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EXPLORING NURSES' FEELINGS ON FLOATING: A PHENOMENOLOGICAL STUDY

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ABSTRACT

The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. Husserl’s transcendental approach assisted in capturing the essence of floating as a lived phenomenon occurring in the nurses’ natural work environment. Karasek job demand-control was the theoretical framework. The study data analysis was conducted using the NVivo 10 software and Giorgi’s six steps, reflecting Husserl’s descriptive transcendental phenomenology. The study purposive sample included eleven full-time staff male and female registered nurses who routinely float to other units. Participants described their feelings on floating during digitally recorded interviews based on three open-ended interview questions aligned with the research questions to address the research purpose. Six themes emerging from the data analysis were (1) workflow process, (2) patients care assignment, (3) work environment, (4) psychological components, (5) sociological factors, and (6) physiological needs. Nurses expressed concerns about their ability to deliver quality, safe patients care in areas different from their area of expertise. In this study, nurses recognized that they have to float for diverse reasons, a finding different from previous studies. A conclusive evidence from this study was that nurses are reluctant to float but will do so comfortably if there were some measures in place to ease the process. The recommendations included ideas for changes in floating based on the data analyzed from participants’ responses.
DEDICATION

I praise the Lord for giving me the strength to succeed in this endeavor despite the innumerable difficulties encountered during these last five years.

I dedicate this study to my family who always encouraged me in becoming a scholar in the nursing discipline.

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Chapter 1

Introduction

Floating of staff nurses from primarily assigned units to care for patients on different units is a common staffing strategy, which generates diverse responses from nurses (Duffy, 2011; Klaus, Ekerdt, & Gajewski, 2012). Administrators use floating in acute and chronic health care facilities during periods of low patient census, unplanned staffing fluctuations, and unexpected staff call-outs (Kirchhoff & Dahl, 2006). Dols, Landrum, and Wieck (2010) analyzed results obtained from focus group discussions with four generations of staff nurses. Nurses across the generations expressed serious concerns about patients’ safety or losing their license when floating in unfamiliar areas. None of them believed “a nurse is a nurse” (Dols et al., 2010, p. 72) and thus should be able to work anywhere in the health care facility. Nurses surveyed viewed floating as an event, which triggers anxiety and unhappiness (Jones & Treiber, 2012). Floating as a staffing strategy continued into the 21st century.

Nurses’ various reactions to floating remained unchanged from the late 20th to the 21st century (Anonymous, 1978; Bates, 2013; Pronger, 1995). According to a study by Banks, Hardy, and Meskimen (1999), 73% of nurses disapprove of floating. Nicholls, Duplaga, and Meyer (1996) surveyed 127 nurses and found that 26% feared making mistakes when delivering care to patients in unfamiliar units. Nurses working in a specialty area lose the generic knowledge and skills acquired during nursing school. The result is a feeling of incompetence when mandated to float. Floating persists as a response to hospitals’ staffing needs (Becker, McCutcheon, & Hegney, 2010).
Mahon (2014) who conducted a qualitative study using a critical ethnographic approach in a pediatric nurse population concluded floating seems outrageous to nurses who float involuntarily. The researcher recommended investigating floating as a cause of job dissatisfaction and abandonment of the institution or the nursing profession. Good and Bishop (2011) described floating as a complex problem with multiple consequences on nurses’ job satisfaction and intent to leave the organization. Nurses in general, develop a routine in their work environment. Floating to unfamiliar areas appears disruptive (Mahon, 2014). Nurses described floating as a difficult stressful, challenging, and fearful experience (Bates, 2013).

There are a few stressful situations associated with nurses working in their assigned unit: death and dying, unsatisfied family members, and tense relationship with physicians, for example. Heuer, Bengiamin, Downey, and Imler (1996) indicated that stress is the most reported health concern experienced in the daily work of 35% of interviewed nurses who float. Findings in a more recent quantitative survey showed that 44% of nurses were unhappy working in acute care hospitals that required them to float and work away from routinely assigned units (Duffy, 2011). Floating deters team building and increases stress (AbuAlRub, Gharaibeh, & Bashayreh, 2012). Recent phenomenological studies on floating were not identified, resulting in a lack of information about nurses’ feelings other than unhappiness and stress.

The choice of a qualitative, descriptive, phenomenological study is ideal to address the shortage of literature on floating and nurses’ persisting concerns. Giorgi (2011) recognized that individuals describe their encounter with a phenomenon accurately, as lived. The sampling was purposive. Two male and nine female staff
registered nurses (determined by saturation) regularly called upon to float outside their routinely assigned units participated in the study. The purpose of the study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. Qualitative research using face-to-face interviews with nurses describing their lived experiences with floating outside routinely assigned units is rare. The following paragraph includes topics addressed in chapter 1.

Information on the background and significance of floating is a fundamental aspect of chapter 1. An appraisal on the nature of the study as well as the research questions and theoretical framework follows. The final section of the chapter comprises a list of formal definitions of terms and the study’s assumptions, scope, limitations, and delimitations. Information in this first chapter will illustrate the significance of the study for leadership and nursing as a profession, along with factors that contribute to the need for floating such as nursing shortage, institutions’ budgetary constraints, and types of reimbursement for patients care by regulatory agencies. Chapter 1 closes with a summary of the fundamental concepts on floating (definition, causes, consequences, etc.) and its implication for nursing practice.

**Background**

Documentation on floating nurses outside their regularly assigned units is retrievable as far back as 1978 (Wiley, 1978). Floating is an approach used to solve sudden changes in acute care hospital staffing requirements. An unexpected deterioration in a patient’s condition, resulting in the need for one-to-one care, exemplifies a commonly encountered disruption in staffing. Other disturbances arise when nurses experience personal or familial emergencies and nursing staff cannot work scheduled
shifts (Estryn-Behar, van der Heijden, Fry, & Hasselhorn, 2010). Nurses would float only if they wanted: floating was voluntary.

In the 1990’s, supervisors began providing nurses with the option to float to other units (or choose to take paid time off) during patient census fluctuations. Managers and nursing supervisors had the authority to contract float-pool nurses where available, per diem, or agency nurses, a more expensive alternative, to fulfill staffing requirements. A written policy on floating was not consistently obtainable in some facilities (Phillipi, 1989). Hospitals’ administrators introduced changes in the above-mentioned process. There was no choice given when changes in staffing needs occurred: nurses must float.

Organizations’ administrators began, with some variations in policies, requiring nurses to float in the late 20th century. Floating shifted from a staff decision (in which a staff member could choose to either float or go home and receive paid time off) to a manager’s command (in which a staff member must float on a rotational basis). After a review of the literature from 1978 to 2014, recent studies on floating, particularly on nurses’ feelings based on lived experiences floating to areas other than their unit-base were not available. Further research to explore nurses’ feelings regarding floating as a lived experience is desirable. In the 21st century, floating still occurs and continues to be a means of supplementing units in need of staff.

In the second half of the 1990s and the early 2000s, floating became mandatory. Nurses floated first in specific units of their health care facilities and subsequently hospital-wide (Roach, Tremblay, & Carter, 2011). This decision coincided with the enactment, in 1997, of new laws on reimbursement for health care services and the
ongoing financial crisis in the United States. Banks et al. (1999) depicted a modification in practice that occurred in a hospital in Nevada in 1997. In reaction to newly enacted reimbursement regulations, health care institution administrators upgraded the floating policy from no floating in closed units to floating hospital wide.

In 2015, floating remains obligatory, because of hospitals’ budgetary restrictions and the many established benchmarks to reach before collecting third party reimbursement. Insurers, especially agents for the Centers for Medicare and Medicaid Services (CMS, 2009, 2012, & 2014), consider claims for compensation after ensuring that executives complied with established regulations. CMS’ representatives’ cancellation of the fee-for-service is a powerful drive for health care managers to move nursing staff involuntarily to areas in need. Walker and Osterhaus (2010) posited that cost containment measures followed this cancellation at all levels. The stated rationale behind mandatory floating was that institution executives hire staff to work into the organization, not for the exclusive needs of patients in one department. Forced floating linked to staffing fluctuations and monetary issues in health care have numerous consequences.

In the late 1970s, an anonymous investigator (1978) conducted an informal survey of nurses and floating. The findings were 75% of nurses participating in the survey expressed strong negative sentiments about floating. Heuer et al. (1996) reported that 59 nurses (35%) who returned a survey conducted on nurses’ stressors acknowledged floating as the most stressful element. Foxall, Zimmerman, Standley, and Benne (1990), examined the existence of stressors and their origins in three different nursing specialties (hospice nursing, critical care nursing, and medical-surgical nursing). The researchers
identified floating as one of the most common stressful events affecting all specialties. It may be a motivation for nurses to work with staffing agencies.

Donovan (1978) suggested that nurses choose to work with staffing agencies to avoid the constraints of stringent schedules and the inconveniences of floating. Owners of private nursing staffing agencies hire nurses trained in multi-specialty areas, ready to work in various hospital units. According to Goodman-Bacon and Ono (2007), these nurses are ready to work when and where needed. They receive applicable benefits such as health insurance upon completion of agreed numbers of hours per week with accommodation reimbursement (travel, housing expenses, etc.) when necessary.

**Problem Statement**

One of the main responsibilities of a seasoned nurse is to educate new RNs. Kowalski and Cross (2010) indicated that this approach assists in fulfilling the institutions’ needs for specialty nurses while validating the RNs’ choice. Unit-based nurses focus on one practice area (Linzer, Tilley, & Williamson, 2011). They develop a sense of achievement becoming a valuable team member in their unit with deep specialist knowledge and expertise (Mahon, 2014). The general problem was that nurses that develop expertise in a single area often gradually lose the broad base theoretical education received (Jones & Treiber, 2012). As a result, nurses obligated to work in unfamiliar areas due to mandatory floating may pose a risk to patient safety (Dols et al., 2010).

The specific problem was that there were no qualitative data (especially generated from phenomenological studies) describing nurses’ feelings on mandatory floating. Hospitals’ administrators introduced mandatory floating in their institutions to reduce
expenses and counteract the fixed rate and bundling associated with reimbursement (Korda & Eldridge, 2011; Xufeng, Russell, Valiyeva, & Miller, 2011). According to Duffy (2011), 44% of nurses (n= 138 of 314) experienced disappointment and anger when called upon to float. A literature review conducted from 1978 to 2014 contained quantitative studies on nursing and floating but no qualitative studies with a phenomenological design. It is necessary to explore nurses’ feelings on mandatory floating using the phenomenological approach to allow nurses to describe their lived experiences of floating.

This transcendental phenomenological study added information to the current literature about nurses’ feelings on floating. It provided leaders in the health care field with valuable knowledge about nurses’ perception of forced-floating. It closed the identified gap in understanding an understudied problem. Findings from this study may prompt hospitals’ administrators to create, revisit, or modify existing policies on floating accordingly. Researcher used epoche or the ability to focus on participants’ description of the lived phenomenon (Husserl, 1970a/1936) to prevent bias. The study sample comprised 11 full-time staff registered nurses as determined by saturation. These nurses have experiences with involuntary floating and work at the designated acute health care facility within one large city of South Florida.

**Purpose Statement**

Floating is a widespread phenomenon nurses encounter routinely throughout their career. The purpose of the study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The central idea was to understand the feelings of nurses (as determined by data saturation during
data collection) when floating to a unit other than their unit-base. Nurses invited to contribute to this research study were currently working full-time in the selected acute health care facility. In this study, the focus was on investigating nurses’ feelings following the lived experiences on floating away from their regularly assigned units by means of a qualitative approach.

This phenomenological study added information to the current literature. It closed the identified gap in knowledge of floating an understudied problem. This research allowed nurses to describe their lived experiences associated with the consequences of floating as health care providers. Findings from this research study may provide direction for hospital administrators to make available the necessary support services for floating nurses.

**Significance of the Study**

Different individuals give diverse meanings to phenomena according to circumstances in which they occur. This study is significant to nurses, leaders in health care institutions, and future research because it contributes to an in-depth understanding from the opinions of nurses on their feelings about floating. It provides information on the lived experience of nurses who must care for patients on unfamiliar units, a common phenomenon concerning the nursing profession. The following paragraphs comprise a description of the significance of floating to nurses, leaders in health care institutions, and the possibility for future studies.

**Significance to Nurses**

This study is significant to nurses because selected participants had the opportunity to express their feelings on floating as a lived experience. It contributed to
an in-depth understanding of nurses’ feelings on floating a phenomenon common to the nursing profession. Data collected during semi-structured individual interviews revealed participants’ perception of floating to different units of a South Florida acute care hospital. The analysis of these perceptions results in the understanding of the advantages and disadvantages of the practice by leaders. The significance of floating to nurses is complex because it influences different aspects of leadership in a health care organization such as scheduling, staffing, etc.

**Significance to Leaders in Health Care Institutions**

The significance of this research to leaders in health care institutions correlates with efforts set forth to improve nurses’ recruitment, retention, and job satisfaction. Understanding how new graduates and experienced nurses react when mandated to float may contribute to the creation of nurse-friendly float policies. This may enhance cost containment by increasing retention and nurses’ satisfaction, which may decrease turnover. To achieve these results, institutions may benefit from understanding what motivates nurses to stay within an organization or leave a system (McGlynn, Quinn Griffin, Donahue, & Fitzpatrick, 2012). Administrators may introduce new retention measures accordingly (McGlynn et al., 2012). If results are significant, leaders in the health care field may prioritize scrutiny of their organizations’ turnover rates and expenditures in units where nurses float most often.

Feelings on floating described by nurses in this qualitative study may increase leaders’ awareness of a practice that if reviewed will direct to other interventions to respond to staffing needs. From their perspectives, nurses having to float may reveal some advantages and disadvantages of the floating practice, during the study. The results
will add pertinent information about floating to the existing literature beneficial to hospital executives. The result of this study will illustrate the personal interpretation and professional encounter of nurses who float to different units of an acute health care facility within a large southern city during periods of low patients’ census. It could represent a motivation for future studies on floating.

**Significance to Future Research**

The expectation for this study is to uncover information about the experiences and emotions associated with floating among nurses. Knowledge generated from the study will add to the limited current qualitative literature describing nurses’ lived experience on the phenomenon and its implications for nursing practice. Themes extracted after interview content analysis will advance knowledge and add further updated information to the present body of literature about nurses’ feelings on floating. The literature contains recent qualitative studies on floating but none phenomenological. Findings from this research are the most current analysis of nurses’ feeling on floating. Husserl (1970a/1936) described humans’ activity as a product of life-world events. The notion that nurses as human beings experience feelings on floating as a phenomenon is central to the study. Other researchers may develop a renewed interest in the phenomenon.

**Nature of the Study**

A qualitative research design based on Husserl’s (1970a/1936) transcendental phenomenology served as the theoretical foundation for the study. The emphasis was in participants’ expression of their inner world (Husserl, 1970a/1936). The focal point for this study was to explore nurses’ feelings regarding floating, as a lived experience. Floating influences nurses’ perceptions of the phenomenon. Phenomenology is
“experiential” (Giorgi, 2010b, p. 177). A phenomenological approach was suitable to this study because the intent was to describe lived experiences with a phenomenon and not to try to quantify nurses’ feelings, as would be the case if a quantitative study was conducted (Walker & Read, 2010).

The study sample comprised 11 full-time staff registered nurses who routinely float to other units as mandated by hospital policy and staffing needs at an acute health care facility within a large southern city. Leedy and Ormrod (2010) posited that a phenomenological qualitative study requires from five to 25 participants based on when saturation (no new emerging ideas) occurs in the data. Participants who voluntarily agreed to be part of the study were licensed registered nurses hired full-time at the designated hospital in South Florida, and they experienced floating consistently on a rotational basis. In this study, the sample included two male and nine female registered nurses. Because of the qualitative nature of the study and the small sample size, it was not possible to conclude whether gender was an important element influencing perceptions of floating.

Nurses float on a rotational schedule (Bard & Purnomo, 2005). Hospital managers maintain a monthly float folder in which the nurse in charge for the shift logs nurses who float (date, time, and shift). The earliest nurse who floated becomes first to float when the need arises. As a rule, the float folder does not contain data on new graduate registered nurses who are floating with preceptors during their scheduled orientation period, those working only by term-limited contract or by per diem, flex/float-pool staff, nurses who volunteer to float, and agency nurses. The managers of the different units keep a current record of floaters (Bard & Purnomo, 2005).
**Study Design and Method**

Different methodologies and designs are available to researchers. The phenomenological design is non-experimental and allows the study of phenomena as lived and interpreted by individuals who experienced the practice of floating. This is the case for nurses routinely scheduled to float according to hospitals needs and census fluctuations. The transcendental phenomenological design was appropriate for the study of nurses’ feeling on floating because it allowed researcher to obtain participants’ description of the phenomenon. Giorgi (2006) posited that bracketing of the transcendental world releases the individuals’ phenomenal world (p. 11). The qualitative method assists in the exploration of phenomena occurring in the individual’s natural settings.

An inquiry into nurses’ experiences with floating in an acute health care facility within a large southern city in South Florida fits the qualitative method chosen. The transcendental approach encompasses steps to explore individuals’ perception of lived events. The focus of a phenomenological inquiry is on describing human beings’ psychological actions and reactions (Alston & Nakhnikian, 2010). The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The findings may reveal nurses’ conscious feelings when floating to a unit other than their unit-base. Husserl (1970b/1901) addressed consciousness as the awareness of objects in the outer world translated into meaning.

The qualitative phenomenological research method was appropriate for the project fulfilling the purpose of uncovering new insights about floating, from a nursing
perspective—a topic in need of further research. In the study, nurses described their feelings about their lived experience with floating. Lived experiences stimulate meaningful description of phenomena (Husserl, 1964/1928). Researchers demonstrated in prior studies that floating is a motivator for low morale, disengagement, perceived lack of organizational support, and intent to leave an organization (Dziuba-Ellis, 2006; Kotzer & Arellana, 2008; Nicholls et al., 1996; Wieck, Dols, & Northam, 2009). The chosen method and design provided the opportunity to examine nurses’ feelings on floating in the 21st century based on participants’ experiences in their natural environment.

Using a transcendental approach assists in capturing the essence of a lived phenomenon as it occurred to individuals (Christensen, Johnson, & Turner, 2011; Leedy, & Ormrod, 2010). Edmund Husserl’s transcendental phenomenology served as the theoretical foundation for the study (Husserl, 2010/1964; Vandermause & Fleming, 2011). Husserl, the father of phenomenology, stated that researchers must have the necessary knowledge of the dichotomy involving the self and the environment (Husserl, 2010/1964). These factors influence individual perception and understanding of pure phenomena (Husserl, 2010/1964). During the interviews recorded active listening, observation, and the use of open-ended interview questions with the intent of identifying, summarizing, and analyzing emerging themes served as a basis for data collection (Merriam, 2009).

A quantitative method (descriptive and experimental) was not appropriate because the intent is not to compute nurses’ feelings and measure variables. Researchers using the descriptive design are concerned with gathering data to identify specific
characteristics of a phenomenon and include descriptive statistics measurements such as percentage, mean, median, etc. in their results. This study was qualitative consequently, it did not contain variables to manipulate as it would have been the case in a quantitative study. With the experimental design, researchers manipulate elements of the study sample (Christensen et al., 2011). Interventions applied to the independent variable serve as basis to measure whether or not a change occurred in the dependent variable.

Researchers using a correlational design evaluate the relationship between variables. These studies in general require a large number of participants for results to be credible and generalizable. Quantitative researchers look for generalizability through validation of relationships to contribute to existing theories. Numerical data collection is a mean to explain, predict, and or control phenomena under scrutiny. There was no attempt to use inferential statistics in this study because not one truth or reality exists when exploring different individuals’ feelings about a phenomenon. Formulation of a strong reliable hypothesis and research questions, which forecast generally the outcome of the study, is necessary in the quantitative approach. In this study, there was no attempt to use statistical inferences, or formulation of hypothesis as would have been the case in a quantitative approach. Hypothesis and theory testing are features of quantitative studies (Creswell, 2007).

There is no formulation of hypotheses in qualitative studies because of their inductive nature. The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The objective was not to calculate a correlation between variables or establish a cause and effect relationships. In a qualitative inquiry, researchers use open-
ended interview questions to elicit a wide range of answers on the topic of interest. Manipulation of an independent variable to examine the response from dependent variables, a feature of quantitative approaches, is not applicable to this study.

**Research Questions**

Formulating the research questions is a significant step in the research process because a well-thought question focuses on the problem under investigation and the method appropriate to achieve the research purpose. Qualitative researchers generally format the interview questionnaire using broad and probe questions. The study evolved around three broad research questions built to explore nurses’ feelings on floating

RQ 1: What are nurses’ experiences when it comes to floating?

RQ 2: What are nurses’ feelings when floating?

RQ 3: What factors influence nurses’ feelings when floating?

Broad and probe interview questions guided the interview process. Listening to nurses answering to these open-ended interview questions may be sufficient to explore and understand floating as a phenomenon. Probe questions were available for further clarification, to address areas not covered during the interview, and to redirect participants toward the topic of interest if necessary. Interview questions are included in Appendix A.

**Theoretical Framework**

A theoretical framework is a set of concepts available in the literature that functions as a blueprint to guide researchers in understanding phenomena (Moore, 2006). Most nursing theorists focused on nursing as a discipline in its relation with the delivery of patients care and nursing education (Im & Chang, 2012). Researchers in the health
care field borrowed theoretical frameworks from psychology because of the lack of nursing theories applicable to some incidents occurring in the profession. Im and Chang (2012) believed that despite changes stirring in the environment, nursing theories remained unchanged. A review of existing frameworks directed to a potential structure for the study.

Various conceptual models available in the literature are relevant to the study of nurses’ lived experience when floating to a different area of expertise. An extensive review of the literature directed to the identification of 19 theoretical frameworks suitable to this study. Following a closer analysis of these theories and their relationship with the complex concepts involved in nurses’ feelings and floating (individual, environment, management, and peers) 15 did not meet the study purpose. These models were not relevant to the many characteristics of the phenomenon.

Some of these models were applicable to one aspect of the phenomenon. Researchers (Grant & Hogg, 2012; Perry, 2011) studied individuals’ response to an event based on lack of self-confidence in the environment (perceived or self-uncertainty, change-related self-efficacy, and coping strategies/adjustment). Dinibutun (2012) emphasized job security as motivator of one’s reactions to an unusual situation. Other researchers suggested that the perception of fit (Saks & Ashforth, 1997) influence individuals’ assertiveness and work outcomes. The retention of five possible theories concludes the above analysis.

The four remaining theories were Maslow’s Hierarchy of Needs (1943), Karasek’s (1979) Job Demand-Control (JDC), Bandura’s Social Cognitive theory/Self-efficacy concept (1977), and Bagozzi’s attitude theory (1992). An elaboration of these
theories ensues. Karasek’s Job Demand-Control (JDC) was the framework for the study. In the next four sections, a description of four pertinent theoretical frameworks follows.

**Maslow’s Hierarchy of Needs – A Theory of Human Motivation**

In 1943, Maslow and the humanists believed that intrinsic/extrinsic motivation is a powerful force behind individuals’ feelings and behavior. Maslow (1943) developed the motivation theory, or theory of the hierarchy of inborn needs, based on humans’ needs; he described five basic levels of needs (physiological, safety, belongingness and love, self-esteem, and self-actualization. A pyramid illustrates the concept behind this theory with five ascending levels, ranging from physiologic needs at the base, through safety, belonging, and esteem, to self-actualization at the apex of the pyramid (Groff Paris & Terhaar, 2010).

Nurses, as human beings responsible to care for themselves and their families, fall into the category of individuals who need to satisfy basic physiologic needs (needs for food, water, safety, shelter, etc.). The higher order of needs includes social needs such as respect, trust, independence, and recognition among others (Vandeveer & Menefee, 2010). Floating to diverse units of a hospital requires the establishment of social relationships with peers to fulfill these needs. Unit nurses working in short-staff situations have little time to dedicate to new comers’ social needs (Pronger, 1995). Maslow’s hierarchy of needs may serve as a foundation to explore nurses’ feelings and behavior when floating to areas of expertise different from their own. Maslow, Frager, Fadiman, and McReynolds (1970) described individuals’ ability to cope in unfamiliar environments based on the concepts of purposiveness, perspicuity, and motivated behavior among other characteristics.
Bandura’s SCT/Self-efficacy Concept

Self-efficacy is someone’s belief in own abilities in achieving a goal or in making an informed decision (Bandura, 1977). Individuals’ level of confidence elicits either a positive or a negative reaction according to perceived threats in the environment. Bandura’s self-efficacy concept, a feature of his social cognitive theory encompasses a cognitive/behaviorist component. Individuals’ behavior (performance) in a familiar work environment may be different in unfamiliar areas with different features.

Directors organize each hospital unit according to the needs of the patient population admitted in these units. In the intensive care unit, there is a readily visible cardiac monitor in each room whereas in the telemetry area, patients wears a portable monitor, a staff from a remote centralized monitoring system is responsible for observing patients’ cardiac rhythm. A door code and temporary login and password is necessary each time a nurse floats whereas in one’s unit access is granted through employees’ identification number, some digits of one’s social security numbers, and fingerprints. Bandura (2009) examined a person’s actions/reactions in relation to psychosocial factors. He posited that cognition plays a major role in human beings’ behavior and performance. This assumption seemed proper to explore nurses who float to an unfamiliar environment. Nurses who float may not work assertively despite years of experience in the nursing profession because of the changes in their work environment.

Bagozzi’s Theories of Attitude

Bagozzi (1992) described the three theories of attitude as “the theory of reasoned action, the theory of planned behavior, and the theory of trying” (pp. 178-179). He described a link between a “person's appraisals, a person's emotions, and a person's
behavior” (p. 178). Bagozzi (1992) in his theory of reasoned action, indicated that individuals first base their behavior on the intention to perform an act, after which a negative or positive attitude results according to perceived consequences of the performance.

In the theory of planned behavior, the concept is the same as in the theory of reasoned action except that in this case individuals believe that they may have control over their external or internal environments. They assume that they can perform required tasks in the environment. The theory of trying relates to individuals’ previous attempts at completing a task, or their intents of trying, and how they link to perceptions of success or failure (Bagozzi, 1992).

**Karasek’s JDC**

The core concept of Karasek’s JDC is the effect of stress and strain on workers (Karasek, 1979). JDC encompasses a three-dimensional paradigm (affective strain, work overload, and control). Affective strain triggers short-term reasoning dysfunction (Tucker et al., 2008). This construct may assist in exploring nurses’ emotional conditions when assigned to float. Another critical concept of JDC is work overload. Nurses working in areas caring for patients with a nurse/patient ratio 1:3 may float to areas in which the ratio is 1:5. Tucker et al. (2008) identified this concern as quantitative overload. If the nurse floats in an area of specialized care with a 1:2 ratio, a different concern may be qualitative overload, or the perception of a disparity between one’s skills and the job demands in a specialty area (Tucker et al., 2008). The nurse/patient ratio in ICU is 1:2 in spite of patients’ acuity or unit census (Debergh et al., 2012).
The ability to complete an assignment is a function of how well an individual is in control of his or her work environment. Jourdain and Chênevet (2010) identified the nurses’ work and social environment as major stress producing factors. Atteya (2012) described three components of stress: physical, mental, and situational. A change in one or all three components triggers a disequilibrium, which influence performance in the work environment. Control of the work environment is critical for nurses to deliver competent patients care.

**Framework Selection**

The most appropriate framework to explore nurses’ feelings regarding floating was Karasek’s JDC. This model contains the main elements addressing nurses’ experiences when directed to float. For Krapohl, Manojlovich, Redman, and Zhang (2010) professional nurses working in specialty areas pursue their career goals through certification, continuing education, and expert practice. Gagnon, Bakker, Montgomery, and Palkovits (2010) recognized that throughout the years, nurses develop critical thinking, autonomy, and decision-making abilities in their chosen specific nursing fields. Tucker et al. (2008) agreed floating to an area different from a nurse’s area of expertise result in decrease cognition and reasoning illustrating Karasek’s JDC affective component.

Humans have feelings that may influence cognition and behavior. The notions of quantitative/qualitative strain and work overload were suitable to explore nurses’ feelings regarding floating as a lived experience in areas with either a high nurse/patient ratio or patients with higher acuity. The concept of work environment control is important to workers in any field. It allows autonomy and decision-making, two crucial nursing
beliefs. Nurses must feel competent and autonomous in making vital decision to save patients’ lives based on education and previous experiences (repetitions of actions/reactions) in specific areas of expertise (Purdy, Spence Laschinger, Finegan, Kerr, & Olivera, 2010).

Karasek (1979) examined the psychological and physical implications resulting from the interactions between individuals, work, and stress. The model encompasses four types of jobs: high-strain, low-strain, active, and passive (Karasek, 1979). JDC is a bi-dimensional model, which includes the concepts of job demand, job control, and their additive/multiplicative effects (Karasek, 1979). Job demand refers to the quantitative and urgency features of a job strong enough to intensify workers’ anxiety levels (Hausser, Mojzisch, Niesel, & Schulz-Hardt, 2010). It entails the amount of tasks to accomplish in a set period (time pressure/time limit) and varies with workers’ abilities to perform in the environment (Turner, Stride, Carter, McCaughey, & Carroll, 2012).

Job control is an employee’s potential to influence the work environment. It correlates with how effectively individuals are in control of their surroundings and their capacities to make informed decisions in a given situation (Karasek, Baker, Marxer, Ahlbom, & Theorell, 1981). A mismatch between job demand (high) and job control (low) results in high stress level, low performance, and psychological and physical dysfunction (Karasek, 1979). Compared to other theories, JDC symbolizes the several issues described by participants mainly, the effect of unfamiliar work environment, job demand, job control, job stress, and resulting strain.

The other models presented Maslow’s, Bandura’s, and Bagozzi’s, although appropriate, are inadequate for the purpose of this study. The researchers only explored
the subject partially as compared to Karasek. Maslow addressed individuals’ basic needs as motivators to accomplish tasks; individuals will do what it takes to meet their basic needs regardless of their feelings and will advance to higher levels of the hierarchy only when meeting these needs. Bandura’s SCT does not include the quantitative/qualitative work overload aspect of a job. Bandura linked self-efficacy to cognition but did not mention the importance of working in a controlled environment.

An individual’s attitude or behavior is the core concept of Bagozzi’s theories (1992). He suggested an existing link between a person's appraisals, emotions, and behavior that could be useful to the understanding of a behavior (Bagozzi, 1992). The purpose of the study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The anticipation is to understand their feelings when floating to a unit other than their unit-base not their behavior.

**Definition of Terms**

This section includes formal definitions of the terms used throughout the study, based on credible sources available in the literature.

*Agency nurses.* Temporary nurses recruited from commercial nursing agencies (Hurst & Smith, 2011) to respond to staffing fluctuations (on one-shift schedules) during short-staffed episodes. These nurses stabilize the nurse/patient ratio in institutions in times of need (Castle & Engberg, 2008). Temporary nurse staffing costs significantly more than permanent unit staffing (Hurst & Smith, 2011).

*Casualization.* A concept indicating when nurses choose to refuse full-time positions voluntarily in favor of a more flexible schedule based on economic pressure and
competition (Becker et al., 2010). These nurses function the same way as float-pool nurses (Becker et al., 2010).

**Floating.** The practice of temporarily moving a nurse from one patients care area to work in another. This tactic is commonly used in reaction to sudden staffing needs. (Kirchhoff & Dahl 2006, p. 23; Klaus et al., 2012).

**Floating in closed units.** The practice of floating nurses to like units; for example, moving a nurse from medical surgical to work on another medical surgical unit or moving a telemetry nurses to work on an ICU to care for patients awaiting transfer to a telemetry unit (Banks et al., 1999; Zolnierek & Steckel, 2010).

**Float-pool nurses.** A group of nurses who float exclusively to areas in need (Larson, Sendelbach, Missal, Fliss, & Gaillard, 2012). These nurses do not work on any specific units. Educated in multiple nursing specialties with a medical surgical background, a float-pool nurse must be available as necessary to meet staffing needs in units that experience sudden increases in patients’ acuity level or timely unit-based staff call-outs (Larson et al., 2012).

**Forced floating.** The act of mandating a nurse to float to units in need as dictated by staffing fluctuations and changes in patient acuity (McHugh, 1997) even if the nurses believe they are not ready or able to provide safe care to an unfamiliar patient population (Nicholls et al., 1996).

**Per diem nurses.** Temporary nurses who respond to last-minute staffing needs. The expectation is that per diem nurses are the first nurses to float and respond to last-minute staffing needs (Goodman-Bacon & Ono, 2007).
Turnover. The act of a nurse resigning from an institution for any reason (Estryn-Behar et al., 2010). Unit-based or unit nurses. Nurses hired to work consistently 36 to 40 hours per week in specific units (Linzer et al., 2011; Wright & Bretthauer, 2010).

Assumptions

Basic assumptions exist with each research problem. The identification of assumptions pertinent to participants and the phenomenon was paramount to the success of this study. The following paragraph is a depiction of some assumptions central to exploring and identifying nurses’ feelings. The central assumption for this study was that nurses who float unwillingly experience feelings that influence their work and patients’ care, thus warranting further research. It is assumed that floating is a significant matter affecting nurses daily lives and health care institutions. Another assumption was that nurses who meet the inclusion criteria will participate in the research study and will answer honestly to the main interview questions during the interview process. These assumptions were based upon a corpus of available research on the nursing practice.

Scope

The scope in a qualitative study can be broad, contributing to the discovery of many truths and the existence of different realities of one phenomenon lived by different individuals. The scope of this study incorporated a careful selection of the sample and the natural setting in which the phenomenon occurs, following the qualitative method guidelines to fulfill the purpose of exploring nurses’ feelings. These nurses must have experienced floating as a phenomenon. The population for this study was nurses who work full-time. Data collection was through individual, semi-structured, digitally recorded interviews in a location agreed upon between researcher and participants. Data
analysis continued until reaching saturation—that is, when no new themes emerged from the data. Units and themes comprised nurses’ lived experience with floating regardless of area of specialty, length of time as a floater, and generational category. The scope of this qualitative study included feelings described by 11 nurses who work in an acute care facility.

Data collection and analysis continued beyond reaching saturation. Two additional interviews scheduled ahead of time concluded data collection after achieving saturation with the ninth interview. Meaning units and themes comprised nurses’ lived experience with floating regardless of area of specialty, length of time as a floater, and generational category. The scope of this qualitative study included feelings described by 11 nurses who work in the elected acute care facility.

**Limitations**

The limitations of this study were associated with the existing debate regarding findings from qualitative versus quantitative research methods. A major limitation of this study was the transferability of the findings. The qualitative study encompassed descriptive, non-inferential statistical methods. Nurses from diverse areas of expertise enrolled in the study experienced different feelings regarding floating as a lived encounter. Participants’ generational backgrounds and experiences may interfere with their feelings. Nurses’ feelings are subject to change. Results may be applicable only to magnet facilities because recruited participants work at a magnet institution.

**Delimitations**

In this study, boundaries were set through inclusion and exclusion criteria. This exploration focused on nurses’ feelings regarding floating as a phenomenon. Nurses
from any specialty area working full-time in the designated acute care hospital in South Florida constituted the study population. The purposive sample involved 11 nurses who met the inclusion criteria.

The methods of recruitment included presenting the project to members of the research committee during a monthly meeting and visiting different units during monthly staff meetings with criteria for enrollment. It became more realistic to disseminate the information about the study during unit huddles, instead of waiting for a monthly staff meeting. Most members of the research committee are full time staff nurses from different units of the hospital (along staff from fields other than nursing). There was no need to post a notice in the facility monthly e-news as planned because participants enrolled steadily in the study within five weeks. The clinical nurse educators at the facility assisted with the dissemination of information by reminding staff nurses about the study.

The following paragraph is a description of the inclusion and exclusion criteria. Participants meeting inclusion criteria were full-time staff registered nurses who float regularly. Exclusions for this study comprise per diem, contract, agency, float-pool, and nursing staff who volunteer to float to other units for a number of reasons (extra-shift, overtime pay, etc.). This study will include participants’ demographics and years of nursing experience for readers’ general information.

**Summary**

Chapter 1 provided an overview of the study. Phenomenological studies on nurses’ feeling about floating as a lived experience are uncommon, creating a need for further studies on the concept. Floating nurses, an approach to meeting staffing needs, is
not new to managers and nursing staff in health care institutions. Administrators changed the floating practice from voluntary to mandatory in the midst of the health care reform, budget cut, the country’s financial crisis, and reimbursement policy changes that begun in the early 1980s. The challenge of choosing a more expensive strategy such as hiring contract or agency nurse to fulfill hospital staffing demands became obsolete. Researchers stated that, at first, nurses floated to similar units or to units that require basic nursing skills; many nurses now float hospital-wide (Banks et al., 1999).

An overview of the study background showed the multifaceted aspect of floating. Researchers believed that floating triggers a cascade of events based on interactions among nurses’ feelings, the work environment, institutional management, and the reimbursement enactments. Researchers citing results from previous studies found floating as a lived experience elicits various feelings in nurses who must float. In this study, 11 nurses from an acute care hospital in Miami described their feelings about floating during semi-structured interviews.

Chapter 1 contained a description of the study problem, purpose, and the appropriateness of the qualitative method and phenomenological design. The theoretical framework included Karasek’s JDC. Karasek (1979) described the main components of JDC as job demand and job control. He referred to the quantitative and urgency aspects of a job, which place physical and psychological strain on workers (Hausser et al., 2010). Job control is a function of the ability and authority used by individuals to control their work environments. This aptitude correlates with the attainment of skills to complete a specific job or the authority to make informed decision freely in the workplace (Karasek...
et al., 1981). A high-demand job is associated with low control, resulting in physical illness, based on the “sprain hypothesis” (Karasek et al., 1981).

The description of the assumptions, definition of terms, limitations, and summary added more data about the study preliminary and intended process. A qualitative, phenomenological study was appropriate to explore the essence of nurses’ feelings regarding floating. Husserl (1998/1913) recognized that phenomenologists capture the nature of individuals’ thoughts on the lived phenomenon. The study sample comprised 11 nurses working in a health care setting in South Florida who met the inclusion criteria. The methods of recruitment included presenting the project to members of the research committee during a monthly meeting and visiting different units huddles with criteria for enrollment. No posting in the facility monthly e-news was necessary, as explained earlier. Results obtained after implementation may inspire leaders in the health care system to review their policies (or create new policies) on floating based on nurses’ shared feelings about floating.

Chapter 2 includes relevant information available in the literature on nurses’ feelings toward floating along with different factors that motivated health care administrators to implement forced floating. The review of the literature assisted in identifying an existing gap in qualitative studies on nurses’ feelings on floating that supports the need for this study.
Chapter 2

Review of the Literature

The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The central idea was to understand the feelings of nurses working full-time in an acute health care institution. Chapter 1 comprised a synopsis of the research study with a description of the major components of the chapter.

The focus of chapter 2 was on an extensive review of available literature on nurses’ feelings when floating. The literature search incorporated a review of current events that may influence floating. These events included budgetary and reimbursement issues in the health care environment; nurses’ education, skills, self-efficacy, and work expertise; nurses’ perception of empowerment and autonomy as powerful motivators of job satisfaction; and the implications of an imbalance between job demand and job control (strain hypothesis). Other components of chapter 2 were a title search strategy and a summary of the salient points identified throughout the review. Chapter 2 ended with a review of the most compelling studies, methods, and research results existing in the literature on the topic.

Documentation

The literature review consisted of the use of different words or word phrases related to the study. A summary of the search is available in Table 1 with the search key words and the types of journals and databases examined. This section contained detailed descriptions of the title search strategies, relevant scholarship, textbooks, and e-books reviewed.
Title Search Strategies

The following key words and short word phrases were used: 1) float and nursing, 2) floating and scheduling, 3) float pool and nursing, 4) nurses attitudes and floating, 5) nursing and floating, 6) nurses and job satisfaction, 7) nurse resource team, 8) nurse staffing equality, 9) staffing acuity, 10) workplace conditions and nurses’ satisfaction, 11) CMS reimbursement enactments, 12) nurses’ satisfaction and hospitals administrators, 13) work environment and stress, 14) self-efficacy, 15) work environment and control 16) leading scholars in phenomenology, and 17) nursing theorists and phenomenology.

Relevant Scholarship From 1978-2014

Resources for the literature review included numerous search engines from online library catalogs: Universities’ e-libraries (University of Phoenix, Barry University), Baptist Health Medical Library, and several specialized online databases including ProQuest, Cumulative Index of Nursing and Allied Health Literature (CINAHL) with full text, EBSCOHost, and Full Text from Ovid. The pertinent scholarly articles retrieved were found in the following database: PubMed; ABI/Inform, Journal@Ovid; PsycINFO; government publications.

The literature reviewed from 1978 to 2014 returned no phenomenological studies on nurses’ feelings about floating. A few seminal inquiries existed in the 1990s (Black, 1990; Foxall et al., 1990; McHugh, 1997; Nicholls et al., 1996; Pronger, 1995) and shed light on previous researchers’ focus and methods in describing the nurses’ feelings and floating. The literature review comprised relevant information related to credible sources portraying potential connections of the phenomenon with other current events. Based on previous published scholarly studies a possible association between budgetary and
reimbursement issues, nurses’ education, skills and work expertise, empowerment and autonomy, work environment and floating emerged. Chapter 2 contained a review of these studies.

Additional searches combining floating with budgetary and reimbursement issues and nurses’ education, skills, work expertise, work environment, and empowerment and autonomy returned 12,500 articles. The process of elimination chosen was the deletion of articles not relevant to the study or non-peer reviewed anecdotal articles of one to three pages, and articles or letters written from anonymous authors except to prove the existence of floating as a phenomenon in the late 20th century. The final literature review included 278 scholarly articles (seminal articles, government and professional associations’ publications, and dissertations), six anecdotal accounts of floating and 23 relevant textbooks and e-books.

Textbooks and e-books Review

The review of books and e-books accessed from diverse e-libraries was paramount in understanding the relationships among research methods, designs, and appropriateness based on a study purpose. The use of ground libraries was practical to check out or buy books not available online. The main topics of these books were the research process, methodology, foundations of qualitative studies, and design. Guidelines for the appropriate use of a qualitative versus a quantitative research were available in these tomes. Further clarification on phenomenology resulted from analyzing books written on Husserl’s idea of phenomenology and transcendental phenomenology and Benner’s interpretive phenomenology. Other books on Bandura’s SCT and self-efficacy and Maslow’s hierarchy were valuable.
Government and Professional Associations’ Publications

Investigations on the fee-for-service and the impact on long-term care hospitals were possible through reviewing the CMS at http://www.CMS.gov following the title Medicare Fee-for-Service Payment at http://www.cms.gov/Medicare/Medicare-Fee-for-Service. The next step was to review the link at hhs.gov/AcuteInpatientPPS for more information. Another valuable study contained results on nurses’ satisfaction from a research conducted by members of the American Nurses Association (ANA) in 2005 at http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/2005/pr04018524.aspx. The American Nurse Credentialing site comprised information on steps to achieve magnet status in their magnet recognition program overview found at http://www.nursecredentialing.org/Documents/Magnet/NewModelBrochure.aspx.

Dissertations Review

A review of published dissertations yielded further information on the topic, but there were no recent dissertations on the exploration of nurses’ feelings concerning floating. Most of the dissertations found are quantitative. In the one qualitative case study identified, Dziuba-Ellis (2006) addressed the supportive role of a nursing resource team in meeting organizations’ staffing demands. Most of the remaining dissertations were quantitative, addressing nurses’ job satisfaction, burnout, and critical thinking. Klaus (2006) conducted a quantitative study on predictors of nurses’ job satisfaction and suggested that qualitative studies were necessary to explore nurses’ feelings toward floating. The literature review result is available in table 1.
Table 1

*Detailed Literature Review Result*

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**Leading Scholars and Phenomenology**

Phenomenology has gained popularity in health care research (Shaw & Connelly, 2012). During the next few paragraphs, readers not familiar with the phenomenological design will compare the three major viewpoints within phenomenology and understand the appropriateness of Husserl’s descriptive transcendental phenomenology for this study. Phenomenology is one of the various designs of the qualitative method.

Phenomenologists share some basic concepts: lived phenomena are observable,
individuals’ encounters are the focus of phenomenology, naturalism derived from objectivism and positivism tied to the scientific inquiry is not an accepted assumption (Center for Advanced Research in Phenomenology, n.d.). The following paragraphs were a description of the three most dominant scholars in phenomenology: Husserl, Heidegger, and Gadamer.

Husserl discontented with the scientific method designed the phenomenological approach, a philosophy and a research method. Husserl described humans’ subjectivity and perception as the basis for the understanding of lived phenomena (Flood, 2010). Husserl’s assumption is epistemological emphasizing the understanding of the essence of a phenomenon, the one central or universal truth for persons who experience the same event (Miles, Chapman, Francis, & Taylor, 2013). Husserl (1998/1913) proposed bracketing or researchers’ isolation from own experiences with a phenomenon to prevent bias. The researcher for this study, a nurse, followed Husserl’s phenomenological reduction as recommended to explore nurses’ feelings on floating eliminating bias.

Heidegger, Husserl’s student introduced his views into the phenomenological inquiry moving from epistemology to ontology. Heidegger believed that individuals react according to their knowledge of the environment. This concept gave rise to the hermeneutic cycle (Converse, 2012). The scholar was most concerned with the being instead of the core of phenomena (Converse, 2012).

Gadamer, Heidegger’s student argued against the statement that researchers should abide by bracketing. This practice may be responsible for a lack of understanding of phenomena (Austgård, 2012). Bracketing a tradition in which researchers alienate self
from preconceptions of a lived phenomenon may become a limitation to the interpretation of phenomenon (Tufford & Newman, 2012).

Table 2

**Most Influential Scholars and Hallmark**

<table>
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<th>Scholars</th>
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<th>Seminal Work</th>
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<td>Hermeneutic Interpretive</td>
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(Austgard, 2012; Converse, 2012; Flood, 2010)

**The Nursing Discipline and Phenomenology**

Nursing is a discipline in which quantitative and qualitative studies are necessary. Gullick and West (2012) determined quantitative researchers’ studies result in valid tools with suggestions on improving quality of life. Quantitative researchers establish cause-to-effect relationship to identify the effect of critical nursing interventions on patients’ outcomes. Empirical results serve as foundation for evidence-based practice and benchmarks. Mitsis, Kelesi, and Kapadohos (2012) using inferential statistics identified nurses’ most common sources of medication administration errors.

There are undeniable benefits to using qualitative research in nursing (Converse, 2012). Nurse researchers may gain insight in nursing phenomena beneficial to nursing practice and patients care based on the philosophy of phenomenology (Earle, 2010). Nurses and patients have subjective feelings (Flood, 2010) not measurable with numbers. Qualitative studies are crucial to understanding patients’ feelings accepting or rejecting care providers’ recommendations (Gullick & West, 2012). Nurses’ personal interactions
with patients and their families in critical circumstances such as imminent death, chronic illnesses, and new diagnoses of terminal conditions generate feelings in all parties involved (Meehan, 2012). Nurses’ feelings in relation to changes in the work environment are important to the delivery of care and patients’ safety. Exploring the feelings mentioned above pertains to the domain of the qualitative method.

Experts in the nursing discipline use the qualitative method in general and phenomenology in particular to improve nursing education and the delivery of patients care. A review of the literature showed a few seminal, phenomenological, theoretical models developed by expert nurses; these models contributed to the advancement of the nursing profession in theory and practice. The following paragraphs summarize the works of Benner, Watson, Parse, and Leininger and their contributions to nursing, all stemming from their use of phenomenology.

Patricia Benner demonstrated that new graduate nurses become proficient through qualifying steps from novice to expert (Benner, 1994). She incorporated the hermeneutical and Heideggerian interpretative phenomenology in her philosophy. Benner understood that nurses acquire global skills as novices mostly guided by protocols (Blum, 2010). They further advance to developing critical thinking and intuitive skills not readily apparent to the external world. In 1994, Benner clarified in her theory that nurses as individuals reflect within themselves and analyze their concerns, practices, and lived experiences. Benner’s theory (1994) serves as a basis to explore how nurses progress from novice to expert in the nursing profession.

Watson (2008) underlined the concept of caring with seven assumptions and 10 structures (the carative factors/caritas) guiding the science of caring. She developed her
theory of caring after 20 years of investigations. She grounded her theory on phenomenology, exploring individuals’ lived experiences in the real world (Bailey, 2009). The essence of Watson’s theory is caring and the carative factors (different from curative factors). Curative factors are those related to traditional treatment focusing on the disease process. The carative factors guide nurses into the caring-healing practice (Lukose, 2011). A relationship exists between individuals’ feelings and their behavior. Watson’s theory addressed nurses’ feelings when delivering care as well as patients’ responses to caring.

Parse (1998) influenced nursing practice by focusing on quality of life and establishing guidelines for patients’ care; she developed the theory of human becoming. Her focus was on individuals and their unique experiences reacting to their environments (Chen, 2010). Parse used the phenomenological-hermeneutic approach as a structure to understand the lived experiences reported by individuals. In her theory of humanbecoming [sic], Parse (2011) acknowledged researchers should focus on participants’ descriptions of the lived phenomenon. She further assumed that “The human is open, freely choosing meaning with situation, bearing responsibility for decisions” (Parse, 2010, p. 258, figure 1). Parse’s theory may serve as a theoretical framework to explore patients’ lived experiences during illnesses. The same applies to patients’ perceptions of the nursing care and nurses’ feelings about a phenomenon (death of a patient, floating).

Leininger and McFarland (2006) demonstrated the benefits of culturally congruent nursing care. Ethnonursing, a qualitative nursing research method to examine nursing care as a phenomenon in culturally diverse patients, characterizes her theory of
transcultural nursing (Leininger, 1997). Leininger (1997) used an inductive mode in her inquiries. She questioned different areas of interest in nursing such as death and dying, disease prevention, illness, and health beliefs according to patients’ cultures (Leininger & McFarland, 2006).

Theoretical Frameworks

Floating is an understudied phenomenon with no recent qualitative inquiries on its association with nurses’ feelings as a lived experience. A number of theoretical frameworks available in the literature (as described in chapter 1) could facilitate the exploration of these feelings. The theoretical models most appropriate to this study were Maslow’s hierarchy of needs (Maslow, 1943, Karasek’s Job Demand Control (Karasek, 1979), Bandura’s SCT/self-efficacy concept (1977), and Bagozzi’s attitude theories (1992). Karasek’s JDC served as the theoretical framework for this study. A description of each of the pertinent theoretical structures follows.

Maslow’s Hierarchy of Needs

Maslow (1943) developed the theory of basic human needs, addressing individuals’ motivations for behavior. Maslow (1943) described a pyramid-like structure with five major needs from the physiologic needs at the base: needs for air, food, water, through safety, belonging, and esteem, to self-actualization at the peak of the pyramid (Groff Paris & Terhaar, 2010). Maslow arranged the human’s needs in hierarchy from lowest to highest. Each level is a benchmark to achieve before proceeding to a higher degree on the scale. A person will not attain a higher level until the basic needs are satisfied.
Maslow established the relationship between psychological illness and the lack of satisfaction of one’s basic needs. An interpretation of Maslow’s theory in the environment of nursing care is that nurses may function to the fullest in a work environment that fulfills their needs (Groff Paris & Terhaar, 2010). They may strive for excellence through professional development, increase autonomy, and critical thinking when their needs are satisfied. Toode, Routasalob, and Suominena (2011) conducted a literature review on nurses’ motivation and the work environment. Individuals’ priorities among other factors constituted a dominant motivator.

One caveat to Maslow’s theory is that if needs appear in a hierarchical fashion, motivation will cease when all needs are fulfilled (C. J. Ifedili & Ifedili, 2012). Individuals in real life situations may experience recurring needs for food or safety at any stage depending on current events happening in the environment. Individuals with diverse socioeconomic status may be at different levels of the pyramid and not necessarily in any specific order (Noltemeyer, Bush, Patton, & Bergen, 2012). A few years later, Maslow added two more needs to his pyramid: the needs for knowledge, aesthetics, and consistencies (Gherman, 2012), which could face the same criticism as above.

Maslow’s theory has its limitations when applied to circumstances other than individuals, a community for example; it does not include environmental, social, or economic status such as minority group or poverty (S. Sen, Sen, & Tewary, 2012). Others validated Maslow’s theory in its relationship with individuals’ public and private housing needs (Zavei & Jusan, 2010). Applying Maslow’s hierarchy of needs to the nursing profession, one can postulate that expert nurses are at the top of the pyramid,
working in their areas of expertise, but the situation may change any day when they are called upon to float. Because of these controversial points of view and conflicts in validation, this framework is not appropriate for the proposed study.

**Karasek’s JDC**

Karasek (1979) analyzed the conditions encountered in the work environment and designed the JDC idea, a seminal model based on the relationships among job demand, job control, and their effects on individuals’ health and well-being. He subdivided job demand into quantitative and qualitative and job control into decision authority and skill discretion. The following is a summary of influential research results from a literature search.

**Quantitative Job Demand**

The quantitative aspect relates to the amount of work expected for the employee to accomplish and the time and pace an employee may use to complete a task in a set period (Karasek, 1979). A nursing shift runs from eight to 16 hours (Rogers, Wei-Ting, Scott, Aiken, & Dinges, 2004). The shift can be four hours if floating occurs in the middle of an eight-hour shift. Floating in the middle of a shift involves a large amount of work in a small window period. JDC has real-world application to nursing.

An example of the quantitative job demand in nursing is a greater nurse/patient ratio for nurses floating from an outpatient/procedural area to a regular medical surgical (med surg) inpatient area. In hospitals, nurse to patient ratios varies from 1:2 in the critical care areas, 1:5 in specialty areas, and 1:6 in the medical-surgical areas (Serratt, Harrington, Spetz, & Blegen, 2011). Other illustrations of this aspect of JDC are the amount of medication to administer during a shift and the numerous nursing interventions
for patients in the medical surgical units (wound care, tube feeding, continuous bladder irrigation, etc.). Job assignment (patients’ acuity) and time constraint are two critical factors of quantitative job demand (Karasek, 1979). These factors influenced participants’ feelings on floating as described during the interviews.

**Qualitative Job Demand**

The qualitative aspect involves the perceived or true level of knowledge necessary to perform assigned tasks (Karasek, 1979). In the nursing field, this applies to a nurse who must float to a higher area of expertise with higher acuity patients. Nurses must deliver competent care to the acutely ill. A main concern with floating in this case is caring for patients with unfamiliar diagnoses and treatment plans. An example is for a cardiac and vascular or telemetry nurse to float in the intensive care areas. The nurse-patient ratio is less (1:2) in these areas (Debergh et al., 2012). The floater must be observant of subtle changes in patients’ hemodynamics and mental status.

**Job Control (Decision Latitude)**

Job control is a worker’s ability or power to control the work environment. It encompasses the concept of skill discretion and decision authority (Karasek, 1979). Skilled individuals perform within the limits of their education and knowledge in a stress-free environment. Decision authority implies the empowerment and autonomy that allow workers to prioritize tasks to complete over time (Notelaers, Baillien, De Witte, Einarsen, & Vermunt, 2012). The more educated nurses are in their field, the more control they will have over the work environment.
Strain Hypothesis

An imbalance between job demand and job control will result in a stressful work environment. Karasek (1979) recognized that the outcome of a high-demand and low-control job is high strain. In the strain hypothesis, Karasek predicted that in a high-strain job the combination of high demand and low control is overwhelming in the work place and results in multiplication of the projected effects (Notelaers et al., 2012). In an ideal work environment, a balance exists between job demand and job control, as described in the buffer hypothesis. In other words, a high control level counterbalances the effects of a high-demand job. Nurses who float voiced a loss of control over events in the unfamiliar environment.

Karasek’s JDC Validity

Hausser et al. (2010) tested the JDC model’s validity. These researchers compiled a 10-year review of 83 studies available from 1998 to 2007, all of which reviewed the use of this model as a predictor of psychological strain in high-demand/low-control work environments. The reported additive effect of the Karasek’s model components as a source of psychological tension was 60 to 68%. Karasek’s model proved valid in a variety of studies involving education, work environment sprain, workplace bullying, staff in medical practice, health care workers, correctional officers, etc. Hussain and Khalid (2011) agreed that high-strain jobs increase employees’ stress as posited by Karasek.

De Jonge, van Vegchel, Shimazu, Schaufeli, and Dormann (2010) published results from a longitudinal study on 267 health care employees. These researchers used subjective and objective approaches to assess the connection between job control and job
demand. The results were that in a work setting, job control reduces the negative consequences of job demand over time. De Witte, Verhofstadt, and Omey (2007) tested Karasek’s hypotheses in a study involving a group of new workers (n= 2,212) in their first jobs. The authors specified that the results obtained from their study were indicative of the appropriateness of the JDC. Karasek’s hypotheses represented a valid theoretical framework to analyze the effect of low control/high demand and strain in the workplace. As postulated by Karasek, a strong relationship exists between job demand and job control.

**Bandura’s SCT/Self-Efficacy Concept (1977)**

Bandura (1977) developed the SCT based on research studies, which established a relationship between a behavior and changes in the environment. He investigated human behavior and its psychosocial elements. The major tenets of the SCT include the interactions among people, environment, and behavior. Gredler (2009) recognized that Bandura in his SCT associated cognition and decision-making and documented links among environment, personal factors, self-efficacy, and behavior. The main concepts of Bandura’s SCT are people (expectations, cognition), environment (situation), self-efficacy (perceived ability to perform), and behavior (coping mechanism).

One of the main assumptions of Bandura’s SCT is self-efficacy. In 1997, Bandura’s work supported that individuals develop and improve their behaviors based on their perception of self-efficacy in a changing environment. He further emphasized that individuals' self-efficacy in the presence of a perceived threat plays a significant role in performance. Self-efficacy is the ability to recognize the threat posed by unfamiliar
circumstances and to develop appropriate coping mechanisms to respond adequately to the perceived menace.

Self-efficacy is a predictor of skill performance (Tyler et al., 2012). Self-efficacy is a thought process, which determines individuals’ actions and reactions in a situation (Bandura, 1991). The self-efficacy model in summary applies to nursing and other professions; a perceived lack of self-efficacy results in a perceived lack of clinical skills. Detailed concepts about the qualitative and quantitative sprain on individuals, important to the study, were missing, which is a reason to eliminate this theory.

**Bagozzi's Attitude Theory (1992)**

Bagozzi (1992) posited that in any given circumstance, links exist among “a person's appraisals, a person's emotions, and a person's behavior” (p. 178). Appraisal is an individual’s perception of a situation. This appraisal includes the individual’s emotional state at the time. Appraisal and emotion may have positive or negative effects on behavior associated with an individual’s beliefs. The core of this theory encompasses the relationships among attitude, subjective norm, and intention of someone determining a course of action (Celuch & Dill, 2011). Bagozzi (1992) described the following three theories of attitude: the theory of reasoned action, the theory of planned behavior, and the theory of trying.

In the theory of reasoned action, Bagozzi (1992) asserted that an intention to perform an act precedes definite enactment. The stronger the intention to act, the more certain an individual will take appropriate steps to perform the intended act. The intention to react to a situation depends on the strength of external and internal pressures. Two components influence intention: attitude (beliefs) and subjective norm (Celuch &
Dill, 2011). This theory affects volitional behavior, or the ability to perform an assigned task (Bagozzi, 1992).

The theory of planned behavior is similar to the theory of reasoned action. There may be internal or external interferences with performing the behavior (Bagozzi, 1992). This theory is comparable to Bandura’s SCT/self-efficacy concept. Perceived ability to perform in an environment serves as a motivator to accomplish a task (Bandura, 1977).

The theory of trying includes past actions as predictors of future behaviors (Hansen, Samuelsen, & Andreassen, 2011). For an individual who has been successful at performing a task in the past, a high probability exists that this individual will perform the same task in the future. The reverse is true about failing to complete a task (Bagozzi, 1992). The same process applies to the worker’s anticipation of a negative or positive outcome based on a behavior (Bagozzi, 1992).

Luigi Leone, Perugini, and Ercolani (1999), comparing the three theories of attitude and their relationships with behavior, believed that more studies were necessary to validate these models. Others stated that the theory of planned behavior is valid, especially when applied to changes in behavior (Kasper et al., 2012). In a study conducted by Wang (2009), variation in attitudes and behaviors correlate with individuals’ skills and judgment. The decision to eliminate the theories of attitude as a possible framework for the study was a result of the lack of consensus on the efficacy of Bagozzi’s theories in the literature.

**Historical Overview of Floating**

Floating is not a new concept. It is traceable as far as 1978 for decades but remained voluntary in some institutions until the nursing shortage arose. At the height of
the nursing shortage from 1999 to 2002, Sukyong (2007) reported a major demand for temporary nursing personnel. Health care institution managers had different options available should unpredictable staffing issues arise (Jeang & Chiang, 2012). A flexible resource some nurse managers used was to contract nurses from a float pool to cover staffing emergencies (Larson et al., 2012). Typically, floating nurses away from units with low patient census during a given shift was often voluntary for nurse (Kirchhoff & Dahl, 2006).

Eventually, administrators decided to cut expenses by avoiding contracting temporary personnel. The higher cost of using this category of personnel increases managers’ operating budget (Hurst & Smith, 2011). Floating became mandatory for unit-based nurses (McHugh, 1997). In times of budget constraints, a permanent staff will float instead of managers contracting an expensive casual nurse. Health care administrators facing financial constraints introduced operational changes system-wide in a variety of institutions (Bazzoli, Lindrooth, Hasnain-Wynia, & Needleman, 2004).

One of the newly introduced measures in the workplace was obligatory floating. Forced floating began in the late 1980s (McHugh, 1997; Nicholls et al., 1996) when health care organizations’ executives implemented processes to cut costs and control hospital staffing (Bazzoli et al., 2004). One surveyed facility discontinued floating to closed units and initiated floating hospital wide (Banks et al., 1999). Nurses who would otherwise float in like units found themselves floating on demand hospital wide except in specific areas such as surgery, mother and baby, etc., which require specific skills and education. Larson et al. (2012) posited that floating exclusively to closed units resulted in the inconvenience of leaving the institution short of staffed while sending nurses home.
from units with low patient census. Nurses continued floating from one unit to another according to the facility policy and staffing needs. Floating may be useful to address the challenging issue of maintaining an adequate nurse/patient ratio in a unit (Chapman et al., 2009).

Floating entails moving staff nurses from unit to unit according to patients care demands caused by staff call-outs, increased patient acuity, and other fluctuations in staffing needs (Kirchhoff & Dahl, 2006). It is not surprising for nurses to begin a shift in their unit and to end “floating” in another unit. This practice, the preferred strategy of 50% of institutions surveyed (Klaus et al., 2012) used to be voluntary. A survey conducted by Kirchhoff and Dahl involving American hospitals with intensive care services that met eligibility criteria elicited a total response rate of 53%. The researchers indicated that the second most common strategies used in time of staffing needs was floating using different approaches.

Although floating nurses may represent an alternative staffing strategy (Kirchhoff & Dahl, 2006), it may lead to retention concerns (Becker et al., 2010). Retention is essential to minimizing the effect of the nursing shortage (Klaus et al., 2012). In a study conducted in 2009, Wieck et al., revealed that health care executives throughout the USA strived to offer the best incentives (residency programs, sign on bonus, etc.) to recruit and retain new graduates and experienced nurses. Armstrong, Laschinger, and Wong (2009) acknowledged that leaders did not invest much effort toward better work environment, which can enhance nurses’ retention in institutions. A variety of initiatives enhances retention.
Nurses usually work in their own units based on a schedule generated within a four-week period. Increased scheduling flexibility appears to be a more effective approach to staffing needs (Dziuba-Ellis, 2006). It is becoming an important, fast-growing factor in decreasing turnover (Spence Laschinger, Leiter, Day, & Gilin, 2009). Researchers described best practices to promote retention as intrinsic (professional development opportunities) and extrinsic (management support and work environment) (Wilkes, 2010; Zeller, Doutrich, Guido, & Hoeksel, 2011). The relationships among job demand, job control, and resources (the equivalent of exhaustion versus motivation) are essential components of a nurse’s intent to resign or abandon nursing (Jourdain & Chênevet, 2010). From this angle, floating may be affecting nurses’ feelings and patients’ care (Klaus et al., 2012).

**Floating and Work Environment Demand**

Unfamiliar work environment increases workers’ perception of high job demand based on Karasek’s JDC. Nurses perceive the work environment as disruptive when mandated to float (Reineck & Furino, 2005). An unhealthy work environment induces stress, which in turn triggers job dissatisfaction (Davey, Cummings, Newburn-Cook, & Lo, 2009). Employee morale decreases, job dissatisfaction increases, and disengagement increases with forced floating (Klaus et al., 2012). An ideal work environment encompasses a safe and supportive atmosphere in which nurses feel competent in the delivery of patients care (Groff Paris & Terhaar, 2010).

Work-related conditions may be responsible for increased turnover (Klaus, 2006). In 2010, Estryn-Behr et al. found that work environment is one of two main issues responsible for nurses’ turnover in a European population of 14,016 nurses who stayed
and 866 nurses who left their jobs voluntarily. In a study by Lu, While, and Barriball (2005), organizational support, professional development opportunities, autonomy, empowerment, flexible scheduling, shared governance and recognition were some requests mentioned by nurses. The incorporation of these factors into an organization’s culture may be significant in building a welcoming work environment and in promoting staff retention.

Nurses are more likely to resign when obligated to float (Wieck et al., 2009) and are unhappy with their jobs floating to areas in which they have not received prior orientation (Duffy, 2011). Floating has a negative effect on nurses’ job satisfaction (Larrabee et al., 2010); not floating increases job satisfaction, and satisfied nurses remain in their jobs (Hansen, 2007; Klaus, 2006). In a large study involving a final sample of 314 nurses, Duffy (2011) showed workplace dissatisfaction or extreme dissatisfaction in 44% of surveyed nurses who floated. This quantitative, exploratory, descriptive study provided evidence of decreased nurse job satisfaction when floating.

Dissatisfaction prompts absenteeism and causes call-outs, aggravating the need for emergency readjustment in staffing (Wright & Bretthauer, 2010) and resulting in floating. McGlynn et al. (2012) believed that a need exists for further investigation of factors that foster workplace satisfaction. Administrators may have to be attentive to nurses’ needs in order to implement strategies that increase and maintain satisfaction in the workplace (Hansen, 2007). Results obtained from the phenomenological study exploring nurses’ feeling regarding floating as a lived experience may uncover nurses’ feelings about floating in an unfamiliar work environment.
Karasek et al. (1981) recognized that demand on workers in an alien setting may influence performance and satisfaction. The demand can be of two types: quality or quantity, which exerts an excessive amount of pressure on employees. Nurses who usually care for one or two patients at a time find themselves assigned to five or six patients in other units. In addition, nurses may work on units where patient acuity is higher than on their home units. Time may become a factor when nurses have to administer routine medication to many patients, document the care delivered during the shift, or educate patients and family members. In these cases, a nurse often leaves the workplace one hour or later after the end of his or her regular shift. It appears that the demand on the staff caused by the unfamiliarity related to working in the new unit coupled with stress induced a loss of control in the work environment.

A unit-based full-time nurse works consistently in the same unit (Linzer et al., 2011). Scheduling nurses to run a unit is a planned managerial activity, which occurs two weeks before the end of the ongoing monthly schedule. The daily staffing plan sheet for each unit fluctuates according to the number of hospitalized patients for the shift (Lucero, Haomiao, de Cordova, & Stone, 2011). Should the census decrease (due to discharges/transfers of patients or other qualifying events), unit managers may shift nurses to other areas in need of staff for four, six, or eight-hour shifts (Reineck & Furino, 2005). Float-pool nurses (casual or temporary staff) who elect to work on demand are cross-trained to float within an institution (Becker et al., 2010). Temporary personnel, contract nurses, and agency nurses are costly, averaging $71 per hour compared to $38 per hour for the unit staff nurses (Larson et al., 2012). Hospital leaders opted to cut staffing cost by using floating as a strategy (Kirchhoff & Dahl 2006).
Floating, a widespread strategy appears to be part of a larger predicament affecting nurses’ feelings. Larson et al. (2012), citing a report from the ANA (2005a), indicated floating affects 29% of nurses from a sample population of 76,000. The study included nurses from the medical-surgical, orthopedic, neurology, and cardiovascular inpatients care units of a large Midwestern community hospital. Respondents described negative feelings about floating. Anecdotal stories written by Wiley (1978) depicted nurses’ negative feelings about floating (discourtesy of receiving unit staff, lack of orientation to the unit, and lack of available resources). Common negative comments ranged from the unknown layout of the float departments and the unit routines (Banks et al., 1999) to inhospitality of receiving staff.

Researchers recognized that some nurses expressed positive feelings about floating. Nicholls et al. (1996) described nurses’ positive statements such as acquiring new skills in different units and assisting coworkers in delivering safe patients care. Some nurses felt floating increases readiness for future advancement should a position open in other units (Gosztyla & Fowler, 1998, as cited in Bates, 2013). Still others believed a major advantage of floating is networking with nurses from different specialty (Nicholls et al., as cited in Bates, 2013). Receiving unit staff’s behavior may play an important role in nurses’ feeling on floating. Crist-Grundman and Mulrooney (2011) emphasized the value of building a work environment in which nurses float without apprehension.

**Floating and Peers’ Behaviors**

The following is an account of some challenges associated with floating addressed in the literature. Pronger (1995) reported that nurses who float perceived the
receiving unit staffs as hostile. The expectation is that floaters are assigned the most complicated and demanding patients of the visiting units (Good & Bishop, 2011). Busy charge nurses must find time to acknowledge and orient the newcomers, and it may not happen. Peers are adamant about receiving floaters because newcomers appear to be burdens, as they are unfamiliar with the unit layouts, routines, and patient populations (Bates, 2013). These factors create negative views toward floating.

Different factors may seem negative when associated with floating. Nurses who float believe that they do not have control over their schedule (Wieck et al., 2009). They acknowledged a lack of the necessary tools and expertise to accomplish their job working in a different area of specialty (Armstrong et al., 2009). Nurses associated a negative work environment with a reduced organizational support (Armstrong et al., 2009). Floaters may perceive the work environment as negative (Larson et al., 2012). The current belief is that stress created by floating and nurses’ perceived temporary loss of empowerment generates burnout (Khamisa, Peltzer, & Oldenburg, 2013), decrease motivation, increase job dissatisfaction (Taylor, 2008).

A review of the literature revealed diverse types of floating models as well as variation in nurses’ comparisons of floating to stressful events (death of patients, medication errors, etc.) associated with nursing care. In the cluster model, nurses float in designated areas (55%); in the open-unit version, nurses float hospital wide (23%). In the closed-unit version, nurses do not float (19%). In a study conducted by Foxall et al. (1990), a comparison of the incidences and origins of nurses’ job-related stress involved 35 intensive care, 30 hospice, and 73 medical-surgical nurses. Despite the variety of
approaches used, the above-mentioned researchers posited that nurses believe floating is a stressful and negative event.

**Job Strain and Floating**

Heuer et al. (1996) randomly selected health care institutions that use floating hospital wide as an approach to solving staffing issues in the upper Midwest of the United States. A survey-questionnaire mailed to participants returned a 35% response rate. In terms of scale items, floating out of the unit was the most stressful item. Neonatal intensive care unit (NICU) nurses ranked floating out of their units a number one stress-producing event (Heuer et al., 1996). Nurses belonging to specialty areas such as intensive care unit (ICU), medical surgical, NICU, and hospice, described floating as a stress-producing event in their daily work. Floating was the second most stressful event (death of a patient ranking first) stated by adult ICU nurses (Foxall et al., 1990). These researchers found that mandatory floating increases nurse’ feelings of strain and affects their relationships with hospital administrators and unit managers.

**Empowerment and Floating**

Empowerment in the workplace correlates with the delivery of quality care (Ning Zhong, Libo, & Qiujie, 2009). Nurses working in their areas of expertise develop critical thinking and assessment skills, allowing them to anticipate deterioration in patients’ conditions. Proficient nurses feel comfortable calling physicians with new data, background, and suggestions about patients’ care. Empowerment supports professional nursing practice (Armstrong et al., 2009). Forced floating may increase nurses’ powerlessness and frustration (Pronger, 1995).
Nurses floating to units different from their own fear making decisions in unfamiliar environments of care (Purdy et al., 2010) that may expose patients to potential harm. Nurses are accountable for judgment calls and actions during the delivery of care regardless of organizational recommendations (Code of Ethic for Nurses with Interpretative Statements, 2010). Pondering on Kanter’s theory of organizational empowerment, Kotzer and Arellana (2008) defined the components of an ideal work environment mentioning access to information as an essential element of a helpful work atmosphere. Positive peer relationship and managerial support increase nurses’ self-efficacy, motivation, and satisfaction. Nurses who float perceived these characteristics as fictional.

**Work Environment Control and Floating**

Work environment control is difficult when nurses float because they are caring for different types of patients in unfamiliar areas. In a workplace with low control and high demand, staffs seemed exposed to psychological distress (Karasek & Theorell, 1990). Dalgard et al. (2009) confirmed that low control combined with high demand in a working environment causes high strain on employees. These results correlated with the components of the demand-control hypothesis of Karasek (1979). These researchers posited that low levels of control and high levels of demand are predictors of psychological strain. Floating in an area other than a nurse’s area of expertise illustrated the suggested performance discrepancy caused by the imbalance between demand and control in the work environment as described in the JDC model.

Perceived self-efficacy is a predictor of performance (Bandura, 1977; Salanova, Lorente, Chambel, & Martínez, 2011). Self-efficacy increases competence, retention,
and job satisfaction (Tyler et al., 2012). Nurses as human beings have a need for the esteem of others, a desire to be in control, and an aspiration for achievement and self-confidence, which, if left unfulfilled, give rise to basic disappointment (Maslow, 1943). Human beings react according to two components: the self and the environment (Bandura, 1977). Observation and evaluation of others’ behavior indicate if external reinforcement may trigger a desired outcome.

Bandura (1974) mentioned that self-activated, conditioned reactions occur according to individuals’ perception and anticipation of outcomes of events. Experiences that appear worrisome naturally affect humans through anticipation of outcomes. People appraise risks associated with actions and events subjectively (Steg, van den Berg, & de Groot, 2012). A connection may exist between prevailing preconceptions about floating as a phenomenon and nurses’ feelings regarding floating.

Professional nurses in most magnet institutions have a Bachelor of Science in Nursing (BSN) degrees. Schlairet (2011) acknowledged the benefits of integrating simulation to the undergraduate curriculum. Nursing students go through four-year processes of classroom education linked with practice in simulation laboratory in their institutions. They further practice nursing skills in the clinical areas with adjunct faculty/clinical supervisors and the entity preceptors in the medical surgical area, the backbone of nursing.

With the nursing shortage, more nurses are educated in specialty areas (emergency care, intensive care, coronary care, neonatal intensive care, etc.) straight from graduation. New graduate nurses go through a program: the Versant Residency in which they learn theory and practice in one area of specialty. Proponents of this program
recognized its success in creating specialty nurses. Studies available in the literature uphold this belief (Trepanier, Early, Ulrich, & Cherry, 2012; Ulrich et al., 2010).

Hospitals throughout the United States adopted residency programs for new graduate nurses to increase retention (Ulrich et al., 2010) on the premise that competency increases new nurses’ retention by decreasing anxiety and helplessness (Ulrich et al., 2010; Halfer, Graf, & Sullivan, 2008). The Versant RN Residency created in 1999 as a pilot project was a valuable tool to prepare new graduates to function in acute care settings. Two other objectives linked to this program were to decrease turnover and to build an environment conducive to learning in which a novice nurse can grow. Besides studying new concepts during classroom theory, new graduate nurses learn from expert nurses by looping into their chosen home units. Ulrich et al. (2010) defined looping as the experience acquired by versant nurses of exposed to the type of population in their chosen specialty practice.

For Ulrich et al. (2010), “The Versant RN Residency curriculum includes classes with case studies, structured clinical immersion experiences with team precepting, structured mentoring and debriefing/self-care sessions, looping to related departments, and competency validation” (p. 365). Hospital administrators implemented the Versant RN Residency model throughout the United States. The main purpose was for nurses to become competent nurses able to work in the clinical areas in need of specialty nurses. Diaz, Erkoc, Asfour, and Baker (2010) recognized that nurses possess different skills and areas of expertise. Specialty nurses float to non-specialty areas, but challenges arise according to differences in the populations served.
Nurses develop critical thinking and competencies in their chosen areas of specialty over the years. Benner (1984) described five stages of nurses’ clinical competence from novice (no experience) to expert (deep understanding of a clinical situation). As a result, specialty nurses perform according to their knowledge and experience in specific areas of expertise. They may encounter some clinical challenges (wound vacuum-assisted closure care, tube feeding, continuous bladder irrigation) because after the years of supervised clinical education in nursing school they have not practiced these skills for a while, working in an outpatient setting. The nurse/patient ratio and the medication to administer to each patient throughout the shift may become problems. Nurses educated in an outpatient setting in which the majority of the patients come for bedside procedures (cardiac and vascular field) may feel incompetent floating to medical surgical areas.

**Floating and Autonomy**

Autonomy is a nurse’s ability to make competent decisions during the delivery of patients’ care, and loss of autonomy represents a professional threat that impedes professional and personal growth (Gagnon et al., 2010). One routinely builds self-confidence and critical thinking over time when caring for patients in one’s specialty (Ingram, 2008). Floating to a subspecialty on the contrary transforms an expert nurse into an apprentice and decreases autonomy. Floaters turn to other staff members for guidance caring for the specific population of the new unit and experience a lack of independence (Zurmehly, 2008). Floating may decrease a nurse’s autonomy and decision-making ability, especially for rapidly deteriorating patients in the critical care specialties (Iliopoulou & While, 2010). Lack of autonomy engenders nurses’
dissatisfaction with hospital executives’ use of one’s skills and competencies (Estryn-Behar et al., 2010).

**Floating and Nurses’ Work Expertise**

A nurse chooses a specialty (medical-surgical, cardiac and vascular, intensive care, etc.) upon graduation, and works his or her way to expertise in that field through theory, practice, and mentorship. One major effect of working away from one’s area of expertise is psychological stress, which generates a perceived feeling of incompetence (Larrabee et al., 2010). A proficient nurses with expertise in one area feels incompetent when asked to float to an unfamiliar unit (Tyler et al., 2012). Nurses accountable for patients’ safety believed that their professional practice falls below standard, wasting their skills and expertise in unwelcoming work environments (Lautizi, Laschinger, & Ravazzolo, 2009).

Researchers based the relationship between floating and stress on floaters’ perceived lack of competence in the new units (Banks et al., 1999; Estryn-Behar et al., 2010; Larrabee et al., 2010). Problem-solving skills weaken in a work environment in which job demand exceeds job control (Bergman et al., 2012). Floating (stressor) is a source of job-related stress (Foxall et al., 1990). In a study conducted in 2005, Reineck and Furino (2005) concluded that specialty nurses viewed floating as a disturbing phenomenon, which disrupts the work environment.

**Floating and Job Satisfaction**

Work environment control is an important component of job satisfaction. Wieck et al. (2009) conducted a study using a non-experimental, correlational design to measure factors influencing nurses’ job satisfaction. Results from data collected from 22 hospitals
in four states revealed floating as a source of dissatisfaction for nurses. A complaint identified was nurses’ loss of control over their schedules and work environments.

Karasek and Theorell (1990) theorized that components of the work environment (job demand/job control) influence decision latitude and create stress in the workplace when unbalanced. They further indicated that stress increases job dissatisfaction. Wiley (1978) suggested that the majority of respondents of a survey conducted in North America disagreed with floating.

**Floating and Managerial Implications**

In the 1990’s floating changed from optional to mandatory for the many reasons described previously. Managers supported by hospital administrators and staffing policies require staff to float routinely on a rotational basis. A daily updated folder kept in the unit is readily available with nursing staff names and dates when floating other units. Lugo and Peck (2008) believed that floating represents a constant source of disagreement between management and staff. This may in turn build nurses’ dissatisfaction in the workplace.

Goldberg and Fleming (2010) indicated that managers must control staff allocation in their units, avoid using contract personnel, and prevent the occurrence of overtime pay. A disagreement transpires between staff and management and creates staff disengagement and low morale in any given hospital unit in which floating is mandatory. Zeller et al. (2011) anticipated that nurses are unhappy and stressed when floating to foreign units. Staff nurses look up to administration for support, oblivious that administrators must maintain cost containment measures because of reimbursement controversies afflicting health care institutions (Goldberg & Fleming, 2010).
Budgetary/Reimbursement Issues and Floating

Health care expenditure, although stable, represents 17.9% to 18% of the gross domestic product of the United States (Korda & Eldridge, 2011; Martin, Lassman, Washington, & Catlin, 2012). Hospitals’ leaders depend on the CMS reimbursement at 40% (Seshamani, Schwartz, & Volpp, 2006). In 1983 and in 1997 governmental changes in health care policies transformed the fee-for-service into the diagnostic-related groups (DRGs) compensation for hospitalized patients (Xufeng et al., 2011). Institutions received payment based on the prospective payment system (PPS) and DRGs (Bazzoli et al., 2004). CMS executives based on the Balanced Budget Act (BBA) enacted the PPS during the early 1980s in an attempt to control the soaring increase in hospitals’ claims and preserve funds ensuring the future of the Medicare Hospital Insurance Trust Fund (Zhang, 2011). Changes in reimbursement may be responsible for hospitalized patients’ early discharge (Fox & Abrahamson, 2009). Further reimbursement policy changes emerged in 1997.

In the United States, strict reimbursement rules also found in countries worldwide may be responsible for hospitals’ loss of funds (McHugh, Van Dyke, Osei-Anto, & Haque, 2011). Assigned patients’ lengths of stay and disease specific paid parameters served as bases for payments (Rouse, Arulambalam, Correa, & Ullman, 2010). Because of the health care reform and the resulting budget constraints, health care administrators initiated a variety of operational changes within their organizations. Leaders reacted to the new reimbursement system by applying cost-containment strategies throughout their institutions such as restructuration (merging like units), preventing overtime pay, and reducing staff increasing the patient/nurse ratio (Bacon, 2010; Bazzoli et al., 2004; Wieck
et al., 2009). These measures resulted in a snowball effect creating a need for the nursing staff to experience regular floating episodes

CMS executives implemented the DRGs to decrease patients’ care reimbursement and to offer recommendations to coders in the United States on how to request payment for patients’ care delivered during one episode (CMS, 2009). This process is not unique to the United States. Administrators in other countries (Thailand, Germany) use this system as a mandatory cost control measure (Pongpirul, Walker, Rahman, & Robinson, 2011; Trocchi et al., 2012). It became critical for CMS’ survival that administrators control the increasing spending growth originated from fee-for-service disbursements to physicians and hospital executives (Wilensky, 2010). In the early 1970s a fee-for-service, instituted by CMS administrators as a reimbursement policy for inpatients and out patients claim became rapidly unmanageable (Wilensky, 2010). Another change that influenced reimbursement in patients’ care was the BBA that became legislation in 1997. Leaders introduced a new reimbursement policy to reduce Medicare payments to third party (Bazzoli et al., 2004). Hospital executives ventured into different lucrative countermeasures in response to these changes.

With the enactment of the PPS based on the DRGs, diverse creative alternatives appeared. Xufeng et al. (2011) uncovered that hospital discharges tripled. Facility administrators pursued contract with local medical schools, anticipating an adjusted reimbursement for indirect medical education (Nguyen, 2011). In the late 1990s, hospitals’ executives began implementing cost shifting onto the private sector in response to decreased reimbursement from CMS, which allocated a fixed fund per case regardless
of patient length of stay (Wu, 2010). An immediate readjustment of services provided to patients followed in the health care setting.

As a reaction to this reduction, health care administrators redistributed hospitals’ services toward outpatient services and decreased patient length of stay when warranted by patient conditions. The direct result of the mentioned measures is a decrease in hospital staffing needs and saving on operating expenses (Younis & Forgione, 2009). A correlation exists between CMS rate of reimbursement, patients’ volume, and service provided to inpatients/outpatients in health facilities (White & Nguyen, 2011). There are many obvious consequences of these changes. The most significant were an increase in nurse/patient ratio, an increase in floating of regular staff nurses to areas in need, and cancellation or hourly reduction of shifts.

**Floating and Patients’ Safety**

Floating appears to have some genuine positive aspects. The literature reviewed comprised reports from nurses who believed that working in other units broadened their knowledge of different patient populations and disease processes and represented new learning experiences (Nicholls et al., 1996). One significant benefit of floating is patient safety. A descriptive cross-sectional study by Mitsis et al. (2012) with a sample population of 176 nurses revealed that nursing workload represented the number-one factor (78.9%) responsible for medication error. Floating assists in matching optimal patients care to basic nursing staff needed.

Furthermore, Gallagher (2012), based on report from a study on staffing in 168 hospitals, indicated that delivering care in a short-staffed unit endangers patients’ well-being with a mortality rate from 7% to 31%. Thus, nursing staff must be available to
respond to patient turnover rate occurring because of a variety of events such as admission, discharge, and changes inpatients’ acuity level during shifts (Lucero et al., 2011). Adequate staffing saves lives. This is one reason hospital managers float nurses to areas in need. Kraus et al. (2012) disagreed that floating is beneficial to nursing staff or patients due to a lack of empirical evidence on the topic.

Despite the challenges churned by changes occurring at diverse ends of the health care system, patient safety remains the main focus of regulatory agencies’ administrators, unit managers, direct caregivers, and the public (Ward et al., 2011). Researchers established positive relationships among patients’ safety, delivery of timely quality care, and adequate staffing (Zhu et al., 2012; Manojlovich, Sidani, Covell, & Antonakos, 2011). Adequate staffing enhances patient safety and prevents negative outcomes (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). The exploration of nurses’ feeling regarding floating was imperative, as researchers posited that this phenomenon induces stress and dissatisfaction, resulting in an exacerbation of staff nurses’ turnover (Estryn-Behar et al., 2010; Iliopoulou & While, 2010; Larrabee et al., 2010).

**Floating and the Nursing Shortage**

Different factors contribute to the nursing shortage, expected to worsen in the next few years (2020) corresponding to the baby boomers’ attaining retirement age (Juraschek, Zhang, Ranganathan, & Lin 2012). The forecasted nursing shortage may reach a total national deficit of $918,232 by 2030 (Juraschek et al., 2012). Floating may be responsible for a high turnover rate (25%), a concern in health care institutions (Lu et al., 2005; McHugh, 1997). Job dissatisfaction created by floating and perceived lack of
flexibility may increase nurses’ intent to leave organizations (Becker et al., 2010). Larrabee et al. (2010) reported that nurses consider floating a stressful event, triggering their intent to leave an institution and aggravating the nursing turnover rate and the nursing shortage. Nurses may choose to transfer to closed units.

Other factors affecting the nursing shortage are the aging of the nursing workforce (American Association of Colleges of Nursing, 2009), workplace practices, and organizational culture linked to nurses’ perception of floating. The profession of nursing encompasses a rapidly aging, female-dominated workforce (Gabrielle, Jackson, & Mannix, 2008). In March 2010, investigators from the U.S. Department of Health and Human Services published a report revealing that 16.2% of nurses were 50 to 54 years old (Health Resources and Services Administration, 2010). Workplace practices, low job satisfaction, and relative salaries are issues affecting the supply, and the labor market behavior of nurses is an issue affecting the demand (Cunich & Whelan, 2010). Organizational culture and managers’ behaviors may play a significant role in nurses’ feelings about staffing approaches used in their units including floating.

**Identification of Methods Used in the Literature Review**

No recent scholarly qualitative studies on floating and nurses’ feelings were retrievable. A general lack of information on nurses’ feelings regarding floating existed in the literature. An in-depth review of the existing literature did not reveal recent qualitative studies on nurses’ feelings regarding floating as a lived phenomenon. The studies found in reviewing the literature were quantitative. Researchers suggested that a qualitative approach was necessary to explore nurses’ feelings regarding floating.
Despite a literature review, two realities remained unexplained about nurses and floating. One reality was that nurses’ experiences delivering patients’ care when floating to different units warranted further study. The second was that nurses’ feelings concerning management, administration, peers, and the work environment when floating to units different from their scheduled units added information to the limited quantitative data available. Responses to these queries were not available in the literature. The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States.

**Summary**

A search of literature published between 1978 and 2014 revealed no recent studies on nurses’ feelings regarding floating. Opinions diverged about whether floating is a negative or positive experience (Banks et al., 1999). Factors such as previous cross-training, the attitudes of the receiving unit staff member, and the floaters’ levels of competence when floating, illustrated positive experiences (Kirchhoff & Dahl, 2006). Nurses communicated that floating hospital-wide without orientation was a negative experience (Banks et al., 1999). A survey conducted by Ornstein (1992) revealed that 73% of nurses were against floating. Nicholls et al., (1996) recognized that floating full-time nursing staff is not a new concept and is a critical strategy to coordinate patients’ care needs to available staff during unforeseeable staffing variances.

Floating existed in the 1970’s but was voluntary in some institutions. Banks et al. (1999) described a change from no floating in closed units to floating hospital wide in order to respond to financial constraints. Forced floating in the early 1980s instigated tremendous concern among nurses fearing harm to patients while working in different
areas of expertise (Gagnon et al., 2010). Floating may be causing absenteeism in the nursing work environment, triggering more floating needs because nurses may call out sick when it is their turn to float (Davey et al., 2009). Full-time nurses scheduled to work in units in which mandatory floating occurs on a rotational basis may experience frustration, low morale, and powerlessness (Pronger, 1995). Perceived loss of autonomy related to floating may create staff dissatisfaction and disengagement (Zurmehly, 2008). Floating affects nurses’ work expertise and induces stress (Duffy, 2011). Stress is a powerful motivator of frustration, discontent, and turnover.

Dissatisfaction generated by floating reinforces nurses’ intent to leave organizations (McHugh, 1997). According to Klaus (2006), further investigation on floating, which appears to have a positive correlation with costly turnover, was necessary. Jones (2008) estimated the cost of turnover per nurse to be about $82,000 to $88,000.

Staffing cost, especially nursing, represents a significant expenditure for health care administrators (Welton, 2011). Spending associated with hiring staff is remarkable, especially for new graduates. Trepanier et al. (2012) determined the cost of educating new graduates to be equivalent to $21,571 to $36,960 per resident, depending on the state sponsoring the course and the nursing specialty chosen. Unit managers and hospitals’ administrators may want to look into floating nurses to unfamiliar areas to prevent premature and costly turnover (Zeller et al., 2011). Retaining new and experienced nurses warrants further interventions (Becker et al., 2010).

Nurses perform with confidence in their areas of expertise. Perceived self-efficacy increases one’s ability to take steps to achieve expected outcomes (Salanova et al., 2011). An organizational culture fostering structural and psychological
empowerment, autonomy, and job stress reduction generates job satisfaction and retention (Larrabee et al., 2010). A balance between job demand and control has a positive effect on critical thinking and problem-solving (Bergman et al., 2012).

Nurses are the most visible segment of the health care system. Researchers emphasized that nurses represent the largest caregivers (25-30%) of health care organizations with 40% of hospital budget invested in the nursing personnel salary and compensations (Friedman, Cooper, Click, & Fitzpatrick, 2011; Welton 2011). Contracting external nursing personnel affects hospital disbursement even more (Peerson, Aitken, Manias, Parker, & Wong, 2002). The delivery of quality care is congruent with unit staffing level during shifts (Aiken et al., 2009). Coinciding with reimbursement changes from the CMS in 1997, managers opted to float full-time nurses available in their units to maintain sufficient nursing staff to ensure an adequate patient/nurse ratio while containing expenditures (Goldberg & Fleming, 2010). Measures affecting nurses’ satisfaction such as mandatory floating may increase turnover in organizations (Klaus, 2006) and a need to hire new staff whose education costs thousands of dollars (Jones, 2008). Staff nurses’ turnover may create an artificial lack of nursing services overlaying a budget problem increasing the need for floating.

Medicare and Medicaid represent the sole insurance providers for 40% of hospitalized patients (Seshamani et al., 2006). Patients living longer are subject to multiple hospitalizations caused by chronic illnesses. Advances in medical technology contribute to the availability of life, prolonging measures associated with long-term rehabilitation needs. As a result, a general increase in health care spending appears to
heighten third-party reimbursement with the health care segment, consuming the private sector’s available funds (Chernew, 2010).

Funds disbursement, reimbursement, and health care expenses are various factors influencing nursing staff reduction, shift cancellation, and staff relocation. Inconsistencies exist in the literature. Some researchers believed floating is a key element in patients’ safety by allowing adequate staffing to units in need (Bates, 2013). Others alleged that floating constitutes a danger to patient well-being by having nurses working in unfamiliar environments. Alonso-Echanove et al. (2003) examined the relationship between nurses who floated to the ICU and the occurrence of bloodstream infection from central lines over two years in eight ICUs. The researchers found a higher rate of infection (60%) when nurses who floated to the ICU cared for patients with central lines. Marschall et al. (2008) validated these findings. Recently, Marschall et al. (2014) suggested that health care personnel should be educated on caring for patients with central line and maintaining a record of staff yearly competency would be the ideal.

Among other measures to prevent infection, Marschall et al. (2008) recommended that handling of central line in the ICU environment by float nurses be reduced. The inconsistencies continue because of a lack of new knowledge about how changes in the work environment, health care system, and technology affect the nursing profession. It will be interesting to understand how nurses felt about the concept of floating as a lived phenomenon.

**Conclusion**

Chapter 2 included an extensive review of the most recent and seminal peer-reviewed articles available in the literature about nurses’ feelings as a lived experience
when floating. The review of literature confirmed an absence of qualitative studies on the topic. Researchers (whether using the quantitative or qualitative methods) seldom inquired about floating in nursing as a phenomenon that may affect the nursing profession and nurses as individuals and patients’ caretakers. Klaus et al. (2012) emphasized that studies on floating are uncommon and no national research exists on the phenomenon and its consequences. Phillipi (1989), conducting a research on administrative practices and floating, discovered that some hospitals’ administrators could not locate written float policies or records of float nurses’ competencies.

A review of the main causes upholding mandatory floating associated this practice with health care institution managers introducing cost-containment interventions to remain financially competitive. One reason for using this process was to counteract a potential loss of funds spawn by CMS administrators’ new reimbursement enactments. Wieck et al. (2009) cautioned about adopting floating as a permanent staffing strategy because it may aggravate the nursing shortage, stimulating workplace dissatisfaction, and turnover by increasing nurses’ intent to leave.

Chapter 2 was a comprehensive analysis of accessible seminal and germinal studies on nurses’ feelings regarding floating as a lived experience. Researchers viewed floating as a plausible multi-dimensional problem involving members of the health care system (nurses, administrators, and other stakeholders) and the nursing profession. Information gathered from the review of the literature may suggest a dichotomy, which links nurses with positive and negative aspects of floating. The American economy may play an influential role in the evolution of floating from voluntary to mandatory.
Chapter 3 contains a description of the proposed study method (qualitative), design (phenomenological), and rationale. Readers will identify the study population (geographic location and sampling method) with the inclusion/exclusion criteria, and the research questions. Chapter 3 involves a detailed description of the informed consent and the protection of participants’ confidentiality. Data collection method (with emphasis on validity and reliability) and analysis will be part of this chapter. Chapter 3 concludes with a summary of the content.
Chapter 3

Research Method

From 1978 to 2014, nurses floated voluntarily or involuntarily to hospital units with distinct patient populations, work environments, and areas of expertise. During the literature review, no qualitative studies on floating as a lived experience were found; a need exists for an exploration of nurses’ feelings when mandated to float. The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. A qualitative method with a transcendental phenomenological design was the approach used in this study. Karasek’s JDC model (1979) served as the study theoretical framework.

Chapter 3 comprises information on the research method and design. The chapter includes the research questions and contains a description of measures to maintain participants’ confidentiality and anonymity. Details on data collection, data analysis, sampling strategies, and informed consent are part of the following paragraphs. Chapter 3 ends with a review of the salient information presented.

Research Questions and Hypotheses

The three research questions for this study were:

RQ 1: What are nurses’ experiences when it comes to floating?

RQ 2: What are nurses’ feelings when floating?

RQ 3: What factors influence nurses’ feelings when floating?

Two research questions address nurses’ feelings about the delivery of care when floating. The other research question inquires about nurses’ feelings about management and the different elements of the environment of care. The fundamental research
questions for the study originated from the numerous events associated with floating and nurses’ feelings regarding floating as a lived experience suggested by past research. A review of the literature did not show recent phenomenological inquiries on the exploration of nurses’ feelings. The emphasis of this research was on nurses’ feelings regarding the delivery of care, management, and the work environment when floating in unfamiliar units. Answers to these research questions are crucial to understanding nurses’ feelings.

Formulation of hypotheses occurs in quantitative studies. There were no hypotheses to test a theory in this study. The qualitative research method follows an inductive, as opposed to a deductive, analysis to explore the topic under investigation. The qualitative method is tacitly associated with inductive reasoning (Huy, 2012) and does not originate from an existing reality or hypothesis (Leedy & Ormrod, 2010). An inductive approach was proper to elicit participants’ descriptions of the phenomenon (Neuman, 2006). Researchers began with a substantial volume of information gathered from participants’ answers to open-ended interview questions during the interview process and systematically examined the text to identify common themes to summarize participants’ lived experiences (Christensen et al., 2011).

**Research Method and Design**

Under the umbrella of the qualitative method are a number of different designs, including phenomenology, case study, ethnography, content analysis, and grounded theory (Christensen et al., 2011). The common feature across these designs is that they constitute a structure for researchers to investigate individuals’ beliefs within their physical environments in real settings (Leedy & Ormrod, 2010). The phenomenological
approach is one of the designs to explore individuals’ experiences as a lived phenomenon (Leedy & Ormrod, 2010) and was appropriate for this study. Various nursing theorists commonly used the qualitative method in their studies of the nursing process and the delivery of patients care (Earle, 2010; Rapport & Wainwright, 2006).

**Appropriateness of Design**

Research methods and designs are specific to the research purpose. The phenomenological design was appropriate for this study because using phenomenology aided in exploring individuals’ perceptions of the lived phenomenon of floating. The purpose of this study was to explore nurses’ lived experiences with floating in an acute health care facility within a large southern city of the United States. This design assists in collecting data for the study by observing participants’ nonverbal cues and following participants’ thoughts throughout a narrow range of inquiry. The inquiry was about participants’ lived personal, natural, and social encounters with a phenomenon that may be significant to their daily routines. One of the useful features found in the qualitative method is the researcher’s ability to redirect participants as necessary toward answering open-ended questions focusing on the study during the interview process (Leedy & Ormrod, 2010). The intent was to identify nurses’ feelings, which are not measurable by numbers.

Using a qualitative method is instrumental in collecting non-statistical data from a small sample of individuals who agreed to participate in a study (Neuman, 2006). As Giorgi (2010a) mentioned, empirical methods are not applicable in a phenomenological inquiry. Transcendental phenomenology allows researchers who may have had similar experiences to appraise others’ understandings of the same event (Christensen et al.,
In this study, this approach was proper because the researcher is a nurse who experienced floating as a lived phenomenon. Investigators use bracketing or epoche (freezing own belief) and construe the occurrence from the participants’ viewpoints to prevent bias (Leedy & Ormrod, 2010). This was the case in this study.

**Identification of Possible Biases and Prevention**

As a nurse with an extensive experience on floating bias may come into play based on previous preconceived ideas on the phenomenon. Tufford and Newman (2012) described bracketing, a feature of qualitative research as a mean to increase researchers’ awareness of own presumptions to prevent bias. A possible bias is for researcher recalling previous encounters with the lived experience of floating to give meaning to unclear participants’ description of the phenomenon transcribing own feelings. Calling participants for a second short telephone interview could help clarify misunderstandings if desirable. Probe questions when necessary, may be useful to inquire deeper into two participants’ response to prevent ambiguity.

Another prospect is to skew the literature review in one direction either the advantages or disadvantages of floating. Bettany-Saltikov (2010) posited that researchers expert in a field may be influenced by own experiences and opinions. A solution to eliminate this problem was to conduct a systematic review of the literature. The search included a variety of trustworthy peer-reviewed research studies addressing the phenomenon. The literature review incorporated quantitative reports of positive and negative nurses’ feelings on floating.

Exploration of the literature revealed that phenomenology is both a research method and a philosophy (Earle, 2010). The use of transcendental phenomenology as a
philosophy served as a foundation to understand individuals’ perceptions of lived experiences that occurred in the participants’ natural environments (Leedy & Ormrod, 2010). The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. A qualitative, descriptive, transcendental phenomenological research design was appropriate to explore nurses’ feelings when floating to a unit other than their unit-base. The focus was on nurses’ genuine descriptions of the lived experience based on Husserl’s transcendental phenomenology. Human subjects share with researchers a structured and objective view rather than subjective feelings on a lived phenomenon (Husserl, 1970a/1936). The phenomenological investigation is ideal when researchers want to discover meanings to a central phenomenon (Flood, 2010). Brief summaries of Husserl’s transcendental and Heidegger’s interpretative hermeneutical phenomenology follow.

**Husserl’s Descriptive Transcendental Phenomenology**

Husserl’s phenomenology is epistemological (Earle, 2010). Events in the outside world take meaning in human consciousness (Husserl, 1970a/1936). Phenomenological researchers focus on one’s conscious perception of the world and on a lived experience, as the participant describes his or her inner feelings rather than offering a casual explanation (Husserl, 2010/1964). Husserl and his transcendental phenomenological approach emphasized the notions of bracketing to uncover the essence of phenomena (Tufford & Newman, 2012). Bracketing was useful to the researcher in the study, as it allowed her to reduce the influence of biases as the data unfold (K. A. Krumwiede & N. Krumwiede, 2012).
**Hermeneutical Phenomenology**

The hermeneutical phenomenological approach, used extensively in circumstances that targeted participants’ lived experiences, became popular as a research method in the 1970s (Charalambous, Papadopoulos, & Beadsmore, 2008). Husserl (1973/1929) described the philosophical, transcendental method in three steps: the phenomenological reduction, or the act of suspending one’s beliefs; the eidetic reduction, or the relationship with pure intuition; and the perception of the appearance of objects in our cognition. Giorgi (2012) agreed that reduction is the correct attitude in descriptive studies. The truth originates from researchers using a systematic and rigorous inquiry research method, phenomenology, especially to understand individuals’ lived experiences (Vandermause & Fleming, 2011).

**Heideggerian Interpretative Phenomenology**

Heidegger, a student of Husserl, confronted Husserl’s transcendental approach (McConnell-Henry, Chapman, & Francis, 2009a). Heidegger addressed the possible involvement of participants and researchers in the study (McConnell-Henry et al., 2009a). The assumption was that previous knowledge plays a critical role in data interpretation. Heidegger focused on ontology and unveiled an interpretative side of phenomenology (Vandermause & Fleming, 2011). The following is a summary of the approaches used by different nursing theorists in building their philosophies.

used by researchers in the phenomenological design is an approach useful to the formulation of hypotheses and theories. Researchers using the quantitative method on issues in need of further studies will use these findings to inform knowledge.

Other Designs

Qualitative inquiry can be used with approaches other than phenomenology, including ethnography, grounded theory, and case study. Researchers use these designs to study a phenomenon in its natural environment and its effect on individuals as a lived experience (Leedy & Ormrod, 2010). There are fundamental differences between phenomenology and the above-mentioned designs. Researchers who choose ethnography focus on behavior of individuals in a specific culture and attempt to observe individuals and describe the cultural activities and beliefs of members of an ethnic group; this research design is ideal to explore the characteristics of one ethnic group. It may be useful to access the group through a member of the specific sociocultural group.

In a case study, the emphasis is usually on the extensive study of one case, which can involve a person, a family, or a community over a specified period. Researchers observe the individual and the phenomenon routinely over a period. In the proposed study, observation of nurses during working hours (a shift or shifts) in which they float is necessary. The observer may need to follow the nurses into different units throughout one day or more. Leedy and Ormrod (2010) suggested that a case study is suitable to investigate how variations in the environment may affect individuals and phenomena.

In the grounded theory design, researchers analyze a general condition, looking into generating a theory from reviewing available data. The problem or situation under evaluation is engrained in the data. The central idea is to explore a process in which
actions and interactions influence involved individuals (Leedy & Ormrod, 2010). Researchers begin by reviewing existing data related to the process and conclude by developing a theory from the collected data (Creswell, 2007).

None of these cited methods fit the study for the following reasons. The purpose was not to identify individuals’ behaviors specific to a culture or ethnic group (ethnography) or to study a phenomenon as it happened in a case over time (case study). The purpose was not to develop propositions into theory grounded in the collected data (grounded theory). In the phenomenological approach, researchers use in-depth interviews of participants recruited from a purposive sample and address participants’ lived experiences with the phenomenon in their natural environments (Leedy & Ormrod, 2010). The latter matched the purpose of this research study.

The phenomenological research design is an inductive, descriptive, qualitative method based on the phenomenological philosophy (Leedy & Ormrod, 2010). This design was appropriate for this study. The primary purpose of a phenomenological study was to explore a phenomenon lived by individuals who agree to describe their feelings during the encounter. The rationale for its use in this study correlates with the intention to explore nurses’ feelings a lived phenomenon (floating). The qualitative method and phenomenological design eased access into participants’ natural selves and intuitions (Husserl, 2010/1964). Phenomenology encompasses the selection of a small number of participants until data saturation occurs (Merriam, 2009), as no inferential statistical analysis is necessary. Data consisted of collecting participants’ recorded answers to open-ended interview questions, sorted into meaningful themes.
Alternative Research Designs

The next section is a review of different research designs pertaining to the quantitative method. The main purpose of this review was to explain the reasons why a quantitative approach (descriptive or experimental) was inappropriate for the study. The following section is a summary of concepts applicable to the quantitative research method and contains an explanation about why this method was not appropriate to the exploration of nurse’ feelings on floating.

Quantitative Research Method

The quantitative designs (experimental, quasi-experimental, and correlational) are useful in establishing correlation and cause-to-effect relationships between variables (Black, 1999). The quantitative method involves the identification of independent variables, which when manipulated may cause changes in the dependent variables. A quantitative experimental study includes a random selection of participants randomly divided into two groups. One group, the control group, is not subject to manipulations, whereas the other group is subject to a specific manipulation or intervention in a controlled environment.

The study design is oriented toward answering a question or a hypothesis and anticipating the result of the study (Pierce, 2009). In a quasi-experimental study (with pre-posttest as a common example), the research concept is similar to the experimental design. The latter involves a lower level of control and manipulation of the population with no random designation. A convenience sample may replace the random sample. A correlational design assists researchers in discovering a positive/negative or no relationship between variables.
The above-mentioned concepts do not apply to the qualitative inquiry and to this study because the focus was on exploring a particular group during a specific lived situation. A quantitative method (experimental, quasi-experimental, or correlational design) would not be applicable to this study because the intent was not to prove or disprove a theory. The goal for this research was not for the author to calculate the percentage or average number of nurses who float. Nurses’ feelings were not measured using inferential or descriptive statistical analysis. In this study, the researcher explored the phenomenon based on non-numerical alternatives.

**Geographic Location**

Defining the geographic location for a study is significant. It may facilitate transferability, provide accurate information about distance/travel cost (related to the project), and guide the researcher in recruiting participants. For this study, the population belongs exclusively to a 457-beds acute care facility in an award winning institution. The facility, a not for profit organization, is located in the southwestern metropolitan Miami Dade area in the state of Florida, United States Of America at about 16 miles southwest of downtown Miami. The general population served includes Hispanic, African American, White, and Asian. These ethnic groups mirror Miami Dade demographics (Cruz & Hesler, 2013).

Contemporary patients care interventions in robotic surgery, cardiovascular services, and cancer care are common in the facility. Nursing and medical staff in the renowned multispecialty establishment provide quality care to a multicultural population in the community. The urban institution, a magnet hospital for nursing excellence, faces staffing fluctuations and challenges related to changes in health care, which intensify the
necessity for nurses to float routinely. The American Nurses Credentialing Center (ANCC) grants magnet designation to institutions that meet established criteria such as developing and maintaining a culture of evidence-based practice, excellence in patients care, nurses’ empowerment, and innovation in the workplace (ANCC, 2014). Participants were staff nurses with different specialties and from different units of the selected hospital.

**Population and Sampling**

Registered nurses remain the largest segment of caregivers in hospitals. The target hospital has an estimated nursing staff of 900. The sampling frame for this study included male and female staff nurses from different specialties working in an acute care facility in Miami, South Florida. These nurses float routinely and involuntarily. The goal for the study was to recruit a purposive sample of 10-15 nurses (until reaching saturation) of all ages, ethnicities, and years of experience. A total of 11 nurses two males and nine females, meeting the study criteria participated in the research (see Appendix B for the Recruitment Process).

Marshall, Cardon, Poddar, and Fontenot (2013) suggested that one method to estimate sample size that will allow saturation is to review similar studies in the literature and verify the sample size at which saturation occurred. This method did not apply to the study. No phenomenological studies exploring the feelings of nurses on floating were found. The evidence transpires not from enrolling many participants but from exploring the feelings of different individuals experiencing the same phenomenon (Nolen & Talbert, 2011). Participants in the research study were full-time employees of the facility described above.
Recruitment into the project was through contacting staff-registered nurses working full-time in an acute care facility in the South Miami area in which mandatory floating occurs on a rotational basis. An approach to enrollment was to present a summary of the prospective study to the research committee chair and council members during the monthly research committee meeting to attract potential participants (see Appendix C for script summary). Participants on this committee, which meets the fourth Friday of every month, are full-time staff registered nurses from different units of the target hospital along with other ancillary employees. A planned initiative to post approved announcements in the facility monthly e-news to increase awareness of potential participants was not necessary. Interested nurses became aware of the study by word of mouth and researcher’s presentation during morning huddles in their units.

Upon receiving institutional review board (IRB) authorization, an e-mail was sent to the unit managers through the facility intranet for assistance with recruitment (see Appendix D for email script). A 10-minute presentation summarizing the major points of the research was necessary to disseminate the information. Appendix E contains the complete interview script study questionnaire. Potential participants read the exclusion and inclusion criteria during the meeting. Additional time for questions and clarification followed each presentation.

Qualified individuals interested in participating in the study communicated with the researcher, whose contact information was on a flyer distributed to nurses participating in the meeting upon request. Nurses contacted the researcher at their convenience via private or work e-mail, work phone, or cellular phone to determine eligibility. Appendix F is the survey questionnaire to ascertain applicants’ eligibility.
The population included nurses who work full-time and experience mandatory floating in the selected acute health care facility within the large Southern city mentioned. The study sample consisted of 11 staff nurses meeting the inclusion criteria.

Five inclusion criteria and five exclusion criteria were used in this study. Participants who voluntarily agreed to be part of the research were registered nurses, hired full-time at the chosen local acute care hospital, and experienced mandatory floating consistently on a rotational basis. Nurses eligible to participate in this study were those required to float routinely. Student nurses cannot float because they are not hired or licensed. They are present in the units to deliver supervised hands on patients care. Individuals that meet the eligibility criteria discussed scheduling an appointment for the interview based on their availability. The setting for the interview was the researcher’s office on her day off, or break time, on Saturdays or Sundays when the unit is closed, or a nursing lounge on either unit.

The five exclusion criteria included the following:

New graduate registered nurses floating with preceptors during their scheduled orientation period are not eligible to enroll in this study. New graduate nurses’ critical thinking skills develop overtime with experience (Klein, 2009). As a result, they are novices in the profession and are unable to make critical decisions even in their areas of practice. In general, once off orientation, new graduate nurses can float six months later. The orientation period varies from four to six months according to the specialty area. Benner (1984) specified that a nurse moves from novice (a new graduate with no experience) to advanced beginner (a nurse performing at an appropriate level) during the second half of the first year post graduation and training.
A category of registered nurses who work only by term-limited contract or by per diem was excluded. These nurses are available to float at any time in areas in which staffing needs exist (Larson et al., 2010). Flex/float-pool staff nurses flexible and educated to care for various types of the patient population in diverse hospital units (Lavoie-Tremblay et al., 2008), cannot be participants in this research. These nurses are multispecialty and essentially hired to float. Unlike full-time staff nurses, float-pool nurses have no home units. Float-pool nurses are part of a hospital central staffing. This approach is an initiative developed in some health care facilities to avoid using the costly services of agency nurses, whose hourly wages ($71) approximately double the wages of staff nurses ($38) (Larson et al., 2012).

Finally, nurses who volunteer to float for extra shifts and overtime pay on their days off, float on a voluntary basis by calling the nursing staffing offices of their hospitals to offer their services. The same applies to agency nurses, flexible registered nurses available through for-profit nursing agencies (Hurst & Smith, 2011). They do not have set units in which they work. Rather, they elect to float in different areas according to their competencies (Hurst & Smith, 2011).

While discussed in the study, there were no restrictions on enrollment based on participants’ entry levels in the nursing profession (associate’s degree, Bachelor of Science). Demographics, number of years of experience, and length of employment at the health care facility collected are presented on a table format as general background information about the facility and the staff nurses. The exclusion criteria included experienced nurses within six months of hire. New graduates not scheduled to float until
after six months off orientation are excluded. These two categories of nurses cannot be part of the study sample because they do not float until reaching the six-month deadline.

The purposive sampling method helped identify a group of individuals who have experienced the phenomenon in a natural setting (Anderson, 2010). As indicated by its name, a purposive sample fits a purpose. Cooper, Endacott, and Chapman (2009) suggested researchers would benefit from selecting participants based on their experiences with the phenomenon under investigation. (Anderson, 2010) acknowledged that in qualitative studies the description of the sample size should reflect its significance within the larger population. Participants selected for this study experienced mandatory floating as a lived experience.

A purposive sampling fitted the purpose of this study. The researcher deliberately recruited nurses mandated to float routinely to other units. Xaba, Peu, and Phiri (2012) believed that choosing a purposive sample corresponds with the researcher’s ability to identify individuals who experienced the phenomenon. The population reflected the study purpose, by including nurses who experience the phenomenon of floating on a regular basis. They represented a group who may have different feelings and perspectives on floating.

The sample size for this study was suitable. An acceptable size range for phenomenological studies is five to 25 individuals (Creswell, 2007). A purposive sample size of 11 full-time registered nurses required to float was appropriate to reach saturation or the point when no new themes emerge in the data. Beck (2009) described saturation as an indication for researchers to discontinue data collection. Qualitative researchers use small study samples because the focus is on understanding a phenomenon, not on
gathering evidence for generalizability purposes (Dworkin, 2012). Enrollment was limited to staff nurses mandated to float.

**Recruitment Process**

Enrollment was contingent on well-defined inclusion/exclusion criteria. Registered nurses meeting the inclusion criteria were the population for this study. They were aware of the forthcoming research through different presentation. The guiding principle for this study was that participants must have experienced the phenomenon under exploration. The inclusion criteria encompassed full-time, staff registered nurses mandated to float routinely on a rotational basis in the selected hospital. Nurses falling into one of the five exclusion categories did not participate in this study. Demographics (age and ethnicity) along with nursing education and work experience collected to describe the sample were not part of the study criteria. The researcher contacted participants who met the inclusion and did not fall under one of the five exclusion criteria for possible enrollment in the study.

The researcher’s contact information (school, work, and private) was available in the flyer designed to disseminate the information to nurses about the prospective study. Appendix G contains a sample of the flyer with researcher’s relevant contact information. Individuals who called the researcher and manifested an interest in enrolling in the study received an invitation to discuss the study inclusion/exclusion criteria. The researcher engaged in dialogue with prospective participants at a time convenient for both parties and focused on the criteria set forth for the study using a survey questionnaire.
The survey completed with each interested applicant became part of the study documentation. Eligible participants selected convenient times and dates to meet with the researcher to begin the interview process. Elected applicants reviewed the study purpose, conditions for participation in collaboration with researcher. The participant and the researcher reviewed the criteria one by one before each interview. Participants who agreed to enroll in the research signed the informed consent (IC), and the interview begun.

**Informed Consent (IC)**

The IC letter was a complete account of the expectations for the study. It contained the study title, the researcher’s name and affiliation, and the research purpose and goals. Participants were aware of the digitally recorded interview process of a maximum of one-hour duration, with additional pertinent details described in the IC. A copy of the IC is available in Appendix H. Participants understood that it may be necessary to schedule a second, shorter conversation on the phone (5 to 10 minutes) for clarification of responses given. Participation was voluntary and risk-free.

No anticipated risks associated with participating in this study existed. Participants were made aware that they may decide to leave the study at any time without repercussions for themselves or their jobs and with no questions asked. The destruction of data collected in this case will be instantaneous. Selected applicants read the IC jointly with the researcher, who took the opportunity to answer any questions they had. The participant then signed two original copies of the IC, and the interview begun. Participants received a copy of their signed written informed consent letter. The second
original copy is locked in the researcher’s office. A mere decision to participate in the study was not acceptable as a tacit consent.

Confidentiality

Preservation of participants and institution privacy is critical. Pseudonyms replaced identifying information (about the participant, other people, or the institution) from the written transcripts of the interviews (see Appendix I for other specific confidentiality information). A drawer at the interviewer’s locked cabinet at work functioned as a secure storage place for the collected data. No one have access to this drawer except the researcher or IRB members upon request. The institution within which participants work was an acute care hospital in Miami, Florida. No attempt to link information collected to participants or organizations was made. The researcher will shred paper documents, scorch collected material (ashes dispersed), destroy tapes, and delete folders after the required period. As a rule for this study, there were no questions asked about participants’ private identifiers such as date of birth, social security number, or employee number. Maintaining the institution’s privacy is an ethical obligation. A method to achieve this goal consisted of a careful review of recorded interviews and transcripts to remove identifiable data inadvertently mentioned during interviews.

Withdrawal Process

Participants were made aware that they may decide to leave the study at any time without repercussions for themselves or their jobs and with no questions asked. The destruction of data collected in this case will be instantaneous. If they choose to do so, a master list developed will be used to identify the participants’ data. The master list contains participants’ randomly assigned numbers, dates and times of interviews, and
other unique identifiers (pseudonym, name, and telephone number). It serves the purpose of identifying accurately the participants who desire to withdraw from the study before, during, or after completing the interview/data collection (see master list in Appendix J). The content of the master list is useful to isolate, identify, and delete data collected from individuals who select to remove themselves from the study, as federally mandated. No participants withdrew from the study.

**Data Collection**

**Study Implementation**

**Primary phase.** After conducting the pilot study, data collection began promptly based on the study methodology flow chart, which contains two phases (see Appendix K). The principles applied to the pilot study were identical to the ones applied during the study implementation. Throughout the primary phase, 1:1 interviews ensued with nine female and two male registered nurses. Digital recordings of participants’ responses occurred. The interviewer took the opportunity to write hand notes to capture participants’ feelings on the lived experience. Saturation resulted with the ninth interview. Observation of nurses’ attitudes, voice sounds, facial expressions, and other non-verbal cues during the interview enhanced data richness.

**Secondary phase.** This phase involved listening to participants answer the open-ended interview questions. Five weeks were necessary to complete the interviews. Nurses expressed their feelings on floating as a phenomenon. Seldom used, probe questions assisted in redirecting two participants toward the study purpose, which was to explore nurses’ feelings on floating. Nurses mentioned different factors associated with
floating. The interviewer used bracketing to prevent bias. The researcher is a nurse who experienced floating in the past and may have preconceived ideas about the phenomenon.

**Process and design.** As stated previously, a qualitative design based on Husserl Transcendental Phenomenology served as a theoretical basis for this study. The researcher used epoche to focus on participants’ description of the lived phenomenon, as recommended by Husserl (1970a/1936). Giorgi’s framework, encompassing six steps and four stages, was a useful tool to analyze collected data (Table 3). A description of the steps used to complete the data collected follows.

Data collection did not begin until several steps were taken. The first step was to obtain a permission to use the chosen site (see Appendix L for form generated by University of Phoenix (UOPX). The selected facility chief nursing officer (CNO) signed this permission to use letter. The second step was the required quality review method (QRM) and IRB review from members of the UOPX. Lastly, before beginning the research process, the facility IRB agreed with the study, a condition posed by the CNO.

After fulfillment of these requirements, the data collection process began. Phenomenological researchers use general open-ended questions during lengthy interviews to elicit detailed information from participants (Leedy & Ormrod, 2010). Participants were the main source of information. The development of carefully worded broad interview questions and probes aimed at eliciting participants’ answers related to the research purpose. This process assisted in refocusing interviewees on the central phenomenon as necessary. The completion time for each semi-structured interview process for this study was about 40 minutes. Data collection consisted of asking broad
interview questions allowing participants to elaborate on the lived phenomenon and describe their feelings in detail. The use of probe questions was on an as needed basis.

Data collection in qualitative studies is dependent on researchers’ involvement in the process and the selection of a setting adequate for interviewing. Conversations, surveys, observations, documents (written or image), and audiovisual materials are common data collection tools in qualitative studies (Creswell, 2007). Data collection took place at the facility premises during the end of the shift of both parties, beginning of the work shift, or weekends. The areas selected by participants for the interview were the researcher’s office or the nurses’ lounge. No new themes emerged from the data after interviewing the ninth participant. After reaching saturation, two scheduled interviews with enrolled participants occurred, and data collection ended.

The participant and researcher interacted during a scheduled meeting. A quiet and private place agreed upon by both parties served as a setting for the interview. All interviews took place on the institution premises. The different location used were the researcher's office on participant’s and researcher’s day off, or break time, on Saturdays or Sundays when the unit is closed, or a nurses’ lounge in the facility. A private location helped in minimizing interruption, preventing distraction, and protecting the participant’s confidentiality.

As a guideline, the researcher selected a purposive sample of individuals who have experienced the phenomenon among the other criteria previously described. Based on this general rule recruitment consisted on a sample of 11 nurses meeting the specific criteria mentioned. Data collection lasted for about 40 minutes divided into a three-part
process comprising building rapport, asking broad, probe questions (if necessary), and
ending the interview.

**Building Rapport with Participants**

At the outset of the interview, the focus was on building rapport with participants,
which took approximately 10 minutes (or more as necessary); at this time, the participant
and researcher became acquainted. A few questions about the participant’s education and
demographics followed. Recording started after completion of the IC process.

**Instrumentation**

In phenomenological studies, the researcher is the instrumentation. Chenail
(2011) emphasized the qualitative researcher’s role as the main instrument in data
collection. The author stipulated that it is essential for the researcher to use open-ended,
broad interview questions. Probe questions may be useful to inquire about important
facts not mentioned by participants (Qu & Dumay, 2011). Broad and probe interview
questions were fundamental features of the questionnaire of the interview process in this
research.

**Asking Interview Questions**

The interview questions guided the research. Semi-structured interviews
conducted with one participant at a time took place at each participant’s discretion on
hospital ground as described previously. The interviewer consciously avoided
interpreting the participant’s perceptions based on her own opinion and possible bias
during the interview.
Description of the Interview

The entire interview process lasted about 40 minutes. The following is a summary of the process. During the first few minutes, the researcher built rapport with the participant, welcoming and thanking him or her for volunteering to be part of the study. The researcher described the interview process and reminded the participant that this is a digitally recorded interview. Participants then are invited to review in detail the IC and sign the two original.

The main interview questions comprised three broad questions. The broad questions are open-ended and address participants’ feelings about floating as a lived experience in general. Each broad question encompassed six to eight probes questions. The probe questions allowed for redirecting participants and further exploring areas in which clarification and more information were necessary. The interview ended by thanking participants and asking if they had additional comments, questions, or recommendations to prevent overlooking of new details. A set of probe questions related to each broad question was available to elicit important information not given by the nurses. The use of probe questions was not necessary during nine interviews. Nine nurses responded to the broad interview questions without the need for probe questions.

The interview was recorded for the purpose of this study. Permission to record the session was part of the general informed consent form. Two digital recorders were available on site for use during the process. After each interview, the materials recorded were uploaded in the researcher’s password protected personal computer (PC) within 24 hours. The uploaded information was transferred into a folder in the researcher “my documents” folder at home. The researcher’s personal computer files/folders are secure
by a firewall and an online backup service by carbonite. When not in use, digital
recorders are in a locked drawer located in the researcher’s office.

Ending the Interview

The interview ended by asking participants to add comments about any part of the
interview. This was the time for recommendations and questions. Any unclear
comments were reviewed with participants to ensure completeness of the recorded
statements by rephrasing or asking for further elaboration on the particular area. The
interview concluded when no new information emerged.

Throughout the interview and during transcription, annotations were made.
Repeated words, words group, and sentences were color coded on a Word document.
The transcription was verbatim. After listening to the recorded interviews four times one
at a time, within 24 hours of recording the interview a word document was generated by
capturing and typing out every word mentioned by participants along with pauses and
sounds. The written account of the interviews directly resulted from answers given to
broad/probe interview and other relevant annotations. Transcriptions saved in a folder on
the researcher’s personal computer password-protected were accessible to the researcher
only and the IRB if requested. Participants’ contact information remained on the master
list. A second brief telephone conversation, within 24 hours after the initial face-to-face
interview and after transcription of the recorded data was not necessary.

Pilot Study and Feasibility

Pilot Study

A newly created folder contained the approved stamped materials received from
the facility Research Council chair and the IRB chair. The original documents locked in
a drawer at the primary investigator’s office are available to members of the IRB for random review. The facility nursing leadership and nursing management received an e-mail with a copy of the approval letter attached. They became aware of the upcoming pilot study and full research study to follow. The clinical nurse educators in areas where nurses float received an e-mail message from researcher as well. The implementation of the pilot study mirrored the actual study protocol as described in the Study Methodology Flow Chart. The researcher observed nurses’ nonverbal cues to capture the core of the nurses’ feelings on floating. Feedback on interview questions and interview process was solicited from the two nurses to evaluate participants’ understanding, study feasibility, etc., modify the interview process, and revise the interview questions as appropriate.

Following approval from all parties involved, a pilot study was conducted before beginning the study. The main reason for the pilot study was to gather information about the degree to which participants understand the wording of broad and probe interview questions. Other benefits from the pilot project were the opportunity to time each session and to identify modifiable factors that influenced the process. Pilot interview testing established rigor and contributed to the development of noteworthy and clear questions (Shorter & Stayt, 2010). The interview process for volunteers meeting the inclusion criteria followed the guidelines established for phenomenological studies and the purpose of this study.

Two nurses meeting the study inclusion criteria participated in the pilot study. The digitally recorded, one-on-one interviews lasted for about 40 minutes instead of the predicted one hour. These nurses were subject to the same requirements established for the target population. They worked in the target organization and met the same inclusion
criteria established for the study. The transcendental phenomenological approach was used during the pilot study. Nurses participating in the pilot study remained as part of the final pool of participants.

As described in the methodology flow chart the researcher observed nurses’ nonverbal cues to capture the core of the nurses’ feelings on floating. Feedback on interview questions and interview process was solicited from the two nurses to evaluate participants’ understanding and revise the questions as appropriate. The pilot study established face validity and the degree to which participants understood the process and questions asked.

**Result of the Pilot Study**

There was no need to modify the interview process further or revise the interview questions because participants described them as appropriate. The first observation noted about the interviews was the first participant answered the three broad interview questions without hesitation or the need for the probe questions. The second participant, on the other hand, seemed hesitant. This interviewee required the use of probe questions to address areas not covered during the interview. The participant required further refocusing on the research study purpose. None of the interviewees thought that modifying the interview process and questions was necessary.

This study was feasible at minimal cost, which included travel time for researcher to meet with the nurses, purchase of gasoline, and purchase of two digital recorders. The recruited individuals did not incur expenses related to travel time and gasoline cost. Participation was voluntary; there was no compensation provided for agreeing to participate in the study. The study was feasible at a minimum cost to the researcher.
It became evident during the pilot that it was simpler to have participants fill out the demographics information on paper to allow more time for the actual interview. Filling out the demographics by hand was the only change in the interview process. Feedback solicited and received from participants about their understanding of the interview questions and the interview process, in general, was positive with no other alterations desirable. There were no issues with either the methodology or the questionnaire.

**Data Analysis**

Researchers using the phenomenological approach face critical responsibilities in analyzing the data collected. Analyzing qualitative data encompasses a thematic approach based on various existing frameworks (Fade & Swift, 2011). One approach is Giorgi’s Six Steps to Data Analysis (1985). He suggested six steps to data analysis based on Husserl’s descriptive transcendental phenomenology (Phillips-Pula, Strunk, & Pickler, 2011). Follower of Husserl, Giorgi (2010b) recommended searching for the essence of phenomena using the phenomenological reduction in which researchers set aside personal knowledge of a phenomenon to acknowledge participants’ account of the lived phenomenon. In this study, reduction was useful because researcher is a nurse who experienced the phenomenon. The use of bracketing increased researcher’s awareness of own feelings on floating. Giorgi’s six steps grouped into four stages served as basis to data analysis in this research. Table 3 is a description of the fundamental elements, which constitute Giorgi’s Six Steps to Data Analysis.
The main device used during the interviews was a digital voice recorder. After the interview took place, uploading and saving of recordings as a sound document occurred on a media player. Listening four times to the raw data recorded digitally to have a sense of the interviewees’ perspective as a whole facilitated the creation of a word document within 24 hours. The transcription was verbatim. After listening to the recorded interviews four times one at a time, within 24 hours of recording the interview, the researcher generated a word document by capturing and typing out every word mentioned by participants along with pauses and sounds. The written account of the interviews directly resulted from answers given to broad/probe questions and other relevant annotations.

Stage one (Giorgi’s step one) began with listening carefully to each participant’s response to the interview questions four times. The transcripts were read thoroughly to understand floating as a phenomenon in its entirety (Holm, Norekvål, Fälun, & Gjengedal, 2012). It was the opportunity for the researcher to immerse into the data to identify the essence of each description of nurses’ feeling on floating (Rowe & Carpenter, 2011). Bracketing was a crucial characteristic of stage one.

<table>
<thead>
<tr>
<th>Steps</th>
<th>Researchers’ responsibilities</th>
<th>Rationale</th>
<th>Stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Read and reread descriptions of experience</td>
<td>Get a sense of the whole</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Divide descriptions into meaning units</td>
<td>Identify significant terms</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Describe the meaning of each unit</td>
<td>Relate each unit to the topic</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Synthesize units</td>
<td>Describe phenomenon</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Analyze the transformed units</td>
<td>Focus on intentionality</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Develop a description</td>
<td>Reflect the experience</td>
<td>4</td>
</tr>
</tbody>
</table>
It was important for the researcher to achieve phenomenological bracketing as described by Glenn and Gilbert-Hunt (2012). Bracketing, eпоche, or reduction, according to Giorgi in agreement with Husserl (1973/1929) was a critical step of data analysis. Reduction is a practice in which researchers with previous knowledge or experiences with a phenomenon reach the 'suspension of belief' in the 'outer world' (Husserl, 1973/1929). Reduction assists in preventing the occurrence of preconceived ideas or hasty conclusion (Husserl). In the absence of reduction, the “entrée” into the phenomenological domain, researchers cannot assert a method to be phenomenological (Giorgi, 2002, p. 201).

During stage two (Giorgi’s steps two and three) data digitally recorded were transferred to the NVivo10 software to identify similarity in words and phrases stated by different nurses during the interviews. Reading the transcripts four times led to the development of meaning units. This was a first-level coding (Jose, 2011). A line-by-line content analysis of participants’ statements according to their experiences with floating helped identifying meaning units. Personal responses constantly compared across other participants’ answers informed developing themes (Yeung, Wong, & Mok, 2011). The content analysis evolved around Giorgi’s steps two and three of data analysis along with Husserl’s transcendental phenomenology. Husserl viewed an individual as a unique human being reacting in the natural environment in which the phenomenon occurs (Greenfield & Jensen, 2012). After an exhaustive content analysis, central themes for each unit appeared.

In stage three, the researcher identified, analyzed, and set aside own assumptions about floating (McConnell-Henry, Chapman, & Francis, 2009b). Answers given by
nurses throughout the interviews were classified according to the questions asked in this study to identify consistencies (Wilson, Elborn, & Fitzsimons, 2011). This was the second level coding in which clustering, labeling, grouping of themes occurred. Themes compared with secondary data allowed the identification of revelatory themes. Stage three encompassed Giorgi’s steps four and five.

Stage four corresponds to Giorgi’s step six. A description of the cardinal themes sorted using the broad and probe interview questions was the hallmark of this stage (Palese, Salvador, & Cozzi, 2011; Wilson et al., 2011). This was the final step of the data analysis process. The identified themes represented the participants’ perception about floating. The researcher combined revelatory themes into statements to write the final document (Murdoch & Frank, 2012). The final document will be published and accessible to the readers in the scholarly community.

Table 4 is a sample summary of the data analysis process. Appendix M is the graphic representation of the codebook development. It contains an explanation on raw data, data transcription, sorting of themes across answers given by different nurses, code labelling, etc. Table 4 (Adapted from DeCuir-Gunby, Marshall, & McCulloch, 2011, p. 145) is a sample of the relationship between data-driven themes, description, and examples. The summary of the data analysis in table 4 is data-driven based on the continuous review of the data collected during the interviews.

Table 4  
Sample Summary of the Data Analysis

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Description/meaning units. What did participants mean</td>
<td>Participants’ quoted words, sentences, or paragraphs</td>
</tr>
</tbody>
</table>
Table 5 is a succinct overview of the data analysis process as described in stages one through four.

Table 5

*Data Analysis Process Summary*

| Stage 1 | Upload and save recordings as a sound document on media player.  
|         | Listen four times to raw data.  
|         | Create of a word document within 24 hours.  
|         | Read raw document four times taking notes and highlighting common words |
| Stage 2 | Organize the word document in heading one style in preparation for auto coding.  
|         | Export data collected to the NVivo Software.  
|         | Auto code imported document in the NVivo Software.  
|         | Conduct a word frequency query.  
|         | Create new nodes based on participants’ answers.  
|         | Identify meaning units significant to participants and the phenomenon. Group each unit according to their meanings and frequency. |
| Stage 3 | Sort common words, word groups, and sentences groups into themes. Connect themes to primary and secondary codes.  
|         | Identify associations existing between floating, the study purpose, and the research questions.  
|         | Identify revelatory themes comparing themes, primary codes, and secondary codes. |
| Stage 4 | Combine themes into statements reflecting participants’ descriptions. Create the final document based on these statements.  
|         | Describe nurses’ lived experience with floating and significance for nurses and patients care, for health care leaders and for future research. |

**Accuracy of Transcription**

Following each interview, the researcher transcribed the participants’ recorded answers to the broad and probe interview questions in a Word document by listening to the recording. The researcher incorporated field notes about the participant’s behavior and non-verbal cues into the typed document. The researcher used a second transcription method, the qualitative data analysis software NVivo 10, to read, listen, organize, and analyze content from the interviews by uploading the recorded interviews in the software. A random audit of the first two of the transcribed interviews was crucial following along with the script to judge accuracy. The transcripts were accurate according to the result of
the comparison between the content of the Word document and data generated from the software. The researcher kept a record of the number of errors. There were less than five errors per transcript.

**Validity and Reliability**

The notion of validity in qualitative research refers to participants’ truthfulness in describing their feelings (Christensen et al., 2011). This study is valid and reliable, and will be valuable to nurses and future research. The researcher established rapport with participants to create a non-threatening atmosphere in which participants felt free to describe their feelings regarding floating. Md. Ali and Yusof (2011) posited that a measure of a study validity correlates with the extent to which researchers focus on participants’ credibility and accountability in the description of the lived experience. Selected individuals met pre-established criteria to minimize confounding influences.

Qualitative researchers do not pursue generalizability but rather explore individuals’ perceptions and thought processes when facing specific situations (Christensen et al., 2011). These investigations are descriptive, interpretive, and epistemological (Merriam, 2009). This study is valid and reliable because of its adherence to strict guidelines pertaining to the qualitative method. The description of initiatives to maintain the validity and reliability of the findings follows in the next sections.

**External Validity**

One way of attaining validity was to remain in contact with participants for a long enough period to establish trusting relationships (Barusch, Gringeri, & George, 2011). The duration of the interview process is adequate, lasting about 40 minutes each.
Another step to ensure validity was to build and maintain rapport with participants to solicit participants’ input on coded transcripts. The following three paragraphs explained how to ensure the integrity of external and internal validity along with reliability in this study.

**Internal Validity**

Internal validity is the extent to which the study method and design align with the research purpose. This alignment was crucial to validate or confirm information generated at the end of the study. Giorgi (2002) recognized that the search for the true meaning of a lived experience results in an objective account of the phenomenon. The numerous variations used in data collection strengthened the internal validity for this study. The population for this study included nurses from different ages and number of years in the field. The structure of the selected population included different ethnic backgrounds and nursing specialties.

**Reliability**

Reliability refers to the degree of stability of the collected data and results. It depends on participants’ ability to remain honest, loyal, and consistent during the interview process (Neuman, 2006). Reliability is a function of the methodological approaches used throughout the study from data collection to interpretation (Md. Ali & Yusof, 2011). The adherence to the guidelines for data collection and analysis ensured reliability of this study.

**Plausibility, Authenticity, and Relevance**

Plausibility (credibility), authenticity or genuineness, and relevance are crucial features of the qualitative inquiry. Carefully scrutinizing collected data for common
themes in transcripts ascertained internal validity comparable to credibility (Thomas & Magilvy, 2011). Authenticity is the extent to which participants are genuine in the description of their feelings. It involves the possibility to contact participants a second time as necessary to clarify ambiguous data. This study is relevant to the nursing profession, consumers of health care, and hospital administrators. It may contribute to an in-depth understanding of the phenomenon of floating from a nursing standpoint. It explored nurses’ feelings regarding floating, a topic with no recent phenomenological reports within 10 years from 2014. During the interview, uncovered issues were relevant to consumers of health care. The identified and ongoing matters described by nurses were significant and may prompt changes to hospital policies and procedures about floating. Comprehensive statements and arguments echoed nurses’ neutral, optimistic, or negative perceptions of floating.

**Rigor in Qualitative Research**

Rigor means adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all the data in the development of a final report. Connections exist among rigor, plausibility, authenticity, and relevance. A rigorous approach reinforces the research findings (Ryan-Nicholls & Will, 2009). Researcher ensured rigor by reviewing data with participants for accuracy and findings for consistency and understanding at the end of each interview. McBrien (2008) posited that methodological rigor increases the reliability and value of qualitative research. Md. Ali and Yusof (2011) reported that numerous approaches for data gathering (interview, observation, and textual analysis) were strategies used for increasing rigor.
Transferability

Transferability in qualitative research refers to the ability to apply findings from a study to another population with the same characteristics (Thomas & Magilvy, 2011). One way of ensuring transferability was to collect thick and rich data describing the study population characteristics, criteria, and geographical limitations carefully (Thomas & Magilvy, 2011). Transferability in qualitative studies is the equivalent of generalizability in quantitative studies. Results obtained from the exploration of nurses’ feelings regarding floating should be the same if conducted in another magnet facility with the same population and similar inclusion and exclusion criteria.

Summary

The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. In chapter 3, readers had the opportunity to understand how the qualitative method based on Husserl’s transcendental phenomenology and steps used in this study matched the purpose of the study. The study design was appropriate and assisted the researcher in exploring participants’ vivid perceptions of the phenomenon as a whole in its natural setting. A pilot project to test respondents’ interpretations of the interview broad and probe questions began following IRB approval.

Chapter 3 included a description of the research population and geographic location. A brief summary of theorists of the nursing discipline who used phenomenological approaches to study patients’ perceptions of nursing care, nurses’ feelings, and other pertinent nursing issues were available. Three broad research questions served as foundation to the study. The described interview questions elicited
answers that facilitated the identification of meaning nurses make of their realities in terms of floating as a lived experience. Probe questions complemented each broad interview question as necessary.

Participants meeting the study inclusion criteria received a packet with a cover letter and an informative letter with detailed information about the research process, purpose, and method. Each participant reviewed the IC form and steps to ensure confidentiality. The study commenced after securing all consents/permissions, and successful completion of the pilot with participants meeting the inclusion criteria.

Elements of the population were nurses who float routinely. In-depth, face-to-face interviews were appropriate for data collection. At the end of the interview, participants clarified any doubts that may have surfaced. Recorded data transcription was verbatim. The process of categorizing and interpreting themes followed. Attention to maintaining validity, reliability, and rigor reinforced the credibility of the study.
Chapter 4

Results

Bedside nurses experience mandatory floating in their careers. Floating is a phenomenon of interest to nurses and hospital administrators. The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The chosen facility was an acute health care facility in a large southern city of the United States at which nurses float regularly.

Three broad questions guided the research:

RQ 1: What are nurses’ experiences when it comes to floating?

RQ 2: What are nurses’ feelings when floating?

RQ 3: What factors influence nurses’ feelings when floating?

Eleven participants who worked as nurses at the selected hospital described their experiences with floating during face-to-face, recorded interviews. Chapter 4 gives a description of the participants' demographics and the results of the study. The coding and thematic analysis process is described. Chapter 4 concludes with a succinct summary of the results.

Participants Demographic

Demographic information of the participants consisted of age, gender, ethnicity, and marital status. Additional data collected included nursing education, years of nursing experience, years working at the facility, hours worked per week, shift worked, and specialty area for readers’ general information. Participants were of various years of nursing experience, ages, and ethnicities. Figures 1-4 represent the demographics by age
group, ethnicity, tenure in years, and gender. Table 6 and 7 represent participant characteristics.

In Figure 1, participants aged 21-31 years were 5 out of 11 for a percentage of 43.45%. The second most common age group was 43-53 or 3 out of 11 for a percentage of 27.27%. In the groups age 32-42, 54-64, and 65-75 there were 3 participants for a combined percentage of 27.27%. Multiple generations work together in the different units. Nurses in the United States of America comprised four generations (Jobe, 2014). The preceding statement reflects the new characteristic of the nursing profession in the 21st Century.

![Figure 1. Demographic Data by Age Group in Years](image)

According to researchers from the US Census bureau, in 2010 the majority of the Hispanic population living in the Southern areas resided in 51 counties in Texas and one (Miami-Dade) in Florida (U.S. (Ennis, Ríos-Vargas, & Albert, 2011). The demographic data by ethnicity has a tendency toward paralleling the population of Miami, Florida with
a percentage of citizens of Hispanic origin close to 70% (Ennis et al., 2011). Figure 2 shows the demographic by ethnicity.

In Figure 2, there are 11 participants: six participants were White Hispanic and one participant was White, for a combined percentage of 63.63%. Four participants were Black/African-American (36.36%).

Figure 3 shows six participants had 1-5 years of nursing experience (63.63%). Two participants had 6-10 years of nursing experience (11.18%) and 11-15 years of nursing experience (18.8%). One participant had 16-20 years of nursing experience or greater (9.09%).
Nursing has been a female-dominated profession, and male nurses have been the minority. The US Census Bureau reported that males represented only 9.6% (Landivar, 2013). In order to reflect the gender disparity, two male nurses (18.18%) and nine female nurses (81.82%) participated in the study, as shown in Figure 4.

Figure 4 below represents the number of participants by gender. Two male (18.18%) and nine female nurses (81.82%) participated in the study. Nursing remains a female dominated profession and male nurses are the minority. In a report from the United States Census Bureau by Landivar (2013), male nurses represent 9.6% in the USA.

Table 6 illustrates the participants’ demographics and other characteristics, including marital status, education, and years working in the selected organization. The majority of nurses in the current study (6 out of 11) were single, and five had earned a Bachelor of Science in Nursing (BSN) and five had earned an Associate Degree in Nursing (ADN). At the time of the study, all ADN nurses had enrolled in a BSN program. One nurse had earned a national specialty certification.
Table 6 contains the participants’ marital status, education, years working in the organization, hours worked per week, national certifications, and whether participants routinely floated to other units. Table 6 also shows that 54% of participants were single, the majority of nurses recruited work 36 hours a week, and all of them float routinely on a rotational basis.

Table 6 contains participants’ marital status, education, years working in the organization, hours worked per week, whether they routinely float to other units, and if participants possess a national certification. In table 6 54% of participants are single, the majority of nurses recruited work 36 hours a week, and all of them float routinely on a rotational basis.

Table 6

Participants Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Nurses n = 11</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>% Frequency</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>36.36</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>6</td>
<td>54.54</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>9.09</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADN</td>
<td>5</td>
<td>45.45</td>
<td></td>
</tr>
<tr>
<td>BSN</td>
<td>5</td>
<td>45.45</td>
<td></td>
</tr>
<tr>
<td>MSN</td>
<td>1</td>
<td>9.09</td>
<td></td>
</tr>
<tr>
<td>Years working in Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>3</td>
<td>27.27</td>
<td></td>
</tr>
<tr>
<td>3-5</td>
<td>2</td>
<td>18.18</td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td>3</td>
<td>27.27</td>
<td></td>
</tr>
<tr>
<td>&gt; 10</td>
<td>3</td>
<td>27.27</td>
<td></td>
</tr>
<tr>
<td>Hours Per Week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>9</td>
<td>81.81</td>
<td></td>
</tr>
<tr>
<td>36-40</td>
<td>2</td>
<td>18.18</td>
<td></td>
</tr>
<tr>
<td>National Certification</td>
<td>1</td>
<td>9.09</td>
<td></td>
</tr>
<tr>
<td>Floating Routinely</td>
<td>11</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Note. ADN = Associate degree in Nursing; BSN = Bachelor of Science in Nursing; MSN = Master of Science in Nursing
Table 7 presents other participant characteristics, including the frequency and percentage of frequency that floating was experienced. The table displays shifts worked and the nurses’ individual specialties. Participants worked in the following units: telemetry, medical surgical, oncology, and respiratory. Table 7 shows the units to which the participants floated the most: 9 out of 11 (81.81%) floated in the medical surgical units; 72% floated to other units 3-5 times during the year.

Table 7

<table>
<thead>
<tr>
<th>Participants Other Characteristics</th>
<th>Nurses n = 11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td><strong>Number of Floating Experiences in 2014</strong></td>
<td></td>
</tr>
<tr>
<td>3-5</td>
<td>8</td>
</tr>
<tr>
<td>6-10</td>
<td>3</td>
</tr>
<tr>
<td><strong>Shift Worked</strong></td>
<td></td>
</tr>
<tr>
<td>7a-7p</td>
<td>7</td>
</tr>
<tr>
<td>7p-7a</td>
<td>4</td>
</tr>
<tr>
<td><strong>Specialty</strong></td>
<td></td>
</tr>
<tr>
<td>Telemetry</td>
<td>5</td>
</tr>
<tr>
<td>Medical Surgical</td>
<td>4</td>
</tr>
<tr>
<td>Oncology</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory</td>
<td>1</td>
</tr>
<tr>
<td><strong>Units</strong></td>
<td></td>
</tr>
<tr>
<td>Medical Surgical</td>
<td>9</td>
</tr>
<tr>
<td>Telemetry</td>
<td>1</td>
</tr>
<tr>
<td>CCU</td>
<td>1</td>
</tr>
<tr>
<td><strong>Nursing experience in years</strong></td>
<td></td>
</tr>
<tr>
<td>1-5</td>
<td>6</td>
</tr>
<tr>
<td>6-10</td>
<td>2</td>
</tr>
<tr>
<td>11-15</td>
<td>2</td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. CCU= Critical Care Unit; 7a= 0700; 7p= 1900. 7a-7p = 12 hours day shift; 7p-7a= 12 hours night shift.

**Data Collection Reflection**

Phenomenological studies are data-driven (Flood, 2010). Data collection is an important step in qualitative studies, as it allows researchers to gather information to
establish meanings of a phenomenon from the standpoint of the participants (Flood, 2010). Prior to beginning data collection, a pilot study was conducted with two nurses who met inclusion criteria. At the conclusion of the interviews, the participants made no recommendations to modify the interview questions.

Data collection began after completion of the pilot study and receipt of the participants’ feedback. Based on the inclusion and exclusion criteria, eligible nurses steadily registered to participate in the study, agreeing on a date, time, and place for the interview to take place. Eligible participants were nurses who had experienced floating routinely as a lived experience. During the transcendental, phenomenological study, participants were made to feel comfortable to facilitate descriptive responses that would give meaning to personal experiences (Chenail, 2011).

Data were collected based on Husserl’s transcendental approach. Bracketing, or epoché, also reflected Husserl’s transcendental phenomenology (Chan, Fung, & Chien, 2013). According to Husserl (1970a/1936), researchers with previous knowledge of a phenomenon must focus essentially on the participants’ accounts of the phenomenon. Bracketing assisted in preventing the researcher's knowledge and judgment of the phenomenon to influence the interpretation of the participants’ feelings about floating. Participants indicated that floating had always been an expected component of the work routine, instituted for the safety of the patients. Participants did not like to float and expressed feelings of anxiety and stress about working in other units.
Data Analysis

Data analysis included inductive analysis of the transcribed interviews and the use of NVivo data analysis software. Before using the software, the researcher read the transcript four times in order to capture the essence of floating as a phenomenon. The following paragraphs are a detailed description of the data analysis based on Giorgi’s method.

Data Analysis Process

Stage 1. Interview transcripts were read four times, line by line (according to Giorgi’s step one/stage one described in Chapter 3 and in Appendix N). Reading the transcript four times assisted with obtaining an understanding of the participants’ description of personal feelings about floating. The identification of similar expressions and terms followed, with similarities in the participants’ words and sentences color-coded in order to facilitate grouping into significant meaning units. After the fourth review of the transcript, data were grouped, described, and examined. Newly found units were linked to the study topic. After synthesizing the units, in order to generate a consistent description of floating as a phenomenon, a unified description of the nurses’ experiences resulted.

Stage 2. Transcribed data were imported into a Word document and then into the NVivo10 software internal sources. The paragraph format for the raw document was used to facilitate auto-coding in the NVivo software. Auto coding automatically creates a node for each participant and participant response. Each document contained the same set of interview questions, and were prepared for auto-coding.
A node is a structure in NVivo, which compiles relevant data in a central location. Nodes are generated from reading coded transcripts and finding common words, word groups, and sentences. Besides participant nodes, the current study contained other nodes for participants’ gender, ethnicity, and other demographic attributes. Common words, word groups, and sentences were highlighted, then dragged and saved into a corresponding new node, which facilitated the identification of specific themes.

A word-frequency query, containing 100 of the most frequently used words with a minimum of six letters, identified the most common words used by participants. Words such as “patients”, “floating”, “nurses”, “changes”, “communication”, “feelings”, “helpful”, “structured”, “experiences”, “routine”, and “halls”, were the most visible in the word cloud. Finding the similarities among nurses’ perceptions of floating allowed for the division of descriptions into meaning units that were significant to the participants' and the phenomenon. Next, each unit was grouped according to meanings about the topic. Themes, primary codes, and secondary codes emerged from the coding process, completing the first-level of coding. Grouping of each unit according to their meanings about the topic ensued. Themes, primary codes, and secondary codes emerged from the coding process completing the first-level coding.

Figure 5 Word Cloud diagram below shows the most frequent words mentioned by nurses in bigger character. Examples of these words are: patients, nurses, floating, feelings, communication, helpful, resources, acuity, structured, etc. The complete Word summary in table form is available in Appendix O.
Stage 3. The second-level of coding occurred in Stage 3. Data collected during interviews fulfilled the purpose of the study. Common words, word groups, and sentences were grouped into themes connected to primary and secondary codes. Data showed an association existing among floating, the purpose of the study, and the research questions. Participants expressed feelings about floating, that when compared with the secondary data, assisted in identifying revelatory themes. The second level of coding was completed during Stage 3.

Figure 5. The most common words displayed above are patients, floating,
Figure 6 displays the six themes that resulted from the data analysis process.

![Figure 6. The six emerged themes are: Workflow Process, Patients care Assignment, Work Environment, Sociological factors, Psychological Components, and Physiological Needs.]

**Stage 4.** Notes taken during interviews were compared to the transcripts. Data were classified into themes and codes. Identified themes were converted to statements in preparation for the final document. Data saturation occurred with the ninth interview. Cope (2014) recognized that data saturation was a function of the adequacy of the sampling and results from a complete investigation of the phenomenon.

Data Analysis was a complex step in this qualitative research. It began with listening to recorded data carefully many times. It continued with transcribing the raw data while making annotations. The transcription was read many times. The result was the identification of themes and codes. The process ended with the combination of findings into statements to advance knowledge. The following section is a description of the coding and thematic analysis process.
Coding and Thematic Analysis Process

Themes and codes. The classification of codes resulted from three basic processes: inductively coding by hand, use of the research questions as a framework, and using the NVivo software to categorize the data. Commonalities in the participants’ responses to the interview questions led to the development of different themes. One theme, for example, Psychological Components of Floating, encompassed participants’ described feelings of stress, fear, and anxiety when floating.

Another coding process involved using the research questions as a framework. The interview questions in the current study targeted nurses’ feelings on floating. The participants’ responses, related to perceived feelings, were considered relevant to the purpose of the study. Words, groups of words, and sentences were analyzed for relevancy. The three broad research questions addressed the purpose of the study.

The third process involved using NVivo 10 software to categorize the data. Categorizing the data helped to identify the frequencies of occurrences of the participants’ words and phrases. The NVivo word-frequency synopsis ranked the factors influencing the participants’ feelings about floating. Identified themes from the interviews (imported into NVivo) were numerically prioritized by number of references and percentage coverage per participants. The references represented the total number of selections coded within the node for all participants (e.g. how many words, groups of words, or sentences shared by participants). The coverage percentage reflected the total characters from the Word document and percentage of the document covered. To ensure accuracy, data were compared throughout the three steps of the coding and thematic analysis process. Table 8 is a summary of themes. Based on a hands-on and electronic
review of data, meaningful units and dominant themes resulted, completing the first-level of coding in Stage 2. Extensive content analysis continued into Stages 3 and 4.

Table 8

Themes by Hierarchy

<table>
<thead>
<tr>
<th>Themes</th>
<th>NVivo References</th>
<th>NVivo Coverage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workflow Process</td>
<td>59</td>
<td>89.78</td>
</tr>
<tr>
<td>Patients care Assignment</td>
<td>57</td>
<td>88.11</td>
</tr>
<tr>
<td>Work Environment</td>
<td>50</td>
<td>72.9</td>
</tr>
<tr>
<td>Psychological Components</td>
<td>37</td>
<td>41.27</td>
</tr>
<tr>
<td>Sociological factors</td>
<td>23</td>
<td>37.85</td>
</tr>
<tr>
<td>Physiological Needs</td>
<td>10</td>
<td>13.1</td>
</tr>
</tbody>
</table>

From the 100 most frequent words identified through the NVivo word query, and after elimination of duplicate and non-relevant words, 50 significant words and word groups emerged. The coding process yielded six themes, 24 primary codes, and 26 secondary codes (see Table 9 and Table 10). The participants’ words and sentences that linked to a psychological aspect of their feelings and experiences were grouped under the theme “Psychological Components”.

Participant statements such as, “I am anxious when I have to float”, were classified under psychological components when a psychological state was referenced. Psychological and physical distress results from anxiety (Panagioti, Scott, Blakemore, & Coventry, 2014). When the same individuals indicated that the anxiety was the product of not knowing when he or she was going to float, a secondary code was indicated. The systematic analysis continued until data exhaustion. Tables 9 and 10 represent study-emerged themes and primary and secondary codes. In Table 9, a description of themes 1
and 2 are provided, with the primary and secondary codes related to the described theme.

The tables show that nurses perceived feelings of anxiety, nervousness, fear, stress, and worry (about receiving a meal break) when floating.

Table 9
*Themes, Primary and Secondary Codes Representation*

<table>
<thead>
<tr>
<th>6 Themes</th>
<th>24 Primary Codes</th>
<th>26 Secondary codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Psychological Components</td>
<td>Stress/Anxiety</td>
<td>Not knowing turn to Float</td>
</tr>
<tr>
<td></td>
<td>Uneasiness/Frustration</td>
<td>Losing control</td>
</tr>
<tr>
<td></td>
<td>Unpleasant</td>
<td>Feelings</td>
</tr>
<tr>
<td></td>
<td>Overwhelming</td>
<td>Uneventful Experiences</td>
</tr>
<tr>
<td></td>
<td>Nervous/ Scared</td>
<td>Fear of Changes</td>
</tr>
<tr>
<td>2-Physiological Needs</td>
<td>Meal break</td>
<td>Late break coverage</td>
</tr>
<tr>
<td>3-Workflow Process</td>
<td>No orientation</td>
<td>Belief that nurses from same entity should know about the floor routine</td>
</tr>
<tr>
<td></td>
<td>Chaos</td>
<td>No identified process for floaters</td>
</tr>
<tr>
<td></td>
<td>Unsure of unit routine</td>
<td>Different patients population</td>
</tr>
<tr>
<td></td>
<td>Patient Population</td>
<td>Different disease types</td>
</tr>
<tr>
<td></td>
<td>Poor communication</td>
<td>Not knowing who is in charge</td>
</tr>
<tr>
<td>4-Patients care Assignment</td>
<td>Tool to do the job</td>
<td>Clean/dirty utility room location</td>
</tr>
<tr>
<td></td>
<td>*Pyxis door code</td>
<td>Supplies/Lounge code</td>
</tr>
<tr>
<td></td>
<td>Unfamiliar task</td>
<td>Away from routine</td>
</tr>
<tr>
<td></td>
<td>Fairness of assignment</td>
<td>Acuity not considered scattered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Worse patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequent discharges admissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain medication around the clock</td>
</tr>
<tr>
<td>5-Work Environment</td>
<td>Unfamiliar environment</td>
<td>Different floors Different routine</td>
</tr>
<tr>
<td></td>
<td>Comfort zone</td>
<td>Available resources</td>
</tr>
<tr>
<td></td>
<td>No help or little help</td>
<td>Nurses/coworkers approach</td>
</tr>
<tr>
<td></td>
<td>No teamwork</td>
<td>to patients care</td>
</tr>
<tr>
<td></td>
<td>Management/Rules</td>
<td>No written process</td>
</tr>
<tr>
<td>6-Sociological Factors</td>
<td>Unfriendliness</td>
<td>“Horrible” attitude</td>
</tr>
<tr>
<td></td>
<td>Unwelcomed</td>
<td>Ignore floaters’ needs</td>
</tr>
</tbody>
</table>

Note. *Pyxis = an up-to-date computerized automated medication-dispensing machine, which functions on granted access (last six digits of nurses’ social security combined with employee identification number or one fingerprint. Nurses can only access a Pyxis in their home-unit except in rare exceptions.*
Throughout Stage 4, categorized themes were examined to define meaningful units according to statements made by participants. Identified themes, description of meaning units, participants' quoted words, sentences, and paragraphs were distributed into three columns. Column 1 encompassed the study-emerged themes. Column 2 described meanings of words expressed. Column 3 listed the participants’ quoted words. Tables 10, 11, 12, 13, and 14 show the common themes, meaning units, and participants’ quoted words in an abridged version. Appendix P contains the complete version.

As outlined in Chapter 3, participants chose pseudonyms to replace actual participant names. The pseudonyms were unrelated to either the participant’s name or ethnicity and were assigned to each participant before beginning an interview. Pseudonyms were used for the sole purpose of retaining confidentiality and ensuring privacy. Names were placed on a master list along with a random number (from 1001 to 11011). The master list also contained the dates and times that the interviews were conducted and other unique identifiers (participant’s pseudonym, name, and telephone number). Nurses provided a pseudonym of their choice used during the interview. The master list described above is kept in a locked drawer, not accessible to anyone else, in the researcher’s office.
Table 10

*Summary of the Common Themes*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning units.</th>
<th>Participants quoted words, sentences or paragraphs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workflow Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of orientation</td>
<td>Carla</td>
<td>… So you have to ask the nurses cause they don’t orientate. Sometimes you have to figure out things…</td>
</tr>
<tr>
<td></td>
<td>Jeanie</td>
<td>I didn’t know where anything was. when a patient asks me, “I need this,” like, I don’t know where to find it. You know? I just feel lost…lost is a good word</td>
</tr>
<tr>
<td></td>
<td>Natalie</td>
<td>so you don’t really get an orientation when you float.</td>
</tr>
<tr>
<td>Chaotic flow</td>
<td>Anna</td>
<td>The work environment. It’s not organized.</td>
</tr>
<tr>
<td></td>
<td>Chelsea</td>
<td>A little bit of chaos I usually don’t have access to the medication room so it’s very chaotic when I first arrive.</td>
</tr>
<tr>
<td>Poor communication</td>
<td>Anna</td>
<td>There’s not enough communication.</td>
</tr>
<tr>
<td></td>
<td>David</td>
<td>and mainly no orientation with poor Communication</td>
</tr>
</tbody>
</table>

Dealing with unfamiliar tasks, which accompanies caring for a different patient population, was mentioned as a source of anxiety. For example, participants reported having difficulties with obtaining a code to withdraw patients’ medication from the Pyxis (i.e. a computerized automated medication-dispensing machine). Inability to dispense patient medication at the prescribed time can put patients at risk for medical complications. Nurses do not want to become known for delivering poor nursing care.
Table 11 displays participant descriptions of encounters with floating as a lived experience and documents why patient-care assignments were perceived as unfair.

Table 11

Summary of the Common Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning units.</th>
<th>Participants quoted words, sentences or paragraphs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients care Assignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fairness of assignment</td>
<td>Bianca — worse patients, a lot of patients that are on pain medication. I am giving medication, giving medication, giving medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carla You can get report from more than 3-4 nurses that…</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We rarely have that on our floor, but it’s because they don’t keep it, like, wing assigned. They have it all over the place. I see more confused patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chelsea you do a lot of discharges and admissions on other med surg floors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caroline I think the assignment may be unfair at times. The issue is that floaters get the worse patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jeanie They started all the floats with the most patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jim You cannot open any door you cannot get your medication. You have to call someone to open them for you</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bianca The last time I floated, I waited more than 44 hou—uh—45 minutes, to get, almost an hour—more than an hour! To get access to the Pyxis.</td>
<td></td>
</tr>
<tr>
<td>*Pyxis door code/Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unfamiliar task</td>
<td>David Sometimes you’re exposed to some things that you don’t really do every day.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jim I have difficulty with some unfamiliar task but I ask the charge nurse who sometimes has patient and can do so much.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anna But patients coming from surgery. Like, this one had an abdominal procedure. I’m not used to all of those type of procedures. Like, I didn’t know that when they came back, what they were supposed to have.</td>
<td></td>
</tr>
</tbody>
</table>

Note. *Pyxis = an up-to-date automated medication dispenser, which functions on granted access (last six digits of nurses’ social security combined with employee identification number or one fingerprint. Nurses can only access a Pyxis in their home-unit except in rare exceptions.
Table 12 illustrates participants’ feelings and experiences with an unfamiliar work environment. Participants described how adjustments must be made when working in a different work environment. Out of a nursing comfort zone, floating nurses must deal with a lack of help from peers.

Table 12

Summary of the Common Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning units</th>
<th>Participants quoted words, sentences or paragraphs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Environment</td>
<td>Unfamiliar environment</td>
<td>Anna Disorganized, unstructured</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bianca A change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carla It’s a new environment it’s something new, it’s not your daily routine So, here, your patients change, your coworkers change, your clinicians…everybody changes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caroline ..away from my comfort zone, routine, and unfamiliarity with the work environment ……</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chelsea A little insecure out of that comfort zone.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>David you feel unfamiliar with the floor…Either way you’re going to be kind of dislodged.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caroline there is not much help.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Natalie And then… you’re thinking that you might not have too much help because, the people you go to, you don’t really know them much.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Priscilla They really couldn’t help me because they were so busy.</td>
</tr>
<tr>
<td>Comfort zone</td>
<td></td>
<td>Anna I find that it’s not a lot of team effort.</td>
</tr>
<tr>
<td>No help or little help</td>
<td></td>
<td>Carla I didn’t see a lot of teamwork.</td>
</tr>
<tr>
<td>No teamwork</td>
<td></td>
<td>Jim I would like to see some rules in certain units in which floating are very painful.</td>
</tr>
<tr>
<td>Management/Rules</td>
<td></td>
<td>Natalie You need your access number.” So, you have everything set up and – little orientation. And access to med room and everything, so you don’t have to keep asking…</td>
</tr>
</tbody>
</table>

In Table 13, participants stated that they felt anxious, stressed out, and scared when notified of a requirement to float. Floating assignments are given within short notice. Participants expressed frustration over not having access to the “float book”.

Additional feelings are described in Table 13.
Table 13

*Summary of the Common Themes*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning units, What did participants mean</th>
<th>Participants quoted words, sentences or paragraphs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Components</td>
<td>Stress/Anxiety</td>
<td><em>Carla</em> We—they have a float book, but it’s not a book that is available to the nurses… little bit of anxiety.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Caroline</em> I am anxious and stressed out.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>David</em> …so you’re a little bit anxious, it’s a little bit stressful.</td>
</tr>
<tr>
<td></td>
<td>Uneasiness/Frustration</td>
<td><em>Chelsea</em> My patient asked me for something simple, “pillow or “pillow case.” I can’t find the room. So there’s a little bit of frustration. So that’s an uneasy feeling because you don’t know what to expect.</td>
</tr>
<tr>
<td></td>
<td>Unpleasant</td>
<td><em>Carla</em> You never know when you’re going to float. You look at the board, your name is not there. That’s how, you know, my name is not there; you are floating. Very unpleasant.</td>
</tr>
<tr>
<td></td>
<td>Overwhelming</td>
<td><em>Jeanie</em> I feel like I don’t have control. Like, I feel like I lose control when I’m out there.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Mary</em> …But it can be overwhelming when you’re not used to it being your floor. So I would say it’s overwhelming for me.</td>
</tr>
<tr>
<td></td>
<td>Nervous</td>
<td><em>Mary</em>…and a little nervous.</td>
</tr>
<tr>
<td></td>
<td>Scared</td>
<td><em>Jeanie</em> I get anxious. I don’t look forward to it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Jim</em> I am scared, anxious, …uncomfortable fearing I am going to have a bad day. I could have a bad day any day in my own unit but I have my usual coworkers and routine.</td>
</tr>
</tbody>
</table>

In Table 14, participants described perceptions of the receiving staff’s attitudes upon arrival to the unit that has been assigned for floating, staff are unfriendly and unwelcoming.
### Table 14

**Summary of the Common Themes**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning units. What did participants mean</th>
<th>Participants quoted words, sentences or paragraphs</th>
</tr>
</thead>
</table>
| Sociological factors    | Unfriendliness                            | **Caroline** Some nurses are friendly and helpful others just ignore you. In some areas, you do not feel welcome.  
**Mary** Others don’t even say two words to you |
|                         | Unwelcomed                                | **David** Sometimes you feel unwelcomed  
**Jeanie** Some are friendly. Not all  
**Jim** I do not feel welcome and feel like a burden  
Some areas have very friendly nurses…Other areas have less friendly people or some ignore you altogether. |
| Physiological Needs     | Meal break                                 | **David** Sometimes when you’ve decided the go on meal break you’ll have to wait a bit more to get your meal break.  
**Mary** I don’t always take a full 30 minutes because, even though someone’s covering me, I don’t feel like they really are covering me. As in, on my floor.  
**Natalie** Because you don’t know the floor, you’re kind of… busy. And you might end up missing your break.  
**Priscilla** So, my meal break I always get, because you need to eat, but it may be a little bit later…and shorter—I didn’t have lunch until 4. |

The data analysis, based on Giorgi’s six steps and the three processes described, aided in coding similar words under themes. The themes, combined with a description of meaning units or what participants meant, and the participants’ quoted words are displayed in Tables 10 through 14. Data interpretation follows data analysis.

**Data Interpretation**

Three open-ended research questions for the current study addressed nurses’ lived experiences and feelings about floating. The interview questions were designed to uncover factors that influence nurses’ feelings when floating. Nurses described their feelings on floating as a lived phenomenon occurring routinely in their natural
environment. Feelings and experiences that emerged from the data were categorized into six themes: workflow process, patient-care assignment, work environment, psychological components, sociological factors, and physiological needs. Text search queries using NVivo resulted in fragments of sentences related to the participants’ words, themes, and primary codes. The results of these queries are shown in Figures 7-21.

The following section is a description of the participants’ accounts of their experiences with floating, their feelings about it, and the factors that influenced these feelings. Primary codes emerging from the participants’ description of the phenomenon are summarized under each corresponding theme. The text search query results (in Figures 7-21) represented words, sentences, or word groups that illustrated nurses’ interpretations of their feelings on floating, that helped to establish the essential themes and primary codes to understand the phenomenon of floating from the participants’ perspective. The primary codes were identified, then grouped by similarities in order to define the themes.

**Theme 1: Workflow Process**

Participants in the current study believed that the workflow process was faulty. Floating nurses were unsure of the process in place to assist them, and there were no standardized practices or protocols from unit to unit. Some resource nurses would give the participants a unit tour upon arrival. At times, the floating nurse would be introduced to the unit staff. Procedures for how to receive floaters are not standardized. The perceived flaws of the process included a chaotic workflow, defective communication, and a lack of orientation.
Chaotic workflow. Nurses described the workflow process in the medical-surgical areas as chaotic. At the beginning of the shift, floating nurses find themselves lost in an unfamiliar unit. Carla said, “Sometimes, you go to the floor, and they don’t tell you who the charge nurse is… Who’s the resource…?” Chelsea noted, “There are things that I don’t know; I’ve never been on their floor.” The participants thought that a packet with information about the unit’s routine would be useful. Jim recalled a valuable list of door codes in some units. For the floating nurse, the routine is different, and the unit appears chaotic when interpersonal communication appears to be lacking.

Figure 7 contains a few words and sentence fragments from nurses who perceived the receiving unit as chaotic.

Text Search Query - Results Preview

dreads it, because of the
Heh. A little bit of
I know I’m going into
chaos
. The work environment? The work
... because I don’t know where
there and the patient load.

Text Search Result for “chaos”

Figure 7. The NVivo software linked words and word groups from participants’ interviews to the word chaos. For example, one participant said about floating “Heh, a little bit of chaos”. Another mentioned, “dreads it because of the chaos”. It is chaos... because I do not know where anything is.”

Defective communication. Communicating patient-care information is a common practice for ensuring continuity of care in nursing. An ongoing challenge has been finding a proper means of communication to enhance patient safety and quality of care. The latest method endorsed by various health care institutions has been the “hand-
off report", which is compiled at the patient’s bedside at the end of the shift (Cairns, Dudjak, Hoffmann, & Lorenz, 2013). Figure 8 contains segments of comments about defective communication made by participants.

Despite the use of the hand-off report, floating nurses had other concerns about communication. On most units, there exists a board that lists patients’ rooms, for example, which Chelsea said is not always easy to understand. The receiving units’ resource nurses do not have enough time to communicate effectively with floating nurses. David cited “…..mainly poor communication with no orientation. Well, they introduce you to a few people in some units… not always.”

There is a difference between communication and orientation. Communication entails establishing a friendly relationship with the receiving unit staff. Clear communication encourages floating nurses to feel welcome and to ask questions when necessary. The hand-off report, for example, is a communication tool used by nurses to review patients’ history and the care they received at the end of the shift. The

![Text Search Query - Results Preview](image)

**Text Search Result for “communication”**

*Figure 8.* The NVivo software linked words and word groups from participants’ interviews to the word Communication. For example, one participant said about floating “No orientation with poor communication”. Another mentioned “No proper hand off report and communication.”
participants in the current study, however, stated that often a proper hand-off report was not available and communication was poor.

Orientation implies touring the unit in order to locate the tools to perform patients care. An orientation of the physical environment should include a description of the patient population, procedures, and common diseases that will be encountered in the unit. An explanation of existing, unit-specific routines should be part of the orientation process. Orientation is the ideal time for the nursing supervisor (or designee) to grant floating nurses temporary access (e.g. to doors and computerized automated medication-dispensing machine) to empower the floating nurse to locate clean and dirty utility rooms, pantry, code carts, and exit doors.

**Lack of orientation.** Orienting floating nurses to the unit was not shown to be a priority. Staff from the receiving unit assumed floating nurses should know their way around solely because the floating nurses worked at the same facility. Participants reported having to search for patients, which were scattered in many different corners of the unit. Another problem was managing the room setting. Floating nurses must deal with semi-private rooms, which present a challenge when private rooms have become a more familiar room setting.
Figure 9 displays the participants’ words and groups of words about the orientation process.

![Text Search Query - Results Preview](image)

**Figure 9.** The NVivo software linked words and word groups from participants’ interviews to the word oriented. For example, one participant said about floating “Oriented to where everything is.” Another mentioned, “you have to get oriented.”

Participants identified different aspects of the workflow process that affect their feelings when floating in a different unit and stated that lack of communication increased the difficulty to function in the receiving unit. One of the issues was a perceived chaotic flow due to a lack of process flow. Another was that the receiving unit staff seldom orientates floating nurses. Participants perceived that receiving units assumed that floating nurses should already be familiar with the unit layout.

**Theme 2: Patient-care Assignment**

A nurse’s workday begins with a patient-care assignment. The nurse’s work shift begins promptly after receiving the hand-off report from the outgoing nurse. One aspect of patients care includes the ability to gain access to the different areas of the unit, in order to prevent delays in patients care. The participants stated that one of the challenges
associated with the patient-care assignment was a delay in accessing the diverse areas of the unit. Participants debated the fairness of the assignment and discussed how patient-care assignments, when floating, could lead to multiple encounters with unfamiliar tasks.

**Access delay.** An access delay is a postponement in obtaining an access code to the doors, medication room, or computerized automated medication-dispensing machine (Pyxis). Nursing supervisors are primarily responsible for granting access to floating nurses. Not all resource nurses can give such permissions. Routinely, floating nurses must wait for the nursing supervisor (or designee) to gain access codes. Alternatively, floating nurses randomly ask unit nurses to open the doors for them to access the computerized automated medication-dispensing machine, or a clean utility room. Jim said, “You cannot open any door; you cannot get your medication. You have to call someone to open them for you.”

Participants stated that the nursing supervisor becomes aware of floating nurse assignments before the floating shift begins. Floating nurses expect nursing supervisors to anticipate the need to grant necessary access in a timely manner. There should not be an access delay. Bianca said, “If you know there’s going to be a float nurse on the floor, and the float nurse is going to need access to the doors, those should have been there ready for the float nurse.” Priscilla stated, “If the supervisor is not there, then you keep asking nurses to open the door for you to get your medication until the supervisor comes and gives you access.” A delay in the ability to access doors and computerized automated medication-dispensing machine disturbs the floating nurses’ workflow and care planning for the shift.
Figure 10 illustrates a text search query with participants who experienced problems accessing the receiving unit door and medication room.

![Text Search Query - Results Preview](image)

Text Search Result for “door”

*Figure 10.* The word groups above linked participants description to issues related to access delay

**Fairness of assignment.** Resource nurses make the assignments for the oncoming shift, perform additional tasks on the unit, and often manage a patient assignment during a given shift. Resource nurses are aware of potential patient discharges for the day. Participants reported that the patient assignment process was unfair because floating nurses often received discharges as patient assignments. Once a nurse discharges a patient, first admissions are given as the next patient assignment, which are labor intense.
Participants perceived that floating nurses were assigned the worse patients, as illustrated in Figure 11.

![Text Search Result for “worse”](image)

**Figure 11.** The NVivo software linked words and word groups from participants’ interviews to the word worse. For example, one participant said about floating “is that floaters get the worse patients.” Another one said “not all worse patients.” “… time I will have the worse patients.”

Participants mentioned that floating nurses received the worst patients as assignments, and that floating nurses have more admissions and discharges than the nurses who work in the unit. Newly admitted patients require multiple, skilled-nursing interventions and are in need of pain medication around the clock. Jim stated, “Most of the time I will have the ‘worst’ patients….you have the first admission; you have all the “q” [sic] every 1 hour pain medication”. Caroline said, “the assignment may be unfair at times. The issue is that floaters are assigned the worst patients.” The job demand
increases for nurses who float because they perceive their patients to be critically ill and may require unfamiliar care (Karasek, 1979).

**Unfamiliar tasks.** Many of the participants acknowledged having to deal with unfamiliar tasks at some point during their experience. David stated, “Sometimes, you’re exposed to some things that you don’t really do every day.” Priscilla said she floats to the telemetry area, where she does telemetry, “but our people are not pure telemetry.” Anna recalled not having the necessary skills to care for the patients at the medical-surgical unit coming from the operating room (OR) with different kinds of procedures, where she’s “not really accustomed” and “not as skilled with the medical-surgical…” In Figure 12, participants expressed concerns about the different tasks they may have to complete while caring for a different patient population.

*Figure 12.* The NVivo software linked words and word groups from participants’ interviews to the word task. One participant said about floating “…many, many, many different tasks.”, another one said “…population is different with different tasks.”
Participants reported that floating to other units has presented a challenge to patient-care delivery due to a delay in accessing the patient-care areas, fairness of patient assignments, and the difficulty associated with completing unfamiliar tasks.

**Theme 3: Work Environment**

The work environment influences nursing practice, and nurses, as individuals, react to the work environment. A positive work environment, in which nurses feel comfortable, enhances the delivery and quality of patients' care and improves nurses' performance (El-Jardalia, Alameddinea, Dumitb Dimassic, Jamala, & Maaloufa, 2011; Purdy et al., 2010). The primary challenges the participants faced in the work environment were: unfamiliarity of work surroundings, decreased level of comfort, and lack of help (or teamwork) from the receiving unit staff.

**Unfamiliarity with the work environment.** Hospital floor layouts vary from unit to unit, making it difficult to locate patients’ rooms. Room numbers are dissimilar, and patients are scattered throughout in semi-private rooms, in multiple hallways. Anna mentioned, “Your patients are not in rooms adjacent to each other. You have one in this wing, two to three in that wing, and in another hall, you have another set of patients.” All of this makes the work environment “unfamiliar” to floating nurses. This unfamiliarity with the surroundings affects the participants’ level of comfort.
Figure 13 shows examples of words and groups of words from participants linked to the unfamiliarity with the surroundings and the nursing care.

**Figure 13.** The NVivo software linked words and word groups from participants’ interviews to the word unfamiliar. One participant said about floating “The feeling of this is unfamiliar.”, another one said “…the unit you float in is unfamiliar.” Further comment from floaters “well, basically you feel unfamiliar.”

**Decreased level of comfort.** Nurses work in an area of specialty and develop critical thinking and experiences in that area. In a few years’ time they become experts and feel comfortable in making sound decisions related to patients care. When nurses float, expertise cannot be acquired or demonstrated. Floating nurses working away from their routine feel that they are out of their comfort zone. Carla said, “It’s something new; it’s not your daily routine. So, here, your patients change, your coworkers change, your clinicians…everybody changes.” David said, “…either way, you feel kind of dislodged.” This comment relates to a lack of control of the environment, a core concept of Karasek’s theory. Chelsea expressed, “a little insecurity out of that comfort zone.” Participants
associated the resulting feeling of discomfort with the lack of help and the absence of teamwork, as is revealed in the text search query displayed in Figure 14.

**Text Search Query - Results Preview**

Figure 14. The NVivo software linked words and word groups from participants’ interviews to the word zone participant said about floating: “away from my comfort zone.” another one said, “…it’s-you are out of your comfort zone.”

**No help and no teamwork.** Teamwork is integral to patient safety and in delivering quality care within a health care organization (Kalisch, Xie, & Ronis, 2013). Kalisch, Gosselin, and Choi (2012) found that institutions with higher levels of teamwork integration had fewer concerns with missed patients care.

Participants in the current study felt that there had been a lack of teamwork demonstrated among the receiving unit staff. Patients’ acuity level was lower in the receiving unit, but patient-to-nurse ratio was higher. Floating nurses were busier than when working in home units. Participants also mentioned that receiving staff rarely offered help. Anna found that “It’s not a lot of team effort. Nurses in these areas seem overwhelmed, unable to deal with their own set of patients, and do not have the time or the need to assist nurses who float to their area.” According to Caroline, “in some areas the nurses are either floaters or nurses from centralized staffing. In this case, there is a lack of support because the entire staff is floating.”
When floating, nurses are taken out of their normal routine, lose contact with their co-workers, and must work in a different unit layout. Participants were uncomfortable in an unsupportive, unfamiliar environment. A core concept from Karasek (1979), affective strain, characterizes this set of circumstances. The perceived lack of help and teamwork, associated with a feeling of discomfort, increased the nurses’ frustration and stress level (see text Figure 15).

Text Search Result for “help”

Figure 15. The NVivo software linked words and word groups from participants’ interviews to the word help participant said about said about floating: “you don’t really have that help,” another one said “…heavy patients. Not that much help.” “I don’t always get that help.” “who you can ask for help.”

Theme 4: Psychological Components

Psychological events can influence behavior. In a perceived intimidating situation, individuals will employ coping mechanisms to aid in their psychological well-
being. During the interviews, the main feelings expressed by participants were those of frustration and anxiety.

**Frustration.** Participants felt irritated when mandated to float. The majority of participants (9 out of 11) mentioned having mixed feelings of resentment and displeasure when receiving an assignment to float. Nurses reported that, in some units “you only learn it is your turn to float when you do not see your name on the board with a patient assignment.” Carla said, “You never know when you’re going to float. You look at the board, your name is not there. That’s how, you know, my name is not there; you are floating.” Most units have a float book, but not all staff have access to it. David stated that “learning you are floating when you arrive at work is disturbing. It’s not going to be what you expected when you left home to go to work.” Participants felt frustrated because of a lack of control in the events causing them to float, and not having the power to refuse to float (because of no valid justification).

In a text search query conducted in the NVivo 10 software, there were six references for “frustration” and three for “frustrated”. The main reason given for participants’ frustration was the lack of information about who would float and when floating would occur. Nurses would prefer receiving notification of a floating assignment well in advance.
Figure 16 shows groups of words that were linked with the word "frustration", as stated by participants.

Text Search Result for “frustration”

Figure 16. The NVivo software linked words and word groups from participants’ interviews to the word frustration participant said about floating: “there is a little bit of frustration.” Another one said “…frustration comes from asking where things are.”

Nurses reported that, in some units, “you only learn it is your turn to float when you do not see your name on the board with a patient assignment.” Carla said, “You never know when you’re going to float. You look at the board, your name is not there. That’s how, you know, my name is not there; you are floating”. Although there is a float book, not all staff has access to it. David believed that “learning you are floating when you arrive at work was disturbing. It’s not going to be what you expected when you left home to go to work.” Participants mentioned that they feel frustrated because of a lack of control on the events causing them to float. They cannot refuse to float without a valid justification.

**Anxiety.** Anxiety is a psychological discomfort that results in apprehension and uneasiness. Participants indicated feeling anxious upon arrival to work and finding an assignment to float. Anxiety can be an emotional reaction to insecurity. Jeanie expressed feelings of anxiety and nervousness because she feels “like I don’t have control. Like, I feel like I lose control when I’m out there.” “When a patient asks me, ‘I need this,’ like, I
don’t know where to find it.” Jeanie stated, “I get anxious. I don’t look forward to it.” Priscilla said, “As soon as you know you’re floating when you come to your floor in the morning, for most people that I know, you’re already feeling anxiety. I am, for sure.” Figure 17 displays participants’ feelings of anxiety after being assigned to float.

Participants show psychological symptoms when floating to another unit. The main feelings reported were frustration and anxiety, which, stemmed from not being informed ahead of time about an assignment to float. Other factors such as the receiving unit staffs’ attitude and lack of friendliness played a role in the floating nurses' experiences as well.

**Theme 5: Sociological Factors**

Sociology relates to the behavior of collective groups within an environment. Adults show different behaviors according to their circumstances, and socialization with colleagues may be developed over time. Participants expressed the need to interact with peers throughout their shift. Questions arise about the unit routine. Floating nurses may need assistance with unfamiliar tasks, but few receiving staff are available, increasing the
difficulty to discuss issues that arise. The main sociological factors mentioned were that nurses from the receiving unit were unfriendly and unwelcoming.

**Friendliness of the receiving unit staff.** Most participants described receiving unit nurses as unfriendly. Participants felt to be “a burden” to the receiving unit staff. Jim indicated that, because floating nurses asked questions throughout the shift, the work routine of the receiving unit nurses was disrupted. Caroline said, “Some nurses are friendly and helpful, others just ignore you. In some areas, you do not feel welcome.” Nurses perceived some members of the receiving staff as unfriendly, as shown in Figure 18.

![Text Search Result for “friendly”](image)

Figure 18. The NVivo software linked words and word groups from participants’ interviews to the word friendly. Participant said about floating: “they are normal helping you. Not friendly.”, another one said “…not excessively friendly.” “Some are friendly, some not, and mainly no.”

**Unwelcoming attitude.** Participants believed that most nurses from the receiving units had an unwelcoming attitude. A floating nurse's presence decreases the patient-to-nurse ratio in a unit. Participants reported that providing needed support to the unit should elicit a welcoming attitude, yet floating nurses still do not feel appreciated by the
receiving staff. Mary said, “Some units, they welcome you, they come to you and say, ‘If you need help, let me know.’ Others don’t even say two words to you.”

Figure 19 shows the text search query about floating nurses who felt “unwelcomed”.

Floating nurses do not feel valued. Seven out of 11 participants felt “unwelcomed”. Most of the floating shifts are usually spent alone with no resources and no assistance. The majority of participants could not create a working relationship with peers from the unit, which prevented them from satisfying their basic physiological needs.

**Theme 6: Physiological Needs**

Participants had admitted that floating is a necessary practice for various reasons. Similar to other professionals, nurses have families to sustain, and physiological needs to meet. Maslow described a hierarchy of needs that affected all humans. Primary human needs that must be satisfied first are located at the base of Maslow’s Pyramid. According to participants, one reason for floating, patient safety, is job security. Participants believed that refusal to float, without providing a valid reason, could result in termination.
Job security. Job security is the likelihood that employed individuals will remain in an assigned job. Kohlrausch and Rasner (2014) emphasized that workers strive to attain job security during their employment years. A need for nurses exists, but health care administrators may freeze hiring or increase the patient-to-nurse ratio because of reimbursement issues from third-party payers. Job security is a powerful motivator that influences a nurse's decisions in the work environment. Participants revealed that the pursuit of job security is one reason that nurses must be open to floating.

Floating is inevitable. Nurses in the 21st century understand that floating is a required. Participants mentioned many reasons why floating is necessary. Priscilla said that floating is inevitable “because people call out, floors are short staff, nurses are sick. So, you have to float.” Caroline stated, “I know we have to float for patients’ safety.” In Figure 20, participants shared some of their rationale for floating, which is tied to being sick (for both the patient and the unit nurse).

During a shift, nurses need to fulfill basic physiological needs, such as receiving adequate water and food. Nurses are entitled to a 30-minute paid meal break. Participants reported, however, that a break is not taken. When breaks are skipped, basic physiological needs are not satisfied.
Basic needs. A common problem is a lack of adequate nursing coverage for a meal break. David said that some nurses must wait before taking a meal break. Mary does not “take a full 30-minute break” because, even though someone is covering her, she is not comfortable leaving the unit. “Sometimes, nurses end up missing their break because they are busy,” said Natalie. Priscilla said that, at around 1600, she always manages to take a meal break, although sometimes it is later. Figure 21 contains some sentences and words associated with the participants’ ability to take a meal break during the shift.

Figure 21. It is the result of the text search query in which the NVivo software linked words and word groups from participants’ interviews to the word meal participant said about floating: “….I didn’t get a meal break.”, another one said “…times, I did not get a meal break.”

The six themes presented represent nurses’ feelings, from their perception about floating. Main concerns included an absence of a workflow process, unfairness of patient-care assignments, and the unfamiliar work environment. The psychological, sociological, and physiological factors described also influenced nurses’ feelings.
Significance of Results and Findings

Participants in the current study gave a substantial account of the lived experience about the phenomenon of floating. Participants were in a unique position to talk about the factors that influenced feelings and experiences in regards to floating, and in answering the three open-ended interview questions. Different words (or phrases) were used to describe the meaning of the lived experience. Words, phrases, or paragraphs (extracted from interviews) served as a basis to develop themes and codes. Identified themes and codes gave true meaning of floating for nurses who are required to float.

Data Analysis Comments

An outlier is an observation that is not congruent with the rest of the data and one that diverges from other data points (Aguinis, Gottfredson, & Joo, 2013). The current study contained a few observations that surfaced during data collection, which diverged from the remainder of the comments. Interviews revealed that one participant enjoyed floating, stating that patients had a lower acuity in the medical-surgical areas. Another comment was in relation to the duration of the interview, which lasted less than the planned one hour. These observations did not affect data collection, data analysis, or the study results. Overall, participants clearly articulated feelings about floating, shared personal experiences with floating, and identified factors associated with floating.

Chapter Summary

Chapter 4 began with a review of the study's purpose, sample, and demographics. Results from the pilot study were included. The pilot study was conducted to ascertain participants’ understanding of the open-ended interview questions. Feedback indicated that the interview questions were clear and easy to understand; no changes were needed.
Participants who met inclusion criteria were recruited for the study. Two male nurses and nine female nurses participated in the study; saturation occurred with the ninth participant. Data were collected by using digitally-recorded, semi-structured, face-to-face interviews on hospital grounds. Interviews were transcribed within 24 hours in a Word document that was formatted for auto-coding in NVivo 10 software.

During the interviews, participants discussed feelings about the requirement to float within hospital units. The two male and nine female nurses gave personal experiences and clarified factors influencing feelings about floating. Through an analysis of responses, groupings of similar words and word groups formed identifiable patterns, and six themes resulted.

Giorgi’s six steps guided the data analysis. A description of Giorgi’s process is available in Chapter 3, Table 4. Phenomenological reduction helped to categorize the participants’ account of the lived phenomenon. A summary of the data analysis process was divided into three columns, which illustrated the common themes, the meaning units, and the participants’ quoted words, sentences or paragraphs, respectively, based on Husserl’s descriptive transcendental phenomenology (Phillips-Pula et al., 2011).

Data analysis began with reading the transcripts of the interviews four times, which facilitated the two-phase, four-stage coding process. A word-search query in NVivo revealed the most common 100 words from the transcript, and by process of elimination, duplicates and synonyms were removed. Themes, as well as, primary and secondary codes, emerged. A codebook, based on the codebook development framework described previously, also resulted. Using the NVivo software, multiple queries followed until selected themes were arranged hierarchically by references and coverage. Excerpts
from the interviews were included to give support to each theme. Other data were organized in tables and figures.

During the interviews, the participants stated their feelings when floating to a unit other than theirs. Two male and nine female nurses gave an account of their experiences and clarified the factors influencing their feelings. Grouping of similar words and word groups formed patterns. Chapter 5 discusses the results and themes of the current study. Recommendations are given to improve the process of floating and for future studies.
Chapter 5
Conclusions and Recommendations

The purpose of the current study was to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The study method was qualitative, with a transcendental phenomenological design based on Husserl’s model. Karasek’s Job Demand-Control (JDC) served as the framework for the study. The purposive sample was comprised of 11 nurses who experienced the phenomenon of floating on a regular basis.

Chapter 5 includes an overview of the theoretical frameworks that guided this study, a summary of the findings from the data analysis, and the interpretation of the study findings considering the existing literature. The chapter concludes with a discussion of the study implications and significance, recommendations, study limitations, potential biases, suggestions for future research, and summary.

Theoretical Frameworks

During the interviews, participants described personal experiences with floating, feelings about floating, and factors influencing feelings when floating to a unit different from the home-unit. As theorized by Husserl (1970 a/1936), individuals who experience a phenomenon make a meaningful interpretation of the lived phenomenon. Nurses who float regularly are in a better position to describe their feelings about the experience (Larson et al., 2012). Participants in the current study expressed emotions based on personal experiences. Husserl’s (1970a/1936) transcendental phenomenology was appropriate for the study’s design, and it assisted in capturing nurses’ thoughts on the phenomenon of floating (Flood, 2010).
Karasek (1979) posited that jobs that are high in demand and low in control adversely influence people's reactions. Karasek’s JDC combined three factors: affective strain, work overload, and control (Karasek, 1979). The three-dimensional paradigm affects individuals working in unfamiliar areas and can apply to a nurse who floats (Bates, 2013). Karasek’s JDC facilitated understanding of nurses’ feelings about floating (Karasek et al., 1981).

The relevance of the qualitative design and the theoretical framework was established throughout the study. Nurses experience affective strain as evidenced by feelings of anxiety and frustration. They also mention a lack of control on the environment of care associated with work overload. The nurses’ comments linked personal feelings to Karasek’s core concepts (Karasek & Theorell, 1990).

The study involved three broad research questions linked to the study's purpose:

RQ 1: What are nurses’ experiences when it comes to floating?

RQ 2: What are nurses’ feelings when floating?

RQ 3: What factors influence nurses’ feelings when floating?

Findings and Interpretations

The use of open-ended interview questions elicited a wide range of responses from nurses on the subject of floating. Each interview question contained seven to eight additional probing questions, which were useful in uncovering important facts not mentioned by the participants (Qu & Dumay, 2011). Six themes emerged from the transcript: (1) workflow process, (2) patient-care assignment, (3) work environment, (4) psychological components, (5) sociological factors, and (6) physiological needs. In the
following paragraphs, each described theme is further compared and contrasted to the existing literature on floating.

**Workflow Process**

Participants in the current phenomenological study saw the workflow process as chaotic, with the beginning of the work shift being particularly challenging and the receiving unit appearing disorganized to the floating nurses. The finding was supported by Nicholls et al. (1996), who sent a two-page survey questionnaire, validated by two panels of experts, to 319 nurses and licensed practical nurses. In a quantitative, descriptive study conducted on nurses’ attitude on floating, Nicholls et al. (1996) found that a common statement among nurses who floated was that the receiving unit appeared disorganized.

Participants in the current study complained of common concerns such as a lack of orientation and the absence of adequate communication. Similar complaints were found in the reviewed literature. McKee, Allen, and Tamez (2014) concurred that the most common complaint from floating nurses is a lack of orientation. Participants commented that no standardized process was available to orient floating nurses upon arrival to the receiving unit. There was no efficient process in place to orient them to an unfamiliar receiving unit routine and layout. The finding was in agreement with Unruh and Nooney (2011) who stipulated that the orientation process for nurses who float needs improvement.

Roach et al. (2011) also found that adequate orientation was important for nurses who floated. Otherwise, nurses become apprehensive when floating in a unit without ample time for orientation (Roach et al., 2011). Nurses should become familiar with the
unit routine in order to function accurately and efficiently (Roach et al., 2011). Lack of knowledge about the unit routine could adversely affect patients care.

Other nurses in the current study described a lack of communication with the nurse in charge. Crist-Grundman and Mulrooney (2011) indicated that clear communication is an important factor in facilitating movement from unit-centered to organizational-centered staffing. Unit-centered staffing is based on the fact that a staff belongs to one unit; whereas, in an organizational-centered culture, staff members belong to the organization. Cairns et al. (2013) identified communication as an essential component of nursing care. Armstrong and Laschinger (2006) found that job satisfaction and patient safety improved with effective communication and access to resources. From the standpoint of the participants, lack of communication increased the perceived chaotic workflow.

**Patient-Care Assignment**

Participants encountered a number of obstacles related to the patient-care assignment and mentioned major challenges faced in the workplace such as: unfairness of patient-care assignments, delays in obtaining access to unit doors and the computerized automated medication-dispensing machine code, and dealing with unfamiliar tasks. Inequities and lack of support in patient-care assignments contribute to decreases in the quality of care and patient satisfaction. The patient-care assignment is instrumental in determining nurses’ care planning and delivery of care. Nurses develop proficiency and become experts in one specialty area over time. Jones and Treiber (2012) observed that nurses working in a specialty area progressively lose the broad base instructions received in nursing school. Brennan et al. (2012) indicated that the patient-care assignment of
nurses should center on the patients’ acuity and the nurses’ competence. By keeping in mind the patients’ acuity, a nurse's area of expertise, and other dynamics, such as possible discharges, a resource nurse can prevent overburdening the nursing staff and improve the quality of care (Daugherty & Scarbro, 2014).

Findings about floating nurses’ perceptions about unfair assignments were conflicting. Participants from the current study often received difficult patient assignments. Concurrently, Nicholls et al. (1996) characterized floating nurses’ assignments as unreasonable. Participants stated that float-pool nurses (i.e. nurses who float exclusively to areas in need and do not have a home-unit) receive a difficult patient assignment even before arriving to the unit. Other findings do not support that belief (Larson et al., 2012). Larson et al. (2012) examined patient-care assignments for float-pool nurses versus unit nurses assigned to float. In 2012, Larson et al. reviewing patterns of patients assigned to float and unit nurses concluded that there was no statistical evidence that float-pool nurses cared for patients that were more difficult, despite a noticeable trend toward difficult assignments.

Good and Bishop (2011) observed that nurses assigned to float were assigned to units more difficult patients so that unit nurses could have time off from chronically ill patients who had been in the unit for weeks. This finding coincides with the current study findings in which some participants stated that in some units their patients were scattered throughout the receiving unit because they were assigned to the most difficult patients. Within other units, floating nurses were assigned less problematic patients when the receiving unit appreciated the floating nurses' role to reduce the nurse-to-patient ratio (Hickman, 2013). In the current study participants mentioned that they would be
assigned less critically ill patients only if there were other nurses from the centralized staffing department working during their shift. Nurses from this department are float-pool nurses who are educated and hired to float from one unit to another. They do not belong to a specific home unit. Hickman (2013) conducted a quantitative study with floating nurses. The surveyed nurses strongly felt (73.6%) that nurses mandated to float should receive a manageable assignment, meaning an equal distribution of stable patients and those needing complex care (Hickman, 2013). Nurses participating in the current study did not feel that their patients’ assignment was manageable or that patients were distributed fairly among the nursing staff.

Another complex component of patient-care assignment was the delay in floating nurses obtaining access to unit doors and the computerized automated medication-dispensing machine code, a problem that has not been unique to participants in this research. Bates (2013), reflecting on her lived experiences with floating, acknowledged spending much time asking for door code access during a shift when floating—an experience that was shared by other nurses. Participants in the present study described the many difficulties they encountered to access the patients care areas when floating. They mentioned that they could not access areas such as the clean utility room or the medication room, for example.

Advances in technology have changed the use of centralized and decentralized medication dispensing (from the pharmacy) with the availability of automated devices (Pedersen, Schneider, & Scheckelhoff, 2012). The elected health care facility as other existing institutions in the USA and abroad implemented a convenient decentralized medication dispensing and managing system in which the medicines are readily available
onsite for immediate use by the nursing staff when ordered or should an emergency arises. Different from automated medication distribution software, an automated device, such as the computerized automated medication-dispensing machine, can be easily accessed to retrieve medication. The medication station described above exists in each patients care unit of the selected institution.

Nurses can use a unique identifier, such as a digital print or a date of birth, to access automated devices. Participants revealed that, when floating, the database for automatic dispensers was not programmed to recognize identifiers of floating nurses. Nurses from other units do not have access to automatic dispensers on the unit when floating unless an authorized individual or designee enters their personal identifier. Hospital systems that require access codes are designed to accommodate multiple users (Colangelo, 2014). Giving floating nurses access is not a technological issue but a logistical issue. Without access to automatic dispensers, doors, and other pertinent areas of the unit, participants in the current study felt that they could not properly deliver patients care in a timely manner because of the delay in obtaining access to the receiving unit door and the medication automatic dispensers. Armstrong et al. (2009) recognized that nurses must have the necessary tools to be able to perform nursing care efficiently. The lack of access mentioned by nurses in the present study results in a delay in patients care related in part to a delay in patients’ medication administration in a timely manner.

Another concern mentioned by participants was the likelihood of facing unfamiliar tasks linked to patients care in an unfamiliar unit, a concern that has been expressed by other nurses as well. Several studies have confirmed that floating nurses encounter unfamiliar tasks because the patient population is different and the unit is
unfamiliar (Good & Bishop, 2011; Larson et al., 2012; Linzer et al., 2011). Nurses have also found that skills acquired in nursing school may not have been performed in a while, especially if such skills are not required in the area of specialty (Roach et al., 2011). Proficient nurses who float feel incompetent primarily because the authority to make clinical (i.e. autonomous) decisions is lost (Hausser et al., 2010; Tyler et al., 2012).

**Work Environment**

The work environment includes the surroundings in which an employee works and functions. An idyllic work environment is a safe and supportive one in which nurses feel competent to deliver quality patients care (Groff Paris & Terhaar, 2010). Competence in a specialty area empowers nurses to function routinely and effectively without asking questions (Purdy et al., 2010). Participants argued that there were contrasting outcomes when floating, due to the many differences in structure, competencies, and rules among units. The themes identified by participants in the current study were: being out of their comfort zone, absence of teamwork, and lack of (or limited) help from nurses within the receiving unit. The aforementioned themes culminate into an unfamiliar work environment.

For nurses who float, an unfamiliar setting may have a positive or negative influence on them, depending on the unit culture (Good & Bishop, 2011). A culture of support in the work environment may have a positive influence on nurses and patients care (Zeller et al., 2011). Calarco (2011) found that improving the work environment contributed to better quality patients care, acknowledging a positive influence on quality of care. Participants in the current study perceived that there were no set guidelines, written processes, or constant resources to assist floating nurses. Schwarzkopf, Sherman,
and Kiger (2012) believed that charge nurses are expected to use the workplace processes to meet the needs of the staff and patients. Thomas (2012) noted that, in some health care settings, the charge nurse has a workload of patients that becomes a priority over other needs. Zolnierek and Steckel (2010) believed nurses who floated should be oriented to the work environment and assigned a resource person who will be available to answer any questions.

Health care is a complex system in which collaboration is necessary for members to achieve quality outcomes such as safe patients care and stakeholders’ satisfaction (Brandrud et al., 2011). Researchers found that teamwork influences staff effectiveness (Paine et al., 2010). Myungsuk, Jun-Gi, and Jungwoo (2014) described the components of teamwork that included: communication, collaboration, coordination, and cohesion. Teamwork components are important for patient safety and quality of care (Kalisch et al., 2013). Participants from the current study reported that teamwork had not been apparent when floating, making the timely delivery of patients care difficult to carry out. Lack of teamwork contributed to feelings of being out of one's comfort zone (Myungsuk et al., 2014).

The work environment for floating nurses appeared to be negative and hostile (Larson et al., 2012). The receiving unit layout was unfamiliar, and the nursing staff or resource nurse had no time to help anyone due to patients care responsibilities and typically appearing to be overwhelmed. Thomas (2012) supported this, stating that one impediment to the charge nurse’s role was having a patient load. Caroline noticed, “There is not much help. The nurses are busy themselves and appear overwhelmed.” Priscilla mentioned, “They really couldn’t help me because they were so busy.” Other
comments from the participants are available in Appendix P. Participants in the current research revealed that teamwork on receiving units is limited, which affects nurses’ performance and, in turn, patient safety.

Psychological Components

Jourdain and Chênevet (2010), and later Unruh and Nooney (2011), reported that a nurse’s work and social environment is stressful. Nursing is a stressful profession due to the constant human contact with patients (Borhani, Abbaszadeh, Nakhae, & Roshanzadeh, 2014). Throughout a work shift, nurses deal with different feelings related to their interactions with patients, different members of the interdisciplinary care team, and patients' family members. The participants in the current study expressed that floating increased their feelings of frustration, stress, and anxiety. Such feelings can be minimized and managed when working with supportive co-workers.

Similarly, some researchers asserted that nurses have reported uneasiness when floating to an unfamiliar work environment (Linzer et al., 2011; Lugo & Peck, 2008). The many difficulties encountered by nurses who float leads to feelings of a lack of self-efficacy, as perceived obstacles appear insurmountable (Bandura, 1977). When floating, participants reported experiencing a number of obstacles (e.g. perceived unfair patient assignments, lack of orientation to the unit, lack of teamwork in the unit) for which they did not have an immediate solution. Bandura (1977) posited that individuals develop coping mechanisms to function during stressful situations according to their perceived ability to reduce threats.

The receiving unit has a unique work structure, which can trigger fear in floating nurses (Banks et al., 1999, Linzer et al., 2011). A stressful experience can result when
changing a nurses’ routine, requiring the nurse to work in an unfamiliar environment, with different types of patients, medical protocols, and disease processes (Jones & Treiber, 2012). During interviews, participants revealed that anxiety, stress, and fear were experienced when floating to a unit other than the home-unit. Participants also related feelings of anxiety caused by not knowing when a floating shift had been scheduled. A study conducted by Good and Bishop (2011) showed a similar finding. Once nurses learned of a scheduled shift to float, fear, anxiety, and frustration was felt (Good & Bishop, 2011). According to Roach et al. (2011), feelings of anxiety and stress can affect both staff and patients. The current study findings reinforced the findings in the studies by Good and Bishop (2011) and Roach et al. (2011).

Nurses must feel comfortable in order to deliver quality patients care. Temporary assignments of nurses to other units decrease levels of comfort (Linzer et al., 2011). Woodard, Havercamp, Zwygart, and Perkins (2012) found that level of comfort was not an indicator of competency, since nurses are comfortable within the home-unit despite stressful situations that may arise. Nurses’ comfort levels changed when floating, mostly because of the changes in the dynamics of the unit (Woodard et al., 2012). Fear, anxiety, and frustration only add to an anticipated stressful experience. The psychological outcome of nurses’ experiences and feelings when floating is low self-efficacy, which can result in a decrease in patient safety and quality of care (McKee et al., 2014).

**Sociological Factors**

Humans develop social behavior through interactions with other people (Ebstein, Israel, Chew, Zhong, & Knafo, 2010). Stress may arise if individuals spend more time alone than with others (Ebstein et al., 2010). Floating nurses, as human beings, have a
need and desire to talk, exchange ideas, and discuss procedures with other nursing staff during a given shift. Mohamed, Newton, and McKenna (2014) addressed an individual’s need for socialization and an aspiration to fit into the work environment. Researchers further indicated that an individual’s social and psychological well-being are a function of their relation with others and a sense of belonging. The social problems identified by participants were the unfriendliness and unwelcoming attitude of the nurses from the receiving unit.

Floating nurses need to establish social relationships with peers because unit-specific tasks can only be learned from nurses who work regularly within the unit (Torunn, Bjørk, Tøien, & Sørensen, 2013). Bates (2013) identified the need to request assistance with unit-specific procedures. To carry out patient assignments, floating nurses also need to understand how to use unit-specific equipment (Roach et al., 2011). Participants from the current study encountered unit-specific job tasks that required guidance from staff nurses who routinely completed the assignments.

Floating nurses felt “unwelcomed” as indicated by the report that unit nurses rarely spoke or did not acknowledge (i.e. ignored) the floating nurses’ presence at all. Nicholls et al. (1996) recommended developing a culture of work environments in which floating nurses could feel welcomed. Similarly, Crist-Grundman and Mulrooney (2011) identified a need for standardized practices on the unit with the expectation of welcoming floating nurses upon arrival. The researchers suggested the creation of a floating policy that focused on nurses’ common complaints when floating (Crist-Grundman & Mulrooney, 2011; Nicholls et al., 1996).
Participants perceived the receiving unit’s nursing staff as unfriendly. Some floating nurses felt compelled to ask questions in order to maintain patient safety, but floating nurses mostly carried out a patient assignment without unit nurse support to include: working with no personal interactions with peers, and dealing with feelings of not belonging. Mohamed et al. (2014) reported that belonging was a basic necessity for human well-being. A lack of socialization triggers stress (Ebstein et al., 2010). Floating nurses’ loneliness, a decreased ability to perform unit-specific procedures, and an inability to use unit-specific equipment while caring for an unfamiliar patient population could contribute to a decrease in the quality of patients care.

**Physiological Needs**

Individuals have basic physiological needs to fulfill. Nurses, like other professionals, must work to provide for their financial needs. According to Maslow (1943) in his theory on the hierarchy of needs, food and water are basic physiological needs. He further specified that a perceived obstacle to the achievement of our basic needs may trigger a psychological strain.

The expectation, if described in an institution’s policy, is that during a shift, nurses, including floating nurses, will have one unpaid 30 minute meal break, not counting paid coffee or bathroom breaks of five to 20 minutes. Surprisingly, federal law does not require employers to allocate lunch breaks to employees; offering meal break time to staff is discretionary. Policies about meal breaks vary from state to state. Florida’s labor law, for example, does not require employers to allow time for a lunch break. Employers may choose to offer lunch breaks, which would be reflected in the organization’s policy.
Kangasniemi, Stievano, Vergata, and Pietila (2013) indicated that nurses have rights and needs. During working hours, regular breaks are one of the nurses’ legitimate rights, if stipulated in the institution’s policy. Generally, nurses in any health care setting anticipate a meal break during their shift. Floating nurses stated that taking a lunch break was difficult because of late coverage or lack of planned coverage, as well as a busy shift. Participants in the current study stated that the receiving unit staff arranges coverage for each other, and the floating nurses cannot find coverage for lunch.

Participants in the current study indicated that a meal break of 30 minutes is authorized in their workplace. Although organizations may allow meal breaks for employees, employees may not take the meal break. Witkoski and Dickson (2010) found nurses who worked extended hours caring for patients, omitted breaks or mealtime. Missing lunch, however, is not unique to the nursing work environment. Payne, Jones, and Harris (2012) conducted a qualitative study using a convenience sample of 24 employees working for a multinational firm and uncovered that busy workers either cannot find time to eat right or do not eat at all.

Floating influences nurses’ rights and needs. Taking a lunch break where authorized is a basic need that may be difficult to fulfill. The inability to have a lunch break relates to Karasek’s theory of a job that is high in demand and low in control (Karasek, 1979). Some floating nurses in the current study ended up with no break for a shift, which they supposed was due to the resource nurse poorly planning the meal coverages.
Summary of Findings

During the interviews, participants described many challenges affecting feelings experienced when floating, one of which was the inconsistencies in workflow. Findings from Nicholls et al. (1996) and Unruh and Nooney (2011) supported the participants' description of issues related to the lack of orientation and communication. Floating nurses felt that the patients care assignment was unfair. There were anecdotal reports that supported the assertion but no quantitative studies that found significance for the claim in the reviewed literature. For example, in a descriptive survey conducted in one facility in which floating was voluntary, the participants mentioned that floating nurses received the worse patients assignment (Nicholls et al., 1996). Larson et al. (2012) identified a trend toward assigning complicated patients to float pool nurses, but the findings were not statistically significant.

There was no mention of the delay in providing access to the medication dispenser to floating nurses in the literature, although Bates (2013) indicated that floaters spent much time asking for door codes. McKee et al. (2014) found a delay in accessing patients’ care areas. Nurses should have access to necessary tools to function in the fast-paced health care environment. Several researchers reported multiple challenges related to the quality of the work environment, as well as the psychological, psychosocial, and physiological factors for floating nurses (El-Jardalia et al., 2011; Good & Bishop, 2011; McKee et al., 2014; Roach et al., 2011). Nurses from the present study acknowledged the many problems encountered when floating. These issues correlated with the findings reported by the researchers mentioned previously.
Implications and Significance of the Study

The current study has several implications for leaders, nursing, patients care, and future research. Leadership (hospital executives and nurse leaders) in the health care setting looks into best practices to make sound decisions to improve employees’ satisfaction, quality of patients’ care, and patients’ satisfaction among others (El-Jardalia et al., 2011; McHugh & Stimpfel, 2012). It is also significant to the front-line nurses responsible for the delivery of quality patients care. The following section is a description of the implication and significance of the study findings. The implications are further broken down into their relationship with each theme that emerged from this current study.

Implications for Leaders

Workflow process. Awareness of the research findings about the workflow process in the receiving units, the lack of orientation for floating nurses, and lack of communication may be of interest to leaders. The perceived faulty workflow process is associated with floaters’ apprehension as described by participants in the current study. Saranto and Kinnunen (2009) recognized the value of strong lines of communication among nurses on a unit as a main component of quality patients care. Based on the participants’ responses about their lived experience with the phenomenon of floating, different factors affected their workday, with the workflow process being a main concern.

Contributing factors to the described chaotic workflow included the absence of a standardized workflow process, a lack of orientation, and the lack of communication. These elements constitute a strain on floating nurses because of their lack of control within the work environment (Karasek, 1979). A more realistic interpretation of the
reasons behind nurses’ feelings of apprehension when mandated to float to another unit may arise. Based on the current study results, nurses’ feelings when floating is the outcome of several important and distinctive factors encompassing the workflow process, the staff’s attitude from the receiving units, and the lack of access to patients care areas, among other dynamics. The fact that these findings from the current study affect nursing care and patient safety may be important to leaders.

**Patients care assignment.** Findings from the literature support the current phenomenological study about nurses’ concerns related to patient-care assignments. Findings from the current study included lack of fairness of floating nurse’s assignments, a delay in obtaining access to unit doors, the automated medication dispensing device, and an increased probability of facing unfamiliar tasks. Participants perceived floating as a challenge linked to work overload, which increases job demands, and adversely influences a floating nurses’ mental and emotional health (Karasek, 1979). The criteria used by resource nurses in different units when deciding patient-care assignments may be of interest to leaders.

An issue that may be of interest to leaders is the delay in patients care as related to access to unit doors and automated medication dispensing devices. Leleu, Capuano, Nitenberg, Travental, and Minvielle (2014) suggested that delays in patients care are an indication of decreased quality of care. Hickman (2013) found that floating nurses did not deliver quality patients care. It may be of interest to leaders whether nurses who float are able to perform according to training and education or are providing care that may compromise patient outcomes (Hickman, 2013).
Work environment. Kalisch et al. (2012) showed a relationship among teamwork, quality of care, patient satisfaction, and nurse satisfaction. A lack of teamwork brings about nursing overload because floating nurses are not able to find the needed help to complete patient assignments (Karasek, 1979). Leaders may be interested in the findings of the current study, which identified a lack of teamwork within receiving units. The Center for Medicare and Medicaid Services, and other third-party payers, link reimbursement for a patient’s care to the patient’s satisfaction with the care provided (Zamora, 2012). Health care institution performances are available on the Internet for prospective consumers to make an educated choice about which facilities offer the best services (Ford, Huerta, Schilhavy, & Menachemi, 2012). The institutions with the best benchmarking reports will remain afloat in the competitive health care market.

Psychological components. Findings from the current study emphasized nurses’ feelings of uneasiness, stress, anxiety, and frustration when floating. Karasek (1979) described such work-related feelings as an affective strain that can initiate a state of short-term reasoning dysfunction, which may affect nurses who float (Tucker et al., 2008). Based on the comments of nurses who have lived the phenomenon there may be a relationship among floating, stress, anxiety, frustration, and the delivery of quality care an association that may draw leaders’ attention (Duffy, 2011; Larrabee et al., 2010; Linzer et al., 2011).

In a prospective mixed-methods cohort study, van Rosse, de Bruijne, Wagner, Stronks, and Essink-Bot (2012) linked quality of care to patient safety. Incidents related to patients’ safety may be of interest to leaders. Kane, Shamliyan, Mueller, Duval, and Wilt (2007) noted that temporary staff is responsible for an increase in patients’ hospital
acquired infections. For Alonso-Echanove et al. (2003) floating is associated with increased incidences of central line associated blood stream infection. However, Kane-Urrabazo (2006) believed that floating decreases injury to nurses and patients by preventing units to be understaffed, and Good and Bishop (2011) stated that the practice of floating has been reported as cost effective although more evidence is needed to support this belief. Nurses’ description of the psychologic effects of floating on quality of care, patients’ safety, and job satisfaction in the current study correlates with nurses’ account of the phenomenon from other research studies (Duffy, 2011; Good & Bishop, 2011; van Rosse et al., 2012). This finding may be of interest to leaders.

Sociological factors. Leaders may be aware of the receiving staff’s unfriendliness and unwelcoming attitude, as mentioned by floating nurses. These findings fit into Karasek’s (1979) qualitative strain component because they exacerbate floating nurses’ existing feelings of situational stress. The results of the current study tie the perceived unwelcoming attitude and unfriendliness of the receiving staff to a decrease in patient safety and quality of care. The conclusions are not unique to the present study and correlate with previous studies (Crist-Grundman & Mulrooney, 2011; Mohamed et al., 2014; Nicholls et al., 1996).

The importance of socialization in the workplace may become meaningful to leaders because of its association not only with workers’ well-being but also with patient safety and the delivery of quality care, elements essential for organizations to prosper (Ebstein et al., 2010; Mohamed et al., 2014; Torunn et al., 2013). When quality of care diminishes, there are financial repercussions and meeting benchmark criterion may be compromised across the health care system (Ford et al., 2012). Poor health care delivery
will lead to reimbursement penalties (Zamora, 2012), dissatisfied employees often resign, and employee turnover is costly (Li & Jones, 2013). Attrition can put a strain on a hospital’s budget and staffing needs, which can lead to decreased patient safety and quality care (Good & Bishop, 2011).

Another implication of interest to leaders in health care institutions is the existing correlation of the findings of the current study with recruiting and retaining nurses, as well as maintaining job satisfaction for nurses. Bates (2013) found that floating increased job dissatisfaction. This perception negatively affects the retention of nurses, a fact that should get the attention of leaders who, in the midst of budget restrictions, face an increase in expenses associated with the hiring and educating of new nursing staff (Larrabee et al., 2010).

Further implication of the findings about increases in expenses, as related to turnover in units where nurses float most often, may be of particular interest to leaders. McGlynn et al. (2012) indicated, understanding nurses’ motivation to stay within or leave an organization helps leaders increase nurse retention and satisfaction, which can help to decrease costly turnover. Trepanier et al. (2012) estimated the cost of educating new staff to be around $21,571 to $36,960 per individual. In the previous three paragraphs, a lack of socialization among peers as illustrated by researchers (Mohamed et al., 2014) and nurses in the current study has some negative effects on different aspects of the delivery of care. These effects are nurses’ dissatisfaction, increased health care administrators’ expenses caused by attrition, and decreased third party reimbursement related to a decrease in quality of patients care.
Physiological needs. The implication for leaders regarding nurses’ physiological needs is related to an enhanced awareness about nurses’ complaints of a lack of rest period during a work shift and its consequences and the importance of breaks during the shift. Witkoski and Dickson (2010) believed that nurses may incur fatigue by being constantly on the job throughout the shift. When nurses cannot take a break (e.g. lunch, coffee, rest, etc.), the work hours prolong with an increased possibility for error in the delivery of care or nurses’ self-injury (Witkoski & Dickson, 2010). When employees do not take a 30 minute unpaid break, employees are adding an extra 30 minutes to the work shift and not earning (or receiving) pay for that extra 30 minutes (U.S. Labor Law, U.S. Department of Labor).

The findings of the present study are significant to leadership in health care organizations worldwide. Based on the results leaders in the health care setting may view floating as a phenomenon, which affects different stakeholders and sectors in their institutions. The participants of the current study were recruited from a magnet hospital. The likelihood that leaders from magnet institutions will be particularly interested in the findings may increase because they attempt to create a nurturing workplace and strive for nursing excellence (Horrigan, Lightfoot, Larivière, & Jacklin, 2013). Furthermore, administrators in magnet hospitals are dedicated to giving staff nurses a “voice” in decisions involving nursing practice (Vartanian, Bobay, & Weiss, 2013). Findings from the current study represent an opportunity to increase leaders’ awareness on floating and its effects on nurses and others whether it occurs in magnet or non-magnet facilities.
Implication for Nursing

Nurses represent the largest segment of health care workers (Juraschek et al. 2012; Sprayberry, 2014). They want to remain in their area of expertise because of their responsibility to deliver safe patients care (Sprayberry, 2014). In the current study, participants described their feelings of increased stress and anxiety when floating and suggested measures that may relieve these feelings; other nurses shared these feelings (Linzer et al., 2011; Unruh & Nooney, 2011). Decreasing floating and mandatory overtime may decrease nurses’ stress (Zeller et al., 2011).

Results from the present study showed that, in general, nurses do not like floating. This is a finding in line with studies conducted by other researchers (Wieck et al., 2009; Zeller et al., 2011). Some nurses described floating as a deleterious practice (Dziuba-Ellis, 2006). Nurses are dissatisfied with floating because it triggers stress, anxiety, and frustration, among other feelings (Good & Bishop, 2011).

There are numerous reasons for the participants’ negative feelings about floating, one of which is working in an unfamiliar environment. Another reason is the lack of access to the patient-care areas. Bates (2013) acknowledged that floating nurses waste time asking for door codes and access, a concern expressed by nurses in the present study. The participants also complained about a lack of orientation in regards to floating, in the current study. For Zolnierek and Steckel (2010) nurses who floated needed to be orientated to the unfamiliar receiving unit. The receiving unit staff, however, has not been welcoming according to nurses who participated in the current study. Crist-Grundman and Mulrooney (2011) recommended the creation of an environment in which floating nurses feel comfortable, with the expectation that someone designated by
management would welcome them upon arrival. Nurses in the present study mentioned that in some units they were not introduced to the resource nurse or the staff upon arrival.

The current study is significant to nurses because the data collected and analyzed revealed participants’ responses to and concerns with the practice of floating. It provides updated information from the nurses’ perspectives on the issues brought forth by nurses who routinely float. It is also significant to nurses because they work best in a healthy work environment. Ulrich, Lavandero, Woods, and Early (2014) described the components of a healthy work environment as the existence of a supportive leadership, the ability for nurses to deliver quality patients care in an atmosphere of respect, and the nurses’ physical and mental safety, among other characteristics. The findings of the current study show the value of nurses’ opinions and their perception of autonomy in the workplace and the effect of a healthy work environment on their satisfaction and patients care.

**Value of nurses’ opinions.** One finding of the current study was that nurses freely voiced their feelings on floating, a practice that affects their daily routine. The current study correlates with findings from Vartanian et al. (2013) who concluded that nurses in magnet hospitals recognized that leaders keenly encouraged staff nurses to participate in identifying problems and evidence-based solutions related to their practice. Aiken et al. (2011) found that magnet hospitals, where nurses have a voice, are the best places for nurses to work. The participants in the current study did not mention whether they had spoken to health care leaders about their feelings nor did they mention the existence of a shared governance or other means of communication with leadership in their facility. Hess (2011) defined shared governance as a strategy in which nurses
collaborate with health care managers to brainstorm and identify solutions applicable to clinical practice.

Overcash, Petty, and Brown (2012) conducted a research on nurses’ perceptions of shared governance. They indicated that nurses caring for patients throughout their shifts are in a unique position to suggest evidence-based solutions to common issues encountered in the environment of care. Involving nurses in hospitals decision-making is significant. It enhances nurses’ satisfaction and retention, increases patient satisfaction, and improves patients’ outcomes (Houser, ErkenBrack, Handberry, Ricker, & Stroup, 2012).

Having a voice in the workplace is significant to nursing practice. Houser et al. (2012) acknowledged that nurses feel valued and supported when asked to participate in decision-making about concerns relevant to patients care and the work environment. In addition, nurses’ involvement in decision-making positively influences the work environment (Graham-Dickerson et al., 2013). Participants in the current study reported that they were dissatisfied with the work environment when floating. Of further significance is that leaders who appreciate and seek nurses’ opinions incur minimal cost to their organizations because of decreased turnover rate because of nurses’ feeling of increased autonomy and empowerment (Houser et al., 2012).

Despite the significance of nurses’ participation in patients care decision mentioned above, nurses’ opinions do not always count. Aiken, Sloane, Bruyneel, Van den, and Sermeus (2013) conducted a cross-sectional survey including 33,659 hospital medical-surgical nurses in 12 Europeans countries, with an average nurse-response rate of 62%. The majority of those nurses who participated in the survey responded that
leaders do not listen to them, nor do the nurses have the opportunity to participate in decision-making for their units or their patients (Aiken et al., 2013). There was no indication of the hospital's magnet’s status.

**Nurses’ autonomy.** Autonomy is a way for nurses to function independently in the work environment based on their education and experience (Dotson, Dave, Cazier, & Spaulding, 2014). Dotson et al. (2014) posited that nurses’ professional autonomy in the work environment signifies that nurses will have the possibility to use their knowledge and experience to make patient-care decisions. A lack of autonomy is a concern for nurses in the current study and others (Estryn-Behar et al., 2010) because experienced nurses stated that they are not self-sufficient when floating out of their area of expertise. Linzer et al. (2011) described the receiving units as unfamiliar, decreasing nurses’ autonomy when floating.

A lack of autonomy has been one of the primary reasons given by nurses who leave their place of employment (Estryn-Behar et al., 2010). Nurses felt that floating negatively influenced their autonomy. Iliopoulos and While (2010) surveyed 431 Greek nurses working in a critical care unit with a 70% response rate and found that if a lack of professional autonomy was not addressed, it increased attrition, job dissatisfaction, and turnover among nurses.

Despite the perceived lack of autonomy when floating, nurses interviewed in the current study did not manifest a desire to resign from their institution. The finding demonstrates nurses’ willingness to abide by the existing floating policy while hoping for changes in the future. The growing trend of developing a centralized staffing unit in health care throughout the US may be one solution. Members of these units are float-
pool nurses who are educated and hired to float. This initiative increases nursing satisfaction by reducing the floating of nursing staff to units other than own (Balik, 2011; Larson et al., 2012; Linzer et al., 2011).

**Effects of a healthy work environment.** A healthy work environment increases nurses’ job satisfaction. Dobson et al. (2014) found that nurses caring for patients within their area of expertise experience a sense of achievement, which increases job satisfaction. This is not the case when nurses float, as mentioned by the participants in the current study and other nurses surveyed (Estryn-Behar et al., 2010; Gagnon et al., 2010). A healthy environment is critical to sustaining nurses’ satisfaction. Ulrich et al. (2014) specified that nurse managers are responsible for creating and maintaining a healthy work environment where nurses can function independently.

Staff nurses want to participate in decisions regarding the environment of care (Gagnon et al., 2010). Findings from a study conducted by Aiken et al. (2013), however, uncovered that a majority of nurses surveyed in almost every country agreed about the lack of opportunities available to contribute in hospital decision-making. The results of the current study included nurses’ suggestions on processes, protocols, and policies to improve floating.

**Implications for Patients Care**

Patient safety is a priority of health care institutions and workers. Becker et al. (2010) mentioned that in order to enable nurses to deliver safe, quality care, nurses’ participation in the development of policies and procedures is essential to meet their needs. These needs, as cited in the previous paragraphs, include knowledge of the unit workflow process and access to the patients care areas. Participants in the current study,
although experts in their particular area of specialty, felt uncomfortable when floating because of a risk that unfamiliar tasks in unfamiliar units may be encountered, making it difficult to care for a different patient population (Hausser et al., 2010; Roach et al., 2011).

Nurses working in one medical-surgical unit were not necessarily comfortable caring for patients in another medical-surgical unit because of differences in the disease process (Bates, 2013). Patient safety may, therefore, be jeopardized and the quality of patients care may decrease. In research conducted by Hickman (2013), respondents did not believe that floating nurses provided safe patients care when working away from their home-unit. In addition, the physical environment may be a concern. Participants from the current study specified that room layouts varied from unit to units, making the floor difficult to navigate. There were no specific results in the literature about other room layouts (or settings); however, several researchers mentioned the need for floating nurses to be oriented to the new unit (Bates, 2013; Unruh & Nooney, 2011).

The findings of the current study are significant for patients care. Nurses anticipate a positive outcome for a patient based on the level of care needed and the seriousness of the patient’s health problems. When a nurse floats to a unit different from the home-unit, patients care may be hindered (Becker et al., 2010). The significance of the current study for patients care encompassed three components as described by participants: 1) a delay in treatment, 2) a possible decrease in quality of care, and 3) concerns about patient safety.

**Delay in treatment.** In the current study, nurses who floated to a unit other than the home-unit expressed concerns about a delay in the treatment of the patients. The
process of receiving an access code may take a few minutes to an hour depending on whether the nursing supervisor or the resource nurse is available. Bates (2013) described the difficulties associated with access codes and locating supplies for nurses who float. Linzer et al. (2011) found that floating nurses were less likely to locate supplies in unfamiliar units.

If a patient complains of pain, floating nurses acknowledged that another nurse working in the receiving unit would have to pull out the needed medication. Nurses also admitted wasting time looking for equipment and supplies. Becoming acclimated to the routines of a unit without assistance can be a challenge for a floating nurse (Linzer et al., 2011). Patient treatment is therefore delayed, resulting in a decrease in the quality of care (Leleu et al., 2014).

**Decrease in quality of care.** Nursing care comprises many characteristics such as patient education, bedside monitoring of a patient’s condition, and psychological support of patients and families (McHugh & Stimpfel, 2012). For Rastogi (2012), quality health care is a function of the nurses’ ability to apply knowledge and implement appropriate interventions that are beneficial to patients under care. This ability is a function of a nurses’ expertise in one area of specialty, performed independently. When mandated to float, however, nurses generally work in another area of specialty, where the nurse has not demonstrated expertise.

Participants interviewed in the current study perceived assignments to be difficult (i.e. sicker patients) and unfair (i.e. patients in need of intravenous pain medication every hour around the clock) compounded by working with a different patient population in an unfamiliar work environment. Under such conditions, quality of care may decrease.
Nurses master certain skills taught in nursing school but may not have practiced the skills for a while in their home-unit. Nurses may not be as capable of completing tasks as they were able to in the past. Purdy et al. (2010) noted that the unfamiliar work environment negatively affects nurses’ decision-making and the completion of tasks in a timely and self-directed manner. The quality of care is decreased, as a result, and patient safety may become a concern.

**Patient safety.** Patient safety is defined as the absence of avoidable harm to patients (van Rosse et al., 2012) and is a component of the quality of care (van Rosse et al., 2012). Strategies to improve patient safety include communication among health care team members, teamwork, and a culture of collaboration as validated by participants in the current study (Brandrud et al., 2011; Cairns et al., 2013; Weaver et al., 2014). Nurses interviewed in the current study mentioned that there was a lack of communication, collaboration, and teamwork between themselves and the staff of the receiving units.

The current study is significant to patients care. By comparing the nurses’ statements to the existing literature, flaws that nurses (throughout the US and abroad) encounter in the process of floating are uncovered, which, in turn, affect patient treatment and safety, as well as quality of care (AbuAlRub et al., 2012; Iliopoulou & While, 2010; Manojlovich et al., 2011; Zolnierek & Steckel, 2010). Nurses participating in the current study reported a delay in patient treatment due to the time it takes for them to receive a code to access diverse patient-care areas. Bates (2013) also acknowledged the effect of the lack of necessary access codes to patient-care areas as a cause for delay in treatment. This delay leads to a possible decrease in quality of care (Leleu et al., 2014). Patient safety and quality of care may be compromised, as a result.
Implications for Future Research

Another implication of the current study is that the results of the current study advance knowledge and add updated information to the present body of literature. There are a myriad of quantitative studies on the subject of floating (Duffy, 2011; Estryn-Behar et al., 2010; Ferlise & Baggot, 2009; Klaus et al., 2012); however, Klaus et al. (2012) believed that a national research on floating was needed and that there was a lack of qualitative studies on floating in the literature. Future qualitative research is necessary in order to explore nurses’ feelings about floating hospital-wide, in combined units, or in different hospital settings.

A need for more information on floating. The results of the current study provide updated information to leaders about nurses’ feelings and experiences with floating. Researchers may be encouraged to explore further the practice of floating and its influence on nurses and health care. Other research studies may result from the current study in order to obtain more insight into nurses’ feelings on floating. Further qualitative studies are needed in order to explore floating in different health care settings.

A need for qualitative studies in non-magnet institutions. Data collection for the current study occurred in a not-for-profit, magnet-designated facility. Using the quantitative method, researchers have demonstrated that there are differences between magnet and non-magnet hospitals (Horrrigan et al., 2013). Researchers have described a lower nurse-to-patient ratio and a better work environment in magnet institutions (Drenkard, 2010). A better work environment has been defined as one in which the patient-to-nurse ratio is lower and the incidence of burnout is decreased, while the nurses’ job satisfaction and quality of care are increased (Aiken et al., 2011).
It would be of interest to explore nurses’ feelings on the phenomenon of floating in a non-magnet hospital. Floating within closed cluster or within restructured units could be the object of research. Larson et al. (2012) stated that staff nurses in various hospital specialty units remained in the home-unit. In an investigation on float pool staff, Larson et al. (2012) did not include nurses who floated in closed-staff units.

**A need for qualitative studies on floating within restructured units.** A restructured unit is a unit that comprises two to three units under one umbrella. Originally, nurses worked in different critical care units (e.g., intensive care unit, coronary care unit, surgical intensive care unit). Once restructured, nurses from these areas floated within all three units grouped under one umbrella (i.e., they floated in closed cluster) (Driscoll, Currey, Allen, George, & Davidson, 2014). These units, especially in the elected hospital, received floating nurses from units in which the nurses possessed a set of intermediate skills, allowing them to work with patients who needed a higher level of care than is required by their home-unit. Qualitative studies are necessary to understand how these nurses feel about floating within a restructured unit.

**A need for information on floating to a higher acuity level.** Some nurses float to care for patients with higher acuity level. Higher acuity level patients may be admitted to the critical care unit for specialized care and are stabilized. Once stabilized and a bed becomes available, the patients are transferred to the next level of care where specialized care is need. Zolnierek and Steckel (2010) indicated that nurses floating to a higher acuity level may care for patients who are stable, are observed for cardiac complications, or are ready to move to a telemetry unit because their condition has improved. A qualitative strain describes when nurses care for patients in need of acute care. A
quantitative strain is when nurses care for patients in areas with an increased nurse-to-patient ratio (Karasek, 1979). Nurses that float where there is a qualitative strain would be an opportunity to explore feelings about floating to a higher acuity level.

**A need for qualitative studies on floating.** Floating is seldom the object of research despite its effect on nurses (Klaus et al., 2012). In fact, no current phenomenological studies exist on nurses who float. Further studies are necessary to explore nurses’ feelings about working in units different from the ones that met the criteria for the current study, both throughout the US and abroad. There have been no studies targeting the feelings of nurses working in for-profit or non-magnet health care institutions. Lastly, it would be useful to understand nurses’ feelings about floating from a lower to a higher acuity level. In addition, more attention to differentiating views on floating by generation would be useful because as described by Jobe (2014) four generations of nurses co-exist concurrently in the US nursing workforce. Nurses in the current study were from three generations: five from Generation Y, four from Generation X, and two baby boomers.

More qualitative studies are needed to explore nurses’ feelings when floating to other hospital settings. Klaus et al. (2012) suggested that researchers conduct a national study on floating as it affects nurses in their work environment, patients care, and possibly patient safety. The current study is the latest information available on nurses’ feelings on floating, and it may be an opportunity for leaders in the health care system to understand nurses' feelings. Researchers may also have a renewed interest in the phenomenon.
The findings of the current study are significant to future research. The existing body of literature does not contain recent phenomenological studies on floating. The current study comprised the most recent qualitative research on nurses’ feelings about floating as a lived phenomenon. The current study may renew other researchers’ interest in the phenomenon.

Findings from the current study added to the limited qualitative literature describing nurses’ lived experience with floating and its implications for nursing practice. The themes that emerged from the current study, following the participants’ interview and content analysis, advanced knowledge and added further information to the present body of literature about nurses’ feelings on floating. The findings may incite other researchers to explore the phenomenon in an attempt to increase understanding of the dynamics of floating in the health care settings.

In the current study, findings corroborated previous research regarding nurses’ description of the negative effects of floating (Larrabee et al., 2010; McKee et al., 2014, Purdy et al., 2010). Nurses who float in other institutions within the US and in other foreign countries expressed the same feelings (Linzer et al., 2011). Nurses may not be as capable of completing tasks requiring a certain set of nursing skills as they had in the past (Bates, 2013). An interesting finding that may worth further research.

**Significance of the Study to the Nursing Profession**

A review of the literature yielded quantitative studies on nurses’ feelings on floating (Duffy, 2011; Klaus et al., 2012). The participants in the present study described feelings of stress and anxiety, corroborated by quantitative studies (Banks et al., 1999; Good & Bishop, 2011; Larrabee et al., 2010). No phenomenological studies were found
on the topic of nurses' feelings on floating from 1978 to 2014. The purpose of the present study was to explore nurses’ lived experiences with floating in an acute health care facility within a large southern city of the United States. The current study contributed to the existing body of knowledge in several ways.

The main significance of the current study to the nursing profession was that it helped to fill a gap in existing literature about nurses’ feelings on floating by providing a current qualitative study on floating as a lived phenomenon described by nurses. The constituents of the nursing professional associations, whose members are bedside nurses, may be interested in floating as a phenomenon. Reading about nurses’ feelings about floating may help other nurses to cope with components of the phenomenon and increase awareness of its relation to a decrease in patients care.

The American Nurses Association (ANA) encompasses 3.4 million members (registered nurses) throughout the United States (ANA, 2015). The ANA and other nursing associations strive for nursing excellence through the development of standards of practice based on nurses’ input (ANA, 2015). With the predicted nursing shortage looming, members of professional associations may want to learn more about floating for the benefit of the health care system (Becker et al., 2010; Cunich & Whelan, 2010).

Dissemination of findings from the present study could be of benefit to the nursing and management professions. Future plans will include a manuscript submission for publication for a nursing journal. The first choice will be to approach the Journal of Professional Nursing which considers articles about nursing practice, research, management, and other topics. A second choice is the Journal of Nursing Scholarship which focuses on improving nursing practice throughout the world. A third choice is the
Journal of Nursing Management which publishes manuscripts concerning advancement of the discipline of nursing in the areas of management and leadership. Peer-reviewed nursing journals like the ones mentioned above would be a suitable way to convey new information to scholars, nurses, and the public worldwide.

Nurses in the present study and others described measures to make floating more convenient (Calarco, 2011; Lavoie-Tremblay et al., 2014). Some of these measures, described by Nicholls et al. (1996), include orientation of floating nurses to the receiving unit, assignment of a resource person to floating nurses, and a welcoming work environment. In the following section, six recommendations are presented to leadership.

Recommendations

The general problem of the current study was that nurses developed expertise in a single area and gradually lose the broad-based theoretical education previously received in nursing school (Jones & Treiber, 2012). Nurses mandated to work in unfamiliar areas may become a hindrance to patient safety (Dols et al., 2010). The specific problem creating a need for the current study was the absence of current qualitative data describing nurses’ feelings on floating. Researchers demonstrated that, throughout the US and abroad, leaders use floating to manage staffing fluctuations (Good & Bishop, 2011; Klaus et al., 2012; Larrabee et al., 2010; Roach et al., 2011; Unruh & Nooney, 2011).

Six recommendations to leadership resulted from the study findings. These recommendations may apply to leadership and health care organizations, both in the country and abroad, in which leaders use floating as an alternative staffing strategy. Roach et al. (2011) found that floating was a technique to counteract staffing issues, but
Good and Bishop (2011) indicated that nurses who floated experienced stress and anxiety. Klaus et al. (2012) stated that hospital administrators should evaluate the effect of floating on nurses before adopting floating as a response to census variation. Leaders are in a unique position to initiate changes in the floating process based on input from staff and best practices (Ulrich, Lavandero, Woods, & Early, 2014). A discussion of each recommendation follows.

The first recommendation is for hospital leaders to invite experienced nursing personnel (i.e. managers and staff nurses) to create a task force in order to conduct a thorough analysis of existing float policy and to look at the overall workflow process. Becker et al. (2010) stated that nurses’ needs are critical when leaders are building strategies and policies to ensure patient safety and preserve the quality of care delivered. Houser et al. (2012) revealed that nurses’ satisfaction and patients’ outcomes improve when leaders involve nursing staff in patients care decisions. With this in mind, the task force might look into developing standardized processes and, if necessary, a renewed floating policy that takes nurses’ needs into consideration.

After reviewing the existing float policy, the task force members could create a unit-specific guide for float nurses based on their evaluation of the policy, the current study, and other existing study findings in the literature. If deemed necessary, this guideline would contain the patient population served, unit-specific protocols, unit routine, and useful telephone numbers for the unit (e.g. resource nurse, managers, unit clerk, etc.). This initiative could be helpful to floating nurses because, as Linzer et al. (2011) acknowledged, floating nurses waste time in attempts to familiarize themselves with receiving unit-specific practices. Bates (2013) found floating in any medical-
surgical unit difficult compared to the floating nurse’s home-unit because the focus was different (e.g. different disease process, different location of supplies, different door codes, etc.).

The second recommendation is to purchase, update, or develop a database system, which would grant floating nurses immediate access to areas of the hospital necessary to perform work-related tasks. Balaraman and Kosalram (2013) pointed out that the right information should be available to the right people at the right time in hospitals. These authors further indicated that it is possible to develop a basic module to create user groups. The availability of such a function would be ideal for floating nurses. For example, a floating nurse needs to have access to different areas of the receiving unit. Currently, floating nurses must wait for temporary access to door codes (Bates, 2013; McKee et al., 2014), and they must ask staff from the unit to open the other doors for them.

The health care field is a dynamic environment in which changes occur constantly, whether in adding new users or upgrading existing software (Homayounfar, 2012). One of the important roles of an information manager should be to meet the nursing staff needs. Leaders responsible for their hospital’s information technology store data in an electronic database (Balaraman & Kosalram, 2013). In health care organizations, where granting floating nurses access is a problem, this database could be reconfigured to permit access to all nurses hospital-wide. The database could include nurses’ unique identifiers, allowing nurses from the hospital to access patient-care areas upon arrival to any unit of the institution. The unique identifiers mentioned by Colangelo (2014) are the nurses’ names, date of birth, and a unique ID used as the access key.
Participants in the current study did not have access to other units. In the home-unit, the login used was based on a biological password such as fingerprinting.

The facility from which the participants in the current study were selected was a health care system with numerous hospitals and urgent-care centers in southern Florida. As of 2015, nurses floated in their assigned hospitals. In the future, a proactive administrator could consider giving nurses access to patient-care areas in all the hospitals and urgent-care centers belonging to the organization. This recommendation is applicable to similar organizations worldwide.

The third recommendation is to have nurses float in designated units in one building of the hospital, creating something called “zone floating”. Nurses enrolled in the current study floated in patient-care areas located in two buildings: the Tower and the Pavilion. There was a main building, which housed the cardiac and vascular care unit, the intensive care unit, the surgical intensive care unit, the mother-baby units, the operating room, etc., but some nurses from these areas do not float to the medical-surgical areas. The Pavilion and Tower buildings house mainly the medical-surgical, telemetry, oncology, and respiratory areas. The Pavilion is located within the main building, whereas the Tower is located on the east side of the buildings.

Banks et al. (1999) described a change in floating from one area to floating hospital-wide because of budget constraints, despite the understanding that unit-based nurses develop skills appropriate to a specific population (Linzer et al., 2011). The medical-surgical nurses in the Tower building could float to the medical-surgical units in the Tower. Likewise, the ones from the Pavilion building would float in the Pavilion. Floating within a similar zone would have many advantages. Floors within buildings
have a similar layout. A familiar room layout may be helpful, although each medical-surgical area is otherwise different (Bates, 2013).

The layout of the rooms is different in these buildings. In the Pavilion, the room numbers run from 1 to 14, then 15 to 27 consecutively and are private rooms. In the Tower, the numbers vary depending on which hallway the patients are in. The numbers do not follow a specific order, as they may vary according to the hallway in which they are located, and the rooms are semi-private. The “zone” concept, if adopted, could reduce the nurses’ confusion about room numbers, as mentioned by participants in the current study. Roach et al. (2011) recognized that nurses who floated were efficient only when they became accustomed to the receiving unit's physical environment and routines. The elimination of scattered assignments (i.e., floating nurses’ patients positioned in different hallways of the unit and private versus semi-private rooms) would minimize confusion and improve the workflow. The above recommendation is appropriate to hospitals with varied unit layouts in patient-care areas.

The fourth recommendation is for unit managers to instruct resource nurses to base the patient-care assignment for the incoming nurses on the acuity of the patients. Brennan et al. (2012) underlined the importance of matching patient acuity to nurse assignment in regards to patient safety and nurse satisfaction. This may reduce the floating nurses’ complaints about being assigned the “worse patients” as compared to those assigned to the receiving unit staff. Floating nurses’ assignments have been difficult and impractical (Good & Bishop, 2011; Nicholls et al., 1996). “Worse patients”, as stated by nurses who float, are patients with multiple care needs such as hourly pain medication and wound care, who may have been in the unit for weeks.
Floating nurses believed that their patients were “hand-picked”. Daugherty and Scarbro (2014) suggested that the resource nurse should be able to match the patients’ acuity to the assigned nurses. Before leaving the unit for the day, nurse managers, assistant nurse managers, or designees could review the patient assignment with the resource nurse. Lastly, the resource nurse could be free of patients care and, therefore, able to help around. Charge nurses with a patient assignment cannot fulfill their role to support floating nurses, a finding that is valid for any health care setting (Thomas, 2012).

The fifth recommendation is to create a “buddy” system in which the charge nurse assigns a “buddy” to the floating nurse. This valuable resource person could help with minor inquiries, assist the floating nurse with unfamiliar tasks, and cover him or her for a timely meal break. The buddy system already exists in some units and makes taking meal breaks easier. Zolnierek and Steckel (2010) agreed that the buddy system could be a useful solution, especially in cases where patient requirements do not match the nurse’s competency. As mentioned by the participants in the current study, accessing a Port-a-Cath (i.e. an implantable venous access for chemotherapy) may become cumbersome if one lacks experience. A buddy from the receiving unit could be very helpful in such cases.

The sixth recommendation is to have a folder (an excel spreadsheet or a word document) in health care institutions shared drive accessible to nurses that contains a record of names and dates when nurses floated. It may also be a notebook. This type of folder is already available in some units of the hospital for nurses to document their float shifts and cancellation dates. This process could be standardized so that nurses would always know when it is their turn to float, eliminating one of the main causes for floating
nurses’ anxiety and stress. In other words, nurses would come to work prepared to float. There were no documented processes in the literature on floating record keeping.

Six recommendations originated from the nurses’ description of their feelings on floating, as described in the above section. These recommendations are what nurses participating in the study said would help them if implemented, and some of these are currently supported by existing quantitative studies. The creation of “zone” floating and the suggestion of creating a system with an updated database to prevent delays in granting nurses access to patient-care areas may be appealing to institutions similar to the one in which the study took place. One recommendation is for leadership to address the issues of the overall organizational process for floating. Leaders could look into a hospital’s float policy, and invest in an updated database system to grant nurses access to units different from their own. Managers could also plan for the resource nurse to be free of patient-care, so that they could walk around and assist floating nurses. Zone floating, a buddy system, and float folder availability are other recommendations to ease the process of floating in any organization. In the following paragraphs, readers will have the opportunity to understand the limitations identified in the current study.

**Study Limitations**

Researchers conducting quantitative or qualitative studies face some degree of limitations, which may influence the study results. There were four limitations in the current study: (1) the debate on findings from qualitative versus quantitative research methods, (2) the feelings of nurses from diverse years of experiences, (3) nurses floating within their restructured unit, and (4) the exclusion of nurses working in the cardiac and vascular unit (CVCU). The following is a discussion of the identified limitations and
their nature, explaining how each one was addressed in the current study and the literature.

One limitation is the debate regarding findings from qualitative versus quantitative research methods. Qualitative studies are descriptive, and there is an ongoing discussion in the literature about whether findings from qualitative studies are transferable (Leedy & Ormrod, 2010; Lipscomb, 2012). Transferability in qualitative research is the ability to apply findings from a study to another population with the same characteristics (Thomas & Magilvy, 2011).

In the current study, the researcher collected precise data, thoroughly describing the study population characteristics, criteria, and geographical location. Thomas and Magilvy (2011) recommended for researchers to maintain rigor throughout qualitative studies showing consistency of the study methods over time and gaining trustworthiness. The purposive sample comprised 11 full-time registered nurses. These nurses have experiences with involuntary floating and work at the designated acute health care facility within a large city of southern Florida. When conducting the interviews, observation, note taking, and restating were strategies used (for clarification), which contributed to the accuracy of the data. The accuracy of the data and detailed information on the sample and location allows other researchers to assess better if the current study findings apply elsewhere or not.

The participants’ various years of experience constituted another limitation to the study. Expert nurses may experience feelings different from new nurses. For example, the feelings of newly licensed nurses who float within six months of hire may be different from those who have worked in an institution for five years or more. Unruh and Nooney

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(2011) found that newly licensed nurses perceived float shifts as an increase in job difficulty and job demand. These authors also mentioned that mature and experienced individuals complained less about work overload.

A further limitation for the current study was the non-eligibility of nurses who float only in closed or restructured units. These nurses were educated to float within their specialty, and they remain in their reorganized units. A restructured or reorganized unit is a combination of like-units under one category. It signifies grouping some units (e.g. coronary care unit intensive care unit and surgical intensive care unit) into one unit. Restructuring units is the trend due to advances in technology (Driscoll et al., 2014). These researchers stated that the coronary care units (CCU) have merged with other units, resulting in a decrease in the existing traditional critical care units. The results of the current study will not apply to nurses who float within their specialty and within a closed unit.

Cardiac and vascular care unit (CVCU) nurses float in other units including the critical care areas, but they could not participate in the current study because the researcher works in this unit. CVCU nurses regularly float caring for patients with higher and lower acuity level. If they were to participate in the current study, it would be an ethical concern because nurses from this unit may have felt pressured to participate in the current study. The researcher excluded CVCU nurses for the current study in order to ensure that subjects would make their decision to be part of the current study independently (participation was voluntary). This exclusion represents another limitation for the current study.
The current study had four limitations, with different factors contributing to each. Researchers using the qualitative method must abide by strict guidelines to ensure transferability because no inferential statistics were used in these studies. Also, nurses’ feelings may change over time according to experiences, generational cohort, and area of expertise. The purposive sample and small size presented a further limitation to the research. Nurses who work within the restructured unit did not meet the criteria for the current study, which enrolled nurses who float away from their home-unit. Lastly, nurses from CVCU were not eligible to participate in the current study. The following paragraphs present the study's potential areas of bias and their implications.

**Potential Biases**

Biases constitute a major concern in research because researchers may present findings that are a false representation of the phenomenon under investigation. Bias may not be avoided entirely in the research process; however, it must be identified, and reported (Malone, Nicholl, & Tracey, 2014). Individuals interested in study results may make decisions or changes in the collection, analysis, and interpretation of the data based on these prejudiced results.

In the present study, the researcher identified four potential areas for bias: 1) literature review bias, 2) data collection bias, 3) data analysis bias, and 4) personal bias. Each will be discussed in the following paragraphs, along with measures that were taken by the researcher to minimize and, hopefully, eliminate their possible impact on the study.

**Literature review bias.** The first potential bias involved the possibility of the researcher to skew the literature review. Bias may skew a study if a researcher does not
follow the proper use of the findings from the literature search (Creswell, 2013). In qualitative research, the participants' interpretations supersede the findings of the literature review at the beginning of the study (Creswell, 2013). At the end of the study, researchers compare and contrast the literature to the study results in order to identify differences and similarities between the study findings and existing literature to ascertain possible biases (Creswell, 2013). These processes prevent researchers with expertise in a certain field from introducing personal experiences and opinions into the literature review search and study findings (Bettany-Saltikov, 2010). Literature review bias is a concern that could affect data collection, data analysis, and the resulting study findings. For the current study, an exhaustive search of the literature prevented the pitfall of skewing the review in one direction. By exploring and contrasting numerous peer-reviewed articles, books, government excerpts, and dissertations against the participants’ description of the phenomenon during the data interpretation phases, the researcher eliminated bias. Bias resulting from data collection and data analysis are addressed in the next two paragraphs.

**Data collection bias.** Data collection presented the second potential area where there could have been bias. Bias exists when the researcher assumes what participants mean without asking for clarification. Consequently, the study results may become unreliable and steer health care leaders in the wrong direction. Malone et al. (2014) recommended that researchers explain unresolved bias to readers, as it may influence the integration of study findings into practice. During the interviews, the researcher wrote hand notes to capture the participants’ feelings on the lived experience. Data richness was ascertained by the interviewer’s observation of the nurses’ attitudes, tone of voice, facial expressions, and other non-verbal cues during the interview (Cope, 2014).
Handwritten notes were used to capture the participants’ feelings on the lived experience. The researcher conducted digitally recorded interviews with eligible registered nurses until saturation. In the current study, participants were asked for clarifications when necessary. The researcher restated unclear words and sentences and asked participants for validation of meanings before advancing further to prevent ambiguity. There was no identified bias in the questioning after the pilot study.

**Data analysis bias.** The third potential area where there could have been bias was with data analysis. Bias in the analysis of the data occurs when researchers who complete the analysis alter the resulting report (Chan et al., 2013). Findings, as a result, may be inaccurate and may constitute a misrepresentation of the phenomenon under study. The researcher in the current study used a systematic and rigorous approach to data analysis, focusing on understanding the participants’ lived experience. The emerging themes from this research reflected nurses’ descriptions of floating.

**Personal bias.** The fourth potential area where there could have been bias was with personal bias. In qualitative studies, the researcher is the instrument. The researcher for the current study, a nurse who experienced floating as a lived phenomenon, identified and eliminated potential biases that might skew the result. Bracketing during the interview process helped to prevent bias, thereby isolating the researcher's knowledge of the lived experience (Husserl, 1998/1913). The researcher for the current study followed Husserl’s phenomenological reduction for eliminating bias, putting aside personal opinions about the phenomenon (Tufford & Newman, 2012). What this means is that the researcher suspended any personal views or experiences with the phenomenon in order to listen to what participants had to say.
Bias was minimized by following a valid methodology for data analysis. Giorgi’s Six Steps to Data Analysis (1985) based on Husserl’s descriptive transcendental phenomenology was used to collect the data (Phillips-Pula et al., 2011). The analysis began with the researcher reading and rereading the participants’ descriptions of experiences. The process was repeated as necessary to have a sense of the whole. In step two, the participants’ descriptions were divided into meaning units by identifying significant terms. In step three, a description of the meaning of each unit was established. The next step was a synthesis of the units into a consistent description of the phenomenon. During step five, the transformed units were analyzed with a focus on intentionality. The final step (i.e. step six) was the development of a description of the common experience.

The researcher uploaded and saved each recording as a sound document on a media player. The researcher listened to the recordings four times and transcribed the recordings into a Word document within 24 hours. This document was then exported into the NVivo software for the identification of the most frequent words contained in the document. Meanwhile, a line-by-line content analysis of the participants’ statements according to their experiences with floating helped to identify meaning units with central themes for each unit. Bias was eliminated through the rigorous approach used for data analysis with a constant comparison of data from the three methods: NVivo, coding by hand, and the participants’ responses to the interview questions across each other throughout the entire process.

Bias is of concern in any study, but particularly in qualitative research because of the nature of how data is collected, analyzed, and interpreted (Creswell, 2013; Leedy &
Ormrod, 2010). Employing the techniques suggested by various experts in phenomenology potential bias was minimized (Cope, 2014; Malone et al., 2014). By including these measures into the data collection and analyses, bias was less likely to influence the results described in this study.

**Summary and Conclusion**

The focus of Chapter 5 was summarizing the transcendental phenomenological study on floating, to include findings, significance, recommendations, discussions about potential areas of bias, implications, and study limitations. The research is significant to leadership because patient safety and nurse satisfaction are two of the crucial indicators of a healthy health care environment (El-Jardalia et al., 2011). Changes in the floating policy may only occur through decisions by leadership. Leaders may implement measures to address the flaws identified by nurses through the current study. According to Zeller et al. (2011), managers could ensure that nurses take regular breaks and paid time off and limit floating to other units as much as possible.

The study is significant to nurses in that floating nurses had the opportunity to describe personal feelings. Nurses do not like to float because the unfamiliar work environment linked to other factors mentioned previously can trigger stress and anxiety. Floaters also believe that working in a different unit weakens their autonomy, which is a major obstacle for nurses to complete patients care (Estryn-Behar et al., 2010). Dotson et al. (2014) believed that nurses should be able to “do their job” and that managers should acknowledge nurses’ involvement in patient safety.

The current study is significant to future research in that it may inspire a renewed interest among researchers in the phenomenon of floating. The sample included 11
nurses with a specialty either in medical-surgical, oncology, telemetry, or respiratory. Researchers could ascertain transferability by conducting a similar study following the same protocol in other hospital settings with the same characteristics. Houghton, Casey, Shaw, and Murphy (2013) indicated that providing a thorough description of the participants’ commentaries enhances the transferability of the study. New investigations could also focus on nurses with different specialties or hospitals without magnet status.

There is a lack of qualitative research on floating. A review of literature from 1978 to 2014 returned no phenomenological studies on nurses’ feelings about floating. Researchers using the quantitative method reported that floating affects nurses’ job satisfaction (Larrabee et al., 2010). More qualitative studies are needed to further explore nurses’ feelings as evidenced by Klaus et al. (2012), who cited a need for a national study on floating and its effect on nurses.

Six themes emerged from an exhaustive data analysis: 1) the workflow process, 2) the patient-care assignment, 3) the work environment, 4) psychological components, 5) sociological factors, and 6) physiological needs. Themes emerged from the nurses’ perceptions and feelings about floating and connected personal feelings directly to the phenomenon. During the interview, participants expressed stress, anxiety, and dissatisfaction when mandated to float. Linzer et al. (2011) stated floating to unfamiliar units was a source of stress, discomfort, and dissatisfaction.

Floating was challenging to nurses who described the receiving unit as disorganized and the receiving staff as unwelcoming and unfriendly (Nicholls et al., 1996). The participants described the receiving unit as chaotic, in that they had to ask questions because there was no orientation provided for them upon arrival. Crist-
Grundman and Mulrooney (2011) believed that it is necessary to develop a standardized policy to create a work environment in which floating nurses feel comfortable.

Various recommendations emerged based on the nurses’ suggestions during the interviews. The recommendations for leaders included the development of a task force to review the float policy. El-Jardalia et al. (2013) hoped that findings from their study would trigger changes in policy based on the serious work environment issues identified. Nurses in these research studies complained about a lack of autonomy, a lack of support from managers, and a heavy workload. The inclusion of a “zone” floating design could be useful because participants complained about the different layouts of the units in which they floated. Administrators could use the advances in technology to create a system, including a database that grants system-wide access to RNs to lessen a delayed access to patient-care areas. Balaraman and Kosalram (2013) described a database system in which the necessary access may be given to the appropriate people.

Unit managers or designees play an important role in introducing measures to decrease floating nurses’ anxiety. They could review the patient-care assignment to alleviate floating nurses’ complaints of receiving the “worse” patients of the unit. Each unit could have a checklist on the unit routine to hand to the floating nurse upon arrival. Ideally, the resource nurse could be free of patient-care to be able to help around. In addition, a “buddy” system has been useful in other areas to answer questions floating nurses have and to help with meal breaks.

There were a few limitations to the current study. The results may not apply to other nurses who have floated in closed units. The cardiac and vascular care nurses who float in the medical-surgical and critical care areas could not participate in the current
study because the researcher worked in that unit. The purposive sampling, small sample size, and the potential for researcher bias constituted further limitations to the current study. Nurses’ feelings may change over time, and the participants’ generational backgrounds and experiences could have interfered with personal feelings; however, this assertion cannot be verified because of the variety of existing clear cut-off years characterizing each generation (Becton, Walker, & Jones-Farmer, 2014; Jobe, 2014).

Conclusion

The purpose of the study was to explore nurses’ lived experiences with floating in an acute health care facility within a large southern city of the United States. The findings demonstrated that nurses who float expressed feelings, which when analyzed, were grouped into six emerging themes. Nurses felt anxious, frustrated, and scared when mandated to float. The main reason for anxiety, frustration, and fear was not knowing in advance when a floating shift was scheduled. Other sources of anxiety included the perceived lack of workflow process in the receiving unit, no orientation upon arrival to the unit, and little or no help from unit staff members when floating.

The problems mentioned above have possible solutions as suggested in the current study’s recommendation section. Leaders could revise the floating policy in order to create “zone” floating, in which the nurses would stay in their own areas. Updating an existing database system to grant access to nurses working in any of the hospitals pertaining to the health care corporation would eliminate nurses’ delay in accessing patient-care areas. Nurse managers could review the assignment for the incoming shift before leaving the unit. A “buddy” system and unit specific guidelines could also be created.
Findings from the current study have contributed to the existing body of literature to advance knowledge on nurses’ feelings about floating. The current study had significant implications for the nursing profession, leaders in health care organizations, and bedside nurses, as well as for future research. Though not eager to float, nurses in the current study agreed that they have to float for diverse reasons mentioned in the interviews, a finding different from previous studies. The literature lacked qualitative studies that explored nurses’ feelings on floating.

The current research results indicated that leaders may play an important role in alleviating nurses’ feelings of stress and anxiety about floating and the subsequent effects on patients care and health care. Other researchers may develop a renewed interest in floating and conduct further qualitative studies on the phenomenon in order to identify further useful strategies to direct leaders toward more strategies to address floating. Findings from the current study (and others in the US and abroad) contain measures that could make floating more convenient (as described by nurses who have experienced the phenomenon).

Leaders who plan to continue using floating as a means to respond to staffing fluctuations may think about taking advantage of the advances in technologies. They may invest in an upgraded information system that would allow for the inclusion of nurses from all units of a hospital group. This intervention, if implemented, may eliminate a delay in gaining access to patient-care areas for nurses who float. With the predicted nursing shortage, leaders may want to consider reviewing their floating policy. This initiative may prevent staff dissatisfaction, burnout, and costly turnover and enhance nurses’ recruitment and retention in health care organizations.
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Appendix A

Interview Questions

Question #1

Tell me about your experiences when you float

Probes

1. How do you feel caring for a patient population other than the typical patient population in your home unit?
2. Describe some of the most frequent problems you encounter when floating
3. How do you feel about the treatment received as far as patients’ assignment and patients’ acuity, for example when you float as compared to the assignment given to nurses to who work routinely in the receiving unit?
4. How do you manage to complete your care during a shift when floating to a different area?
5. What does a typical workday like when you float in an area with a higher patient/nurse ratio
6. What goes through your mind knowing it is your turn to float to a lower area of expertise.
7. How do you complete expected tasks in an unfamiliar unit in which each patient has multiple care needs (medication administration, wound care, tube feeding, etc.) as compared to your home unit?

Question #2 Describe your feelings when floating?

Probes

1. How do you feel about floating as a lived experience in an area with higher acuity patients?
2. How do you feel your skills and competencies help in the delivery of care when you float?
3. How do you feel about making patients care decisions when you float in a higher area of expertise?
4. What resources are available to you when you need assistance?
5. Describe the electronic documentation process in different areas
6. Describe your feelings floating to a lower acuity unit and compare this experience to floating in a higher acuity unit
7. How do you manage your meal breaks?

**C) Question #3** Tell me about factors that influence your feelings about floating

**Probes**
1. How do you see your feelings influencing your work environment?
2. How do you perceive your relationship with management on floating?
3. What do you think about the hospital administrators who approved the float policy?
4. What is your perception of the collaboration between you and your nurse-peers in the receiving unit?
5. Describe your relationship with peers from the receiving unit when you float
6. Describe the acuity of patients assigned to you when floating
7. What are the resources available to you when you float?
8. What are examples of support you would need to help you deal with floating?
Appendix B

The Recruitment Process

Define Inclusion Criteria

Define Exclusion Criteria

Define Study Sample

Recruit Eligible Participants

Distribution of Flyers
Publication in e-news

Meeting with Managers, council chairs, and RNs

Recruitment Process

Recruiter

Recruiter

By: Marie-Paule M. Lafontant February 12, 2014
Appendix C

Script/Summary of the Research Study

Good Afternoon everyone, my name is Marie-Paule M. Lafontant. I am a doctoral student, enrolled in the doctoral program in education with a specialization in curriculum and instruction at University of Phoenix (UOPX). As a requirement for graduation, I must complete a research project. Thank you for giving me the opportunity to present a summary of my prospective study to you. The reason I am here today is to invite interested registered nurses to participate voluntarily in my research on floating. My contact numbers and email addresses are available in the flyer distributed. The following is a brief summary of the study.

**Study Title**

Exploring Nurses’ Feelings on Floating: A Phenomenological Study.

**Purpose**

The purpose of the proposed study is to explore nurses’ lived experiences floating in an acute health care facility within a large southern city of the United States. The central idea is to understand the feelings of 10-15 nurses working full-time in an acute health care institution when floating to a unit other than their unit-base.

**Background**

An extensive review of available literature on nurses’ feelings when floating from 1978 to 2014 revealed no current published qualitative studies. Floating relates to the changes in the health care associated with the numerous reimbursement schemes established by the Center for Medicare and Medicaid services (CMS). A unit manager must plan on adequate staffing to maintain an acceptable patient/nurse ratio according to
hospital policy. Seventy-five percent of the elderly population, the uninsured, and the retirees receive health care coverage through the CMS.

Method/Design

The chosen method/design is qualitative/transcendental phenomenological (Husserl’s). To meet inclusion criteria, participants must be full-time staff RNs who float regularly. Exclusions for this study will comprise per diem, contract, agency, float-pool, and nursing staff who volunteer to float to other units for a number of reasons (extra-shift, overtime pay, etc.). The population for this study comprises a sample of 10-15 staff registered nurses. Scheduled interviews will take place on participants’ day off and in a place agreed upon.

RQ 1: What are nurses’ experiences when it comes to floating?
RQ 2: What are nurses’ feelings when floating?
RQ 3: What factors influence nurses’ feelings when floating?

Relevance to clinical practice/Significance

Findings from this study will be the most recent analysis of nurses’ feeling on floating. The researcher will summarize the personal interpretation and professional encounter of nurses who float to different units of a southern acute care hospital during periods of low patients’ census. Results from this study may trigger alterations in floating policies.
Appendix D

Email Script to Managers/Invite to Present Study in a Staff Meeting

Good Afternoon,

My name is Marie-Paule M. Lafontant. I am a nurse and a doctoral student, enrolled in the doctoral program in education with a specialization in curriculum and instruction (EdD/CI) at University of Phoenix (UOPX). As a requirement for graduation, I must complete a dissertation.

I am asking you to invite me for a brief 10 minutes presentation to your staff during your monthly staff meeting or a huddle to inform staff of the project and recruit potential study participants.

Attached is a synopsis of the presentation for your review along with a copy of the flyer that I will distribute to staff nurses. I am looking forward to hearing from you at a suitable time.

Thank you

Best regards

Marie-Paule M. Lafontant, MSN, RN-BC
Appendix E

Complete Interview Script Study Questionnaire

1-Welcome:

I am pleased to welcome and thank you today as you decide to be a participant in my research study on exploring nurses’ feeling on floating.

2-Introduction (self; participant’s name /pseudonym)

My name is Marie-Paule M. Lafontant. I am a registered nurse. I am pursuing a doctoral degree in Educational Leadership, with a specialization in Curriculum and Instruction program (EdD/CI) at University of Phoenix. At this point, I would like you to tell me your name and a pseudonym of your choice that we will be using during the interview. If you prefer, I may assign a pseudonym to you.

3-Consent review and description of the interview process

You met the inclusion criteria and agree to enroll in the study. Let us review the study purpose, conditions for participation, and informed consent. If you do not have any questions you may sign the informed consent (IC), and the interview will begin. As you understand, I am interested in exploring nurses’ feelings on floating as a life-lived experience. The study encompasses a semi-structured interview (dialogue/conversation) about your feelings on floating. I will be asking you open-ended questions to which you will choose to answer or not. I may need clarification on some of your answers and may ask more questions during the process. Be aware that the interview is recorded. There are no risks to participating in this interview. You may withdraw from the interview at any time. The entire process will take approximately 1 hour.
4-Recording

We will begin the recording with my asking you a few questions about yourself (Demographics, gender, ethnicity, marital status, number of children, etc.). I will start now if you are ready.

a. **Demographics**  Please tell me how old you are (age range)
   
   21-31, 32-42, 43- 53, 54- 68

   **Ethnicity:** Black, White, White Hispanic, Black Hispanic, African Americans, Asians, other

   **Marital status:** married, divorced, widowed, separated, partnership, single

b. **Education** (AD, BSN, MSN, PhD, EdD)

c. **Tenure as a nurse** in years  1-5, 6-11, 12-17, 18-23, 24 or greater

d. **Years in organization**

e. **Hours worked per week**

f. **Shift worked**

g. What is your **area of specialty** (med-surg, telemetry, intensive care, other)

h. Do you have a **certification** in your field of expertise? Yes or No

i. **Experience with floating.** On average how many times you floated last year (5-20)

j. In which **units** you float (med-surg, intensive care, other)

**A) Broad Interview Question #1**

Tell me about your experiences when you float
Probes

1. How do you feel caring for a greater number of patients than the typical nurse/patient ratio in your home unit?
2. Describe some of the most frequent problems you encounter when floating
3. Describe your perception of the assignment you receive compared to the nurses who work in the receiving unit
4. How do you manage to complete your care during a shift when floating to a different area?
5. What does a typical workday like when you float in an area with a higher patient/nurse ratio
6. What goes through your mind knowing it is your turn to float to a lower area of expertise.
7. How do you complete expected tasks in an unfamiliar unit in which each patient has multiple care needs (medication administration, wound care, tube feeding, etc.) as compared to your home unit?

B) Broad Interview Question #2 Describe your feelings when floating

Probes

1. How do you feel about floating as a lived experience in an area with higher acuity patients?
2. How do you feel your skills and competencies help in the delivery of care when you float?
3. How do you feel about making patients care decisions when you float in a higher area of expertise?
4. Describe the resources available to you when you need of assistance
5. Describe the electronic documentation process in different areas
6. Describe your perception of floating to a lower acuity compared to floating in a higher acuity unit?
7. How do you manage your meal breaks?

C) Broad Interview Question #3 Tell me about factors that influence your feelings about floating

Probes
1. How do you see your feelings influencing your work environment?
2. How do you perceive your relationship with management on floating?
3. What do you think about the hospital administrators who approved the float policy?
4. What is your perception of the collaboration between you and your nurse-peers in the receiving unit?
5. Describe your relationship with peers from the receiving unit when you float?
6. Describe the acuity of patients assigned to you when floating
7. What are examples of support you would need to help you deal with floating?

D) End-of-Interview

Do you have any other comments? Would you like to elaborate further on any part of the interview?

Do you have any recommendation that you would like to make?

Do you have any questions?

There could be a possible second brief meeting for clarification of answers
Please remember not to discuss the interview process, content, or your answers to questions asked with any potential or actual candidates until publication of the study result.

Thank you
Appendix F

Survey Questionnaire to Ascertain Applicants’ Eligibility

1- Are you a licensed registered nurse?
2- Are you hired full-time at this local acute care hospital?
3- Do you experience mandatory floating consistently on a rotational basis?
4- Are you a new graduate in the orientation period?
5- Are you a registered nurse working only by term-limited contract or by per diem?
6- Are you a member of a Flex/float-pool nurses based in this acute care hospital?
7- Do you volunteer to float for extra shifts and overtime pay on your day off.
8- Do you work for a nursing agency?
Appendix G

Flyer/Announcement

If you have any questions about your rights as a research participant you may contact [redacted].
If you have any questions about your rights as a research participant, you may contact Maria Arnold at (786)527-9282, Baptist Health South Florida Institutional Review Board.
Appendix H

Informed Consent: Participants 18 Years of Age and Older

Dear participant,
My name is Marie-Paule M. Lafontant. I am a registered nurse and I am a student at the University of Phoenix working on a Doctoral degree in education with a specialization in curriculum and instruction (EdD/CI) at University of Phoenix. I am doing a research study entitled “Exploring Nurses’ Feelings on Floating: A Phenomenological Study.” The purpose of the research study is to explore the lived experiences of nurses on floating in an acute health care facility within a large American southern city. The central idea is to understand the feelings of 10-15 nurses working full-time in an acute health care institution when floating to a unit other than their unit-base. Your participation will involve meeting with me for a one hour semi-structure interview. I will record, review, and summarize your answers to open-ended questions exploring your feelings on floating, peers’ reaction, and hospital management. It may be necessary to schedule a second, shorter meeting (5-10 minutes) for clarification of responses given. Your participation may be terminated without your consent if you change your status from full time staff to part time or you resign before meeting with the researcher or the interview process.
You can decide to be a part of this study or not. Once you start, you can withdraw from the study at any time without any penalty or loss of benefits. The results of the research study may be published but your identity will remain confidential and your name will not be made known to any outside party.
In this research, there are no foreseeable risks to you (none)
Although there may be no direct benefit to you, a possible benefit from your being part of this study is that the results will provide recent information to scholars in the nursing profession. The hope is that result from this study will enlighten peers and administrators on understanding nurses’ feeling related to the floating phenomenon. It may trigger changes on the floating policy. There is no cost to you for participation.
If you have any questions about the research study, please call me at 305-283-6634 or send me an email at mpmlpa@msn.com
If you have any questions about your rights as a research participant, you may contact Maria Arnold at (786)527-9282, Baptist Health South Florida Institutional Review Board.
In addition, for questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.
As a participant in this study, you should understand the following:
1. You may decide not to be part of this study or you may want to withdraw from the study at any time. If you want to withdraw, you can do so without any problems.
2. Your identity will be kept confidential.
3. The researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. Interviews will be recorded. You must give permission for the researcher, to record the interviews. You understand that the information from the recorded interviews will be transcribed. The researcher will develop a way to code the data to assure that your name is protected.
5. Data will be kept in a secure and locked area. The data will be kept for three years, and then destroyed.
6. The results of this study may be published.
“By signing this form, you agree that you understand the nature of the study, the possible risks to you as a participant, and how your identity will be kept confidential. When you sign this form, this means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here.”

☐ I accept the above terms. ☐ I do not accept the above terms. (CHECK ONE)

Signature of the interviewee ______________________________ Date ____________

Signature of the researcher ______________________________ Date ____________
Appendix I

Signed Confidentiality

Exploring Nurses’ Feelings on Floating: A phenomenological Study
Marie-Paule M. Lafontant

CONFIDENTIALITY STATEMENT

As a researcher working on the above research study at the University of Phoenix, I understand that I must maintain the confidentiality of all information concerning all research participants as required by law. Only the University of Phoenix Institutional Review Board may have access to this information. “Confidential Information” of participants includes but is not limited to: names, characteristics, or other identifying information, questionnaire scores, ratings, incidental comments, other information accrued either directly or indirectly through contact with any participant, and/or any other information that by its nature would be considered confidential. In order to maintain the confidentiality of the information, I hereby agree to refrain from discussing or disclosing any Confidential Information regarding research participants, to any individual who is not part of the above research study or in need of the information for the expressed purposes on the research program. This includes having a conversation regarding the research project or its participants in a place where such a discussion might be overheard; or discussing any Confidential Information in a way that would allow an unauthorized person to associate (either correctly or incorrectly) an identity with such information. I further agree to store research records whether paper, electronic or otherwise in a secure locked location under my direct control or with appropriate safe guards. I hereby further agree that if I have to use the services of a third party to assist in the research study, who will potentially have access to any Confidential Information of participants, that I will enter into an agreement with said third party prior to using any of the services, which shall provide at a minimum the confidential obligations set forth herein. I agree that I will immediately report any known or suspected breach of this confidentiality statement regarding the above research project to the University of Phoenix, Institutional Review Board.

Signature of Researcher

 Printed Name

 Date

Signature of Witness

 Printed Name

 Date
Appendix J

Master List

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Appendix K

Study Methodology Flow Chart

Purpose of the Study

Explore Nurses’ feelings on floating as a lived experience based on Husserl’s Transcendental Phenomenology and Giorgi’s Steps for Data Analysis

Pilot Study

- Recorded 1-on-1 interviews (2 participants meeting the study criteria)
- Observe nurses’ nonverbal cues
- Capture the core of the nurses’ feelings on floating
- Solicit the two nurses’ feedback on the interview questions and process
- Analyze feedback data
- Modify interview process and revise interview questions as appropriate

Primary

- 1:1 Interviews with 10-15 nurses (as determined by saturation)
- Capture Participants’ feelings on the lived experience:
  - Interviewers’ notes
  - Digitally recorded data
  - Observation

Secondary

- Nurses’ feelings on floating
  - Nurses’ perception of floating as a phenomenon
  - Study goal: explore nurses’ feelings
  - Content: factors associated with floating
  - Process/design: 1-Husserl transcendental Phenomenology
  - 2-Giorgi’s framework

Stage 1

- Listen to raw digitally recorded data twice (sense of the whole)
- Transcribe data
- Read transcribed data to capture the essence of floating as a phenomenon
- Bracketing stage

Stage 2

- Transfer data to NVivo10
- Re-read transcripts three times
- Develop meaning units and dominant themes
- Complete first-level coding
- Continue extensive content analysis

Stage 3

- Correlate data on floating with study purpose: second level coding
- Compare themes with secondary data
- Identify revelatory themes
- Grouping of revelatory themes

Stage 4

Combine themes into statements and write final document

Closing Document

- Description of nurses’ lived experience with floating and significance
  - Significance for nurses and patients care
  - Significance for health care leaders
  - Significance for research
  - Submit Final Dissertation to University of Phoenix

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Appendix L

Scanned Permission to Use
PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

Please complete the following by check marking any permission listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☐ I hereby authorize Marie-Paule M. Lafontant, a student of University of Phoenix, to use the premises (facility identified below) to conduct a study entitled “Exploring Nurses’ Feelings on Floating: A Phenomenological Study.”

☐ I hereby authorize Marie-Paule M. Lafontant, a student of University of Phoenix, to recruit subjects for participation in a conduct a study entitled “Exploring Nurses’ Feelings on Floating: A Phenomenological Study.”

☐ I hereby authorize Marie-Paule M. Lafontant, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled “Exploring Nurses’ Feelings on Floating: A Phenomenological Study.”

☐ This study cannot be initiated without prior approval from

[Signature]

Date

[Name]

[Title]
Appendix M

Codebook Development Graphic Representation

Raw Data: Written account of the interviews based on answers to broad/probe interview questions and other relevant information

Data Transcription

Transcripts and Sections Coding, themes identification

Sorting Themes across answers given by different nurses

Codes labeling (primary, secondary) definition, and rationale

Codebook Final version (application and revision)

By: Marie-Paule M. Lafontant February 12, 2014
Appendix N

Giorgi’s Data Analysis Approaches

The search for the essence, according to Husserl, allows the researcher to present findings to others. The essence is that which holds the parts or aspects of the phenomenon together

1. Read and reread descriptions of experience to get a sense of the whole
2. Divide descriptions into meaning units by identifying significant terms
3. Describe the meaning of each unit and relate each to the topic of study
4. Synthesize units into a consistent description of the phenomenon
5. Analyze the transformed units focusing on intentionality of co-researchers
6. Develop a description of the common experience

Giorgi, 1985, as cited in Phillips-Pula et al., 2011, p. 69
### Appendix O

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## Summary of Themes

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Jeanie I didn’t know where anything was. when a patient asks me, “I need this,” like, I don’t know where to find it. You know? I just feel lost…lost is a good word  
Natalie …. Because they think you… it’s the same hospital, so you might know where everything – so you don’t really get an orientation when you float.  
Anna The work environment. It’s not organized.  
Chelsea A little bit of chaos I usually don’t have access to the medication room so it’s very chaotic when I first arrive. There’s a delay throughout my day because I’m not oriented to the unit.  
Bianca I felt that it was kind of disorganized  
Anna There’s not enough communication. Administration could reinforce the rules of creating these protocols Ensure proper hand off report and communication  
David and mainly no orientation with poor communication |
| Chaotic flow              | Poor communication                        | Anna ...worse patients, a lot of patients that are on pain medication. I am giving medication, giving medication, giving medication  
Admissions and discharges  
Carla You can get report from more than 3-4 nurses that… We rarely have that on our floor, but it’s because they don’t keep it, like, wing assigned. They have it all over the place. I see more confused patients.  
Chelsea you do a lot of discharges and admissions on other med surg floors  
Caroline I think the assignment may be unfair at times. The issue is that floaters get the worse patients.  
Jeanie They started all the floats with the most |
| Patients care Assignment  | Fairness of assignment                    | Bianca ...worse patients, a lot of patients that are on pain medication. I am giving medication, giving medication, giving medication  
Admissions and discharges  
Carla You can get report from more than 3-4 nurses that… We rarely have that on our floor, but it’s because they don’t keep it, like, wing assigned. They have it all over the place. I see more confused patients.  
Chelsea you do a lot of discharges and admissions on other med surg floors  
Caroline I think the assignment may be unfair at times. The issue is that floaters get the worse patients.  
Jeanie They started all the floats with the most |
<table>
<thead>
<tr>
<th><strong>Unfamiliar task</strong></th>
<th><strong>Pyxis door code/Access</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline</td>
<td>The frustration comes from not able to function because of some codes for doors, lounge</td>
</tr>
<tr>
<td>Natalie</td>
<td>you keep asking nurses to open the door for you to get your medication</td>
</tr>
<tr>
<td>Jim</td>
<td>You cannot open any door you cannot get your medication. You have to call someone to open them for you</td>
</tr>
<tr>
<td>Bianca</td>
<td>The last time I floated, I waited more than 44 hour—uh—45 minutes, to get, almost an hour—more than an hour! To get access to the Pyxis. And, in the meantime, a patient is calling me for pain medication. I don’t have a code—and I don’t have access to the Pyxis</td>
</tr>
<tr>
<td>David</td>
<td>Sometimes you’re exposed to some things that you don’t really do every day.</td>
</tr>
<tr>
<td>Jim</td>
<td>I have difficulty with some unfamiliar task but I ask the charge nurse who sometimes has patient and can do so much.</td>
</tr>
<tr>
<td>Anna</td>
<td>But patients coming from surgery. Not a—for those different type of procedures. Like, this one had an abdominal procedure. I’m not used to all of those type of procedures. Like, I didn’t know that when they came back, what they were supposed to have.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Work Environment</strong></th>
<th><strong>Unfamiliar environment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carla</td>
<td>It’s a new environment it’s something new, it’s not your daily routine So, here, your patients change, your coworkers change, your clinicians…everybody changes.</td>
</tr>
<tr>
<td>Caroline</td>
<td>The unit you float in is unfamiliar There are units in which everyone is either a floater or from centralized staffing.</td>
</tr>
<tr>
<td>Anna</td>
<td>Disorganized, unstructured</td>
</tr>
<tr>
<td>Bianca</td>
<td>A change.</td>
</tr>
<tr>
<td>Comfort zone</td>
<td>No help or little help</td>
</tr>
<tr>
<td>Caroline</td>
<td>.away from my comfort zone, routine, and unfamiliarity with the work environment I know we have to float but if there are processes in place to make us feel better and function that would help.</td>
</tr>
<tr>
<td>Chelsea</td>
<td>A little insecure out of that comfort zone.</td>
</tr>
<tr>
<td>David</td>
<td>you feel unfamiliar with the floor you’re going to so you’re not in your comfort zone. Either way you’re going to be kind of dislodged.</td>
</tr>
<tr>
<td>Caroline</td>
<td>there is not much help. The nurses are busy themselves and appear overwhelmed.</td>
</tr>
<tr>
<td>Natala</td>
<td>And then… you’re thinking that you</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Psychological Components</th>
<th>Stress/Anxiety</th>
<th>Carla</th>
<th>We—they have a float book, but it’s not a book that is available to the nurses… little bit of anxiety.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Caroline</td>
<td>I am anxious and stressed out.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>David</td>
<td>…so you’re a little bit anxious, it’s a little bit stressful. I think that is frustrating somehow.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Priscilla</td>
<td>As soon as you know you’re floating when you come to your floor in the morning, for most people that I know, you’re already feeling anxiety. I am, for sure.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anna</td>
<td>Feel anxious—Because I know I’m going into chaos.</td>
</tr>
<tr>
<td></td>
<td>Uneasiness/Frustration</td>
<td>Chelsea</td>
<td>My patient asked me for something simple, “pillow or “pillow case.” I can’t find the room. So there’s a little bit of frustration. So that’s an uneasy feeling because you don’t know what to expect.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carla</td>
<td>You never know when you’re going to float. You look at the board, your name is not there. That’s how, you know, my name is not there; you are floating. Very unpleasant.</td>
</tr>
<tr>
<td></td>
<td>Unpleasant</td>
<td>Jeanie</td>
<td>I feel like I don’t have control. Like, I feel like I lose control when I’m out there.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mary</td>
<td>…But it can be overwhelming when you’re not used to it being your floor. So I would say it’s overwhelming for me.</td>
</tr>
</tbody>
</table>
| Nervous | Mary… and a little nervous.  
Jeanie I get anxious. I don’t look forward to it.  
Nervous  
Jim I am scared, anxious, stress out, uncomfortable fearing I am going to have a bad day. I could have a bad day any day in my own unit but I have my usual coworkers and routine. |
|---|---|
| Scared | Sociological factors  
Unfriendliness  
Mary Others don’t even say two words to you  
Caroline Some nurses are friendly and helpful, others just ignore you In some areas you do not feel welcome.  
Jeanie Some are friendly. Not all  
Jim I do not feel welcome and feel like a burden Some areas have very friendly nurses… Other areas have less friendly people or some ignore you altogether. |
| Unwelcomed | Physiological Needs  
Meal break  
David Sometimes you feel unwelcomed  
Jeanie Some are friendly. Not all  
Jim I do not feel welcome and feel like a burden Some areas have very friendly nurses… Other areas have less friendly people or some ignore you altogether.  
Mary Others don’t even say two words to you  
Natalie Because you don’t know the floor, you’re kind of… busy. And you might end up missing your break.  
Priscilla So, my meal break I always get, because you need to eat, but it may be a little bit later… and shorter—I didn’t have lunch until 4. |

Note. *Pyxis = an up-to-date automated medication dispenser, which functions on granted access (last six digits of nurses’ social security combined with employee identification number or one fingerprint. Nurses can only access a Pyxis in their home-unit except in rare exceptions.*