Keenan 1999) and to intensify the workloads of nurses (Adams, Lugsden, Chase, Arber & Bond 2000). Nurses can perceive these new public sector management practices as 'alien' (Bolton 2004), particularly when the promises of a quality service have not

been matched with additional resources. Radical changes in the health care environment may result in mounting frustration among nurses (Chan 2001), increased job dissatisfaction, decreased organisational commitment, lowered morale, and the increased frequency of industrial actions (Butler & Parsons 1989, Hayes 1993, Landeweerd & Boumans 1994, Aiken et al. 2002). In addition, changes in the expectations of nurses have affected the psychological contract between nursing staff and management. In this paper, 'managed health care pressures' provide the background for understanding the nature of current nursing turnover and shortages.

NURSING TURNOVER AND SHORTAGES

A caution must be placed on the nursing turnover literature to date since most studies have been conducted on full-time employees. Research by Werbel (1985) and McBey and Karakowsky (2000) suggest that a different set of forces affect the job withdrawal process of part-time employees than is the case with their full-time counterparts. Unlike the full-time work context where individuals leave an organisation as a result of their dissatisfaction with 'internal job-related' matters, part-time employees are often 'pulled' away from their jobs due to external factors such as family commitments, hobbies, or other work demands (Pollert 1988, Burgess & Campbell 1998, Junor 1998, ACIRRT 1999, McBey & Karakowsky 2000). The significance of these findings is that for part-time employees, such as agency nurses, turnover may be largely beyond the control of the hospital's management (Moody 2003). As a result, there is a great need to conduct additional research to identify how the causal factors of turnover vary between part-time or agency nurses, and their full-time colleagues.

Contemporary turnover research on full-time nurses draws heavily upon the model conceptualised by March and Simon (1958), in which it is proposed there are two key steps in the turnover process: (1) perceived desirability to leave, and (2) perceived ease of movement. Turnover for full-time nurses is instigated by internal 'on-the-job' factors which cause dissatisfaction (stimulating a 'desire' to leave), and results in actual turnover behaviour when the individual perceives relative 'ease' in leaving the organisation (e.g., attractive external job alternatives). For example, the graduate nurse program has given nurses greater flexibility (i.e., Bachelor degree in nursing can be a stepping stone to allied health professions, medicine, research, epidemiology, administration, and pharmaceutical company representation), which provides nurses with increased job mobility. The immediate antecedent to exiting the organisation is for the individual to express 'intentions to quit' (Youngblood, Mobley & Meglino 1983, Steele & Ovalle 1984). Applying the turnover model developed by March and Simon (1958) to the nursing environment, the managerial focus for turnover strategies for full-time nurses should be focused on eliminating job dissatisfiers (i.e., poor salary, lack of recognition, and workplace bullying) and encouraging a supportive working environment (i.e., teamwork, considerate supervision, training opportunities).

Some commonly examined antecedents of nursing turnover include job stress as a result of job burnout (Robinson, Clements & Land 2003), job dissatisfaction (Dworkin 2002), dissatisfaction with salary or benefits (Apker, Ford & Fox 2003), organisational climate of the hospital (Gormley 2003), poor nurse-physician relationships (Rosenstein 2002), workplace bullying (Hamilton & Pearce 2003), and unsuitable work schedules (Cangelosi, Markham & Bounds 1998). A study of the turnover intentions of 114 Singaporean nurses reported work-related factors such as whether nurses liked their jobs, had collegial work relationships, and were able to use their nursing skills and achieve recognition (Chan & Morrison 2000). More recently, researchers (Atencio, Cohen & Gorenberg 2003) have switched their attention to factors such as the ageing nursing work force and the weakening of enrolment in nursing degrees, which could pose a tremendous strain on the labour supply in the near future. Some of the negative consequences of high nursing turnover include the costs of recruiting and selecting new nurses (Cohen-Mansfield 1997), the cost of losing nurses with experience and knowledge (Chan 2001), diminished capacity to provide safe and effective care (Aiken et al. 2002), and an overall increase in nursing workloads (Gifford, Zammuto, Goodman & Hill 2002).

Arguably, a major reason for nurses leaving their profession is the perception of a lack of professional respect and recognition by hospital administrators, doctors and the broader community. According to Professor Judy Lumby, Executive Director of the Australian College of Nursing, nurses are working within hospital hierarchies that are 100 years out of date (Lumby 2004). In such a hierarchical environment, doctors are seen as the only credible professional voice in health and nurses are merely 'handmaidens', even though they are highly trained employees who outnumber doctors fourfold.

Another reason for nurses being undervalued is that there is a lack of definition about the role of nurses in today's health system. In the past, a nurse cared for the non-medical needs, such as providing emotional and physical support. Now there is much overlap in the roles performed by nurses and doctors, resulting in a lack of clarity on the respective roles. There is a great need for doctors to give up certain roles and tasks and to take on higher level roles and tasks, and to 'hand over' some of the clinical decision making to appropriate qualified and trained nurses. Doctor-nurse divisions are reinforced throughout the community by a lack of representation at the federal government level. Doctors, as represented by the Australian Medical Association and Chief Medical Officer, tend to dominate the health care debate. Nurses' voices tend to be marginalised as they only have representation at the state government level. The Dean of nursing and midwifery at Newcastle University, Australia, Professor Kathleen Fahy, says that a big part of the problem of keeping nurses is "the lingering perception of many that their role in health care remains undervalued" (Dow 2003: 4). It seems that until nurses are given an equal voice, nursing shortages will continue to grow as nurses leave the profession in frustration and insufficient numbers are being trained to replace them.

A lack of professional recognition of nurses reflects the fundamental differences that exist between bureaucratic

and professional modes of work organisation in hospitals (Benson 1973, Raelin 1986). The bureaucratic structure of hospitals is often not conducive to enhancing nurses' job satisfaction and commitment (Gifford et al. 2002, Bolton 2004). Because nurses participate in two systems (the profession and the hospital) there will always be potential conflict associated with the hospital's attempts to deploy nurses in a rational, unitary manner with respect to its efficiency targets and goals (Bacharach, Bamberger & Conley 1990). A fundamental area of disagreement is the 'clash of values' with respect to defining quality health care (Bolton 2004). Hospital management assesses quality in terms of outcomes: cost-effectiveness, patient turnover, and patients' complaints. Health care professionals include outcome measures in their definitions of quality, but also stress the importance of process issues such as the health care setting and how care is delivered (Hogston 1995). This can lead to heightened stress and frustration for nurses, particularly where additional resources are not available to accompany quality initiatives (Bolton 2004).

Several studies of nursing turnover highlight the importance of continuing training/education opportunities, and opportunities for advancement in reducing nurse attrition (Coile 2001, Lacey 2003, Vaughn 2003). Education and training can lead to feelings of increased self-worth and respect, as well as recognition by peers and organisational managers (recognition programs), which can be highly satisfying in nature. Furthermore, education can also improve the 'fit' between the nurse and her/his job requirements (Stengrevics, Kirby & Ollis 1991). The one caveat is that educational benefits are unlikely to be realised if nurses are overworked (Vaughn 2003).

THE PSYCHOLOGICAL CONTRACT AND CHANGES TO NURSES' JOB EXPECTATIONS

A further means of analysing the growing levels of dissatisfaction among nurses with their experience of nursing work is via the concept of the psychological contract and perceptions among nurses that this contract has been increasingly violated in recent years. The 'psychological contract' has been defined by Rousseau and others as the individual employee's subjective perceptions of the mutual obligations between employer and employee. Because it is subjective, this contract is characterised by bounded rationality in that it reflects the employee's incomplete, selective and potentially distorted view of the relationship (Rousseau & Ho 2000). As such, it may overlap with but also differ from matters codified in written contracts of employment.

The psychological contract thus fills the perceptual gaps in the employment relationship and shapes day-to-day employee behaviour in ways that cannot necessarily be discerned from a written contract. A violation of the psychological contract may elicit negative attitudinal consequences, including feelings of dissatisfaction, resentment, anger and mistrust. In turn, these emotions may produce a range of negative work behaviours ranging from lower commitment and reduced effort to higher absenteeism, sabotage and exit. A violation occurs when the employee experiences a discrepancy between the actual fulfilment of obligations by the organisation and what it has previously promised to do (Anderson & Schalk 1998).

In stable contexts, an existing psychological contract is likely to be reaffirmed by custom, practice and norms in relation to work effort, with substantial convergence between employer and employee understandings of the basis of the exchange. However, as contexts change, so too will employer expectations, employment practices, and employee perceptions of mutual obligation. Change heightens the possibility of incongruity between promise and fulfilment, and hence, the potential for perceived violation.

Guest (1998) has developed an extended model of the psychological contract (from the employee perspective) and this model represents a particularly useful way of understanding the attitudinal and behavioural impact of employment practices at the scale of the individual employee. Rather than representing the phenomenon as a homogeneous state of mind, Guest (1998) identifies three factor categories linked in a linear fashion: causes, content and consequences. Causes, or inputs to the contract, include organisational culture, human resource practices, prior experience, expectations, and work/life alternatives. Content, or the state of the contract, has three main affective components: trust, 'felt-fairness' and a sense of 'delivery on the deal'. Consequences include key attitudes, such as job satisfaction/dissatisfaction, job security/insecurity, organisational commitment, and motivation, as well as the full range of work behaviours, from interpersonal and work relations and prescribed task performance to attendance/absence and organisational citizenship behaviour; that is, behaviour of a non-prescribed, extra-task nature (Guest 1998).

Buchanan and Considine (2002) published an extensive study of the reactions of nurses in New South Wales (NSW) to changes in work practices and their subjective experiences of nursing work. Nurses interviewed noted that the inputs into their psychological contract via changes in work practices and expectations had dramatically changed in recent years. Nurses in NSW believed that the increased focus on 'running the hospitals like a business' had given rise to a focus on increased patient throughput. This increased focus on cost controls and throughput had resulted in significant changes in work practices. There were not only more patients in NSW hospitals, but there were patients with more serious injuries and diseases who are less able to undertake tasks such as washing and feeding themselves. There were strong perceptions that this increased workload had not been accompanied by increased staffing levels. In addition, nurses experienced increased responsibility for decision-making, in some cases involving work previously undertaken by doctors. Nurses also had increased responsibility to manage agency nurses and to assist more junior and less experienced nurses (Buchanan & Considine 2002).

These changes in inputs to the psychological contract were leading to a sense that management was failing to 'deliver on the deal' nurses expected to receive when they commenced nursing. This was fuelling growing dissatisfaction and perceptions that the intrinsic rewards on offer had also declined considerably. Changes to

hospital management practices and budgeting and ongoing problems with understaffing have reduced the time available to nurses to provide one another with the necessary support required to provide adequate patient care and to undertake their jobs effectively. There were also limited opportunities to undertake on-the-job training and for knowledge transfer between older and newer, less experienced, nurses. These developments combined to result in more stressful, more intense and less satisfying work for many nurses (Buchanan & Considine 2002). Furthermore, changing work practices and increasing work pressures had also made more intense other longstanding problems that continued to impact on job satisfaction levels. Such changes include more shift work, limited opportunities for career progression, and perceptions that nurses were not receiving the level of respect that they deserve from other professions within the health sector and among the community.

Among NSW nurses there was a widespread perception that while pay may not be the key factor motivating them to undertake nursing work, pay levels were too low for the intense nature of the tasks they experienced. In addition, there was a range of 'extras' that nurses had to pay for, such as parking and fees associated with undertaking education and postgraduate qualifications. The study by Buchanan and Considine (2002) concluded that:

> The intrinsic rewards offset the extrinsic weaknesses such as shift work, limited career paths etc. New management approaches, however, have gradually reduced nurses' ability to undertake those parts of nursing which delivered intrinsic rewards. Under these conditions the balance between intrinsic rewards/extrinsic liabilities has been broken. Pay increases would probably go part of the way to addressing this anomaly, but on their own they will be inadequate. (p. 46).

Such conclusions emphasise the importance of intrinsic motivation. The challenge and diversity of the job itself can be the primary motivator, particularly where professionals and knowledge workers are concerned. Intrinsic motivation and rewards are emphasised in the Job Characteristics Model conceptualised by Hackman and Oldham (1976, 1980). Building on Herzberg's two-factor theory model, Hackman and Oldham (1980) identified five job characteristics that are said to result in high levels of intrinsic motivation. These include a focus on: task identity, or the extent to which the worker is able to perform a complete cycle of tasks; task significance or the overall status and importance of the job; skill variety; autonomy, the extent to which workers can decide for themselves how the job will be performed; and feedback, the extent of feedback from supervisors and co-workers on the quantity and quality of work.

In addition, research by Canadian psychologists Judy Cameron and David Pierce suggests that extrinsic and intrinsic rewards can make a joint contribution to job satisfaction. Cameron and Pierce (1997) used a meta-analysis of some 100 studies of reward-performance effects to argue that intrinsic and extrinsic motivation combine in an additive way to increase overall motivational force. They found that people generally enjoy doing a task more rather than less when they receive an extrinsic verbal or tangible reward. In particular, they found that praise led to greater task interest and performance.

RETENTION STRATEGIES IN NURSING

Before presenting a variety of different strategies that can be utilised to influence nursing turnover, it is important to note that turnover is not necessarily negative in its impact or consequences. Turnover can be functional or dysfunctional, and it is unrealistic and even undesirable, to seek the complete elimination of 'labour wastage' (Dalton, Krackhardt & Porter 1981). For example, turnover is certainly 'functional', and positive in its consequences for both the employee and the organisation if it occurs early in the employment relationship when it has become apparent that there is a serious mismatch between an individual's 'ksao' (knowledge, skills, abilities and other characteristics) and the job-related requirements of the organisation. Thus, the recommendations proposed in this section will focus on different approaches that can be utilised to reduce dysfunctional turnover behaviour among nurses in health care settings. The central argument being made is that there is no panacea or 'one size fits all' solution that will eliminate all dysfunctional turnover on its own. Rather, it is critical to identify different aspects of the employment situation and subsequently to target specific strategies towards controlling turnover for each of these different work settings.

Despite the documented substantial costs associated with nurse turnover (the cost of replacing a nurse is estimated to range from $US10000 to $US145000 (or up to 150 per cent of the nurses' annual compensation), depending upon the type of job, level of experience and clinical skills (Barney 2002, Contino 2002), only 20 per cent of U.S. health care settings had nurse retention programs, and of these, only 10 per cent were deemed to be effective (Barney 2002). A common program component of hospitals and health care settings that do have retention programs is climate or culture surveys that can be used to gauge the perceptions of nurses, especially with regard to their unit culture and quality of work life (Coile 2001, Gifford et al. 2002). Another effective method is simply, yet rare in its occurrence, having managers communicate directly, frequently, and respectfully with nursing staff. Studies of voluntary nursing turnover have found that reasons for leaving which were reported to third parties differed substantially from those reported to employers upon departure, suggesting nurse-administrator relationships were typified by a lack of trust and poor communication linkages (Cline, Reilly & Moore 2003). Furthermore, administrators need to understand that nurses, as trained professionals, expect to be provided with autonomy (Aiken et al. 2002) and the opportunity to provide input and recommendations on how to improve their work setting (Lacey 2003, Ribelin 2003).

Given the high costs and work disruptions that can be associated with elevated turnover rates, it may be surprising

to learn that many administrators do not measure turnover for their organisation (and sub-units), or do so ineffectively (Waters 2003). Exit interviews should also be conducted with departing employees, preferably by third parties, in order to determine some of the reasons behind the decision to leave the organisation (Contino 2002). It is hard to devise effective strategies to reduce turnover when key decision-makers are unaware of the true costs and consequences associated with losing their nursing staff.

A key aspect of the work environment for nurses is the nature of professional relationships with physicians, an aspect of nursing that is in dire need of attention from administrators. Despite nurses having reported this factor as one of their 'top 5 reasons for staying' in health care settings, very few organisations mention the existence of positive collegial relationships as being an important component of their retention strategies (Lacey 2003). Chan and Morrison (2000), and Friedrich (2001) argue that nurses are more likely to stay in a hospital where they perceive that there is a positive relationship with their immediate supervisors.

With a global shortage of nurses, hospital administrators can no longer turn a 'blind eye' to the disrespectful behaviours exhibited by some of their physicians. The refusal of these individuals to accept nurses as valued professionals and key members of the health care teams help to create an environment that may result in high levels of voluntary nurse turnover (Kimura 2003). Such an environment results in feelings of anger, despair, and depression among nurses, and could lead to increased stress, decreased work performance, absenteeism, and higher levels of turnover (Barney 2002). Physicians who bully nurses and exhibit the aforementioned behaviours must be confronted and directed to change their behaviour, with written reprimands and progressive disciplinary actions being taken until corrective behaviours are observed.

Not surprisingly, patterns of nursing turnover rates are similar to other occupational groups in that they are highest for new entrants, and individuals with very little professional experience (Lacey 2003). This finding highlights the need for increased attention to be directed to improving selection methods, as well as developing programs for new-hires such as orientation and induction training. Retention strategies for part-time nurses should also focus on providing them with the greatest possible degree of work and scheduling flexibility, so that the job fits in well with their lifestyle, family, friends and other external commitments (McBey & Karakowsky 2000, Lacey 2003, Waters 2003).

One of the most effective ways to prevent turnover is for administrators to do their utmost in ensuring they have the 'best fit' between nurses and their job requirements, from the onset of the employment relationship (Barney 2002). By utilising 'realistic job previews' (Wanous 1978) in the selection process, HR managers can help suppress applicants' artificially high and unrealistic expectations about the job that almost inevitably lead to subsequent job dissatisfaction, the precursor to turnover. By supplying job candidates with salient information about negative, as well as positive, aspects of the job, HR staff can encourage individuals to self-select a job only if it is perceived to be a good match with their own specific needs, skills and competencies. Some important selection techniques, such as work tours, use of biographical-data (e.g., to check for past role behaviours such as 'team' membership or leadership, whether or not the applicant is a 'job hopper') and the structured involvement of 'work teams' in the interviewing process, may be used to reduce the subsequent turnover of new hires.

Orientation/induction training programs should provide new hires with the information they need to reduce stress and to gain a foothold in their new job environment (Waters 2003). Mentoring programs partner each new nurse with an experienced/expert nurse who serves as the new entrant's coach, counsellor and role model (Verdejo 2002, Lacey 2003). A U.S. medical centre which implemented this type of mentoring program reduced the turnover rate of new nurses from 34 per cent to eight per cent in just one year (Verdejo 2002).

As a final note, it is important to recognise that in some circumstances administrators may be largely powerless to reduce turnover behaviour. Although in many cases, turnover is a gradual process of the withdrawal of the individual from the hospital setting, this is not always the case. Situations of 'catastrophic turnover' occur when one specific incident or issue triggers the immediate exit of the individual from the organisation, and little or no previous indication of 'intentions to quit' was evident (Sheridan 1985, Mitchell, Holtom, Lee & Graske 2001, Mitchell, Holtom, Lee, Sablynski & Erez 2001). Managers are victims of external economic conditions and can do little to control or influence these environmental factors. Turnover may be pervasive in some occupations and industrial sectors if the supply of certain types of skilled personnel is scarce, and employment prospects in the outside job market are conducive to worker movement. Numerous studies have corroborated the strong inverse relationship that exists between unemployment and labour turnover rates (Mobley 1977). This relationship extends to poor performers, who exhibit a much greater tendency to quit their jobs if external job opportunities are plentiful (Keller 1984).

CONCLUSION

As many hospitals around the world continue to face nursing shortages, the pressure to attract and retain competent nurses is paramount. The nursing shortage crisis is the result of a combination of factors, such as dissatisfaction with current workloads, mandatory shift work, limited career opportunities, perceptions that nurses lack status, tensions in their relationship with other health care professionals, and declining levels of remuneration and job autonomy. While the migration of certain nurses cannot be avoided (e.g., due to poor individual-organisation fit, and retirement), hospital administrators have become increasingly focused on retaining competent nurses in order to maintain quality patient care.

The strategies discussed in this paper have emphasised ways of retaining nurses who are already in a hospital or

health care setting. In conjunction with these strategies, administrators are recommended to help increase their supply of nursing talent by conducting open-houses, social events, professional clinics, as well as internship sessions (Wiggs 2001). Agency nurses may be used as a short-term strategy. However, the use of agency nurses presents at least three challenges. First, agency nurses are expensive, and thus, will increase the hospital's expenditure. Second, critical knowledge that is relevant to patient care may be lost after the agency nurses finish their shifts, which could have a serious impact on the quality of patient care. Third, the use of agency nurses may encourage a less cohesive workforce, as agency nurses often get paid proportionately more. The development of linkages and collaborations with university nurse training programs may prove highly advantageous to both parties, particularly if it leads to increased flexibility in nurses obtaining training and degrees.

The paper made particular reference to the concept of the 'psychological contract' or individual employee's subjective perceptions of their expectations at work. It was suggested that many nurses may perceive that their psychological contract has been violated as a result of the shift to running hospitals as businesses and resultant increases in patient throughput. Such developments suggest that hospital administrators need to focus on both extrinsic motivators in the form of increased pay and conditions to attract and retain nurses, and on intrinsic rewards (Cameron & Pierce 1997). The Job Characteristics Model of Hackman and Oldham may provide a useful framework in which to consider improving the intrinsic motivation of nurses via its focus on improving task identity and significance, skill variety, autonomy and job feedback.

Improving the quality of work life of nurses may, therefore, prove to be an effective long-term approach to increasing hospital nurse retention. A report by the Nursing Executive Centre found that flexible work scheduling, a realistic, sustainable workload intensity, and increased compensation were valued most highly by the nurses they surveyed (Waters 2003). Their findings are corroborated by other studies which reported that nursing pay, although important, is not as critical to preventing turnover as is a positive workplace culture that facilitates teamwork, encourages continuous learning, accountability, trust and respect, and flexible scheduling . That is, nursing turnover and shortages needs to be understood from a broader focus than just job dissatisfiers. Recent research exploring the relationship between the culture of hospitals and nurses' quality of work life is encouraging in that it gives hospital administrators a framework by which to identify management practices that can enhance nurses' job satisfaction and commitment.

The nursing shortage crisis in many developed countries is likely to exacerbate the difficulties faced by hospital administrators in developing countries. The migration of nurses from Africa and Asia to the United States, Canada, the United Kingdom and Australia, has already created nursing shortage problems in several developing countries (Heitlinger 1999, Choo 2003, Reilly 2003). For example, the recruitment of nurses from Malaysia by Canada (Burke 2003), from the Philippines by the United States (Choo 2003), and from other Asian countries, has resulted in a global nursing supply that is severely depleted. Consequently, hospital administrators from the affected developing countries will be facing extremely fierce competition for nurses drawn from a greatly reduced pool of available nursing talent. Until the global nursing supply crisis is remedied, the key implication for hospital administrators is to proactively seek to implement human resource practices that will attract new nursing talent, while retaining high performing nursing personnel currently employed by their organisation.

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