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Floating Nurses to Specialty Areas

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Floating Nurses to Specialty Areas

by

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Abstract

As the largest group of health care providers, nurses play a vital role in the safety and satisfaction of patients. Despite this vital role, the nursing shortage continues to grow. As a result of this shortage and to fix staffing insufficiencies, nurses are frequently assigned to work in an area that they are not familiar with. This reassignment of a nurse to a different unit from their normally assigned unit is referred to as "floating." Nurses that are reassigned to a different unit from their normally assigned unit are referred to as "float nurses." Some healthcare professionals believe the use of float nurses to provide care compromises patient outcomes, safety, and satisfaction. The purpose of this study was to evaluate the perceptions of registered nurses regarding the use of float nurses to provide care. The participants consisted of 33 registered nurses all working in the acute care setting. Of the 33 participants who responded, the majority (55.3%) worked on a critical care unit. The majority (65.8%) of the participants had been floated to a unit that requires different competencies than their primary assigned unit. The participants completed 13 questions related to their perception of the use of float nurses to provide patient care. Statistical analysis revealed the majority of nurses most strongly agreed with the following four questions: (1) RNs should receive special training prior to being floated to a unit other than their primary unit, (2) RNs floated to a unit different from their primary unit should be recognized on the clinical ladder, (3) RNs who are floated are provided extra support, and (4) RNs floated should be given lighter patient assignment. The majority of nurses most strongly disagreed with the following three questions: (1) RNs floated to a unit different than their primary unit provide safe care to

their patients, (2) RNs should be floated, and 3) RNs are satisfied with the level of care

provided by RNs who are floated to their unit.

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CHAPTER I

Introduction

Nurses are the largest group of healthcare service providers in the nation (Hughes & Clancy, 2009). In response to the nursing shortage, nursing executives meet the challenges of increasing patient days and hours of nursing care by floating staff or temporarily relocating nurses from their assigned unit or area to a different unit or area to care for patients for that shift for several hours. Floating is seen as essential for nursing to survive in today's healthcare environment (Rudy & Sions, 2003). As the nursing shortage continues to grow, it is important to understand the effects of floating on the patient, as well as the nurse. In a study by Kane, Shamliyan, Mueller, Duval, and Wilt (2007), it was noted that use of non-permanent staff increases the patient risk for health care associated infections (Hyun, Bakken, Douglas, & Stone, 2008). "Today's patient demands a nurse with specialized skills. The absence of necessary knowledge and skill has resulted in poor nurse-patient rations, further intensifying the shortage" (Edmunds & Scudder, 2009).

Statement of the Problem

Today in nursing, competency is a subject of great importance. Nursing competency has a direct effect on patient health, safety, and outcomes (Axley, 2008). The gap between supply and demand for RNs in 2000 was estimated at 110,800 full-time employees with this shortage predicted to increase to a deficit of 1 million nurses, with 36% of RN positions vacant by 2020 (Edmunds & Scudder, 2009). Nurses are the "front line" staff in most health care systems. As the main professional component they are recognized as essential to delivering safe and effective care. Research has shown there is a direct link between nurse staffing levels and patient care outcomes. Nursing shortages,

along with understaffing have been linked to the following negative outcomes; increased

mortality rates, adverse events after surgery, increased cross infection rates, increased

accident rates and patient injuries, and increased incidence of violence against staff

(Buchan & Calman, 2004).

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Purpose

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The purpose of this study was to identify registered nurses' perception of the use

of float nurses to provide patient care. Understanding registered nurses' (RNs) perception

of the effect of being relocated to a unit or area different from their assigned unit has the

potential to increase nurse retention, improve patient care, and increase patient and nurse

satisfaction with the healthcare setting.

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Conceptual Framework

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Patricia Benner's Novice to Expert theory was used to guide this study of RNs'

perception of the use of float nurses to provide patient care. In Benner's theory there are

five levels of skill acquisition in clinical nursing: Novice, Advanced Beginner,

Competent, Proficient, and Expert. Benner views the novice nurse as lacking background

experience to the situation they are involved in and not having the ability to differentiate

between relevance and irrelevance. A novice nurse requires guidance.

The advanced beginner nurse has enough experience to grasp the situation they

are involved with. They are oriented by task completion but still do not grasp the

situation on a larger perspective. An advanced beginner nurse still relies on help from the

more experienced nurse, but can demonstrate marginally acceptable performance because

of real life situations they have dealt with. An advanced beginner nurse is guided by rules

and oriented by task completions. In this study, the registered nurse floated to a unit or

area different from her assigned unit was considered to be an advanced beginner in the unit floated to.

A competent nurse is a nurse who is identified by consistency, predictability, and time management skills. A competent nurse begins to determine which elements of the situation warrant attention and which can be ignored. A proficient nurse is one who perceives the situation as a whole, the total picture. They see relevance in the situation. In this study, the registered nurse is considered to be a competent nurse in their assigned unit.

A proficient nurse is much more involved with the patient and the family, and is able to recognize and implement skills to changes in the patient as they evolve. The proficient nurse is confident in their self. An expert nurse is one who no longer relies on the analytical principle to connect the understanding of the situation to an appropriate action.

An expert nurse sees the big picture, possesses know-how, demonstrates a clinical grasp, has resource-based practice, and can see the unexpected. An expert nurse knows their patient (Tomey & Alligood, 2006).

Benner considers the aspects of a situation that nurses recognize because of previous experience and attributes of a situation that can be explained without previous experience in the situation in determining skills level of nurses. She defines competency as "an interpretively defined area of skilled performance identified and described by its intent, functions, and meanings". In this study competency is considered to be the level of care nurses provide in the reassigned area.

Benner identifies domain as an area of practice having a number of competencies with similar intents, functions, and meanings. In this study, domain is considered to be the type of unit the registered nurse is primarily assigned to.

Research Question

The research question for this study is: What is Registered Nurses' perception of the use of float nurses to provide patient care?

Assumptions

The following assumptions were made for this study:

- Registered nurses, upon employment, are assigned to a particular patient care unit or area in the acute care setting.

- Registered nurses are reassigned or "floated" to provide patient care in areas or units different from their regularly assigned unit.

- Registered nurses acquire a level of competency based on their experience in their assigned unit or area.

Operational Definitions

The concepts for this study are float nurse, patient care unit, and clinical competence. In this study, the float nurse is defined as a registered nurse who is reassigned to a patient care unit or area different from his or her permanent unit. Patient care units or areas are nursing units that provide patients with care based on a particular diagnosis, age, severity of illness, or procedure. Clinical competence is the knowledge and skills learned through clinical practice and experiences that has a direct and positive effect on the health, safety, and outcomes of patients. In this study, clinical competence

includes skills performance related to an area of patient care which is acquired through orientation, training, and experience in that area.

CHAPTER II

Literature Review

An intense review of the current, existing research literature revealed a scarcity of research on the topic of the use of float nurses to provide patient care in the acute care setting. Because of the lack of literature available on this topic, research is needed to determine the impact of the use of float nurses on clinical competence, the nursing profession, and patient outcomes.

A study by Liu, Kalisch, and Zhang (2007) assessed the safety culture as perceived by clinical nurses in acute care hospitals in China. The sample was 217 registered nurses from 19 different hospitals in a large city in central-southern China. The nurses were recruited from a patient safety related seminar and were either a staff nurse or a nurse manager. Participation was voluntary and anonymous. The rate of participant response was 82.5%. The subjects were given a two part survey questionnaire that addressed demographics and safety culture questions. The questionnaire was designed based on several currently used safety culture assessment tools. The questionnaire domains were leadership and management toward patient safety, feedback and communication about errors, staffing, nonpunitive error reporting, learning from errors, staff cooperation, and perceptions of overall inpatient safety. The following aspects of safety culture were reported by the majority of respondents to exist in their facility: shift change procedures, hospital and nursing leadership giving patient safety a priority, encouragement of the reporting of errors, open discussion about errors and their prevention, and staff teamwork. The respondents also indicated that the following indicated a lack of safety culture: inadequacy of staffing, lack of hospital safety

committees, staff feeling fearful to report errors, and the existence of punishment and shame for the staff making an error. Of the respondents, 51.6% indicated the safety level of patients was hard to judge, 36.4% considered it safe or very safe, and 9.7% thought the care was unsafe or very unsafe. Looking at the respondents' age, gender, and education or type of service there was no significant differences in perceptions of the safety culture in China's hospitals. However, those who responded from a larger hospital reported a more positive atmosphere of open discussion about errors than those from smaller hospitals (p =.012). The nurse managers and the nurses' perception of equal attention to both patient safety and staff safety varied, with nurse managers indicating a more positive response (p =.03).

The limitations of this study were the use of only one city in China which limits the generalizability of the study. The researchers recommend a larger-scale investigation be completed among nurses in various parts of China (Liu et al., 2007).

A study by McHugh (1997) explores the use of computer simulation modeling to examine the costs and staffing outcomes of two different "float" policies in a Midwestern Veterans Administration (VA) hospital. The research questions were: (1) Does unrestricted floating throughout the hospital produce a better fit between patient care requirements and nursing resources than float policies which restrict the number and type of units to which an individual nurse may be floated? (2) Does unrestricted floating throughout the hospital produce lower wage costs than a staffing pattern in which supervisors are restricted from floating nurses to unfamiliar units? The study was conducted at a 400-bed, tertiary care VA hospital in the Midwest. One simulated year of model performance in a patient care unit was the unit of study. The two staffing patterns

were simulated for 10 years in 11 different patient care units, which produced a sample size of 220 "unit years." The replicated hospital had approximately 300 beds that were actually used on a daily basis and had general medical, surgical, and psychiatric care services. Since the hospital nurses did not cover staffing shortages in the outpatient clinics and extended care services that existed, they were not used in the study. The staffing pattern used by the subject hospital was clustered unit floating (CUF). The simulation language used was the Henriksen Implementation of the General Purpose Simulation System available from Wolverine Software. The independent variable was staffing pattern, which had two levels, unclustered verses clustered unit transfers. Additional variables that were constant for the two simulation models were hospital unit structure, mean unit workload, daily workload variation, and mean staffing levels. The dependent variables were direct hourly wage costs, number of understaffed shifts per year, number of overstaffed shifts per year, and cost of overstaffing. Results of the study revealed there was no significant difference between restricted and unrestricted unit transfer staffing patterns for direct wage costs (t[9]=.05, p=NS), that UUF staffing pattern produced significantly fewer understaffed shifts per year than the CUF pattern (t[9]=29, p<.01), and there was no significant differences between the two staffing patterns for costs of overstaffing (t[9]=3, p=NS). Since the staffing costs between the two patterns do not differ, it may be beneficial to look at the quality of nursing care and staff satisfaction between the two (McHugh, 1997).

Kirchhoff and Dahl (2006) explored information collected in a national critical care survey developed by the American Association of Critical-Care Nurses (AACN). The survey was divided and administered in two phases, the facility phase and the unit

phase. To participate in the facility phase, the hospital must have had one or more of the following types of units: any type of ICU, step-down units, progressive care units, telemetry units, PACUs, and other units where nursing care is provided for acutely and critically ill patients. Exclusions were hospitals that had less than 50 beds. The numbers of eligible facilities included in the sample were 658. Of the 658, only 120 (18.2%) participated. During the unit phase the responding facilities were asked to submit lists of their critical care units, including progressive care units, telemetry units, step-down units, and PACUs, and to provide contact information for the unit managers (Kirchhoff & Dahl, 2006). There were 576 critical care units listed from the 120 responding facilities. The unit managers of the 576 critical care units were sent the unit phase of the survey. Of the 576 critical care units, 300 (52.1%) responded to the questionnaire.

Data for a full 12 month period was requested to be submitted, preferably from the most recent completed fiscal year. The facility survey included questions on the following topics: demographics about operations, evaluations, nursing staff reimbursement and incentives, staffing, quality indicators, and information on critical care units and contact information for critical care unit managers. The unit survey included questions on the following topics: operations, acuity systems, staffing, policies on visitation and end-of-life care, administrative structure, documentation, certification, professional advancement, vacancy/floating, staff satisfaction, orientation, association membership, wages of registered nurses (RNs), advance practice nursing, and quality indicators.

Of the 120 responding facilities, 52% provided information on budgeted RN full-time equivalent (FTE) positions. In regards to staffing, respondents were asked which

factors they considered in determining the number of nurses needed for their basic

staffing plans. The most commonly considered factor, by 88%, was the expected patient

outcomes. Ranking next was the need for specialized skills and the skill mix of the staff.

Respondents were also asked what they used when they needed to adjust staffing to

manage sudden or emergency admissions or sudden increase in patients' acuity. The most

commonly used strategy, by 70% or more, was calling in regular staff RNs on their days

off, calling in regular staff RNs early, and juggling current RN staff to make do. The next

most used method was floating RNs from other critical care areas, with floating RNs

from non-critical care areas being the least favored. In the study, the most predominate

way units managed floating among their staff was via clustered unit floating (55%).

Clustered unit floating requires staff to be floated, but to designated units only. Of the

remaining units, 23% were required to float to any unit within the facility, and 19% were

not required to float outside their unit. The study also revealed that progressive care units

were more likely to float RNs from non-critical care areas. A limitation to this study was

that the unit results did not reflect hospitals nationwide, allowing the total results for each

question to be skewed to the activities of the more dominant units in the sample

(Kirchhoff & Dahl, 2006).

A study to explore assessing nursing competence and whether the Australian

National Competency Standards (ANCI) for registered nurses demonstrates correlations

with the Finnish Nurse Competency Scale (NCS) was done by Cowin et al. (2008). A

cross-sectional non-experimental survey design was used to gather data from new

graduate nurses participating in a yearlong transition to Graduate Nursing Program at

three acute care public hospitals located in metropolitan Sydney, Australia. The

convenience sample was 116 new graduate nurses. The participants completed both the ANCI and the NCS. The ANCI consist of four domains with 14 elements. Within the 14 elements are 51 items. The domains are professional and ethical practice, critical thinking and analysis, management of care, and enabling. The NCS consist of seven domains and contains 73 items. The seven domains are teaching-coaching, diagnostic functions, managing situations, therapeutic interventions, ensuring quality, and work role. Examination and interpretation of the correlational matrix for the ANCI and NCS domains and factors convergent validity was tested. Pearson's r was calculated to determine the amount of convergence and demonstrated a positive correlation (0.75) between measures. A number of statistically significant relations between the two competency measures were revealed with the correlational analysis.

The results of this study demonstrated convergent validity for the ANCI and NCS as total measures, and high correlations for the domain of enabling (ANCI) and the factor of helping (NCS) at 0-75. The researchers believed the "high correlations in this study demonstrates that the items measured are probably related to same construct. However, this does not automatically mean that it is the construct of competency." Recommendations for further assessment using a greater variety of competency assessment measures and the MTMM method to provide clearer evidence of convergent validity were made.

A study by Reineck and Furino (2005) explored the nursing workforce, the personal aspects of being a nurse, and the numerous challenges of the nursing profession today. A cross-sectional descriptive study design was used. A stratified random sample of 3, 296 RNs was selected from a population of 153,626 RNs who held a valid, unrestricted

license to practice as an RN in Texas. Surveys were mailed to members of the sample with a response rate of 34%. The statistical software, SPSS-X version 11, was used to analyze the quantitative data. Qualitative data analysis was used to analyze one open-ended question.

The average age of a working Texas RN was 44.5 years. The response from the Texas RN workforce compares to the national workforce in respect to age, gender, and education. Of the employed RNs, 63% work in acute care hospitals. That is a 17% decrease since the year 2000. The average time a RN has been employed at the same facility is 7.4 years. The most frequently reported work environment issues were increased paperwork (82%), increased severity of illness (70%), RN turnover (61%), voluntary overtime (53%), need for second language skills (58%), government regulations (64%), and pressure to reduce time "on the clock" (51%). Texas RNs (55%) also reported an increase in the number of patients assigned. This is similar to the national trends tied to adverse outcomes for both nurses and patients. In the handwritten comment section, 17% of RNs reported staffing as the second most frequently reported workplace issue. From the comment section the following eight main themes emerged; workload, results of heavy workload, shifting staffing, inconsistency between perceptions by clinical nurses and those by administration, staffing shortages among support staff, need for state intervention, staffing shortages on night shifts, and impact of patient severity of illness. In regards to theme shifting staffing, the assigned levels of nurses were perceived as inadequate and floating and reassigning was perceived as disruptive. In regard to work satisfaction, 75% of RNs report general satisfaction, 72% report

exhaustion, and 59% report frustration. A limitation noted in this study was the small

number of responding RNs to the survey (N=801).

CHAPTER III

Methodology

Research Design

The study to explore registered nurses perception of the use of float nurses to provide patient care is a descriptive quantitative study utilizing survey methodology. The descriptive design allows one to gain knowledge and a clear picture of how registered nurses perceive the effect of the use of nurse floating to provide patient care.

Sample

The sample for this study included registered nurses working in acute care hospitals in selected regions of eastern and western North Carolina. Inclusion criteria included employment in a primarily assigned unit in an acute care hospital on a full or part time basis. Registered nurses working on an as needed basis were excluded from the sample.

Setting

The RNs participating in the study were employed in acute care hospitals providing patient care in eastern and western North Carolina. The acute care hospitals provide care for all ages and populations and include community and tertiary care. The hospital services include emergency, medical, surgical, critical care, pediatrics, behavioral health, rehabilitation, women's health, interventional cardiology and radiology, outpatient surgery, and Cardiac Rehabilitation.

Ethical Considerations

Prior to data collection, the study was approved by the Gardner-Webb University Institutional Review Board. An informed consent form advising the participant of their

rights was distributed along with the survey questionnaire (Appendix A). Participants were instructed to refrain from putting any identifying marks on the surveys to maintain anonymity and confidentiality. Participation in the study was completely voluntary. There was no compensation or benefits to encourage or discourage participation of registered nurses in this study.

Instrument/Measurement Methods

The researcher questionnaire, Registered Nurses' Perception of Nurse Floating (RNPNF), consists of 13 items to assess perception of nurse floating on a Likert scale ranging from one - strongly disagree to five - strongly agree. The RNPNF was evaluated by two experienced nurse managers for face validity. Expert number one had 12 years of experience as a nurse manager and 27 years of experience working with nurses floated from other units. Expert number two had 11 years of experience as a nurse manager and 35 years of experience working with nurses floated from other units. In addition, the RNPNF was piloted with two experienced registered nurses for clarity and ease of completion. Experienced RN one had 14 years of practice as an RN and 13 years of employment on the current unit, and took two minutes to complete the survey. Experienced RN two had 28 years of practice as RN and 16 years of employment on current unit, and took 20 minutes to complete the survey. Both RNs recommended no addition or removal of any questions on the RNPNF.

The survey packet included the RNPNF and a Demographic Information sheet (Appendix B). The Demographic Information sheet ascertained the participant's employment in acute care, type of unit, experience with floating, educational level, years of RN experience and years of employment on their current unit.

Data Collection Procedure

Registered Nurses participation was solicited at professional meetings, and through friends via Facebook and email. Those agreeing to participate were mailed the survey packet consisting of the informed consent form, the RNPNF and the Demographic Information sheet, and a return self-addressed stamped envelope.

CHAPTER IV

Results

Demographics

The participants consisted of 33 registered nurses all working in the acute care setting. A total of 33 completed Demographic Information sheets and RNPNF research questionnaires were collected. Of the 33 participants who responded, the majority (55.3%) worked on a critical care unit. The following Table 1 illustrates the frequency and percent of the nurses' primary assigned unit.

Table 1

Frequency and Percentage of Type of Unit Primarily Assigned to Work

	Frequency	Percent
Medical Unit	5	13.2
Surgical Unit	6	15.8
Critical Care Unit	21	55.3
Emergency Department	2	5.3
Behavioral Health Unit	2	5.3
Women's Health Unit	1	2.6
Out Patient Surgery, Endoscopy, Pain		
Clinic, Medical Treatments	1	2.6

The majority (65.8%) of the participants had been floated to a unit that requires different competencies than their primary assigned unit. The current educational preparation of the participants was almost equally divided between associate degree (36.8%) and bachelor degree (36.8%). The following Table 2 illustrates the frequency and percentage of the sample according to current educational preparation.

Table 2

Frequency and Percentage of Participant's Educational Level

	Frequency	Percent
Associate Degree	14	36.8
Bachelor Degree	14	36.8
Master Degree	4	10.5
Diploma	1	2.6
Total	33	86.8
Not indicated	5	13.2

The participants' years of practice as a RN ranged from one year to 43 years with the mean years of practice being 15.24 years. The participants' years of employment on their current unit ranged from three months to 43 years, with the mean years of employment being 7.41 years. Table 3 illustrates the measures of central tendency for the participants' years of practice and employment on their current unit.

Table 3

Mean and Standard Deviation of Years of Practice as RN and Year of Employment on Current Unit

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Years of Practice	33	1	43	15.24	11.048
Employment on current unit	33	.3	43.0	7.409	7.9620

Perceptions Related to Nurse Floating

The participants completed 13 questions related to their perception of the use of float nurses to provide patient care. Statistical analysis revealed the statements on the RNPNF that the participants most agree with and least agreed. The majority of nurses most strongly agreed with the following four questions: (1) RNs should receive special training prior to being floated to a unit other than their primary unit, (2) RNs floated to a unit different from their primary unit should be recognized on the clinical ladder, (3) RNs who are floated are provided extra support, and (4) RNs floated should be given lighter patient assignment. The majority of nurses most strongly disagreed with the following three questions: (1) RNs floated to a unit different than their primary unit provide safe care to their patients, (2) RNs should be floated, and (3) RNs are satisfied with the level of care provided by RNs who are floated to their unit. The following Table 4 illustrates the measures of central tendency for each of the 13 questions on the RNPNF.

Table 4

Mean and Standard Deviation of Questions on the RNPNF

	Mean	Std. Deviation
I feel registered nurses should be competent to provide care for patients in any area in the acute care setting.	3.82	1.211
I feel registered nurses floated to a unit different than their primary unit provides safe care to their patients.	3.06	.966
I feel registered nurses should receive special training prior to being floated to a unit other than their primary unit.	4.15	.939
I feel registered nurses should be monetarily compensated for being floated to a unit other than their primary unit.	3.82	1.211
I feel registered nurses floated to a unit different from their primary unit provide satisfactory patient care.	3.18	.882
I feel registered nurses floated to a unit different from their primary unit should have a minimum of two years of registered nurse experience.	3.91	1.027
I feel the ability of registered nurses to float to a unit different from their primary unit should be recognized on the clinical ladder.	4.30	.847
I feel registered nurses should be floated to a unit different from their primary unit.	2.75	.950
I am satisfied with my work experience when I am floated to a unit different from their primary unit.	3.27	1.098
I am satisfied with the level of care provided by registered nurses who are floated to my unit.	3.06	.982
I provide extra support to registered nurses who are floated to my unit.	4.38	.609
I feel registered nurses floated to a unit different from their primary unit should be given lighter patient assignments.	4.15	.755
I feel registered nurses should not be floated to a unit requiring different competencies than their primary unit.	4.00	.968

The majority of RN participants agreed or strongly agreed with eight of the questions on the RNPNF. Sixty percent of the sample felt registered nurses should be competent to provide care for patient in any area in the acute care setting. Seventy-one percent of the sample agreed registered nurses should receive special training prior to being floated to a unit other than their primary unit. The majority of the sample (52.6%) believed registered nurses should be monetarily compensated for being floated to a unit other than their primary unit. Fifty-seven percent of the sample believed registered nurses floated to a unit different from their primary unit should have a minimum of two years of registered nurse experience. The majority of the sample (70.7%) agreed or strongly agreed that the ability of registered nurses to float to a unit different from their primary unit should be recognized on the clinical ladder. Seventy-nine percent of the sample agreed or strongly agreed that they would provide extra support to registered nurses who were floated to their unit. The majority (73.6%) of the sample agreed or strongly agreed that registered nurses floated to a unit different from their primary unit should be given lighter patient assignments. Sixty-three percent of the sample believed registered nurses should not be floated to a unit requiring different competencies than their primary unit.

CHAPTER V

Discussion

A competent nurse has the foresight to see and to respond appropriately to planned and unanticipated situations. Competent professional nurses understand their own limitations and are able to autonomously provide safe care according to defined responsibilities, professional standards, education, and qualifications. A nurse that has a sound feeling of competency in the professional role of nursing is more apt to work as a team member and appreciates the roles and points of view of the coworkers. Benner emphasizes nursing practice requires the nurse to integrate skills and knowledge that are learned with a quality of character and expertise, which is developed with ongoing education and experience (Axley, 2008).

Interpretation of Findings

The research study had a total of 33 registered nurses who worked in the acute care setting participate. There was a strong agreement among the majority of RNs regarding using nurse floating to provide patient care. The nurses strongly felt that nurses should receive special training prior to being floated to a unit other than their primary unit, that nurses who float to a unit different from their primary unit should be recognized on the clinical ladder, that they provide extra support to registered nurses who are floated to my unit, and that registered nurses floated to a unit different from their primary unit should be given lighter patient assignments. The nurses also strongly felt that safe care was not provided to their patients by RNs who floated to a unit different than their primary unit, that RNs should not be floated to a unit different from their primary unit,

and that they were not satisfied with the level of care provided by RNs who are floated to their unit.

Implications for Nursing

Nursing shortage continues to be a challenge for healthcare and healthcare nursing executives. As the challenge continues, the effects of patient safety and outcomes must be considered when nurse floating is used as an option to staff nursing units on a temporary basis. Studies have linked poor patient outcomes to using nurse floating to fix staffing issues. The study of nurses' perception of nurse floating to provide patient care correlates with current research when it comes to patient safety and outcomes. Nurse floating also effects nursing satisfaction. In turn, nurse satisfaction has a direct relationship with the nursing shortage. "The decision to float nurses to units in which they are unfamiliar with the patient problems and nursing care has long been cited as a reason for dissatisfaction and turnover" (McHugh. 1997, p. 294).

Implications for Further Research

The study explored registered nurses perception of nurse floating to provide patient care. Due to the effects nurse floating has on patient safety and quality of care, the researcher suggests further research into a solution other than nurse floating needs to be investigated and evaluated. Nurse floating not only has its negative effects on patient safety and quality of patient care, it also has its negative effects on nurse satisfaction and the nursing shortage. The nursing shortage is one of the most problematic current human resource challenges (Buchan & Calman, 2004). Therefore, healthcare requires an option that does not affect patient safety, quality of care, or further contribute to the nursing shortage.

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Appendix A

Study Title: Registered Nurses' Perception of Nurse Floating

Investigator: Deborah Hickman, RN, BSN

Dear Registered Nurse,

As part of the requirements for the Master of Science in Nursing Degree, I am conducting a study about registered nurses' perception of the use of nurse floating to provide patient care. You are being invited to take part in this research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

The purpose of this study is to examine perceptions of registered nurses, employed in the acute care setting, regarding the use of nurse floating to provide patient care. Nurse floating is defined as the temporary relocation of a nurse from his or her permanent unit to another unit to provide care for patients for that shift or for several hours. Your expected time commitment for this study is approximately 30 minutes. You are being asked to complete two brief surveys. Please circle the most appropriate response to each question based on your perception.

The risks of this study are minimal. These risks are similar to those you experience when disclosing information to others. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose. There may be risks that are not anticipated. However, every effort will be made to minimize any risks.

There will be no direct benefit to you for your participation in this study. However, we hope the information obtained from this study may be used in assigning nurses to provide patient care in the acute care setting. There is no monetary compensation to you for your participation in this study.

If you do not want to be in the study, you may choose not to participate and leave your answers blank or decline to return the survey packet. Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you do decide to take part in this study, your return of the survey will be considered your consent. If you decide to take part in this study, you are still free to withdraw at any time and without giving a reason. You are free to not answer any question or questions if you choose.

Your responses will be anonymous and confidential. Please do not write any identifying information on your questionnaire. Should you have any questions about the research or any related matters, please contact the researcher at dhickma1@gardner-webb.edu or phone 704-856-0318 or my professor, Rebecca Beck-Little at rbeck-little@gardner-webb.edu or phone 704-480-8126.

By returning the survey packet, I confirm that I have read and understood the information. I understand that my participation is voluntary and that I am free to withdraw at any time.

Appendix B

Demographic Information:

1. Are you employed in an acute care setting?

    _____ Yes

    _____ No

2. Type of unit you are primarily assigned to?

    _____ Medical

    _____ Surgical

    _____ Critical Care

    _____ Emergency Department

    _____ Pediatrics

    _____ Behavioral Health

    _____ Rehabilitation

    _____ Women's Health

3. Have you ever been floated to a unit that requires different competencies than your primary unit?

    _____ Yes

    _____ No

4. Current educational level:

    _____ Associate Degree

    _____ Bachelor Degree

    _____ Masters Degree

    _____ Doctoral Degree

5. Years of practice as an RN: _____

6. Years of employment on your current unit: _____

Registered Nurses' Perception of Nurse Floating

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I feel registered nurses should be competent to provide care for patients in any area in the acute care setting.					
I feel registered nurses floated to a unit different than their primary unit provides safe care to their patients.					
I feel registered nurses should receive special training prior to being floated to a unit other than their primary unit.					
I feel registered nurses should be monetarily compensated for being floated to a unit other than their primary unit.					
I feel registered nurses floated to a unit different from their primary unit provide satisfactory patient care.					
I feel registered nurses floated to a unit different from their primary unit should have a minimum of two years of registered nurse experience.					
I feel the ability of registered nurses to float to a unit different from their primary unit should be recognized on the clinical ladder.					
I feel registered nurses should be floated to a unit different from their primary unit.					
I am satisfied with my work experience when I am floated to a unit different from their primary unit.					
I am satisfied with the level of care provided by registered nurses who are floated to my unit.					
I provide extra support to registered nurses who are floated to my unit.					
I feel registered nurses floated to a unit different from their primary unit should be given lighter patient assignments.					
I feel registered nurses should not be floated to a unit requiring different competencies than their primary unit.					